A clinical vision of a reformed NHS
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Specifically, they:

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- bring such issues into formal discussions with other healthcare organisations
- respond to national consultations on health matters
- when appropriate, provide a united voice for the medical profession

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A clinical vision of a reformed NHS

The NHS is in the midst of a period of wide-ranging reform – everything from changes to the payment by results system and implementation of practice-based commissioning, to the new 18-week target. The NHS Confederation has been arguing that it is not always clear to frontline staff what the reforms are trying to achieve. Clinicians in particular have been unhappy about some of the Government’s reforms and that they have not been involved sufficiently in their design.

In late 2006, with the Joint Consultants Committee (now the Joint Medical Consultative Council), we decided it was time to shift the debate from a critique of the reforms to a more positive vision for a reformed system. We did this by asking doctors what it would be like to practise in a reformed NHS that was based on their own vision or experience of creating change themselves. The only constraint was that their ideas had to be consistent with what we know about patients’ wishes and that there was no additional money or magic wand available. We asked them:

- what kinds of changes would you like to see in services for patients?
- what would be different to current practice?
- what would it feel like to work in such changed services?
- how, if at all, would relationships with patients be different?
- how, if at all, would relationships between staff be different?
- what would remain the same as current practice?

We found that many doctors were frustrated by aspects of the reform programme. However, instead of the cynicism we might have expected, most of the respondents were very clear about what they want to achieve and many were finding ways to make it happen in spite of obstacles. The level of energy, innovation and ingenuity we found was extremely heartening and often inspiring. In chapter 3 you can read a selection of the stories we heard from the range of clinicians we interviewed.

As part of this work we asked Angela Coulter from Picker Institute Europe to summarise what we know about what patients want from the NHS. Picker’s report can be found in appendix 2.

From the doctors’ responses, we identified a number of design rules – general rules that provide a basis for providing a high-quality service in a range of service models (see page 4).

The design rules are a set of ideas that do not dictate how they should be implemented. We believe they provide the basis for the sort of clinical vision that has been missing from the reform programme.

In conclusion we believe there are clear actions for Government, particularly on the process of involvement where there is a need for a significant change in approach. In particular, there is a need to check that policy does not make it hard to do the right thing for the patient.

However, it is in the hands of clinicians and managers to create change in their own organisations. Many of the changes the doctors told us about can be made with little government involvement. The fact that many clinicians have taken the opportunity to create change means it can be done. A failure to do so will leave serious consequences for the NHS and its patients.
Design rules

• The values that underpin the system – doctors have very strong personal values and see medicine as having a moral purpose to care, heal and make a difference. In their everyday work they are committed to integrity, compassion, altruism, continuous improvement, excellence and working in partnership with the wider health team.

• Getting the basics right – seeing the system from the patient’s perspective and providing care in a high-quality, clean, quiet and comfortable environment.

• The design of the system doctors work in – doctors want to work in a system rather than a disorganised, poorly co-ordinated and disparate set of services that do not connect.

• The nature of relationships with patients – the wish to create services that are timely and highly responsive to patients’ needs and the importance of patient feedback.

• Interactions with colleagues and the organisation – working in a system of teams and one that promotes professional interaction and high-quality interpersonal relationships.

• Learning, measurement and feedback – the system needs to be based on continuous learning and the analysis of empirical data, using evidence where possible. More data about performance is required.

• The way change is managed – goals and targets for change need to talk about patients. Leaders of change need support and it is important to establish a culture of working together.
In the last decade, the NHS has changed more radically than at any other time during its 60-year history. There has been a substantial injection of funding, resulting in new buildings and more staff. There have also been several attempts to alter the way in which healthcare is delivered, with greater choice for patients and clinical practice based increasingly on objectively verified evidence. Modern healthcare is expensive and it has therefore been important to ensure that the additional money put into the system has been used as efficiently as possible.

Clinicians were well aware of the shortcomings of the previous system and have been broadly supportive of the direction of reform. However, there have been frequent criticisms of the detail of the reform packages, of apparent inconsistencies between various strands of policy and of unintended consequences for patients and for staff. A common perception has been that the changes have been imposed from the centre and that those who are directly responsible for looking after patients have not been adequately consulted about the principles underlying reform packages, nor about the most effective way of implementing them. Doctors have been particularly critical, alleging that the changes have often been under-researched and applied without attention to detail, dangers that they themselves strive to avoid in everyday clinical practice. Given that reform was necessary, how would these same doctors have gone about the task?

We identified a number of examples where clinicians had successfully reformed their working practices and have attempted to draw together some of the design rules that underpinned their work. We believe these can be used in the future to improve the process of reform. It has been a fascinating and heartening experience. Important common features include searching for innovation and improvement, measuring success from the patient’s perspective, using data effectively for feedback and being prepared to deal with obstacles in a constructive way. We believe that these examples demonstrate that high levels of commitment and dedication still exist within the medical profession and that these and other professional values can be harnessed effectively, and often inexpensively, to enhance the care of patients. Solutions to local problems are best found locally. Engagement of professionals, both clinical and managerial, in finding local solutions for mutual problems offers hope for effective and sustainable reform of healthcare in the future.

Bill Dunlop  
Chairman of JMCC
Chapter 1: Introduction

This work emerged from a discussion between the BMA’s Joint Medical Consultative Council (JMCC forthwith and previously known as the Joint Consultants Committee), The NHS Confederation and the Secretary of State for Health in late 2006. The conversation had dwelt on the growing unhappiness among the clinical community about the direction of the Government’s reforms. There was considerable anxiety about the impact of market mechanisms on long-term condition management, teaching and education, relationships between professionals, and the viability of some surgical services. Above all, there was a feeling that there had been insufficient involvement of clinicians in the design of many of the reforms.

The NHS Confederation has argued that the absence of a clear story about what the reforms are trying to achieve in ways that are meaningful for frontline staff has been a major problem. The Department of Health has responded positively to this challenge but so far the narrative still tends to be framed in terms of explaining the reforms rather than describing a vision for some possible futures that represent an improvement for patients and staff. Much of the language is technocratic and many of the reforms appear to be designed to deal with elective surgery and other episodic encounters with NHS. This makes them much less appropriate to the emergency care and long-term conditions that constitute the majority of the work of the NHS. The BMA’s A rational way forward for the NHS in England (published in May 2007) identifies a number of important changes required to deal with these issues, but we felt it was possible to go beyond this.

Instead of providing more critique of the reforms we asked doctors to describe what it would be like to practise in a reformed NHS based on their own vision or experience of creating change themselves. The only constraint was that what they describe must be consistent with what we know about patients’ wishes and that there was no additional money or magic wand.

From this we have identified a number of design rules that would need to be in place at the front line and at organisational, local system and national levels to allow this vision to be realised. This inductive method is quite different from the usual analysis that generally asks how the reforms affect doctors. Instead we asked what reforms are required to facilitate the practice of excellent medicine.

The idea of design rules is a very important concept underpinning this work. These are general rules that provide a basis for creating a high-quality service. We prefer rule to principle because these are not fundamental laws; they are often simply a starting point, or way of finding solutions by trial and error, that can be applied in a number of different ways. It is possible to create a variety of different service models, all of which are faithful to the underlying design rules.

The result of this analysis is a set of recommendations for all parts of the system from Government to the frontline clinician. Other reports have tended to concentrate on structural change or changes to national policy, whereas we have attempted to remain focused on the delivery of care.

It is important to note that we could have completed the same exercise with nurses, allied health professionals and managers and we believe we would have found many of the same things. The focus on doctors was pragmatic and took advantage of the JMCC’s leadership in working with The NHS Confederation. For more detailed information on the methodology see appendix 1 on page 42.
What we found

In some of our workshops we asked participants to reflect on the aspects of the doctor’s role that they would want to keep, stop or do more of, a sample of some of their responses are detailed in the table below.

Reading the popular medical press and postings on websites we might have expected to encounter cynicism, disillusion and negativity. Perhaps because of the deliberate selection bias built into the design of our work, we found little of this. Many doctors were frustrated by aspects of the reform programme but most of them seem to have responded by being very clear about what they wanted to achieve and finding ways to make it happen despite the obstacles they face. The level of energy, innovation and ingenuity we found was extremely heartening and often inspiring.

One of the most common criticisms made of the NHS and other health services is that they are designed for the benefit of the people providing the service. However, we found that the doctors we spoke to had redesigned their service with the needs of the patient very much in the forefront of their minds. A number of them seem to have discovered an important insight that is increasingly backed up by research evidence that trying to look after patients without looking after the staff is self-defeating.

We quickly found that the same themes and ideas were coming up in the interviews, focus groups and large group discussions. From the first relatively small number of interviews we already had a rich collection of design rules and ideas. We also discovered that many of the doctors we spoke to had clear ideas about design rules for the development of new ideas and the management of change. Although this had not originally being part of the scope of our work, it became clear that a significant reason for dissatisfaction among doctors was as much to do with the implementation of the reform programme as it was to do with the content.

Perhaps the most surprising finding was that relatively few of the changes that are needed to achieve the vision that the doctors discussed are in the hands of Government. Undoubtedly there are aspects of the current reforms that are a significant

### What is it like to be doctor in the NHS?

<table>
<thead>
<tr>
<th>What do we want to keep?</th>
<th>What do we want to stop?</th>
<th>What do we want to do more of?</th>
</tr>
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<tbody>
<tr>
<td>Working in a value based system where the patient comes first</td>
<td>Activity for its own sake</td>
<td>Team-based working</td>
</tr>
<tr>
<td>Use of evidence</td>
<td>The clinician/manager divide</td>
<td>Networks</td>
</tr>
<tr>
<td>The ability to care as well as cure</td>
<td>Barriers between professional groups and services</td>
<td>Measurement with meaning – clinically important/ measurable/useful for patients, doctors and managers</td>
</tr>
<tr>
<td>Training and education</td>
<td>Target mentality</td>
<td>Integrated primary, secondary, tertiary and social care</td>
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<tr>
<td>Skills and professionalism</td>
<td>Health inequalities</td>
<td>Systems where the culture of care is as important as the clinical care</td>
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<td></td>
<td>Paternalistic relationships with patients</td>
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obstacle to the achievement of some parts of the vision. However, a number of these can be worked around or even ignored and making the changes would not necessarily alter the overall direction of the Government’s reform program. Examples include removing the perverse incentives and obstacles to collaboration that result from using the payment by results system for the management of long-term conditions or creating mechanisms for much better clinical involvement in the design of policy initiatives.

Much of what needs to be done is in the hands of doctors, other clinicians and local managers. This raises a very important question – what is holding them back from doing this? Top down direction and the loss of local autonomy resulting from the way the policy has been implemented and performance managed over the last few years was often mentioned as a reason for this. However, this is not an entirely adequate explanation. A number of interviewees mentioned resistance from their colleagues, risk aversion by management and a lack of time to allow experimentation, reflection and the acquisition of the skills required to rethink the way that services are provided.

### The structure of this report

Chapter 2 sets out the design rules that have emerged in our discussions and chapter 3 illustrates how some of the doctors we spoke to have created services that demonstrate the design rules in action.

Chapter 4 looks at what action needs to be taken across the system, by Government, by individual organisations, by local systems and at the clinical front line to help to create the environment in which clinicians other organisations can take charge of the agenda to develop excellent services.

Appendix 1 outlines the methodology used and appendix 2 contains a short review of what we currently know about what the public and patients expect from the NHS, which was used to test the ideas emerging in the work.
Chapter 2: Design rules for a new NHS

Describing a vision for a system as large and complex as the NHS is difficult. It is easy to make broad statements but these generally lack enough specific content to be useful and have the problem of defining the system from the top down – precisely what we have been trying to avoid. Our work is premised on the need for a clinical vision that is created from the front line upwards and so our starting point was to ask doctors to describe what it would be like to practise in a reformed system. While other professional groups were represented on our steering group and in the discussion groups the focus of the study was doctors.

The only constraint we imposed in our discussions with clinicians was that this would have to be delivered without additional funding. We were not specific about what we meant by reform because the aim was to create a definition of reform working inductively from their descriptions of the future or, in some cases, the services they had created themselves.

Many had a clear vision and had often already made significant progress towards achieving their goals. The services we saw and people we spoke to were often inspiring but their models cannot simply be picked up and transplanted – they need to be tailored and adapted. Design rules are a useful way of dealing with this as they articulate a set of ideas but they do not dictate a particular way of achieving the desired result. There may be a number of very different ways of constructing a service depending on local circumstances and patient preferences that are still faithful to the basic design.

This chapter presents the design rules that the doctors were already using or that underpinned their thinking about the nature of a reformed system to deliver improved care for patients. We propose that these rules can be suitably adapted for local circumstances and specialty and that they provide the basis for the sort of clinical vision missing from the most of the current discussion on reform.

