In the five years since its launch in March 1998, NHS Direct in England and Wales has established itself as the world’s largest provider of telephone healthcare advice. NHS Direct now handles over half a million telephone calls and NHS Direct Online half a million on-line transactions every month. Consistently 30–40% of calls to the telephone service are about children.

From the Government’s perspective, NHS Direct is intended to symbolise the changing relationship between the NHS and patients, supporting patients in becoming better informed and more able to exercise choices over their own health and health care. This is a matter of economics as well as philosophy because a public empowered in this way is more likely to be fully engaged with the Health Service, to have better health outcomes, and require less expensive health provision in the long term. At least that’s the theory.

If it symbolises burgeoning public expectation on the one hand, NHS Direct is also being used as an instrument of change on the other. For example, in taking over out-of-hours contacts in primary care, in the integration of emergency services, and in legitimising telephone consultation and triage and the decision support systems that underpin it. Different sectors of the organisation have also been used as test beds for a range of projects and enhancements to the service. This entrepreneurial diversity has characterised NHS Direct from the outset, but the organisation has grown so rapidly that all this activity has left the Department of Health hastily erecting strategic goal posts for the future, to restrain NHS Direct from hurtling off in all directions at once.

CAGING THE GOLEM

As a result, the organisational structure of NHS Direct will change during 2004, with the introduction of a single national provider (perhaps a Special Health Authority) and commissioning undertaken by consortia of Primary Care Trusts (PCTs) to whom budgets for local developments will ultimately be devolved. Judging from experience of PCTs to date, this is not a recipe for bringing either sweetness or light to the proceedings; key elements of control will probably remain in the centre but it will be another important reason for paediatricians to engage with commissioners. However, the immediate aims of this are more prosaic and will mean that staff are employed by a single national body rather than a range of host organisations, and that a phase of consolidation and convergence takes place.

Individual call centres will be fully nationally networked so that calls can be distributed to wherever there is capacity on the system. The practicalities of establishing virtual call centres are considerable and require a new “Intelligent Telecoms Network” and national databases both for routing callers and for holding local information to which nurse advisers can refer. These systems are expected to be operative by mid 2004. Call centres will presumably remain the units of day to day operation and will be the points of contact with local communities. Bringing leadership and coordination to the management of the network will be essential and the risk is that local information will not be shared and interpreted consistently. Just how all this will be implemented remains to be seen.

There is significant variability between present sites in terms of the number of calls handled per full-time equivalent nurse, the lack of use of algorithms during triage, the frequency of alterations to the dispositions recommended by the clinical decision support software, and referral rates to A&E departments for symptomatic calls (national average 11.2% with a range of approximately 6–17% across all 22 sites in England and Wales). These variations are unlikely to be eliminated simply by wiring everything together; they need to be understood much more thoroughly before the virtual curtain descends because they suggest the possibilities of significant operational and training problems on the one hand, and unacceptable ambiguities in the current decision support software solution on the other.

COURTING MELTDOWN

By the end of 2006 NHS Direct will be a single point of access for out-of-hours care, and it is expected that it will then be capable of handling 16 million calls each year. It will also have to cope with significant peaks in demand, far greater than anything it has experienced so far. More nurses will need to be employed (numbers have not been announced) but strategies have been developed to minimise this requirement and to enable nursing staff to concentrate on the “core business” of telephone consultation. Information will be provided by other routes such as NHS Direct On-line and NHS Direct Digital Television; calls will be prioritised initially by non-clinical call handlers using specific computerised protocols and directed to the most appropriate part of the service (including the ambulance service); those patients who are identified as being very likely to require a face-to-face consultation could be fast tracked by call...
handlers to GP out-of-hours services or to A&E services. There could also be specific options to fast track certain paediatric calls, but the likely consequences must be thought through first with paediatricians and then carefully monitored.

THE MULTICHANNEL EXPERIENCE

Maximum use is to be made of new technologies such as digital television (DTV). The overall objective is the delivery across England of an “NHS Direct branded health and healthcare information service” on DTV from 2004. Intriguing is the potential to deliver the concept of a “personal health space that could provide secure access to patient records and on-line transactions”. Transactional services already tested in a preliminary way include talking to and seeing an NHS Direct nurse during consultation, a system for booking an appointment with a GP through the TV, an SMS text messaging reminder service for children’s vaccination doses, and a call-back service to ask for further information from a local service. These innovations will not be part of the initial remit but they do give an insight into what is coming, and a meaning to the multichannel terms in which NHS Direct is now being described.

