

The Royal Colleges Focus Groups

Final Report



The Patients Association

The Patients Association is a national healthcare charity providing patients with an opportunity to raise concerns and share experiences of healthcare. We were set up more than 40 years ago and use the knowledge gained from patients to work with the National Health Service (NHS) and other healthcare providers in improving services.

Working with a range of organisations providing health services we receive income through individual members, corporate members in the commercial sector, specific project work, consultations and events. We are an entirely independent organisation and do not receive any funding from the Department of Health or any other government body.

Through our Helpline, correspondence and research we learn from patients the issues that are of concern to them and work towards improving the healthcare we all receive. The research we carry out give us a unique understanding of the real issues in healthcare and enables us to campaign for the changes necessary to improve patient experiences across the UK.

Charity number: 1006733

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I. Background to the Patients Association

For more than 40 years, the Patients Association has campaigned on behalf of patients to ensure that the NHS offers healthcare of high quality, and that the rights of patients are fully respected.

Our own research and Helpline enquiries, confirmed by daily media headlines, highlight those aspects of healthcare most disliked by patients:

1. postcode lottery for treatment and drugs,
2. healthcare acquired infections (HAIs),
3. mixed sex wards,
4. lack of dignity,
5. and access to basic NHS rights.

are the most commonly mentioned.

The Patients Association raises these concerns with the Department of Health on a regular and continuous basis, directly and through the media. We urge accountability at all levels of NHS care. In line with this approach, the Association was keen to highlight the reality for patients against the rhetoric too often heard about patients' experiences of the NHS. In order to gain a fuller picture, the Patients Association invited experienced representatives of NHS users – Patient Liaison Groups (PLGs) of the Royal Colleges – to a breakfast meeting to determine the most important topics currently faced by patients. Prior to the breakfast meeting, a brief questionnaire had been circulated to the attendees to give them the opportunity to identify the most common patient issues that came to the attention of the PLGs. These responses were analysed and collated to set the agenda and structure of the breakfast meeting (see Appendix 2).

II. Description of the breakfast meeting

The main objective of the breakfast meeting organised at the beginning of September 2007 with the majority of Royal Colleges representatives was to obtain an accurate representation of the situation NHS patients face when receiving (or trying to receive) healthcare and to gather comprehensive details on NHS users' experiences.

In order to maximise the contribution of all participants, the Association decided to use a specific qualitative research method to carry out this project: the consensus focus group methodology. Three groups were organised and were asked to work on the different health issues already identified in the preparatory questionnaire. The participants had to consider the proposed health themes in four stages defined as follows:

- (a) The ideal situation to be met within five years
- (b) The current achievements reached in the considered area
- (c) The barriers slowing down all kind of improvement on this specific subject
- (d) The strategies to be implemented so as to reach the ideal situation and to tackle all existing barriers.

Fifteen Royal Colleges' representatives participated in the focus groups, divided in three groups of five persons. The following Colleges were represented: the Royal Pharmaceutical Society, the Royal College of Paediatrics and Child Health, the Royal College of Surgeons, the Royal College of Physicians of London, the Royal College of Pharmaceutical Medicine, the Royal College of General Practitioners, the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Royal College of Radiologists, the Royal College of Anaesthetists, the Royal College of Physicians and Surgeons of Glasgow, as well as the British Medical Association (see Appendix 1).

Each group was invited to nominate a spokesperson (*rapporteur*) to report back to the whole meeting at the end of the two hours work.

The overall organisation of the meeting was led and facilitated by Roswyn Hakesley-Brown and Katherine Murphy, respectively Trustee and Director of Communications of

the Patients Association. Isabelle Goncalves was in charge of coordinating the meeting logistics.