We identified design rules in a number of areas:
- the values that underpin the system
- getting the basics right
- the design of the system doctors work in
- the nature of relationships with patients
- interactions with colleagues and the organisation
- learning, measurement and feedback
- the way change is managed.

1. Values that underpin the system

“Patients are at the heart of everything we do.”

Simon Lenton, Consultant Paediatrician

We found that the doctors we interviewed clearly had a very strong sense of personal values. This was apparent from what they discussed and the language used, rather than from any explicit statement. The clinical vision for reform of the NHS we have started to set out here has its roots in the values that encouraged doctors to enter medicine. The principle that medicine is more than
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a business seems to be fundamental to the people we spoke to. For many, it has a moral purpose about caring, healing and making a difference. This seems to inform their vision for their services and underpins their ideas about the nature of the relationship with patients and colleagues that they want to see.

Box 1: Doctors in Society: Medical Professionalism in a changing world

Medicine is a vocation in which a doctor’s knowledge, clinical skills and judgement are put in the service of protecting and restoring human well-being. This purpose is realised through a partnership between patient and doctor, one based on mutual respect, individual responsibility, and appropriate accountability.

In their day-to-day practice, doctors are committed to:

- integrity
- compassion
- altruism
- continuous improvement
- excellence
- working in partnership with members of the wider healthcare team.

These values, which underpin the science and practice of medicine, form the basis of a moral contract between the medical profession and society. Each party has a duty to work to strengthen the system of healthcare on which our collective human dignity depends.

The values and vision set out in Doctors in Society: Medical Professionalism in a changing world surfaced in a number of the conversations we had (see Box 1). In addition, in the system imagined by our discussants, doctors are:

- positive and optimistic – this came across in the interviews, but was also mentioned by several interviewees
- compassionate and motivated by the desire to care for patients and families; open with patients and relatives
- highly-skilled and competent and willing and able to acknowledge their own limitations; able to tolerate and work with uncertainty
- flexible and open to new strategies; inspired to innovate
- intellectually engaged with the problems of modern healthcare and the world around them; curious and alive to new evidence and insights – not just about medicine but the system that delivers it
- committed to continuous improvement and the elimination of waste and able to bring their knowledge and skills to bear to redesign and improve the systems they work in
- actively involved in training and education, providing role models for future generations of doctors
- committed to team working and to co-operative relationships with colleagues – including non-clinicians and particularly managers
- loyal, with a sense of belonging
- ambitious for their own practice/service/department
- leaders and followers where appropriate
- intolerant of bad behaviour by colleagues.

Within the wider system they:

- actively take responsibility for their pre-eminent position in the NHS and in wider society and constructively use their authority and influence. This is made difficult by the fact that many doctors seem to perceive that this position of influence has been undermined by recent changes in the NHS
2. Get the basics of care right

Perhaps the most obvious design rule of all is seeing the system from the patient’s perspective. Sometimes this was expressed as the care doctors want for themselves and their loved ones; others more directly referred to the views and ideas of the patients they were dealing with. The stories we collected often referred to the need to pay attention to the basics of care and the other systems that patients encounter.

This means that patients feel safe and cared for. They know the people looking after them, it is clear who is responsible for their care, and who they and their relatives should talk to. There is concern that the impact of the Working Time Directive, Hospital at Night and the perception of the consultant contract as a time-based contract has undermined some aspects of this, although there is no evidence that care has suffered.

There needs to be a high-quality environment that is clean, quiet and comfortable with staff who treat patients and each other with respect. The importance of really good nursing care, administrative systems that work and other clinical and non-clinical support cannot be overstated. This requires rigorous attention to the detail of how these services operate that is not always present in the NHS.

3. Creating a system

A common theme was the desire to work in a system – rather than a disorganised, poorly co-ordinated and disparate set of services that do not connect, which is stressful and frustrating. Patients, doctors and clinical teams experience delays and teams spend precious time working around problems that should not have occurred.

Good systems do not just happen, they need to be designed and this process needs to have clinical input or be designed by clinicians. Some of the elements of a well-designed system identified in our discussions include the following:

It is systematic. The current system is often immensely complex. Even a relatively simple process can involve many staff, in different departments and organisations, who often have little or no knowledge of one another. In complex systems the person responsible for each step in process often designs it to work optimally for them rather than for the effectiveness of the process as a whole. The doctors we interviewed saw the ability of clinicians to understand the whole process and how it fits together as a key skill. Doctors are not taught this directly but they do learn about complex systems with feedback loops, they apply this knowledge to the physiology of their patients and they gain other transferable skills in learning about consultation. Improvement methods are borrowed from business but the skills used to treat complex problems in medicine can also be applied to organisations with a bit of adaptation and imagination.

An important implication of this is that safety and reliability are key system properties that need to be designed in from the start and continually monitored and improved.

It is integrated and networked. The divisions between primary, secondary, tertiary and social care were a common theme in our discussions. Both sides of the primary/secondary divide...
regarded it as artificial and very unhelpful. Worse still, they felt that both sides were drifting apart – partly as a result of the current reforms. In mental health this is especially true. The need to maintain financial balance, which can only be achieved by a focus on the most expensive patient care packages, allows less time and focus on the volume of GP referrals and support. One GP told us: “I want my [specialist] colleague down the end of the corridor – even if it’s a virtual one.” The introduction of some financial incentives and the recent practice in some areas of discouraging GPs from getting telephone advice from consultants was seen as major violation of this principle. Many of the doctors we spoke to saw networks as a key part of the way healthcare will be delivered in future but were concerned about the extent to which some of the current reforms were undermining them.

It anticipates. The doctors wanted systems that help to anticipate the need for care rather than just respond to it. EWS (Early Warning Scoring System) is a good example of this rule already in everyday practice in many hospitals and registries and risk scoring is already well developed in primary care. In children and older people services there may be even more scope to go upstream, for example to help prevent avoidable injury.

It provides a diagnosis and a plan as soon as is practical. This rule appears almost banal but it was raised by many as a key part of safe systems and contrasted with the delays, hand-offs and avoidance of decision making that is still found in some areas. Patients need to speak to or be seen by a senior decision maker as soon as is appropriate in their illness. This may not always be a doctor but it is someone senior and experienced so that decisions are prompt and do not depend on whether the patient’s need occurs during working hours and on a weekday, or at night or the weekend.

It values continuity. Continuity is important for the patient, for safety and also for the doctors we spoke to. This is not just because of the need to track outcomes, but also because of their wish to be more than technical operatives producing a component in an industrialised process. Some of the current reforms were seen as fragmenting care and continuity must be designed into care pathways.

It provides the tools for the job. The availability of a rapid, high-quality opinion without diagnostic support is of limited value and so a key design rule is the availability of appropriate diagnostic and other support when it is needed. In secondary, acute and mental healthcare, this means much more being available in real time and at weekends. For primary care it also means being able to access diagnostics and other clinical support, particularly imaging such as CT and ultrasound scans, echocardiography and other physiological measurement more quickly and conveniently and without having to route referrals through outpatients. Other tools to do the job include:

- having the case notes available with the results in them (a particular issue out of hours). A shared electronic record would be an enormous boost to networked working, continuity and consistent care
- administrative and clerical support for doctors
- access to skilled pharmacists
- access to a range of non-medical services – especially in primary care
- decision support tools, for example with good safety monitoring and drug interaction alerting functions.

Standardise what can be, but value judgement. Many of the design rules and changes required to create the type of system described here require more standardisation. Many of the doctors we interviewed had introduced pathways, guidelines, care bundles and other attempts to standardise care, particularly to improve safety and adoption of best practice. There is acknowledgement that there is too much variation that cannot be accounted for by differences between patients.
However, there is a concern that many patients do not fit the guidelines and that their overuse is potentially harmful. One doctor suggested a resolution to this: “The purpose of medical training is to equip doctors to make a judgement about when to depart from the guidelines but they need to document it. Accountability for these decisions is the best defence of autonomy.” A key part of this is producing intelligent information linked to case mix tools to provide material for reflective learning and informed judgement.

Break down barriers and provide care in new settings. A number of the doctors we spoke to were already breaking down the primary/secondary divide. They were operating a design rule based on using technology to change the pattern of care and support patients and other clinical staff using telephone, visiting specialist nurses, email and, for some patients, remote monitoring of biometric data. Some mental health trusts use SMS text to remind service users about appointments and when to take their medication.

Incentives and reforms support doing the right thing. We encountered a number of examples where the design of the incentives and rules in the system create barriers to doing the right thing for the patient. This is especially true where a new clinical model reduces the use of hospital, uses telephone, email or other new ways of delivering care, shifts multiple outpatient visits to a one stop clinic or where the use of a more expensive procedure, drug or technology reduces cost in the future but costs more now. The doctors we spoke to found this aspect of the reform variously dispiriting, infuriating or corrosive of the values they believe in.

4. Relationships with patients

A systematic review of the literature on patients’ priorities for general practice care, which examined 19 studies published between 1966 and 1995, found that the most important factor was ‘humaneness’, which ranked highest in 86% of studies that included this aspect. This was followed by ‘competence/accuracy’ (64%), ‘patients’ involvement in decisions’ (63%), and ‘time for care’ (60%) (Wensing et al, 1998).

The relationship with patients in a reformed NHS will change. While national policy emphasises the importance of choice, our interviewees suggested a more subtle approach in which the relationship is negotiated to fit the patient’s wishes, including how active they wish to be in their care management. In mental health services our informants reported that there has been a strong impetus from service users and carers to have their views understood, respected and for them to be partners in their own care. This had been captured in the 10 Essential Shared Capabilities Framework (2004). A number of the doctors we interviewed were keen to try and reduce the more traditional dependency relationship that many patients have. This implies being as open as possible about the limits to care and the uncertainty of the outcomes. They recognised that this is a challenge.

A second difference in emphasis between the doctors and the national policy was their concern,
reflected from the anxieties of patients and relatives about impersonal and insensitive care, getting lost inside the system and the way that systems, including the reforms themselves, can get in the way of high-quality personalised care.

“We need to challenge the underlying assumptions and beliefs in western medicine that lead to so much fragmentation and dehumanising of practice. We need to change the language we use and we need to make explicit that compassion lies at the very core of everything we do.”

*Humanity and compassion in the practice of medicine, Youngson (2007)*

All the doctors we spoke to wanted to create services that were timely and highly responsive to patients’ needs but they did not generally mention choice as being the main driver for this. More emphasis was put on use of patient feedback, approaches that attached importance to patient preferences and creating systems that are capable of responding flexibly to variations in what patients want.

Spending more time with patients, including the ability to have the time to look at the patient’s complete needs was a common theme. This might mean having some patients seen by other professionals or improving the system to release time currently spent dealing with the problems it creates. One of our contributors told us that analysis she has been involved in indicates that 58% of senior doctors’ time is spent in meetings and travel time. Modern technology offers the opportunity to create time to be spent seeing patients.

While it is important to make the best use of professionals’ time, a number of doctors described how changes were also needed to stop patients’ time being wasted from badly designed or poorly co-ordinated care or poor administrative systems. One respiratory physician described how he felt his outpatient service was adding little of clinical value but did involve large amounts of the patients’ time, mostly in travel and waiting rather than receiving care. He said: “They don’t have long to live and we waste a whole day of their life each time we see them – often only so the SHO can tell them they are doing OK.” In other words he believes that patients’ time has a value too. His response was to redesign the service using specialist nurses to monitor his patients and see them when they need it, using the weather forecast and risk scoring to identify those patients who need care before they become acutely unwell.

**Summary of design rules:**

1. A focus on humaneness and compassion remain key
2. The extent involvement that patients want needs to be carefully negotiated and aim to reduce any dependency relationship
3. Use feedback to inform the relationship
4. Create ways to spend more time with patients who need it
5. Patients’ time has value – look for ways to make the best use of it.

### 5. Other key relationships

**5.1 Colleagues**

Many of the design rules in section 3 of this chapter require team working and high-quality relationships with colleagues. There are a number of other design rules that appeared to be important.

The system is team based. The literature on teams suggests that clarity about the role of team members is a key feature of their success. The doctors we interviewed were absolutely clear
about the contribution of their teams. Their teams had clear allocation of responsibility, including non-medical members of the team taking on leadership roles or tasks usually performed by doctors in some cases. This was particularly striking in the New Ways of Working programme (2003) in mental health where the work of the consultant psychiatrist was refocused so that they are no longer clinically responsible for all patients seen by the team. Instead there is now a model of distributed clinical responsibility with each member of the team responsible for their own actions with their own professional code of practice. The psychiatrist then is an important, highly-expert member of the multi-disciplinary team but their expertise is maximised by ensuring that they only see people with the most complex needs. This frees them up to provide supervision and advice to colleagues and to be involved in service development, system redesign, clinical governance, education and training, and other activities.

Our interviewees were not threatened by this, they were clear about their unique contribution and had played a key role in the design of the team. Feeling secure is a prerequisite for being able to share power and responsibility. This is important because working in a well-functioning team is a crucial part of dealing with the inevitable stress and anxiety that is part of providing healthcare.

