King's Fund

NHS Direct

Learning from the London Experience

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Acknowledgements

Executive summary

NHS Direct is a nurse-led telephone help line providing advice and information about health and health care. Two pilot services were launched in London in spring 1999. The west London service is integrated with a general practice out-of-hours co-operative and the south London service has been developed in partnership with the London Ambulance service. A third NHS Direct service will be launched in south London in 1999, and the whole city covered by mid-2000. This report presents findings from an interview-based study of the implementation of NHS Direct in London, drawing lessons for development of the service elsewhere and identifying possible future roles for NHS Direct.

Interviews were conducted with health professionals and user representatives involved in the introduction of NHS Direct in London. The interviews focused on practical aspects of implementing the service, factors facilitating and obstructing implementation and possible future roles for NHS Direct. Twenty-nine interviews were conducted, from which five key themes were identified about the development of NHS Direct:

1. The background context and style of implementation affect the level of professional co-operation with NHS Direct

- rapid implementation of national policy on NHS Direct has ensured the service is established, but has alienated many general practitioners and may reduce their willingness to participate in developing new roles for NHS Direct
- recent changes in general practice out-of-hours arrangements mean that many doctors and patients are now used to nurse telephone triage, which has facilitated the introduction of NHS Direct.

2. Partnership and integration are key to the successful implementation and development of NHS Direct

- developing effective working relationships between partner organisations in NHS Direct is essential for its successful implementation
- developing other roles for NHS Direct will require that it is seen as a fully integrated part of the local health system rather than an 'add-on' service
- the two London NHS Direct pilot sites illustrate the potential for changes in inter-professional working relationships between doctors and nurses and for developing new ways of joint working.

3. The partnerships between health care organisations providing NHS Direct require complex operational management

- appropriate management structures, accountability systems and inter-organisational relationships are essential for the smooth running of the service
- tensions exist between centralising the service and retaining local flexibility and responsiveness
- IT development must keep pace with the needs of the service.

4. The impact of NHS Direct on the quality of health services remains unclear

- national standards are required to ensure uniform quality across all NHS Direct sites. Possible areas for setting standards include staff recruitment and training, IT provision and support and protocol quality

- NHS Direct could promote more evidence-based standardisation of health services but this may require local acceptance of national protocols, which may be hard to achieve
- if backed up by rapid information transfer, NHS Direct does not necessarily jeopardise continuity of care
- there is a risk of inequitable access to NHS Direct. Well-targeted publicity and careful monitoring are essential to ensure the service is accessible to and used by groups that find it hardest to gain access to health services.

5. In future, NHS Direct could fulfil a range of roles as part of an integrated network of primary care services

- possible future roles for NHS Direct include health promotion, 'outreach calling' and participation in integrated care pathways
- the successful development of new roles for NHS Direct will require collaboration between relevant primary care stakeholders – including the many GPs who are currently ambivalent about the service.

NHS Direct is now well established in two areas of London and call numbers are rising. Both services face the challenge of ensuring widespread access to the service by all groups and developing quality assurance mechanisms.

There is scope to develop the role of NHS Direct as an integrated part of the primary care services available to a community. Such developments will require participation by many local primary care clinicians – including those GPs whose current ambivalence is a response to the rapid introduction and expansion of NHS Direct before its impact on other health services is fully understood. As more evidence emerges about the costs and effects of NHS Direct and its impact on other parts of the NHS, informed discussion

about the service will become easier and this may help to engage the local health professionals whose collaboration is essential for further development of the service.

1. Introduction

NHS Direct is a nurse-led telephone helpline which was launched in three pilot sites in 1998. An evaluation of the first three sites is still underway and, although preliminary results show high satisfaction amongst service users, it is too early to draw conclusions about the impact of NHS Direct on patient health and on other NHS services. Despite this, the service is being rapidly expanded and two London sites were among the second wave of NHS Direct sites launched in spring 1999. By the end of 2000 the service will cover the whole country.

This report describes an interview-based study of the implementation of NHS Direct in west London and south London. It aims to draw lessons from the London experience in order to inform the development of other NHS Direct services and to identify possible future roles for this nation-wide telephone helpline.

2. Background

2.1 History of NHS Direct: the policy context

The intention to develop a national direct access NHS telephone service was announced in the White Paper, *The new NHS: Modern, Dependable*, published in December 1997.[1] However, the concept of emergency telephone helplines was first promoted in the Chief Medical Officer's Review of Emergency Services in July 1997. Forming part of the Government's medium to long-term strategy for emergency services, the review concluded that piloting and evaluating emergency telephone helplines was a priority.[2]

Telephone triage is not a new idea. It is estimated that in the USA, over 12 million people have access to freephone consultations, and that 12–28 per cent of all primary care is conducted over the telephone.[3] In recent years, the growth of managed care in the US has led to the expansion and formalisation of telephone triage systems aiming to direct patients to appropriate levels of care.[4] One approach is that of 'patient risk assessment' whereby a nurse adviser on a telephone will talk to a patient using iterative computer generated algorithms and protocols.[3]

Initially, triage services were used by health maintenance organisations (HMOs) and health plans to direct patients to affiliated hospitals.[4] However, as health care costs rose, their role shifted towards encouraging self-care where possible (often in conjunction with self-care manuals). Many HMOs now oblige patients to telephone a charge-free number before accessing care for any medical service except clear emergencies. Patients who do not comply are billed for the services received, unless they were physically unable to ring.[4] The role, development and direction of telephone triage in the US has thus been influenced by the different financial incentives and structures operating there.

Telephone triage is also well established in other countries including the UK, Denmark and Sweden. British GPs have long given telephone advice and are increasingly managing patient demands for urgent appointments and visits using triage by a duty doctor. Nurse triage has been used in GP out-of-hours co-operatives[5] (co-ops) and accident and emergency departments[6] (A&E) for some time. Danish arrangements for out-of-hours care include universal direct telephone access to a GP with a triage function. The telephone doctor decides whether a caller requires a home visit, a consultation in an out-of-hours consultation room or telephone advice.[7] In Sweden, telephone advisory services at health centres started because demand for appointments with GPs exceeded supply. Patients make a free call to a nurse for advice or referral to a doctor or elsewhere.[8]

Although telephone triage is not a new concept, its universal provision within the NHS *is* new and can be seen as a response to current problems with waiting times for GP appointments and inappropriate use of emergency and out-of-hours services. NHS Direct adds to a range of changes in primary care which have taken place over the last decade. There has been a gradual reduction in home visiting and a rapid increase in the provision of GP co-ops, with patients increasingly used to contacting a professional other than their own doctor at nights and at weekends. There has also been a gradual extension of the nursing role. This includes widening the role of practice nurses and the development of 'nurse practitioners', with skills that overlap with those of doctors.

A recent survey undertaken by the King's Fund and the Evening Standard found that, after exclusion of those for whom it depended on the nature of the problem, 57 per cent of respondents would prefer an immediate appointment with a nurse to a next-day appointment with a doctor.[9] In an innovative nurse-led primary care clinic at which a doctor was also employed, up to 60 per cent of patients chose to see the nurse quickly rather than waiting for the doctor.[10] This indicates that many patients are now prepared to consult a nurse, and often choose to do so, rather than wait longer to consult a doctor.

Alongside these powerful influences, we are increasingly a '24-hour society', where use of technology is stimulating evolution and revolution.[11] The Internet and ready access to information is facilitating patient autonomy. Increasingly, patients are demanding instant access services, whether it be for banking, shopping or health care.

This combination of pressures within the NHS, and within society, have produced a situation where the 'time is right' for an immediate access telephone service using up-to-date information technology to offer evidence based health care and advice.

2.2 The launch of NHS Direct and the aims of the service

The White Paper, *The new NHS: Modern, Dependable* introduced the idea of NHS Direct in late 1997 and made it clear that the service would be quickly extended:

> *At home, we will provide easier and faster advice and information through NHS Direct, a new 24-hour telephone advice line staffed by nurses. We will pilot this through three care and advice helplines to begin in March 1998. The whole country will be covered by 2000.*[1]

Three pilot sites were launched in March 1998 in Milton Keynes (Buckinghamshire), Preston (Lancashire) and Newcastle (Northumbria). All three sites were run by local ambulance services although each was organised differently in terms of the location of call-handlers and nurse advisers and the transfer of information between them. In addition, each used a different software system for triage support and each served a different size and type of population. An evaluation of the first three pilot sites was commissioned and interim results were published in January 1999 (see below) NHS Direct's expansion was already underway with bids submitted for second wave pilot sites in summer 1998.

Thirteen sites were selected reflecting different organisational arrangements for NHS Direct (one linked to a GP co-operative, others to hospital A&E departments or ambulance services), and these started in March/April 1999. The first and second wave sites cover 40 per cent of the population of England and Wales. Drawing lessons from these pilots, guidance on how best to configure NHS Direct services was issued in a circular on the final stage of the national rollout.[12] Third wave sites, being launched at the end of 1999, will increase coverage to 60 per cent and the whole country will have access to NHS Direct by the end of 2000.

The aims of NHS Direct were unclear until publication of the interim report on the evaluation of first wave pilots. Here, the purpose of the service was described as providing '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'.[13] Four specific objectives were also presented:

- to offer the public a confidential, reliable and consistent source of professional advice on health care, 24 hours a day, so that they can manage many of their problems at home or know where to turn for appropriate care
- to provide simple and speedy access to a comprehensive and up-to-date range of health and related information
- to help improve quality, increase cost-effectiveness and reduce unnecessary demands on other NHS services by providing a more appropriate response to the needs of the public
- to allow professionals to develop their role in enabling patients to be partners in self-care, and help them to focus on those patients for whom their skills are most needed.

2.3 Evaluation of NHS Direct pilot sites

An evaluation of the three NHS Direct pilot sites was commissioned by the Department of Health. The evaluation aimed to:

- describe the three pilot sites
- describe the activity of the sites
- evaluate the impact of NHS Direct on the volume of demand for first contact emergency care, and caller satisfaction with the helpline
- monitor and report on any major system failures
- establish the views of the sites and professional and patient groups on the contribution of NHS Direct to out-of-hours care
- measure the cost consequences of the service.

