Policies affecting Human Resource Management in the NHS and their Implications for Continuity of Care

prepared by
>   Charlotte Humphrey
>   Kathryn Ehrich
>   Bairbre Kelly

on behalf of the research team at King's College London
Kathryn Ehrich
David Guest
Charlotte Humphrey
Bairbre Kelly
Myfanwy Morgan
Sally Redfern
Jane Sandall

Address for correspondence
>   Charlotte Humphrey
>   Florence Nightingale School of Nursing and Midwifery
>   King's College London
>   James Clerk Maxwell Building
>   57 Waterloo Road
>   London SE1 8WA

Email: charlotte.humphrey@kcl.ac.uk
Telephone: 020 7848 3646

Contents

Appendices

Acknowledgements

We are grateful to the NCCSDO for funding the study. We would particularly like to thank everyone who participated in the expert seminars and contributed so constructively to the discussions.

Executive Summary

This report presents the findings of a study commissioned by the National Co-ordinating Centre for NHS Service Delivery & Organisation R & D (NCCSDO) to explore the impact on continuity of care of current and projected policies affecting human resource management in the NHS. The study was carried out between April and October 2001 by a multidisciplinary research team from King's College London. The study was part of a national programme of work on continuity of care commissioned by the NCCSDO.

The deployment and attitudes of the NHS workforce are important factors in determining whether patients experience continuity of care. Some policy initiatives affecting workforce practice may be deliberately designed to impact on continuity of care; others will do so unintentionally through unanticipated effects. In addition to the policies which focus specifically on human resources, many of the major developments in other aspects of the health service – such as the restructuring of organisational boundaries, the implementation of new philosophies of care, and developments in information technology – impact significantly on where, how and by whom patients are cared for and how health professionals do their work. The amount of change, rate of change and nature of change occurring in the service as a whole are all likely to affect continuity of care, influencing both where and how problems occur, and how they may be addressed.

Study aims

- To explore the implications for continuity of care of the wide range of generic policy initiatives currently affecting management and use of human resources in the NHS.

- To consider the effects of these initiatives on continuity of care in four specific areas of care chosen to serve as exemplars of the service as a whole, and to identify examples of good practice whereby potential barriers to continuity may be addressed.

Research methods

The study comprised a policy document analysis followed by a series of expert seminars.

Document analysis

For the purposes of the study, 'policy documents' were defined as written proposals emanating from the Department of Health or NHS Executive which have had, or seem likely to have, a significant impact on the direction of developments in health and social care. Following an initial trawl of all potentially relevant documents published since 1 May 1997, a subset was selected for detailed analysis on the basis that the documents appeared:

- to have significant implications for human resources in the NHS

- to have a potential impact on continuity of care

- to be generic, with service-wide effects

- not to have been superseded by more recent initiatives

- to have some possibility of being implemented.

A framework was devised to group together the various different strands of policy that featured in the documents under six thematic headings:

1 Reconfiguration of services

2 Information and information technology (IT)

3 Flexible workforce

4 Quality, safety and standards

5 Better working lives

6 Patient-centred care.

A briefing paper was then prepared for the expert seminars containing a summary of the main elements of each policy theme, some examples from the relevant documents and some provisional suggestions as to how policies within each theme, if implemented as planned, might be expected to affect continuity of care.

Expert seminars

Four one-day expert seminars were held to explore the implications of the policies within each theme in greater depth by looking at the effects of their implementation in selected areas of care:

1   maternity care

2   primary care

3   mental health care

3   and cancer care

chosen for their capacity to serve as exemplars of the service as a whole. Each seminar involved a small, multidisciplinary group of people with expert knowledge of the service and direct experience of the issues affecting continuity of care in the relevant area of care. The groups were designed to incorporate a variety of perspectives including those of users and carers, health professionals, managers, researchers and policymakers; they included people involved as users, providers and planners at national and local levels. Each seminar consisted of a series of facilitated discussions, taking the six policy themes in turn, and focusing on the following questions:

•   Do the policies enhance or support continuity of care and in what way?

•   Do the policies generate new problems for continuity and what are they?

•   What can be done to optimise the benefits and minimise the problems?

The seminar discussions were audiotaped and subsequently transcribed. The content of the discussions was analysed by taking each policy theme in turn, extracting the sections relevant to that theme from all four transcripts and grouping these together. The collected material for each theme was then examined across all four areas of care, identifying points which addressed the impact of the policies on human resource issues and, in turn, the effect of these on continuity of care. Examples of barriers to achieving continuity of care, as well as of practices which helped to ensure continuity of care, were identified within each theme.

Findings

Reconfiguration of services

Policies within this theme are concerned with reconfiguring the health service to create a more integrated and seamless service and to shift the focus of decision making towards those directly involved in

providing patient care. Reconfiguration includes redefinition of organisational boundaries through expansion, contraction or merger, reallocation of roles between organisations, and changes in the way services are provided at local level.