**The system promotes professional interaction.**

It is very important for doctors to be able to meet their colleagues, both formally and informally, and have the time to discuss cases, exchange information and build the relationships that allow the free flow of information, including giving frank feedback. We heard a practical example of this from GPs in that they like to be able to refer some patients to a named doctor. Their reasons for this included knowledge of the particular expertise of the consultant and a wish to avoid particular individuals because of issues about their approach to patients.

“The most often cited example is the removal of staff canteens. You can’t discuss cases with colleagues when you could be sitting behind their relatives. The speed of referral is far faster (often by days) if you catch someone in the corridor/canteen rather than a referral form or a message on the secretary’s answerphone.”

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Critical care consultant

**Ensure high-quality interpersonal relationships.**

Our interviewees mentioned the sometimes hostile culture and were concerned about levels of tension and conflict they often found between individuals, teams and departments. This was particularly true of relations between people in different teams.

A culture of mutual respect and support, the ability to give feedback without it being perceived as criticism and ways of resolving conflict were seen as very important. The doctors we spoke to also reflected on the lack of support they felt they got from colleagues.

**The system has leadership and management.**

Both large and small systems require leadership and management. Our hypothesis, drawn from our discussion, is that the closer the system is to the patient the more likely it is to require clinical leadership. Many of the doctors we talked to do not have formal leadership positions but are clearly exercising leadership in a number of ways. This means that many, if not the majority of consultants and GPs, have key leadership and management roles as part of their everyday practice. This implies that they have an important role in creating the system in which they work rather than simply responding to it. However, it should be noted that leadership and management is not a substitute for designing systems that work.

5.2 Relationships with managers

Managers are colleagues too. The Confederation has previously published a report following a
meeting with the JCC (now the JMCC), Academy of Royal Medical Colleges and BMA on defining a new relationship between management and the medical profession (Edwards, 2002). This work suggested a recasting of the relationship between doctors and the organisations they work for and a shift in what doctors give to their organisation and what they can expect in return. The themes that emerged in our discussions included a number of ideas about the obligations of both sides in this relationship.

Managers need to:
- involve clinicians in leadership and management
- use evidence to make decisions
- support clinical innovators.

Doctors need to:
- get involved in leadership and management
- take an active role in solving problems
- continuously work to improve care and systems
- avoid the use of their power of veto.

Both:
- have an obligation to treat each other with respect
- must work within the budget available.

5.3 Relationship with the organisation
A very striking finding in our discussions was the extent to which the doctors we spoke to did not feel valued by their organisations or the hierarchy in the NHS and the Department of Health. Whether or not they are correct is irrelevant, it is the perception that is important and has serious consequences. Many of the reasons for this feeling relate to a number of issues that are explored elsewhere in this report, including the way change is managed, a feeling of disconnection from the policy and decision-making process and the clash between what they want to achieve and the obstacles in the system. However, many issues were smaller, apparently less significant, but still symbolically important indications taken as an expression of a loss of their value. The design rules for a reformed NHS need to consider how organisations make all their staff feel valued and pay attention to some of the processes, symbols and small details that create the impression of an organisation that does not care.

Summary of design rules:
- promote professional interaction
- ensure high-quality interpersonal relationships
- redefine the relationship between doctors, managers and their organisations
- pay attention to the causes of clinicians feeling disconnected and not valued
- small things can make a big difference to how people feel they are valued.

6. Measurement, learning and teaching
A reformed system needs to be based on continuous learning and the analysis of empirical data, using evidence where possible. Both require information collection and feedback. The design and operation of the sort of system that our doctors want to create also requires much more data about performance. This discussion gave rise to the following design principles.

High-quality data about outcomes, patient experience and key processes need to be collected. A number of rules flow from this:
- data must be relevant to patients and clinicians and about the things they value
• ensuring that this data is collected is a key responsibility of clinical staff – a number of our doctors were collecting their own data in much higher levels of detail than the hospital systems, but standard data can also be useful if used properly
• clinical leaders analyse and use data on current workloads, case loads and actual patient case histories and have a deep knowledge of current workload and processes of care
• the system trains doctors (and managers) in analytic tools and techniques to enable them to redesign care processes
• the system develops the infrastructure and staff to support measurement of process and continuous feedback and use of the information for improvements
• there is a focus on measuring the right things
• information may be qualitative as well as a quantitative.

Education and learning is a responsibility of all. The obligation to educate does not just relate to trainee medical staff but also to colleagues, other professionals and patients and their relatives. This implies that clinicians must be ready to learn from these sources too.

7. The way change is managed

Many of the doctors we spoke to had strong ideas about design rules for the way that change is managed in the NHS.

Talk about patients. Goals and targets should be communicated in language that talks about patients. For example, reducing rates of patients missing appointments and cancellations; shorter waiting times; and management of policy discomfort and anxiety so that patients can retain in or return to work.

Map out the detail. The detail of the consequences of changes for individual consultants and other health professionals needs to be worked out in advance. How will recommended improvements affect rotas, job plans, schedules of clinics, schedules for theatres, continuing professional development and so on? This mapping should include actively looking for the unintended consequences of the idea.

Support the leaders of change. Clinicians who lead changes in working practices should be supported by managers and administrative staff. There needs to be an agreed project management approach including progress chasing, arranging meetings, documenting decisions, supporting multiple efforts to communicate using multiple avenues and occasions, and communication.

Get the process right. Change processes have to be managed intelligently with decisions taken with clinicians on the floor as much as possible.

Establish a team culture/culture of working together. Aiming for major change with people who do not know each other or who are not used to working together as a team is hard. Agree a six-month plan, a review and amend as appropriate.

Use evidence and research. We found a general view that too many change projects are not based on robust evidence. The presentation of baseline objective data provides a sound basis for an intelligent discussion for non-confrontational change management.

Change is continuous and long term. The idea that there is a short-term process that then stops was not consistent with the approach of many doctors we spoke to, particularly as they saw themselves being in the organisation for some time.

We also found that many doctors prefer empirical approaches, time to change and small-scale experimentation. They were highly suspicious of big projects, jargon and central initiatives.

This raises a difficult question about how large-scale change can be achieved and whether
some of the conservatism that could result from this approach may obstruct progress that is genuinely needed.

**Conclusion**
The common features of all the inspiring examples of change, good practice and high-quality systematic care are curiosity; the use of data; continual questioning and searching for innovation and improvement; feedback; constant learning; using the patient as the measure of success; and being prepared to deal with obstacles and opposition in a positive and constructive way.
Chapter 3: What the doctors told us

To get a broad range of views we asked clinicians from a wide range of specialties to describe in very practical terms what they thought it would be like to practice medicine in a system that had been reformed, or to describe how they had created their own service and how it differed from more traditional models. Key areas of enquiry included:

- what kinds of changes would you like to see in services for patients?
- what would be different to current practice?
- what would it feel like to work in such changed services?
- how, if at all, would relationships with patients be different?
- how, if at all, would relationships between staff be different?
- what would remain the same as current practice?

This chapter sets out what a selection of doctors told us in response to these questions.

Vascular surgery

Simon Dodds is a vascular surgeon based at Good Hope Hospital – part of Heart of England NHS Foundation Trust. He described his first outpatient clinic as a consultant as an unhappy experience. "Afterwards I got the staff together and said we seem to have three choices", he said. "We could put up with it, but it would make me mad. I could leave, but I have only just got here, or we could fix it."

Simon has the advantage of being a fully trained computer software systems designer, as well as a surgeon. He made a careful diagnosis of the system's problems and conducted a series of experiments in redesign, analysed the results and made further refinements.

A new one-stop clinic is designed to allow patients to flow between the different stages of their visit with the minimum of delay. For example, the ultrasound machine is now located in the clinic and the examination takes place as part of the one-stop clinic.

Simon used a computer-based simulation model to test a range of clinic schedules before implementing his solution. While the principle is that the care is designed around the needs of the patient rather than the staff, this approach also avoids the problem of staff finding they have too much or too little work at different times. By designing delays out of the process the new schedule has increased clinic capacity and reduced waiting times, at no additional cost.

The one-stop clinic and the leg ulcer service are both based on the idea of ensuring that key decisions happen as early as possible in the patient journey. In the old system patients with leg ulcers being cared for by a district nurse had a long wait for a vascular opinion, via a GP referral. In the new system Simon and his vascular nurses access a secure, shared electronic patient record (EPR) with digital pictures added directly by the district nurses and can provide advice or book the patient into the clinic. The pictures can be measured and the progress of the ulcer charted on a record which the community nurses and the vascular team share. This also creates the ability to do multi-disciplinary audit with ease.

Simon makes frequent reference to the importance of his team in making his system work and his service is designed to use the most appropriate...
member of staff for the job. He clearly has a passion for improvement. His ability to see the system, diagnose its problems and his interest in what the staff think have been crucial. Although his model is the product of the application of a set of technical solutions, he actually places more emphasis on the emotional and cultural issues that need to be dealt with.

**Key learning points**
- Use the insights of staff to improve the patient experience.
- Get the details right and eliminate the niggles and irritations.
- Consider the whole patient journey – not just your bit of it.
- Use empirical methods and small experiments to create improvement.
- When the system does not work it is usually a problem with the system so avoid personalising blame.

**Emergency medicine**

Andrew Stein is a consultant physician at University Hospitals Coventry and Warwickshire NHS Trust. He has helped create a system for managing emergency medicine that echoes many of the design rules in chapter 2. The system is built around a 24-hour take that is very hard work but does force all the participants to cancel clinics, endoscopy lists and other distractions. In this way, the medical take, which accounts for two-thirds of the admissions in most hospitals, is prioritised. He believes that if the admitting wards run smoothly, so does the rest of the emergency department. And, if the system works more smoothly, it is better for patients. Andrew was clearly enthusiastic about the improved service he is able to deliver.

To make this system work, he believes it is vital to have high-quality initial management of patients with complex conditions, for example directing patients to specialists as soon as possible. Also key is making sure key activities are happening in general medicine, regardless of the weekend, bank holiday and so on. This includes outpatient clinics so that patients can be seen by a specialist as soon as possible rather than being admitted and provides a method for giving GPs urgent advice or dealing with a patient where there is no clear diagnosis. However, it requires other back-up services (for example radiology) to work on a daily basis. As well as high-quality management initially, it is important to actively manage all stages of the patient journey. Andrew has imposed a ‘no pyjamas’ rule for patients who require social care rather than admission. He says: “Once they have changed into their pyjamas, they could be there for months”.

He believes there are key roles for other professionals too, for example nurse-led discharge wards for patients requiring rehabilitation or complex packages to go home that recognise nurses’ different skills and approach to patient management.

Medical leadership is an important part of the system – taking responsibility for managing the system and making change. However, Andrew is clear that there is a key role for managers, particularly on the longer-term issues. He also thinks it is important to work with local GPs to ensure they understand the system and how to get the best out of it. And removing historical tribal rivalries within the hospital is also important, for example building closer links between emergency and general-acute physicians so that both are comfortable seeing patients in each other’s ‘territories’.

**Vision for the future**

Andrew has many ideas about how the system could develop that would change the shape of the hospital and its shape in the wider system. He recognises the challenges this presents but argues that this will be better for patients. His ideas also create ways of working for doctors that use their skills, connect them better to patients and create more variety:
A clinical vision of a reformed NHS

- A high-tech front end to the system to ensure rapid diagnosis.
- More daily clinics (including weekends, and bank holidays) to deal with emergencies without admitting.
- More nurse-led wards.
- More use of communications technology.
- Close links to social care services.
- Merging of NHS and social care budgets.
- The ability to take patients home or facilities in the community for IV antibiotics and other active treatment.
- Much closer links to general practice including consultants having a considerable amount of their work in the community.
- Increase pace of movement to a 24/7 hospital.
- Better information to medical ward teams, for example their length of stay, mortality, re-admission rate and quality of discharge. As there are nearly no performance parameters in emergency/acute/general medicine, there is little incentive to work harder or smarter. The well-known four-hour A&E target addresses quantity/speed of admission, but not the quality of what happens (and the discharge process) when the patient gets there.
- Formal investigation of deaths and clinical errors in emergency/acute/general medicine, as in general surgery and obstetrics. Traditionally, this area has been poor at audit and clinical governance.

**Key learning points**

- High-quality management of patients at all stages of the patient journey – this includes referral to specialists as quickly as possible and not admitting patients who only require social care.
- General medicine activities need to happen daily, regardless of the weekend, bank holiday and so on.
- Other professionals have a key role to play, for example nurses running discharge wards.
- Medical leadership is key but the role managers play is also important, particularly on the longer term issues.
- Important to work with local GPs and remove internal ‘tribal rivalries’.

