Customer Service in the NHS

RESTRICTED

Report by

June 2000

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Improving Customer Service in the NHS

We undertook this assignment, on a not for profit basis, recognising the short time frame of 26 days over an eight week period. As a result we would like to stress that some of our observations may be deemed to be superficial. However, the short time frame had a number of advantages, it enabled us to:
a) retain our external perspective
b) hear the experiences and concerns of staff at the front line and
c) stay focussed on the customer experience and service quality.

The Brief from the Department of Health:

Make initial recommendations on:

1) A programme of staff training to improve customer focus
2) Systems for spreading best practice in customer service
3) Guidance to improve the environment in NHS buildings
4) The staff roles and responsibilities within the NHS & DOH which would be required to implement the strategy.

Our aim was to examine these issues "with fresh eyes" and consider them in terms of the quality of service delivered.

At our first meeting with the steering group we pointed out that service quality can't be 'painted on' via a training course, it has to be built in. Also that the basis of high-quality service is a well-designed product delivered effectively by people appointed for their potential to deliver it well and trained to deliver it well.

The Project Team

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An external consultant who has worked extensively with Virgin Atlantic, helping to develop their award-winning customer service strategy.

The process:

We undertook a programme of desk and field research, visiting 9 major hospitals (incl. one from the private sector), doctors surgeries, walk in centres and a day surgery unit. In line with the brief we looked at 3 major areas:

Access – for patients to use the NHS and barriers preventing them from doing so and physical access to NHS hospitals.
Communications – from how hospitals and doctors deal with patients and staff to the provision of entertainment and communications systems for patients.
Environment – Physical surroundings; the design of new hospitals; cleaning and maintenance; the ordering process, delivery and quality of food.

- Given the scope of our brief, we have not looked in depth at the areas of mental health or links with social services, but have picked up serious concerns about both.

Summary

During the course of our study we concentrated on customer service issues. Our observations may be appear to be critical, unfortunately, there was little to praise from the point of view of customer service.

Observations

Access
- Long waiting times throughout
- Physical access is poor

Environment
- No demarcation between front and back of house
- Tatty, scruffy, dirty

Communications
- Inefficient communication with Patients
- Poor sharing of Good Practice

Staff and Morale
- An organisation under Siege
- Management by cascading paper
- A strong appetite for change

Leadership
- We have seen some shining examples of leadership; but sadly too few.
- There is a need to shift the emphasis from administration to leadership

Conclusions
- The main causes of the poor quality of service we observed were poor staff morale caused, in part, by a lack of leadership and a service designed around the system rather than the customer.

Recommendations
- We identified a number of ideas, each of which would have a positive effect.
- Some suggestions are obvious and easy to install. Many have been suggested by people around the service, but not put in place.
- Individually, however, these ideas do not address the fundamental issues.

Revitalisation Plan

We are recommending a plan for revitalising the NHS, consisting of:
- A building programme, (a rallying point about which people can get excited)
- A review of the way the service is measured
- A leadership development programme to build morale

Communication

For any plan to be implemented effectively, it has to be thoroughly communicated to all staff to encourage buy in.

Main Observations

Access

Waiting Times

Long waiting times for outpatient appointments and elective surgery along with reports of rogue doctors have represented the public image of the health service in recent months.

Waiting times are both symptom and effect of much deeper problems in the NHS. Attempts to address waiting times 'head-on' have resulted in a plethora of new initiatives in a service well used to dealing with 'initiative overload'. One result has been for staff to fudge waiting time reports. Another has been to secure significant additional expenditure for the Health Service.

Facilities

Medical technology is continually advancing and people are living longer. More strokes, cancers, cataracts and joint replacements are expected; new procedures and therapies are being developed; post-operative recovery times are shortening. These represent major forces in shaping healthcare for the future. Design of buildings and jobs, structure and services will have to be sufficiently flexible to adapt to constantly evolving needs and expectations.

Physical Access

Physical access is poor in most hospitals we saw. General hospitals tend to be close to the centre of town. This was obviously once an advantage, but has become a problem as towns have grown in size and traffic congestion has increased over the last 100 years. The traffic problems have also spread onto hospital sites. Few areas are designed for access by car, making it difficult to 'drop-off' and 'pick-up' patients. Some sites were so large (90 acres) that they ran a bus service around the site. Walking across the site was out of the question for most people.

Ambulances seemed to be expensive and inefficient for all but emergency transportation.

Car parking was very difficult at most Hospitals (except those in central London, paradoxically). We were told that local authorities restricted the number of car parking spaces allowed, gradually reducing them as building development progressed. Car parking is a direct service quality issue, and also a major staff problem. This is not joined-up government.

Recommendations for improving **access** are shown in Section A.

Rationing

Improvements in access and a reduction in waiting-times will stimulate demand. For example, health screening (whether as part of pre-admission procedures or regular health checks) uncovers previously unknown conditions, particularly in older people. Healthcare has a potentially unlimited demand so, given limited resources, it is necessary to control supply, and that means rationing.

The patients association suggested one approach to rationing healthcare. (They also made the point that it is about rationing rather than prioritisation, because the latter suggests that it may be provided 'in turn'). A model of rights to services based on the Patients Association suggested approach is shown in Appendix 1

Environment

Cleanliness

The hospitals we saw were mainly housed in very old structures (some more than 200 years old); built to serve a much smaller urban area and population. Built in an era of very different technology and methods of transport.
The age of the buildings was no excuse for the general poor state of repair and cleanliness we encountered. That represented poor attention to basic standards.
The main entrances of virtually all the hospitals we visited were dirty. Cigarette extinguishers that had clearly not been cleaned for weeks; the area was strewn with cigarette ends; chewing gum stuck on the ground and in the carpet.
Many of the main entrances of the hospitals we saw looked tatty, scruffy and dirty.

Front and back of house

There appeared to be no demarcation between front and back of house.

- Large rubbish skips were parked in stairwells and by main entrances. It was often difficult to establish which areas were public areas and which were 'out of bounds'.
- It was easy to gain access to virtually any area of the hospital unchallenged (even the maternity areas) - the administration block was the usual exception!
- When examining the plans for a new General Hospital we found that a corridor to be used when moving patients between ward and theatre would also be the main thoroughfare for visitors, deliveries and taking out the rubbish. Undignified and unhygienic for patients.

Customer Focus

In one Hospital, the part-time Chairman's office was about the same size as the A&E waiting area, but considerably cleaner and much more pleasantly decorated. In another Hospital, the main public area was large, stylish, airy and well maintained – the Chief Executive had to make do with a 'portacabin' (nicely decorated) round the back. The first was an NHS hospital, and the second run by BUPA. It certainly gave an indication of the focus of attention; the customer or the senior administrative staff.
There were modern, well cared-for units in the oldest hospital; and scruffy, dirty wards in some of the new buildings.

Scale

It seems that many hospital rebuilds are modelled on what existed before. The main concessions to change being attempts to fix those areas which are not working too well. "Replacing 19th century monuments of civic pride with 21st century monuments of civic pride".

- If all new development is concentrated on General Hospitals, they will remain part building-sites for the foreseeable future – they will never be finished, encouraging a philosophy of 'rebuild' rather than maintain.
- They are remote for many people. Difficult to get to and difficult to get around.
- They are too large, like small towns employing thousands of staff.
- Staff become anonymous in such large units – poor performance is more possible and less likely to be tackled. Morale suffers.