Most of the policies for reconfiguration were seen as potentially beneficial for continuity of care, when and if they were fully implemented and allowed to settle down. However, there was some concern about the perceived preoccupation with structural change, when functional and cultural issues were equally important. Attention was also drawn to a lack of fit between the various different initiatives. Participants commented on the many practical difficulties associated with implementing change in such a complex system and the danger that multiple and rapid change distorted priorities and distracted attention from the fundamental objective of providing care. There was a strong view that some continuity within the system was necessary to provide continuity of care for patients. A major hazard of continuous reorganisation was that it damaged morale and those involved adapted by disengaging and continuing as far as possible down familiar paths, rather than actively participating in and taking advantage of new opportunities.

Information and IT

Policies in this theme are concerned with improving the ways in which information is used, accessed and transferred within the NHS and between health and social care services through system modernisation.

Policies capitalising on developments in information technology were recognised by all participants as having the potential to revolutionise the use of information in the NHS. Generally, new developments which were seen as enhancing or supplementing traditional modes of communication were welcomed, while those perceived as aiming to substitute for personal interaction or paper records were viewed with greater scepticism. Even where IT policies were accepted as potentially beneficial for patient care, it was acknowledged that there were many obstacles to overcome before these benefits would be fully realised. These included orientation of existing systems, fear of and unwillingness to engage with IT, skills deficits, costs of adequately resourcing the necessary infrastructure and concerns about confidentiality, security, and dependability of IT systems.

Flexible workforce

The aim of policies within this theme is the creation of a skilled, flexible and integrated workforce capable of responding to the needs of patients.

Policies for a more flexible and integrated workforce were seen as potentially beneficial in creating a more responsive service for patients. However, the blurring of boundaries within and between professional groups was hazardous in a professional culture where specialisation is highly valued. The danger was that skills that were shared with others became a low priority for individual practitioners. Equally, when staff were asked to extend their roles in the absence of additional resources, some aspects of care risked being done by nobody or no longer being seen as anyone's primary responsibility. Policies which focused on ensuring integrated teamwork might be more successful in avoiding these problems. Innovative ways of working which engaged staff enthusiasm and helped meet patients' needs were welcomed, but it was noted that their very success might lead to a draining of energy and resources from other less-favoured aspects of care. Similarly, specialised services which increased the coherence of care for particular categories of patient or health need were beneficial for patients who fitted within that framework, but were potentially detrimental to those with less coherent needs.

Working flexibly to provide continuity of care required sufficient numbers of staff. If promoted in the context of a full staff complement working together as a team, it could help with recruitment and retention problems by making jobs more varied and interesting. In the present context of staff shortages, many of the strategies for flexible working would be very difficult to achieve and might exacerbate pressures on existing staff.

Quality, safety and standards

The aim of policies in this theme is to ensure delivery of a consistently high-quality, equitable service. Central strands of this policy theme are performance assessment, professional regulation, clinical governance and National Service Frameworks.

Policies which ensured the achievement and maintenance of high-quality care were regarded as fundamentally important for continuity, not least because continuity could not be advocated as desirable unless the competence of those providing care was guaranteed. However, concern was expressed about how the present policies in this area were working out in practice. In the right circumstances, guidelines and standards might be extremely helpful in ensuring continuity, but too many guidelines applied inflexibly might have the opposite effect, increasing uniformity and undermining the ability of the service to be responsive to different patients' needs. Participants were anxious that continuity of care might be ignored as a marker of quality, because of measurement difficulties and the lack of strong evidence of its benefits. At the same time, there was concern that continuity should not be valued indiscriminately, or automatically associated with high-quality care, because in some circumstances it might be neither

necessary nor beneficial. There was general agreement that the increasing emphasis on quality and accountability had led to serious problems of poor morale, lost goodwill and increasing defensive practice which must inevitably be damaging for patient care.

Better working lives

The aim of policies within this theme is to provide a better service for patients by increasing staff recruitment and retention. This is to be achieved by restructuring terms and conditions of employment for NHS staff and enabling them to strike a better work–life balance, thereby making the health service an more attractive place to work.

Policies to improve recruitment and retention of staff were identified in the seminars as central to achieving continuity of care. Participants repeatedly emphasised the severity of the staffing crisis and the detrimental effect this had on the ability of the service to function effectively. Staffing shortages were seen as the key obstacle to the implementation of a wide range of policies in other themes which had the potential to enhance continuity.

One major recent change in working patterns, the reduction in junior doctors' hours, had been experienced as largely negative to date, although it was acknowledged that there could potentially be benefits for continuity of care once the system was reoriented to accommodate this change. The general focus on more flexible working, both day to day and throughout careers, was widely welcomed, but this endorsement was qualified by concerns about the impact of part-time working on the ability to provide personal continuity and on organisational and workforce stability. It was agreed that the policies needed sensitive and imaginative implementation that took account of local circumstances. Participants were concerned that the capacity of the various 'better working lives' policies to produce results would continue to be undermined by financial, organisational and societal factors which were largely beyond the control of NHS policy.

Patient-centred care

This theme captures those policies that emphasise reforming the NHS as an organisation built around the needs of patients. It includes a commitment to prioritising the experience of patients at an individual level as well as achieving a more equitable and fairer service for the wider population.

