NHS Direct
NALM Information

NALM

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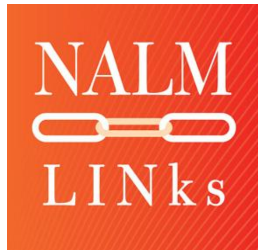

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NHS Direct

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NALM INFORMATION aims to provide NALM members with information about NHS and social care organisations, their policies and key events that affect access to and the quality of care.

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1. Background information on NHS Direct

NHS Direct - Background Information

General information: http://tinyurl.com/ygl4jfr

NHSD Statistics: http://tinyurl.com/yenfupk

NHSD Vision

To be the national healthline, providing expert health advice, information and reassurance, using their telephone service and website, and to be the NHS' provider of choice for telephone and digitally delivered health services.

NHSD Board Meeting – February 17th 2010 – Key Points

1) **Meetings of NHS Direct** are held monthly in Riverside House, on Southwark Bridge, just by the River Thames in London.

2) **Review of the role and function of NHS Direct** – article below: NHS Direct—a telephone helpline for England and Wales.

3) **Directors of NHS Direct.** There are 11, of which 6 are Non Executive Directors. All Board members are white, the Chair and one other member is female and the remaining 3 three current members are male. There is one current vacancy.

4) **The NHSD core service is commissioned** by the East of England Strategic Health Authority (SHA)

5) **Approximately 8 million calls are received** each year by NHS Direct and the budget is £121.6 millions.

6) **In the spirit of openness** the Board intends to video its public meetings and make these available on their website. But there is no place on the agenda for the public to ask questions. However, the Chair and Chief Executive were very willing to talk to me outside of the formal meeting when I attended their Board meeting on February 22nd 2010.

7) **The dedicated pandemic Fluline** service ended on February 17th 2010. The contract was between the DH and a call-centre provider. It was set up using 'emergency powers'. The DH now has a model procurement process for future events of this type.

8) **Patient safety** was not high on the agenda of the Board meeting that I attended, but was referred to in the Corporate Scorecard Summary under the heading of 'Patients and Quality – safe and clinically effective services'.

9) **Patient views** on the services. A sample of patients is interviewed 6-8 weeks after receiving the service to gather their views on the service.

10) **Service model** requires that calls first go to a Health Adviser and, if necessary, are referred to a Nurse Adviser. It was reported that each day 1000 excess calls are being referred from Health Advisers to Nurse Advisers. Advisers handle 18/20 calls/hour.

11) **Staffing is currently 140 whole time staff below establishment**. There are problems with recruitment and, therefore, recruitment from groups of staff other than nurses is being explored, e.g. from amongst occupation therapists.

12) **I spoke to the Chair, Joanne Shaw and the Chief Executive, Nick Chapman** after the meeting and expressed concern about complaints arising from transfer of Category C calls from the ambulance service to NHS Direct. I also raised the issue of clinical outcomes of calls and asked how NHSD meet the expectations of the public who dial 999 and find they have been transferred to the NHS Direct service.

13) **I raised a number of questions with Nick Chapman and his response follows**

Malcolm Alexander
Chair, NALM

2. Correspondence with NHS Direct

From the NHS Direct Chief Executive

8th Floor Riverside House 2a Southwark Bridge Road London SE1 9HA

March 12th 2010

Dear Malcolm,

I am writing to confirm that NHS Direct has completed its search for the information which you requested in relation to Category C calls handled on behalf of the London Ambulance Service (LAS). I am sorry for the delay in responding.

In the last year NHS Direct has received eight formal complaints in relation to the handling of Category C calls received from LAS.

Of these eight complaints the main issue was the caller expectation that they would be provided with an ambulance, and their dissatisfaction when their assessment did not lead to one being dispatched.

As a result of these complaints we reviewed the way we explain our service to patients, and made changes to improve the information we provide on why and how we are handling their call.

Please see attached the updated Category C call script which was agreed with Ambulance Services in December 2009.