Known and predicted changes in society, transport, demographics and technology require a different approach.
Recommendations for improving **environment** are shown in Section B.

Communications

Phones / not letters

Communication with patients seemed inefficient and antiquated. Most communication was by letter. Communications need to reflect the way the world has changed and be telephone-led which is a much more personal medium. It is also cheaper and friendlier. A patient who banks by telephone, books holidays or shops on the Internet, whose work and personal communications are dominated by mobile phone and e-mail will be frustrated by an NHS who can only offer communication by letter, with appointment times that are dictated, not negotiated.

Internet / call centres

NHS Direct is a step in the right direction. The software employed by the system (which is being adapted for use in Walk-in Centres) could also be put to good use elsewhere in the NHS such as in GP surgeries.

Signage

Signage was confusing, in some hospitals we could not tell which was the main entrance and the plethora of signage was confusing and sometimes misleading. We understand that a tremendous amount of research has gone into this and we felt this was reflected in the newly built hospitals we visited.

Uniforms

We were often unable to tell who was in charge when we entered a ward and it was interesting to learn that the Chief Executive of one of the Trusts (a life long NHS professional) had exactly the same problem. This needs to be addressed by consistent uniforms and legible nametags with titles.

Talking to patients

Many examples of clinical staff patronising (particularly old) patients were reported to us, not addressing the patient but a relative and sometimes as if the patient wasn't present. We were surprised to see that, despite the Patient Advocate idea having been expressly praised in Greg Dyke's report, so few Trusts had instigated this idea.

Bedside communications

We saw two examples of customer friendly communications – the Patient Call and Patient Line systems of which the latter is the better solution. We had identified the need for a bedside TV and communications system with the ability to provide e-mail and access to hospital systems such as X-rays and test results and it was good to see that it existed. The biggest problem in installing this system in more hospitals was simply the bureaucracy involved, despite the fact that it did not require any financial investment from the hospitals.

We collected scores of information booklets and leaflets; many produced independently, covering the same topic, surely there are opportunities here to save costs.

We saw some outstanding examples of good practice in our study, but no obvious mechanism for recognising it or sharing it with other groups

Recommendations for improving **communications** are shown in Section C.

Staff Issues

About one third of NHS employees are administrative and support staff (excluding DOH staff dedicated to the NHS). A ratio of 1 admin for every 2 clinical staff seems a high proportion, particularly in light of clinical staff complaints about the growing burden of administration in their jobs. Even understanding that some 'customer-facing' positions are classified as administrative, surely, better economies of scale should be expected. We were told that there is a shortage of clinical staff. 'Raiding' the 3rd world for nursing staff is ethically questionable and can only be a short-term expediency.

Morale

The NHS seems like an organisation under siege, lacking direction and leadership, pulled every which way by initiatives, politicians and the media.
It would be impossible to completely remove the NHS from politics because it represents such a large proportion of GDP. It is unfortunate, however, that party political affrays and sensationalist media coverage, both of which are very damaging to the morale of NHS staff, seem to be unrestrained.
Within the service there is an impression of "management by cascading paper", all ideas and instructions being passed down from above. The dead hand of bureaucracy seems to stifle imagination and flair and obscure responsibilities.
There was a view that there were too many initiatives, "a new one every week". Clearly the volume is burdensome and some thought should be given to limiting the number of initiatives set. We were told that DOH initiatives / policy often seemed conflicting, and that even an acknowledgement of the current stresses would be welcomed.

Inspirational Leadership

The ward managers make the difference. As with any front line activity, the biggest impact on the quality of service delivered is the leadership capability of the front-line supervisor.
We saw some magnificent examples of front line leadership in our study:

- The enthusiasm of the manager of the minor injuries clinic was infectious (sic). The greatest motivator for her was knowing that she was making a difference in cutting the queues in a busy A&E department.
- The dialysis ward which had low staff turnover, low sickness absence, no problem recruiting new staff. It was set in an old pre-fabricated building, seriously overcrowded, with outdoor garden sheds acting as the main storage area. It was run by an outstanding Ward Manager.
- The caring Ward Manager of the elderly people's ward who continually fought off attempts to patronise her patients. She insisted on everyone treating them with dignity and respect. She also had no difficulty finding staff for her ward and keeping them.

The function of Trust management appeared to be more about administration than leadership. This was particularly evident in the relationship between Trust managers and consultants, which often resembled an uneasy peace. In difficult times, consultants are much more likely to turn to their professional association than Trust managers for support. Trust managers seem to be more concerned with distancing the Trust from claims of malpractice or negligence than in supporting their employees. It doesn't make sense for any organisation to alienate the senior professionals on whom it is dependent, no matter how difficult they may be to manage.

Positive Feedback

It's well known that people respond better to praise than criticism. "A pat on the back is worth a thousand lashes". Praise energises people, criticism angers or depresses them. Praise focuses attention on good work.

During our study when we praised people for the obviously good work they were doing, they were rather taken aback. It seems that the habit of praising people has been lost in many parts of the NHS. Similarly, Trust Managers had little idea of how they were performing compared with other trusts, but they wanted to know.

The measurement systems currently in place seem to be essentially critical, focusing on what is not achieved rather than on what is.

Internal magazines and newsletters are a convenient vehicle for communicating values and good news, so the photograph of Harold Shipman on the front cover of one staff magazine we saw seemed crass and inappropriate.

Recruitment and Training

Outstanding front line managers probably do more than anyone or anything else to retain staff in the Service. How are they recruited, trained and recognised? We discovered that during recruitment, very little attention was paid to anything other than qualifications and clinical experience. In most cases, clinical staff self-selected by choosing to be trained in medicine, the NHS employing virtually all of those who qualified. It seems that very little attention is paid to training in interpersonal effectiveness / customer service skills.

On promotion to front-line management positions, we heard that staff received little or no associated leadership training, or much guidance on what was expected of them in their new role.

Who held the responsibility for the quality of service delivered was often unclear (except in the cases of the outstanding front-line managers).

Some staff seem to have become indifferent to the needs of patients: the nurse reading a newspaper at the nurses station. The ward manager who seemed unconcerned about the dark (blood?) stain on the ceiling of an admission ward. The manager who was too weary to once more raise poor standards with the cleaning contractors. The Senior Manager who walked round the hospital only once a month. Most are probably decent people who just need a little leadership and direction.

When asked why they worked in the Health Service, the response of most clinical staff indicated that it was because they wanted to help and heal people. That 'Nobility of Purpose' seems to be swamped by the problems currently facing the service.

When we asked a group of three Doctors and two Nurses, all of whom had children if they would be encouraging their children to follow in their footsteps, all replied that they would not. It's a damning indictment.

Given that there is a shortage of clinical staff, and the time taken to bring clinical staff on stream is 2 – 7 years, then it is much quicker to stop staff leaving than to recruit new ones.

Recommendations for addressing some of these **staff issues** are shown in Section D

Conclusions

Below we have compiled the conclusions we reached about service quality in the NHS, which have shaped the recommendations we are making.

