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The Royal College of General Practitioners

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31 March 1988

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The Right Honourable Margaret Thatcher MP
Prime Minister
10 Downing Street
London SW1A 2AA

Dear Prime Minister,

Thank you again for inviting me to join you on Sunday 27 March for your review of the National Health Service. It was a great pleasure amd privilege to work with you and I very much appreciated the chance of coming to Chequers.

I did not feel I answered clearly several points about general practice about which you were asking, and I was grateful to you for making it clear that you would welcome letters afterwards.

INTRODUCTION

Professor Sir John Butterfield in his introduction spoke about the mass of medical problems in the community. These are handled mainly by general practitioners who deal with 90 per cent of medical problems and refer about 10 per cent to hospital. In my own practice we refer 4 to 5 per cent; half of the conditions we do send to hospital are for routine surgery.

As you know, 97 per cent of the population are registered with general practitioners and we think this is the most widely used public service. Since there are 225 million consultations each year between patients and family doctors, the average is as many as four consultations per patient per year. Of all the professions, we have the greatest face to face contact with the British population.

At present general practitioners are already looking after over 90 per cent of all patients with asthma, high blood pressure, chest infections, middle ear infections, arthritis, and with depression.

The great majority of patients with diabetes and thyroid disease and many other similar diseases are already being seen in general practice and cared for at home. We also see all the many problems of society such as drinking and British general practice leads the world in integrating the prevention of disease with treatment.

We are now ready to do more. We hope to save unnecessary referrals to hospital and to do much more of the follow-up of disease, which is often done more expensively in hospitals.

One of the reasons the National Health Service is so much more cost effective than many other Western countries is the considerable efficiency of general practice in containing this huge load of illness and saving it from being handled at greater cost in hospitals.

This "gate-keeper" function is likely to become increasingly important in the future. I hope therefore that cost-effectiveness will be a major topic for consideration in your review of the National Health Service.

CORRECTIONS

During the seminar some errors of fact were stated which need to corrected for your records.

1. Proportion of Government spending on the NHS

First, it was suggested that the proportion of the National Health Service budget spent on general practice was about half National Health Service spending. In fact, the actual proportion of the Health Service spent on family practitioner services is about 22 per cent and within this the proportion actually spent on general medical services represents about 7 per cent of the National Health Service.

Even after allowing for all the increase in resources and the improved development of general practice in the last few years the figures published by the Secretaries of State (1986) show that the entire cost of general practitioners' incomes, professional expenses including staff, drugs, telephones, medical equipment, postage and car allowances, and all professional expenses combined comes to £23 per patient per year.

This is the most cost-effective general practitioner service in the western world.

2. Career earnings

The second error was the statement that general practitioners were now as well paid as specialists. This is factually wrong.

The Review Body on Doctors' and Dentists' Remuneration can give you an authoritative statement for the relative career earnings and pensions received.

3. Education and research

May I also correct any misconception I may have given you about the need for education and research in family doctoring. As you

said, the initial period of training as a general practitioner in the National Health Service is now about nine years. My concern was in relation to the years after qualification and the need to help keep general practitioners up to date.

There is also a tremendous need for more research in general practice to find out the way diseases arise, what the various risk factors are and what the best way is of tackling them. We also need to research how best to do medical audit and the most efficient way to work.

We do now have some very exciting evidence that general practitioners can identify risk factors for the main killing diseases. One general practitioner, Dr Maurice Stone, has been able to reduce statistically significantly the number of patients with coronary thrombosis in his practice. If we can discover the best way of doing this in everyday general practices then we have a good basis for teaching the skills required and attacking the illness that causes the most adult deaths in Britain.

NUMBER OF PATIENTS PER DOCTOR

You asked about the average number of patients per general practitioner.

The average number of Health Service patients per general practitioner in England and Wales is now 2,011 and has fallen from 2,275 in 1977.

ACHIEVEMENTS

You asked what gains had been achieved in return for this important investment. In summary they are:

1 Early discharge from hospital

You have spoken in the House about the considerable reduction in the number of days now spent in hospital - a measure of improved efficiency of the hospital service.

Obviously if patients are discharged home after an average of say 9 days instead of 12 days as previously, then the complications and problems arising between days 9 and 12 are now handled by general practitioners instead of hospital doctors.