**General practice**

We interviewed a number of GPs individually but also a group of over 20 GPs participating in the RCGP leadership programme. This detailed review of our results added significantly to the richness of the findings. The doctors on the leadership programme had a number of different accounts of what they would like to see in the future. Some closely resembled traditional models of general practice, others’ visions were much closer to the sort of healthy living community resource typified by Bromley-by-Bow, and some envisaged a polyclinic type model with visiting and resident specialists, diagnostics and minor procedures being easily available. Others thought the traditional partnership model still had mileage but that partners would increasingly have to work together to deliver services. They thought that even basic primary care could benefit greatly from a more collective approach by GPs, the sharing of support, sub specialisation between practices and coming together to commission or provide secondary care services. All envisaged growing roles for other clinical staff in the services that result and most of them were expecting to spend more time with fewer patients.

David Lloyd is a GP in Harrow, north-west London. Being a GP in a reformed system looks quite different from how he practises now:

- Before even going to work he envisages being able to look at emails from his patients – greatly reducing the number that need to see him face to face.
• He then speaks to the patients who have asked for appointments and is able to deal with a significant number of these on the phone or is able to refer them directly to other professionals in the practice, order diagnostic tests or arrange a time to see them.

• His computer shows the biometrics of his patients with Chronic Obstructive Pulmonary Disease (COPD), heart failure and other long-term conditions which have been collected by home-based monitoring equipment.

• He will speak to some of the practice team about the small number of patients who are a cause for concern, allowing them to intervene to reduce the likelihood of admission to hospital.

He sees consultations being much longer than now because they are more complex and there is significant diagnostic uncertainty. A range of investigations and specialist advice would need to be much more easily available to make this system work. Imaging and physiological investigation would be available directly to primary care. David sees primary care working very closely with consultants and that both are available for each other by phone, email and face to face in a number of settings.

Patients with established care plans and minor conditions will generally be dealt with by other members of the primary care team. Serving a commuter area, it will be important to offer some services, particularly those for working age adults, outside office hours.

David would spend the time released by the more effective management of patients in education for healthcare staff and patients, keeping up to date, planning service development and commissioning.

Medical chief executive

Mark Goldman is a consultant vascular surgeon, as well as chief executive of Heart of England NHS Foundation Trust. When asked about being a doctor and medical leader in a reformed healthcare system, he starts from the premise that not only is change unavoidable but that the pace is likely to increase. He believes less of this change will come from the centre as the health service in the foreseeable future is going to be much more devolved with fewer levers for the centre to pull.

He foresees major challenges from the independent sector but that the most significant impact will be felt in primary care. He does not think primary care is well set up to adopt some of the approaches that will be required to meet the challenges of changes in demand and expectations. New providers, vertically integrated hospitals or social care may take advantage of these new opportunities. He expects that primary care will become more interested in maintaining wellness.

He sees hospitals moving up and down the care pathway, supported by much more use of IT – not just for records, but also for home-based monitoring and other complex tasks. Hospitals may increasingly look like an HMO (health maintenance organisation), holding the risk for the management of defined populations. Practice-based commissioning is most likely to focus on smaller scale improvement but Mark is uncertain about its ability to deliver major strategy change.

New challenges for medical leaders and their staff in this new environment will include the following.

• Managing a care system rather than just a building or a part of the process. As we found in other interviews, Mark sees the creation of an integrated system supported by technology as a key objective on the way to delivering improved care. The provider, not the commissioner, puts the package and the pathway together.

• Creating a workforce that can deliver this will be a major challenge. Mark said: “The current approach to workforce planning is completely unsatisfactory and much more local approaches
for all post-qualification professional education – including medicine – are required, although there are some unique aspects in medicine that need to be respected”. More variety, more modular approaches and different methods of delivering postgraduate training will be required. The rigid way medical roles are defined is probably not appropriate for some of the ways that trusts will need to structure their workforce.

- Collaboration with primary care, as seen in the local Kaiser pilot.

Mark sees some significant challenges for doctors as well as their leaders. He believes they will need to get used to:

- working in smaller hospitals with fewer beds
- spending much more time outside the hospital
- anticipating the need for care rather than just reacting to it
- all day case or overnight stay for elective care
- rapid change in the nature of some specialties, for example he thinks his own specialty of vascular surgery will almost disappear and there will be a major reduction in the use of invasive surgery
- much more use of high technology diagnostics which will need to be immediately available
- more time will be spent teaching, mentoring, reviewing, working with others and co-ordinating
- less drama.

He said: “This is more complex, more challenging and less immediately rewarding, which means that the profession has to change the way it sees itself – or that work has to be done by someone else.”

Mark draws an important lesson from good management that he believes could be of great value to medicine. “Poor managers spend their time running around solving problems, putting fingers in the dyke,” he said. “We have systems and processes in place to meet the targets but not by having the chief executive push the beds up and down the corridor. If we have a problem we sit down and plan our way out of it – we don’t just work longer and harder. This means that we have time for thinking and planning ahead. Medical care has to develop the same kind of thinking.” He continued: “The model of dipping into cardiac failure every few weeks, being rushed in, filled up with diuretics and sent back out there is utterly absurd. We have to do better.”

Mark sees clinical leadership as key to this and a key goal is to create a collective and mutually supportive clinical leadership community. He told us: “Doctors need to step up to do clinical leadership but they need managers to support them and they need to work in a very sophisticated way. Clinicians can create vision but can’t deliver it.”

He has a strong sense of values:

- do the right thing for the patient – don’t play games to move the patient to maintain financial balance. This means that the incentives need to be properly aligned.
- the start and finish of every discussion has to be “what we have done today to make things better for patients?” Mark says: “That’s the touchstone. It’s very easy to lose this”.
- clinical leadership is so important – it can ensure that each element of the organisation maintains its value base. Clinical leadership is not about shroud waving. It’s about finding solutions to very difficult problems by using the opportunities that improving clinical practice can offer.

Mark points out that what chief executives say is invested with great significance by staff. He knows that the way he talks to staff and how he and his team behave have a major impact on setting the tone. He talks about patient experience and believes organisations should reward patient care in every way they can. He says: “This can be tedious but you can’t let it go”.
He clearly has high expectations of his consultants. He expects them to have a clear vision of what they are trying to achieve; how the world they are operating in will change; how they need to change to deal with this; and how they should behave. He expects that they will set themselves challenging goals and be prepared to be held to account for them.

**Diabetes**

John Dean is a Consultant Diabetologist at Bolton PCT, where he is also medical director. His enthusiasm and interest in the system in which he works, the curiosity he exhibits about new ideas, and his values about caring for patients are very clear.

The design of the service started with the patient and is designed to provide integrated care. He said: “We have designed a service where the patient is the focus of all care, be it primary or secondary. The integration of care between these two areas has transformed the service in the years between 1989 and 2006 and the process is still continuing.” John inherited and accelerated a process of change. The idea that change involves both continuity and progress is important.

Improving the service meant that more people with diabetes were identified and the number of patients increased by 20% between mid 2003 and the end of 2005. Most care was already taking place in primary care and the number of specialist sessions held in GP practices to support GPs as the diabetes population grows has been increased.

Determining the cut-off point between treatment by the GP and referral to the specialist team at Bolton Diabetes Centre (BDC) is decided by a model which has been developed with primary care. General practices opt to provide one of five levels of service, relating to the appropriate level of competency. All are now in the upper three of five levels. In addition the specialist diabetes team from the BDC attend sessions at general practices to see patients with more complex needs who might previously have had to travel for an appointment.

Referral at the point of diagnosis is now comparatively rare, leaving specialists free to deal with the most complex cases. John said: “The specialist team does the icing on the cake. It’s the rest of the team that makes a difference.”

As a ‘reformed’ specialist clinician and clinical leader he has three main roles, but overall as a local expert for his clinical area he:

- provides expertise in local service design and co-ordinated delivery (through clinical leadership of the network and the specialist team)
- provides expert care to those with complex needs (as part of the multi-disciplinary specialist team) wherever they need it, for example in general practice, in hospital, or in the specialist centre
- educates and advises other health and social care professionals.

The key feature is that this is without boundaries of organisation or profession, and is focused on the overall objective of improving the health of the population, and helping people live well with their diabetes. This is supported with high-quality process and outcome data.

Patient empowerment and involvement is very important because of the role that patients need to play in their own care. Nurses run training for patients and significant effort has gone into improving the communication with patients and the information available to them. The service has recently worked with the Design Council to develop new ways of helping patients take control of their care, communicate their wishes more effectively and participate in the design of their own care.
Key learning points
• The patient has to be the focus of all care, both primary and secondary.
• Use tool to determine the cut off point from care by the GP and referral to specialist.
• Communication, including opportunities to meet, between primary and secondary care services is important.
• Patient empowerment, involvement and feedback is very important.

Children’s palliative care

Simon Lenton is a paediatrician at Bath and North East Somerset PCT. He was appointed in 1987 as Consultant Paediatrician with a Special Interest in Community Child Health, managing children with long-term conditions, some of whom have life-threatening or life-limiting conditions.

He soon realised that traditional outpatient slots of 20 minutes and the usual six-month or annual review was not meeting the needs of this group of children and families. Talking to families, Simon realised that services were poorly co-ordinated and lacked continuity. He said: “Families were subjected to multiple assessments that were often poorly communicated to others involved, and there was not a joined up response across health, education and social care.”

He decided to try to ascertain how many children and families were in this situation, what their needs were, and how they could be best met and used a grant to ascertain the prevalence and morbidity of non-malignant life-threatening conditions in children. The prevalence was four times higher than expected, pain management was a major issue and the burden of caring, particularly for mothers, and the impact on other family members was revealed for the first time.

Simon told us: “Proactive care is the norm. The rule of thumb is that if a problem is thought likely to occur it is included in the child’s care plan.” This means that parents do not lurch from one crisis to another but are supported to anticipate likely developments in the child’s condition. This is particularly important in developing end-of-life plans.

Sibling groups provide support and understanding for other children in the family who often miss out on discussions and family life where a sibling has a life-threatening condition. They often think about their siblings and their future, but often cannot talk to their parents because their parents get upset. The groups enable them to express their concerns, discuss them with professionals, realise they are not alone and make social contact with other children who understand.

The service also began to address wider issues such as employing carers for these children. Carers were employed by health, education or social care as appropriate. The carer team now followed the child, were appropriately trained assessed and received ongoing support from the Lifetime Service.

The Lifetime Service grew from a service just covering the Bath clinical area to one covering the whole of Bristol and expanded from a single nurse and psychologist to a team of 21 nurses, 4 psychologists and a team of 50 carers for children with complex health problems (although these are not all full-time posts).

The impact for local paediatricians is that these children need to be seen less regularly, the community children’s nurses consult with local and specialist paediatricians as required, parents are spared unnecessary outpatient appointments at the quality of their lives is improved.

The future
This model of service delivery is equally appropriate for all people with long-term conditions or disabilities, particularly when they require a multi-agency approach. It fits well with delivery of care outside hospitals; empowerment of patients and their involvement with decision-making;
clinical leadership; and devolved innovation/learning at a local level with spread of success nationally.

**Key learning points**
- Achieving significant change requires long-term commitment.
- Listen to children and families.
- Significant change requires practical vision.
- Improved services are completely dependent on the quality of the multi-disciplinary team.
- Continuous learning and improvement are an integral part of service delivery.
- Use opportunities as they arise.

**Anaesthetics/theatres – getting the basics of care right**

As consultant anaesthetist and clinical director for theatres at Salford Royal NHS Foundation Trust, Kathy Teale is a practising clinician and manager.

She would like to see people rewarded for improving quality on the wards – merit awards given for good patient care. In her view, the merit award system needs a complete revamp and a focus on patient care.

Kathy believes patient experience needs to have far more emphasis than it has received to date. She wants the quality of care in her hospital to be as she would want it for herself. She told us: “It is all about compassionate care and communication. A certain level of basic care should be there as a right. Hospital should be a pleasant experience for the patient. It matters how they are treated and spoken to.” Kathy believes hotel services and standards of cleanliness should be up to standard. This is separate to the quality of the actual surgery the patient is having.

She also thinks there should be a lot more contact between patients and doctors, on a more equal basis. “Doctors can be slow to change, and resist giving up their power,” she said. “The relationship between doctors and their patients tends to be one-sided. Doctors are really quite frightened of talking to patients and they avoid it. It tends to be seen as time-wasting.” She would like the trust’s merit award system to reward doctors for spending time with patients.

Kathy talked to us about relationships with nursing. “Nursing has changed,” she said. “Previously, most nurses were trained in Britain. Now, most of them are not trained here and this can be a problem if it means the nurses are more hierarchical and less willing to challenge the doctors. We need to have far more mutual respect and equality.” She believes that in many ways it is good that nurses are now expected to take on more difficult and complex roles. But she believes it takes nurses away from caring for the patient and means that junior doctors spend less time with the patients than before.