- We observed little customer focus in the NHS. As a matter of course, the patient is required to fit into the system, rather than the other way around. Those examples of good service we saw were instigated by good leaders and operated in spite of the system.
- Although inadequate funding was the most commonly raised reason given for poor services standards, the leadership capability of managers (particularly front-line supervisors) was by far the biggest driving force in the examples of good and poor service we observed.
- Staff are beleaguered under a steady rain of instructions, initiatives and criticism. They seem to have lost the sense of pride associated with working in the Health Service and some of the public appears to have lost confidence in them.
- It's not surprising that, in the event of a problem (be it mistake or misunderstanding), clinical staff are more likely to turn to their professional association than to their 'line managers' for support.
- Current quantitative measurement systems are used primarily to criticise failures and not surprisingly encourage staff to fudge reporting – particularly waiting times.
- Hospital design is not fit for purpose. The A & E areas are too small, and there is little differentiation between front and back of house. Not surprising, given the age of most hospitals.
- Unfortunately it seems that the fundamental design flaws are being replicated in the next generation of hospitals.
- General Hospitals have become too big to be manageable, too big for customers ("I had to walk miles"); too big for staff; too big to be located in the centre of town.
- Practices of 2 or 3 GP's are too small to offer a reasonable range of services (inc. 'out of normal working hours' surgeries); cover for holidays and sickness; and 'colleague monitoring' of standards and performance'

But there are some opportunities

- A new tranche of money has been committed to the NHS.
- The NHS certainly needs to change and there is a strong appetite for change among the staff.

Recommendations

The recommendations we make fall into two categories. Firstly, those actions that will have a positive effect, or are 'overdue' for attention. These are shown in the appendices.
Secondly, we have recommended a more fundamental review of the way the service is designed and delivered.

Some improvements are obvious and relatively easy to implement, e.g.

- **Patient line**
  Provides entertainment, information, and communications for patients, providing a sense of privacy in a multi-bed ward. No cost to the health service. See Recommendations C/8
- **Patient Advocates.**
  Deals with breakdown in service before it becomes a real issue. Helps to continually improve quality of care. Potential to save millions of pounds by avoiding litigation, 'nipping it in the bud'. (Costs for 1 per Trust - £40k x 400) = £16 million. See Recommendations Section C/2

Other 'obvious' improvements take longer or are more difficult to introduce, e.g.

- **Contracting staff for a 24/7 service** (including no bank holidays).
  Essential if the NHS is to deliver its promise to customers. See Recommendations Section A/8
- **Increasing flexibility of clinical staff.**
  The extension of the Nurses role into areas which were previously the sole domain of Doctors has already improved efficiency and service. See Recommendations Section A/2, Appendix 4
- **Sharing Good Practice**
  Many of the answers already exist within the service; there is a danger of constantly 're-inventing the wheel'. See Recommendations Section C/3, Appendix 5

Although important, these do not address the immediate, fundamental issues involved in delivering high quality service.
Pressures from politicians and the media and have created a readiness for change within the NHS, but public confidence and staff morale is probably at its lowest ever. A new survey, set of promises or another long-range plan will not satisfy the public or the professionals in the service. They want action. More controls, restrictions and assessments will simply distract staff from their true purpose and desire – i.e. helping, healing and caring for sick people.
The action must be visible, tangible, positive and capable of making an impact within a year. Although some things (such as training new professionals) take much longer, they too must be started now.

To significantly improve service quality, the NHS must dramatically improve staff morale and genuinely incorporate customer focus into the design and delivery of health care services.
The current system is deeply imbedded in the past. It was designed in a different era with different values, technology and demographics. The current system is failing patients, staff and taxpayers.
This means fundamental change rather than trying to tune what exists.

Recommendations continued - An NHS Revitalisation Plan

This addresses the two major issues of poor staff morale and the service delivery system. The aim is to:

- tap into the 'noble values' of the Service – the desire to help and heal people
- stem the flow of staff out of the service
- attract nurses back to the NHS
- design the service around the customer, not around the system and staff
- take full account of today's needs and anticipated future needs

A Building Programme is at the heart of the strategy. Remodelling the infrastructure of healthcare facilities, both buildings and environment. Reducing the size of secondary care units and increasing the size of primary care units. See Appendix 4

Supporting this we are suggesting **changing the way the service is measured.** Focusing on achievement rather than shortfall. Using performance measures as the basis of improvement rather than to punish. More assertive PR and internal communications focusing on successes rather than failures. See Page 12, Recommendations Section D/5

The whole revitalisation plan being supported by a **Leadership Development Programme**, based on the characteristics of excellent leaders within the organisation. See Recommendations, Section D/3

A National Hospitals Building Plan

New buildings provide a great rallying point for beleaguered staff and dissatisfied customers. An opportunity for a new start. Reaffirming values and setting new standards of quality and care. Taking the best from the past and reshaping it for the future.
General Hospitals become the centres of excellence for acute care supported by:

- GP practices, larger than current, to permit a reasonable level of service to be delivered. See Appendix 5
- A network of 'Poly-Clinics', for GP services, minor injuries and day care procedures. See Appendix 4
- Intermediate care / rehabilitation units linked with social services to ease the burden on General Hospitals and help patients to return home. See Recommendations Section A/2
- A number of specialist hospitals concentrating solely on elective surgery requiring 1+ to 5 days stay. Private hospitals could be utilised for part of this work. See Recommendations Section A/7

The rebuilding programme must address the borders between Regions and Trusts. It appears that currently, each Trust works largely in isolation. It has been suggested that general hospital sites can be subdivided into separate specialist/elective centres, to help build smaller teams. Our concern with this is that it fails to address the major problem of size from the customer's point of view.
The plan we are recommending will quickly show that the NHS means business. There can be quick, tangible evidence of a new approach and commitment to the customer.

Recommendations continued - Change how NHS is Measured.

Currently failure is often rewarded e.g. by the allocation of more funds to address waiting lists - success is normally ignored or penalised with tougher targets. Performance needs to be measured in such a way that:

- success is recognised and celebrated
- supports a culture of best standards and practice
- improves / lifts morale

A less burdensome system than at present, to try to minimise 'fudging' the measures. Qualitative measures such as safety and cleanliness may require more subjective judgement, but they address the key issues directly. Similar facilities such as Poly-Clinics allow 'like with like' comparisons to be made.

Make use of ratios e.g. ratio of direct to indirect staff. Comparisons made over time allow improvements to be measured e.g. number of procedures accomplished this quarter compared to last year; number of operations cancelled compared with last year, number of clinics that started on time; average length of stay compared to last year.

Customer satisfaction can be measured through surveys of patients and their relatives & friends. Front line staff are often the best placed to monitor quality of service, because they know better than anyone else the range of service quality, best and worst. Of course, they will not provide honest, regular information if it is not used or only used to punish or criticise them. See Recommendations Section D/5

In place of league tables, we suggest an intranet system where all Trusts report their statistics. This would be a confidential system where each Trust can access only their information and compare them against the average, upper and lower quartiles of all the Trusts. No one sees who is best or who is worst. In this way, the NHS has an overview and can see which Trusts are doing well and also which need help.

The best way to find out what measures should be used is to ask the people giving and receiving the service.

Current accounting systems frustrate attempts at efficiency.
E.g. reducing DNAs scheme required an investment of £40K to save £350K but was cancelled as it represented budgetary expenditure. A more pragmatic view is required.

A Leadership Development Programme

- Identify those people who are currently seen to be excellent leaders at all levels in key jobs the organisation, in particular first and second line supervisors.
- Study role models in each key job to find out in detail the approach they take to their work and the personal qualities they demonstrate.
- Use these 'competencies' to determine selection criteria, design of training and appraisal systems.
- Make training for leadership positions mandatory, before appointment.
- Training will have to be specific to the role, grounded in reality and delivered in modular form to minimise the time away from work.

Section A.

