House of Commons

Committee of Public Accounts

NHS DIRECT IN ENGLAND

Fortieth Report of Session 2001–02

HC 610

House of Commons

Committee of Public Accounts

NHS DIRECT IN ENGLAND

Fortieth Report of Session 2001–02

Report, together with Proceedings of the Committee and Minutes of Evidence

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Committee of Public Accounts

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Footnotes

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EVIDENCE (*Wednesday 6 February 2002*) (HC 610-i, Session 2001–02)

WITNESSES
Sir John Bourn, KCB, Comptroller and Auditor General . . . . . Ev 1
Mr Glenn Hull, Second Treasury Officer of Accounts . . . . . Ev 1
Mr Nigel Crisp, Permanent Secretary, Department of Health; Mr Paul Jenkins, National Project Manager, NHS Direct, Department of Health; and Mr James Robertson, Account Director, National Audit Office . . . . . Ev 1

LIST OF REPORTS PUBLISHED IN SESSION 2001–02

FORTIETH REPORT

The Committee of Public Accounts has agreed to the following Report:

NHS DIRECT IN ENGLAND

INTRODUCTION AND LIST OF CONCLUSIONS AND RECOMMENDATIONS

1. NHS Direct provides healthcare information and advice to the public in England (and Wales) through a telephone helpline and an associated on-line service. The remit is to provide easier and faster health advice and information to the public. NHS Direct is already the world's largest provider of telephone healthcare advice, receiving 5.3 million calls in 2001–2002. The on-line service provides an e-mail health information enquiry service and web links to health information.[1]

2. On the basis of a Report by the Comptroller and Auditor General,[2] we looked at the implementation and delivery of NHS Direct, and the impact of NHS Direct on the public and on the NHS.

3. In the light of this examination, the Committee draws three overall conclusions.

- NHS Direct has quickly established itself as the world's largest provider of telephone healthcare advice, and is proving popular with the public. It has a good safety record, with very few recorded adverse events. Departments should consider what wider lessons they could learn from the successful introduction of this significant and innovative service on time.

- Current priorities are to complete the programme of integration with out-of-hours general practitioner services and establish closer links with ambulance services and accident and emergency departments. The Department now needs to set a clear strategic direction for the service in order to avoid it becoming a victim of its own success by trying to do too many things at once.

- Callers are currently waiting too long to speak to a nurse. NHS Direct expects that its capacity to handle calls will be improved greatly by forthcoming technological improvements in call routing and staff rostering, but it also needs to improve response times overall and review productivity levels at individual sites to cope with increasing demand.

4. Our more specific conclusions and recommendations are as follows.

(i) The Department of Health has not yet set clear longer term objectives for NHS Direct. While the immediate priorities are full integration with out-of-hours healthcare providers followed by the handling of 999 calls deemed non-urgent by ambulance services, there are a large number of other possible scenarios for future development of the service. The Department should set clear objectives within a medium-term development plan, with appropriate outcome measures on issues such as patient satisfaction. The plan should include a clear statement of the priorities and timetable for the integration of NHS Direct with other parts of the NHS.

(ii) NHS Direct does not yet have a human resources strategy that would allow it to take co-ordinated action to minimise the impact of its nurse recruitment on organisations elsewhere in the NHS. The Department of Health should move

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[1] C&AG's Report, para 1; *Official Report,* 17 April, col. 1034W

[2] C&AG's Report, *NHS Direct in England* (HC 505, Session 2001–02)

swiftly to finalise its strategy, in part to provide assurance to hard-pressed NHS trusts that the wider needs of the NHS are being taken into account.

(iii) Satisfaction with NHS Direct's service is high. Where general practitioner services out-of-hours have integrated with NHS Direct, patients are generally comfortable with speaking to NHS Direct. Nevertheless, many patients value being able to speak directly to their general practitioner, and NHS Direct are rightly committed to giving them that choice.

(iv) There are wide variations in the levels of productivity across sites: the number of calls handled per full-time equivalent nurse varied significantly in 2001–02. A minimum level of staffing is required to deal with unpredictable surges in demand, and the capacity of the network is being increased through the introduction of new computer call-routing software which will allow calls to be distributed more easily to sites with spare capacity. While this should allow sites to operate at optimum staffing levels, the Department of Health should also review the number of calls handled at each site to ensure that all are operating efficiently.

(v) Awareness of NHS Direct remains too low among some groups within the population, including ethnic minorities. Use of interpreting services indicates that NHS Direct is only reaching a tiny proportion of its potential non English-speaking callers. By the end of 2002 all NHS Direct sites should be aware of the patterns of ethnic minority habitation and social deprivation within their catchment areas, and have devised specific initiatives to encourage the use of the service by these groups.

(vi) Integration with providers of general practitioner services out-of-hours is a key priority for NHS Direct. It is learning the lessons of pilot projects and making progress in overcoming the initial technical problems experienced. NHS Direct now needs to maintain the momentum to ensure that it achieves full integration at current project sites and meets its timetable for future projects.

(vii) It is too soon to measure the impact of NHS Direct on the NHS as a whole. The evidence so far suggests that NHS Direct has the potential to save costs by re-directing callers to more appropriate forms of care. NHS Direct should take forward evaluation of the costs and benefits of the service, relative to possible alternative uses of these NHS resources.

Implementing and Delivering NHS Direct

5. NHS Direct's telephone and on-line healthcare information and advice services were implemented across England in less than three years, to the demanding timetables set by Ministers. This was a significant achievement given the innovative nature and scale of NHS Direct.[3] The service has quickly established itself as the world's largest provider of telephone healthcare advice, and is proving popular with the public.[4]

6. The tight timescales meant that implementing NHS Direct's telephone helpline service proceeded alongside piloting. There was little formal opportunity for lessons from pilot sites to be incorporated, although short lines of communication between the centre and sites allowed key lessons to be taken forward.[5] While Ministers had taken the decision at the outset that NHS Direct was to be introduced across the country, the model of NHS

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[3] Q84; C&AG's Report, para 2
[4] C&AG's Report, paras 1, 11
[5] ibid, paras 3, 1.5

Direct has been influenced by a continual process of piloting, learning from that experience, and modifying as implementation progressed.[6]

7. The overall aim of NHS Direct is to provide easier and faster advice and information for people about health, illness and the NHS so that they are better able to care for themselves and their families.[7] More detailed objectives for the service have been slower to develop, as have measures of success. A more comprehensive performance measurement and management framework has since been developed, which attempts to clarify responsibilities at different levels of the organisation, and to determine how NHS Direct fits with the wider responsibilities of the NHS. NHS Direct also recognises that it needs to make a number of strategic decisions about future development of the service.[8]

8. NHS Direct employs the full-time equivalent of 1,150 nurses, 80 per cent of which have been recruited from elsewhere in the NHS. There is a fear in other parts of the NHS that NHS Direct might be creaming off some of their key staff, particularly from accident and emergency departments. NHS Direct sites have taken a range of measures to minimise the impact of recruitment on other healthcare providers, including providing clinical placements and rotating staff, and encouraging staff to combine working part-time within NHS Direct with working in another part of the NHS. NHS Direct is currently developing a staffing strategy for the service.[9]

9. The true cost of NHS Direct will reflect both: the cost of employing agency staff, where they are replacing nurses recruited by NHS Direct; and compensating factors such as the potential of NHS Direct to reduce demand on other NHS services, and reductions in agency costs through use of the NHS' own agency, NHS Professionals, run from NHS Direct sites.[10]

The Impact of NHS Direct on the Public

10. NHS Direct impacts on the public in a number of different ways. We looked in particular at the quality of customer service provided, use of the service by minority groups and safety.

(a) Quality of service to customers

11. National surveys have consistently shown that over 90 per cent of callers are satisfied with the service they receive from NHS Direct.[11] In addition, in areas where integration with general practitioner out-of-hours services is well established, patients are generally comfortable with speaking to NHS Direct. Nevertheless, there are a significant number of patients who would like to speak to their own doctor, rather than NHS Direct, when seeking advice outside normal working hours. NHS Direct acknowledges that it should respect patients' wish to speak to their own doctor if they would prefer.[12]

12. However, NHS Direct is not achieving its internal target for 90 per cent of calls which require nurse advice to reach a nurse within five minutes (Figure 1), or an alternative NHS-wide target for 90 per cent of out-of-hours calls which require nurse advice to be completed within 20 minutes.[13]

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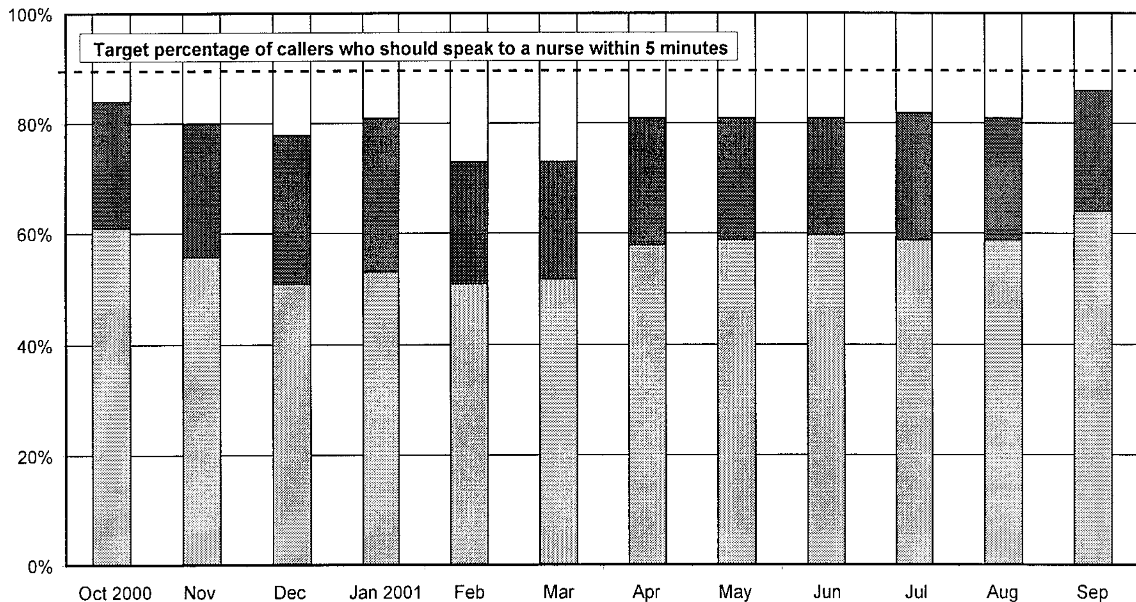
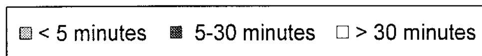
[6] Q29
[7] Q14; *The new NHS – modern, dependable*, Department of Health, 1997
[8] Q84; C&AG's Report, para 1.31
[9] Qs 5, 52; C&AG's Report, paras 1.25, 1.30
[10] Qs 17–26
[11] C&AG's Report, para 2.2
[12] Qs 9–10
[13] C&AG's Report, paras 2.10, 2.14