The preliminary report[13] (published in January 1999) concluded that NHS Direct had made an encouraging start. It found that:

- caller satisfaction was high, with 97 per cent of callers surveyed saying they had been 'satisfied' or 'very satisfied' with the service
- call volumes were initially lower than expected, but these were increasing
- NHS Direct is especially used as an out-of-hours service, with call rates highest during evenings and weekends
- the service was of benefit to parents, with 25 per cent of calls about a child of five or under.

However, there was variation in call handling between sites, and marked variation in the population call rates (from 23–148 calls per 1000 population per year). Some callers expressed dissatisfaction with the publicity of the service, and there were fewer calls than

expected from people over 65. The study showed little impact on use of other NHS services, although this issue will be assessed further in the final report. The preliminary evaluation, therefore, was broadly positive, but raised some questions requiring further examination.

2.4 Impact of the rapid development of NHS Direct

The rapid development of the three pilot sites into a nation-wide service raises many questions. The time from announcement of the service to launch of the three pilot sites was very short, triggering a sceptical response from the GP community. The rapid rollout of the service to other sites before the evaluation results were available also met with criticism. At the GP Committee Representatives Conference in May 1999, GPs expressed concern that the Government's crusade to modernise the NHS threatened GPs' central role in the NHS.[14] They sought reassurance that NHS Direct would be abandoned if the evaluation of the first wave sites showed it to be unsuccessful. They also wanted assurance that general medical services funds would not be used to finance the service.

Delegates at the July LMC (Local Medical Committee) conference expressed further concerns about NHS Direct undermining the role and gatekeeper function of GPs, and called for evaluation before rollout.[15] The BMA Annual Representatives meeting, also in July, saw further criticism of NHS Direct and demands for clarification of clinical and legal responsibilities. This conference also deplored the failure to evaluate the service before rollout.[16] In contrast, advocates of the service argue that the NHS has to change with society, and that NHS Direct is a patient-oriented service, providing a good and modern service.[17]

Are these criticisms valid? What is the impact of rushing the introduction of the new service? Are GPs concerns well founded or will the predictions and aspirations of the advocates be realised? How might NHS Direct develop in future? The following study of the first two NHS Direct sites in London examined some of these questions to inform the development of other NHS Direct sites in future.

3. Aims

The main aims of the study were:

- to draw lessons from the implementation of NHS Direct in London which may help inform development of the service elsewhere
- to identify possible future developments and directions for NHS Direct.

Secondary aims were:

- to review published literature on telephone health services, out-of-hours primary care and other relevant topics in order to inform the conclusions of the study
- to identify unresolved policy questions about the expansion of NHS Direct.

4. Methods

Interview-based case studies were conducted in the two London NHS Direct sites. Preliminary interviews were held with two people who were particularly involved in establishing NHS Direct in London (the Medical Director of west London, and the Project Manager of the *Immediate Access Project* that was evaluating the south London site). A list of people closely involved with the two London services was developed from the preliminary interviews and is included at Appendix 1.

Semi-structured interviews were conducted covering progress in establishing the service to date, barriers and facilitators for implementation, and perceived future directions for NHS Direct (see Appendix 2). Each interview lasted approximately one hour. Interviews were recorded and respondents were informed that quotes would be used in a non-attributable way.

Analysis

Key themes were identified through content analysis of the interviews. Descriptions of the two London sites were sent back to one interviewee in each site for confirmation of accuracy. The results were clustered into five main areas presented under the theme headings:

- the background context and style of implementation
- the importance of partnership working for developing the work of NHS Direct and integrating it with existing services
- operational issues and information technology
- quality and the impact of NHS Direct on clinical care
- understanding current and future roles for NHS Direct.

Relevant literature on each of the five main areas was identified and reviewed to examine its consistency with ideas presented by interviewees.

5. Results

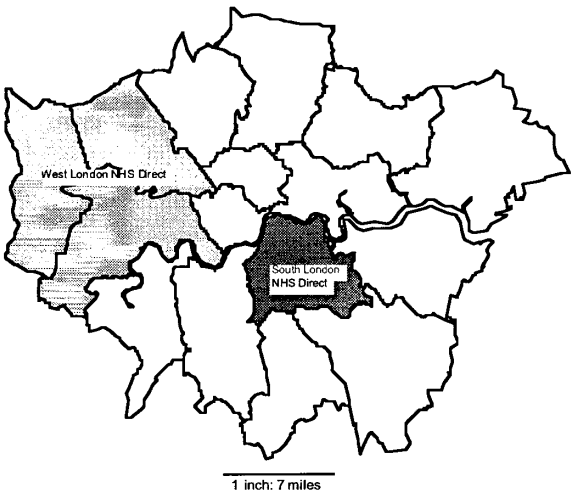
Twenty nine respondents were interviewed across the two London sites (see Appendix 1), including representatives from NHS Direct, the local health authorities, the associated community trusts, local accident and emergency departments and GPs. Also included were representatives of the London Ambulance Service (a partner in one site), the London Regional Office and patient representatives in the form of community health council (CHC) members and the president of the Patients' Association. Two interviews were by telephone and the rest were conducted face-to-face.

Description of the London NHS Direct sites

The two second wave London NHS Direct services, based in west London and south London, have developed independently and quite differently, although both use the 'TAS' (British Telephone Advice System) triage software system. A third wave London service will be launched in south west London in December 1999, with a fourth wave service covering the north central area starting in 2000. This raises strategic issues about how the four services should interact with each other and a pan-London steering group has been set up to manage issues of common interest such as cross cover in emergencies and IT development.

It is also important to remember that the population of London includes many ethnic minority communities (one health authority has residents with 149 different mother tongues) and a higher proportion of homeless people than other parts of the country. Ensuring that NHS Direct is accessible to these people presents a particular challenge to the London services.

Figure 1: NHS Direct sites in London



West London NHS Direct

In west London, NHS Direct developed in close association with a large general practice out-of-hours co-op (formed in 1994 through a merger between four co-ops in Brent, Harrow, Ealing and Hillingdon). The new Harmoni co-op later merged with one further service (Ted-doc) to cover a total population of 1 million NHS Direct was established jointly between a local health authority, the local community trust and the co-op.

Harmoni had used nurse triage (supported by TAS triage software) since its launch in 1994, with nurses offering telephone advice, referral to a GP-run primary care centre, a GP home visit or advice to go to A&E. The co-op employed the nurse advisors, and charged GPs for calls to the service made by their patients. In return, the GPs working for Harmoni were paid for their work. There was thus a well-established history of nurse telephone triage, and patients and professionals were accustomed to this as a way of working.

The west London NHS Direct service is the only first or second wave pilot site built around a GP co-op and the service is run from the co-op premises in Southall. It is staffed by the equivalent of 40 full-time nurses (over 65 nurses in total) who are employed through the Community Trust, about half of whom had previously worked for Harmoni.

The co-op still exists and employs GPs to cover five drop-in primary care centres and to provide home visits, but no longer employs the nurses (who now work for the local community trust). Patients of co-op doctors who ring their surgery out-of-hours are given the number for NHS Direct and are only transferred to Harmoni if the nurses consider GP advice necessary. Patients of non-Harmoni GPs who call NHS Direct and require GP advice are asked to telephone their own GP, where the triage will have to be repeated.

Because of this link with Harmoni, the call volume at west London NHS Direct is probably the largest in the country. Call volumes reached 13,000 calls per month in June and are still rising with the highest call volumes outside GP surgery times. (It is not possible to identify whether callers used the NHS Direct number or the Harmoni co-op number.)

The west London pilot site has a part-time medical director and full-time general, development and finance managers. It is run by a steering group which is chaired by the Chief Executive of a local health authority; the group includes the NHS Direct medical director and general manager, a GP from Harmoni, a Community Trust representative and representatives of the three local health authorities.

South London NHS Direct

The south London site evolved from previous work in Lambeth, Southwark and Lewisham Health Authority (LSL HA) about demand management in out-of-hours and emergency care. Joint work had already been undertaken between A&E departments, the

Community Trust and local GPs and the 'Out-of-Hours Project' team had evaluated various schemes. Within the LSL HA area, a GP co-op called SELDOC covers around 70 per cent of the population, with the remainder covered by Healthcall (a deputising service).

The service was developed jointly by the health authority, the Community Trust and the London Ambulance Service (LAS). The Out-of-Hours Project team (now renamed the Immediate Access Project) – an academic research and development team – was also involved in bidding to become a second wave site. The Community Trust, 'Community Health South London' (CHSL), is the lead accountable agency. The service is based in three sites – the call centre is in Bow (at the LAS second headquarters), the nurse centre is in Dulwich hospital, and there is a 'Health Shop' in Waterloo (a drop in centre providing health information). The call-handlers who receive and log all telephone calls before passing them to the nurses are employed by the London Ambulance Service, the 20 nurses are employed by CHSL and the information staff in the health shop by the health authority. The SELDOC co-op operates from a site adjacent to the Dulwich Hospital NHS Direct site and SELDOC GPs are contracted to provide back up if NHS Direct nurses have a query they cannot answer. Pharmacy backup is provided by CHSL and the Guys and St Thomas' Trust.

Patients calling the NHS Direct number are given information by call-handlers, referred to the health shop for complex information queries or passed to the nurses. The nurses can advise on self-care or recommend attendance at A&E, urgent GP attendance or a non-urgent GP appointment. Out of surgery hours, if NHS Direct callers are triaged as urgent their details are faxed to SELDOC or Healthcall, and the duty doctor will phone the patient back (thus bypassing a second triage system). The south London site currently takes approximately 4,000 calls per month with highest call volumes out-of-hours.

The south London pilot site is run by a consortium including representatives from the health authority, the LMC, CHSL, London Ambulance Service, SELDOC and the Immediate Access Project. A nurse adviser and a Health Shop worker are also present.