III. Issues Raised

Prior to the meeting, invitees were asked to define the 3 main themes applicable to their Royal College Patient Liaison Group. These were:

1. Patient safety
1. Training of surgeons
2. Communication
3. Individualised care
4. Patient consent (especially digitalised images)
5. Competency
6. Risks/benefits of medicines
7. Participation in clinical trials
8. Regulation of healthcare professions working outside the UK on clinical work affecting UK Patients (tele-reporting of radiological imaging)
9. Fitness to practice
10. Dealing with health inequalities
11. Out of hours care
12. Service changes and reconfiguration
13. GP appointments (access & continuity)
14. Access to service

This list was then broken down under the time frames (a)-(d) above (ideal situation in five years, current achievements and barriers, strategy outline to achieve ideal) for discussion between the 3 groups based on the experience of the patients they represent.

♦ (1) Patients' Safety

Patients' safety emphasizes the reporting, analysis and prevention of medical error and adverse healthcare events, i.e. harmful and undesired effects resulting from medication or other medical intervention (such as healthcare acquired infections, more specifically MRSA, C. Difficile, etc.). If some of these events do not trigger significant effects, there may well be certain repercussions. This heading assumes the fact that patients and their relatives require and expect high standard of safety within the NHS. Royal Colleges' representatives confirmed recent health media articles that basic requirements on patient safety cannot be guaranteed in all NHS Trusts.

This being so, there was general agreement that the **ideal situation** within 5 years would be a total absence of critical medical incident, including healthcare acquired infections (HAIs) within NHS Trusts. Participants of group A also highlighted the need to share best practice amongst healthcare professionals. The creation of the National Patient Safety Agency was seen as a main **achievement**. **However**, participants acknowledged that high bed occupancy and patient turnover, the requirements of working time imposed by the European Working Time Directive (EWTD) and the constant reorganisations of the NHS introduced by the Department of Health constituted important **barriers** to the attainment of such ideal situation.

When considering **strategies** to reach optimum patient safety, all participants were agreed on the necessity for better leadership and training of medical professionals. Continuing revalidation of every healthcare provider (in terms of knowledge and competencies) was regarded as central to achieving the best possible patient safety.

“Are patients having the right pills? the right treatment? the right operation?”

“The question of hygiene in hospitals should be sorted out!”

“You don't usually have infection when things are sterile!”

“Hospital standards tend to be interpreted as wards to be clean, when mostly it's actually what people do with their hands!”

“The ideal would be that people learn from other people’s mistakes, sharing their practice and exchanging best practice. (...) People could also learn from near misses instead of keeping it quiet!”

- “MRSA is supposed to be down?

- “The problem is that they don’t record it properly because they only record blood tests (...) and it is the same problem with C. Diff.”

♦ (2) Training of surgeons

Because any defect in a surgeon’s practice can have serious consequences for their patient’s health and recovery, high quality of surgical training needs to be assured and competency constantly monitored throughout the years in practice.

In considering this, members of group A agreed that the **ideal situation** to be achieved within five years time would be to ensure that all practitioners benefit from a full and complete experience in their speciality. In addition, and because the confidence patients have in their surgeons affects greatly the way they cope with treatment and surgery, the guarantee of competence must be considered the overriding objective when contemplating changes within surgeons’ training. Alongside this, Royal Colleges’ representatives highlighted the need to develop non-invasive techniques. When considering the **current achievements** on this issue, participants recognized the increased consideration of patients’ experiences and discussions. However, group A members considered that the lack of long term planning and the European Working Time Directive were important **barriers** to the achievement of the described ideal situation.

In discussing the **strategies** that needed to be implemented to achieve the ideal scenario, group A agreed that the introduction of *Continuing Professional Development* and a surgeon’s regular revalidation to practice were basic requirements.

“For patients, the ideal situation is that they do not want an invasive intervention, if there is another technique possible...”

“Revalidation of competencies to check if the individual is completely able to provide care, if he is fully competent...”

◆ **(3) Communication**

Lack of communication takes many forms and means different things to different people. In addition to the communication between patient and healthcare professional, it may also include clinician to clinician, NHS service or organisation. For several years research has pointed to the consequences of poor communication for a patient’s recovery and treatment. It was not surprising therefore that the Royal College’s representatives highlighted this issue as being one of the most important problems faced by patients on a daily basis.