If there are other complaints that have been received by the Patients' Forum of which you would like us to be aware, then please do pass these on.

You asked about how NHS Direct monitors the clinical effectiveness of our service. The clinical effectiveness of our service is embedded throughout the lifecycle of recruitment, training and continuing professional development of all our staff.

The key features of our clinical safeguards are that we:

- Conduct regular call reviews with our staff to ensure the quality and safety of the service is maintained.

- Provide our staff with clinical supervision to allow structured peer support, and undertake a programme of clinical audit to provide assurance that we are meeting recognised quality standards.

Survey the satisfaction of patients, and have processes for receiving and investigating complaints, feedback and incidents to ensure that we are responding and learning from the experience of users of our services.

You also posed three additional questions by email, the answers to which are set out below:

1. NHS Direct's core service is commissioned by the East of England Strategic Health Authority and the taking of Category C calls forms part of this service.

2. At the 22 February board meeting, agenda item 9 "NHS Direct's Core Contract for 2010/11" related to the whole of NHS Direct and not just the East of England.

3. At the 22 February board meeting, agenda item 7 "Corporate Performance" referred to 97% of calls being answered and you queried what happened to the other 3% and how this sits with NHS Direct's contracted levels.

The contracted level of answered calls is 8 million, and approximately 7.7 million calls have been answered because we have received fewer calls than anticipated.

It is worth noting that for the NHS Direct core service, namely the 0845 4647 number, we answered 100% of contracted calls.

ANNEX: UPDATED NHS DIRECT CATEGORY C SCRIPT

"Hello, my name is ...., a Health Advisor.

I am telephoning you from NHS Direct, your call has been passed to us by the ambulance service.

I am going to take some more details and then pass your call to one of our nurses who will make a more detailed assessment and advise on the best way of helping you.

The information given to the ambulance service indicates that your condition does not require an immediate ambulance response but if the Nurse Advisors think that an ambulance is needed then they will arrange one, can I take a brief reason for your call."

Agreed with Ambulance Services in December 2009.

3. Research Study on NHS Direct

NHS Direct — a telephone helpline for England and Wales

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NHS Direct is a nurse-led telephone helpline covering England and Wales. The intention to develop this helpline was announced in December 1997 in a White Paper, *The New NHS, Modern and Dependable* (Department of Health, 1997), following recommendations in the Chief Medical Officers' report, *Developing Emergency Services in the Community* (Calman, 1997).

Three initial pilot sites were set up in Lancashire, Milton Keynes and Northumbria, and began taking calls in March 1998. The project was extended in April 1999 to cover 40% of the population of England and by November 2000 was available throughout the whole of England and Wales. NHS Direct provides 24-hour advice and information via 22 call centres and is the largest telephone health care service in the world. A similar system is planned in Scotland, NHS 24.

NHS Direct now takes, on average, about 100,000 calls each week. Over 1000 whole time equivalent nurses are employed by NHS Direct and use a computerised decision support system when giving advice to callers. The system supports safe and consistent clinical advice and appropriate referral to NHS services.

The assessment of clinical risk is of central importance in the decision-making process and, in an emergency, NHS Direct will access the emergency services immediately or, if appropriate, refer the caller to a crisis helpline. A National Clinical Reference Group has been established to ensure the clinical validation, safety and appropriateness of NHS Direct's clinical decision support system. Using interpreter services, NHS Direct is able to respond to callers whose first language is not English and advice and information has so far been provided in 40 languages.

NHS Direct has expanded its service delivery and has:

- Launched NHS Direct On-line, an internet health information site (http://www.nhsdirect.nhs.uk)

- Published the *NHS Direct Healthcare Guide* (Department of Health, 1999*a*), providing basic home care advice on the most common symptoms about which people call for advice

- Launched NHS Direct Information Points, providing public touch screen access to the information available through NHS Direct On-line.

