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PRIME MINISTER

A BETTER SERVICE TO PATIENTS

HC53: Note by the Secretary of State for Health

DECISIONS

This note had its origin in a proposal from the Chancellor that the White Paper should list practical improvements to be made in the way patients are treated. The group agreed that they should get special attention in the White Paper, as part of the general approach of bringing out the benefits that patients would receive from the Government's reforms. The group had in mind specific changes to make the system more responsive and friendly to patients and to improve their comfort and convenience. Mr Clarke's paper deals with improvements of this sort, but its emphasis is more on improvements in the quality of medical care. Important though these are, you may want to ensure that the more modest but still highly visible practical improvements the group originally had in mind are not lost sight of. You may wish to ask the Chancellor and other members of the Group whether there are any particular practical improvements of this kind, other than those mentioned by Mr Clarke, which they wish to see followed up.

2. Other issues you may wish to discuss are:

i. the effectiveness of the complaints procedure, not mentioned by Mr Clarke;

ii whether his proposed method of getting the necessary improvements through quality assurance programmes by the health authorities will be effective, in the face of possible inertia by the professionals;

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iii whether his proposed new acute sector advisory service will be sufficiently independent of the professionals, and whether it might have a role in ensuring good medical standards in the private sector;

iv whether there are any risks that publishing a set of health indicators, as he proposes, would in practice strengthen demands for more spending.

ISSUES

Making the service more personal

3. Paragraphs 8 and 9 of Mr Clarke's paper list some specific proposals for making the service in hospitals more personal. They include counselling for distressed patients or their relatives; ensuring that patients are welcomed to the clinic or ward; ensuring that a full range of optional extras is available to patients on payment; and a review of appointments procedures to ensure that patients are seen within a reasonable period. Other possibilities are:

i better and more cheerful facilities in waiting rooms;

ii more flexible visiting hours in hospitals;

iii an end to the still widespread practice of waking hospital patients very early, so as to fit in with nurses' shift arrangements.

You may wish to ask Mr Clarke to examine these or any other possibilities which the group can suggest.

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Complaints

4. The paper does not mention the complaints procedure. This is sometimes the cause of public criticism, partly on the ground that in practice it is dominated by professionals. You might ask Mr Clarke how often the complaints procedure is used, whether usage is increasing, who receives and responds to the complaints, and whether it is dominated by the professionals. More generally, can he think of any improvements?

The quality assurance programmes

5. Mr Clarke proposes that the necessary changes should be made by requiring all health authorities to draw up quality assurance programmes whose progress will then be monitored. This may be right but you may wish to raise three points:

a. Can we be sure that this quality-assurance process will produce the necessary improvements, which could require big changes in the thinking and habits of the professionals? The Department of Health have applied pressure for improvements for some years, but it is not clear how much real change they have secured. You may wish to ask whether it is right to reject the idea of specific targets (paragraph 8).

b. You may want to be sure that the process does not concentrate solely on improving the quality of clinical care and ignore the improvements in the comfort and convenience of patients which were the original reason for this study. For example, will the process ensure that optional extras are available to patients at a charge (paragraph 8iii)? This has no connection with medical care. But it would be useful both to make the system more responsive to patients, and to blur the distinction between the public and private sectors.

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Costs

6. Mr Clarke says (paragraph 17) that the quality assurance initiative might cost £20m over 2 years. You may wish to confirm that he is not asking for extra resources on that account.

The acute sector advisory service

7. Mr Clarke proposes a new acute sector advisory service which would be available to management to monitor the quality of clinical services. This also may be a good idea, but you could raise the following points on it:

a. How will it fit in with the proposal in the medical audit paper, HC50, that management can initiate an independent professional audit? Will such an audit be provided by the new service, or by a separate body? You will wish to avoid a proliferation of overlapping initiatives.

b. What will the composition of the service be? Paragraph 20 says it will be professionally led, and even implies that it will have exclusively professional membership. You may want to check that the service will be sufficiently independent of the professionals.

c. Could the new service play a part in dealing with the need, identified by the group at its last meeting, to ensure that the private sector has satisfactory medical standards? Mr Clarke says (paragraph 19) that he has rejected the model, adopted in the USA and Canada, of an independent body formally accrediting hospitals against a set of national quality standards. You may want to ask what role if any the new service would have in relation to the private sector.

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Health indicators

8. Paragraphs 27 and 28 recommend developing a set of published health indicators. This is a long-standing idea in the Department of Health. They say that the indicators will show the benefits of NHS expenditure. But it can be argued that there is also a risk that they will generate demands for more expenditure to achieve particular target levels for the indicators. More fundamentally, there is the question whether the Department can be certain enough of the link between health spending and health improvement to be confident that the indicators will move in the right direction. You may wish to raise these points.

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Cabinet Office
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