They defined the **ideal situation to be reached in 5 years time** as one where all staff would fully understand the importance of this issue and where no complaint would arise because of poor communication. Group A also emphasised the active role for patients in this matter so that within five years they would have realistic expectations in respect of healthcare outcomes. The group acknowledged recent positive **achievements**, with communication being now a formal component of medical training. Patients tend now to be much more involved in the planning of their care and in new clinical policies introduced in the NHS.

The main **barriers** faced by patients with regard to communication arise where there is poor implementation of policy and high profile negative role models. Time was also mentioned as another barrier to best practice in communication. Participants agreed three main **strategies** to tackle communication dysfunction in patient-doctor interactions: (1) constant revalidations of healthcare professionals’ abilities to practise, (2) ongoing medical training assessment and (3) successful patient groups’ campaigns.

“Patients are very stressed, and in a stressful situation you do not absorb what you are told. People who are telling us things need to realise that they have to repeat things several times to make sure they understand.”

“(...) and it’s simple things like if you are being told bad news, it’s important that you have somebody else with you either a member of a family or close friends so they can know what you were told because you are told things but then after you totally forget the rest of it...”

“All doctors should be tested in a suitable way and if necessary with revalidation (...) to make sure they understand the crucial nature of communication because if you cannot communicate, all actions with your patients (...), with your colleagues, you are affecting patient safety, outcomes in patient health... All these things can be affected by poor communication!”

“If patients are not comfortable, they are not going to give you the information necessary to do the differential diagnosis.”

♦ (4) Individualised care

Each patient experiences and perceives his/her condition and its treatment in a unique way. This individual perception, often a source of anxiety, must be taken into account by healthcare professionals when providing care to patients. Instead of being dehumanised and feeling reduced to a mere bed number, patients should be treated as individual human beings. Such an attitude is a proven essential of a patient’s satisfactory recovery. Participants strongly highlighted the importance of treating patients as individuals.

The ideal situation to be reached in five years time was a service where personalised patient plans were the norm and where attention to an individual’s details would be assured. Major **improvements** have been achieved in this specific area: Royal Colleges’ representatives acknowledged that a patient-centred philosophy is being implemented within the NHS and that changes in healthcare professionals’ training are underway. However, the overall lack of time and other time constraints for healthcare

professionals together with emotional barriers are themselves important **barriers** to the effective introduction of individualised care. Thus when advocating **strategies** to attain the ideal situation, it is very important to make communication a single academic discipline within doctors' training and to develop integrated care systems that would focus on the transition points.

“Lots of protocols have been developed but everyone is an individual and what’s important for them is different, (...) being treated as a person as opposed to a number!”

“The ideal is that every patient would be treated in that way, this being the norm as opposed to being an exception!”

“Health service people should recognise that being in an hospital is a whole experience; it’s not just for surgeons operating, the ward clerk, or taking a note, or a person delivering a cup of tea or coffee ... no, it’s a whole experience, and that’s sometimes forgotten by surgeons...”

“All staff should recognise the patient portrait that they are working with people...”

“Little things such as giving more attention can make huge differences!”

◆ (5) Healthcare professionals' competency

Of necessity patients are required to rely on their healthcare professional's qualifications as a guide to competence. Qualifications encompass both professional skills and personal behaviour in order to provide good care to patients. Competence includes professional and personal characteristics as well as the training received. Professional failings can trigger horrific consequences for patients. It is essential therefore that professional competence is assured. On this issue, group A members came to the conclusion that the **ideal situation** would be the establishment of international

standards in healthcare professionals' training, with a particular focus on patient safety. Today, some **achievements** have been attained, as illustrated by today's wider and better defined standards of competence. Again, however, enhancements are affected by **barriers** such as the Medical Training Application Service (MTAS), the European Working Time Directive (EWTD) and the PMETB (Independent body responsible for GPs training in the UK). The **strategies** proposed by participants to resolve these difficulties included greater collaboration by Royal Colleges (including the PMETB) and improved organisation of patient consultations.