She gave this example: “The other day I went to the ward to see a patient. The junior doctors and nurses were all at the nursing station. When I found my patient I discovered she was having an acute asthma attack. Somehow, this was not seen as anyone’s job. It’s almost as if there is a barrier between patients and staff.”

Kathy’s trust recently brought people together to talk about quality. “This is encouraging,” she said, “although it can be annoying when managers talk about it as if they had just invented it. We have not been listened to in the past, and when we have opposed something as bad for patient care, I think we’ve been seen as a spanner in the works.”

She continued: “Centralisation makes things less efficient and less personal. We need smaller units, not larger ones. In that sense, the plans for London, with polyclinics, are not new but they are the right ones. Some of my colleagues worry that this is a way of opening the door to the private sector. But if we could guarantee that they would remain in
the NHS I would not be against it. Hospitals are becoming bigger all the time – enormous, unwieldy and impersonal. And that’s not good for the staff or for patients."

**Key learning points**

- Strive to provide care that you would like to receive yourself.
- Doctors need to be more aware of what is happening and work more closely with managers.
- It is important to build relationships between hospital doctors and GPs.
- Organisations need to operate on a human scale.

**Psychiatry**

Geraldine Strathdee is consultant psychiatrist and clinical director at Oxleas NHS Foundation Trust and a clinical adviser to the Healthcare Commission on their clinical strategy. She believes that the culture you work in impacts on how well you can heal people, physically or mentally. She said: “It is important to have a peaceful calm collaborative way to move forward”. Geraldine is also a self-confessed ‘change junkie’. While she embraces change as an inherent part of being an NHS employee, she is committed to making improvements for patients. She told us: “I love change. I want to know what the best way is to do things”.

Geraldine believes successful change management or service development hinges on a management ethos of working in the spirit of collaboration between managers and clinicians and the use of intelligent data.

One of the first steps she took in her post as clinical director was to disband the medical advisory forum and, with colleagues and senior managers, set up a new multi-disciplinary forum that includes both consultants and managers. The focus moved away from medical management to service management and development. Geraldine recognises that mental health services are perhaps more flexible and adaptable to change than others, purely because of the extent of transition they have experienced – everything from large organisations providing hospital-based care to increased community provision, multidisciplinary team working and increased collaboration with community agencies. However, key to change is a critical mass of clinicians and managers within the organisation who share the same values and want to work together. She says: “This has been crucial to developing the collaborative ethos within the trust and, through recruitment, this has been strengthened.”

Linked with collaborative working styles is the use of data in the trust. A lot of time is spent extracting data from the wealth of collated information – data that can be used to help clinicians manage their performance. Data can include information on admission rates, use of the Mental Health Act and medication, and data about caseload and mix can be used in appraisals. Also important is a good supply of data and a ‘safe’ culture that allows clinicians to discuss differences in their practice. For example discussion about differences in the use of ECT might include “am I depriving people of ECT?”, “are you using it too much?” and “how does our case mix differ?” This reflective style is known to develop good practice and professional development.

Geraldine told us that having good data to hand has also enabled the trust to make efficiency savings. An analysis six years ago identified that almost 25% of the total spend for the service was going on out-of-area treatment placements (OATs). Further to a cost analysis the money has now been repatriated into delivering services locally so that now only 10% of the total spend goes on OATs. As a consequence the trust now has eight new services in line with the National Service Framework for Mental Health, including early intervention services, assertive outreach, crisis resolution teams, home treatment teams,
rehabilitation services, and psychological therapies, meaning that a wider range of services is available at more locations. Geraldine believes that the options available and the approach to care delivery means service users are reassured that compulsory detention is part of a considered range of interventions rather than a first port of call. The use of trust surveys of service user satisfaction shows that the percentage of service users in the trust feeling that they are being treated with dignity, being shown their care plans and given better information, and being offered support to return to work, is increasing year on year. Although keen to admit the trust is not perfect, Geraldine is rightly proud of the progress that is being made. But she is always looking for opportunities to improve things further for patients.

Two major innovations are being piloted at the trust at the moment:

- a prescriptions information service
- development of care packages for service users whose care accounts for 20% of the budget.

The prescriptions information service is being set up in response to service users asking for different types of information rather than the quite cold and factual information already available. Focus groups found that service users want the basic facts, for example “what have I got and what will it mean for me?” But in addition they want to know how others with the condition have coped, what strategies they have used to lead fulfilling lives and how to get back into work. The trust is undertaking a major redesign of its intranet, aiming to provide information that is easily accessible to service users, carers and staff through video diaries and podcasts of service users talking about their experiences of mental illness.

Geraldine’s trust is also looking at developing different care packages for the service users who account for 80% of the budget based on the international healthcare finding that 80% of spend is on 20% of the service users with the most complex and long-term care needs. These are the service users of low volume but high costs to the service and who have a complex profile – often psychosis, substance misuse problems, many having experienced physical, emotional and or sexual abuse, with poor education, physical health problems and have a high propensity for social exclusion. Using service level reporting (SLR) methodology the trust is reviewing the costs of intensive multi-agency community care packages for such service users to compare high cost tertiary inpatient models. The aspired for package would include intensive assertive outreach, access to a rehabilitation unit, and collaboration with the community agencies (local authority appointees, police, probation, anti-social behavioural unit). It would be a very intensive customised evidence-based programme of care rather than containment in expensive inpatient units.

So what of the future role of the medic? Geraldine feels that doctors should be able to combine management responsibilities with frontline patient work. They should be able to contribute to service improvement, drawing on the intellectual rigour from training, and their clinical experience. By being up to date in the latest interventions and well versed in NICE guidelines and research, they should ensure that they are delivering the best that medicine can offer. She said: “Doctors play a key role in providing coherence and maintaining standards in a team and should have the breadth and depth of knowledge to act quickly to make improvements. Above all, I would like to see doctors in the future taking an increasing interest in health and not just illness.”

New ways of working
Oxleas NHS Foundation Trust was a London pilot site for new ways of working in mental health, starting with its medical staff. Geraldine told us: “Through a focus group of 49 senior doctors we developed an audit tool linked to appraisal to identify how we were spending our time, what would make us more efficient and if other
disciplines could develop enhanced roles and do the work equally effectively. Audits showed that 40% of the outpatient clinic time could be better spent in providing crisis support, teaching, leading special developments, for example OATS reengineering, dual diagnosis, improving acute care, implementing electronic care records and focused NICE implementation. The enhanced roles for other disciplines implemented included nurse-led memory clinics, nurse prescribers in continuing care services, nurse practitioner-led physical health initiatives across both the community and inpatient services, accessible e-learning training programmes and even some social workers trained as phlebotomists!

Key learning points

- Successful change management hinges on a spirit of collaboration between clinicians and managers and the use of intelligent data.
- Good data enables clinicians to discuss differences in practice and trusts to make efficiency savings.
- Clinicians with management roles should not lose their frontline patient work.

Read other stories from older people’s services, neurology, obstetrics, respiratory medicine and critical care on The NHS Confederation’s website at www.nhsconfed.org
Chapter 4: Implications and conclusions – creating a conducive environment

Introduction

In chapter 2 we set out the design rules for a reformed NHS that emerged from our discussions with a sample of doctors who had created their own version of this. Chapter 3 tells some of their stories. Many of the doctors had developed new service models and improved ways of doing things but it was clear that there was more that could be done to help clinicians wishing to change their services overcome bureaucracy, poorly designed policy, sceptical colleagues and other obstacles.

In this chapter we examine the changes needed to create the sort of NHS that reflects the vision of the doctors we talked to – one that will meet the needs and expectations of patients and the public. We developed the conclusions about the policy and other changes implied by the design principles with the help of our steering group and expert advice from two focus groups.

One of the important aspects of the design rules in chapter 2 is the extent to which solutions are in the hands of local organisations, managers and clinicians rather than the DH. There are a number of changes that the DH could make to the design and implementation of policy. However, while these are a necessary part of changing the NHS, they may not be sufficient.

In keeping with the approach of this study – that is to build the story of a reformed system – we start at the front line and end with national level changes. First, however, there are a number of changes in approach that are required at all levels.

General implications

Patient-centred care. The centrality of patients to the redesign of care was the key feature in the interviews with doctors. The challenge has always been how to move beyond platitudes and rhetoric into reality. Some of the answers suggested in the work of the doctors we interviewed included:

- changes in the way that professionals involve patients in decisions about their care and reducing their dependency on the professional
- using patient experience and advice in the design of policies and services and in assessing individual, team, organisation and system performance
- developing much better feedback mechanisms to collect and use this information
- removing obstacles to spend more time with patients
- much more focus from all parts of the system on the basics of care delivery, kindness, dignity and the way that the system can confuse patients or waste their time.

Values. The importance of underpinning values in our descriptions of the components of a reformed NHS is striking. We consider these in more detail below but the general lesson is that more time and effort is needed to articulate the values of the NHS
and to ensure that quality is at the heart of the way that staff and teams think and operate. It is clear how easily values can be undermined by the behaviours that people exhibit. The more visible and senior the individual, the more their behaviour influences others. At all levels of the system we must ensure that the behaviour of all levels of staff is appropriate and that bad behaviour at odds with the values of the system is challenged.

Creating a system. The implications of this work is that the frontline doctors and medical leaders we spoke to definitely considered themselves to be part of a system made up of clinical networks, organisations that work together and colleagues who collaborate. In every case improving integration and avoiding fragmentation was seen as important for patients and professionals. This was not just about information flows but also about relationships, mutual understanding and the need to provide continuity for the patient as well as to avoid errors resulting in poor co-ordination of care. The reason this is important is that there are divergent views about the nature of the NHS and in particular whether in future it will tend to be more of a set of autonomous organisations linked together by contract. The doctors we spoke to have models of care that rely on the ability to create systems and to make these span organisations with as few bureaucratic barriers as possible. They consider themselves to be part of a system and also part of a series of interlocking mini-systems that are highly complex to navigate but essential to doctors’ ability to perform. The paradox is that these individuals are also often very competitive.

Judgement and control. The importance of professionals and organisations having control over their work and the space to exercise judgement is beginning to be recognised by Government, although there is some anxiety that it is easy to slip back into old habits of command and control. It is clear the effects of hierarchy have created problems for frontline doctors and their organisations, but they have also caused significant difficulties for Government, not least in the sense of disconnection that hierarchy has produced in many frontline staff. Greater discretion to exercise judgement and take control of one’s own work tends to be associated with:

- improved problem solving
- higher levels of innovation
- increased responsiveness
- reduced stress
- higher levels of discretionary effort – it is easier to get alignment between individual and organisation objectives.

Control of one’s working life or organisation was a strong theme in our interviews with doctors. There is strong evidence to suggest that this is a very significant predictor of how people feel about their work and the alienation of many medical staff may be related to this perceived loss. However, there was general consensus that professional autonomy is not an acceptable reason for high levels of variation in outcomes or approach. The Royal College of Physicians’ work on professionalism has started a debate on the meaning of responsible autonomy and the need for accountability. There is further work to do to develop the approach to this at all levels in the system.

Involvement. Whether at the level of the frontline, the organisation, the local system or nationally, the need to ensure that clinicians are properly involved in decision making was a recurring theme in a number of our discussions. The perceived failure to do so and where advice had been sought but not listened to was a source of very major concern and was cited as a contributory factor in problems with the national IT programme and the electronic recruitment system for junior doctors.

Change management. Some of the way that change is planned and executed at all levels of the NHS needs to be rethought. The design principles in chapter 2 suggest that there needs to be better use of evidence, more attention to the practicalities
of implementation, better involvement of those affected and a bias in favour of approaches that are empirical, based on trials and able to be locally customised. In particular, there needs to be much more use of health services and policy research to inform decision making.

Symbolism. One of the recurring motifs in our discussions was a number of small irritations that have assumed far more significance than would appear to be justified. Examples ranged from car parking, cups of tea in outpatients and the centralisation of clinic booking. We suggest that, far from being trivial, these issues are connected to the issues of values, behaviour, autonomy and control detailed above. The implications of this are that all parts of the system need to consider much more carefully what meaning and significance their proposals and ideas may carry. The current interest in the design of incentives based on an economics-based approach also needs to be tempered with psychological insight.

Narrative. One of the most significant criticisms of the current reform programme is that it lacks a clear narrative that speaks to clinical staff in ways that relate to their everyday roles. All the participants in the system need to find a way of explaining the ambitions for the service in ways that are truly engaging. This work suggests that conversations need to start with how to improve services for patients.

Measurement and assessment. Feedback and measurement are key themes in most of our interviews and many of the policy recommendations are dependent on much better data systems and a culture of collecting and using information. One of the key design principles in chapter 2 is that there should be a focus on measuring the right things. As noted above, without this the ambition of developing a truly patient-centred service will be impossible to achieve. It is clear that a substantial improvement is required in the systems for collecting data about outcomes and activity. The experience of the cardiothoracic surgery audit and Intensive Care National Audit (ICNARC) suggests that high-quality data is most likely to be collected when clinicians take responsibility for this within a nationally defined set of definitions.