Recommendations for Improving Access

1. GP's People can't get to see their GP as quickly as they would like, leading to ever increasing pressure on A & E Departments.	1. Operate a 2-tier assessment system for appointments. Telephone requests for appointments, ask 2 simple questions to determine: a) What time of day do you get appointment? Are you in full time work? If so – you go on the list for a lunchtime, evening or Saturday appointment. If not – home worker, out of work or retired – normal hour's appointment. b) How soon do you get an appointment? Triage on the phone – are you in pain? Could a nurse deal with it? (17 practices set this up after their receptionists attended a half day best practice seminar) 2. Reorganise GPs practices to have a minimum of 4 GPs in urban practices, to provide rostered out of hour surgeries to: 3. Extend GP's surgery hours 4. In inner city areas – walk in medical centres with GPs, in addition to nurses, then they could do many more routine tasks – vaccinations, smear tests etc. Current nurse-only model is of limited use.
2. Long waiting times in A&E Some A&E units are reportedly "like a zoo on Saturday Night"	1. Doctors to do triage. If everyone has to see a doctor in A&E, then turn the current triage system on its head and make a doctor the first point of contact (he has to spend time with them anyway – do it at the start of the process, not the end!). Trials of Continuous Dynamic Triage (CDT) carried out by Professor A. D. Redmond, resulted in 33% of patients being sent to their GP, chemist or home with assurance, 33% to X-rays or for treatment and only 33% triaged to see a doctor. Waiting times reduced by 60%, delivering an immediate improvement in Service Quality (when triage was conducted by a nurse, patients waited 2½ times as long.) Apparently, other studies have reached different conclusions about the relative merits of Doctor or Nurse doing triage. Both need consideration. 2. Minor injuries unit in all A&E's run by nurses. 3. Children's department in all A&E's so they do not have to wait for long periods with disruptive adults. 4. Consultants working hands-on in A&E 5. More Emergency Nurse Practitioners 6. Medical assessment wards/room for GP referrals to A&E <u>Mid term solution</u> 1. Bridging teams made up of social services, district nurse, hospital staff to ensure patients' homes are fit for their circumstances and that they don't come back in through the revolving door a few weeks later. 2. Rosters of local GPs in A&E 3. Increase A&E budgets <u>Longer term solutions</u> 1. Provide alternatives to General Hospital A&E units. 2. Walk in medical centres next to A&E and in areas of high demand e.g. city centre / tourist areas.

3. Long waiting times in Outpatients	1. Extend Out patient consultation times • Evening appointments as a "norm" (3 session days) • Saturday clinics 2. Operate same system as GPs for appointments 3. Change primary mode of communication from sending patients letters and cards (10 weeks before!) to phoning them. Don't over book appointments for consultants in case patients don't show up. 4. Publish weekly list of consultant's clinics that have started on time (and those who didn't – drive behaviour). 5. Consultants to telephone some patients for follow up rather than bring them into Outpatients (distance consulting). GPs to see more follow up patients after discharge from hospital. 6. Use taxis as well as ambulances for outpatients requiring transport to stagger appointments rather than have all patients arriving at the same time. 7. Improve patient experience by providing crèches for outpatients <u>Mid term solution</u> 1. Rapid replication of the booked admission scheme 2. Hold outpatients clinics elsewhere to free up space in hospitals/parking
4. High rate of do not attends (DNAs) at out patients	1. Each hospital with outpatients needs to have a small call centre that will call all outpatients on their 2nd or follow up appts. 3 days before (1st not necessary as 'everyone always comes for their initial appointment'). 2. The call centre should publish a FreeCall hot line for the cancellation of appointments. This can be automated so it can be available 24 hours a day. 3. Inform customers (when making arrangements) that DNAs cost the NHS £250 million per year in order to change behaviour.
5. Carers are not sufficiently supported by GPs	1. Carers to have access to their charge's records 2. Empower pharmacists
6. Insufficient Car Parking for Visitors We are told that the most often discussed subject at every Trust meeting, is car parking and the problems it brings. While local government has its own agenda to reduce car parking, it seems ridiculous that, by comparison, supermarkets seem to be able to get planning permission for huge numbers of parking spaces. At hospitals, upset and stressed relatives having sometimes rushed there, get more upset having to spend valuable time looking for a parking space.	1. Provide multi-storey/underground car parks. Example of local government and national government not working together so this will need government intervention. 2. Offer staff loans for train travel, bus season tickets and the purchase of a bicycle or moped to reduce parking on site 3. Stagger shifts • Ease staff handovers • Don't conflict with outpatient appointment times 4. Use taxis instead of ambulances for collecting non-wheelchair patients for outpatient appointments. Taxi costs are about one tenth of ambulance charge and are a more efficient service, tailored to patient's needs. <u>Longer-term solutions</u> 1. Introduce 'drive-through check-in' to areas with severe traffic congestion problems (i.e. not just drop-off points). Support with a facility to check in for appointment e.g. hand held computer. A guide can escort elderly / infirm to outpatients to a waiting area/clinic. Able car driver can park in remote location and return to accompany outpatient. 2. Move administration staff off site. For example: payroll, medical records. Trusts to examine which functions could move. Modern communications facilitate this easily. For those Trusts short of space, set targets for moving admin. off-site. 3. Ease patient record stowage – ten year old stored off site to free up space

7. Unacceptably long waiting times for elective operations 60% of all hospital activity is caused by emergencies; therefore planned elective surgery has to take 2nd place.	1. In the short term, use private hospitals to do some operations for the NHS. 2. Have operations performed in the evening and at weekends Sweat the assets, i.e. operating theatres stand empty. Establish full 24/7 operation of hospital's assets. Need to involve staff and unions in contract re-negotiations. 3. Avoid cancelling operations after admission by instituting pre-admission screenings. Chelsea and Westminster use a computer system operated by nurses to assess patient's fitness' for general anaesthesia for elective surgery. This could be made available elsewhere, 4. Incentivise consultants to do more operations in the summer 5. Cancellation of operations is often due to a lack of beds. 7 to 8% of beds are often occupied by patients who have nowhere to go but don't need a bed – use existing patient hotels for these patients at a fraction of the cost. 6. Morning rounds at 08.00 to free up beds 7. Live Bed system (from Shrewsbury – Chelsea and Westminster have one too) to reduce consultants 'blocked beds'. 8. Discharge lounges – sensible discharge policy and bridging teams with social services staff <u>Longer-term solutions</u> 9. Specialist centres for elective only operations 10. Use freed up space in hospitals to provide additional wards and extra beds (moving out patient's clinics and administration staff off-site). 11. Create more 'patient hotels'. Patient hotel costs - £40 per night compared with £260 per night on an acute ward. Need to encourage more clinicians to buy-in to the idea
8.Inconsistent level of service at night, weekends and public holidays, We have noticed that due to lack of staff, areas such as laboratories and administration (access to records) are closed on public holidays. The statistics bear out that if you are admitted with an emergency during the night, you have a much worse chance of recovery than during the day. You are often seen, and perhaps operated on, by the least qualified medical practitioners.	As with airlines, retailers or hotels – contracts must reflect the 24-hour, 7-days a week nature of the work. 1. Change contracts for new staff so those bank holidays become normal working days, grant additional holiday entitlement in lieu. 2. Re-negotiate bank holiday closures with unions, grant additional holiday entitlement in lieu. 3. Re-negotiate consultant contracts to roster senior consultants to be in hospitals at night, weekend and bank holidays. Insist on flexibility in new appointments.
9. Moving patients from ward to ward	1. Integrated medicine wards need to be more widespread.