Activity in the two London sites.

The rate of calls received was much higher in west London since the total number of calls included those to both NHS Direct and the GP out-of-hours co-op (which are triaged by NHS Direct nurses).

Table 1: Call rates per 1000 population per year in west London and south London NHS Direct Sites, June–July 1999

West London NHS Direct Calls per 1000 population/year*		**South London NHS Direct Calls per 1000 population/year**	
June 1999	87	June 1999	24
July 1999	117	July 1999	28
% increase	34%	% increase	16%

Source: NHS Executive, NHS Direct Project Team. *Summary monitoring report.* July 1999

*Includes calls to NHS Direct *and* calls to the Harmoni GP out-of-hours co-op which are answered by NHS Direct nurses.

Both sites deal with enquiries about a wide range of topics, illustrated in Table 2 by the ten most frequent subjects of calls about adult health problems received by west London NHS Direct, July–September 1999.

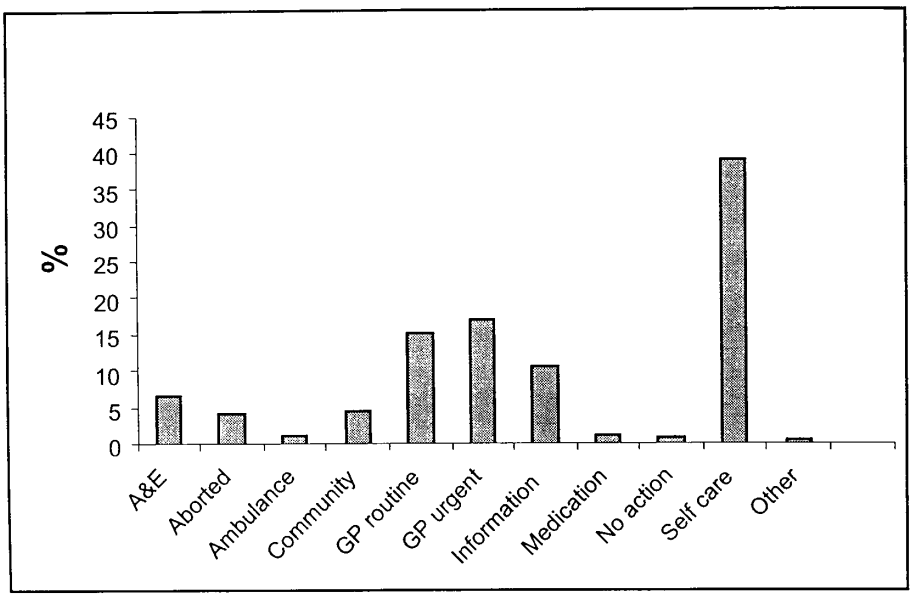
Table 2: Top ten presenting complaints for calls to west London NHS Direct, July–Sept 1999

Presenting complaint	% of calls
Fever	9.3
Abdominal pain	7.7
Vomiting	5.2
Headache	5.0
Breathing difficulties	4.0
Urinary symptoms	3.7
Dizziness	3.7
Chest pain	3.6
Back pain	3.4
Diarrhoea	3.1

Source: West London NHS Direct activity data.

The outcomes of calls to south London NHS Direct during May–July 1999 are illustrated in Figure 2. The largest single triage outcome group was advice to self-care (35 per cent of callers) with a further 30 per cent advised to see their GP and approximately 10 per cent given information.

Figure 2: Outcomes of calls to south London NHS Direct, May–July 1999



Source: South London NHS Direct activity data.

Differences between the sites

There are several key differences between the two London pilot sites. These include:

- west London, based on a GP co-op with major GP involvement in the pilot service; south London, working in partnership with the co-op and other stakeholder agencies
- London Ambulance Service is integrally involved with the south London site but has no direct involvement in the west London site
- west London site handling much larger call volumes due to overlap with calls to Harmoni co-op and thus employs a larger number of nurses
- west London pilot is based on one site, with call-handlers and nurses and linked GPs sitting next to each other; south London pilot is split over three sites, linked electronically.

Analysing the interview data, five themes emerged of particular importance to implementing NHS Direct and facilitating its future development. These were:

- the background context and style of implementation
- the importance of partnership working for developing the work of NHS Direct and integrating it with existing services
- operational issues and information technology
- quality and the impact of NHS Direct on clinical care
- understanding current and future roles for NHS Direct.

5.1 Background context and style of implementation

Both national and local factors affected the way in which NHS Direct was received by health professionals. This, in turn was thought to have shaped the level of co-operation with implementing NHS Direct in the two London sites.

Key lessons

- Rapid implementation of national policy on NHS Direct has ensured that the service has been established but has alienated many GPs along the way. This has reduced the willingness of some local GPs to participate in developing NHS Direct.
- Recent changes in GP out-of-hours arrangements and the introduction of GP co-ops mean that many doctors and patients are used to nurse telephone triage. This has facilitated the introduction of NHS Direct.

Introduction and launch of NHS Direct

Both London sites had a history of innovative out-of-hours primary care provision and nurse triage was already established in west London. Although this local history was thought to have eased the introduction of NHS Direct, other factors had made the launch more difficult. Local GPs were affected by the scepticism and hostile publicity created at a national level by the scant consultation with clinicians over the development of NHS Direct; its expansion before evaluation results were available and the perception that NHS Direct is being used by politicians to divide nurses and doctors.

NHS Direct was slipped in, in the midst of PCGs. We didn't get any opportunity as GPs to consult on it, ... I was shocked by the little thought given to the effect on GPs ... The government is trying to play off nurses and doctors...

I feel very cynical about what's happened... All the national negotiation that should have been done through the GMSC hasn't been done, so you have to do it locally, and that makes people feel vulnerable, and it makes it a lot harder work for us here.... The speed of rollout is phenomenal.

At a local level, concerns expressed by the south London LMC about where legal responsibility lies for patients referred to NHS Direct via a message on a practice answerphone made GPs wary of becoming involved in the service.

...the LMC was against it because it is not clear who carries legal responsibility if something goes wrong, and it costs about eight times as much per call compared with GP out-of-hours ... [local] doctors, on the whole, have been very against it.

Further reasons for GP scepticism include the opportunity costs of spending on NHS Direct which could have been used to improve existing out-of-hours services and a concern that long term funding for the service will be top-sliced from GP budgets.

More widespread consultation when introducing NHS Direct may have reduced suspicion about these issues, eased the introduction of the new service and facilitated collaborative work. In the west London site, for example, negotiations between NHS Direct and Harmoni have resulted in a seamless hand-over of patients who are thought to need a consultation with a GP with no need for further triage. Attempts to negotiate a similar hand-over for patients whose GPs use the Healthcall deputising service (30 per cent of west London patients) were underway but progressing slowly. There was a feeling that these negotiations would have been easier with stronger support amongst these GPs for NHS Direct.

Patient expectations

In west London, the prior use of nurse triage by the Harmoni co-op meant that local patients were becoming used to not having immediate telephone access to a doctor. The introduction of NHS Direct there reflected less of a change than in the south London site.

Patients already had their expectations changed by the co-op; NHS Direct was not that much different.

With the co-op, patient culture and expectation changed; home visits dropped overnight from 80 per cent to 15 per cent. Patients now expect to be triaged by nurses. Therefore, when NHS Direct arrived, it was not a major change, although some patients don't like it.

However, not all respondents shared this view, some will still prefer the traditional 'doctor led' health service.

Personally speaking, if I'm ill, I want a doctor, not a nurse, you don't get a doctor at NHS Direct...

CHC representatives had been involved in establishing NHS Direct and CHC interviewees thought it important to involve users at an early stage when planning and developing the service.

One key message is about engaging consumers at an early stage – people who want to use the service. Why are we not talking to them?... It has been led by the professions with virtually no involvement from the voluntary sector or CHC as to how to set it up.

Intra- and inter-professional factors

Although there has been strong resistance to the advent of NHS Direct amongst many GPs, there is a growing acceptance within the GP community that change is inevitable. This may facilitate their acceptance of NHS Direct in the long run. Thus, one GP commented:

GPs locally will not do out-of-hours work, they don't want to do it... we must accept the consequences if we refuse to work out-of-hours.

Another put it more strongly:

General Practice is practised in a 19th century fashion, our patients now live in different ways, we have different sorts of patients, with different sorts of problems. If you have to look at providing care to a population, and you started with a blank sheet of paper, you wouldn't invent General Practice as it is now, you'd have a much wider range of primary care providers, including telephone services such as NHSD, including drop in centres for minor illness, and including primary care specialists and illness specialists, which is what I suspect GPs will become... General Practice has to respond and find a niche in a primary care service which will be increasingly nurse oriented. General Practice as we know it today has to change and has to evolve, we have a very 19th century model and we have to move to a 21st century model.

For NHS Direct to be successful, change is also needed in the inter-professional relationships between doctors and nurses, requiring doctors to accept nurse triage and the possibility that patients can be advised to attend their GP by a nurse. There were initial concerns about this, although for the most part, it seems to be working well, with doctors respecting the quality of advice given to patients by nurses.

There were some anxieties about whether GPs would accept nurse advice – it's been OK on the ground, although there are some tensions in the organisational accountability aspects...

GPs, where they were aware of what the nurses had said, said they thought the quality of advice was very high.

However, another comment illustrated that tensions do still exist:

Nurses take twice as long as doctors to do half as much ... medicine is an art, not a science, you can't protocolise everything.

5.2 Partnership and integration

Two factors which were argued to affect the success of NHS Direct were the extent to which stakeholders are working together and whether NHS Direct is well integrated with other local primary care services.

Key lessons

- Developing effective working relationships between partner organisations in NHS Direct is essential for its successful implementation.
- Developing other roles for NHS Direct will require that it is seen as a fully integrated part of the local health system rather than a centrally imposed 'add-on'.
- The two London NHS Direct pilot sites illustrate the potential for changes in inter-professional working relationships between doctors and nurses and for developing new ways of joint working.