At the front line

This work suggests that there are some significant opportunities for doctors to seize the initiative in a number of areas and that doing so would have major benefits for patients. In a number of cases it is a matter of continuing with a direction that is already well established.

Professionalism. As noted in chapter 2, many of the values in the Royal College of Physicians’ *Doctors in Society* report were supported but more needs to be done to ensure that they are enacted. Some doctors told us that there has been huge progress in the last decade but that a number of their colleagues have some way to go in terms of:

- team working
- recognising the importance of the financial implications of clinical decisions
- adapting to the demands of a new relationship with patients which is likely to include much more shared decision making, longer consultations and a significant change in the balance of power (see appendix 2).

A culture of complaining. A number of our interviewees commented on the tendency of many people in the NHS, particularly doctors, to talk it down and to derive great satisfaction from telling stories that reflect badly on it. Some of this is born of frustration and an inability to influence the system. Part of this could be addressed by helping clinicians deal with some of the issues that frustrate them (resulting from poorly designed systems) and this is considered later in this chapter. However, several of our interviewees felt that some of this behaviour was
unprofessional and should be challenged, although clearly it is important to recognise that staff have the right to express their views.

**Relationships with colleagues and building teams.** This raises the interesting question about who are considered to be colleagues and part of the team. Further work is required to develop a team-based approach in the NHS generally and our work suggests that this would pay significant dividends for patients, staff and organisations. The Royal College of Surgeons recommends that all clinicians should be taught team working skills. Its *Professionalism* report and the GMC’s *Management for Doctors* make a number of similar recommendations on this. Psychiatrists and care of the elderly physicians have been working in multi-disciplinary and multi-agency teams for over 20 years now and much could be learnt from their experience.

The ability to give and receive feedback is an important part of improvement and our participants thought that more needed to be done to develop this. In particular, an issue that recurred is the need to challenge poor behaviour, bad practice or management and how difficult this is, particularly when it is another doctor that is responsible. More of this is needed but training and support is also required. Failure to challenge bad behaviour undermines the values of the team and the organisation and makes other change harder to achieve.

**Variation and waste.** Many of the doctors saw a key part of their role to be reducing waste and eliminating variation that is not the result of the characteristics or preferences of the patient. Pathways and guidelines have some role in this but a number of our respondents pointed out that they need to be used with caution and that it is possible to standardise too much and create systems that get in the way of effective practice. As with systems thinking and design, there are some tools and techniques that will need to be learnt, although an increasing number of doctors are familiar with these techniques.

**Working in different settings.** A number of our discussions involved models in which doctors, particularly hospital specialists, will increasingly be working outside the hospital. This brings some new challenges and some adjustment, but those we spoke to said it has some very refreshing positive aspects too.

**New skills.** The ability to design systems, to solve the problems of complex systems and to use methods to ensure that the right care is delivered in the most effective way are key skills. Most doctors are not taught them formally, although they receive training in a number of analogous disciplines as part of their medical training.

Programmes such as OSPREY that teach system design and improvement skills to doctors clearly have a lot to offer, but there are limited places. Consideration should be given to a major expansion of these programmes and to incorporating some of the key concepts into post graduate training more generally.

**Leadership.** The importance of the doctor as a leader and, where appropriate, a follower, has been well rehearsed elsewhere but it is clear that there is more to do. An important insight is that many of the doctors who have been changing their services are not necessarily in formal leadership positions but have used leadership and management skills as part of their day-to-day role as doctors. The GMC’s
position that there is an important managerial component in most doctors’ roles was supported in our discussions. This means that it may be necessary to give more support and training to doctors to assist in making the most of this part of their role, particularly where they are working in highly complex organisations or systems.

Box 1: Views on clinical leadership from the workshops

Doctor leaders:
- undertake training in service improvement and master the hard, analytic and technical skills of measurement and monitoring and the use of communications and other soft skills that leaders require to change their own and others’ behaviours
- have the authority to act
- are properly rewarded for taking on management roles and responsibilities
- are supported in their role, particularly in dealing with difficult situations
- have an established and respected career
- do not tolerate bullying
- do not allow arguments about variation between patients to stand in the way of standardising care that should be standardised
- provide support for innovators
- keep the organisation focused on patients’ needs.

Appraisal and feedback. Major changes in the regulation of the medical profession are underway. Regular appraisal is already in place for most doctors and this will be expanded to provide data on which to base revalidation and recertification. Such developments should provide the opportunity for valuable feedback about clinical practice and for reflective learning. However, it is clear that for such a system to be effective, doctors must have confidence in the information provided to support the process. Appraisal is still in the early stages of development and it is clear that continued effort is needed to ensure that meaningful appraisal takes place.

The organisation and local system

The design rules have a number of important implications for organisations and local systems.

Designing systems. We found many examples where doctors had carefully designed and well-functioning services that worked very well for patients until it was necessary to encounter the wider organisation, which was often much less well organised. There were huge benefits where trusts and PCTs had invested time and effort in designing efficient support services, high-quality flows of information and responsive diagnostic and other clinical support. It is particularly challenging to design services that will meet the needs of a diverse range of clinical departments, each with its own schedule and list of often incompatible requirements. Investment in the time, skills and support to engage in this activity, which many clinicians are good at, is required.

Tools for the job. Although some of the unhelpfulness of the wider system can be attributed to the genuine difficulty of designing complex services to meet multiple needs, this is not always the case. More attention needs to be given to some of the basic systems required to ensure that clinicians have the tools to do the job, for example, having all the notes for patients available in outpatient clinics. This is also significant, given the danger of creating an impression that staff are not valued, or of incompetence, or both.

Managerial support. As noted above many doctors we spoke to were pleased with the managerial support they receive on a day-to-day basis but there was a general view that they need
more help in this area, particularly when changes are being planned or implemented. Others were less happy and there was a view that more attention should be given to the quality of management, in particular in the middle layers. This is the subject of a separate study by the Confederation that will suggest that the problem is only partly about the quality of the individuals and also has systemic causes. Doctors also wanted managers to do more to stand up to poorly thought-through policy ideas and top down direction and there was concern about the perceived culture of bullying in some parts of NHS management. The need for managers to be less risk averse and process driven (also a defence against risk) is important.

Responsibility and control. A key area is the need to create an environment in which clinicians have as much control over the organisation of their work and environment as possible. Clearly there is some tension with the needs of the wider organisation and trade-offs between different groups of clinicians who need to work together in a co-ordinated way. One example of this is the concern about the loss of the ability to choose to which clinician to refer a patient. Partly this has symbolic significance, but it is also important practically in terms of ensuring that the patient gets to the most appropriate person.

Support to innovators. The doctors we talked to thought that organisations should be more willing to provide support to innovators in terms of time, resources and help overcoming obstacles. Many organisations were seen as being too risk averse. Boards need to review their approach to risk and innovation and how frontline clinicians and middle managers can be given more space to take risks.

Relationships between primary and secondary care. There was general concern that primary and secondary care had become more estranged over the last few years and that this was to the detriment of both, and potentially harmful to patients. Organisations and local systems need to find ways to encourage a more productive way of working that allows a free flow of information and collaboration in the management of patients, particularly those with complex or multi morbidity. The language of shifting work from one sector to another may be less helpful than ideas of designing new pathways, which may have the same result, but avoid perpetuating the idea that the two domains are not intimately connected.

National medical leadership

National medical leaders. There is an important role for national clinical leaders, in particular to reinforce the message that individual doctors have a significant part of the solution in their hands. They also have a key role in defining of what professional behaviour looks like and helping to deal with obstacles to this at national and local level.

Doctors traditionally look to representative organisations, such as the BMA, to reflect their views in discussions at national level. However, the BMA is also a trade union and these two roles may sometimes be challenging to resolve. Leadership of a different sort is provided by the medical royal colleges. It sees its role as providing advice on standards and education. Individual leaders in all of these organisations are elected rather than appointed to office. Its capacity for effective national leadership is therefore variable. It would be valuable to provide a system of induction for individuals in these roles so that they share a common understanding of the national systems with which they have to interact.

Very few doctors are involved in national policy within policy making organisations, as opposed to providing a professional organisation input. Sessional secondments to DH, National Institute for Mental Health in England (NIMHE), Health and Social Care Advisory Service (HASCAS), Healthcare Commission (HCC) and other national policy and regulatory organisations would enable doctors to
 bring a perspective into their workplace and into helpful policy organisation. The recent appointment of a national medical director could provide an impetus for this sort of initiative.

National policy-making

A number of significant changes need to be addressed in the way that national policy-making is approached, the assumptions that underpin it and the way it is implemented.

Integration and continuity matter. Policy should avoid fragmentation. The design rules in chapter 2 strongly suggest that more needs to be done to support integration and continuity for those clinical areas where it is important. The implication is that, while the market reforms are appropriate for elective surgery and other treatment where there is less need for continuity, some modification of the approach is required to fit the reforms to the clinical model for long-term conditions and other areas where continuity matters. The importance of integrated electronic records in achieving better integration cannot be understated and the obstacles to implementing this will need to be overcome if this objective is to be achieved.

None of the doctors we interviewed made recommendations for structural changes in the NHS, in fact those who mentioned reorganisation deplored the effect of previous attempts. However, they were concerned by some of the barriers created by the divisions between primary and secondary care and between health and social care which were seen as largely irrelevant to patients and a source of inefficiency, delay and poor communication. This implies that policy should be much more concerned about creating well-designed integrated services and using modern technology that are convenient to use, rather than trying to shift work from one administrative category to another. This, in turn, has implications for the design of the payment by results (PbR) system.

Networks require more attention and support. A number of clinical models for the more complex conditions, for emergency care, cancer and a number of other specialist areas, require further development. Clinicians appreciate the advantages of a well-organised efficient system, within which each participant has a well-defined role, meaning that patients are offered care that is most appropriate for them with the minimum of bureaucratic interference and unnecessary delay. However, the development of clinical networks may be hampered by the principle of contestability. This apparent dichotomy needs to be resolved. Practical and imaginative solutions can often be devised at local level. What is needed is a clear national statement that such developments are welcome, alongside policies in place to support their effective operation.

Ensure policy supports doing the right thing. The design rule we identified states that reform mechanisms should promote doing the right thing for the patient. This is closely related to the point above about avoiding fragmentation and promoting integration. One significant area that needs to be reviewed is the design of the PbR system so that there are fewer disincentives for hospital doctors to design models that reduce admissions or outpatient attendances. At present the fact that costs fall less quickly than income has the potential for innovation of this sort to cause problems for hospitals who find they are losing work and have few options for increasing income from elsewhere.

Pay much more attention to implementation issues. One of the most significant issues that emerged from our discussions with doctors was about the implementation of policy, including ensuring that there is sufficient time for change to be made and that implementation is considered in the design of policy. The design rules on change management that we discussed in chapter 2 could form the basis of an approach to some types of change that would be more likely
to produce change that is supported by clinicians and which would work for patients.

**Involvement.** The lack of involvement of doctors in policy-making was a common theme in our discussions. Where there is involvement there was some doubt about whether there is sufficient attention given to the views of the profession. There was a strong view that national policy-makers need to do better in this area. Similarly, if doctors are to become more involved in policy-making they will need to articulate a positive vision rather than focusing on current problems.

**Unresolved issues**

Some implications of the design rules do not so easily translate into policy recommendations.

**Workforce.** We did not explicitly address the issue of the future of shape of the medical workforce in our discussions as this is the subject of other joint work between the Confederation, NHS Employers and the JMCC. The design rules outlined in chapter 2 suggest that there needs to be an increased availability of generalist skills and earlier availability of expert diagnostic advice. The workforce that could deliver this could be organised in a large number of ways. The options for change and redesign of the workforce are being considered in a number of forums, but the need for the NHS to articulate a much clearer view of the shape of the workforce (particularly doctors) is becoming urgent. Following our design rules the redesign of the workforce needs to be based on the needs of the patient and the creation of effective teams, rather than the enhancement of roles and the promotion of particular professional roles.

**Human scale.** We detected a theme in a number of our discussions that suggested a strong preference for organisations that work on a scale that is small enough to allow the development of high-quality relationships. Buildings, environments and work programmes that allow people time to interact, exchange information in a confidential setting and develop some mutual understanding came up in discussions a number of times. One doctor said: “It is easier to be disrespectful and unhelpful to someone you don’t know on another site or in a distant part of a huge campus than to someone you might see in the canteen or in a long corridor from which there is no escape.”

**Being part of an organisation.** The requirement for more care to be delivered on a network basis and the desire for a human scale organisation raises some unresolved questions about the relationship between doctors and hospitals. Experience from US not-for-profit organisations (Best 2006) also suggests that exclusive relationships with employed doctors is the most effective way to ensure clinical engagement in quality, improvement and leadership. Further work is needed on how to get the best of both of these apparently incompatible positions.