“In the one hand, you have the concept of competencies: it's knowledge, skills and experience – so, the training is more explicit about what is required to reach a certain level of competency (...), and in the other hand, the timings that are not available, what means that the skills and experience is dismissed (...), therefore the question as to whether or not what people have been traditionally expected to be able to do can virtually be expected so, we are actually talking about changing how the service is delivered.”

“Patients are not looking at the competencies of the individual; they are looking at the competencies of a team, of everybody delivering...”

“Does the patient worry who's delivering the care? No, as long as they feel that they are competent, and competency for them is actually about trusting that everybody knows what is going on....”

“Patients' groups highlight concerns about quality insurance and patient safety.”

♦ (6) Patients' consent

Patients depend on healthcare professionals during their treatment. Patients own their bodies and must give enlightened consent based on informed choices to the doctor's proposal to care. This consent, established in law, must be given with full knowledge of the incurred risks and consequences. It is also important that this consent covers all aspects of healthcare. Thus, digitalised images must not be used without patients' informed consent as it affects patients' privacy.

Royal Colleges' representatives agreed that a proper opt-in system for consent to all kind of digitalised images (i.e. sent abroad, used for training and used for research) should ideally be introduced **in 5 years time**. It was acknowledged by patients' representatives that digitalised images are a great **achievement** per se as they are easily transferred for consultations and are cost-effective. However, group C members admitted that they also present intrinsic **barriers**: because they correspond to an IT system, the utilisation of digitalised images is barely controlled. In addition, the fact that images are being sent abroad constitutes another difficulty to their regulation. In the current situation, Royal Colleges' representatives concluded that consent forms should to be introduced as a **strategy** to reach the fundamental ideal of a proper opt-in system. They argued that controls should be in the hands of patients.

“A lot of patients do not know what happens to the images that were taken of them. They are not told that something is going to be sent abroad and we think that patients ought to be told that.”

♦ (7) Drug risks and benefits

The experience of Royal Colleges' representatives on this subject was most valuable. Patients must be made aware of the problems they may have to face because of their effects of medication on them.

The participants tried to define **the ideal situation** in five years time and information appeared to be of most importance. An extensive supply of information leaflets, indicating clearly the risks and benefits, is expected to be available in the near future. To this can be added the necessity of consultations organised with interested parties. The Royal Colleges' representatives noted three significant **achievements** to date: (1) important information is currently available for patients; (2) the science of risk is quickly developing and (3) many websites offer lots of information in this matter (NHS Direct and Colleges websites). Unfortunately, there are many **barriers** to a better knowledge of medicines' risks and benefits: the privacy issues of pharma companies as well as the lack of transparency due to the complicated language used on the information sheets provided. It also seems that it is difficult for patients to know which information they can trust. When considering **strategies** to implement to reach the ideal situation, Royal Colleges' representatives indicated that more education in understanding risk and the co-operation of patients' groups are needed so as to achieve more widespread and understandable information on medicines risks and benefits.

“It is crucial that patients can understand the information they received regarding the risks of medicines.”

♦ (8) Patients' participation in clinical trials

Patients can volunteer to participate to clinical trials. These trials which correspond to research studies designed to test the safety and effectiveness of drugs and treatments can have critical consequences on a patient's health. As a result, it is vital that patients are fully protected when undergoing (or planning to undergo) clinical trials.

The Royal Colleges' representatives raised this issue during the meeting. For them, in an **ideal situation**, patients should receive extensive education regarding clinical trials and the relevant authorities should develop a properly financed regulatory system, whilst guaranteeing follow-up for participants' results. The clinical trials system as currently

implemented offers great **achievements** as it generally allows most serious incidents to be avoided. However the obvious lack of confidence consequent upon the present system constitutes a real **barrier** to the attainment of the ideal. This being so, the focus groups participants tried to define new **strategies** that would lead to this ideal place. More attention to education on this issue and clear explanations of the procedures are essential.

“Patients participate in trials without being told what the risks are, or they’re told which the risks are in a way they can not understand.”

“There is no medicine that is totally safe.”

“Do patients realise what’s involved when participating to a trial? Are they told everything about it?”