Partnership working

Partnership working was said to be the key to making NHS Direct work, with the benefits described as:

- enabling the development of joint protocols and quality standards
- dealing with problems highlighted by NHS Direct, such as improving the uniformity of services across the local area covered

- facilitating joint work on the strategic development of primary care and emergency services.

The value of working in a committed, strong partnership was expressed by many respondents:

> *Partnership is the key – the community trust brings experience of clinical issues, the Ambulance service has expertise in IT/infrastructure, and the Health Authority; but the partners retain the different cultures within each organisation.*

> *The consortium has worked very well, reducing tension,... we've reached agreement about clinical governance, corporate governance, complaint handling; given that we've all got different methods to manage these... it's worked very well, and better than expected.*

Successful partnership required that key stakeholders became involved as early as possible. Several west London interviewees noted that, by basing NHS Direct around the GP co-op, 70 per cent of local GPs were involved from the start. Most west London interviewees felt that the link with Harmoni had facilitated and driven the introduction of NHS Direct although one manager argued that the close link may have alienated other GPs.

> *The link to Harmoni had positive and negative points: Lots of Harmoni GPs were on board but it may have turned off others who saw it only as a Harmoni project.*

The benefits of close interagency working were particularly evident when differences were noted in the quality and availability of services between different boroughs in the NHS Direct area.

It highlights cracks in the system, working across four boroughs, we can see which services are good and which are bad. The nurses pick up on this, for example, out-of-hours mental health services vary enormously across the boroughs. We've set up a joint working group to work out how to improve things.

Involvement of other professional groups differs between the two sites. In south London, a nurse adviser and an information specialist are on the consortium; in west London, neither of these groups are formally represented.

Problems with partnership working

Interviewees also described various barriers to developing effective working partnerships. The concerns of the south London LMC about legal liability were mentioned above, but despite the resistance this generated among GPs, a good working relationship has been developed with the SELDOC co-op. SELDOC are represented on the consortium and involved in discussions about developing the service further.

GPs have been a barrier, in so far as they've voiced opposition, both nationally and locally, but it hasn't stopped the service running ahead... having SELDOC on board has been critical.

Further problems were noted with respect to management systems and professional accountability between the different organisations and groups involved in providing the service – an issue discussed in section 5.3.

Communication is also important when several agencies are working together and some interviewees stated that effective internal communication depended on personal relationships which were taking time to develop. Good communications must also be developed with external agencies and other out-of-hours services.

Integration

Several interviewees commented on the importance of NHS Direct being embedded in and integrated with other local primary care services. Respondents talked of it as an extra service rather than a duplication of or replacement for existing practice. One interviewee explained how he saw NHS Direct fulfilling an increasingly important role in local primary care services, where the recruitment of GPs was particularly difficult.

> *In one part of this area, 50 per cent of GPs will be retiring during the next few years, and it's proving extremely difficult to recruit. I see NHS Direct as an essential part of the future of primary care in this area, not just a minor add-on.*

One barrier to developing NHS Direct as an integral part of the local health economy is the variability of other health and social services available to callers. Working across borough and health authority boundaries exposes differences in provision, making it hard to develop protocols which apply to all callers. This is an area where a locally based service where triage nurses have an extensive knowledge of available services becomes particularly important.

> *One barrier arises because services vary across the patch, nurses need local knowledge of the patchwork of services in different areas.*

If NHS Direct is to be embedded in the local health economy, integrated with other primary care services, there needs to be agreement about the roles it should fulfil. The more innovative potential roles for NHS Direct which are described in section 5.5 will require the involvement of a wide range of primary care practitioners, service users and, in some cases, hospital clinicians. Without good working relationships between all relevant stakeholders it will be much harder for NHS Direct to integrate with other primary care services.

5.3 Operational issues

NHS Direct depends upon effective interaction between callers, health professionals and complex information technology (IT). Furthermore, both London services are run by different agencies and must cope with a wide range of caller (patient) needs, changes in demand throughout the day and a frequently changing information base for the service. This raises a number of operational issues about NHS Direct – particularly in relation to organisational relationships between partner agencies, staffing, publicity and IT – which may facilitate or hinder implementation of the service.

Key lessons

- Appropriate management structures, accountability systems and inter-organisational relationships are essential for the smooth running of the service at a local and national level. Tensions exist between centralising the service and retaining local flexibility and local knowledge.
- IT is a crucial component of NHS Direct and IT development must keep pace with the needs of the service.

Organisational arrangements for NHS Direct

The rollout of NHS Direct across London and the rest of the country raises questions about the most suitable organisational arrangements for the service. In relation to London, several interviewees described the tension between establishing a single, London-wide service offering economies of scale and a standardised service across the city or a cluster of inter-connected local services able to cross cover each other when necessary. The latter would offer better local knowledge of services; local responsiveness and flexibility; and would be more likely to generate the sense of local ownership required to integrate NHS Direct with other local services (see above). Several interviewees commented on the problems of running a single service for a large area:

> *One call centre nationally would be dangerous, as you always must allow for equipment failures... five or six regional centres could work.*

> *... you need local information networks, nurses who know the patch; local sensitivity and understanding... the call centre could be larger, but... one national centre would be a different service.*

> *...the balance between standardisation and local flexibility is crucial... if there are big units of NHS Direct, they won't have good relationships with PCGs.*

One situation for which a national service could be beneficial is where interpreters are required. One interviewee suggested there should be a different number for each language, allowing callers to contact an interpreter who could then liaise in a three-way phone link between the caller and their local NHS Direct service.

At a local level, several interviewees described the organisational problems arising when different groups of health professionals are involved in providing a service run by three different organisations:

Management structures have been a barrier: the nurses are managed through the Community Trust, but the call-handlers, everyone else and the building are managed through the NHS Direct general manager. Having two management structures is messy, as it takes time to make decisions... One key message is that managerial structures and relationships need to be clear.

What does the consortium mean by partnership working, when one agency is accountable... one thing I'm interested in is how partnership arrangements work in a formal setting, so that you can put pressure on the accountable agency, and how you can disperse that to exercise a degree of leverage...

Accountability is further complicated by the division between organisational and professional hierarchies for the clinicians involved in NHS Direct. For example, if a nurse is concerned about the clinical recommendations made by the triage software, should the problem be referred to a general manager or more senior clinician?

The nurses are professionally accountable to the Community Trust, but operationally accountable to the NHS Direct general manager... if there's a problem, sometimes it's difficult for them to know who to contact...

Interviewees felt that both effective operational management and the strategic development of NHS Direct will proceed through influence and negotiation, requiring good inter-professional working relationships between managers and clinicians. West

London respondents felt that the close relationship between NHS Direct and the pre-existing Harmoni co-op had helped in this respect.

Funding for NHS Direct

The first wave pilot sites were very well funded, and the second wave sites have, likewise, been relatively well resourced. However, there is an expectation that the third and fourth wave sites will receive relatively lower levels of funding compared to the initial two waves. Several respondents commented on this, and the fact that to provide a good service is not cheap:

> *In the first wave there were no cost constraints at all. In phase two there was very little cost constraint but in phases three and four there is now being developed a national cost model and the budgets will be lower. We're already looking locally at how we will manage things if the phase three funding formula is applied to us.*

> *People underestimate the resources required, and underestimate the positive effects if the right resources are applied... Some of the third wave sites are under-funded... one key message is 'Don't do it on the cheap'.*

Staffing

Despite current problems with nurse recruitment, neither London service had problems with recruiting nursing staff. In south London, over 200 nurses applied for a total of twenty posts (many from outside the London area rather than from local trusts). Nurses are employed as G grades although one interviewee questioned the relevance of the traditional grading system for NHS Direct, noting that a competency framework is being developed which may be more appropriate to the nature of NHS Direct work. The nurses received training for telephone triage work: west London nurses received six days of

training at Thames Valley University followed by 30 hours of study to produce a diary of calls; south London nurses receive a 12-week training period including sessions about the organisation of local services, a week of mental health training and education about other clinical specialties.

In west London most of the nurses work part-time for NHS Direct and part-time in other clinical roles. In south London most of the nurses work full-time for NHS Direct. Several interviewees described the benefits of retaining a clinical commitment in terms of ensuring up-to-date clinical knowledge, exercising clinical judgement and using subtle sources of information for decision making. These nurses will, however spend less time using NHS Direct software/protocols and have less time for communication and team building within NHS Direct.

- *We support using part-time nurses who are still also working in the NHS; for those full-time [at NHS Direct], in the longer term, it will be a major training issue to keep them up to date; we would favour people working half and half.*

  We're trying to keep the nurses in touch with clinical work; encouraging part-time work only.

Publicity

Several interviewees stated that publicity for the service had been inadequate and problematic. An initial decision to stagger publicity in order to avoid an unmanageable rush to use the service had resulted in a slow start and there were post office related problems with delivering leaflets. Several interviewees felt that publicity had been inadequately targeted at ethnic minority groups, elderly people, refugees and other disadvantaged groups. In addition there was limited distribution of leaflets and cards with the NHS Direct phone number by local GPs and A&E departments, although A&E

consultants explained this was due to a lack of materials rather than opposition to the service. One further problem was that it was not possible to use pan-London media (such as Capital Radio or *The Evening Standard*) for a service that covered only two parts of the city.

> *...the lack of publicity, which is mostly beyond our control, is a concern. The thing that really worries me about it is that the publicity is not appropriate and it's not targeted ... London needs a separate strategy... to cater for ethnic and other groups and also with regard to advertising: in Northumberland, they can use local radio or the local newspaper; we can't do that as we don't have a 'Lambeth Southwark and Lewisham' radio station or newspaper.*
>
> *... Publicity was increased gradually until the service was up to capacity and we're now looking at more innovative publicity for example in bus shelters or on bus tickets...*

Information Technology

Reliable information technology is essential for NHS Direct, with three points of particular importance for establishing and running the service. These relate to the choice of decision support software, the need for reliable hardware, and plans to cope with system failure and the need for reliable IT support.