13. The number of calls handled per full-time equivalent nurse also varied significantly across NHS Direct's sites in 2001–02 (Figure 2). Factors influencing this included how well established sites were, and the learning curve associated with their transfer to a new computer decision support system.[14] There will always be some down-time at sites, as calls do not arrive in an even flow, and there are unpredictable surges in demand within more predictable peaks. But NHS Direct acknowledges that the variations in productivity are currently too wide.[15]

Figure 1: Time taken for callers to speak to a nurse in the year to September 2001



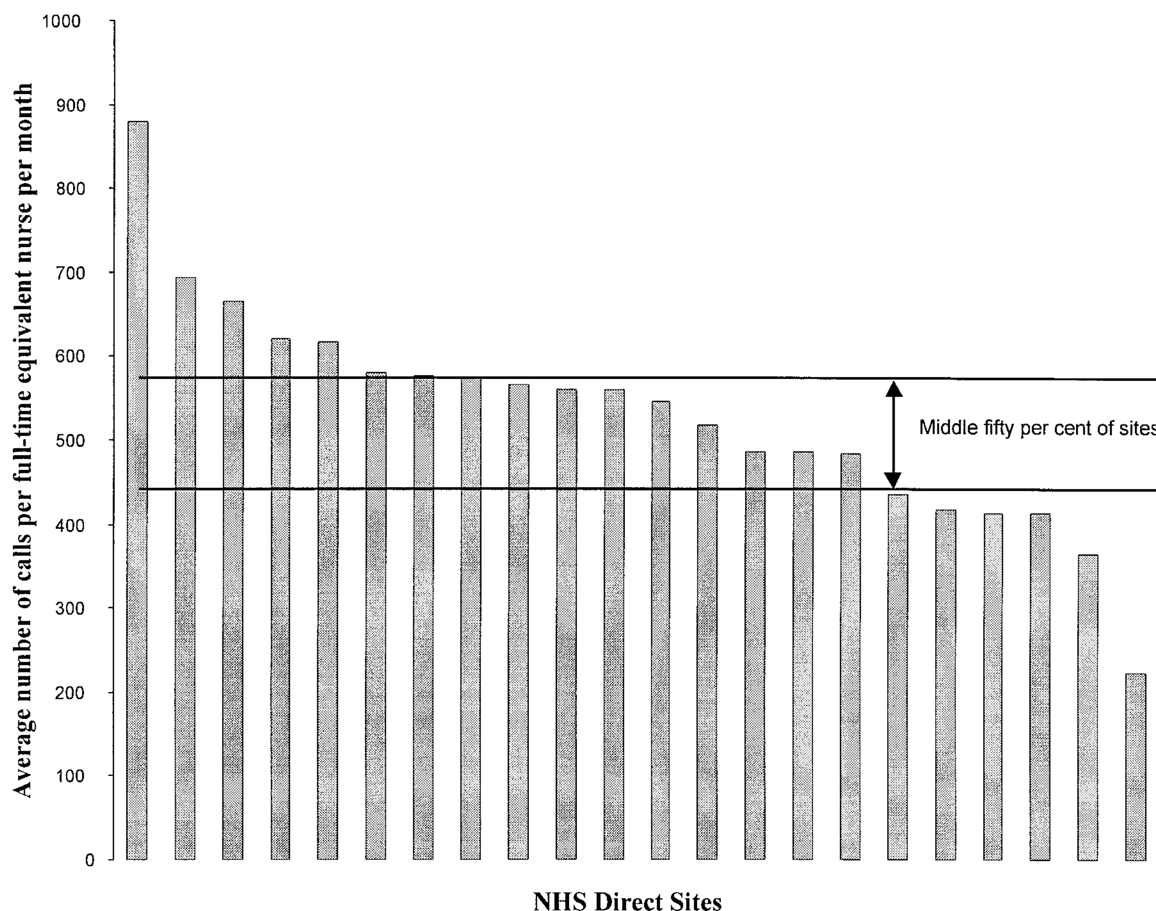
Note: Number of sites supplying data varied over time. Site not included if data supplied for less than half the days in a month



[14] C&AG's Report, para 2.12

[15] Qs 32, 37–38

Figure 2: Predicted average number of calls per full-time equivalent nurse per month in 2001–02*



*based on expected call volumes and employment levels contained in site business plans

14. Standardisation of computer software is allowing NHS Direct to make better comparison between sites, including benchmarking of processes so that ways of improving on the time taken to handle calls can be identified.[16] NHS Direct is also investing in a more sophisticated computer-based capacity forecasting and staff rostering system, so that it is better able to match staffing requirements with demand.[17] In addition, capacity is being increased by developing systems to move calls to another part of the country if one particular site is busy, which should allow for more efficient use of nursing staff.[18]

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[16] Qs 6, 32
[17] Q80
[18] Qs 6, 80

(b) Use of the service by minority groups

15. Regular tracking suggests that over 60 per cent of people are aware of NHS Direct when prompted. However, some groups—younger people, people over 65, ethnic minority groups, less advantaged social groups and people with disabilities—are either less aware of NHS Direct or use it less, but have equal or greater need for the service.[19] In setting up the service, NHS Direct has focused on building up overall awareness amongst the population, but is now bringing in more tailored initiatives to tackle lower levels of awareness in certain sections of society. There will shortly be a specific campaign targeted at younger people, and later in the year one for older people. In addition to these national campaigns, there is also an ongoing process at a local level where staff from NHS Direct sites go out to talk, for instance, to older people's luncheon clubs, engage with religious communities, and talk to schools.[20]

16. NHS Direct offers a translation service in over 200 languages. However, interpreting facilities have been used sparingly to date – only about 1,000 times out of 3.5 million calls received in 2000–2001. This suggests that the service has reached only a tiny proportion of those people who would prefer, for example, to receive advice in Asian languages only.[21]

17. NHS Direct has produced guidelines for its sites on raising awareness amongst ethnic minority groups, although at the time of a National Audit Office survey in June 2001 nine of the sites had not undertaken any initiatives to increase awareness amongst their ethnic minority populations.[22] By January 2002, five of the nine sites had implemented the national guidelines and the remaining sites have plans in place to implement them fully during the course of the year.[23] In addition, NHS Direct has piloted a routine programme of ethnic monitoring of callers in one site in London, which is to be rolled out nationally. And now that the service is operating on one computer system and has comparable data, NHS Direct is able to do some systematic work to map patterns of usage in wards or smaller units to look at factors such as social deprivation, ethnicity and patterns of usage.[24]

(c) Safety of the service

18. NHS Direct has a good safety record, with 29 adverse events cases being reported in the three years to June 2001 – fewer than one for every 220,000 calls.[25] Sites are required to report adverse events to NHS Direct's national advisers on nursing and medical issues. These advisers review the events, and recommend actions for individual sites and NHS Direct nationally.[26] NHS Direct's nurses use a computer decision support system to assist them in providing advice to callers. National bodies review the clinical content of the system to ensure that it is in line with United Kingdom best practice. The relevant royal colleges input to this review.[27]

19. NHS Direct uses the available networks to determine the consequences of its actions for callers. When adverse events are identified where the ambulance service or general practitioner is called out, where there has been a coroner's investigation after the event, or sometimes from a direct complaint from the patient themselves. However, NHS Direct, in common with other clinical services, cannot find out every consequence of its actions.[28]

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[19] Qs 7, 45; C&AG's Report, para 10
[20] Q7
[21] Qs 46, 79
[22] Q72
[23] Ref footnote to Q72, Ev 10
[24] Qs 75–78
[25] Q39; C&AG's Report, para 2.16
[26] Q42; C&AG's Report, paras 2.15, 2.17
[27] Q41
[28] Qs 42–43

20. The advice provided by NHS Direct can vary from caller to caller, depending on how a caller describes the symptoms they are experiencing. The judgement of a skilled nurse therefore plays a vital role in interpreting clearly what patients say about their symptoms, and relating that to the guidance given by the computer decision. If there is any doubt, then the nurse should advise a caller to see a doctor.[29]

THE IMPACT OF NHS DIRECT ON THE NHS

21. The NHS Plan envisages that NHS Direct will play a pivotal role in the provision of healthcare services to the public by 2004, especially through its function as the gatekeeper to out-of-hours care. NHS Direct is also introducing a range of additional initiatives at the local level.[30] We looked in particular at: NHS Direct's integration with providers of GP services out of hours, and with emergency services; other services provided by NHS Direct; and at the impact on the NHS as a whole.

(a) Integration with general practitioner out-of-hours services

22. A review of out-of-hours services in England commissioned by the Department of Health recommended a model putting NHS Direct at the hub of out-of-hours care (Figure 3).[31] NHS Direct would use its position as a national service with universal clinical standards to provide a gateway to other services, either by people calling it directly or by automatic call transfer from a general practice. The Government accepted this recommendation. As a first step towards implementation NHS Direct aimed to integrate with 22 general practitioner out-of-hours providers by March 2002, through a programme of exemplar initiatives located throughout the country. Together with a further 12 providers already integrated with NHS Direct, this covers 10 million people.[32]

23. NHS Direct has experienced some teething problems in achieving integrated working with general practitioner out-of-hours providers, including difficulties with the incompatibility of technology.[33] These have been tackled through the sharing of experience between sites, and the development of a standard way of communicating between NHS Direct's computer decision support system and the IT systems that providers use – although there were still some issues to be ironed out.[34] The direct electronic links between NHS Direct and out-of-hours providers established for the exemplar sites mean that callers do not have to go through the same information twice as records of the advice given can be shared automatically.[35]

24. By March 2002 access to out-of-hours care through NHS Direct covered seven million patients, and the Department intend to extend this coverage to 10 million patients over the following couple of months. The Department's target is for the whole country to have access to out-of-hours general practitioner care through NHS Direct by 2004.[36]