“Patients must take seriously into account that the trial may go wrong!”

- ◆ **(9) The regulation of healthcare professionals working outside the UK on clinical work affecting UK patients**

The regulation of healthcare professionals working outside the UK on clinical work affecting UK patients (e.g. tele-reporting of radiological images) was highlighted by patients’ representatives. Following their concerns, for the majority of patients, **the ideal situation** in five years time would be the introduction of (1) audited regulators, (2) agreed standards and (3) standard contracts. Currently the main **achievement** is that some regulation has been defined in the European Union. When drawing up a **strategy** to tackle the **barrier** of lack of controls, participants said it was necessary for authorities to develop standards.

“Where are these healthcare professionals regulated? How are they regulated?”

- ◆ **(10) Fitness to practice**

Another issue raised by participants was fitness to practice. On this, **the ideal situation** to be achieved in 5 years time would be a robust, clear, multidisciplinary revalidation system, with wide public involvement in its development. A majority lay membership of fitness to practice boards was also required.

The Royal Colleges' representatives agreed that many **achievements** have been reached in this area: the revalidation systems, the presence of lay representatives on boards and the existence of PALS (Patients Advice and Liaison Services). However, participants were agreed on the paradoxical role of PALS as they can constitute **barriers** to achieving the ideal situation. In addition, the system is perceived as confusing for both patients and healthcare professionals. The lack of information and knowledge of rights constitute significant obstacles to improvement. **Strategies** in place to tackle such barriers included the development of understandable and timely information (quality not quantity), the greater involvement of lay people in process and the development of a transparent *whistle-blowing* culture.

- ◆ **(11) Health inequalities**

The UK suffers from important differences in health depending on geographical areas and social groups. Health inequalities are a central issue of healthcare access, and contrary to the NHS principle of equity. Patients' representatives agreed that a wider public involvement in public health and the effective handling of health inequalities would be the **ideal situation** to be achieved within five years time. Some **achievements** have been attained, such as the smoking ban. However, many **barriers** remain: area-lifestyle, and hard to reach groups, where language may also be a real difficulty. Therefore when deliberating on **strategies**, Royal Colleges' representatives concluded that extensive work with hard to reach groups should be put in place and that more resources should be dedicated to this issue, with increased political will.

- ♦ **(12) Out-of-hours care**

The term ‘out-of-hours care’ refers to care delivered between 6:30 pm and 8:00 am on weekdays and at all times during weekends and public and bank holidays. As highlighted by the Patients’ Association and confirmed by the media, many concerns have been raised with the current organisation of out-of-hours services. Patients have forcefully complained about the present difficulties in accessing healthcare professionals during weekends or after their working day.

Consistent with this observation, Royal Colleges’ representatives considered that urgent improvements were needed regarding out-of-hours care and thus the **ideal situation** to be reached in 5 years time was an efficient 24 hour healthcare access system, which would satisfy patients, with continuous and appropriate training guaranteed for all healthcare staff. Current **achievements** on this issue were acknowledged by participants: patients today can easily access *NHS Direct* for out-of-hours healthcare information and advice (although numerous problems have been reported) and *Accident and Emergency* waiting time appears almost to have been reduced to the 4-hours standard set by the Department of Health. Unfortunately, in spite of these improvements, Royal Colleges’ representatives reported some important **obstacles** to further improvements this area: patients still consider the information on the out-of-hours care pathway very difficult to access. This is particularly illustrated by the significant lack of signposting to the right services. Patients’ representatives blamed the 2004 General Practitioners contract, under which general practitioners (GPs) may opt out of the provision of out-of-hours services by losing a part of their earnings which they regard as insignificant. When considering **strategies** to attain the ideal situation, participants highlighted the urgent necessity to improve and develop the out-of-hours information signposting in order to provide patients with a better understanding of the current pathway to be followed. Finally, attendees drew attention to the central role of PPI (Patients and Public Involvement) program in following-up patients’ satisfaction regarding out-of-hours.