Section B.

Environment

1. Poor standards of cleanliness Domestic services are often outsourced and are one of the main areas, along with maintenance, where savings are often made in order to free up budget for clinical demands.	1. There needs to be clarity of responsibility for standards in cleaning. 2. Domestic staff have to feel part of the team, not second class citizens. They often have more contact with patients than any other staff but receive the least training and rewards. Therefore – induction courses for all staff, working with the management of the outsourced resource to embrace the values of the organisation via regular appraisal systems, 3. Ward Housekeeper who is part of the ward team who, even if outsourced, has responsibility to the ward manager.
2. Wards and corridors are cluttered and untidy It looks unprofessional and gradually erodes standards	1. Use just in time deliveries of supplies to reduce storage on site. 2. Design-in more storage space into new buildings 3. Hold bulk stocks in hospital 'warehouse'
3. It is too easy for people to a access almost any areas of a hospital Clinical staff don't want to restrict visiting times or numbers of visitors	1. Limit access: – staff only areas – patient areas – visitor areas 2. Clearly indicate through signage which areas are out of bounds to the general public. 3. Supply visitors passes for access to semi-restricted areas 4. Ensure that ward visitors check-in with ward nurse 5. Put some limit on visiting hours 6. Operate security locks on out-of-bounds areas, to ensure that public can only gain access if accompanied by staff. 7. Build-in front and back house split and access arrangements into new buildings. Use hotel models for deliveries, waste disposal, and housekeeping activity. Use décor and signage to support.
4. Poor Standard of Decoration and facilities in Waiting Rooms	1. Spend more on most frequently visited areas (e.g., A&E & Outpatients) ♦ Cleaning and maintenance ♦ "Waiting" facilities. Entertainment (at least reading) ♦ Queue management (how long is delay), TV monitor for information ♦ Refreshments (as a minimum a decent beverage vending machine) ♦ Sufficient seating 2. Televisions in waiting rooms (with broadcast TV, news subtitled on teletext if desired) 3. Music in waiting rooms (volume/style etc)
5. Poor signage Often hard to find main entrance	1. Use commercial style signage/design etc 2. Make clear how to get to the main entrance (from the outside) and exit (from the inside) 3. Consider people flow and signage in new building design.
6. Lack of seating for visitors in wards	4. More simple stacking / folding chairs available 5. Stools for under bed stowage 6. Longer-term, redesign bed – incorporate swing out stools

7. Noisy wards at night	1. Admission wards e.g. no overnight admissions to general wards 2. Smaller wards with maximum of 4 people, mixture of 4 bed and single bed rooms
8. Food and ability to eat it While patients cannot express an informed opinion on the quality of their anaesthetic they certainly can on the food they are served.	1. Spend more on food – BUPA Hospitals spend £5+ per day, at least twice as much as NHS hospitals. 2. Offer food on demand. In airlines a selection of cook/chilled meals are loaded and heated just prior to delivery. Passengers can choose from that day's selection. This system can easily be adapted by hospitals, eliminating the need for patients to pre-order 24 hours in advance. While airlines can and do run out of the most popular choice due to lack of stowage space, hospitals can simply call on reserve stocks. With portion control, nutrition advice such as the content and calorie count of each meal can be included in the menu. Special meals such as Kosher, Vegetarian options etc. will need to have 24 hours notice as these tend to be deep-frozen. 3. Same day ordering of food, not 24 hours ahead (avoid patients receiving previous bed occupants choice) 4. Vegetarian options on menus 5. Ward Waitress who reports to Ward Manager, to take orders from the patients and ensures that they get something suitable to eat. The introduction of a Ward Waitress has been found to dramatically reduce wastage and food costs. The Ward Waitress we saw operating at Nottingham City Hospital was in an Oncology Ward where the patients often need to be coaxed into eating. The Ward Waitress, wears a waitress uniform, has opportunities for NVQ qualifications in silver service and nutrition. As well as serving the food, she can also provide tempting snack alternatives for patients as it were 'under the counter' e.g. bowls of soup, scrambled eggs on toast. Snacks are prepared in a ward kitchen, outside of regular meal times which is a truly patient-focussed service. The Ward Manager receives reports from the waitress on patient's food intake. The patient has the full attention of the Ward Waitress. We were quoted a reduction in wastage of 40% since the introduction of the Ward Waitress, in addition to improved nutrition. 6. Train Health Care Assistants as Nutrition monitors to ensure that patients eat properly and, where appropriate, gain weight. We saw this at Addenbrookes where HCA's monitored patients each shift + helped them to eat and monitored quality and calorie intake. 7. Colour pictures of food on menus. 8. Diet deli concept is about to be trialled in Brighton, microwaveable individual portions and snacks that can be purchased with vouchers by patients and visitors.

Section C.

Improving Communications

1. Access to Health Information	1. Use 'In Touch with Health' touch screen systems in larger GP Practices and outpatients. 2. Publish a small booklet containing basic information on health, common illnesses (cause and effects), a simple diagnostic process, how the NHS works, etc. All of this information currently exists in a variety of booklets and leaflets. Make it available to GP's and schools. 3. Develop a Search engine for NHS web to allow people to look for relevant medical information 4. Patients education – make it accessible 5. Booklets, audio, video, leaflets, contacts of groups etc, web-sites, NHS direct. Central database of what is available. Downloadable copy.
2. Patient's Advocate **Growing Incidence of Patients Unhappy with the Treatment They Have Received Taking Legal Action Against Health Trusts** This often involves enormous amounts of time spent in investigations, doctors suspended needlessly and punitive damages paid to patients. N.B. according to the BMJ, the cost of medical negligence in the NHS rose by 7% a year during the 1990's.	1. To improve the handling of patients concerns, every General Hospital should have a Patient Advocate. Leaving aside the benefits to the patients and their families, this is easily justified in the reduction of costs and management time. It is essential that Patient Advocates have the backing of and direct access to the Chief Executive of the Trusts. • The Patient's Advocate in Brighton was introduced in 1994 when she dealt with 98 patients in her first year. Last year she saw over 1000 patients. The position has proved to be a great success and has led the hospital to identify many areas where they needed to improve care and facilities such as dealing with bereavement and providing staff with suitably decorated rooms to use and methods of doing it. The Trust learns from her experiences, how patients and their relatives expect to be treated. • She sees her role as being a 'friend within the system'. She is there to be objective, and help patients to make a complaint, though she is not part of the formal complaints process. 21% of patients come to her intending to make a complaint, after she has seen them and, perhaps, has acted as a go between with the consultant or staff concerned, this reduces to 5%. • Patients need to believe that they are being listened to and, if nothing else, receive an apology or have the opportunity to have a second opinion. She is customer focused referring to patients as 'clients'. She is there to identify problems but not to solve them, that is up to the management of the hospital. Its important that the Patient Advocate has direct access to the Trust's Chief Executive and is involved in induction training. • We would see the ideal situation as an independent advocate working closely with the hospital's Quality Manager. • A Patient's Advocate with support and on-costs would add-up to approx. £40,000. (£16m for 400 General Hospitals) 2. There is also a strong argument for a staff advocate to whom staff can turn without resorting to their union representative.

