cates that there may be about 4500 men and 400 women in prison with recent or current psychotic illness. A single professional team with a ring fenced health and social care budget for severe mental illness community care must replace existing fragmented arrangements. Offenders are especially vulnerable to social exclusion, and local psychiatric and social services need a shared ideology of commitment and engagement rather than deflection and avoidance. Nothing short of a government wide response is required. Department of Health action has effected substantial but still insufficient development of local medium secure forensic psychiatry services,[11] but health care in the prisons remains a Home Office responsibility. The responsibility for rehabilitation and reintegration into stable communities is shared by many government departments. The secretary of state for health's cabinet colleagues should be reminded of their common responsibility for a just and effective response to the needs of this most vulnerable and marginalised group in our society.

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NHS Direct

Evaluate, integrate, or bust…

The gradual introduction of NHS Direct, the 24 hour health telephone helpline due to be a national service by the year 2000, is a small but important symbol of the modern NHS.[1] It has been designed to respond to the fastest growing influences on service industries: consumerism and technology.[2] NHS Direct aims initially to do for the health service what cash machines have done for banking: to offer a more accessible, convenient, and interactive gateway. Its longer term aim should be to help the NHS change its predominant ethos from paternalism to partnership.[3]

This method of delivering services is not particular to health care. Telephone services in other sectors have been one of the fastest growth areas in employment in the United Kingdom. However, the speed of planned growth of NHS Direct (pilots launched March 1998, more bids invited May 1998 and announced in July 1998, 19 million people (40% of England's population) to be covered by April 1999) might suggest that fulfilling political promises precedes rigorous evaluation. A more likely interpretation is that the research is aimed at clarifying not if NHS Direct develops but how. At this rate of expansion, the learning needs to be rapid and responsive.

Those charged with developing and evaluating NHS Direct need to address five key issues. Firstly, to ensure that NHS Direct is both safe and effective, evaluation should establish the best process (how are the calls answered, which decision support software works best?) and the best content (on which guidelines should the advice be based?) for the service. Until recently the evidence on the safety and effectiveness of telephone consultations services has been mixed. More robust evidence is now emerging, as in the study by Lattimer et al in this week's issue (p 1054).[4] This shows no increase in the rate of adverse outcomes (such as death) in people managed by a nurse telephone consultation service with decision support software when compared with those managed by doctors in the traditional manner. As the authors acknowledge, the promising results of this research probably depend on the setting, the method of training of the nurses, and the particular decision support software.

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The second challenge is to ensure that a national service develops national standards. Do we perpetuate the natural experiment of pilot sites developing the service differently for too long, or do we stifle creativity by imposing uniformity too early? Too much individual autonomy for too long in the development stage may cause the same problems for NHS Direct as it has done for general practice computing systems.

The third challenge is to develop NHS Direct as an integral part of the NHS with a coordinating function for accessing health (and health related) services. The gateway to the NHS is changing rapidly with the development, and likely convergence of, general practitioner cooperatives, primary care groups, health information services, nurse telephone consultation services, and NHS Direct. A strength of the NHS is its potential to provide a seamless service, promoting col-

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laboration within and between sectors while avoiding duplication. It would be ironic, wasteful, and confusing if NHS Direct developed independently of services provided by general practitioner cooperatives. Outside the NHS there must be an equally seamless integration with social services and other welfare agencies. Fortunately the recently announced second wave of NHS Direct pilot sites has a strong flavour of integration. The collaborating agencies include ambulance trusts, community trusts, cooperatives, health information services, health authorities, voluntary agencies, and research units, many of them working closely with social services.

Fourthly, a service that promotes access using technology will always risk helping those parts of the population who least need help. The service needs to be equally accessible to those without English as a first language, mentally ill people, and carers.

Lastly, NHS Direct has the potential to be much more than just a telephone help line—yet there is a risk that it will not be allowed to develop that potential. It should be the beginning of a range of systems that provide convenient, reliable, and interactive gateways to health and other welfare services. In reverse, NHS Direct offers the NHS the possibility of catering more directly for the special needs of particular individuals and groups and of promoting health rather than just responding to need. Self care in general, and support for self care (in the form of services such as NHS Direct), are extensions of the NHS, not substitutes. Moreover, fears that giving people alternative means of access increases demand inappropriately are largely unfounded.[5 6] More than just advice and telephone consultations can be offered. Managing chronic disease, dispensing prescriptions, and booking hospital appointments could all be possible. Why should booking an appointment to see the doctor around the corner be more complex than booking a plane to see the family around the world?[7] The same analogy applies to professionals. Just as people can check their personal financial information from almost any bank machine around the world, so clinicians should be able to have rapid access to up to date accurate medical information via a simple interface. As NHS Direct may become Welfare Direct for the public, an analogous service could provide Knowledge Direct for the professional.

On the evidence available, we should keep developing and evaluating the "prompt, accessible and seamless" service that the government proposes.[1] More than any other health system in the world, the NHS is well placed to develop direct services as part of a fair gateway to collaborative welfare. With adequate support, evaluation, and integration, services such as NHS Direct can keep the founding principles of the NHS relevant for the next 50 years.

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Changing practice in maternity care

It's hard to know what works

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The tenet that clinical practice should be guided by rigorous evidence has become so ingrained that clinicians who are slow on the uptake are seen as not aware of the evidence, bogged down by tradition, or—worse—having selfish motives for ignoring evidence. Rarely is the evidence itself questioned. Yet, if evidence were a straightforward concept, there would be no reason for the two disciplines that appear to be governed by it, law and medicine, to be at loggerheads so often.

The evidence available does not necessarily reveal what you are interested in for a particular situation. Thus many reviews in the *Cochrane Library*, the gold standard of systematic reviews, devote no attention to adverse effects in assessing the effectiveness of health care interventions (Bastian H, Middleton P. Cochrane Colloquium, Amsterdam, 1997). Yet any intervention (be it advice, screening for disease, drugs, or surgery) that is likely to be beneficial for some people is also likely to harm others. Even if the evidence is clear on the effectiveness of an approach, it does not necessarily reveal how to pursue that approach. For example, systematic reviews may show benefits of antibiotic treatment for preterm prelabour rupture of the membranes, but they do not show what to prescribe and for how long.[1–3]

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The paper by Wyatt et al in this issue (p 1041), addressing how to enhance the use of evidence, itself demonstrates how "evidence" can fall short of being evidence.[4] Although this group used evidence's golden tool, the randomised trial, they chose the toss of a coin as the method of randomisation. This process should be secure, but there is good evidence that it is not.[5 6] Of the four outcomes addressed, two showed a statistically significant imbalance between intervention and control groups before the trial and two differed significantly in completeness of outcome assessment before or after the trial.

Thus, before the trial, vacuum extraction was used in 36.1% of women in intervention units and in 54.5% in control units (difference 18.2%; 95% confidence interval 11.2% to 25.3%). Appropriate suture material