There was consensus that a health service genuinely based on the principles of patient-centred care would take more account of users' perspectives on continuity of care. This might lead to a broader view which went beyond the present focus on individual patients, clinical services and health-defined needs to consider how continuity of care in

general might be provided for different populations or social groups. However, participants emphasised the cultural and professional obstacles to achieving such a fundamental shift and the difficulty of influencing these through policy alone. It was also noted that patients differed and might have conflicting needs. Some patients had greater expectations and were better able to express them; some patient groups were already better provided for by the existing structure of services. For such reasons it was felt that a commitment to patient-centred care made the difficulties of providing a fair and equitable service if anything more acute.

Discussion

In the policy documents analysed for this study, continuity of care did not generally stand out as a clear goal or priority. While the concept of continuity was sometimes mentioned as an issue in the general aims, it was certainly not defined as a key driver and rarely featured in the more detailed objectives. In most of the documents it was not explicitly considered at all, but remained concealed as an implicit component of the wider goals of integrated care or patient-centredness.

Nevertheless, despite its relative invisibility in policy, during the initial document analysis undertaken for this study it was possible to identify clear potential gains for continuity of care within the intended goals of all six policy themes. These potential benefits were acknowledged and appreciated in all the seminar groups, albeit with caveats about some particular aspects of the policy objectives. And yet the overall tenor of the seminar discussions was much less positive than these assessments might imply. The main reason for this is that many of the policy objectives are still some way off being realised, the process of implementation is often difficult and painful and in some cases there are doubts about whether the long-term aims are actually achievable. In the meantime, some genuine opportunities for improving continuity have already emerged, but in other respects the ability of staff to provide continuity of care appears to have been more compromised than enhanced by the changes underway.

The impact of policy on continuity of care

During the seminar discussions, one factor that emerged as being of key importance in determining both the capacity and motivation of staff to provide continuity for patients was the extent of continuity in the system over both space and time. This includes continuity of people, places, roles, knowledge and information. To the extent that current policies affecting human resources in the NHS enhance or reinforce such system continuities, they were perceived as increasing the potential for providing continuity of care. Where they create

discontinuity, or exacerbate existing problems, that potential was seen as being diminished and less likely to be realised.

Impact on continuity in the system

The ways in which the policies discussed appear to be affecting system continuity are summarised in Boxes 1 and 2. In broad terms, developments in respect of information and IT were perceived by seminar participants as playing the most positive role to date, whereas policies involving reconfiguration were more consistently experienced as having negative effects. Many policy initiatives in all the themes were recognised as having a mixed impact, with the balance of beneficial and undesirable consequences varying for different groups of patients.

Box 1 Perceived beneficial effects of policy implementation on continuity in the system

- increased continuity of information

- increased consistency of practice

- increased continuity of place for patient care

- increased continuity of staff

- increased collaboration between staff

- increased flexibility of practice

Box 2 Perceived negative effects of policy implementation on continuity in the system

- exacerbated effects of staff shortages

- more fragmented care

- decreased collaboration between staff

- diminished continuity of staff

- decreased continuity of knowledge

- loss of leadership

- increased inequity between different patient groups

Impact on staff attitudes and values

In addition to the effects of policies on continuity within the system, it was made clear in the seminars that policies might also affect the capacity of staff to provide continuity of care by influencing how they felt and thought about themselves and about their patients. In this respect also, it was recognised that the majority of the policies discussed were aimed in the right direction and would, if realised, have

beneficial effects. For example, it was acknowledged that greater engagement of clinicians in decision making should in theory raise morale and enable the service to become more responsive to patients. It was also agreed that the general commitment to increase involvement of patients in the design and evaluation of services and to take the perspective of users seriously should encourage staff to extend their thinking beyond clinical aspects of continuity of care for individual patients and to take a wider view.

However, for every instance cited of such positive developments, there were many more counter examples where policies were seen as damaging morale. The general consensus seemed to be that, in the short term at least, the effect of many of the policies discussed had been to diminish motivation and undermine constructive commitment to considering how continuity of care could be assured. In this respect, the most negative views were again expressed about the policies involving reconfiguration and also about those concerned with quality, safety and standards. In respect of the first theme, the experience of perpetual change was seen as leading staff to disengage from strategic thinking beyond their immediate responsibilities and to cling to the familiar, even when this might be inappropriate. It was also widely acknowledged that the preoccupation with practical problems of implementing change distracted from providing patient care. In respect of the quality agenda, the main anxiety was that loss of confidence associated with an environment of constant monitoring and implicit criticism was resulting in more defensive practice, loss of goodwill and increasing unwillingness to 'go the extra yard'. There was also concern that the increasing preoccupation with measurable aspects of quality based on hard evidence of benefit would draw attention away from more complex issues like continuity, which were harder to define and measure.

Reasons for the problems

In the seminars it was fully acknowledged that change was necessary for the health service to develop and progress, and that even the most desirable changes would inevitably generate some disruption. However, it was also widely agreed that some of the problems in the present case were exacerbated by weaknesses in the policies themselves, while others reflected potentially intractable difficulties associated with their implementation.

Problems with policies

The overarching concern in relation to current NHS policy was that there was simply too much happening, too fast, with unrealistic time frames for implementation. In addition, doubts were expressed about the apparent lack of joined-up thinking both within and between the various policy areas. This was reflected, for example, in the poor 'fit'

between various components of reconfiguration, in the potential contradiction between strategies for increasing flexibility for staff and those aimed at creating a more responsive service for patients, and in the desire for a patient-centred service which was also equitable and of a consistent standard. A third area of concern was that, despite the overall excess of change, some aspects of policy remained too limited in extent or too narrowly framed to have the desired effects. This concern applied particularly to some of the initiatives within the theme of better working lives.