3. Poor Spreading of Good Practice. The Beacon system has been quite cynically received and we are told the work involved to submit an idea for an award is out of proportion to the financial benefits on offer in relation to the large Trust budgets. GP's value the prestige much more than the small financial award.	1. Seminars for sharing good practice. Entry only to the staff responsible for the initiative who can demonstrate that their idea has been put into practice and worked. No £300 per day conference attendance fees. See appendix 6 2. Local Health Authorities to be tasked with identifying best practice. They can host and facilitate seminars easily. Set targets for Health Authorities. 3. We heard of initiatives that improved the service to patients, and gave efficiency savings. However, some have been abandoned because they represented additional cost to the budget (even though overall they saved money) 4. We feel that Beacon awards are more suitable for GPs but awards need to be increased to a more realistic level. £10k not £4k 5. National Centre for Best Practice with a budget for spreading best practice. Trusts have to bid for monies and justify the efficiency savings they anticipated.
4. Difficult to find your way around hospitals	1. We have seen some examples of maps provided for patients & visitors to find their way around some hospitals. This needs to be more widespread. 2. Improved signage. There should be a common style throughout the NHS. The language needs to be much more customer friendly. Base it on current best practice. 3. Patient guides (operated by WRVS or volunteer groups) 4. Guides for blind patients rather than systems for them to find their way around.
5.Many short consultant appointments for certain subjects e.g. dermatology	1. Video cameras or digital cameras in GP's surgeries to send photos to specialists. (could work for 'skin and bones' – resolution currently not good enough for soft tissue)
6. Low standard of catering for visitors in hospitals	1. High street franchises to operate coffee bars/ food outlets.
7. Hard to get accurate feedback on the patients experience	1. Research Friends & Relatives, as well as patients who are incredibly vulnerable while they are in hospital 2. Make use of "Expert" Patients as 'mystery shoppers' 3. "How are we doing?" cards 4. Ensure that patient's views (feedback/surveys etc) used are worked into procedures/service delivery. 5. Ensure staff know how they / the hospital is doing.
8. It is difficult for friends and relatives to telephone patients in hospitals	1. Provide telephones through e.g. Patient Call– make it easier to phone in and out. 2. The Patient Line system should be in all General Hospitals. This provides phone, radio and TV in one system. Doesn't cost the hospital anything but costs are covered by inbound calls to each patients dedicated extension for 50 pence per minute. Radio and breakfast TV is free, rest purchased via cards from a vending machine. For those who can't afford the modest fees, hospitals can use partially used cards that are turned-in on leaving as well as charitable donations. The technology already exists to provide email addresses. Can also use the bedside terminal for clinical staff to consult records and test results.

9. Unable to show broadcast TV in waiting rooms	1. Provide free TV licenses or exempt hospitals 2. Patient line will provide TVs as part of their package
10. Patients feel talked down to and dis-empowered	1. GPs should give patients a copy of consultant letters (as they do in private practice). 2. Communication training for doctors, greater emphasis on communications as part of their training curriculum
11. Patients and even other staff cannot tell who is in charge in a ward	1. Make it clear from uniforms, who is in charge. Differentiate Ward Manager's uniform (e.g. dark blue); be consistent throughout the NHS. 2. Ward Manager should do a patient round and introduce him/herself. 3. Staff name badges with large type that old people can read.
12. Nurses spend a lot of time looking for records	1. Employ (lower cost) support staff to do the administration. They become the experts and more efficient with records. Nurses will be freed-up to do nursing. 2. Use technology Patient records on Smart cards – scan written records
13. Amount of time nurses spend recording care plans for patients	1. Move as much as possible to the bedside, have the nurse write it up as they sit next to the patient. 2. Where patient line is installed, work with them to develop the system to use the bedside screen to record care plan information (via voice processing software?), access X-rays, patient records, test results and as a bedside diagnosis aid.
14. Using Computers and Data Management Most Trusts we visited have different computer software systems and are all developing their own bespoke applications. Hence we hear about the 'Live Bed' system in Shrewsbury that the Royal London would like and the Pre-Admissions screening system from Chelsea and Westminster developed on a specialised U.S. software platform which nobody else in the UK uses.	1. There need to be clear guidelines issued by the NHS, who are funding the new technology, on common protocols regarding the structuring of databases. Otherwise, the dream of a national patient database is unrealistic i.e. : Records / appointments / e-mail / correspondence / stores / data warehousing 2. There needs to be a 'clearing house' within the NHS for software applications to be made available around the organisation. The NHS is unhappy about dictating which software hospitals and GPs should be using which results in a wide variety of software in use. Many Trusts are developing bespoke applications, which could be put to good use by others in the NHS. We saw the Pre-Admissions Screenings software at the Chelsea and Westminster and heard about the Live Bed bookings system at Shrewsbury, which other Trusts wanted to use. There needs to be a centre where details of programmes in use and specialist applications are recorded. I.T. Departments could then contact the centre and ask for details of available applications, which would run on their systems platform. The clearance office would then arrange a simple licensing agreement with the developer / owner of the programme. In return for help setting up the software and providing telephone support, the developer would receive a royalty fee from the new user. 3. It's clear that in many hospitals, that the facilities provided for doctors to write to patients is inadequate. Up to date computers, software and printers need to be freely available as well as guidance on the form, content and presentation of letters.

Section D.

Staff Issues

1. Induction Training Hospitals can feel large and impersonal; induction training should be mandatory for all staff, including contracted staff.	1. Post out pre-joining material for new employees e.g. booklet on hospital's core values, who's who, the aims and vision of the hospital. The power is in all levels of employee being together as new people – a sense of common purpose. 2. CEO and/or other Senior managers should attend induction training sessions, albeit briefly. A valuable opportunity to introduce the hospital culture, team and expected behaviours.
2. Too many initiatives and "management by cascading paper"	1. Limit the number of concurrent initiatives to relieve pressure. Free up management time. 2. Senior people in hospitals to be more accessible to "front line" staff e.g. Talkback sessions at Addenbrookes, where directors meet groups of staff on monthly basis.
3. Developing Leaders The single most important factor in creating high quality service is leadership. Studies of service quality have found that the motivational environment of the workplace has a profound effect on the quality of service delivered. Managerial style and behaviour of the group leader is crucial to the organisational climate. This can be improved through the training of managers/supervisors.	1. Trust managers to be trained using programmes of Learning Sets rather than off site lengthy programmes – use live issues as study subjects, stay close to hospital. 2. Leadership Programmes – Identify and promote and groom leaders for the future. Health Authorities have an overview – task them with talent spotting and making recommendations. 3. Identify the Role Model Leaders and "replicate" them: a) Redesign competencies based on role models b) Recruit using the competencies c) Train using the competencies d) Regularly assess performance based on competencies e) Annual appraisals for all staff, (including doctors) f) Train role models in coaching skills, give responsibility to coach colleagues and reward for extra responsibility g) Develop culture where good work is frequently acknowledged and celebrated h) Fast-track the role models in every job 4. Leaders should be trained and tasked with responsibility for creating a positive organisational climate. • Flexibility – staff feel it is easy to take the initiative and to get new ideas accepted rather than being burdened by bureaucratic rules, policies and procedures. • Responsibility – People are free to get on and do their jobs without having to constantly check with their boss. • Standards – High standards are expected. Challenging goals set to improve performance. • Recognition – Staff feel that they are valued as individuals and recognised for good work, rather than only criticised when something goes wrong.. • Clarity – The organisation's purpose and direction are clear and expectations and work procedures are well organised rather than confused or chaotic. • Team Spirit – Colleagues co-operate effectively to get work done, and people feel proud to be a member of the team.