Choice of decision support software

There are three decision support software systems available to support nurse telephone triage. Choosing between them requires a trade-off between the length of each call, the quality control mechanisms for the system and the amount of clinical flexibility allowed to the nurses. Both London sites are using the British Telephone Advice System (TAS)

which is quicker and allows more clinical judgement than available American packages. Comparing two of the packages, one interviewee explained:

> *... The Access [American] system is by far the best product and it is backed up by a huge quality improvement project so you can monitor the nurses and see if they deviate from the protocols but it takes 15 minutes to do an average call. An average TAS call takes about 7 minutes so across the country you'd have to have double the number of nurses which is financial suicide. TAS does have tremendous potential and it is easier to use but it does need to be developed.*

There was no evidence to support rumours that one or other software package performs better in specific clinical situations.

Hardware issues

Contingency plans are required to deal with a major system failure. A fire in an electricity sub-station caused such a failure in west London, testing the service's capacity to cope with such events. British Telecom was contacted and all calls were redirected to south London. Many of the respondents interviewed reported that this had been a useful learning experience about what to do in the event of such a failure, and that the situation had been managed seamlessly and well. There were no adverse clinical events reported as a result of this failure.

> *Shortly after the service started, an electricity sub-station fire caused a power cut for several hours...we had to transfer calls to south London... it was completely beyond our control, and I was happy with how we coped.*

Another important hardware problem relates to the compatibility of telephone exchanges with NHS Direct equipment. Incompatibility with some exchanges means that residents of some NHS Direct areas are not able to access the service because their BT exchange lies outside the area. Conversely, some non-residents can access the service because their exchange lies within the NHS Direct area. This causes confusion if people receive advertising leaflets through their door but cannot access the service. One CHC also reported directory enquiries giving the NHS Executive number instead of the NHS Direct number, causing additional confusion.

Some respondents were concerned about the limitations of NHS computer technology – in particular the lack of an Intranet to provide good up-to-date information to nurses about local services and the slow progress being made with electronic patient records.

IT support

West London NHS Direct has no on-site IT support so breakdowns and other major problems can cause difficulties. LAS involvement in south London provides access to high specification call handling technology which allows rapid call transfers and makes the service more resilient if there are technical problems. However, the LAS manages IT in south London, which was seen to have created some tensions.

> *Technology has been hugely problematic and that has brought tensions to our partnership because LAS is formally responsible for making sure all is OK...*

In addition to day to day operational support, several interviewees discussed the need for a high calibre IT manager to oversee IT aspects of the strategic development of NHS Direct across London. This would involve ensuring each London service could provide cross cover for the others; developing an intranet for access to London-wide information

on health related services and implementing relevant parts of the NHS information management and technology strategy. Interestingly, it has not been possible to recruit an IM&T manager for the London-wide service.

5.4 Quality and impact on clinical care

Questions about quality arise both in terms of NHS Direct itself and of its impact on the quality of other health services. The former is shaped by the organisation and reliability of the service, the quality of NHS Direct staff, the protocols they use and the clinical outcomes they achieve, and is reflected in patient satisfaction with the service.

The Sheffield evaluation of first wave pilot sites includes an assessment of patient satisfaction with NHS Direct and the two London sites are undertaking their own surveys on this topic. Sheffield researchers are also evaluating the impact of NHS Direct on the use of other health services. The current study offers complementary insights into the quality of NHS Direct in relation to staff, training, triage software, and the need for widely accepted quality standards for NHS Direct. It also examines the potential impact of NHS Direct on the quality of other health services in terms of standardisation of services, continuity and access.

Key lessons

- National standards are required to ensure uniform quality across all NHS Direct sites. Possible areas for setting standards include staff recruitment and training, IT provision and support and protocol quality.
- NHS Direct could promote more evidence-based standardisation of health services but this may require local acceptance of national protocols which may be hard to achieve.

- If backed up by rapid information transfer, NHS Direct does not necessarily jeopardise continuity of care.
- Well-targeted publicity and careful monitoring are required to ensure that the service is accessible to and used by groups that often find it hard to gain access to health services.

The quality of NHS Direct

There was widespread agreement that as a national service provided at multiple local centres, standards will be needed to ensure the quality of NHS Direct. Interviewees suggested that these may cover staff training, IT provision and back-up to cover system failures and protocol development. No formal set of quality standards for NHS Direct has yet been identified, but a number of issues were seen to be key determinants of the quality of the service.

Quality of nursing staff

Many interviewees commented on the high quality of the nursing staff recruited and felt that local training programmes had prepared them well for telephone triage work. West London interviewees also felt that retaining a clinical role was an important way of keeping up clinical skills and judgements. Debate is underway about identifying a set of core competencies for NHS Direct nurses that would move away from the current grading system, but ensure their clinical competence.

Computer protocol quality

Given that the nurse advice is largely prescribed by the software protocols used, quality could in some ways be measured by adherence to these protocols. This raises questions both about auditing adherence to protocols and about the quality of the protocols themselves. One characteristic of the TAS system used in both London sites is that it

allows more clinical judgement than other triage software systems enabling nurses to use the nuances of conversation to influence their interaction with the caller (with the option of requesting advice from a back-up GP if worried). Despite this flexibility, the quality of advice given will be largely a reflection of the quality of the protocols followed. Plane Software, who produce TAS, have a multi-specialty panel of experts who have agreed the protocols. Changes can be made on a national basis if agreed by this panel, or on a local basis as a local 'amendment' to reflect local policies. Sites can request changes to the software, which are referred to the national panel. South London also has a local, multi-disciplinary Expert Review Panel to review protocols, identify gaps and recommend changes. Concerns about inefficiencies in the system for reviewing and changing protocols were expressed by one interviewee.

> *TAS is the best system but there are gaps in the protocols. To change them... suggestions have to go to the national Plain Software group... which takes six months if they agree there is a gap... Gaps include Genito-Urinary medicine, sickle cell disease, the morning after pill... nurses have other bits of paper they use instead for these things... but this is bitty, and leaves us vulnerable.*

Clinical outcomes

Perhaps the most important measure of the quality of NHS Direct is the clinical outcome of each patient-nurse interaction but this is hard to assess. It is not routinely possible to 'track' a patient through the system and it would take a formal study to follow up a cohort of callers to assess their subsequent clinical outcome and whether the nurse advice was appropriate. Several interviewees felt such follow up is crucial to assess the effectiveness of NHS Direct.

We need reliable research on the effect in terms of outcomes and compliance... it would be a very expensive service if people ignored all the advice given...

Access to NHS Direct services

Several interviewees stated that promoting access to NHS Direct for groups that find it hard to use health services is an essential task for a high quality service. However, many expressed concern that publicity had not been targeted to these groups and CHC interviewees argued that literacy may be poor in minority ethnic groups so leafleting alone would be insufficient. Other suggested modes of publicity include word of mouth from health-care or other workers, advertising through religious centres, shopping centres and on bus tickets and shelters, and targeted talks to specialist groups.

Publicity was inadequate, but this was not necessarily [NHS Direct's] fault. One of the leaflets in Urdu was incorrectly ...translated and has been withdrawn to be re-done. There are leaflets in six languages, but there are 149 languages in Ealing, so we can't do them all and there is only 30–35 per cent literacy in some groups... We need to reach people through physical outreach work, Health Visitors telling mothers, the CHC outreach worker, talking to specialist groups.

For ethnic minority groups, both the London sites use 'Language Line' – an interpreter service which provides speakers of a wide range of languages. Patients ringing NHS Direct can be connected in a three-way link with an interpreter who can then act as intermediary between the caller and the nurse. This service was praised by several interviewees as offering good access to non-English speakers. However, the caller must still be able to make the call-handler or nurse understand in which language they wish to communicate. One interviewee suggested moving towards a national system with a different NHS Direct number for each language. Initial calls could be handled at a national centre by speakers of

the appropriate mother tongue who could then contact the caller's 'local' NHS Direct centre and interpret in a three-way conversation.

Both sites are studying ways of improving access for homeless people; the feasibility of placing dedicated freephones in hostels for the homeless is being explored. For new refugee communities, both access to a phone and language may pose problems for using NHS Direct. One person suggested giving out information about NHS Direct to refugees at their port of entry.

Impact on the quality of other health services

Three more general issues were highlighted about the potential impact of NHS Direct on wider health services:

- enhancing the standardisation of services through sharing and auditing up-to-date evidence-based protocols and through work to reduce discrepancies in services across an NHS Direct 'patch'
- impact on continuity of care
- effect of NHS Direct on access to other health services.

Standardised, evidence-based health care

The use of computer driven protocols offers the potential to increase the provision of standardised, evidence-based advice throughout the health service. However, the balance obtained between widespread standardisation and local ownership will determine the extent to which protocols are acceptable to local health professionals.

> *I see NHS Direct playing a big and important role in developing protocols to be used by everyone, not just NHS Direct nurses, along with NICE and CHIMP...*

I would have thought there was a role for NHSD in improving quality... in improving access and promoting consistency of advice given.

A standardised, protocol driven service also creates opportunities for auditing clinical practice. Nurses' advice can be audited by presenting similar calls to different nurses and reviewing the advice given. Similarly, if patients are advised to attend the primary care centre, each doctor working at the centre will have access to the same facilities and the medical management offered could be audited against locally determined standards.

NHS Direct is potentially one of the largest quality assurance mechanisms we've ever had in the NHS, it has huge potential... We have a good idea of what's going in the door [of the primary care centre]. We could control for case-mix going in and follow up what comes out. We know there are huge variations in nurse triaging patterns, and after controlling for case-mix, there are different outcomes ... Imagine being able to do that for GPs... if you could feed that into an education system and say we recommend the following personal learning portfolio, then follow up to see if it works.

Several interviewees commented that NHS Direct has highlighted variations in services across the local area. One example of this relates to mental health, where access to out-of-hours services varies widely between areas. A working party has been established to collate information across the west London NHS Direct area, aiming to develop a comprehensive list of services available and to standardise the terminology used.