Problems with implementation

The most fundamental barrier identified to the successful implementation of policies in all six policy themes was the chronic and continuing shortage of staff. While the various strategies for improved recruitment and retention were widely welcomed, they were seen as unlikely to be sufficient to counter the adverse effects of wider social, demographic and economic factors which were largely beyond the control of policymakers in the NHS.

The problem of insufficient staff pervaded all the seminar discussions, but other problems of implementation were more closely linked to particular policy themes. Regarding reconfiguration, for example, the temporary distortions and discontinuities generated by the incremental adoption of specific new initiatives were seen as inevitable effects of introducing change in a complex system. In respect of information and IT, barriers to implementation were identified both in respect of staff scepticism, skills deficits and lack of familiarity with the relevant technology, and in the unreliability and imperfections of the information systems currently available. Both of these were acknowledged as having the potential to improve over time assuming there was adequate investment in both training and resources. With regard to developing genuinely patient-centred care, many of the problems were seen as linked to deep-rooted cultural assumptions which might be modified over time by education and example, but were unlikely to be overturned in the short term by policy initiatives alone.

Recommendations

The general conclusion from this study is that if and when current policies affecting human resources in the NHS are fully implemented, the capacity of staff to provide continuity of care for patients is likely to be enhanced in a number of ways. In the meantime, however, the impact of the various policies on this aspect of care appears to be rather more equivocal, because of the damaging effects of the process of policy implementation on continuity within the system and on staff attitudes and values. If continuity of care is accepted as an important element of quality in health care, attention must be given to developing

strategies which support system continuity and to developing a better understanding of the role that continuity of care can play in improving patient care.

Supporting continuity in the system

Possible strategies for reinforcing continuity in the system include:

- making the most of opportunities for strengthening and reinforcing system continuity by identifying and disseminating examples of successful strategies for increasing continuity of people, place, roles, knowledge and information (some of those suggested during this study are listed in Appendix E)

- being alert to the potential hazards to continuity generated by system changes and developing active policies to anticipate such hazards and minimise their impact

- where possible, diminishing the pressure on staff and systems by slowing down the rate of change and allowing realistic time for consolidation

- supporting the development of resilient systems such as managed practitioner networks that can sustain connections irrespective of how structures may be changing underneath

- considering how service innovation in one area may impact upon another and ensuring that any potentially detrimental consequences are anticipated and addressed

- when designing new guidelines or safety standards, ensuring that their effects on aspects of care such as continuity are considered and addressed

- when redesigning services with patient input, ensuring that account is taken of the user's whole experience, not just the aspects perceived as clinically relevant

Reinforcing continuity of care as an objective

As mentioned earlier, while continuity of care is an important priority for health service users and is recognised as such by many of those involved in providing care, it tends not to stand out as a key priority in national policy documents. One reason for this relative lack of visibility may be that continuity of care is an 'apple pie' concept – its desirability is taken for granted and it is not therefore seen as needing special mention or defence. As was suggested in the seminars, such status can be both a strength and a limitation. On the one hand, few people are likely to argue against the benefits of continuity. On the other, few may see the need to define its strengths or actively defend it as a concept. Without such critical analysis, continuity of care runs the risk of being over-simplified as an idea, with insufficient attention given to

the less obvious or measurable dimensions. It may be valued indiscriminately as a necessary good, despite the fact that the evidence for its clinical benefits is fairly limited and, in some circumstances, it may be relatively unimportant to patients or even undesirable. Alternatively it may undervalued as something important only to patients, ignoring its role in providing satisfaction to staff or as a means of ensuring or measuring quality.

To avoid such distortions, and ensure that continuity of care is appropriately valued by staff and strengthened as a policy objective, it will be important to:

- undertake robust research to establish the value of continuity on patient outcomes

- ensure that all concerned in providing or planning patient care appreciate the various dimensions of continuity of care, including its potential significance as something which goes beyond health care and beyond the care of individual patients

- acknowledge that continuity of care has different resonances for different patients and in different areas of care and understand when it is likely to be most important or most inappropriate

- develop measurable criteria and targets for all dimensions of continuity and include these as elements in staff and systems appraisal

- identify aspects of working practices that support continuity of care and provide satisfaction to staff, and use these as criteria for evaluation

- identify ways in which continuity of care may act as an agent of quality, for example by enabling staff to see the consequences of the care they provide.

The Report

Section 1 Introduction

1.1 Structure of the report

This report is about the implications of a wide range of policies affecting human resources in the NHS for the capacity of various parts of the NHS and social care to deliver continuity of care. It is based on the findings of a six-month study commissioned by the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO) as part of a larger programme of work on continuity of care. The study took place between April and September 2001 and was carried out by a research team from King's College London.

- **Section 1** of this report (Introduction) sets out the background to the study, defines the aims and research approach adopted, and explains the structure of the study, which involved a policy document analysis followed by a series of expert seminars.

- **Section 2** (Document analysis) describes the approach taken in the policy document analysis and outlines the framework of policy themes generated by this process.