2. Day care surgery

Day care surgery is another advance achieved by hospital doctors and is being used increasingly.

By definition, patients are at home the night after day care surgery, so again any complications or anxieties that arise in either the patient or his family leads to a call to the general practitioner.

3. The mentally ill and the mentally handicapped

During the last few years an unprecedented number of mentally handicapped and mentally ill patients have been discharged from long stay hospitals. Tens of thousands of these patients are now on the lists of general practitioners and their considerable needs for medical advice are being met outside hospital.

In Exeter we have closed two mental hospitals and my own general practice now includes a group of quite disturbed patients, including several schizophrenics, most of whom have been in mental hospitals for many years.

4. Demographic change

There has been a substantial increase in the number of the elderly in the population, especially the elderly elderly. Their care falls mainly to general practice.

Of the elderly:

93 per cent are at home in the care of general practitioners
4 per cent are in residential homes and private nursing homes also in the care of general practitoners
3 per cent remaining are in geriatric beds in hospitals under the care of geriatricians.

In addition:

40 per cent of all the over 75s live at home alone
33 per cent of all the over 75s have seen a general practitioner within 4 weeks

(General Household Survey, 1985)

You asked about home visiting and what problems old people have.

The figures for my own patients over the age of 75 are:

5 per cent have cancer
5 per cent have had a coronary thrombosis
5 per cent have had a stroke
5 per cent have dementia
5 per cent have diseases like thyroid failure and vitamin B12 deficiency which general practitioners can well diagnose and treat without referral to hospitals
10 per cent have cataracts
12 per cent have had arthritis bad enough to have had a joint already replaced
Another 12 per cent have arthritis in a form which requires treatment
12 per cent are depressed, a tenth of whom have suicidal thoughts or who at least feel that life is not worth living
30 per cent are deaf.

The average number of different medical problems per patient among the over 75s is six and the range is between one to ten.

5. Preventive medicine and health promotion

There has been a dramatic increase in the amount of personal preventive medicine and health promotion provided by general practitioners and their teams.

I enclose a photocopy showing the provision of cervical cytology for women in two adjacent health districts including my own as just one illustration of how one of your Government's present priorities is being implemented.

(Postgraduate Medical School, University of Exeter)

The figure shows the striking improvement in the performance of general practitioners. In 1979 they took less than half the cervical smears. However, they have increased the proportion in every year since, and for every cervical smear now taken outside general practice (in a hospital, family planning clinic, woman's welfare clinic or cytology clinic) general practitioners in this population of just under half a million now take four.

MEDICAL AUDIT

You spoke about the importance of medical audit and asked for solutions.

The experience of the Royal College of General Practitioners over about 12 years is that there are three main requirements:

1. Education

Education is needed in order to achieve a change in professional attitudes and to acquire the necessary skills. A local educational person is needed such as a local general practitioner tutor.

2. Information

A reorganization of records and data is needed in most practices. This usually means a microcomputer if it is to be done systematically. We greatly welcome the speech last year by the Secretary of State in which he said he planned to put a microcomputer on every general practitioner's desk.

3. Incentives

Worthwhile medical audit takes time. If it is to be encouraged incentives are required and certainly the removal of the many existing perverse incentives.

I enclose a short paper for you on medical audit in general practice.

VISIT TO MY PRACTICE

If when you are next passing through Exeter, perhaps on your way to Cornwall, I would be delighted if you could find about an hour to see a demonstration of medical audit in my general practice which I have been very keen to develop.

EVIDENCE TO YOUR REVIEW OF THE NHS

I would be very grateful if I could give evidence to you for your Review, either as an individual or on behalf of the Royal College of General Practitioners, as you prefer.

I would be very pleased to answer any enquiries or give you any further information you would like.

With best wishes

Yours sincerely

Denis Pereira Gray

Denis Pereira Gray

ENCLOSURES

1. Figure showing source of cervical smears
2. Paper on medical audit in general practice

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Royal College of General Practitioners (1987) The Front Line of the Health Service. Report from General Practice 25. London: RCGP.