For mental health, we're using NHS Direct to help achieve the target of 24-hour access to acute services... we're doing a mapping exercise, by client group, by borough, by day/time of the services available, and how to access them, so NHS Direct staff have full information about services...

Impact on continuity of care

Critics of the service have argued that that continuity is a cornerstone of British primary care, which is jeopardised by NHS Direct. Most interviewees accepted that continuity is important for patients with a chronic illness or for groups with complex needs such as older people but several suggested that younger working patients with acute minor ailments would choose prompt service from a competent doctor in preference to seeing the same doctor repeatedly.

> *Continuity is something which seems to me to be played up by GPs. There are clearly subsets of the population for whom continuity is critical. But for a large proportion of the population who don't make much use of primary care then continuity isn't really an issue. If I need to see a doctor I don't care who I see... just want to see somebody quickly because of all the other things going on in my life.*

NHS Direct was argued to contribute to current demand for rapid access to health services. However, a GP who acknowledged that not everybody wants continuity of care also recognised the potential problem of overlooking the issue.

> *I had a bright young city type this morning, on his way to work, for him it doesn't matter... but in the end, patients will suffer because continuity of care won't be there for those who need it...*

Most people argued that fewer patients now have continuity – which is mainly offered by single handed and 'personal list' GPs during surgery hours. Patients registered with group practices increasingly see a doctor other than their own or another member of the primary health care team and for them a complete up-to-date patient record was seen as the linchpin of continuous care. In theory, NHS Direct can inform each patient's usual

GP about their call and the advice given to maintain this continuity. Indeed the west London NHS Direct site routinely faxes every caller's GP (if the caller agrees to this).

I think continuity of care is a myth, because unless you have a single-handed GP you'll not get continuity; that single-handed GP in London is extremely unlikely to run his own out-of-hours, so there is no continuity in the evening, if you go to casualty, there's no continuity, and if you see another partner in the same practice you're assuming accurate and full record keeping...

Continuity ceased to exist many years ago. Most general practices are now group practices and the continuity is much more about the record than about the doctor you go to see. I think there is real value in having a complete patient record.

Impact of NHS Direct on use of other services

Critics of NHS Direct have warned that it may unveil unmet needs and unleash massive demand for other services. Although few interviewees saw it as a problem if NHS Direct results in referrals for people with previously unmet needs, the key question is whether the service can ensure more appropriate use of other NHS services. Interim results from the Sheffield evaluation show little effect on activity levels in other services.

Both London sites compile monthly data on triage outcomes, which could act as a proxy measure of effect on other services if compared to the 'pre-call intention' of NHS Direct users. However both sites have found that data on 'pre-call intention' are often incomplete and there is no routine way of knowing if callers act upon the advice they are given and change their intended use of other services. A study is underway in south London to track the actual service use of a cohort of callers advised to attend their GP or A&E, which will give a more accurate picture of the real effect of NHS Direct advice on use of other services.

Clinicians (GPs and A&E consultants) interviewed for the current study thought that NHS Direct had had little impact on use of their own services. GP views varied as to whether the service had reduced out-of-hours work load or increased their routine workload, but all felt it was too early to draw firm conclusions. However, several A&Es had introduced a system to divert telephone requests for advice to NHS Direct and these consultants reported that their staff members now spent less time on telephone queries.

> *It was heralded as reducing the number of patients coming to A&E but this is manifestly nonsense, it's had no effect whatsoever... However, we have been redirecting initial calls from the public to NHS Direct – maybe 20–30 calls per day – and that has been helpful. We're not particularly well geared up to handle them... in the sense that there's nobody sitting by a phone ready to answer, and so we give an uncontrolled response... we may not be able to offer sensible or helpful advice, and perhaps more importantly, it is not recorded... that moderately considerable load has been effectively taken off our shoulders by NHS Direct.*

The Ambulance service has seen no reduction in 999 calls although there had been some expectation that NHS Direct could reduce the number of category C (less serious) calls.

5.5 Current and future roles

Although currently used mainly for out-of-hours advice, interviewees envisaged a variety of additional roles for NHS Direct in the future.

Key points

- NHS Direct is currently mainly used as an out-of-hours advice service and there is scope to develop its day time and information roles.
- NHS Direct could fulfil a range of roles within a local health economy including providing information and advice, health promotion, outreach calling and participating in integrated care pathways.

Current roles

Most respondents agreed that the main current role of NHS Direct is providing health advice, and information – although several interviewees felt that the information role is currently underused. It is mainly used as an out-of-hours service, although this pattern is beginning to change. It also appears to have a role in providing reassurance, someone accessible to speak to, *'a sounding board'*.

It's a nurse led, health advice, health information service providing local information on amenities... it's a focus for the public who don't want to bother the doctor, but who want reassurance, or confirmation of what they plan to do.

It's the first 24-hour service developed in the NHS for decades... providing a guide to other services... a reassurance role, a referral role, also providing information... there are three core things that NHS Direct does: it provides health advice, information on health, and information on health services ... at the moment 95 per cent is health advice, but that will shift in the future.

It fulfils the role that granny used to fill... not exactly a shoulder to cry on, but there to listen and suggest appropriate resources... it's fulfilling a role in society which the

NHS has not explicitly outlined before... carried out by many services, which I hope we can add to and in many cases replace.

Both sites can call back to patients to check whether the advice given was appropriate, either calling them after a specific time to check on clinical progress or asking the patient to call again to say whether symptoms are resolving. Many interviewees commented that this further reassurance was valued by patients.

Triage is an important function that was also mentioned, with NHS Direct nurses directing callers to the appropriate service if needed.

Initially we thought it would be an advice line... but it's not straightforward advice, it's more triage, because of the GP out-of-hours work.

It's providing a very good triage service, and also assisting people who are worried or concerned... it's particularly necessary here, as we have a lot of single handed practices in one area... it's much better that people can get hold of someone to talk to.

Others said there was a definite 'gap' in services, which NHS Direct was filling.

It's useful for unregistered patients as we have a 30 per cent turnover, that means 30 per cent change GPs each year, and the CHC get calls asking how they can get advice... it is covering a gap, there definitely is a gap.

Another role mentioned was as a 'second opinion service', although NHS Direct nurses will not directly challenge advice from another clinician but may advise a caller to contact

their GP to discuss the matter further. A few respondents stated they did not know what role it was fulfilling.

Future roles

Several potential future roles were mentioned, falling into the following broad groups:

- an **enhanced information role**, including links to other agencies, such as social services, environment and housing, and voluntary agencies; acting as a single point of access to information about services for the public and professionals
- a **role in enhancing access to health services** for groups who traditionally have difficulty accessing health care
- proactive **outbound calling**, including **health promotion** work, for example, in chronic disease management or calling patients to remind them about outpatient appointments; also a **role in integrated services** bridging primary and secondary care (for example, calling patients discharged from hospital)
- **NHS Direct online**: the web site providing information online; and the NHS Direct **health guide** self-care booklet
- an extension of these ideas is that NHS Direct could become ***the*** **gateway to the NHS**.

Enhanced information role

Several respondents thought the information role could increase, with NHS Direct becoming recognised as a 'single point of information' on health. To achieve this, information needs to be collated and accessible for the nurses but several interviewees reported that it will require substantial work to collate all necessary information and ensure it is kept up to date. The IT infrastructure required to enable such developments must keep pace with the requirements of the service.

I think to have a national health information line is a very good idea... a health information point providing information about health, social services, pharmacists, phone numbers...

... a single telephone number giving a clear idea of all services available, encompassing health, social services, housing, environment, voluntary organisations... for professionals and patients too...

Enhanced access to health services

The *potential* for NHS Direct to provide enhanced access to disadvantaged groups was highlighted by several respondents, although concerns about *current* accessibility to such groups and plans to improve access and publicity were mentioned earlier.

- *We need more thinking about the objectives of the service, are we trying to increase access for marginalised groups, or are we providing a second opinion for the middle class 'worried well'. We should be doing the former, and the service should be targeted thus – at homeless people, and ethnic groups with the interpreting service.*

Outbound calling and integrated care

Outbound calling, in various forms, was mentioned by many respondents. Suggested roles include health promotion, particularly for patients with chronic diseases and links with secondary care services such as calling patients newly discharged from hospital to check on their progress, calling patients to remind them of outpatient appointments, or calling patients who did not attend their appointment. These activities could fall within an umbrella of 'integrated care', with NHS Direct bridging and cementing the link between primary and secondary care. Such 'integrated care' would also require adequate supporting IT systems.

Outbound calls will increase for delivering and monitoring care, for example for patients discharged from hospital, elderly screening by phone, newly diagnosed patients with diabetes or coronary heart disease... as a package of care between NHS Direct, primary care and hospital – integrated care.

A local voluntary organisation already phones the isolated to check how they're getting on. This could be a useful role for NHS Direct.

Views differed about the appropriateness and feasibility of NHS Direct undertaking such proactive calling. At the moment, outbound calling could fill in the quiet periods during the day time/GP surgery hours. However, as the service becomes busier, this may become less feasible. The idea that NHS Direct could become involved in GP and hospital appointments was not universally welcome:

I wouldn't want it to be handling GP appointments, nor managing outpatient appointments... it's not for NHS Direct to do that... I wouldn't want to see NHS Direct ringing people up saying 'are you coming to your outpatient appointment'.

Views were also expressed that such outbound calling may be seen as intrusive, raising issues about confidentiality and data protection. It is not clear how cold calling, or proactive calls would be received by members of the public.

NHS Direct online and the health care guide

Another role for NHS Direct will be in NHS Direct online – part of the NHS web site – offering an interactive guide to minor ailments. This will also link to the National Electronic Library for Health. An NHS Direct health care guide will also be developed

covering common ailments and problems on which NHS Direct nurses are routinely taking calls. Nurses will be able to send out the guide if they think it would be helpful.

The online bit will increase, and it could provide a useful information service for health professionals about services... a gateway to the electronic library for health.