- **Section 3** (Expert seminars) outlines the format and purpose of the expert seminars which were held with a range of stakeholders in four specific areas of care.

- **Section 4** (Findings) presents the integrated findings from the document analysis and the seminar discussions, relating to each policy theme in turn.

- **Section 5** (Discussion and recommendations) draws together the findings of the study to generate an analysis of the relationship between policies affecting human resource management in the NHS and continuity of care as experienced by patients.

Note on terminology

The terms 'patients' and 'carers' are used throughout this report to refer to the wide range of users, clients and consumers of health services, because this reflects the language of most of the policy documents examined during the study.

1.2 Background

The efficient deployment of human resources in the NHS is perennially important because of the significance within the NHS recurrent budget of spending on staff salaries (Martinez and Martineau, 1998). It is also well recognised that staff play a central role in facilitating the provision of a high-quality service and determining whether the objectives of health care reform are achieved (Buchan, 2000). A key aim of the modernisation agenda of the current government is to develop a more user-orientated and responsive health service (Ham, 1999) and this orientation is reflected in the increasing emphasis on consumer-led indicators of quality such as choice, access and continuity of care in health service policy and political rhetoric. The new emphasis demands not only that the NHS is adequately and appropriately staffed, but also that the staffing structure is tailored to provide a more flexible, user-oriented service.

There has been considerable activity on issues relating to human resource management in the NHS in recent years. This reflects growing concerns about recruitment and retention, quality of working life and appropriateness of care. The 1997 white paper *The New NHS: Modern and Dependable* (Department of Health, 1997) emphasised the role of staff involvement in reforming the NHS, and this was reaffirmed by the publication in 1998 of a new human resources strategy document for the NHS (NHS Executive, 1998). Since then, initiatives relating specifically to developing the workforce have included reviews of the education, roles and responsibilities of NHS staff to support more flexible working practices and strategies to improve equal opportunities, enhance career opportunities and ensure a better work–life balance for staff (Department of Health, 2000; NHS Executive, 1999; NHS Executive, 2000).

In 1999 the NCCSDO undertook a listening exercise aimed at discovering what issues were most important to those delivering, organising and receiving health services in the UK (NCCSDO, 2000). The current emphasis on user interests was reflected both in the approach adopted for the listening exercise, which incorporated extensive consultation with users, and in its findings, where high priority was accorded to user interests by a wide range of stakeholders. The listening exercise identified ten areas of particular concern to service users and NHS staff. These included a range of issues with direct implications for the NHS workforce, such as co-ordination across organisations, interprofessional working, and continuity of care. This last topic was the first area chosen for further work. The NCCSDO commissioned a scoping exercise on continuity of care, with a brief to provide definitions and identify conceptual boundaries, map the existing evidence of the impact of continuity on the process, outcomes and costs of care, and to identify likely directions for research (Freeman *et al.*, 2001). This led to commissioning of a range of short-term and longer-term projects on specific aspects of continuity of care.

The deployment and attitudes of the NHS workforce are important factors in determining whether patients experience continuity of care. Some policy initiatives affecting workforce practice may be deliberately designed to impact on continuity of care, others will do so unintentionally through unanticipated effects. In addition to the policies which focus specifically on human resources, many of the major developments in other aspects of the health service – such as the restructuring of organisational boundaries, the implementation of new philosophies of care, and developments in information technology – impact significantly on where, how and by whom patients are cared for and how health professionals do their work. The amount of change, rate of change and nature of change occurring in the service as a whole are all likely to affect continuity of care, influencing both where and how problems occur, and how they may be addressed.

The purpose of this research study was to illuminate this interface between policy and patient care by examining the present and potential implications for continuity of care of the wide range of current policies affecting human resources in the NHS.

1.3 Study aims

The aims of the study were:

- to explore the implications for continuity of care of the wide range of generic policy initiatives currently affecting management and use of human resources in the NHS

- to consider the effects of these initiatives on continuity of care in four specific areas of care chosen to serve as exemplars of the service as a whole, and to identify examples of good practice whereby potential barriers to continuity may be addressed.

1.4 Research approach

The purpose of the study was to determine the effects of real policies in the real world. While this might appear to be a concrete and straightforward task, it presents important temporal and conceptual difficulties for research. First, it requires exploration of the effects of policies that have not been fully implemented, whose consequences are therefore not yet wholly evident. Secondly, it requires investigation of a chain of causes and possible effects that are not necessarily explicit and may be unintentional. Many policies have an impact on the use and management of human resources without that being their primary objective. Both human resource and other NHS policies may have significant effects on continuity of care, irrespective of whether they are designed to do so. In practice, few policy documents mention continuity of care, and even fewer state it as a primary objective.

Human Resource Policies and Continuity of Care

The consequence of these difficulties is that the study demanded a considerable element of speculation and necessarily incorporated some leaps of the imagination. It was not possible to use conventional evaluation methodology, since there were no appropriate aims against which the policies could be evaluated, nor achieved outcomes specific to continuity of care which could be measured. Equally, the question could not be addressed through undertaking a systematic review, because there was no directly relevant research literature. The absence of any obvious tried and tested strategy increased uncertainty but also gave us greater latitude in deciding how to go about the task.

