COMMENTARY

Audit

NHS Direct
A Lee

Commentary on the review by McLellan

As recognised by the National Audit Office, in just five years, NHS Direct has established an impressive track record for customer satisfaction and patient safety, empowering patients to make better informed choices about their own healthcare. It has also clearly identified its potential to contribute to wider developments in the NHS. Building on this success the government is investing in NHS Direct to meet the anticipated growth in demand for its core service and to enable the service to play its part in the modernisation of out-of-hours services.

In this issue, McLellan highlights appropriately the multi-channel aspect of provision via telephone, digital television, internet, and information kiosk. He also rightly identifies some of the challenges facing the service. The move to a single national provider from the current association of 22 separately hosted sites will play a significant role in meeting these challenges; there have already been several key developments in the service made possible specifically by this direction of development, as set out in Developing NHS Direct.

NHS Direct introduced standard national reports for clinical indicators in the spring of 2003. These include the sorting of symptomatic calls, rates of use of algorithms to support assessment, and rates of selection of a different endpoint than that recommended by an algorithm. The reporting is done at site and individual clinician level. Together with other elements of NHS Direct’s Performance Framework, such as use of standard national call monitoring tools, this will form one of the most highly developed systems of performance monitoring of a large group of individual clinicians in the NHS.

As with any performance management, great care has to be taken to avoid unintended pitfalls, including misinterpretation. There are multiple factors that potentially contribute to variation in performance, such as the age/gender profile of callers, the proportions of core 0845 and GP out-of-hours work undertaken, and even the precise arrangements with different OOH providers. The ‘significant variability’ stated by McLellan is therefore an over-simplification at this early stage after introduction. Work to clarify the degree to which apparent variation in the clinical indicator reports represents actual variation in performance is ongoing but clinical indicator targets, taking account of internal and external studies to date, were set in October and sites are beginning to manage clinical performance against these.

One example of the further work being done is the Gold Standard Sorting Study. Throughout July 2003, a major study was undertaken to benchmark NHS Direct against GPs in clinical risk tolerance for primary presentations (first point of contact) by telephone. One hundred and twelve GPs from across the whole of England and Wales have taken part in this study; the results will be submitted for publication and have been used to contribute to the sorting of indicator targets.

Managing peaks in demand is not new to NHS Direct. The call volumes for Christmas week 2002 were 50% higher than the average weekly volume in the autumn of 2002. There are a number of technical, process, and staffing developments already underway, some of which McLellan refers to, that will increase NHS Direct’s capacity and efficiency so that the increased call volumes over the next few years will not require a pro rata increase in staffing to that currently in post.

Increasing consistency, transparency, and system development are three of the challenges raised. This autumn will see the roll out of a standard national process of initial prioritisation of calls incorporated in the clinical support software. Prioritisation of calls has been done since NHS Direct started in 1998, but up to now has been done in multiple ways at different sites. NHS Direct has also introduced new governance arrangements for NHS CAS (Clinical Assessment System) since Easter and the peer review process has also recently evolved using lessons learned from earlier practical problems in engaging a wide range of expert opinion. Objectives for NHS CAS development now include the ability to analyse links between individual nodes in the algorithms and endpoints plus the ability to receive feedback on outcomes.

Paediatric calls are a very important part of NHS Direct’s work. In the first quarter of 2003–04, 24% of NHS Direct’s calls were for children aged up to 14 years (over two thirds of these for children up to 5 years). The lack of specific focus on paediatrics in the publications on NHS Direct referenced is not a reflection of ‘indifference’ in the service. NHS Direct has worked with CHI on development of the child protection self audit tool for Boards released earlier this year, with the NSPCC on guidance and training, and is contributing to work on the NSF for Children. Sites have developed training in consultation skills specific to paediatrics with advice from paediatric departments and there is a precedent for developing these into a standard national form; for example, the ‘SCAN’ training NHS Direct already uses to train staff in consultation skills for mental health issues. There is more to be done and the service is not complacent about this aspect of its work. I am grateful for Dr McLellan’s input to NHS Direct during his term as RCPCH Lead for NHS Direct and look forward to working with his successor to continue to address the challenges of this next period of development.

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Commentary on the paper by Benninga et al

When the editorial committee discussed whether to accept the paper by Benninga et al for publication, some members raised concerns over the propriety of undertaking rectal manometry on children with abdominal pain. In response, the authors promptly provided their correspondence with the appropriate ethical committee (institutional review board). These revealed that the authors had properly obtained approval for the investigation in constipated children, their siblings (following fully informed consent), and those undergoing endoscopy for other conditions.

We accepted the authors’ explanation that the children with a prime complaint of abdominal pain had been referred to their specialised dysmotility clinic. The inference is that those referring the patients considered their pain might be due to constipation.

They wrote: “... in our outpatient clinic, the standard work-up for all children with functional defecation disorders or functional abdominal pain (irritable bowel syndrome or recurrent abdominal pain) includes a thorough medical history and complete physical examination, colonic transit studies, and rectal barostat studies.”

A related issue was raised recently in the correspondence columns of Thorax concerning a paper detailing bronchial biopsies performed, as a research procedure, on children with asthma whose prophylactic medication had been discontinued for the preceding month.