Gateway to the NHS

An extension of the concept of 24-hour direct access to NHS Direct would be to develop its role as *the* gateway to the NHS. In April, Tony Blair announced a plan to extend the role of NHS Direct as a gateway to the NHS, enabling the nurse to pass the caller on to a doctor working out-of-hours, or to social services or mental health staff – depending on the person's need.

Views about whether NHS Direct should or could be *the* gateway were mixed; with some respondents thinking that it can and will fulfil this role in future. However, the majority thought that it should be an *extra* gateway, with NHS Direct embedded and working alongside other services and patients able to choose how they wish to access different NHS services. Some people questioned whether, if NHS Direct took on this wide role, the existing service will ultimately suffer.

It should be THE gateway to care – 'care direct', ultimately linked with other services ... it should be putting people who seek help in touch with the right agencies.

It should be embedded in the local health economy, not an extra service, but an embedded one; however, it shouldn't be THE gateway, this would worry me, as it would be a disservice to patients.

6. Discussion

NHS Direct will be a nation-wide service by the end of 2000, and plans for implementing the third and fourth wave sites are well underway. Final results from the evaluation of the first three pilot sites will soon be available and will help us to understand better about patient attitudes to nurse-led telephone triage and the impact of NHS Direct on other health services. The interview study reported here offers complementary information, based on the practical experiences of health professionals involved in implementing NHS Direct in two London sites. Drawing on these results and also on relevant literature, the following section reviews the lessons learned from the introduction of NHS Direct in London and raises three general questions about the future development of the service:

- How does NHS Direct compare to the expectations of its advocates and critics?
- What will enable the potential future roles of NHS Direct to be fulfilled?
- What impact will NHS Direct have on the wider NHS?

6.1 What lessons can be learned from the introduction of NHS Direct in London?

The two London sites demonstrate that, despite opposition from doctors both nationally and locally, NHS Direct can be established as a viable local service. However, the perception by GPs that central policy makers were determined to force through the development and nation-wide expansion of the new service, irrespective of evaluation results, is not without costs. Many GPs have become alienated and sceptical, maintaining a distance from the service and making it harder to negotiate the shared protocols required

for a high quality service (e.g. for the seamless transfer of patients between NHS Direct and other local health care organisations).

Despite these problems, both London services are now well established with rising call numbers and several factors appear to underlie this success. First, the environments into which NHS Direct was introduced – linked to a well-established co-op which already used nurse triage in west London and to a team with a long history of developing and evaluating innovative out-of-hours primary care in south London – facilitated the introduction of the service. Second, both sites have established good working relationships between partner organisations which was considered essential for developing the service agreements and joint protocols required to run NHS Direct. The partnerships allowed skills to be shared and generated ownership of the service among local health professionals, although they also create complexity in terms of organisational structure and accountability. Third, particularly in west London, the fact that 70 per cent of GPs participated in the co-op and many local patients were already used to nurse triage in out-of-hours primary care was thought to have reduced resistance to change.

While the above factors facilitated the introduction of NHS Direct, several others have made its inception more complicated. In both sites there were problems with integrating the information database with a triage software system which was not designed to take it so much necessary information about local services is not available online. A clear need was identified for a high level IT specialist who could work across all London sites and improve the quality of the service. The LMC representative on the south London consortium was concerned about legal responsibility for patients advised to call NHS Direct, which had a knock-on effect on the attitude to the service of local GPs. Guidance on legal liability is imminent and is likely to identify different levels of liability depending on how the caller obtained the NHS Direct number (from an advert or from a GP answerphone) and the relationship between the GP and the co-op. Publicity for NHS

Direct was considered inadequate both in terms of distribution and of targeting groups with specific needs. Finally, the complexity of developing management systems and organisational and professional accountability across three partner agencies also made implementation more difficult.

In the longer term, it will be essential to develop standards for NHS Direct services and mechanisms to monitor and improve quality. A national financial framework is being developed for the service and it remains to be seen whether other national standards will be set (e.g. for call answering times, staffing and training levels and clinical governance) or whether these will be left to local discretion.

In addition to these general issues, the introduction of NHS Direct in London creates some specific problems which may affect the service in other big cities but are unlikely to be faced everywhere.

Ethnicity and language

The fact that approximately 150 different ethnic groups are represented in the London population with almost as many mother tongues spoken, creates a real challenge for NHS Direct. Both London services use Language Line to provide interpreters for non-English speaking callers and both have translated publicity materials into several languages. But there is still a feeling that NHS Direct is relatively inaccessible to these groups. A suggested solution to this problem would provide a single national number for non-English speakers (or a different number for each language to be covered). Callers would be able to talk to a call-handler who spoke the relevant mother tongue and who could arrange a three-way link to the caller's local NHS Direct service.

Pan-London publicity

London-wide media (e.g. *The Evening Standard* or Capital Radio) could not be used to publicise NHS Direct since only two areas of the city were covered. This problem will resolve when the service covers the whole city.

Cross-borough service differences

Both services covered multiple boroughs, with differences in the availability of various health and social services (e.g. mental health services) to callers from different areas. A west London working group had been established to map available services and work towards increasing uniformity of provision. In the meantime, advice about available services had to be tailored to individual callers. This highlighted a key benefit of local NHS Direct provision rather than a London-wide service. Until IT systems can provide comprehensive and up-to-date information for the whole of London, local services are able to provide more accurate information about local health and health care facilities.

6.2 How does NHS Direct compare to the expectations of its advocates and critics?

The Department of Health aims for NHS Direct were to provide 24-hour access to professional advice and information; to develop self-reliance and enable callers to self-care and to manage demand for other services.[13] In his discussion of NHS Direct, Pencheon saw the service as a modern, technologically driven gateway to the NHS which would allow patients to act in partnership with health professionals and which could be seen as 'the beginning of a range of systems that provide convenient, reliable and interactive gateways to health and other welfare services'. These might include meeting the special needs of particular individuals and groups; health promotion work; managing disease; prescribing drugs; and accessing hospital services.[11]

In contrast to these positive visions of an easily accessible 24-hour service, many GPs, including representatives of the BMA General Practitioner Committee and delegates at the National LMC conference predicted that NHS Direct would undermine the role of GPs and create inappropriate demand for services. There was also concern about who would take legal responsibility for the care of patients using NHS Direct. From a patient perspective, the studies cited above[9, 10] show that many people are willing to choose an appointment with a nurse in preference to waiting to see a doctor. By extension, they are likely to be willing to use nurse triage services, at least in some circumstances.

So how do the realities of NHS Direct live up to these predictions? The service certainly provides 24-hour access to professional advice and information. Evaluations of other nurse triage services have shown that nurses are able to handle approximately half of all calls on their own.[5, 18] A significant proportion of callers have been advised to self-care, although results are awaited (from the Sheffield researchers and the Immediate Access Project study of the south London service) about whether callers follow this advice and whether they are able to self-care when advised to do so.

In terms of demand for and use of other health services, the current interview study can provide only soft evidence of the impact of NHS Direct. A&E consultants said the service had not affected the number of people attending A&E but had reduced demand for telephone advice. GP interviewees did not report any noticeable impact on patient use of their services, or on their relationship with patients. Anecdotal evidence from discussion with GPs who were not involved with NHS Direct (and – as non-participants – were perhaps less likely to exaggerate the impact of NHS Direct) also suggested it was not affecting demand for appointments. The impact of NHS Direct on continuity of general practice care will be considered in section 6.4 below.

Quantitative assessment of the effect of NHS Direct on demand will provide more reliable information, although there are methodological problems with such work.[19] Nevertheless, interim results from the evaluation of first wave pilot sites (based on a relatively small number of calls) showed no significant change in the use of other services after the launch of NHS Direct. The final results of this evaluation will soon be available to judge whether the service is contributing to demand management. Shekelle and Roland suggest that, although there is little formal evidence about the effect of telephone triage on demand, the fact that many American health care providers are introducing such services 'provides strong anecdotal evidence that advice lines reduce the demand for more expensive physician services'.[20]

Patient representatives reported that NHS Direct was popular, allowing people to seek advice and reassurance at times when patients were often reluctant to call their own GPs. It could thus be argued that NHS Direct increases the accessibility of health services for some patients. However, concerns remain about the use of NHS Direct by groups with special needs and these are discussed further below.

6.3 What will enable the potential future roles of NHS Direct to be fulfilled?

Several future roles were described for NHS Direct: enhanced access to health care for specific groups, outreach calling, health promotion, participation in integrated care pathways, online information and acting as the main gateway to the NHS. For people with access to the Internet, the NHS web site will include an online information service, providing 24-hour, nation-wide access to health information. Other potential roles for NHS Direct are likely to be more local both in their focus and their development.

It is too early to know whether NHS Direct will develop to fulfil this wide range of roles, but several factors may support or inhibit such developments. First, NHS Direct would need to be perceived as an integral part of the local health economy and able to contribute to a range of services, rather than as an 'add-on', unrelated to other aspects of primary care. Second, good working relationships between partner agencies and other relevant groups are essential for negotiating protocols and standards for the new service. If the new roles envisaged for NHS Direct include work across the primary care/acute sector interface then collaboration with hospital clinicians will also be required.

The extent to which these extended roles are developed will be shaped by local circumstances and the particular pressures in each local health economy. Although there are now many other primary care professionals who could participate in and develop new roles for NHS Direct, GPs remain the first point of contact for most patients and, as such, will be key players in any such developments. It will thus be essential to ensure that GPs who are currently suspicious of or ambivalent about NHS Direct are fully involved in its future evolution.

6.4 What impact will NHS Direct have on other parts of the NHS?

Some of the strongest criticisms of NHS Direct have related to its potentially damaging impact on other health services particularly in terms of continuity of care, access to health services and staffing. How justified do these criticisms seem to be and what questions do they raise about the rollout of NHS Direct?