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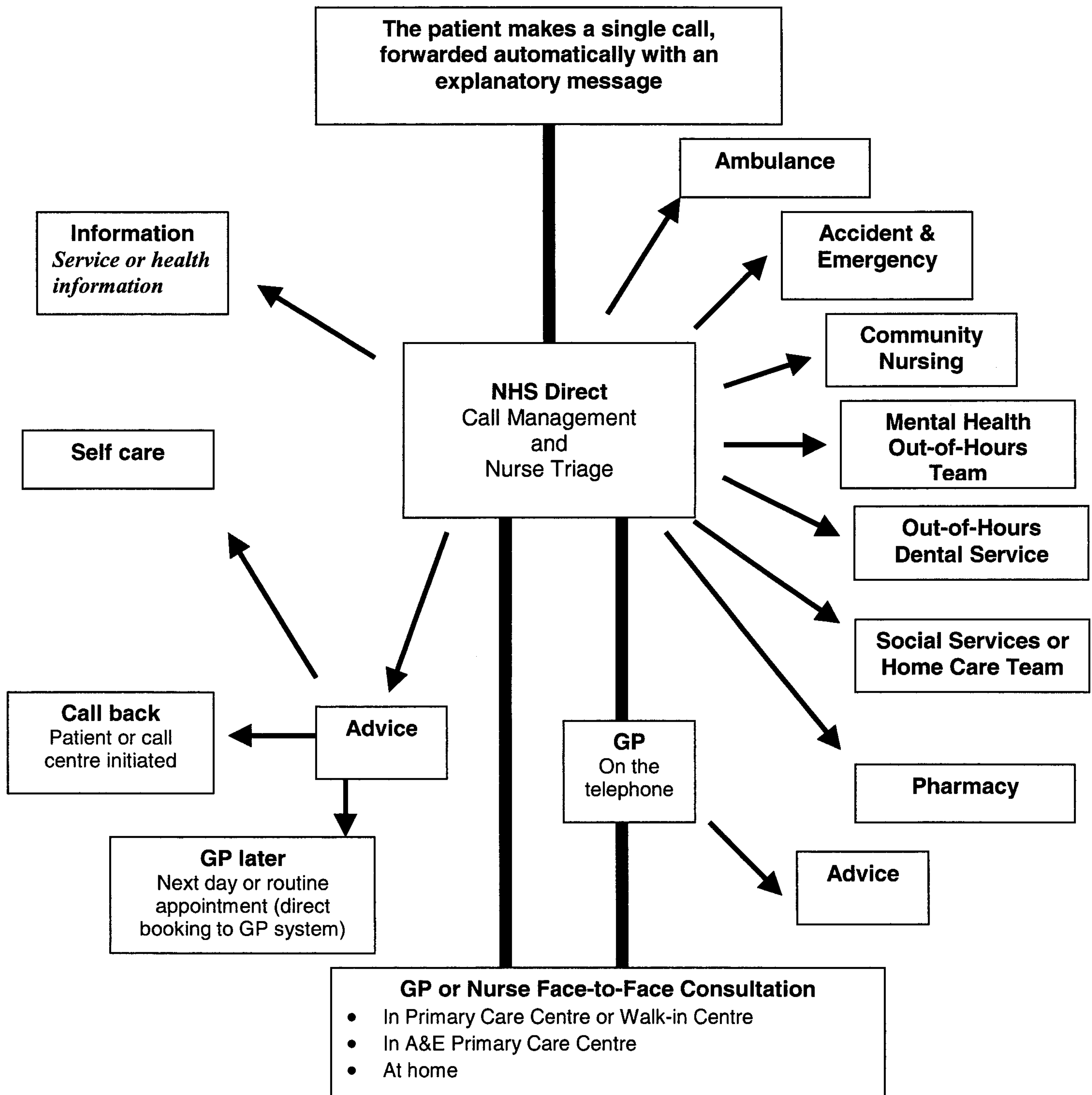
[29] Qs 69–70
[30] C&AG's Report, para 3.1
[31] ibid, para 3.7 and Figure 8
[32] ibid, para 3.7
[33] ibid, para 3.10
[34] Qs 8, 96
[35] Q68
[36] Qs 90–91

Figure 3: NHS Direct as a gateway to out-of-hours healthcare



Source: Independent Review of GP out-of-hours services in England (2000): *Raising standards for patients—new partnerships in out-of-hours care.*

(b) Integration with emergency services

25. NHS Direct has strong historic links with emergency services, and the original trigger for the setting up of the service as it is today came from the Chief Medical Officer's review of emergency services. NHS Ambulance Trusts provide more than half of NHS Direct sites.[37]

26. There is scope for calls to ambulance services that are not deemed emergencies by call-takers to be transferred to NHS Direct for advice or information. The Reforming Emergency Care strategy [38] highlighted this as a priority and suggests that the handling of 999 calls will be brought together with calls to NHS Direct by 2004. At least four NHS Direct sites are currently assessing such calls on behalf of ambulance services.[39] The Department of Health has stated that, building on the experience of these pilots, NHS Direct could handle a proportion of less urgent ambulance calls, thereby providing those patients with a more appropriate response to their needs and freeing up ambulances to deal with more urgent cases.[40]

27. NHS Direct is also taking steps to integrate with accident and emergency departments — so far, at least 13 sites are taking calls on behalf of a range of such departments. Evaluation of such schemes suggests that transferring calls to NHS Direct can save the full-time equivalent of two nursing posts over a 24 hour period in a hospital's accident and emergency department, with these staff now seeing patients rather than answering the telephone. In addition, the Reforming Emergency Care strategy sets out plans to pilot a face-to-face version of NHS Direct's decision support software in 25 accident and emergency departments by March 2003.[41] There are also currently pilots in walk-in centres and in one primary care trust in GPs' surgeries. NHS Direct can therefore integrate with emergency services not only by doing their work but also by exporting some of its techniques and approaches to other settings where they are likely to benefit.[42]

(c) Other services provided by NHS Direct

28. At the local level NHS Direct sites carry out a range of other tasks on behalf of healthcare providers, such as validating in-patient waiting lists on behalf of acute hospitals, reminding patients about out-patient clinic appointments, and working with social services to provide robust support to child protection initiatives.[43] There is a risk that these initiatives, while useful, could lead to NHS Direct losing its original focus.[44]

29. The Department explained that, outside peak times, NHS Direct will have spare computer resources and expertise available. Instead of hospitals setting up their own call centres, it makes sense to use this infrastructure to deliver the additional services which local healthcare providers need. In addition, at the national level NHS Direct has been working with the new Care Direct service which is designed to provide a range of information and advice to older people. Instead of reinventing the wheel, those calls are initially routed to NHS Direct call centres, answered as Care Direct but by NHS Direct staff with the appropriate training. This has the benefit of making good use of existing infrastructure, and helps create a seamless way into health and social care advice. The Department acknowledge, however, that they need to have a very clear remit about what they provide as a call service, and a strategy for the use of any spare capacity.[45]

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[37] Q84; C&AG's Report, para 3.12
[38] *Reforming Emergency Care – practical steps,* Department of Health, 2001
[39] C&AG's Report, paras 3.13–3.14
[40] *NHS Direct Four Years On*, Department of Health, 2002
[41] C&AG's Report, para 3.13
[42] Q92
[43] C&AG's Report, para 3.17
[44] Q87
[45] Qs 2, 85–88

(d) Impact of NHS Direct on the wider NHS

30. NHS Direct re-directs large numbers of callers away from the course of action they had originally intended, which has implications for workload elsewhere in the NHS. Analysis suggests that NHS Direct is offsetting around half its running costs by encouraging more appropriate use of NHS services. Research has also shown some possible reduction in demand for general practitioner services provided outside normal working hours. However, it will be some time before NHS Direct is achieving the sort of call volumes that will allow it to have a visible redistributive effect on the pattern of access across the NHS as a whole.[46]

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[46] Qs 1, 88; C&AG's Report, paras 3.3–3.4, 3.21

MINUTES OF PROCEEDINGS OF THE COMMITTEE OF PUBLIC ACCOUNTS

SESSION 2001–02

WEDNESDAY 6 FEBRUARY 2002

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon
Mr Barry Gardiner
Mr Nick Gibb
Mr George Osborne
Mr David Rendel
Mr Gerry Steinberg
Mr Alan Williams

Sir John Bourn, KCB, Comptroller and Auditor General, was further examined.

The Committee deliberated.

Mr Glenn Hull, Second Treasury Officer of Accounts, was further examined.

The Comptroller and Auditor General's Report on NHS Direct in England (HC 505) was considered.

Mr Nigel Crisp, Permanent Secretary, Department of Health, was further examined; Mr Paul Jenkins, National Project Manager, NHS Direct, Department of Health, was examined; and Mr James Robertson, Account Director, National Audit Office, was examined (HC 610-i).

Mr David Rendel declared a non-pecuniary interest in that his wife is a General Practitioner.

The witnesses withdrew.

The Committee further deliberated.

* * * * *

[Adjourned until Monday 11 February at half past Four o'clock.

* * * * *

MONDAY 17 JUNE 2002

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon
Mr Ian Davidson
Mr Frank Field
Mr Nick Gibb
Mr George Howarth
Mr Brian Jenkins
Mr George Osborne
Mr David Rendel
Mr Gerry Steinberg
Jon Trickett
Mr Alan Williams

Sir John Bourn, KCB, Comptroller and Auditor General, was further examined.

The Committee deliberated.

Mr Brian Glicksman, Treasury Officer of Accounts, was further examined.

* * * * *

Draft Report (NHS Direct in England), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 3 read and agreed to.

Paragraph 4 postponed.

Paragraphs 5 to 30 read and agreed to.

Postponed paragraph 4 read and agreed to.

Resolved, That the Report be the Fortieth Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That the provisions of Standing Order No. 134 (Select Committees (Reports)) be applied to the Report.

The Committee further deliberated (informal consideration of draft Report on Royal travel by air and rail).

* * * * *

[Adjourned until Wednesday 19 June at Four o'clock.

MINUTES OF EVIDENCE

TAKEN BEFORE THE PUBLIC ACCOUNTS COMMITTEE

WEDNESDAY 6 FEBRUARY 2002

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon	Mr George Osborne
Mr Barry Gardiner	Mr David Rendel
Mr Nick Gibb	Mr Gerry Steinberg

SIR JOHN BOURN KCB, Comptroller and Auditor General, and DR JAMES ROBERTSON, Director, National Audit Office, further examined.

MR GLENN HULL, Second Treasury Officer of Accounts, HM Treasury, further examined.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL: NHS DIRECT IN ENGLAND (HC 505)

Examination of Witnesses

MR NIGEL CRISP, Permanent Secretary, Department of Health, and NHS Chief Executive, MR PAUL JENKINS, National Project Manager, NHS Direct, examined.

Chairman

1. Good afternoon and welcome to the Public Accounts Committee. Welcome back, Mr Crisp. You are going to reply to our questions on NHS Direct. Could you introduce your colleague?

(*Mr Crisp*) Yes, Mr Paul Jenkins, who is the national project manager for NHS Direct. In the light of your annual report, he has been the national project manager for the last four years and this is an extremely successful project that he has managed.

2. Perhaps I could start by looking at your overall objectives. If you turn to page four of the Comptroller and Auditor General's Report, you will see paragraph 19 there and it lays out the need for more strategic management and clearer objectives. I wanted to ask you what your key priorities for the future development of the service are. In relation to that, perhaps I can refer you to page 23? If you look at page 23, you will see there is a check list there of various things that might be done in paragraph 3.17. Could you tell us a bit about your ideas for the future?

(*Mr Crisp*) As you appreciate, NHS Direct was set up to provide information and advice and has been piloting various approaches for the future. The one big issue which is in the list here is the link with the out of hours GP service, so that people will ring one telephone number to get access to the GP out of hours service but also to NHS Direct. That has already been piloted very successfully and has reduced GP workload. What you also have is a list of other processes and other ideas here. Another one which is on this list which has also been piloted in a number of areas is the linkage with the 999 calls. With 999 calls, we can make sure we draw off into other services people who may not need an emergency ambulance to take them to hospital. You will also see there the one about validation of in-patient lists. We are working with NHS Direct about providing information on consultant waiting lists.

3. Do you want to say a word about integrating your online services with other services?

(*Mr Jenkins*) We launched the website as a stand alone health information resource in December 1999 which complements the telephone service in terms of access to approved websites and self-care information. We took that a stage further this November when we launched the first interactive service on the website which allows patients to mail into us very specific health information queries that they cannot find information about on the main website. The direction of travel will be to look at a range of things, maybe into the areas of clinical advice that we could make available through the website as well as through the telephone service, recognising that some people might find that medium more accessible than having to discuss particular problems over the phone.