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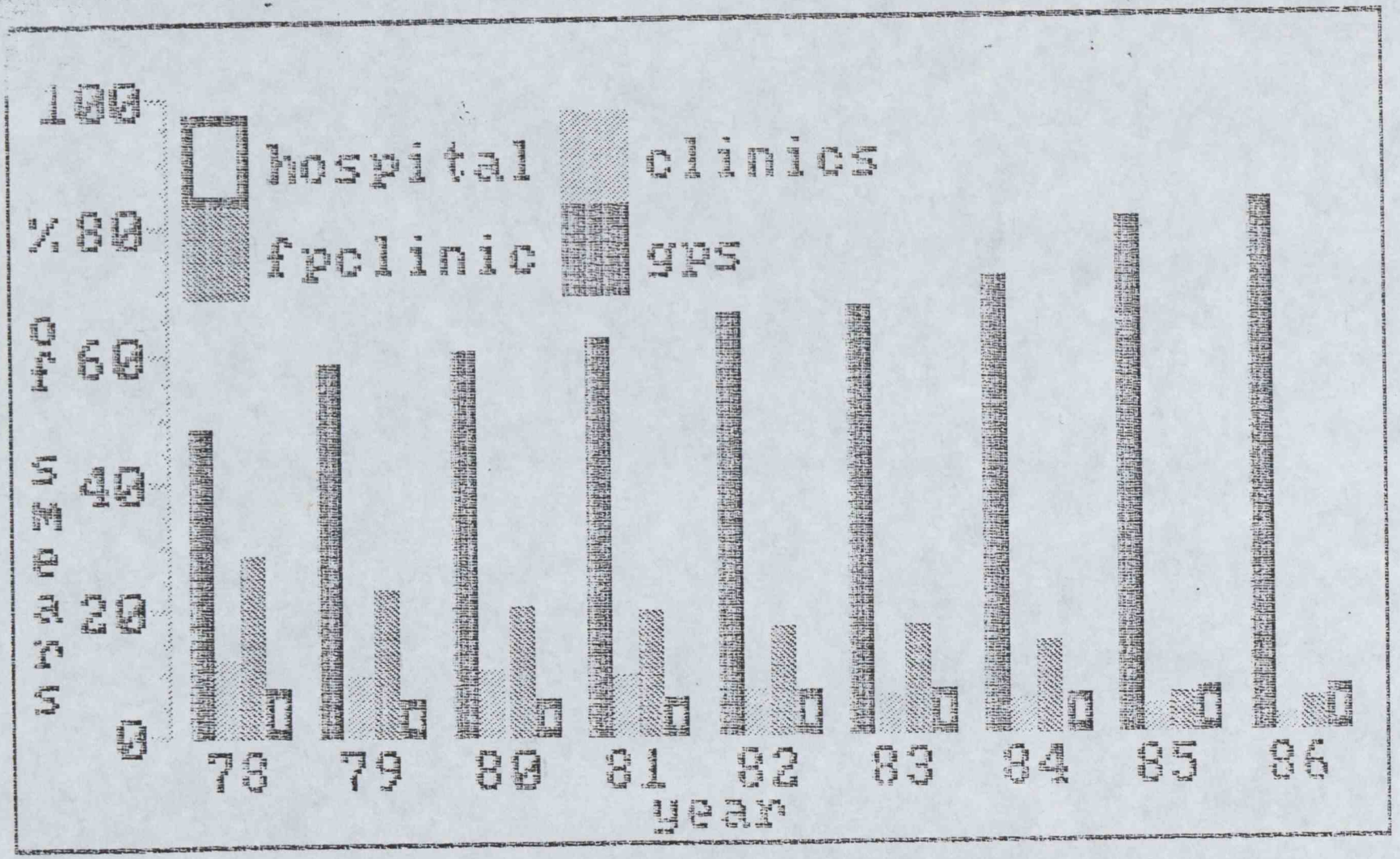
SOURCES OF CERVICAL SMEARS IN THE EXETER AND NORTH DEVON HEALTH DISTRICTS

Population involved = 431,635



Source: Postgraduate Medical School, University of Exeter
(Anthony and Kelly from Pathology Laboratory and Analysis from Department of General Practice)

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31st March, 1988.

The Right Hon. Margaret Thatcher,
Prime Minister,
10 Downing Street,
London SW1

Dear Mrs. Thatcher,

I thought you might like to read some good news about the National Health Service. **CENTRAL MIDDLESEX HOSPITAL** is a lovely, friendly hospital - the sort the National Health Service should be proud of. In addition, you will be pleased to hear, we are also very efficient financially and have controlled our previous overspending.