Rationale and evaluation

The development of NHS Direct was underpinned by two major policy concerns (Florin & Rosen, 1999): consumerism and the growth of the '24-hour society'; and the need to manage the growing demand for primary and emergency services. Its overt purpose is to provide "easier and faster advice and information for people about health, illness and the NHS so that they are better able to care for themselves and their families" - (Department of Health, 1997).

NHS Direct published specific objectives in its most recent prospectus, *NHS Direct 'A New Gateway to Healthcare'* (Department of Health, 2000), which noted "it is not a substitute for existing healthcare services, rather it is an additional service whose role is to ensure that, by using consistent clinical criteria, the right people get the right service at the right time". Some believe that it may be more than a telephone helpline and has the potential to create a fundamental shift in public participation (Pencheon, 1998).

Before the creation of NHS Direct, there was little evidence that such telephone helplines affected the nature and volume of demand for health services (Munro *et al*, 2001).

However, there was some evidence that telephone consultations may reduce subsequent use of health services, at least in the short-term (Balas *et al*, 1997; Gallagher *et al*, 1998; Latimer *et al*, 1998). The affects on population demand and longer-term effects are not known.

An evaluation has been carried out on the first wave sites (Munro *et al*, 2000). The nurses giving the telephone advice have the broad options of giving self-care advice or advising the caller to contact another service with a suggested degree of urgency.

About a third of callers are given self-care advice. The callers' presenting problems vary widely, but most are immediate problems relating to self-limiting illnesses.

Results from the three pilot sites found a low rate of calls, a six-fold difference in the calls over the sites, but high caller satisfaction. Calls were received mainly out of hours and there were substantial differences across the three sites (Florin & Rosen, 1999).

Results at the end of the first year showed that 72% of calls were received out of normal working hours and 22% were about children under 5 years (Munro *et al*, 2000). The telephone line had no effect on the use of the Accident and Emergency (A&E) and ambulance services, but the use of general practitioner (GP) cooperatives showed a small but significant fall (Munro *et al*, 2000).

These results suggest that NHS Direct appears to be used as an 'out of hours' service with a case-mix similar to that of GP cooperatives, but different from A&E departments. The data suggest that NHS Direct had little significant impact on the demand for urgent health care.

The advice offered by nurses at the first wave sites appeared to be well received by callers, with 76% finding the advice that they were given very helpful and 20% quite helpful. Only 5% did not find it helpful. Ninety-seven per cent acted on the advice they were given, 66% finding it reassuring, 35% found it helped them to contact the right service and 23% thought it helped them to deal with the problem by themselves (O'Cathain *et al*, 2000).

The mental health components of NHS direct

NHS Direct is a general health service but inevitably receives calls from those with mental health difficulties. In a survey of 12 sites over a period of 2 weeks in November 2000, 85,165 calls were officially logged, 2.8% (range 1 - 4.4%) of these were calls regarding health (Payne *et al*, 2001). However, anecdotal information from nurse advisors indicates that many more calls have a mental health component. In addition, nurse advisors find responding to such calls difficult and anxiety provoking.

These figures highlight the need for education and training in mental health for nurse advisors. The NHS Direct mental health project was developed in line with the *National Service Framework* (NSF) *for Mental Health* (Department of Health, 1999*b*).

The NSF for Mental Health

Improved 24-hour access to services is highlighted in the NSF. Standard three of the NSF refers to NHS Direct and recommends that any individual should be able to use this for first level advice and referral on to specialist helplines or to local services.

NHS Direct can also provide 24-hour access; information on the availability of local mental health services and helplines; and systems that will allow liaison with local mental health teams for people on enhanced Care Programme Approach (CPA).

The NHS Direct mental health project

A project team was established in April 2000 and mental health site leads were established in every call centre.

The objectives of the project were to:

- Establish a list of local statutory first-line and crisis services
- Establish links with local mental health services and telephone helplines and develop protocols for referral
- Train nurse advisors to respond effectively to mental health calls
- Review and develop mental health algorithms
- Establish links with NHS regional offices and social care regions.