4. Are we conceivably going to get some sort of chat room in the future or are we going to get members of the public able to access the algorithms so that they can go through the symptoms themselves?

(*Mr Jenkins*) It is probably somewhere between the two. We already have some very simple algorithms on the website which allow people to look at problems themselves and decide whether to seek help or not. What we may be able to do is develop a more sophisticated version of that, closer to what nurses use, but in a real time consultation with the nurse, allowing the nurse to check the validity of what a patient is coming back with, and perhaps to pass out a picture of a rash or other information that helps a patient decide what the problem might be.

5. Mr Crisp, I know that NHS Direct takes a very small proportion of the total number of nurses but there is a fear, is there not, that it may be creaming off some good staff. Would you say a word about that and what you are doing to minimise this risk?

[**Chairman** *Cont*]

(*Mr Crisp*) The total number of nurses is 1,150 whole time equivalent, which is a very small proportion. Something of the order of six per cent at this stage are people who could not work in an ordinary nursing environment and it provides a lot of opportunity for people who cannot do lifting or whatever and also part time opportunities. It is bringing people into nursing who might otherwise be leaving the profession. The point you are no doubt wanting to get at that is also in this report is that as NHS Direct developed we have not had a really strategic HR strategy to make sure that it fitted in with minimising any potential impact.

6. Could I refer you to page 12, paragraph 2.10, which deals with the time it takes you to get to speak to a nurse. If you look at paragraph 2.10, it seems to be a pretty impressive record. I tested this myself last night. I rang up NHS Direct at seven minutes past seven. My call was answered at 12 minutes past seven by a very polite lady. I briefly described my symptoms. I put the phone down at 7.15 and she said a nurse would ring back. I waited an hour and a quarter for a nurse to ring me back. I know it was in the evening, but we look at things like this in reports and they seem to proclaim a wonderful picture. She did ask me what my name was, what I did and how I found out about NHS Direct. I said I was doing a parliamentary inquiry the next day on it. Maybe that is why it took an hour and a quarter for them to ring me back. When she did ring me back, it was immensely impressive and I thought the way the questions were asked was far less discursive than talking to one's own GP. The advice she gave was very good and useful so I congratulate you. My wife rang you last year and she was told that she was going to be called back by the dentistry equivalent and they never rang back. It is purely anecdotal but do you want to say a word about how you are coming to grips with this problem?

(*Mr Crisp*) We record these timings through the system. The figures here are impressive, given that what we are doing is not providing a simple service over the phone. This is a more complex service than most. We also try and measure patient satisfaction and there are very impressive records of patient satisfaction, despite some people waiting longer than we would want. On some of the following pages it shows the number of calls taken by a nurse. This autumn, we are now able to make comparisons between sites because we are using the same kit. We have also been learning as we have gone how you try and target your staff to anticipated workloads, but it is quite fluctuating. We are getting a better grip on that.

(*Mr Jenkins*) It has been one of the banes of my job that very often your friends and acquaintances can come back with their very direct experience of using the service, which is a very positive thing. Our call handlers are trained so if you have been presenting with symptoms which were of considerable concern your call will be prioritised. If you had been presenting with symptoms of a classic, life threatening condition, you would not have even spoken to the nurse; you would have been patched straight through to an ambulance. We would also prioritise around young children or people with threatening conditions. We are putting a lot of effort into expanding capacity in the service so that we can deal with some of the challenges in terms of increased demand but also to improve our responsiveness. One of the things we will increasingly be able to do is if a particular site is busy move your call to another part of the country to ensure that you get a quicker answer. They will be able to access the same information as your local site. We have also introduced standard decision support system. We are much more able to benchmark processes and shorten transaction times so that we can handle more calls and get to callers quicker.

7. Her advice to me was to go away and take a paracetamol, which is the usual advice given by the NHS. Can I refer you to page 16, paragraph 2.32, and the difficulty that you are having in accessing some social groups such as young people and those over 65? Tell us a bit about what you are trying to do to increase take-up amongst these groups.

(*Mr Jenkins*) Inevitably in the first three years of setting up the service our focus has been on building up overall awareness of the service. We do regular tracking of awareness of the service which suggests that over 60 per cent of people when prompted are aware of NHS Direct and just under 30 per cent have spontaneous awareness. We are aware that that awareness is lower in certain sections of society and we are now able to bring in very tailored initiatives to improve awareness in those groups. That can operate nationally. In the next month or so we will be starting a specific campaign targeted at young people and later in the year a specific campaign targeted at older people. There is also an ongoing process at a local level where people go out to talk for instance to older people's lunch clubs, engage with religious communities and talk to schools. It is something that we take very seriously. We recognise that we are in an acceptable position now but in two or three years' time when the service has grown to its wider take-up we must have even awareness and take-up of the service in all sections of society.

8. Could I refer you to page 21, paragraph 3.10? That is this problem with GPs out of hours. What are you doing to ensure that these problems will not recur?

(*Mr Crisp*) There have effectively been teething problems within those schemes.

(*Mr Jenkins*) One of the things that NHS Direct has been quite good at doing is that, although we have 22 locally based providers that together form the national service, we have a good tradition of passing on experience from one provider to another so that we ensure that those who are starting new schemes of integration with a GP out of hours are advised by people who have been through the experience. We make improvements to IT systems and other processes that take account of what we have learned. We get the planning of staff and capacity right more quickly than in some of the earlier schemes. What we are now building on is much greater confidence from GP out of hours providers and NHS Direct has a positive impact on their workload. We are operating in a better climate in terms of working with our partners in that sector.

[**Chairman** *Cont*]

9. One problem that worries me is that NHS Direct takes on more and more workload. If you ring your GP out of hours, you are put through to him automatically and then, as we see in paragraph 3.11, that would become more and more within working hours. It is a very valuable service to people where they can ring their GP and talk to someone they know. We have already seen in recent years the virtual elimination of GPs being prepared to go out through the night so if you ring your GP at night you are put on to a locum. Are we going to have a system within four or five years whereby if you try and ring your GP you are not going to get through and you will be put through to somebody you have never met before, who no doubt is very competent but you just do not know them?

(*Mr Crisp*) I do not think we have yet a clear position on what the access route to GP services will be in four or five years' time. You have the pilots referred to here; you have also the people who are working in primary care collaborative, which is about developing access to GP services. They are establishing some of their own telephone services within the individual primary care sites. What is most important is that there is the partnership between NHS Direct and local GP premises so that we can get people to the right place. In some cases, that may mean that the GPs are dealing with the calls themselves; in other cases, it may mean that NHS Direct are the most appropriate people to deal with them.

10. That is interesting but you have not given me reassurance that people are going to continue to have the right to ring up their GP and talk to him or her.

(*Mr Jenkins*) When the schemes of out of hours integration start, there are a significant number of patients who, perhaps because they do not know that the arrangements have changed or whatever, are a bit bemused. They say they would like to talk to their doctor. When they say that, we will pass them straight through to the doctor's service. Two years down the road in the more established schemes, that question never arises and patients are quite comfortable. Their expectation is they will talk to a nurse. If we take patients and listen to their experiences, we do not have a problem. If we try and force a change that goes against what people want, then we get into difficulty.

11. What NHS services do you think are going to be most affected by NHS Direct in three or four years' time? After all, this is now costing £99 million. Could that be spent better elsewhere on providing more hip operations or whatever? In that context, how do you see this developing and how is it going to affect the rest of the NHS?

(*Mr Crisp*) It is complementary to the rest of the NHS. This report brings out the fact that effectively you can put together a cost analysis which suggests about half its costs are met by providing a different sort of service. I think it will be affecting the service quite significantly. I have been in contact with Surrey Ambulance Service where they now have a scheme whereby doctors referring patients to local hospitals go through the Surrey Ambulance system, which is linked in with NHS Direct and as a result people are not only able to equalise pressure between hospitals where patients are referred, but also a number of patients end up being offered some different sort of treatment, rather than admission to hospital. This is part of how we communicate and manage the NHS in a lot of different ways. You have talked about the examples of where we provide access to GP services. It is going to be quite widespread as a very significant way of getting information to patients and helping them to find the right bit of the service.

Mr Rendel

12. My wife is a GP, just to declare an interest. We are told that in the White Paper that set up NHS Direct the aim was to provide easier and faster advice and information for people about health, illness and the NHS so that they are better able to care for themselves and their families. Is that still the aim of NHS Direct?

(*Mr Crisp*) That is the essential aim, yes.

13. How do you measure whether you are getting better and whether you are enabling people to care for themselves and their families better?

(*Mr Crisp*) There is quite a developed programme of asking people what they think. There is a significant amount of talking to patients about what they feel about the advice they are getting. You have also seen some of the evaluation studies that are taking place about whether or not, as a result of people ringing NHS Direct, they have decided to do something different from what they would have done beforehand.

(*Mr Jenkins*) In some of the academic evaluations of NHS Direct, quite substantial caller surveys have probed about "has NHS Direct helped you to deal with a problem of this kind better as a result of the advice we have given?" We scored around 80 per cent in patient satisfaction.

14. I fully appreciate that patients are satisfied and that is good news. I wonder to what extent the patients saying they have changed what they otherwise would have done is realistic in the sense that, had they gone to the GP and had the advice given by NHS Direct been that they need another form of help, whether that would not have happened had they gone to the GP anyway. I wonder how you can measure whether NHS Direct has changed something that would have happened anyway?

(*Mr Jenkins*) Yes, that might be true in some cases but we have allowed patients to do that from the comfort of their own home. We have that response to them available 24 hours a day, seven days a week when they perhaps could not contact their own GP. We have been perhaps able to give them time and reassurance that having to wait for the answer would have avoided.

15. They would not necessarily have had to wait for the answer if they had rung their GP. If you ring a GP in the middle of the day, you can sometimes get through. Equally, if you ring them at night, you may get through to a locum service which could give you advice perhaps as quickly as NHS Direct.

(*Mr Jenkins*) In some cases that is true. The reason why so many people have used this service is a very strong indication that people do not perceive they are able to get those answers in the way you suggest. In

[**Mr Rendel** *Cont*]
some cases, people are getting a different answer from NHS Direct than they would have got from other options.

16. You said NHS Direct has given a different answer from what they would have got from other options?

(*Mr Jenkins*) Sometimes people are nervous or anxious about bothering the doctor. They leave a problem longer and a lot of our life saving stories are often people who were leaving a problem but get worried and give NHS Direct a ring and are rushed to hospital or the GP is called very quickly. This is a service available around the clock and there is no stigma of being foolish if the problem turns out to be nothing. I think it is an important addition to what the NHS does.

17. How many agency staff do we currently have in the NHS working in A&E departments, on average?

(*Mr Crisp*) I do not know.

18. Is it in tens, hundreds, thousands, tens of thousands?

(*Mr Crisp*) There are of the order of 270 A&E departments. During the course of an average weekend, I would guess it would be more than 1,000.

19. Roughly the number of nurses working for NHS Direct?

(*Mr Crisp*) Potentially, but I am giving you a pretty rough estimate.

20. Your costings presumably are on the basis of what you have to pay to the nurses in NHS Direct itself?

(*Mr Jenkins*) Yes.