**The role of the independent sector.** This did not emerge as a very significant issue in our discussions with doctors. There was some anxiety about the potentially adverse consequences of poorly planned independent sector involvement that is reflected in the BMA document. However, this seemed to be more related to the way that the policy had been implemented rather than the use of independent sector providers per se.

**Difficult trade-offs.** A number of trade-offs are required where the design rules or aspects of current policy are not fully compatible. There is no neat solution to these but our work suggests that it would be helpful if they were more explicitly acknowledged. Some of the doctors we discussed this with thought that the failure to do this was part of a general failure to listen by policy-makers. Trade-offs include:

- integration and networks versus competition – there may be little chance of competition or contestability
• continuity versus choice – patients value both but how can we avoid fragmentation and a loss of continuity if there is choice of many different providers for parts of care? Is it possible to have a pathway specified by commissioners with different parts of it provided by a number of unconnected providers? Many of our respondents thought that this will be difficult.
• efficiency and convenience versus the need to follow up patients to be able to monitor outcomes.

Figure 1: Summary

- Time and space to do this
- Invest in measurement
- Ensure that there are many opportunities for feedback
- With the organisation
- With colleagues
- With patients
- Being valued by the organisation
- New approaches to change management
- Learn, teach and develop
- Purpose and values
- Patient centred
- Professionalism
- Quality
- Clarity of purpose
- Caring and compassionate
- Integrated and networked
- Team based
- Organised
- Pathways where appropriate
- Remove the obstacles
- Provide the tools to do the job
- Remove waste
- Value the time of patients and staff
- Continuous improvement
- Redefined relationships
- Create a system
Conclusions
It is very difficult to summarise the very rich ideas we have learnt from the people we interviewed and who participated in our discussion groups. There is also the danger that too many ideas in health policy are simplified in ways that remove the complexity that is necessary for them to be effective. The diagram on page 38 summarises the key themes that have emerged in the report and recommendations for action. The idea that this is based on a continuous process of improvement, measurement, feedback, redefinition and further striving to improve is key.

There are clear actions for Government in areas such as payment by results, policy on networks and the process of involvement where there is a need for a significant change in approach. Above all there is a need to check that policy does not make it hard to do the right thing for the patient. Box 2 (page 40) shows some of the key recommendations for policy-makers but there are even more action points for the rest of the system contained in the rest of this report. As we have noted, a significant number of the changes can be made with little government involvement. The question now is how to release the creativity of the clinical community, not just doctors, and enable them to change the way the system works.

The report raises some further questions to address:

- there is more to do to understand why the doctors we interviewed had made so many changes but many of their colleagues had not or found it very difficult
- we need to understand how to help middle managers become effective in supporting clinicians to make change
- measurement and feedback are crucial to achieving many of the goals identified in this document – what are the obstacles and priorities for action?
- what is the best way of involving clinicians in policy-making and other key decisions?
- how can networks operate effectively?

If the ability to change the system is largely in the hands of the people who run it, why have they not taken the opportunity? The answer is not a clinical engagement exercise but seems to lie in focusing on improving the quality of services and the experience of patients. The fact that many clinicians have taken the opportunity to create change means it can be done. There needs to be much more of this, and quickly. Failure to do this will have serious consequences for the NHS and its patients.
1. Review the shape of policies that may be undermining the development of well designed integrated care. Aspects of payment by results need attention, particularly in the area of long-term conditions. The policy obstacles to the development of networks need to be reviewed and ways found to foster their development, while not losing the advantages of choice, contestability and competition.

2. Make a clear statement of values and ensure that behaviour is congruent with them. This applies to politicians and leaders as well as doctors.

3. The general direction of giving organisations more autonomy has significant benefits, but clinicians are clear that they want to work in a system of organisations that work together rather than one that is just connected by contracts, and one that delivers the outcomes that patients want, that is good citizenship and social inclusion for housing and work.

4. The idea of a compact that defines the relationships between different parts of the system, for example between the NHS and Government, organisations in local health systems or doctors and their employers need to be developed as the basis for identifying how relationships can be improved. Giving staff appropriate control over their working life needs to be an important objective – it is now accepted that this is not a licence for idiosyncratic behaviour which hinders the adoption of practice that improves quality and safety.

5. Pay more attention to the process for policy making, the way it is explained, the evidence on which it is based, the mechanisms for involvement and the potential unintended consequences - in particular the symbolic content that may send powerful, unintended and unhelpful messages.

6. The split between primary and secondary care should increasingly be regarded as an artefact of how medicine was organised before the second world war. Policy should aim to create well-organised integrated care as locally as possible. Attention should be given to the growing rift between primary and secondary care and more done to encourage them to work in partnership. New models of joint working and shared responsibility and ways of dealing with the perverse incentives in the current system need to be found.

7. Put significant effort into the development of information and measurement systems for outcomes, key processes and patient experience that will help clinicians identify opportunities for learning and improvement. It is very important that Connecting for Health delivers but also that there is much more work involved than simply implementing new information systems.

8. There are a number of skills and approaches that doctors need to learn to be effective and to be able to make the changes needed in the systems around them. Training and education needs to be developed to meet these needs. This should be accompanied by a very significant investment in the development of clinical leadership.

9. There is a key role for national medical leaders to set the tone, help set out the vision and to promote the new vision of medical professionalism of the type found in The Royal College of Physicians’ *Doctors in Society*. 

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**Box 2: Summary of policy recommendations**

1. Review the shape of policies that may be undermining the development of well designed integrated care. Aspects of payment by results need attention, particularly in the area of long-term conditions. The policy obstacles to the development of networks need to be reviewed and ways found to foster their development, while not losing the advantages of choice, contestability and competition.

2. Make a clear statement of values and ensure that behaviour is congruent with them. This applies to politicians and leaders as well as doctors.

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Intensive Care National Audit (ICNARC) [www.icnarc.org](http://www.icnarc.org)


Appendix 1: Methodology

Approach

After some debate with our steering group and other advisers we agreed that the best approach was to use focus groups to consider the care that should be given to patients with common conditions. However, it became clear that the practical obstacles to assembling these groups and the potential to become lost in the detail of particular clinical conditions was significant. A focus group approach was used to examine elective surgery, emergency medicine and general practice but we found that interviews with individual clinicians produced a much richer and more wide-ranging discussion of the issues. It also proved easier to get individuals to describe their vision rather than create it in groups.

Potential interviewees were identified by asking chief executives, medical directors, members of our steering group and the wider membership of the JMCC and the Royal Colleges to nominate doctors they thought had interesting ideas or practical experience that would shed light on our research question.

One obvious question and criticism of this work could be why it just concentrates on doctors, and does not include other staff groups and patients? The reasons for this were partly pragmatic because of the limited resources available for the project and because the main medical leadership bodies were involved. It was also thought that this group needs to be most engaged with defining how the NHS should be improved. We took the view that there is already a very large amount of research material on what patients and the public want from the NHS and this evidence is reviewed by Angela Coulter in appendix 2. Furthermore, it was also clear that the group that has had the most difficulty with some of the reforms and the least likely to be actively involved has been the medical profession. We considered that the view of doctors would be a useful starting point for a discussion and in fact representatives of other professions sat on our steering group and were members of some of the focus and discussion groups.

Interviewees were asked to describe in very practical terms what they thought it would be like to practice medicine in a system that had been reformed, or to describe how they had created their own service and how it differed from more traditional models. Key areas of enquiry included the following:

- what kinds of changes would you like to see in services for patients?
- what would be different to current practice?
- what would it feel like to work in such changed services?
- how, if at all, would relationships with patients be different?
- how, if at all, would relationships between staff be different?
- what would remain the same as current practice?

From these interviews we extracted a number of common themes about how the services had been designed, their interaction with other parts of the healthcare system, the process of change and the other lessons that could be drawn from the experience. In addition, we were able to use a number of large gatherings of doctors, managers and other professionals to test the emerging thinking and to suggest new design rules.
We drew on a considerable amount of previous thinking in this area, including work by:

- NHS Confederation and the Modernisation Agency
- The Royal College of Physicians (RCP) working group on acute medicine
- The RCP’s work on medical professionalism
- GMC guidance
- The Royal College of Surgeons’ recent report on team working
- The USA Institute of Medicine *Crossing the Quality Chasm*
- The Institute for Health Care Improvement in the USA.
- Healthcare for London: a framework for action

These sources identified a number design rules drawn from the theory of operations research, quality improvement, safety and reliability, change management and from the empirical development of high-quality clinical services. These were also discussed with the interviewees and focus group participants.

The resulting design principles and policy implications were tested with our steering group, a wider group of clinical and non-clinical leaders, a group of clinical and medical directors from primary and secondary care brought together by BAMM and a group of over 20 GPs participating in the RCGP leadership programme. This detailed review of our results added significantly to the richness of the findings. The draft report was extensively tested with members of a steering group and a number of other doctors who generously gave us their time to review our work.
Appendix 2: What do patients and the public want from healthcare?

Angela Coulter, Picker Institute Europe

Introduction

Public expectations are frequently presented as a major problem for health systems. Patients are seen as demanding, often unrealistic, and much less willing than previously to place their trust in health professionals. The spectre of inexorably rising expectations leading to impossible demands on health systems and unmanageable burdens on healthcare professionals instils fear, but how true is this picture? Are people’s expectations really that unreasonable? Are they more critical of health professionals than they used to be? What is it that they want?

The Picker Institute has spent many years researching patients’ needs, expectations and experiences. Distilling the knowledge from these studies has led us to summarise what patients want in terms of eight dimensions of patient-centred care (see box 1).

This appendix considers these aspirations in more detail and looks at how service delivery currently matches up. However, first it is important to recognise a distinction between the views of citizens and those of patients.

Patients and citizens look at things differently

What we want as individual patients and how we articulate these needs can be very different from our collective aspirations as citizens or members of the public. The eight areas of importance that patients identify (see box 1) are related less to collective experience and more to the individual, personal experience of receiving treatment and care.

Box 1: What patients want

- Fast access to reliable health advice
- Effective treatment delivered by trusted professionals
- Participation in decisions and respect for preferences
- Clear, comprehensible information and support for self-care
- Attention to physical and environmental needs
- Emotional support, empathy and respect
- Involvement of, and support for family and carers
- Continuity of care and smooth transitions

By contrast, as citizens we may be concerned about more abstract notions of what constitutes a ‘good’ service, for example:

- affordability – free at the point of care
- universality and equity
- safety and quality
- health protection, disease prevention.

As patients, we do not lose our citizen concerns at the door of the GP surgery or the hospital, but we do prioritise our own interaction with the system and especially with the health professionals who deliver our care.

Patients tend to be much more positive about the NHS than the population as a whole, with larger
majorities of recent patients agreeing that the NHS provides a good service, is improving, and is as good as health services abroad. For example, national patient surveys in the last five years show clear evidence of waiting times coming down – for GP appointments, hospital appointments and hospital admissions – while this is less likely to be believed by the public.¹

This dysjunction between patients’ and citizens’ views is a paradox that takes some explaining. Some authors have suggested that public opinion polls of the NHS tap into more general views on the Government of the day and are strongly related to fluctuating political opinions.² Others have highlighted the influence of the media and the effect of negative attitudes among NHS staff that may contribute to the worsening public image.³ If the media, encouraged by public service unions such as the BMA, the RCN and Unison, supply a constant flow of critical stories, patients who have had relatively good experiences may feel they have just been luckier than others. In fact, patients mostly report high levels of satisfaction although they may be critical of particular aspects of their care.

Access, choice and continuity

Waiting times in primary and secondary care
The NHS was founded on the principle of equal access to all on the basis of need rather than the ability to pay. Since its creation, however, the service has been plagued by problems of access. Most attention has focused on long waits for elective procedures, and this problem, which once appeared intractable, now seems to be under control. Waiting times have improved dramatically since 2002, including waits to see GPs and hospital consultants and to be admitted to hospital. In 2006 77% of patients said they were seen by a GP as soon as necessary – up from 58% in 2004.⁴ Almost no patients are now waiting longer than nine months for planned hospital admission and in some parts of the country the service is well on its way to achieving the ambitious 18-week target and the four hour wait target for emergency access.