Our response was to adopt a pragmatic approach, basing the study on the most appropriate information available, but giving precedence to the experience of those with first-hand knowledge of what is happening in health and social care. In defining relevant policies, we decided against the use of technical definitions of human resources as a filter for inclusion, going instead to the policy documents themselves and developing a framework for analysis on the basis of what we found them to contain. In setting the parameters for discussion of continuity of care we used the dimensions of continuity proposed in the scoping exercise commissioned by the NCCSDO, which was based on analysis of existing research findings. For information about the impact of the policies we consulted with people who are experts, not because of their academic or theoretical knowledge (although some of those involved do have such expertise), but because they live and deal with the effects of those policies from day to day.

Section 2 Document analysis

2.1 Definitions

Human resources

The aim of the study was to consider the impact on continuity of care, not just of 'human resources policies', but of all policies affecting the use or deployment of human resources in the NHS. In the absence of any formal criteria for deciding which policies might have such effects, the decision was taken to incorporate any policies which appeared likely to influence how people work in the NHS, and how, where and by whom patients are cared for. The scope of inclusion for documents was therefore greater than those formally defined by title or by source as specifically concerned with the use or management of human resources.

Continuity of care

Continuity of care was defined according to the five dimensions developed by the NCCSDO scoping exercise (see Box 2.1). In the report of this exercise, it was proposed that one or more of these dimensions would need to be achieved for patients to experience a co-ordinated and smooth progression of care.

Box 2.1 Dimensions of continuity

1 Continuity of information

Effective information transfer following the patient; consistency of information given to patients; harmonisation of common data management

2 Cross-boundary and team continuity

Effective communication between professionals and services across team and organisational boundaries; smooth transition between care settings and health care professionals

3 Flexible continuity

Flexibility within the service to enable adjustment of provision to the needs of the individual as they change over time

4 Longitudinal continuity

Care from as few professionals as possible, consistent with other needs

5 Personal continuity

Provision of one or more named individual health care professionals with whom the patient can establish and maintain a therapeutic relationship

---

Source: Freeman et al.*, 2001*

Policy documents

For the purposes of this study, 'policy documents' were defined as written proposals emanating from the Department of Health or the NHS Executive which have had, or seem likely to have, a significant impact on the direction of developments in health and social care. This definition led to the inclusion of documents of varying status, ranging from those which have clear legislative force such as the 1999 Health Act (Stationery Office, 1999) to consultation documents, where these appeared to contain the most comprehensive account of a proposed reform. Generally, reports and proposals from other sources were excluded, but one or two exceptions were made to this principle to include documents which had particular relevance and potential significance. Because the brief for the study was to look at recent and projected policies, the analysis was limited to documents produced since 1 May 1997 when the current government came to power. The timing of the study meant that no policies announced after 1 June 2001 were considered in the initial document analysis, although some significant initiatives which were published slightly later, such as *Shifting the Balance of Power – Securing Delivery* (Department of Health, 2001), were discussed within the seminars.

2.2 Selection and analysis

Identification of relevant policy documents

Identification of relevant documents was complicated by the fact that no comprehensive list of NHS policy initiatives was found to be available. In the absence of such a list, possible documents for inclusion were found through a combination of different methods including searching of relevant government and professional websites and journals concerned with health policy and discussions with librarians and other colleagues. This process continued until the point was reached where all new material identified appeared to relate to initiatives already covered. During the seminars, a final attempt was made to ensure that all key documents had been considered by asking participants to point out any significant omissions.

The initial collection of 60 documents identified as potentially relevant to the study is listed in Appendix A. From these, a subset was selected for more detailed analysis. The criteria for selection were that the policies they related to appeared:

- to have significant implications for human resources in the NHS
- to have a potential impact on continuity of care
- to be generic, with service-wide effects, rather than relating to specific areas of care
- not to have been superseded by more recent initiatives
- to have some possibility of being implemented.

Where there were several documents relating to a particular strand of policy, one was selected to represent that strand. The intention was to include a sufficiently wide range of documents to ensure the validity of the analysis, while avoiding unnecessary duplication.

Analysis and grouping by themes

We devised our own framework for grouping together the various different strands of policy that feature in the documents under six thematic headings (see Box 2.2). The policy themes emerged and were refined further as the analysis progressed. The themes were grounded in what we found in the documents, rather than theoretically derived, but they reflect broader trends that have been identified in other commentaries on health policy over the past four years. The rationale for grouping policies in this way was to make the lessons of the study less time-specific, and to go beyond particular initiatives to consider broader trends in policy.

Box 2.2 Policy themes

1 Reconfiguration of services (e.g. primary care trusts, redrawn organisational boundaries, new service links)

2 Information and IT (e.g. electronic patient records, data protection)

3 Flexible workforce (e.g. skills, skill mix, flexible deployment, education, training)

4 Quality, safety and standards (e.g. performance assessment, clinical governance, guidelines and standards)

5 Better working lives (e.g. flexible hours, improved career paths)

6 Patient-centred care (e.g. care pathways, user-oriented service)

Each document included in the sub-set was analysed to:

- generate a summary description of its main policy aims

- establish its status (e.g. consultation document, parliamentary bill)

- identify links to other earlier and more recent policy initiatives

- identify which of the various policy themes it addressed

- consider which of the five elements of continuity of care it might affect.