21. Of the ones that have come from the NHS, about 80 per cent could have been working otherwise in the NHS?

(*Mr Jenkins*) That is right.

22. It seems to me that you are under costing the real cost to the NHS of NHS Direct in that if those nurses were not working for NHS Direct you might be able to use them as NHS nurses rather than agency nurses who I imagine always cost you more.

(*Mr Crisp*) You are getting into the process of planning and priority setting which we go through in the department and in terms of how you spend your money you have to make decisions about whether you believe that this service has done a lot of things to speed up and improve care.

23. I am not saying that it is the wrong decision to use the nurses in this way, but if you are going to judge whether it is right to do it you have to get the costs right. It seems to me the overall cost to the NHS is not the 80 million a year but rather more than that because, on top of that, you ought to be adding the extra cost of having agency nurses in A&E who you otherwise would not have had to use.

(*Mr Crisp*) We should not assume that these nurses would go and work in A&E. You can make comparisons with nurses working in coronary and heart disease or in A&E.

24. We are offering a completely new service and as a result of that we have fewer nurses available to work in A&E departments or wherever. Therefore, we are using more agency nurses within the NHS so the overall cost to the NHS is not just the direct cost of NHS Direct; it is also the opportunity cost that you have lost because you have to have more agency nurses working in other areas of the NHS.

(*Mr Crisp*) The argument, with respect, applies to our extension of coronary heart disease services, does it not?

25. I have no doubt it applies elsewhere but if we are to judge the value of NHS Direct we ought to be judging it against the real cost of NHS Direct which is not just the direct cost but also the additional cost that the rest of the NHS has suffered.

(*Mr Jenkins*) One of the things that NHS Direct is doing, particularly with out of hours GP services, is reducing some of the demands on medical manpower, so we are using nurses to help manage another problem in terms of manpower within the NHS, in terms of the number of available doctors. One of the interesting byproducts of the NHS Direct call centre infrastructure is that we have been able to use that to deliver the NHS's own agency staff service, NHS Professionals. The telephone side of that service is now delivered from our call centres and using a lot of the same infrastructure and expertise. That is a way of reducing to the NHS the costs of employing short term, temporary staff. It is a byproduct of the fact that we have invested in infrastructure for the delivery of the main NHS Direct service.

26. What you appear to be saying is that there are other ways in which NHS costs have been reduced by the introduction of NHS Direct. Fine. If so, let us include those too. What I am suggesting is we really ought to get the costs right and not just base ourselves on what is the initial, direct cost of NHS Direct because there may be other costs and perhaps other savings involved. If we are really to get a handle on whether this is worthwhile or not, we ought to get the costs right. It seems very odd that we have been talking for years about the government needing to introduce these major schemes as pilot schemes, first of all, and then to evaluate your pilot scheme. When you have evaluated your pilot scheme, you take a decision as to whether to roll this out across the country. In this case, you seem almost immediately to have rolled it out without anybody having a chance to evaluate whether the pilot scheme was showing good effect or not. Why was that done?

(*Mr Crisp*) There was some evidence coming out of those pilot schemes. There were three originally. There was also a view taken that the early indications were good and that this was meeting an obvious need.

27. There was a view taken that the early indications were good? What evaluation was done?

(*Mr Crisp*) The first formal evaluation beyond those done internally was the one referred to in these papers.

(*Mr Jenkins*) We have had an ongoing programme of evaluation through the rolling out of NHS Direct and we got feedback from that at three stages during the lifetime.

28. That was an evaluation of the total effect or the pilot schemes?

(*Mr Jenkins*) It was looking at all aspects of the pilot schemes, issues around take-up, popularity, consumer satisfaction, impact on other services and

[**Mr Rendel** *Cont*]

clinical safety. We have a growing body of evidence through the course of rolling out the service that proves the concept and is giving valuable input into how we roll it out. The original White Paper gave a commitment to roll out NHS Direct. We have always been clear that evaluation of the service and piloting was about the way that it was rolled out and what its eventual scope could be rather than the concept. You can argue that that might have been different, but those were the rules of the game.

29. In effect, you are saying that this was yet another government scheme that was not properly piloted because the decision was taken before any evaluation was done that the whole thing would go ahead. That may be the right decision but it seems to be another case in which the government, having said it would do a pilot, in this case has not.

(*Mr Jenkins*) It depends what you want out of piloting. Piloting here has very strongly influenced the way in which the service has developed. The model of NHS Direct as it is currently organised has very much been influenced by a continual process of trying piloting, learning from that experience and modifying as we go along. The concept of having NHS Direct or not was not piloted because that was a decision ministers took at the outset.

30. Can I go on to paragraph 2.28 on page 16 where we learn that a number of people claim that they followed the advice they were given, 97 per cent, but quite a few did not follow the advice. What has made you say that they did not? What sort of advice are we talking about here? Were they advised to take some pills and they did not or were they advised that there was nothing much wrong with them and they continued to think there was? What difference are we talking about here?

(*Mr Jenkins*) That has been followed through in Sheffield's evaluation. There may be a difference in the time frame in which people take the advice. Maybe they are told to contact their doctor in four hours and they contact the doctor in 12 hours. Also, people's conditions will change. They are worried at a particular point. The advice was appropriate at that time. They wait a couple of hours and the problem goes away. My experience with the health pattern of my children shows that to be very common. In general, we find that at the point of patients presenting to the service there is a high level of appropriateness about the advice we gave.

Alan Williams

31. Our witness was too polite to say so, Chairman, but, when you made your phone call last night and you faced that long delay, had you considered the possibility when you said it was for a parliamentary report that they were looking for a psychiatric nurse? The Report reads very favourably and I am very impressed with it. If I ask about some figures that may not necessarily sound too good, I hope I have got them wrong. If we look at table 5 on page 14, permitted average number of calls per full time nurse per month, if we look at the first column on the left hand side, there are nearly 900 calls per month per nurse. Which site is that?

(*Mr Jenkins*) East Midlands.

32. It looks a lot until you work out seven days a week, 24 hours a day and that works out at one call every 50 minutes; yet your target is about six and a half minutes per call. That figure suggests a degree of under used capacity but if we go to the other end of the table on the right hand side there you have what I work out as being 220 calls per month, which works out at seven calls per day. That does seem in both cases to imply that, despite the good figures, there is a tremendous under use of manpower capacity and, in the second case, very gross under use. Would you agree with that?

(*Mr Crisp*) We have to have a balance between the availability of nurses to answer the calls and the number of calls coming in. There will always be some down time within a system. Secondly, this is a very wide variation, much wider than we want to see. Since we have had the same systems operating across the whole country, we are able to make better comparisons and the extremes are narrowing, but there is still a lot of work to do to get the productivity up to the levels that we want.

33. I was interested in the left hand side and the right hand side, to see if we could explore any particular reasons. The right hand is one quarter of the workload of the left hand figure. One call every three hours 20 minutes would suggest that there is something wrong at that site. You have 22 sites and I think you gave an answer that there are 1,150 whole time equivalent nurses. That works out at five full time equivalents per site.

(*Mr Jenkins*) About 50 per site.

34. What sort of variation do you have in the total number of nurse full time equivalents available at each site?

(*Mr Jenkins*) It varies in full time equivalent terms between 30 at the smallest sites to over 100 at the busiest.

35. Has anyone been inspired to provide you with a piece of paper to show which the two sites were?

(*Mr Jenkins*) It is West London on the left hand side and Essex on the right hand side.

36. What do you think would account for such an incredibly wide variation?

(*Mr Jenkins*) In terms of working out the overall number of calls per nurse, the amount of available time on the phone is reduced by allowances for leave and sickness. Also, time for professional development and training. One of the reasons why there is so much variation in this data is that this data effectively predates our move to a single, national system. One of the key factors that we explored in the procurement for the system we have chosen was the average call length those systems generated. Because nurses are following some set protocols, the system does affect the total transaction times. The sites on the right hand side of the graph historically use one of the latest to move over to the new decision support system and conversely on the left hand side.

37. With the prediction being one every 55 minutes, why is it that you are not able to meet your target of replies within five minutes?

(*Mr Jenkins*) Those calls do not come in every 55 minutes. Probably there is one every 55 minutes in the dead of night but you still have to have two or

[**Alan Williams** *Cont*]
three staff on to cover that for safety and clinical support reasons. At 11 o'clock on Sunday morning, we are probably talking about 70 or 80 calls.

38. Are there predictable peaks consistently across the country?

(*Mr Jenkins*) There are predictable peaks in general. There are within those very dramatic surges of demand within a period.

39. In the briefing we have from the NAO, we are told that NHS Direct is operating safely. They quote a figure of only 29 reported cases of an event during a call that caused physical or psychological injury to a patient, fewer than one for every 220,000 calls. At first sight, that sounds very impressive but when you look at the wording again it only applies to events that took place during a call. What evidence do we have of the safety of the advice that is given in what happens to the patient after the call? If someone drops dead two minutes later and had been told to take an Aspirin, that would not be included in these statistics, would it?

(*Mr Jenkins*) It would.

40. How?

(*Mr Jenkins*) Whenever a patient has been in recent contact with NHS Direct and an adverse event happens to them afterwards, that can be anything up to 24 hours after the advice.

41. What mechanism is there for ensuring that the quality of advice that has been given is good?

(*Mr Jenkins*) We use a decision support system. We have national review bodies that look at the clinical content of that system to ensure that it is in line with United Kingdom best practice and those groups have input from the relevant royal colleges.

42. What we are told is sites are required to report adverse events to NHS Direct national advisers. What mechanism is there to ensure that that information is (a) being correctly recorded and (b) that there is a follow up to ensure that something has not happened within, say, two, three or four hours? How is that done so that you can give us the reassurance you have tried to?

(*Mr Jenkins*) I do not think any clinical service can find out every consequence of its actions. We use all available networks. A lot of our services are connected to the ambulance service so they will provide information from the patient's GP, sometimes from a direct complaint raised by the patient themselves.

43. If Joe Bloggs, living alone with no family, phones at 11.30 at night and is given advice but dies at 6.30 the following morning, is there any way you would know of that?

(*Mr Jenkins*) If the ambulance service was called out or his doctor was called out or if there was a coroner's investigation after the event.

44. The NAO has looked at this. Are you satisfied that the situation is statistically sound?

(*Dr Robertson*) Yes. We have looked at the statistics and it is a good safety record. We would not want to say any more than is in the report which is that the system appears to be operating safely.

45. We are told there are certain social groups which do not make as much use of you as they might. It is interesting that although once young people find the availability of the service seem to use it more enthusiastically, the young and the old are two groups that seem less aware of the existence. They make up a big part of the population. Then we are told that in addition the ethnic minorities are less aware and that the less advantaged social groups are less aware. This suggests an epidemic of less awareness, does it not? What are you doing about it?

(*Mr Jenkins*) The levels of awareness are lower than for the general population but they are not massively lower. We are talking of 10 or 15 per cent. The profile of how awareness of the service has built up as a new health service is not unsurprising because it would follow the trend of adoption of many new things in society. We are now clearer about the groups that we are not reaching. We are doing some very specific marketing targeted at younger people and older people at the national level this year. Our sites continue a rolling programme of contacting voluntary groups and other local agencies to get the message over about the service. Particularly in respect of older people, the awareness and take-up of the service will significantly increase as we integrate with GP out of hours services. People who have an established relationship with their GP probably see that as a natural way of contacting help. They contact NHS Direct and they will then hopefully perceive NHS Direct as a way of dealing with a whole range of problems.