However, the ending of Saturday morning surgeries in the majority of general practices has led to increased dissatisfaction with primary care access arrangements and a growing demand for more flexible opening hours.⁵ Patients would like surgeries to offer both immediate and advance appointments to see a GP, but refusal in some practices to offer advance appointments has been a perverse consequence of government targets to guarantee access to all patients within 48 hours.⁶

New ways of accessing health advice
There is growing interest among patients for alternative sources of healthcare advice.⁷ For example, a national evaluation of the first wave of NHS walk-in centres found that patients valued the speed of access and convenience of the location and opening hours.⁸ Almost four out of five people attending walk-in centres were very satisfied with the service they received, and 97% said they would probably or definitely use the service again. Similarly high levels of user satisfaction have been reported for the NHS Direct telephone helpline.⁹

Varying the skill mix in the primary care workforce has the potential to relieve some of the pressure on GPs, increase capacity and improve patients’ access to care. While scepticism has been expressed about whether patients would accept alternatives to GP consultation, studies have shown that patients are willing to be seen and treated by nurses or other healthcare practitioners, and are often more satisfied with the care they receive from them.¹⁰

There is considerable interest among some patients for electronic communication with health professionals, including receiving health information and advice via email. Trials of email consultations in the UK have shown high levels of patient satisfaction,¹¹ but email communication is available in very few practices at present. A recent analysis of data from the Commonwealth Fund’s international health policy surveys found
considerable variation in the proportion of patients saying they could communicate with their doctor by email, ranging from 16% in the UK to 27% in New Zealand. There appears to be a largely unmet demand for this facility: 40% of UK patients expressed a desire for email communication with their doctor.

Inequalities in access
An even more significant access problem is a general trend referred to as the ‘inverse care law’, whereby availability and utilisation of services is lowest among those with the greatest need. When measured against their respective needs for healthcare, affluent groups tend to make the greatest and most efficient use of services. Other groups sometimes face barriers to accessing appropriate healthcare, including ethnic minorities, asylum seekers and new migrants, homeless people, prisoners, rural residents, and people with physical and learning disabilities.

For each of these groups, there is often a complex and dynamic interplay of factors accounting for their relatively poor access to health services. For example, rural populations experience higher levels of geographical isolation and a lack of public transport, the effects of which are exacerbated by the increasing centralisation of services. It is also sometimes difficult to recruit and retain doctors in remote rural areas, in part due to concerns about social isolation and excessive out-of-hours duties.

Ethnic minority communities can face barriers due to language problems or lack of familiarity with services, but may also be less likely to initiate or receive healthcare if it is not sensitive to their cultural and religious needs. However, patterns of use among ethnic minority groups do not straightforwardly indicate a problem of under-utilisation; over-use of primary and emergency care services has also been documented. The reasons for this are not fully understood, but possible explanations are that ethnic minority patients are not always appropriately referred to specialist care, that they are less active or effective self-carers, or that they are more demanding because of greater health needs and/or higher service expectations.

Patient choice
Many patients feel they should be able to choose who to consult or where and when to be treated. Studies of patients offered a choice while on the waiting list for elective surgery have demonstrated that the offer of a choice of treatment location is popular. Patients can and do make choices, often weighing up a complex combination of factors to arrive at the decision that feels best for them. They have to consider factors such as their present health status and symptoms, impact on employment and activities of daily living, length of wait, travel arrangements, convenience for family and friends, and where they will receive the best treatment and care. Most need support in making the decision, in the form of help with practical arrangements and reliable information, especially about the quality of care in the different hospitals.

Having a choice may be popular, but the leading priority among the majority of patients and the public is to have access to good local services everywhere.

Continuity
The heaviest users of primary care services – older people and those with chronic conditions – tend to place particular value on continuity of care from professionals they know. Younger patients, commuters and those with urgent needs are more willing to trade continuity for faster access to alternative primary care services. Continuity and co-ordination are especially important for some groups of service users. For example, the need for better community support for carers and for people with long-term mental health problems are perennial themes in patient surveys.

Despite the apparent popularity of walk-in centres, there is little evidence of a desire to dismantle the registered list system in general practice. While they may not express it this way, the concept of a
familiar ‘medical home’ provides a sense of security that is important to many patients. Some may want freer access to hospital-based specialists.

Continuity of care is important to patients but it is a more complex concept than is often assumed. It can be defined as the experience of a co-ordinated and smooth progression of care, but this can be provided by more than one person or organisation. It requires excellent information transfer, effective communication between professionals and with patients, responsiveness to individuals’ changing needs, care from as few professionals as possible consistent with other needs, and named individual professionals with a co-ordinating role and with whom the patient can establish and maintain a relationship.23

Information, education and support for self-care

Self-care
It is often forgotten that most healthcare, perhaps as much as 85%, is self-care.44 In looking after themselves and their family members lay people provide a far greater quantity of healthcare than do health professionals. Hannay used the metaphor of an iceberg to illustrate the point that health professionals, even those working in ‘first contact’ care such as general practice, see only a small fraction of the afflictions that could potentially trigger a consultation.45 Self-care also incorporates the actions that people take to prevent ill health, for example avoiding unhealthy behaviours and adopting healthy ones.

There is much enthusiasm for the concept of ‘expert patients’, people who are proactive managers of their chronic conditions. Patient organisations have been at the forefront of efforts to get self-management recognised as a key component of healthcare. For example, the Long Term Conditions Alliance (LTCA), a coalition of patients’ organisations in the UK, piloted the Californian self-management education

programmes that led to the establishment of the Expert Patient Programme by the DH.

In a recent survey of people with long-term health conditions, 90% reported interest in playing a greater role in treating minor ailments, and 87% were interested in more actively managing their chronic condition.26 Another study found that patients were extremely positive about plans to introduce patient-accessible electronic medical records.27 Importantly, patients are more willing and motivated to assume responsibility for aspects of their care, such as managing their medication regimes, when they feel assured that professional support is available to them if they need it.28

The type and level of support needed by patients who are self-managing chronic health problems depends on the individual’s knowledge, confidence and skills, and these are highly variable.29

Health literacy and information provision
The ability of patients to play an active role in protecting and improving their own health depends on their level of health literacy. Health literacy has been defined as “the ability to make sound health decisions in the context of everyday life – at home, in the community, at the workplace, the healthcare system, the market place and the political arena”.30 The term encompasses basic health knowledge; the ability to read, comprehend and evaluate health information; the capacity to apply health preventing, promoting and self-care behaviours; the confidence to communicate effectively with health professionals; and making appropriate decisions about illness and treatment. Inadequate health literacy can have profound health and financial consequences.31–33 Studies have found that patients with low health literacy:

- have poorer health status
- are at greater risk of hospitalisation and have longer hospital visits
- have higher rates of admission to emergency services
• are less likely to adhere to prescribed treatments and self-care plans
• have more medication and treatment errors
• have less knowledge of disease management and health-promoting behaviours
• have decreased ability to communicate with healthcare professionals and share in decision-making
• are less able to make appropriate health decisions
• make less use of preventive services
• incur substantially higher healthcare costs.

Reviewing the evidence, the American Medical Association concluded that health literacy is a stronger predictor of health status than age, income, employment status, education level, race or ethnic group.33

**Information therapy**

Studies indicate that most patients want more information than they currently receive and that health professionals frequently overestimate the amount of information they supply.34 Information needs are shaped by demographic characteristics including age, gender and socio-economic status, as well as the patient’s particular circumstances, beliefs, preferences and styles of coping.35 There are also important differences due to patients’ skills and abilities, with particular needs arising from low literacy, auditory/visual impairment and non-English speaking.

The type of information that is sought by an individual patient is likely to change during the course of their illness.36 In the initial stages following diagnosis, there is a preference for practical information to support care decisions, including information on treatment options and their likely outcomes. More in-depth and specific information needs emerge later, when the patient’s focus often turns to issues of self-care and long-term prognosis.

Research points to the importance of tailoring information to patients’ needs and characteristics. In comparison to general information, personalised materials tend to produce better health and service-related outcomes and are more highly valued by patients themselves.37 38 Computer-based systems are one means by which a tailored approach to consumer health information provision may be achieved, using the patient’s medical record.

**The clinical encounter**

**Communication**

Patients want to consult healthcare professionals who are good communicators, with sound, up-to-date clinical knowledge and skills, who are interested and sympathetic, involve them in decisions, give them sufficient time and attention and provide advice on health promotion and self-care.39 A systematic review of the literature on patients’ priorities for general practice care, which examined 19 studies published between 1966 and 1995, found that the most important factor was ‘humaneness’, which ranked highest in 86% of studies that included this aspect. This was followed by ‘competence/accuracy’ (64%), ‘patients’ involvement in decisions’ (63%), and ‘time for care’ (60%).40

Most patients give very positive reports of the communication skills of their doctors, although younger people tend to be more critical than those who are older. More than 80% of respondents in a 2004 national population survey said their GP usually gives them sufficient time, listens to them carefully and provides clear explanations of their treatment.41 However, communication failures are still the most frequent source of patient dissatisfaction and complaints and sometimes patients are dealt with in a paternalistic and even patronising manner. One of the most common problems is the failure to recognise that many patients want to play an active role in decision-making.
Involving patients in treatment decisions

The traditional model of decision-making assumed that doctors and patients shared the same goals, that only the doctor was sufficiently informed and experienced to decide what should be done, and that patient involvement should be confined to giving or withholding consent to treatment. This approach now seems seriously outdated. Many, if not most, patients nowadays expect to be given information about their condition and the treatment options, and they want clinicians to take account of their preferences. Some expect to go further: to be actively engaged in the decision-making process, or even to take the decisions themselves.

Shared decision-making has been defined as “a process in which patients are involved as active partners with the clinician in clarifying acceptable medical options and in choosing a preferred course of clinical care”. When choosing a treatment or preventive procedure the aim is to select options that increase the likelihood of desired health outcomes and minimise the chance of undesired consequences. In modern clinical practice there are often multiple options for treating a problem and these decisions are sometimes ‘close calls’, i.e. the benefit/harm ratios are uncertain or marginal. In these circumstances the best choice depends on how an individual patient values the potential benefits and harms of the alternatives. In shared decision-making the intention is that both the process of decision-making and the outcome – the treatment decision – will be shared.

Patients cannot express informed preferences unless they are given sufficient and appropriate information, including detailed explanations about their condition and the likely outcomes with and without treatment. Decision aids designed especially for this purpose have been shown to facilitate clinical decision-making in ways that benefit both patients and clinicians. They can also be highly cost-effective.

Some have argued that the desire for greater involvement is restricted to a minority group of young, white, middle class patients, but the evidence does not support this. The desire for participation has been found to vary according to age, educational status and disease severity, but these factors explain only part of the variance. The only way to find out patients’ preferred role is to ask them, but their responses may be influenced by previous experiences. Some patients may assume a passive role because they have never been encouraged to participate and remain unaware of alternatives.

The national patient surveys carried out among patients in NHS organisations in England consistently reveal gaps between patients’ desire for involvement and their experience. For example, 48% of respondents to the 2006 national adult inpatient survey indicated that they would have liked more involvement in decisions about their treatment and care, as did 31% of respondents to the 2006 primary care survey. Of those prescribed medicines in primary care, 45% would have liked more involvement in the choice of medication and 42% would have liked more information about medication side-effects.

Doctors in the UK appear to be more reluctant to involve patients than those in other developed countries. Two international population surveys carried out by the Commonwealth Fund in 2004 and 2005 asked patients if their doctor involved them in treatment decisions (figure 1 see page 50). Overall, only about half of the 8,000 or so respondents said they had been involved in decisions about their care. While the situation was not very good in any of the countries, the UK was significantly worse than the others with only about 40% of patients saying the doctor involved them and listened to their preferences. Indeed, these surveys suggest the UK is lagging significantly behind in efforts to engage patients more actively in their care. Patients in the UK were less likely to have been invited to take part in a review of their medicines or to have been given information about medicine side-effects than patients in the other countries. British patients
were given less help to cope with recovery and rehabilitation and fewer than one in five patients with chronic conditions had been given a self-management plan. The UK had the highest smoking rates of the six countries, the heaviest alcohol consumption, and the second worst record on obesity (after the USA). British patients were the least likely to report that their doctor had given them advice on preventing ill health.

Building partnerships

Patients’ expectations are changing, but it is important to see this as an opportunity rather than a threat. The changes we see in patients’ expectations are mirrored by changes in other aspects of everyday life. Consumerism is becoming a more powerful force – it will not go away. Paternalistic approaches will be less readily tolerated in future, and health professionals may find they need to devote far more time to explaining and negotiating, but the rewards of a more equal partnership could be greater understanding, more shared responsibility and more appropriate and effective healthcare.

What most patients and citizens want is the security of knowing that health services will be there when they need them, that their views and preferences will be taken account of by health professionals, that they will be given the help they need to help themselves, that they can access reliable information about their condition and the treatment options, and that they won’t have to worry about the financial consequences of being ill. They also want health professionals to show that they understand what it feels like to experience illness and undergo treatment, to anticipate their needs for information and support, and to treat them in a kind and dignified manner.
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A clinical vision of a reformed NHS

For some time, The NHS Confederation has been arguing that it is not always clear to frontline staff what the Government’s wide-ranging NHS reform programme is trying to achieve. Clinicians in particular have been unhappy about some of the reforms and about their insufficient involvement.

With the Joint Consultants’ Committee (now the Joint Medical Consultative Council) we asked doctors for their vision of practising in a reformed NHS. This report tells their stories, sets out a number of design rules for providing high-quality services and looks at what doctors, managers, medical leaders and policy-makers need to do.

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