4. Interpersonal Skills Training for Front Line Staff We heard concerns regarding staff/patient interactions e.g. patients and carers talked down to, treated insensitively, left feeling confused – "I felt like a medical condition, not a person". Appropriately trained staff will enhance the quality of the patients experience.	1. Recognise that all staff who interact with patients have a responsibility for the patients' experience – not just clinical staff. 2. Identify who the customer is i.e. not only the patient, but also the relatives and carers. 3. Identify those in the organisation who have excellent interpersonal skills – the role models. Utilise their best practice in training design. 4. Use research data from patient surveys, patient focus groups and feedback from "expert patients" to design training and service procedures. 5. Use role play exercises to rehearse and train desired skills e.g. involve staff and patients in identifying top ten issues in patient/staff interface (may vary between groups). 6. Concentrate training on solving the top 10 issues. 7. Teach in one-day modules of repetitive role-play. 8. Should be part of initial and remedial training. 9. Training to include the notion of "Service Recovery" i.e. the confidence and empowerment of staff to recover service failures as much as possible at the time they occur. Customers report higher satisfaction after there has been a breakdown in service, which has been managed well than if there was no breakdown at all. Therefore, it is important to have measures in place to anticipate things that will go wrong so that the 'service recovery' routine swings into action. As we say at Virgin Atlantic: 'Mistakes are inevitable, dissatisfied customers are not.' Staff in each area, need to brainstorm the common breakdowns that happen and agree with their line managers how to manage those situations best. In most organisations, there are usually, at most, ten things that go wrong regularly. Training staff to deal effectively with those and providing written 'what if' guidelines will cover most eventualities. The others you can't anticipate. 10. Include training in how to say "No" i.e. gently with an explanation when a request cannot be met. Encourage/allow staff to "bend the rules" a little for the customers benefit. 11. Training should be supported by assessment and feedback to staff on their performance.

5. Positive Feedback During our study when we praised people for the obviously good work they were doing, they were rather taken aback. Has the habit of praising people been lost in parts of the NHS? Current measurement systems seem to be essentially critical.	An immediate opportunity exists to reinforce good behaviours and celebrate staff successes. Some options are: 1. Formally and frequently acknowledge work done well e.g. a commendation letter from manager. 2. Make it easier for patients to give feedback. Introduce a comment card. Ensure staff are fed back results, incorporate into staff assessment. Use patient's comments if negative, as a staff development opportunity. 3. Extend the comment card to colleagues i.e. anyone can write up a colleague who has done a good job, is a good team player, gone that extra mile etc. The people who consistently receive accolades or those who do an outstanding job can be publicly acknowledged e.g. staff newsletter, employee of the month etc. 4. Ensure the data from patient satisfaction surveys is regularly fed back to staff/published. 5. Use data to design patient's services. 6. Encourage a culture where managers "catch people doing things right" (not wrong). 7. Consider the use of "mystery shoppers" – as used by many customer-focused organisations i.e. Recruit "expert patients" who are frequent users of the hospital and /or carers. They often have a good knowledge of hospital life and service issues. They could be asked to regularly score/rate various aspects of hospital service.
We heard of many issues regarding the training and roles of 2 main groups of staff in hospitals: Nurses and Auxiliary staff – including contracted staff.	
6. Nurses Training Concerns	1. Professionalisation of the Nursing service has helped to bridge the gap between what nurses and doctors do, to the benefit of the patient. 2. However Project 2000 is causing concern – viewed as too theoretical, with little practical training until well into the course. 3. Trainees are lost to the NHS if they fail the theoretical work. Need to capture them. A huge loss of investment. 4. Orientation Course of three months to ascertain vocation for the job. Opportunities for assessment of ability to learn. Hands on experience in dealing with patients. Would provide extra hands on busy wards. 5. Preceptor role needs to be reviewed i.e. all slightly more experienced nurses supervise/coach trainees. 6. Recruit only role model nurses as preceptors and train in coaching skills. – OR - Ward Managers to pick up the role of coach/assessor. 7. Trainees should spend sufficient time in a ward for the ward manager to be able to assess meaningfully.
7. The role of Ward Manager needs reviewing. "Bring back Matron?" Opportunities for advancement such as the nurse specialist, the nurse consultant and nurse practitioner encourage ward managers to move on, leaving less experienced nurses to run the wards.	1. Recognise this key role in hospitals, 24-hour responsibility and little training for managerial position. 2. Introduce a formal programme of training for nurses as they are promoted to Ward Manager. 3. Training to include ward management, coaching, appraisal skills, resource planning etc. 4. Aspiring Ward Managers could take the training prior to appointment, to assess aptitude and commitment. 5. Give responsibility for ward cleanliness standards to ward manager. Contracted staff should have dotted line responsibility to ward manager for cleaning. 6. Introduce new titles and grades for technical clinical staff (e.g. skilled microsurgery technician) and recognise multiple parallel career paths. 7. Review pay and grade for Ward Manager.

8. Health Care Assistants HCA's have significant opportunities for interaction with patients. Their people and basic nursing skills should be recognised as a key support in the wards.	1. H.C.A. job title does not reflect the basic nursing skills this role demands. Call them nursing assistants so patients understand their role. 2. Possibly the thrust to "professionalise" the nursing service has unwittingly demeaned the standing of HCA role. Create clear career path for HCA's who have vocation but perhaps not aptitude/desire for a professional nursing qualification. 3. Register the HCA's as lower grade nurses / nursing assistants to recognise their contribution to the quality of patient's experience. 4. Train in interpersonal and communication skills and emphasise during training their role in interpreting patients' needs and feeding back.
9. Auxiliary Staff – including contracted staff (e.g. Porters, Cleaners, Catering, Security staff etc) These front line people have a significant amount of patient/customer contact either directly or informally.	1. Recognise the effect "front line" staff have on patient/customers experience. 2. Include in induction/core values training. 3. Include in interpersonal skills training. 4. Ad hoc training for specific roles e.g. wheelchair and blind/deaf training for porters/receptionists. 5. Performance management of contracted staff - Hospital staff to audit work - Hospital and Contractor to agree competencies and job specifications. Hospital to follow up and effectively manage the contractors overall performance. 6. Re-examine effectiveness of contractor relationships e.g. cleaning – Ward Manager to have responsibility. e.g. ambulance service where all outpatients were delivered at 2pm to wait for appointments.
10. Recruitment and Retention	1. Establish and communicate recruitment/promotion criteria for each role. 2. Nurses - career path to be clear - review role, status, training and pay of Ward Managers - more to encourage ex nurses back to work e.g. crèches, flexible hours. - registration of HCA's 3. Private investment in on site staff facilities e.g. hairdressing salons, gyms. 4. More effective use of existing clinical staff i.e. more flexibility of duties, removing lines of demarcation. 5. New contracts with consultants and nurses to allow extended flexible working. 6. Flexibility in all clinical staff salaries to reflect regional differences. 7. Flexibility in consultant salaries to hire in overseas stars to attract commercial investment.

Appendix 1

Rights of Access to NHS Healthcare Services

Based on an approach suggested by the Patients' Association.