Appendix B contains the summary analysis sheets prepared for each of the documents selected.

A briefing paper (Appendix C) was prepared for the expert seminars, containing a summary of the main elements of each policy theme, some examples from the relevant documents, and some provisional suggestions as to how policies within each theme, if implemented as planned, might be expected to affect continuity of care. The purpose of the briefing paper was to provide a common starting-point for seminar participants to reflect upon beforehand and to set up a framework for discussion on the day. The six policy themes were presented alongside the five dimensions of continuity of care as a 'tool for thinking with', to encourage participants to reflect on a wide range of policies, consider their actual and potential effects on how care is provided by people working in the NHS and, in turn, reflect on the possible consequences for a variety of aspects of continuity of care.

Section 3 Expert seminars

3.1 Seminar design and format

Areas of care

The initial policy analysis was deliberately wide ranging, concentrating on generic initiatives with service-wide implications rather than those relating to specific areas of care. The purpose of the expert seminars was to explore the implications of the various policy themes in greater depth by looking at the effects of their implementation in four specific areas of care selected for their capacity to serve as exemplars of the service as a whole.

The four areas chosen were maternity care, primary care, mental health care and cancer care. In all four areas, continuity of care has been identified as a key objective by both users and health professionals (Department of Health, 1993; Marks, 1994; Brandon and Jack, 1997; Sandall 1998; Howie *et al.*, 1999; Glendinning *et al.*, 2000; Heslop *et al.*, 2000; Luker *et al.*, 2000). In each case, both organisational and workforce issues have been identified as presenting barriers to achievement of such continuity. Each of the areas cuts across a different range of organisational and service boundaries, but all four require fast and efficient access to acute services while also providing ongoing care in community settings. It was anticipated that, between them, discussions in these areas would identify a wide range of issues regarding the impact of the generic policies on continuity of care, with each one contributing a slightly different range.

Seminar participants

For each seminar, the aim was to bring together small, multidisciplinary groups of six to eight people with expert knowledge of the service and direct experience of the issues affecting continuity of care in the relevant area of care. Each group was designed to incorporate a variety of perspectives including those of users and carers, health care professionals, managers, researchers and policymakers and to include people involved as users, providers and planners at both national and local levels. Potential participants were identified using a range of local and national contacts and networks in the health service, voluntary sector, universities and the Department of Health. Initial contact was made by telephone and e-mail and invitations to participate were accompanied by detailed information about the aims and context of the study. Overall, 60 people were approached and all of these expressed considerable interest in participating in the study. However, because of the tight timescale for the project, which meant that seminar dates had to be fixed before inviting potential participants, many of those

initially approached were already otherwise engaged. Where people invited were unable to come, we asked for and followed up their suggestions for alternatives. Two intending participants (one user representative and one employment relations adviser) unfortunately had to cancel at the last minute. The names, job titles and other relevant roles of the 25 people who eventually participated in the four seminars are listed in Appendix D. As may be seen, this is a very heterogeneous group, ranging from individual carers and staff working at the grass roots to national policy leaders. Additionally, several of those involved had roles and experience that cut across the divide between user and professional, clinician, manager and policymaker. Because of the small numbers involved, each of the seminars incorporated a slightly different mix of perspectives which influenced the discussions, for example by varying the extent of preoccupation with managerial, clinical or user issues. The detailed content of each discussion was also coloured by the distinct cultural, contextual and topic-specific policy environments of the four areas of care involved. However, despite these differences, the range and content of views expressed on all the major themes discussed was largely consistent across all four groups.

Seminar format

The four one-day seminars took place in June and July 2001. In advance of each seminar, participants were sent a copy of the briefing paper described above. Each seminar was attended by four members of the research team who began by outlining the purpose of the study and reiterating the rationale behind development of the policy themes and the various dimensions of continuity of care. This was followed by a series of facilitated discussions, taking each of the six policy themes in turn and focusing on the following questions:

• Do the policies enhance or support continuity of care and in what way?

• Do the policies generate new problems for continuity and what are they?

• What can be done to optimise the benefits and minimise the problems?

It was emphasised that while the primary focus was on the implications of generic policies with service-wide effects, account should also be taken of more service-specific initiatives where these were clearly relevant. In respect of each policy theme, participants were encouraged to identify useful examples of practice where actual or potential barriers were being dealt with more or less successfully. It was made clear at the beginning of each seminar that the aim of the day was to engage in a free-ranging discussion, with no presumption of agreement or pressure to achieve consensus. To encourage open expression of views, it was agreed that all reporting of the seminars would be anonymised, with no points individually attributed by name or

affiliation. The seminars were conducted on the explicit premise that everyone involved had expert knowledge within their own domain and thus conventional hierarchies of power and status would not be relevant. This principle of equal value was successfully adopted and the tenor of all four seminars was one of reciprocal respect.

Each seminar was audiotaped with the participants' permission and subsequently transcribed. Summaries of the points raised in each discussion were prepared from the transcripts and copies circulated to the participants.