In addition, an evaluation of the project was commissioned (Payne *et al*, 2001).

Mental health site leads - the majority of whom were experienced nurses or social workers seconded from local mental health trusts, were placed in each site. Mental health site leads have played a pivotal role in establishing links with local mental health, non-statutory and voluntary service providers, and providing support, training, education and clinical supervision to nurse advisors.

The current project was completed in March 2001 and at that time significant progress had been made on all objectives. The evaluation results were very encouraging and will be used to develop future mental health work in NHS Direct. Funding has been provided to ensure that the role of mental health site leads continues on a permanent basis for every site.

The mental health project is the only ‘specialist’ role that NHS Direct, as a generic service, has established.

Future objectives

Targets are currently being agreed for the next 2 years. Work is presently being carried out on:

- Continuing links with local statutory and non-statutory providers
- Consolidating the established mental health education and training of nurse advisors and extending this to cover other groups such as older people and children and adolescents
- Development of more discrete algorithms that reflect the wide range of mental health presentations and enable nurse advisors to give relevant, appropriate and safe advice
- Developing protocols that will enable the exchange of information between NHS Direct and local mental health service providers. Of particular importance are those individuals on enhanced CPA for whom, with the patient's agreement, it needs to be established as part of a care plan what role and support the clinical team would like NHS Direct to offer.

Important in making NHS Direct work well are the use of good software support with algorithms written and reviewed by clinicians, training of nurse advisors, alliance with local services and the use of collaboratively agreed protocols. NHS Direct has a role to play in the implementation of the NSF within the context of other policy initiatives.

Conclusions

NHS Direct was established as part of central directives contained in the 1997 White Paper (Department of Health, 1997). The development of the mental health component was promoted by the NSF for Mental Health. It is only one of several initiatives designed to address public access to national health services.

While there are many telephone helplines in the UK, NHS Direct represents the first national generic health telephone advice service and represents a novel departure for the health service.

The preliminary evaluations suggest that it is well used and accepted by the public. However, concern has been expressed that NHS Direct may miss potential emergencies, give inconsistent advice and make unnecessary referrals to over-stretched A&E departments (*Guardian*, Tuesday 8 August 2000; Farrer *et al*, 2000; Lawson *et al*, 2000).

Florin and Rosen (1999) have suggested that it highlights the tension between policy goals of consumer responses and the management of demand, and were concerned that continuity of care may be affected. They were wary of extending NHS Direct because "the impact of this plethora of health services on need and demand for NHS care is little understood and there is a danger that these services will foster inefficiency. Developments in easy access primary care should be built on the strengths of existing systems rather than cut across them".

However, one of the key targets for NHS Direct is to develop a greater confidence in the public as to their own capacity to look after themselves and this focus is intended to empower callers, where appropriate, to take responsibility for themselves and their families.

This intention has so far been supported by the findings of Munro *et al* (2000, 2001), that around a third of callers received self-care advice, and the findings of O'Cathain *et al* (2000) that 97% acted on the advice they were given.

Presently there is insufficient information with which to judge the effects of NHS Direct and its important outcomes can only be judged in the long-term. The behaviour of individuals in relation to the experience of common physical and mental problems is intricate (Mechanic, 1986) and it is unlikely that we are in a position to confidently judge the way in which the service will be used by the public, but it is likely that several complex effects will operate (Munro *et al*, 2000). Because of this, the effects of NHS Direct on demand are likely to be complex and it may be that new demands will be created, particularly as the service expands and as public attitudes and expectations alter.

The early work by Munro *et al* (2000) does not indicate an increase in demand on emergency services, but any future changes may be borne by the helpline itself. In view of this it is important that thorough liaison and cooperation is achieved with general practice, secondary care and voluntary services. Nevertheless, NHS Direct is an innovatory departure for the NHS and its effects are not likely to be neutral; it may have radical consequences for public participation and attitudes and will reflect the challenges that must be faced by health services in a changing world.

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