“How to access services appropriately? There are a lot of people asking how to access out-of-hours services appropriately: people are not quite sure about whether to go to A&E, try GP out-of-hours, wait for GP in-hours or go to a walk-in centre ... what do these places actually mean, what should people do, what is available?”

♦ **(13) Service changes & Reconfigurations**

There was general agreement that further service reorganisation and reconfiguration should be put on hold until public and patient involvement was more developed and could assist the process. The **ideal situation in 5 years time** would be robust methods of public scrutiny of NHS board decisions with change accepted by the public as a means of improving health services. **Current achievements** included the good examples being set by established PPI (Patients and Public Involvement) on consultation and it was felt that Health Oversight and Scrutiny Committees worked. **Barriers** to achieving success were that patients were the last to know in a locality about proposed changes. This in turn led to reluctance, fear, and wrong assumptions. There was often suspicion that other drivers were at work, such as cash deficits, European Union requirements of PPI (Patients and Public Involvement) commitments. **Strategies** to achieve the ideal centred on establishing clear pathways to PPI (Patients and Public Involvement), the creation of public overview boards, and the democratic election of health boards. These were regarded as the basis for ensuring that changes and reconfiguration were viewed as a positive process.

- ♦ **(14) General Practitioners Appointments**

Despite the 48-hours target defined by the Department of Health, access to GP practices remains a problem. The Patients' Association, via information on its Helpline, and the Royal Colleges patients' representatives reported that patients complain about the obstacles to GP access. Patients face barriers when phoning to obtain an appointment, and subsequently find appointments are in many cases cancelled or postponed. In addition, because of unavailability, patients are not guaranteed a consultation with their own general practitioner. When a patient's pain and/or critical condition were added in, there was a need for urgent change.

The **ideal situation** in 5 years time was quite simply universal access in less than 48 hours to an assigned GP. Flexible and extended hours for accessing GP practices were considered to be essential, along with other means of contacting surgeries, such as email. Royal Colleges' representatives acknowledged some **achievements** such as the significant increase in new GPs recruits (aside from the reported training problems) and the introduction of the *NHS Direct* service allowing access to healthcare information 24 hours a day. However, the 2004 GPs contract (and GPs contracting out-of-hours) remains the main **barrier(s)** to any improvement in the out-of-hours system and primary care accessibility. Participants also agreed that work should be undertaken on the attitude of practice's receptionists, some of whom appeared most unfriendly to patients. Different **strategies** to reach the ideal situation expected by the vast majority of NHS users were mentioned: while the review of the GP contract remains central, there was a need to change the independent contractor status of GPs and the develop staff training systems.

“A lot of things of the new GP contract have not been working for patients.”

- ◆ **(15) Access to healthcare services**

As previously highlighted, access to healthcare services presents numerous problems and runs contrary to the NHS founding principles for patients. Beyond the difficulty of out-of-hours access, patients and their representatives have great concerns on the shortage of healthcare professionals with the knock-on effect to registering with GP or dental practice. The current situation faced by patients is unacceptable and participants urged the Department of Health to make the necessary changes required to achieve **the ideal situation**: a clear and unequivocal definition of the patient's healthcare pathway. In addition, health and social care needed to be linked, and waiting times shorter than the Department of Health's current timescales should be considered. Participants acknowledged that there had been some recent **achievements**: waiting times seemed to have shortened and choice (when and where available) appeared to be a higher priority than before. But access to healthcare services remains a **barrier** that patients still face in their daily NHS experience. Group C members highlighted the lack of information about choice of services, the existence of hidden waiting lists, and the difficult access to dentist and hospital (because of closure, location of services and transport/parking issues). When considering **strategies** to achieve the ideal situation for healthcare services access in 5 years' time, patients' representatives favoured polyclinics and multidiscipline teams based in one healthcare building, to enable a holistic approach to patients' general care. Finally, participants attached significant importance to the development of the Expert Patients Programme and to long term conditions teams in the achievement of optimal healthcare services accessibility.

V. Future work perspective

The Patients Association is most grateful to the participants from the Royal Colleges for their valuable and wide-ranging contributions to the meeting. They brought, and represented, the experience of many patients, and offered constructive, viable solutions and remedies to the problems raised. Chief among these were patient safety and access.