I enclose an article from last week's Nursing Times which outlines some of the changes at **CENTRAL MIDDLESEX HOSPITAL** which have resulted in there being very few vacancies.

I am convinced that our approach could be successful elsewhere, and I do feel that the general public should be aware that there are progressive and innovative hospitals in the country (even in an Inner City area like Brent!).

In addition, I would like to add that I have only been successful (and even appointed) as a result of the Griffiths Re-organisation. My Unit General Manager is extremely supportive and allows me the freedom to implement ideas. Life before was a very different story!

I hope you enjoy reading the article and, as it states, there is an awful lot more!

I would be pleased to hear your comments.

Yours sincerely,

Dave Brook
MBA, DMS, Dip.M., SRN, MBIM, A.Inst.M.,
Director of Inpatient Services.

DB/BK.

RECRUIT AND RETAIN

BROOKING NO OBSTACLES

Nurse managers must move with the times and look at daring initiatives to recruit and retain staff. Martin Vousden met the director of in-patient services of a London hospital who is not only brimming with novel ideas but puts them into practice

A 'bring and buy' sale, staff barbecue and quiz competition may not seem to have much to do with recruitment and retention but Dave Brook at the Central Middlesex Hospital will argue the point.

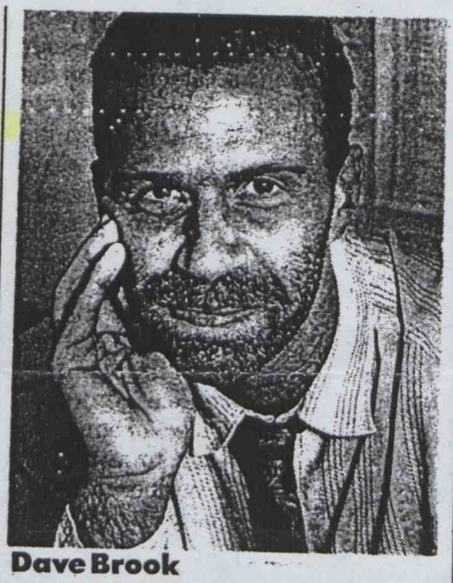
Mr Brook, director of in-patient services at the hospital, thinks that social and 'fun' events are as important to a workforce as other, more traditional management iniatives. He rejects what he calls 'nursey nursey' management, prefers everyone to call him by his first name and has introduced more changes in his year in post than many people manage in a career.

But he is not a flash whizzkid who dazzles to deceive — at least not if results are anything to go by. For example, when he took up post there were 60 trained nurse vacancies, now there are three. And this in a London hospital, supposedly among those worst hit by retention problems, which faces stern competition in recruitment from nearby industrial complexes!

'I want to get away from the old image of nurse managers because there are a lot of fuddy duddy people around who do not want to change', he says. 'I want to break down the idea of what a DNS is. I do not operate an "open door" policy because that's a fallacy. People cannot just drop in and see me, because I might not be there or I might be busy doing something else. But people can ring at any time and arrange to see me.'

One of his priorities was to bring his budget, which was overspent, under control; he is now underspent. A large part of the overspending was caused by the reliance of the hospital on agency staff.

'When I started here there was a policy that our nurses could work agency shifts at the hospital down the road but not here', he says. 'We changed the system so they could do agency work in their own hospital. After all, they know the place and are familiar with our way of working.'



Dave Brook

There used to be a nurse bank but the finance department could not cope with the fact that a nurse might work 20 hours one week and 30 the next.

Dave Brook tried to sort out the difficulties facing the finance department but could see no way round their problems, so he created his flexi-pool. This means that people are contracted to the hospital for a set number of hours a month. Then they get paid, like everyone else, at the end of each month for their contracted hours. But *when* they work the hours is open to negotiation between the nurse and the ward.

The nurse has the advantages of contracted employment, such as paid sick leave and *pro rata* annual leave, while the hospital has a happier, more flexible workforce that is familiar with the routine at the Central Middlesex.