46. I am glad that you have this contract for 200 languages and for translation facilities to be provided. I realise how difficult it must be to determine where to locate what. If I had more time, I would ask you about that. Turning to paragraph 2.41 on page 18, it says there that interpreting facilities have been used sparingly to date, only about 1,000 times during 3.5 million calls. That means there has only been one caller every 3,500 that has needed interpretation, which suggests that you have a very specific communication problem here, far more difficult than getting to the young and the elderly. How are you going to overcome the problem of ethnic awareness of the service?

(*Mr Jenkins*) It is about communication. We are tackling a range of ways of communicating with the representatives of different ethnic minority communities. It is also about increasing training and awareness amongst our staff and adapting our service to the particular needs of those communities. What I would be arguing is that, while general awareness has grown quickly and the service is popular, we may have some barriers to overcome with some sections of society who are perhaps initially less happy with this method of accessing services. It is a process of two way communication, us communicating what the service can offer to them but also hearing and adapting our services to the requirements of those callers.

Alan Williams: I look forward to an update in a couple of years and I wish you well.

Mr Gibb

47. This is a great report. NHS Direct is a great idea. If you have food poisoning, it is nice to be told not to eat more food. I would not have known that. When I had food poisoning in my twenties, I had to sit in a disease ridden waiting room for an hour to be told that. How do you ensure that calls are not coming from abroad?

(*Mr Jenkins*) Because it is an 0845 number, the arrangements bar international calls.

48. What about e-mails from abroad?

(*Mr Jenkins*) We require some registration information. For instance, being able to give a United Kingdom post code, so we make it clear that we are only offering this service to residents of the United Kingdom.

49. What is the target time for calls being answered by the initial handler?

(*Mr Jenkins*) We do not set a specific target for that. We measure people's satisfaction with the front end of the service in terms of the number of people who abandon their call before getting through. The average performance is 30 seconds. We play a message at the beginning, when people get through to the service, explaining important information about confidentiality of their information. 30 seconds after that is the average performance.

50. I also did try this today but I abandoned my call because I thought I was not ill. You do not have a system on the phone that tells you that you are number 15 in the queue and your call will be ten more seconds?

(*Mr Jenkins*) We have not, largely because we take the view that particularly for people who are ill we probably do not want to put an awful lot of extraneous stuff on before people get through to the service. If we are especially busy, we will put a message on that explains this to callers and encourages them to stay on if they need urgent advice.

51. In paragraphs 2.15 and 2.21, you are proud that there are not these adverse events and things are going well. My worry is the inverse, that there might be a tendency to be over-cautious in order to avoid adverse events and therefore if that tendency continues the whole service becomes irrelevant. Do you think there are dangers of being over-cautious?

(*Mr Jenkins*) I would rather be over-cautious than under-cautious. We are very careful to keep the quality of our advice under review. The fact that we have a centralised decision support system means we can continue to review that and modify that. If we feel in any area that we are over referring to particular services or being particularly cautious on some issues, we can review the advice and modify that. Where we are integrated with GP services gives a very good window. If they are telling us that we are sending them a whole lot of inappropriate referrals, that is a prompt for us to look at the system we use and the quality of the training and performance of our nurses.

52. Is there a system of returning nurses back to the front line after they have been with you for a period so that they can refresh their experience?

(*Mr Jenkins*) We are finding that a lot of nurses will probably move through NHS Direct over a period of two to three years. This is not a job for life. It is natural to get the very interesting and different experience of giving advice on the phone and move on to other things. We also deliberately encourage clinical placements and rotational posts between NHS Direct and face to face settings in a number of sites. A significant group of our staff are part time and may well combine working within NHS Direct with working in a GP's surgery or in A&E at the same time. The principle of not just working on the phone we see as a positive virtue rather than a problem.

53. Paragraph 2.14 talks about a target time of completing calls within 20 minutes, 90 per cent, and all within 30 minutes. Is that not giving an incentive to rush calls?

(*Mr Jenkins*) No. That target was identified by the out of hours review team on the basis that the end of the call is the point at which you have definitively dealt with the issue of clinical risk. At the end of the assessment you know if the patient is sick and needs to be referred urgently or if the patient is able to look after themselves or whatever.

54. You do not think it will lead to an incentive to terminate calls earlier?

(*Mr Jenkins*) Like every target, it is the way it is implemented. A good call completed in 33 minutes is much better than a hastily completed call completed in 29. We will look at this target along with all sorts of other measures of how we perform.

55. Finally, a slightly flippant question about the Consumer Association mystery shopper. You have your own mystery shoppers, which is a good thing, but was this mystery shopper exercise authorised by you?

(*Mr Jenkins*) No. They did tell us that they were doing it, but we did not approve of the methodology.

56. I wonder if they ought to be doing this because it is taking up nurses' time for their own business purposes and they are not really ill. Why would you approve these things? Would you not condemn them for doing that?

(*Mr Jenkins*) Clearly anybody taking an independent assessment of what we do, in a sense, if it is not abused is, I think, a good thing because it is, in a sense, another way of getting confidence and issues out to the public. I think our concern about this was not the doing of the exercise but the lack of comparison, some of the methodology of assessing NHS Direct calls and some of the lack of comparison with other services. They made very absolute statements about NHS Direct against what would happen to you if you contacted your GP or contacted another service.

Mr Gibb: Thank you.

Mr Steinberg

57. I am not too sure whether I have used the service or not. In the North-East, in Durham, we have been on this out-of-hours doctors' scheme for a long time now which when it was originally introduced I did not, frankly, approve of it, I thought the doctors were just skiving and I thought if you rang your doctor you should able to speak to your

[**Mr Steinberg** *Cont*]

doctor. However, about 18 months ago I rang this service up, or about a year ago—I am not sure if I got through to my out-of-hours doctor or whether I got through to the NHS Direct—and at the end of the day I got the pain killers, so it must have worked

(*Mr Crisp*) I wonder if it matters, actually, because these things need to be integrated?

58. I do not know how it works, but I should do because I am in the target group, 55 or 56 year olds, and will probably need it more in the future. However, I mentioned this to the Member for Carlisle and he was very complimentary. He had used it, he got a rash or something and he was told to put some cream on it. I did not go into anything further about where this rash was or where he had to put the cream, but apparently it worked, so that is pretty good. One of the things that actually I loathe, and I think Customs & Excise used it, was one of these services where you telephone somebody and then you get a recorded message where they tell you to press a button, then another button, then another button, this service does not do that, does it?

(*Mr Jenkins*) The only circumstances in which we do something like that is if there is a major health scare, if there is something in the news, and we told lots of people to telephone NHS Direct about that one issue then in terms of dealing with the increased volume of calls efficiently, for example, if you are calling about the infected health care worker at X hospital press one, if you are ringing for general advice press two. We, and ministers, both share your loathing of that.

59. Good, I am delighted about that. This was touched upon by another member in paragraph 2.8 on page 12, where we are told that originally the message was 40 seconds in length at the start of the call, therefore it does not surprise that a lot of people put the telephone down. That is a long time to listen to somebody withering on. What was the message originally saying?

(*Mr Jenkins*) The message was detailing all of the information that we are legally obliged to tell people about the uses to which the information they give NHS Direct will be put. This would be one of the cases where the spirit of the service, in terms of testing things and changing them, is very true. We got some significant feedback. We looked at the abandoned call figures.

60. You knew how many calls were being aborted, did you?

(*Mr Jenkins*) We could see an increase. We asked callers about this in the caller survey and we used other inferences and we talked to the data registrars office and got agreement to change the message so that it was shorter.

61. Right. Figure 3, I am always dubious about going to these charts because I never know whether I understand them or not, so if I have the wrong end of the stick please tell me. On this particular chart it shows in one of the call centres there was two per cent of calls abandoned after 30 seconds and at the far end of the graph 10 per cent of the calls were abandoned after 30 seconds. Why is there such a discrepancy between the sites?

(*Mr Jenkins*) Again, I think one of the reasons that counts here is there have been at various times some significant variations of the business of sites. Certainly one of the ones on the far right is a site with a very heavy volume of GP out-of-hours calls which do present a lot of the same thing, which, of course, is some of those issues. One of the things we are doing in the service is we can do clever things with the telephone system of NHS Direct where it begins to start routing calls round the country. It looks not just in one call centre but right across the nation for who is available to take a call. Effectively when we have introduced that we should eliminate both the discrepancy and also the problem.

62. You have basically answered the question I was going to ask. If you live in a certain part of the country do you go to a specific call centre or is it a sort of scheme where if one call centre is busy then it is transferred to another call centre?

(*Mr Jenkins*) At the moment we have set the service up on the basis you get routed to a local call centre. We are to able to move calls round the country to compensate for different levels of business, to some extent, at the moment. The plan is that we begin to start routing the calls round the country more systematically so that we can improve access.

63. The point Mr Williams made, where one centre is very busy and another is not, the centre where they are not so busy—

(*Mr Jenkins*) That will drive some very big improvements in productivity because you do not have nurses frantic in one part of the country where others are relatively less busy.

64. It is a bit like the television licence call centre centres, when you phone you are all over the place.

(*Mr Jenkins*) The important thing we have to get right is that the nurse has access to the local information that allows them to refer people to the right services and understand. Clearly somebody giving advice about where to send a patient who needs help at one particular level in West London is very different from somebody in Cornwall. We have put a lot of investment in developing those information systems that allow you to get those choices right wherever. What we have found is that patients do not mind where they are answered, as long as we sort their problem out they are quite happy being answered wherever the call lands.

65. We are told that you have cut the message from 40 seconds down to 30 seconds and this was introduced from the end of December, so we are only into it. It is working, is it, not so many people are putting the phone down now?

(*Mr Jenkins*) It is probably a bit early to look at the information, but certainly anecdotally there has been less negative reaction to the message.

66. Fine. I am very impressed with the Report, as everyone else seems to be, I am also very sceptical about the whole thing, I am becoming more and more conservative with a small 'c' as I get older. The old idea of being able to phone your doctor up still appeals to me rather than talking to somebody who you do not know, if at the end of day you get the right advice that is the important thing. Paragraph 3.9 on

[**Mr Steinberg** *Cont*]
page 21 talks about the partnership with the out-of-hours GP service. "Over time, callers start to call NHS Direct when they find their calls are diverted there anyway", I think that is what happened to me, "it is not clear what happens to callers who ring off when they find their call is diverted who want to speak only to their GP". That is a bit like me, really, if I cannot get through to my GP, which is impossible these days anyway even during the day to be honest—I am being facetious—what happens then, can you follow that up?

(*Mr Jenkins*) Except for a small number of doctors who still do their own out-of-hours arrangements your chances of speaking to your own GP out of surgery hours is minimal. NHS Direct is merely saying that instead of talking to another doctor you are talking to a nurse first.

67. What about the person who demands a visit? By rights you can, can you not, no doctor can refuse to come out to you, is that right?