Bush and colleagues pointed out that bronchial biopsy would be included among those high risk procedures which the Royal College of Paediatrics & Child Health considers unjustified for research purposes alone. The investigators, who practice far from the guiding light of the RCPCH, responded that informed consent was received from parents (they did not state whether children consented) and that, in any case, they watched the children closely with a view to exclude any disadvantage by cessation of prophylaxis.

So here is the dilemma: research projects require ethical committee approval while standard clinical practice may require only informed consent. In the case of the paper published in this issue, it seems that at some point research had elided seamlessly into routine practice. Once a procedure becomes part of a routine clinic work-up then it is presumably no longer a research project. In the case of the Thorax paper it appears that research regarded in one country as requiring ethical committee approval demands only parental consent in another.

We decided to publish the paper by Benninga et al because it contains valuable information for our readers and we accept there are grey areas, especially in tertiary care, as between research and standard clinical practice. I doubt that we would have published the Thorax paper.

I no longer write as editor, but I know that ADC does not intend to soften its line, but rather strengthen it, when it comes to ethical standards. During 2002, five papers submitted to ADC ended up being reported (after rejection) to the Committee on Publication Ethics (www.publicationethics.org.uk). We have passed on our concerns about four of them to the appropriate head of department or chief executive, asking him or her to mount an enquiry. We are likely to do the same about an alleged attempt at duplicate publication which we are still investigating.

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Health economics in paediatrics

The literature is smaller in children than for adults

Health economics has developed on a truly massive scale in the past 20 years. As the pressure on health budgets has grown, so too has the “priesthood” seen by politicians and funding agencies as well equipped to answer key questions about what health care should and should not be provided. In practice, the tools and answers of health economists are severely limited, by methodology, politics, and ethics. But while not answering key questions, economic analysis can shed light on the questions and give those making the decisions a much clearer idea of the choices they face.

Analysis to help choice of treatment, for governments and insurers, usually falls into one of three categories: cost minimisation; cost effectiveness; and cost utility. However, definitions vary in practical use and many authors have now merged some of these categories into cost effectiveness or cost benefit studies.

A cost minimisation study is the simplest, focusing on comparing treatments with an (assumed or demonstrated) identical outcome. For example, an early UK study compared bottled
Oxygen with use of an oxygen concentrator. Both provide oxygen with similar (assumed) effects so the economic choice is the therapy that minimises costs.

Costs in most theoretical discussions in economics include costs to all, specifically the value of what is given up to achieve something. There is much theoretical discussion about the use of average or marginal cost, the latter covering the actual change in costs rather than the average across a range of activity. Some things can be free, for example, if there is spare capacity in a system (a spare bed or a vacant and staffed theatre session), and marginal costing tries to take account of this. But marginal costs are often very context specific and there is widespread use of average costs in the practical literature. Also, while costs to citizens and families are theoretically important, practical studies often concentrate on the costs to the health care system alone.

Where outcomes have been measured in some standard units, it is possible to develop a cost effectiveness study. This looks at the cost of achieving each unit of outcome (for example, patient-year free of symptoms, case cured) using each treatment. Here the emphasis is on the incremental cost of achieving an extra unit of outcome by switching from one treatment to another. But cost effectiveness studies of this kind beg the question of whether treatment should be provided. That is, they do not ask the question “Is the health gain worth the cost?” but only “How much more outcome (in standard units) can we get for our money?” For example, a case cured may offer little gain relative to a case uncured if a disease is self-limiting and causes little long term health damage.

When outcomes are measured in more detail, typically by assessing the length and quality of life gains achieved by alternative treatments, we have a cost utility study. Utility was originally a definition in economics for the benefits of consumption (of goods and services, not lung disease). Terms such as welfare or wellbeing can be substituted for utility without too much loss of meaning and it is clearly only a short step from welfare to health.

In cost utility studies, changes in health are ideally measured using specialised instruments to assess the changes in individual capacity and the value attached to each element. A range of other techniques have been used to try to elicit values from what usually remain hypothetical choices. It is clearly very difficult to decide whether you would rather have ten years with moderate pain or eight years with no pain until you have had experience of the pain for some time. But equally, we are often assessing potential treatments in advance so the views of what the healthy would spend to avoid something may be more relevant than the views of sufferers, after the event.

In this issue, Ungar and Santos have examined the literature reporting health economics studies in paediatrics. They find a much smaller literature than for adults, reflecting, in their view, the greater complexity of research on children. There is no doubt that children raise particular problems, but these may be of degree rather than distinction. Of course, children may struggle to value the alternative outcomes from the treatments available explicitly. But this may be less important, in policy terms, if decisions on treatment are made by their parents or other adults. Other factors limiting economic research on children include the reduced level of research by pharmaceutical companies on the smaller market for children’s therapy and perhaps the greater concentration on research in chronic diseases, where expenditure is high and some outcomes rather marginal. There may also be a tendency for children’s health care to gain priority due to the age of those suffering, rather than explicit evaluation of outcomes, so that there is less technical scrutiny of paediatrics (though this explanation is speculative).

Interested readers should see Drummond and colleagues (also available in other languages), and may wish to consider the Distance Learning Course in Health Economics at the University of York (http://www.york.ac.uk/res/herc/distance.htm).

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