Continuity of care

Continuity can be defined as 'longitudinal' or 'personal', with the former referring to repeated visits to the same doctor over time and the latter to an ongoing therapeutic

relationship between patient and doctor.[21, 22] Clearly, NHS Direct cannot provide repeated access to a single clinician, but the impact of this on other primary care services is hard to assess. Benefits have been associated with continuity of care in certain, clinical conditions. These include improved compliance with treatment, reduced number and duration of hospital visits, reduced consultation times and lower use of tests, although there are methodological difficulties with some of the research.[21] Several researchers have shown that patients value continuity, which is associated with increased satisfaction[23, 24] and evidence is mixed about whether certain groups are more likely to achieve good continuity than others. Thus, Roland *et al*[25] found no association between age and continuity, but Freeman and Richards observed that older people were much more likely to achieve good continuity than children.[26] Sweeney and Pereira Gray[27] observed a high proportion of patients from social class 4 and 5 and of patients with marital, parent-child and relationship problems failed to achieve good continuity.

Despite the benefits which continuity seems to confer, various trends in general practice are jeopardising repeated access to the same clinician. These include group practices which do not require patients to see the same doctor; the growth in out-of-hours GP co-op, the growth of managed care and the development of care pathways through which many patients now see members of a health care team rather than a single practitioner. These trends are resulting in a growing emphasis on continuity of *information,* with a complete and accessible patient record seen as a way of supporting high quality, continuous care. There is, however, little research on the extent to which these changes preclude the maintenance of personal continuity with a particular clinician.

In its current telephone advice and information role, NHS Direct may have little impact on continuity of care. Callers' GPs can be informed about contact with NHS Direct (west London NHS Direct does this with the caller's permission) and those who are thought to require investigation or treatment will be referred to services which have traditionally

shared information with GPs (A&E or primary care centres) preserving continuity of information. It may also be that there is a cohort effect in the use of NHS Direct with certain groups (such as young fit people who do not necessarily value continuity) opting to use the service and others (such as the elderly or people with chronic diseases) choosing to contact the health professional with whom they maintain personal continuity. This may offer a partial explanation for interim results from the Sheffield evaluation showing a slight under-representation of older callers. (Other possible explanations include not having a telephone, unwillingness to use the telephone for health consultations, preference for continuity of care with their own doctor, hearing impairment and lack of awareness of the service.) More research is needed to understand these issues better.

It is possible that the planned walk-in centres will have more impact on continuity and clinical outcome than the telephone service. It would be theoretically possible to receive repeated treatment from several walk-in centres with each encounter uninformed by previous episodes. This could result in clinical warning signs of a serious condition being missed, even if relevant information was sent to the patients usual GP. Although the continuity of *information* offered by electronic records would prevent such problems, the necessary NHS-wide IT infrastructure still seems a long way off.

Access to health care

There is a danger that NHS Direct will conform to the inverse care law,[28] being most used by healthier people with easy access to a telephone and less well used by groups with greater health problems. There was concern amongst interviewees that publicity was not adequately targeted to groups which find it harder to gain access to health care and that initiatives would be required to make NHS Direct more accessible to these groups. Local data analysis does not allow breakdown by ethnic group or language spoken, but many interviewees thought that ethnic minorities were under-represented among callers.

The current policy of monitoring the ethnicity of NHS users is important for understanding whether NHS Direct provides differential access to different patient groups. Little has been written about existing telephone triage systems in relation to equity of access and the question requires further study. There are however, a number of questions to be addressed.

First, what will be the best way to ensure that non-English speakers and people without direct access to a telephone (or, in future, to a computer) will be able to use NHS Direct? Various options were described earlier and both London sites are considering installing freephones in hostels for homeless people, but it will be essential to monitor progress with these developments and to involve users in identifying the best ways to increase access. It is worth noting that many US HMOs offer freephone access to their telephone triage systems,[4] whereas NHS Direct calls are charged at the national rate.

Second, onward referral of NHS Direct callers to other services needs to be monitored. Will differences in the ability of different groups to access health services – including NHS Direct – be perpetuated in onward referral to other services? Research will also be needed to establish whether class or cultural factors affect the triage decision made.

Finally, a question arises about what would constitute equitable use of NHS Direct given that some people may choose not to use the service, preferring to maintain longitudinal and personal continuity with their usual clinician. Here too, additional research is needed to explore why non-users of NHS Direct choose to use other forms of primary care.

Nurse recruitment problems

Although hospitals in the two NHS Direct areas have not experienced problems with nurse recruitment since NHS Direct was launched, national rollout of the service may have more impact. The Royal College of Nurses has identified a shortfall of 8000 full-time

nurses in the NHS[29] and some hospitals already have to recruit nurses from abroad.[30] The number of nurses which will be needed by a nation-wide NHS Direct service is unknown and depends, to some extent, on the range of roles which each local service tries to fulfil.[31] Furthermore, while some nurses may return to work, given the opportunity to participate in this flexible and physically undemanding form of practice, others may transfer out of clinical practice, exacerbating current nursing shortages.

The practice in west London of encouraging NHS Direct nurses to continue part-time clinical work will help to mitigate this problem, but monitoring of nurse recruitment is needed to identify emerging problems quickly. One further issue relates to a possible move away from the employment of all NHS Direct nurses at 'G-grade' salaries. If this practice is replaced by the use of competencies as criteria for recruitment of nurses paid at different levels, it may become harder to attract nurses for NHS Direct in the future.

7. Conclusion

In conclusion, this study has highlighted the main opportunities and problems associated with implementing NHS Direct in two London sites. The importance of effective inter-organisational and professional partnerships and the engagement and participation of all relevant health professionals have been emphasised as essential for the successful development of NHS Direct.

Two main issues which must be monitored as NHS Direct extends across the capital are the extent to which the service is used by disadvantaged groups and its impact on other health services. Questions about the quality of NHS Direct and its impact on the quality of other health services also require further consideration and evaluation.

Appendix 1: List of interviewees

The respondents listed below were interviewed. Two interviews were conducted over the telephone, these are indicated by *; all the other interviews were conducted face-to-face.

West London

NHS Direct	Medical Director
	General Manager
	Development Manager
	Nurse Manager (one of four)
Health Authority	Chief Executive, Hillingdon HA (also Chair of pan-London steering group)
	Director of Corporate Management, Brent & Harrow HA
	Assistant Director, Ealing, Hammersmith and Hounslow HA
Community Trust	Chief Executive Harrow and Hillingdon Healthcare Trust
Accident & Emergency	Consultant, West Middlesex Hospital
	Consultant, Ealing Hospital*
	Consultant, Northwick Park Hospital
GPs	Three GPs in the NHS Direct area
CHCs/users	Chief Officer, Ealing CHC*
	Chief Officer, Hounslow CHC
	Chairman, Patients' Association

South East London

NHS Direct	General Manager (currently employed by Community Trust)
Health Authority	Assistant Primary Care Director, Lambeth, Southwark and Lewisham HA Practice Nurse Consultant to Lambeth, Southwark and Lewisham HA
Community Trust	Pharmacy Manager, Community Health, South London
Evaluation Team	Project Manager, Evaluation team
Accident & Emergency	Consultant, King's College Hospital
Ambulance Service	Director of IM&T, London Ambulance Service Research Officer, London Ambulance Service
GPs	One GP in NHS Direct area General Manager of SELDOC GP co-operative

Other

London Regional Office	Director of Nursing Assistant Director of Nursing

Appendix 2: Interview guide

NHS DIRECT Interview

Respondent .....

Date .....

INTRODUCTION: Respondent Details

Name:

Position:

NHSD site: W, S or both:

Face to face/telephone interview:

Place of interview:

Date of interview:

Name of interviewer:

SECTION A: BACKGROUND OF NHS DIRECT LOCALLY

1 In 2–3 minutes, can you tell me about the history of NHSD locally?

- **What is your role/involvement with NHS Direct?**

- How did OOH cover operate before NHSD?
- Is there a background of telephone triage locally?
- Local enthusiasm or otherwise?
- Local population?

SECTION B: ACTUAL EXPERIENCE OF NHSD

2 Now NHSD has started, what do you think of it?

- **Effect on you/your service?** (Demand, workload, relationship with other services.)

- **Effect on patients, GPs, A&E, ambulance service, other services?** (Demand, workload, relationship with other services.)

- **Impression of effect on overall demand for health services?**

- Is this what you expected?
- **Drivers locally, and barriers?**
- **Organisational/operational difficulties locally?**
- Pre-launch preparations adequate?
- Do you have an impression of who is using the service?

SECTION C: PURPOSE/ROLE OF NHSD

3 What purpose/role do you think NHSD is *currently fulfilling*?

- **Is this what you *expected*?**
- **Is this what you think it *should be*?** (Manage demand, increase access, patient empowerment, political response to consumerism, extra gateway v. the gateway.)

- **Stated aims for NHSD when it started – do you think these are being fulfilled locally?** (Encourage self-care, provide information, reduce unnecessary demand, and increase appropriateness of professional 'use'.)

- How do you see NHSD in the context of current developments in primary care?

- Do you think the concept of NHSD is good? (Strengths and weaknesses.)

SECTION D: THE FUTURE

4 What do you see as the future for NHSD?

- Continue? In what form?

- Any other ways NHSD could be used/useful?

SECTION E: OVERALL VIEW

5 In summary, what do you think of NHSD so far?

6 Any other comments?

- Key messages from experience in this site?

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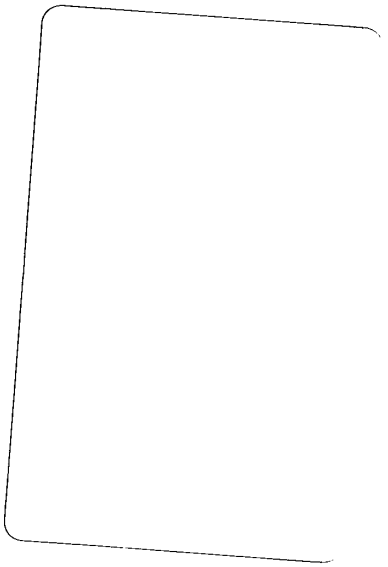

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