(*Mr Jenkins*) Nor do we try and stop that. When people put a lot of pressure on us we will put the call through. One of the things the doctors like about the nurses handling this is they are very good at talking to patients, persuading patients to do what they are advising to do and reassuring them that that is the right course of action. It is not arbitrary, we are talking about process of negotiation.

68. Okay. The last bullet point, again, I was interested in, says "The NHS Direct exemplar programme will reflects the fact that integration works much more efficiently when there is a direct electronic transfer of calls from the out-of-hours and NHS Direct, and callers referred to a GP by NHS Direct do not have to go through a second consultation to confirm NHS Direct's advice." People do not want to have to go through the same information twice, has this been prevented? I have a feeling when I did it I did have to go through the information twice.

(*Mr Jenkins*) As we have now set up what we call the exemplar programme, which is the latest round of integration, there are direct electronic links between NHS Direct and the GP out-of-hours organisation. If a patient is then put through the GP out-of-hours provider has all of the demographic details plus all of the information of what the NHS Direct nurse said to that patient.

69. Being Devil's Advocate about questioning, I find it difficult to come to terms with somebody over the telephone telling me what to do without being able to examine me. I have seen the day when you would do that, where you would ring a doctor up and they would say, "No, we are not going to give you that, you have to come into the surgery." Do you think that is the right way to go about things? Do you think this way of actually moving is medically correct?

(*Mr Crisp*) I wonder if Mr Jenkins can talk you through a bit of an algorithm, what the nurse does when she talks to you. It may not be a physical examination but it starts to answer some of the questions.

(*Mr Jenkins*) The whole system is predicated really on talking a patient through the symptoms they have and ruling out the things that might be the sign of something more serious. If it is not possible to rule it out over the phone then they need a face-to-face examination and consultation. You are working through an algorithm that rules out all of the serious consequences of some symptoms first and then gets to the point where it is actually appropriate and safe to give self-care and self-care advice. I think I would argue that our safety record demonstrates that that is an appropriate way of operating but it is based on if there is an issue of doubt and if a physical examination is necessary to establish some advice then you must ask the patient to go and see a doctor.

70. It does not surprise me at all that advice will vary from one nurse to another nurse to a caller, because even though you have certain symptoms how you describe those symptoms can be different even though the symptoms are the same and therefore it does not surprise me that the advice can be different and varied. Again, that worries me.

(*Mr Jenkins*) That is why we need nurses doing this job and not just lay people at one level. If the answers were crystal clear the computer system could decide this for itself. The reason why we have nurses is they are able to interpret clearly what patients say about their symptoms and they relate that to the advice that is in the computer system.

71. I was also quite, I would not say worried, but I was very suspicious about a thing Mr Gibb mentioned as well, the mystery calls that were done by a *Health Which*. I thought that it was very cheeky and very rude to do something like that, as well as wasting the nurses' time. I do not believe, as the Chairman did, that you can give a symptom over a telephone when you do not have those symptoms and, therefore, I do not think you can get an accurate response. If are you not feeling ill how can you say that you are. How accurate is the information that they got? When you do your mystery calling those people will not be ill, they will be false symptoms, how can you be sure that you are getting valid advice?

(*Mr Jenkins*) Perhaps what you will not get is some of the nuances of somebody who is anxious and worried about a problem in a genuine sense. For our mystery shopper survey we construct clinical scenarios and we do brief the people very clearly about what the implications of those symptoms are and how they might feel and what they might answer if they are given supplementary questions by the nurse. We feel for our own purposes it is done in the right way, it is a valid tool, not the only tool. One of the best ways of evaluating the quality of what we do is actually listening to real calls, which we have a programme of doing.

Mr Steinberg: Right.

Mr Gardiner

72. Unlike Mr Steinberg I do not think I am getting more conservative as I grow older, either with a small 'c' or large 'C'. I just want to say I think it is an excellent report. Clearly it has been a great job of work setting it up and congratulations for that. I am delighted that it was a Labour government initiative. My remarks where they are critical should be set in that context. What I would like to refer you to is paragraphs 2.38 and 2.39, where it says, "NHS

[**Mr Gardiner** *Cont*]

Direct has produced guidelines for sites on raising awareness amongst ethnic minority communities." In the following 2.39 it says, Nine sites out of the 22 had not undertaken any initiative at the time of the survey in June 2001. I would like to know how many of those nine sites still have not followed those guidelines?

(*Mr Jenkins*) That is not information I have at my fingertips. We can let you have that. What I would say is that we have communication staff at the centre of NHS Direct and in each site and reaching these harder to reach groups will be the main focus of what we ask them to do in the coming year and, I think, beyond. It will be an area we will continue—[1]

73. I hope it will not be beyond. My next question to you is, what is the deadline by which you will have had all of the sites implement those guidelines?

(*Mr Jenkins*) That must be in the course of this year.

74. By December of this year all sites will have rolled out those guidelines in full?

(*Mr Jenkins*) That is right.

75. Thank you very much. Can you tell me what mapping has taken place in relation to the ethnicity of the local communities that each of the sites serve and what the proportion of the calls received has been?

(*Mr Jenkins*) There are two things that we are about to do here, first of all we have successfully piloted in one site in London a routine programme of ethnic monitoring of callers, which will be rolled out to all sites. This is not just for ethnic minority groups, we are also looking at a whole range of things. Now we have everyone operating on one call system and have comparable data we will be looking to do some systematic work about mapping, patterns of usage on wards or smaller units of geography so that we can look at things like social deprivation, areas where there is a large ethnic minority population and look at why patterns of usage may be different in different places.

76. What you are saying to me is that no mapping work so far has been carried out?

(*Mr Jenkins*) Not on those criteria because we have not had the basis for that information. We have clearly looked at bigger divisions, age and other criteria.

77. I am simply focussing on ethnicity here.

(*Mr Jenkins*) That is information we will have this year and this mapping will happen.

78. That mapping will happen by December this year?

(*Mr Jenkins*) Yes, indeed.

[1] *Note by witness:* At the latest review of local communications activity, 22 January 2002, five of the nine sites had implemented the guidelines on raising awareness amongst ethnic minority communities. The remaining sites have plans in place to implement the guidelines fully this year. We have an ongoing commitment to review progress. In order to ensure sites implement these guidelines, we request monthly communications activity plans from the sites and also conduct fortnightly teleconferences with the communication leads in order to monitor progress.

79. If I can take you over the page now to section 2.41, where the Report says, "Estimates suggest that over 600,000 people prefer to receive medical advice in Asian languages alone." Just taking that figure of Asian languages, as a percentage of the population of England I think that works at out at about 1.5 per cent. The other figures that you have there, "only about 1,000 times during 2000–01 out of a total of 3.5 million calls", people did use the interpreters' facilities. I think you will find that that is 0.0285 per cent. If you take one as a percentage of the other then you are looking at only reaching 1.9 per cent of your target population of 600,000. I think that is a pretty appalling statistic and it shows exactly why the mapping needs to be done, the monitoring needs to be done and the roll out of those programmes needs to be done by December this year, would you agree?

(*Mr Jenkins*) Yes, I would agree that we need to reach more of those communities. Can I add a further point, we clearly can look at a number of the different media that we deliver NHS Direct through. We already have audio content on the NHS Direct website in a range of languages and we are looking to considerably expand that content again during the course of this year.

80. I note what the Report says about those contracts and I was delighted to see that that was in place. If I can switch tack now and refer you, again, to Figure 5, just to ask you, what peak-flow management you have in place? This is relating to the remarks that my colleague Mr Williams asked.

(*Mr Jenkins*) We have a range of things. First of all, we have a routine programme of looking to forecast the amount of traffic that will come into NHS Direct and doing our best to roster staff accurately against that we are in the process of investing in a more sophisticated computer-based capacity forecasting and rostering system that will make that a lot more sensitive and allow us to mull round the variations in calls. The system that I described earlier about being able to route calls to the next available person will also be very powerful in busy times, just being able to shave off the marginal seconds here and there in terms of making the best use of staff. The other things we would been looking to do, which are now a lot easier that we are all operating on one support system, is we are can do some very detailed analysis of our processes and look, particularly where they are supported by IT, to see if you, for instance, gave a drop down menu instead of having to get the nurse to type something, would that shave 30 seconds off the call. The beauty about this is if you multiply that across millions of calls then you have large savings in efficiency.

81. Specifically, you will know, that the electricity web predicts its surge times, its peak times very much in line with television schedules. I wonder if have you noticed any particular surge after *Casualty*.

(*Mr Jenkins*) Yes. Not necessarily after *Casualty*.

Mr Gardiner: Hypochondriac times.

Chairman: Or after PAC hearings!

(*Mr Jenkins*) Anecdotally during the World Cup there was a noticeable surge of calls after particular games had finished or before they started.

Mr Gardiner

82. Right. Trying to make the same point a bit more seriously, can you tell us what profiling has been done to predict with real specificity the peak times that you anticipate?

(*Mr Jenkins*) There are two things. In a very general way there is quite an established pattern of demand. The evenings during the week, the weekends of the week and the mornings of the rest of the weekend days are our busiest times. On bank holidays we are usually one or two times busier than we are on a normal day. This new more sophisticated system for forecasting and rostering will allow us to take that down from hours to minutes. The other thing that has a big influence on demand is illness. We invested in a programme of tracking symptoms, like flu-like symptoms, that will have an impact on our demand but will also have an impact on the rest of the NHS. We feed NHS Direct's data about flu symptoms as one of the variety of indicators that help the rest of the NHS decide what pressures there will be during the winter. This winter we were very accurately able to understand what sort of Christmas period we were going to have two or three weeks beforehand in terms of the way that that flu indicator was going.

Mr Gardiner: Thank you very much.

Mr Osborne

83. Like other members of the committee can I congratulate you on the way this has been implemented. I hope people throughout the NHS and indeed other public services can introduce this because it has obviously been extremely efficient. Like everyone else can I put my comments now in that context. I am a little bit concerned that the NHS Direct, as I understand from this Report, emerged out of the Chief Medical Officer's Report into emergency services as a way of alleviating pressure on emergency services but that that clear role has become much more profuse. I wonder if you would comment on the workshop that the NAO organises, this is paragraph 1.32 on page 9, of NHS Direct staff. One of the things they found was that this workshop, the people who work in the service, found the objectives lack clarity and measurability and leave some uncertainty about the role of NHS Direct. They make explicit reference to NHS Direct and a wider NHS, and so on, could you say something about that?

(*Mr Crisp*) Let me make one comment. This is an exact reflection of the fact there are a lot of possibilities here and we are starting to explore a number of different issues. This NAO Report very accurately reflects the fact that we are now at a point where we need to make a number of significant strategic decisions about where we go from now, having established the basic service.