The Patients Association looks forward to building on the partnership established at this meeting and to future joint work for the benefit of patients and the enhancement of the Service. A date has been set for the next meeting, at which this will be pursued – 17th April, 2008.

Appendix 1 – Groups

Group A

Royal College of Physicians

1) Margaret Goose

Royal College of Surgeons Patient Liaison Group

2) Mary Bay

Royal College of Anaesthetists

3) Richard Young

Patients Association

4) Dr Elisabeth Grosch

Group B

Royal College of Physicians and Surgeons of Glasgow

5) Phil Dolan

Royal College of General Practitioners

6) Antony Chuter

Nursing and Midwifery Council

7) Marie Saldanha

Royal Pharmaceutical Society

8) Vanda Thomas

Group C

Faculty of Pharmaceutical Medicine

9) Kathryn Swanston

Royal College of Radiologists

10) Chris Wiltsher

BMA's Patient Group

11) Simon Young

12) John May

Royal College of Obstetricians and Gynecologists
13) Natalie Teich

Royal College of Pediatrics and Child Health
14) Sophie Auckland

Appendix 2 – Flipchart sheets

Group A

➤ **Patient Safety**

Ideal in five years time

- No critical incidents
- No Hospital Acquired Infections
 - Share best practices

Current Achievements

- NPSA
- British/Alderhey
Climbie/Shipman Cultural }
}

Current Barriers

- High patient T/O
- EWTD/Office hours
- Constant reorganisation

Strategy to achieve ideal

- Leadership/Training
- Time constraints
- Revalidation

➤ **Training of Surgeons**

Ideal in five years time

- Fully experienced practitioners
- Patients fully confident in surgeons competence
 - Non invasive techniques

Current Achievements

- Greater patient discussion

Current Barriers

- ITC
- Lack of long term planning
 - EWTD

Strategy to achieve ideal

- CPD
- Revalidation

➤ **Communication**

Ideal in five years time

- All staff understand the necessity of communication
 - No complaints regarding poor communication
 - Public has 'realistic' expectations of outcomes

Current Achievements

- Part of formal training
- Patient involvement in care
- Policy on patient matters

Current Barriers

- Sparse policy implementation
 - Time
 - Negative role models

Strategy to achieve ideal

- Revalidation – Patient feed-back
 - Ongoing training assessment
 - Campaigns by patient groups

➤ **Individualised care**

Ideal in five years time

- Personalised patient plan as norm
- Attention to detail/supervision

Current Achievements

- Patient-centred philosophy
- Change of training emphasis

Current Barriers

- Negative role models
 - Time constraints
 - Emotional barriers

Strategy to achieve ideal

- Training (all professions)
- Integrated care systems

- Focus on transition points

➤ **Competency**

Ideal in five years time

- International consistency and equivalence
- Quality assurance of training standards – handover
 - Patient safety

Current Achievements

- Competencies better defined
 - Wider competencies

Current Barriers

- MTAS
- EWTB
- PMETB

Strategy to achieve ideal

- PMETB/Colleges collaboration
- Highlight concerns via patients groups

Group B

➤ **Fitness to practice**

Ideal in five years time

- Robust, clear, multidisciplinary revalidation system
- Majority lay membership of fitness to practice boards
- Wide public involvement in development of revalidation system

Current Achievements

- That there are revalidation systems
- That there are lay reps on boards
 - PALS

Current Barriers

- PALS
- Confusing disempowering system for patients/ health professionals
 - Ignorance/lack of information and knowledge of rights

Strategy to achieve ideal

- Better clear information – quality not quantity
- Encourage transparent *whistleblowing* culture

- More lay involvement in process

➤ **Dealing with health inequalities**

Ideal in five years time

- Action taken on health inequalities
- More public involvement in public health

Current Achievements

- Postcode lottery
- Smoking ban

Current Barriers

- Cultural aspect depending on area-lifestyle
 - Engaging with hard to reach groups
 - Language – catering for BME