In addition to the flexi-pool came flexi-time; a familiar concept in business, but less so in the health service. One of the ward sisters drew a profile of staff allocation in her ward which showed a big fall-off during the evening. She matched this to a profile of activity which showed that there needed to be less of a concentration of staff in the middle of the day, much of which was created by the four-hour staff overlap. The new system means staff are distributed more evenly across the day.

Dave Brook says: 'I felt we were stopping people coming into nursing by being so rigid and inflexible about working hours. So we decided to pilot flexi-time on one ward. I saw the unions and emphasised that it was voluntary and, obviously, the shifts that people wanted to work had to be agreed in advance. It started with people just shifting an hour or two at the beginning or end of their shift.'

In a short time, other wards wanted to adopt the same system and, in the process, voluntarily agreed to reduce the shift overlap from four hours to one. Any nurse manager who has tried, above the protests and outrage of nurses, to reduce the overlap by directive will no doubt be encouraged at the thought that such a reduction can be achieved, without an outbreak of civil war!

'All the wards have a core period that must be properly covered but then it's give and take around that', Dave Brook says. 'We did try to extend the scheme to night duty but that creates greater problems. Nevertheless, we will be trying again; at the moment we have one nurse who works from 7.00pm to midnight and it would be nice to extend that sort of arrangement.'

Hospitals are an excellent breeding ground for rumour, gossip and disinfor-

mation, so the next step for Mr Brook was to find a good way of communicating some of his ideas, and what was happening, around the workplace. In typical style he came up with LIPS, a staff newsletter. The acronym stands for 'Latest in In-Patient Services' and all newsletters have a pair of lips imprinted in the corner. The first issue offered a £10 prize to anyone who could guess their owner (it was a member of the unit management group).

The first issue referred to BOFFINS (Brent's Opportunities For Finding Inovations in the Nursing Service), which is a thinktank-type group to 'innovate and gain the active support of senior management by implementing ideas'. The first idea from BOFFINS was to hold a 'Central Challenge' — a University Challenge-type quiz on general knowledge and work-related specialist questions.

Forty-eight three-person teams entered and a grand final was held at which Su Pollard, the actress from *Hi de Hi*, presented the prizes. Four teams, representing virology, bacteriology, porters and maternity, fought in the final. To almost universal approval, the porters won.

BOFFINS also suggested a staff barbecue, held last summer, which was paid for by donations from grateful patients. Other social events included a Christmas party for staff and a grand Valentine's day ball.

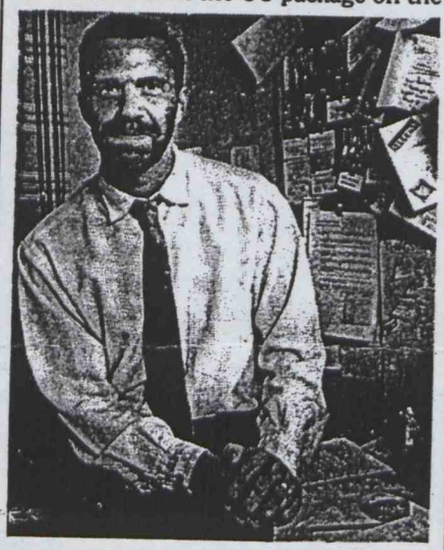
'Social events are a very important part of the culture of a place', says Mr Brook. 'I'm trying to recreate the sort of atmosphere that used to exist in hospitals — the balls, dances and other events that made them a fun place to work in. I want to recreate a feeling of corporate identity.'

The need for a 'corporate identity' and 'marketing' liberally sprinkle his conversation. It is not enough to have a good idea, he believes; you must convince others that it's good because it is they who will implement it and decide whether it works or fails.

Staff development is a pet subject and something to which he has given a lot of thought. Like many other hospitals, the Central Middlesex has a staff nurse development course that runs for 18 months: six months surgical, six months medical and six months specialist experience. It starts with a week in training school, discussing what it means to be a staff nurse and how working lives will change.

Out of 13 students who passed their finals at Christmas, 11 are staying. Mr Brook did not have jobs for all of them but employed them anyway, knowing that vacancies were coming up. He has also created a senior staff nurse post because one of the most difficult groups to retain are staff nurses, and he thinks they should have some form of career progression other than simply waiting for a sister's post to come up.