(*Mr Jenkins*) Two things, one very direct follow-on from that workshop was a programme of work which we have nearly completed to develop a more comprehensive performance, measurement and management framework within NHS Direct, which was an attempt to understand responsibilities at different levels of the organisation but also the varying things that NHS are responsible for, like clinical safety, access, impact on the rest of the NHS fitted together so that both staff and the senior management of the service had a clearer idea of how things fitted together. The other point I would echo is that this is very much the time to say these are the priorities for NHS Direct, certainly in terms of what is delivered consistently as a national service. I think it is noticeable that instead of NHS announcements being made as an announcement in NHS Direct they are now imbedded in wider strategy documents, like the one that was published last October round reforming emergency care, saying how will NHS Direct play a role in our attempts to reform wider access to emergency care or as part of a wider strategy or the provision of the GP out-of-hours services. That is exactly right, not to see NHS Direct as an end in itself, but to see it as an agent for wider change within the Health Service.

84. Thank you for that. On paragraph 3.17 on page 23 there is a whole lists of local initiatives NHS Direct sites have undertaken. I wonder if I can go through each one, I will skip the patient waiting list, because I have a bee in my bonnet about that, and I will go on to number two, which is, "reminding patients about out-patient clinic appointments in the North West", which is an area I represent. That is a great idea. We know that that it is a big problem if people do not turn up for operations and appointments. Is that really something that NHS Direct should be doing?

(*Mr Jenkins*) It is going back to saying that if you have a call centre infrastructure there are lots of things you are can deliver from that infrastructure. If you recognise the profile of our demand we have to equip our call centres to deal with the Sunday morning surge of calls, which means on Tuesday mornings there are a significant number of spare desks and spare computers that can be used to deliver some of these other services. Instead of hospitals having to set up their own call centres, their own facilities, there is already an infrastructure and expertise to deliver that kind of service.

85. Another one, "Working with social services to provide robust support to child protection initiatives". Can you tell me something about that?

(*Mr Jenkins*) Again, there are a there number of services that we have done working with social services, again using the infrastructure that is available to us. One thing to highlight as well is on a national level we have been working with the setting up of the new Care Direct service which is designed to provide a range of information and advice to older people round the spectrum of issues that concern that population. Instead of re-inventing the wheel those calls are initially routed to NHS Direct call centres, answered as Care Direct but by NHS Direct staff with the appropriate training. I think there are two benefits to the wider public good there, one, is we are making good use of existing infrastructure but, secondly, an opportunity to actually create a seamless way into health and social care problems. As we all know for older people in particular health and social issues are often confused.

86. These are all very good things. My concern is that the Permanent Secretary, Mr Crisp, is going to start saying, we are great, we have this giant switchboard for the NHS, and your service is going

[**Mr Osborne** *Cont*]
to lose the focus of its original function because obviously the Permanent Secretary will be looking for efficiency savings. Perhaps I can ask both of you whether you think that is a risk. Mr Jenkins first.

(*Mr Jenkins*) I think the answer to it is that we have to have a very clear remit about what we provide as a core service, people contacting NHS Direct. I think, as we have tried to say today, that is about people who contact us on the 0845 number, the integration, the GP service link with ambulances and other emergency care services. We must not do anything else that compromises the quality or efficiency of that core service if there is the infrastructure and expertise available to do other things, particularly things you may want to do in one place and not do in another place. They are not so much a priority as long as we have some clear rules of how that is organised and clear ways of managing poor service. I think that is going to be a good investment for the NHS.

(*Mr Crisp*) Can I make two points. These are questions, as you can imagine, that within the management process we also ask. Firstly, the point here about getting absolutely clear what the strategy is right at this point. We need to have a core business and let us be clear how else we are using it. Then the question I have asked about NHS Direct is how big can it get? What is the scalability? What size can we grow it? It is already the largest such service in the world, having grown from nothing to 120,000 calls a week. We have now got a strategy for expansion which allows us to see how much their capacity we think we can handle within our current infrastructure. We are having some decisions about what that is so when we look at the bigger strategy picture, if there is some spare capacity here, we can decide what we should use it for.

87. You are not going to allow Mr Jenkins' excellent operation to be turned into a giant switch-board for hospitals reminding people about operations and so on?

(*Mr Crisp*) We need to have value-added services. Which are the things that will work? I think this out-of-hours issue and the very clear evidence that is coming through that it is reducing GPs' workload is a very important benefit to the NHS. Let's get a cost-benefit approach here. This takes us back to some of the earlier discussion about the waiting times, the points the Chairman introduced, let's not let these standards slip by turning ourselves into something different that we cannot do.

88. A related issue, obviously if there is a confusion within the rest of the Health Service about the role of NHS Direct, that might impair good relations between NHS Direct and local services. One of the disappointing things in the Report, I am looking here at paragraph 3.5, page 19, is where it says: "NHS Direct has to date only reached its desired state of integrated service delivery with a few health care providers in a few locations." In other words, the integration with local health care providers is not quite as it should be. Do you see that as a problem that you are working on?

(*Mr Jenkins*) I would see it as a problem if it continued to be the case. I think as the new kid on the block it is very hard, especially when you are a service like NHS Direct that sits in the middle of virtually everything, to make contacts and build relationships with every other part of the system within a short period of time. I am now confident that that relationship is getting much more well-established and people are seeing NHS Direct as an established bit of the furniture and understanding what it can offer. It is something we continue to need to work on.

89. Are you going to hit your March 2002 target of integrating with providers of out-of-hours services covering ten million people?

(*Mr Jenkins*) Yes.

90. You have only got a month. Is that the beginning of March or the end of March?

(*Mr Jenkins*) Those plans are in hand. It may be that some of them, because of the timing of Easter this year, happen just the other side of Easter which is on the cusp of March and April, but yes, in essence.

91. What about the integration with emergency services which, as I said at the beginning, was the original inspiration for this.

(*Mr Jenkins*) We already handle advice calls to a significant number of hospitals and some of these schemes have been evaluated and it suggests that it saves two whole-time equivalent nurses in those A&E departments, who are now seeing patients rather than answering the phone. We are keen to encourage that service in particular to become, if not the norm, the case in a large number of hospitals. One of the other ways that we are looking to integrate is through the decision support computer system that has been purchased for NHS Direct, which is already being piloted in a number of face-to-face settings. If the principle of this (which is that it helps you make safe, consistent clinical decisions) works in telephone advice, it could equally work elsewhere. We have a commitment to pilot the system in 25 A&E departments. We also have pilots in walk-in centres and in one primary care trust in GPs' surgeries. NHS Direct can integrate with emergency services not only by doing their work but also by exporting some of its techniques and approaches to other settings where they are likely to have benefit.

92. If I can in the last couple of minutes available to me pick up on something that Mr Gibb was asking about which was about the rotation of staff through NHS Direct working in the local NHS. You said that it was a good idea and the sort of thing you tried to encourage. It is not something you require, is it, yet? Is there a danger that people who just work on the phone and do not go into hospitals regularly will lose their clinical experience or lose their hands-on feel for health issues?

(*Mr Jenkins*) I do not think we feel that in any absolute sense. There is no evidence that those who have worked on the phones for two or three years in some of the more well-established sites are any worse than people—we are talking in all cases here about people who have got a significant amount of previous experience of working in a range of settings. One of the things we also find about the call centres is that they are quite a powerful school in a way. You are bringing together nurses from a very wide range of backgrounds, mental health nurses, A&E nurses, primary care nurses, people who in the normal course of work would not interact with each other. I think they have a great opportunity to learn from each

[**Mr Osborne** *Cont*]

other. If you go into one of our call centres you will see a lot of informal consultation about particular calls between people from different nursing disciplines.

93. One of the things—it may have changed—that nurses said to me a couple of years ago was that the NHS in general has not been a terribly good family-friendly employer, to use the jargon. Mothers who want to work part time have not always found it easy to come back as a nurse. Are you setting an example to the rest of NHS about being a family-friendly employer?

(*Mr Jenkins*) I would hope so. There are things that we are uniquely able to offer because we are able to offer work at all times of the day and night and can mould that around people's particular circumstances. So I think there are a lot of people who work for us who choose particular types of shifts because that fits into family commitments. One constraint on the service which we have to be up front up about is that because our demand is very skewed towards the out-of-hours period, we do need a lot of staff to work at the weekends and evening periods. You cannot compromise on that because that is when the callers and the public need us.

(*Mr Crisp*) I think NHS Direct exemplifies quite a lot of things about how we need to change the NHS. The use of technology, the flexibility, the getting directly to people, and the notion that people will ring you back seem to be very important points. On this other point about flexibility of bringing staff in, in fact, there are a number of people working in NHS Direct centres who would not be able to work in other sorts of centres in the NHS as nurses and bring their experience to play. There are a lot of lessons that we can learn about how you do something like this and make really quite substantial change.

Chairman

94. Thank you very much. There are a few questions coming from Members. The 0845 number is charged at local rates. Does the NHS receive any income from this number? If yes, how much? If not, why not?

(*Mr Jenkins*) We do not. Because an 0845 number is a way of balancing between local call charges and trunk call charges, we have to pay a premium to use that number, although because of our volumes at a considerable discount to other users.

95. Thank you for that. In the brief provided to us helpfully by the C&AG, it tells us: "Early experience has shown that integration of NHS Direct with providers of GP services outside normal working hours is already yielding reductions in workload for GPs. There have, however, been some teething problems in achieving integrated working, including the incompatibility of information technology". What is being done to remedy this? What is the timescale? In other parts of the public services this has been a serious problem such as the Police, I am told.

(*Mr Jenkins*) Effectively, the problem has been cracked in that for the range of site integrations rolled out this autumn we now have a standard way of communicating between our decision support system and the IT systems that GP out-of hours providers use. There are still some small issues about ironing that out, but in essence that is a question of fixing rather than new development.

96. If, as we know, there is a message read to you, how will this work when NHS Direct calls are brought together with 999 calls? You do not want to delay people with a message.

(*Mr Jenkins*) If we are taking a call that has come in on 999 there is an exemption of the confidentiality message or any other kind of message; they will get straight through.

97. Arising from Mr Williams' example of the man living alone who calls at 11.30 and is given advice and dies the next morning, I do not understand how the information gets back. If you are given wrong advice by a GP, if you go to your GP with a lump and he says it is nothing, immediately the family starts realising there is something wrong. I do not see how you correlate this information. You mention that you get all the information back from the information service. This chap is not going to complain. Unless families actually complain that the advice was wrong, how do you know about it?

(*Mr Jenkins*) If anybody—family, GP—picks up that the person has been in contact with NHS Direct (without any implication that the advice was wrong or right) and raises that with them, we will track that down and will treat that as a potential adverse event.

(*Mr Crisp*) In that particular case maybe one would never know that he had rung NHS Direct, which is no doubt why he chose it.

Chairman: I just wanted to thank you and perhaps, as we are being broadcast, we should ourselves publicise the number of this excellent service—0845 4647. Certainly, as I have said, I have personally found them very helpful indeed. May I thank you for the way you have given your evidence. We expect that from the Permanent Secretary However, I hope I speak for my Committee when I say, Mr Jenkins, how particularly impressive we have found your performance. You are knowledgeable, competent, articulate and open with us. That is very impressive. Perhaps it comes from being in charge of the project for five years and perhaps the rest of Whitehall will take note. Thank you very much.

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1 Managing Risk in Government Departments (HC 336) 23/11/01
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2 Improving Construction Performance (HC 337) 05/12/01
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3 The Cancellation of the Benefits Payment Card Project (HC 358) 06/12/01
Government Reply (Cm 5393) 14/02/02

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