Strategy to achieve ideal

- Engaging with hard-to-reach
 - More resources
 - Political energy

➤ **Out-of-hours care**

Ideal in five years time

- 24 hours access to required care (efficient)
 - Service that people are satisfied with
 - Continuity + appropriate training

Current Achievements

- NHS direct
- 4 hour A&E waiting time

Current Barriers

- Access to information
 - Health profs
 - Public
- GP contract (out of hours)
- Lack of signposting to right service

Strategy to achieve ideal

- Information signposting
- PPI programme to determine satisfaction GP/out of hours service

- Connecting for Health (to work)

➤ **Service change and reconfiguration**

Ideal in five years time

- Nothing changes until larger PPI involvement
- Independent meaningful overview board public for sec 33 / H&S 2001
 - To be a vehicle for positive improvements

Current Achievements

- Some PPI now
- Some good examples of consultations sec33
 - HOSC do work

Current Barriers

- Patients last to know
- Reluctance/fear/assumptions
- Other drivers cash/EU/politics PFI

Strategy to achieve ideal

- Clear accessible routes to PPI
- Creation of public overview boards
 - Make it a positive process
- Elect people to health boards by public

➤ **GPs appointments: Access – continuity**

Ideal in five years time

- For everyone to be able to get appointments within 48 hours with own GP
 - More flexible/extended hours for GP practices
- Other ways to access appointments system besides telephone

Current Achievements

- 24hours access to a health professional
 - More GPs

Current Barriers

- GP contract
- GPs contracting out of hours
- Attitude of dragon receptionists

Strategy to achieve ideal

- Review the contract
- GPs NHS employees not independent contractors

- Training of staff and system development

➤ Access to services

Ideal in five years time

- Patient pathways – clear where to go
- Joined up services (health and social care)
- Shorter waiting times than current targets

Current Achievements

- Waiting times have got shorter
- Patient choice (where available)
- Greater choice of NHS services

Current Barriers

- Lack of information about choice of services
 - “Hidden” waiting lists
- Access to hospitals (closure/location of services + transport / parking issues)
 - Access to dentists (NHS)
 - Allied health profs

Strategy to achieve ideal

- Polyclinics – Multi-disciplines teams in one place
- Holistic approach to patient’s health + social care needs
 - EPP + long term condition teams continue

Group C

➤ Patient consent, especially for the use of digitalised images

Ideal in five years time

- Proper opt-in system for consent
 - Sent abroad
 - Used for training
 - Used for research

Current Achievements

- Digitised images bring benefits
- Easy to transfer for consultation
 - Cost benefits

Current Barriers

- It is an IT system

- ♦ Images being sent abroad - EU

Strategy to achieve ideal

- ♦ Develop consent forms
- ♦ Controls under patient's control

➤ **Risk, benefit of medicines**

Ideal in five years time

- ♦ Understandable leaflets, showing risks and benefits
 - ♦ Interested party consultation

Current Achievements

- ♦ There is information available
- ♦ Science of risk benefit is developing
 - ♦ NHS Direct/College websites

Current Barriers

- ♦ Privacy issues in pharmacies
- ♦ Language in which information is provided
 - ♦ What information to trust

Strategy to achieve ideal

- ♦ Education in understanding risk
- ♦ Co-operation between patient groups

➤ **Participation in clinical trials**

Ideal in five years time

- ♦ Participants receive education
- ♦ Properly financed regulatory system
- ♦ Follow-up with participants - results

Current Achievements

- ♦ Present system avoids most major problems
 - ♦ Carefully regulated

Current Barriers

- ♦ Confidence lack in the system

Strategy to achieve ideal

- ♦ Education
- ♦ Explaining procedures

➤ **Regulation of those working outside the UK on clinical work affecting UK patients, e.g. tele-reporting of radiological images**

Ideal in five years time

- Audited regulators
- Agreed standards
- Standard contracts

Current Achievements

- Some regulation in EU

Current Barriers

- Insufficient controls

Strategy to achieve ideal

- Develop standards



listening to patients,
speaking up for change