BACK TO THE FUTURE

Many of the issues previously raised about children in NHS Direct have been acknowledged by the organisation, but there is still much to be done to transform good intentions into genuine solutions. More focused priorities in the new structure may accelerate progress. Only 1% of NHS Direct nursing staff have a background in paediatrics and yet professional background and experience determines the formulation of the mental image of the patient that seems fundamental to the process of telephone consultation in practice. Work on telemedicine links has been put on hold, and it is not clear whether current clinical decision support software can compensate for a lack of clinical experience and knowledge, particularly in recognising important but subtle paediatric cues. Further clarification is badly needed. National standards for training in paediatrics relevant to NHS Direct and related organisations are required. The competencies necessary to manage paediatric consultations should be accredited, renewable, and externally validated. If this happens, NHS Direct could work considerably better for children and young people, and paediatricians would be more inclined to endorse it.

PRIORITIES AND OUTCOMES

Reports about NHS Direct have serially failed to analyse the adequacy or appropriateness with which children are served by the organisation, and the Central Project Team do not routinely collect information by the age of the caller or patient. Although there is a national mechanism for obtaining advice from relevant external agencies, the actual arrangements and the impact they have had, are much more threadbare than implied in official statements and reports. Better communication and more transparency are required. The teams involved in the maintenance and development of clinical systems and the entrainment of best evidence or consensus need to be developed more imaginatively and resourced more comprehensively. The highest priority of all, however, should be given to the acquisition of detailed clinical outcome measures and methods to feed these data into a process of continual evaluation and development of clinical systems. This is in sharp contrast to the data currently, and perhaps necessarily, produced which better describe the attributes of a commercial call centre operation than an important clinical service. These are changes that could gather pace as the new organisation becomes unshackled from direct political control.

THE FATE OF CHILDREN—FRICASSEE OR RAGOUT?

In terms of innovation and overcoming the sheer practicalities of building a complex new organisation, NHS Direct has been a remarkable success. Equally significant is the potential that the organisation has in the future. The devil for NHS Direct and its related services lies in the detail and in the consequences of its actions. Nowhere is this more true than in its capacity to deal with children appropriately. The first module of the Children’s National Service Framework (NSF) and the accompanying consultation document eloquently establish a philosophy of service to children. It would be logical if the full NSF for Children contained proposals to raise the profile of children in NHS Direct and suggested a range of specific standards for meeting their needs. Many of these could be cost neutral or reinforce decisions already taken in principle but not yet implemented, and so stand a chance of escaping the final ministerial red pen. The startling indifference to children in recent national reports about NHS Direct is unacceptable and shows how far there is still to travel, virtual reality or not.

REFERENCES


6 National Clinical Indicators. Health Information Unit. NHS Direct. February 2003.

7 Centre for Information Behaviour and the Evaluation of Research (Ciber), Department of Information Science, City University, London. First steps towards providing the nation with health care information and advice via their television sets: An evaluation of pilot projects exploring the health applications of digital interactive television. Report to the Department of Health, December 2002.


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APPENDIX

Suggested Core Requirements for Appropriate Service Provision for Children and Young People by NHS Direct

General requirements

1.1 Children are a large and vulnerable client group. Their safe and effective care requires specific national performance standards and regular audit.

1.2 New organisational arrangements are proposed from April 2004 in which an NHS Direct National Provider will be accountable to a Strategic Board that will include Primary Care Trust (PCT) and Strategic Health Authority (StHA) representatives. Services will be commissioned by consortia of PCTs. Commissioning managers will link between the national provider and the PCT consortia. NHS Direct is nurse led and operates in a primary care context but it is important that paediatric medical and nursing expertise are included at Board level and within the commissioning consortia to help NHS Direct work well for children and families. Collaboration with the relevant Royal Colleges is essential in establishing validation of clinical content and training and sharing information about the development of professional networks.