GREEN	*AMBER*	*RED*
Provided as a right	Duty bound to consider, funds permitting. Right of appeal	Pie in the Sky. Once core service has been provided
• Core services and standards	• Each case considered individually 'on its merits' • Fertility treatment	• Fertility treatment on demand • Sex Change • Cosmetic Surgery
UK citizen / resident	Quid pro quo arrangement • EU • Arab states • US • etc	Funded through charity or International Development agency • 3rd world • other

Appendix 2

Doctors

A common criticism of doctors is that many have limited communication / interpersonal skills. More time should be given to training doctors and medical students in these skills. We learned that 'A' level English is likely to become a prerequisite for medical students (not solely sciences). This will bring increased numbers of potentially better communicators into the profession.

Junior doctors particularly may benefit from role-play exercises in relating to patients e.g. in the area of giving bad news. Role play exercises in the importance of appreciating other members of their teams are appropriate as working practices become more flexible. E.g. At a Beacon status PCG practice we visited, although the demarcation between doctors, nurses and other staff remained clear, there was a tremendous sense of teamwork because the staff there felt that the doctors valued the contribution they made, and were open to (and acted upon) their suggestions.

Consultants pay is an emotional rather than a strictly economic issue. Assuming the NHS employs 1m people, consultants (25,000) represent only 2½% of the workforce. Changes in their pay have a minor impact on the overall expenditure. All doctors combined represent less than 14% of the workforce. However, their pay is high compared with most other front-line staff in the NHS, who are reckoned to be poorly paid.

We heard stories of consultants abusing the maximum part-time contract and enjoying high earnings. However, the average 50 hours per week worked in the NHS (51.3 for whole-time consultants, 48.7 for maximum part-time) in return for an average salary of about £70k (low compared with other highly trained professionals), suggest that the NHS is getting a good deal. (The Review Body on Doctors' and Dentists' Remuneration)

We heard that highly trained surgeons may be spending too much time on administration, rather than surgery. In which case, managers are failing to use the skills of their consultants in the most cost-effective way. However, we also heard that there were instances of inappropriate behaviour by Doctors which would not be tolerated in commercial organisations e.g. being late (or failing to attend at all) NHS meetings, NHS outpatients consultations and NHS operating sessions. While we stress this is not widespread, systems need to be introduced (such as a computer log in system) to monitor attendance. This type of behaviour should be evaluated during the annual appraisal.

A new contract for consultants is required. Not in our brief, but on the face of it, the 'Work Sensitive Contract' proposed by the HCSA provide clarity of expectations and rewards.

Whatever approach is taken, the new contract should address concerns such as:

- The conflict of interest between, getting waiting lists down and offering patients private treatment.
- Also it is highly unusual for any organisation to allow their employees to spend part of their time working for a competitor and few employers would tolerate 'moonlighting' in ones spare time.

It was also suggested to us that perhaps consultants should be given the choice of:

a) Doing private work only (and to be able to contract their services to NHS Trusts) or

b) Higher salaries to work for the NHS while being allowed to do some private work in the confines of their employer's hospital.

c) A new contract is also needed for GP's, if they are to be encouraged to offer extended surgery opening hours and work in bigger practice groups.

Appendix 3

Public confidence and the quality of clinical care

Again, while this falls outside of our brief, we have undertaken this work at a time when almost daily the public's confidence in the standard of medical care in the NHS is being eroded by revelations of doctor's incompetence or negligence. The patient should regard the competence of their doctor as a 'given' assurance. The public's confidence must be restored by effective clinical governance.

While the Commission for Health Improvement will go some way to meeting this aim, there are those in the medical profession who are proposing a Medical Inspectorate. The aim of the Medical Inspectorate would be to make doctors accountable and look at health practice in each region.

A short-term solution would be to ensure that every General Hospital employs a Quality Manager, to ensure ongoing monitoring of clinical standards, spreading good clinical practice and encouraging continuous improvement.

Appendix 4

Poly-Clinics
(Combined GP Clinics and Day-Surgery Hospitals)

Key Characteristics
• Based in the community. • Serving a population of 100,000 or less. • Modern buildings on a small site. • Easily disposed of • Associated with GP practices. • Run by GP's who also have part ownership. • Also fed by other GP practices • Served by Specialists and Consultants.
Provides
• Full range of normal GP services • Core opening hours (GP service available) from 7.30 am to 8.30 p.m. Monday to Friday, and Saturday morning. • Day surgery (e.g. cataracts, hernias, etc) • Other day procedures (e.g. some Dialysis & Chemotherapy; physiotherapy; antenatal care). • Minor injuries clinic (including x-ray, ultrasound and ECG facilities and a mini-lab) open 7 days a week. • Pre-admission screening service for General Hospitals. • Outpatients Services (by phone, GP or visiting consultant). • Lead on preventative care via health education & health promotion clinics (including links with local schools) • Base for community nurses, midwives, health visitor's etc.
Must Have
• A 'critical mass' of staff – probably 8 or more GP's. • Computerised patient records and computer links to General Hospitals. • Much greater flexibility of clinical roles. • A crèche for children of staff and customers. • Some scope for growth and flexibility. • Tight discipline applied to the range of services and opening hours, (e.g. closed overnight) to prevent them expanding into full-blown hospitals. • Well-established links with appropriate social services (e.g. social worker on site).

Should also include Dentists, to address the lack of NHS dental services available and problem of small dental practices having to 'go wholly private' in order to survive financially.

Hospital – *"an institution where the sick or injured are given medical or surgical care"*

Appendix 4 continued

Costs / Benefits

- Cost £2m – £3m for a conversion up to £5m for a new build.
- Buildings either owned by NHS Estates and leased out to GPs or GP's lease from property company or part owned by GPs/NHS
- If partnership, costs to NHS approx. £1 - £3M, the rest being GP funded
- Costs to NHS for 400 units to cover England of around £600M, same cost as 2- 3 new general hospitals.
- Could be located near out-of-town retail parks (usually served by efficient public transport and large car parks – great for rural community), on inner city 'brownfield' sites, or in currently-unoccupied NHS buildings.
- Customer-centred rather than Doctor-centred approach.
- Helps to remove single doctor practices (all practices need a minimum of 4 doctors to be able to offer the minimum acceptable level of service)
- Allows rapid replication of successful design, including great potential for modular units to ensure good value.
- Keeps people out of large district general hospitals, which can concentrate on acute cases. Reduces extent of hospital acquired infections.
- Offers career options for clinical staff.
- More productive than a general hospital, consultants are paid per procedure not session and achieve 6 – 7 procedures rather than the usual 4 per session.
- Offers choice for patients. Including choosing to pay.
- Provides many opportunities for benchmarking and realistic 'like-for-like' comparisons
- Eventually takes most walking patients out of A&E units in general hospitals (A&E presents one of the worst images of the Health Service).
- Provides a tangible evidence to the public that action is being taken.
- Scale allows more effective leadership and improved morale.

Staffing

- Attractive to entrepreneurial GP's (and other clinical staff) and also GP's who want to work for a salary (i.e., not run a business)
- Consultants will see the opportunity of "earning money by performing repeat operations"
- As now, more nurses will need to be trained. However the day hospital will be a much more attractive environment in which to work and will encourage nurses to return to the service.

Appendix 5

GP Practices
• GP practices should be minimum of 4 GP's in order to provide: - realistic cover for absence - basic self-assurance of quality - reasonable range of services offered • May have to use more salaried GP's in some urban areas. • May have to be NHS owned clinics in inner city areas. Offer salaried GPs incentive payments with 2/3-year contracts. • May have to make arrangements for remote offices / special transport arrangements in some rural areas. (But still part of a practice of minimum size). • Should include Minor Injuries Clinics in larger GP practices, particularly those in tourist areas.