There is also an organisation called GROUP (Getting Results from the Open University Package). Two sisters run a course based on the OU package on the



nursing process. Each is involed in two courses but one changes every time. Therefore, sister A will run groups one and two, sister B, groups two and three, and so on. The course runs for one day a week over seven weeks.

Mr Brook likes nothing better than a snappy acronym and one of his latest is the SQUAD, Standards and Quality Development Group. He says: 'Nurses are quick to say that standards are being compromised or falling but often they do not know what their standards are. We want people to set their own standards and link them to the overall policy statement.'

This statement, a copy of which is in each ward, says the aim of the hospital is to 'provide a flexible, developed team who will provide the best possible patient service within the restraints of given resources. Key objectives include maximising potential, innovations and efficiency and providing opportunities within a caring and supportive management environment.'

The language may be a bit tortuous but the intention is clear. Another acronym is SAS, which refers to the Stocks and Supplies group. Mr Brook visited a ward one day and found it stocked 2 400 face masks; another had five boxes of size five surgeons' gloves; as Mr Brook comments, 'I didn't know there were that many midget surgeons in the country.' This sort of unnecessary stockpiling was clearly responsible, at least in part, for the fact that the supplies budget was 18% overspent a year ago; it is now 21% underspent.

The first step to effect a change involved a 'bring and buy' sale. An amnesty was declared so that all wards could bring their surplus stocks to a central room where they were swapped for more appropriate supplies.

'We looked at stock control and drew up a proper stock level for each ward and department,' he says. 'We have a central store for equipment so people are not saying things like "that's my syringe pump".

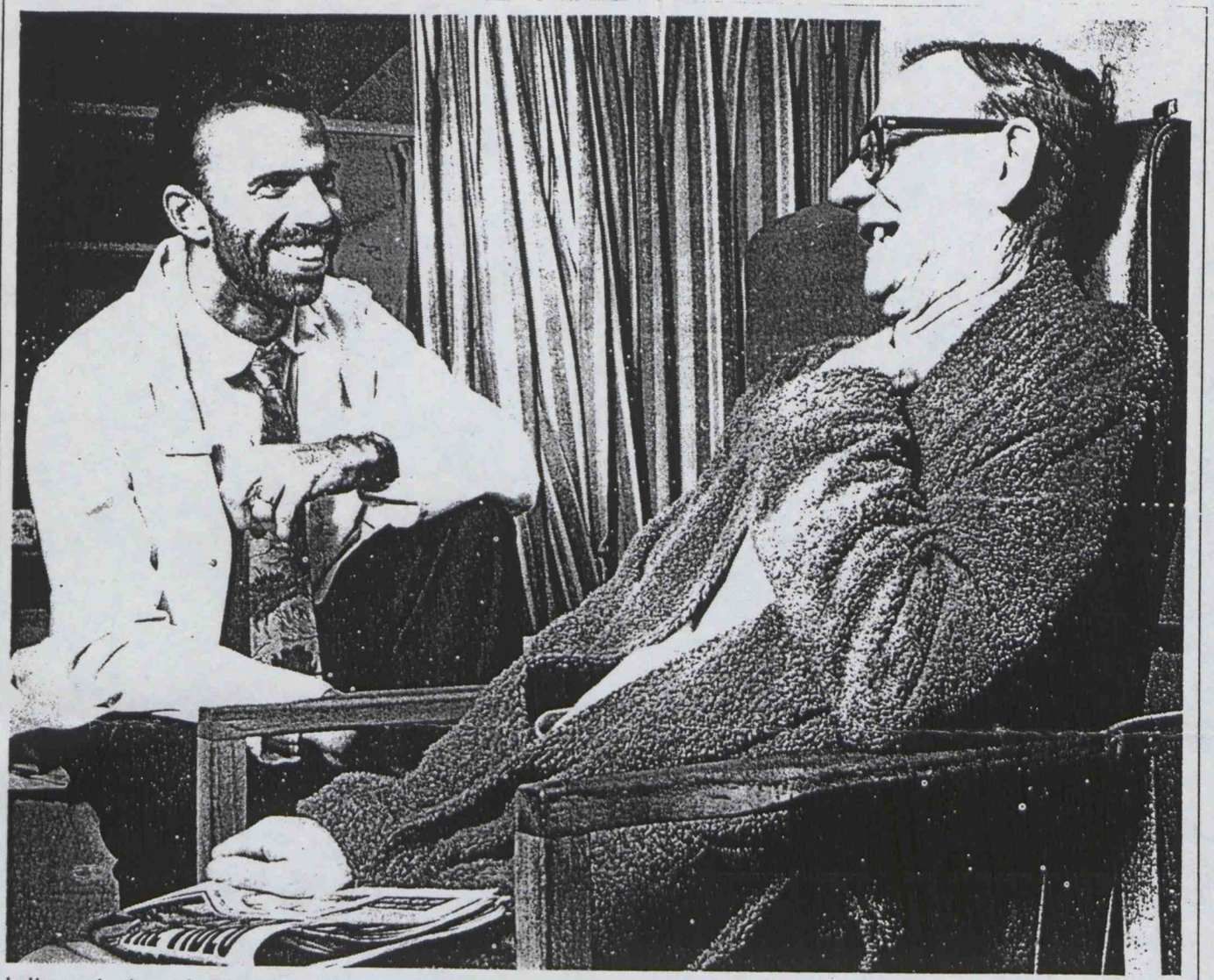
'We now have a nurse manager for control and expenditure. He has a pricing gun so the ward staff know the cost of everything they use. Ordering is easier, broken equipment can be repaired quicker and the next step is to put in a computer link between here and the district supplies office in Paddington.'