1.3 On each shift, at each site, there should be a lead nurse with the knowledge, understanding, and accredited competencies in paediatrics to advise colleagues about children and young people.

1.4 Each NHS Direct site should have a named and specifically trained nurse for child protection. Local child protection policies should be developed with the relevant Area Child Protection Committees within the context of a national standard, and there must be clear lines of communication with local child protection agencies and an understanding of how local networks function to protect children and young people.

1.5 With the introduction of virtual networked contact centres it is essential to develop the capacity to filter recommendations for disposition so that specific local
circumstances and provider arrangements are taken into account to match a child’s specific medical needs.

1.6 Children and parents or carers should be consulted about the development of relevant clinical content including the recommended formulation of questions generated for nurse advisers by the NHS Clinical Assessment System (NHS CAS).

1.7 Prompt and secure electronic communication between NHS Direct and referral services is essential and requires development. NHS Direct should receive standardised discharge notification from those to whom it refers so that outcomes can be monitored and used to inform the development and maintenance of all clinical pathways.

1.8 Children who fail to attend A&E or other urgent disposition when recommended to do so by NHS Direct must be followed up. There may be occasions when important child protection issues are disclosed by the failure to attend. Systems must be introduced to enable such situations to be identified. This will require much improved liaison with local providers.

1.9 Adverse events and serious clinical incidents involving children must be fully analysed to expose generalisable lessons whose application could improve the service and prevent recurrence. External paediatric opinion should be obtained as part of the internal review process and all episodes should be reported to the National Patient Safety Authority.

Training requirements

1.10 National standards for training in paediatrics relevant to NHS Direct and related organisations are urgently required. The competencies required to manage paediatric consultations should be accredited, renewable, and externally validated.

1.11 Secondments and rotational programmes with paediatric units should be encouraged so as to renew and maintain clinical skills for nurses specialising in telephone consultation, whilst offering ward based nursing staff insight into the operational aspects of NHS Direct.

Requirements related to Clinical Content
1.12 There must be separate and specific adult and paediatric streams of clinical content across all parts of NHS Direct and related organisations.

1.13 Clinical content, prioritisation pathways, and triage-pathways must be consistent across the UK.

1.14 Objective and systematic assessment against the benchmark of evidence based practice or best UK consensus must take place before clinical content or systems are used in service. A regular programme of maintenance should be in place to take account of new information and changing practice.

1.15 Triage pathways and face-to-face pathways must be evaluated in use and outcomes fed back into the assessment mechanism. This should be a continuous process and given high priority.

Requirements Concerning Specific Clinical Issues

1.16 Young children (especially those under the age of five years) are likely to have a greater need for direct clinical assessment than other age groups. Dispositions should take this into account and monitor the workflow consequences to other providers to determine appropriate thresholds.

1.17 When a parent calls back with continuing concerns about the same episode of illness in a young child, it must be recognised that this significantly increases the level of potential urgency. This should be reflected in faster track handling and a lower threshold to refer for face to face assessment.

1.18 A fast track route that makes use of the child’s usual referral and treatment pathway should be used to manage children with long term disabilities or disorders who develop a superimposed acute illness for which NHS Direct is consulted. Where no such pathway is available or appropriate, normal triage should take place. The additional risks of the underlying long-term disorder need to be considered in allocating an appropriate disposition.

1.19 When triage pathways define the possibility of a significant clinical issue (or fail to exclude it) in a child below the age of six months of age (six months beyond term for those born prematurely) a direct clinical assessment is required.
1.20 There should be specific arrangements within a national standard to deal with the situation in which a child calls for help or advice in person. This includes operational and training issues about consultation with young people.
Requirements for Research & Development

1.21 The operational and demographic data routinely collected by NHS Direct is a strength of the organisation. It is essential that these data are not wasted but used effectively to maintain and develop its clinical systems and made accessible for research. NHS Direct should be accountable for using the data it holds in this way.

1.22 Variation in performance between different call centres must be monitored and analysed continuously. Such variations may suggest the need for important modifications to clinical systems or operational procedures. Variations in the rates of particular dispositions between call centres may yield important information about the validity of thresholds for specific types of referral and have significant consequences on the resources required of other providers.