And it might soon be possible for Central Middlesex nurses to work one day at that supplies office as part of their 'job swap' scheme. This is a voluntary arrangement whereby nurses will work, for a half day or so, as a porter or admissions clerk or in some other capacity. The idea is for people to satisfy their curiosity about what other staff really do, and gain an appreciation of other people's problems. The scheme is voluntary but one Dave Brook hopes many nurses will take advantage of.

Another new appointment, in addition to control and expenditure, is a nursing officer who is now responsible for bed management. 'I see her role as measuring the quality and quantity of care', Mr Brook says. 'She has got a quality control element in her job and she has to see whether we deliver what the patients want. Of course, that's not always possible but it's equally important, if you can't deliver the service you want, to go and tell people why you can't.'

All of these initiatives are, of course, aimed at improving patient care. Another way of doing this, Mr Brook

RECRUIT AND RETAIN



believes, is through BRAINS — Brent Research and Implementation in Nursing Research group.

'I support research but a lot of people waffle about it without putting it into practice,' he says. 'I am advertising for a research staff nurse and two others have been sent on an ENB research appreciation course.'

All of the above is not to suggest that the Central Middlesex has no problems. It does. The first is that two wards may have to close this summer becuse the hospital is short of 50 staff. Two years ago the training school failed to recruit enough learners, and 50 staff taken away from any hospital will create enormous problems. But, as Mr Brook says, 'I can control trained nurse numbers but not learners. Another problem is that we are in an industrial environment, competing with other employers for potential staff.'

It comes as no surprise to discover that he went to some of these local industries and tried to enlist their support in solving some of his problems.

For example, two large supermarkets, Tesco and Asda, run free bus services for their staff who work unsocial hours. Mr Brook asked if they would consider making a couple of extra stops to pick up nurses, and drop them off on the way past the hospital.

Tesco seem unimpressed but Asda are showing interest in the idea. The payoff for them would be good customer relations and the opportunity to take off-duty nurses straight to the local Asda supermarket.

In a similar initiative, local firms have also been approached to see if they will pay for a creche to open at the hospital. If this happens they will have an excellent facility for their staff, run by qualified nurses, and Central Middlesex staff can also use it.

If all this stimulates you to apply for a job at the hospital, you will be offered an interview, if that is appropriate, within a week of receipt of your applicaiton. Mr Brook says: 'Whichever nursing officer is around will arrange the interview, irrespective of whether the vacancy is in "his" area. After all, you employ people to work in a hospital, not one small part of it, and it makes no sense at all to keep an applicant waiting, sometimes for weeks, because the nursing officer is on holiday or sick leave.'

One failure he sees is the comparative lack of success of a 'back to nursing' course he wanted to run.'We put a programme together but had little response from our advertisement; it seems there just aren't that many people in this area who are interested,' he says.

In case you were wondering, this has not been a comprehensive list of the innovations and ideas that Dave Brook has introduced in the past 12 months, but they are all we have space for.