3.2 Analysis of seminar findings

Each of the four seminars generated a transcript of approximately 35 000 words. The seminar findings were analysed using a modified version of the 'framework' approach developed by Ritchie and Spencer (1994) for use in applied policy research. The data were analysed by taking each policy theme in turn, extracting the sections of discussion relevant to that theme from all four transcripts and then grouping these together. The collected material for each theme was then examined across all four areas of care, indexing the transcripts to identify points which address the impact that the various initiatives within each theme are predicted to have, or are already having, on human resource issues and, in turn, the effect of these on patient care (see box with worked example overleaf). The analyses for each theme were undertaken independently by the three researchers (KE, BK and CH) and were then cross-checked and finalised by consensus.

Because of the very wide range of issues to be covered in a limited amount of time and the free-flowing nature of the discussions, it was neither appropriate nor feasible for the facilitator to intervene during the seminars to ascertain the precise extent of consensus on each point made.

In presenting the findings we make clear which issues evinced general agreement, which were raised by participants in all the seminars and, conversely, which were seen as particularly significant in one or other of the groups or were identified by fewer individuals. Where contrasting points of view were expressed, these are noted, but there were few instances of explicit disagreement and no dissenting voices have been excluded.

Human Resource Policies and Continuity of Care

Process of analysis	Worked example
1 For each of the six policy themes, identify and extract relevant sections of discussion in all four seminar transcripts and read through to gain familiarity with content across all the seminars for this theme	Policy theme 5: Better working lives
2 Identify main types of change within this policy theme which influence how people work in the NHS and how, where or by whom patients are cared for	Main types of change identified: • reduced working hours • flexible patterns of employment • clearer career pathways

3 For each type of change, identify and bring together all points made about:
 	
• potential implications
 	
• actual current effects
 	
(including both positive and negative implications for patient care in general and continuity in particular, and both intended and unintended impacts)
	Summary of points made regarding flexible patterns of employment
	
	• potential implications:
	
	  – *positive*: improved retention, increased staff numbers, reduced reliance on agency staff, higher morale, higher energy levels, greater efficiency all leading to improved patient care
	
	  – *negative*: none identified
	
	• actual current effects:
	
	  – *positive*: reduced absenteeism
	
	  – *negative*: problems of appropriate cover for part-time staff; difficulties for succession planning; concerns over clinical competence of part-time staff; instability and increased mobility in workforce; potential problems for clinical governance

Human Resource Policies and Continuity of Care

(continued)

Process of analysis	Worked example
4 For each type of change, identify all examples given of strategies to optimise the benefits or minimise the problems for continuity of care	Example identified regarding flexible patterns of employment: • A group of district nurses who were unable to physically hand over cases due to their part-time working arrangements used audio-recordings of case details to ensure their job-share partners were kept up to date
5 For each policy theme, identify factors suggested in seminars as affecting capacity of changes to achieve intended goals	Strategies intended to improve staff recruitment and retention seen as undermined by: • financial constraints keeping NHS salaries down too low • organisational and cultural barriers to part-time working • negative media imagery of public sector

Section 4 Findings

The findings for each of the six policy themes are presented below. Each section begins by clarifying the aims incorporated in the theme and identifying the key documents associated with those aims. This is followed by a summary of our initial analysis of the potential implications of policies within that theme for continuity of care, based on extrapolating from the proposals in the documents. This introductory information was incorporated in the briefing paper for the expert seminars and provided the background for the subsequent discussions.

For each policy theme, a distillation of the seminar discussions is then presented, focusing on participants' perceptions of the actual effects of the policies in practice, and organised to reflect the main issues identified as potentially problematic during the seminars. Examples of ways in which potential problems may be addressed are incorporated in the analysis and are also presented as a group in Appendix E. Each section concludes with a summary of the key issues.

Note on referencing

The full references of the key documents identified for each theme can be found in Appendix A, listed in chronological order. These documents are not cited in the reference section of the report unless they are also mentioned elsewhere in the text.

4.1 Reconfiguration of services

Policy aims

The policies within this theme are concerned with reconfiguring the health service to create a more integrated and seamless service and to shift the focus of decision making towards those directly involved in providing patient care. Reconfiguration includes redefinition of organisational boundaries through expansion, contraction or merger, reallocation of roles between organisations, and changes in the ways in which services are provided at local level. Major strands within this theme include the development of a primary care-led service and the facilitation of joint working between health and social care.

Human Resource Policies and Continuity of Care

Key documents

- *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare* (1999)

- *Working in Partnership: Developing a Whole Systems Approach* (2000)

- *The NHS Plan* (2000)

- *Raising Standards for Patients: New Partnerships in Out-of-Hours Care* (2000)

- *Implementation Programme for the NHS Plan* (2000)

- Health and Social Care Bill (2001)

- *Shifting the Balance of Power* (2001)

Potential implications for continuity

The development of an integrated primary care-led service may have a positive impact on **cross-boundary and team continuity** as a consequence of more effective and integrated multidisciplinary working.

The NHS Direct gateway to the NHS is intended to create a streamlined experience for patients, but may be perceived as a barrier to **longitudinal** and **personal continuity** if patients lose direct contact with the particular professionals with whom they have had a personal and/or long-term relationship.

Joint working between health and social care providers is intended to increase **cross-boundary and team continuity**, and could improve **flexible continuity** as well as **continuity of information**.

Expanded clinical responsibility for specific professional groups such as nurses and consultants as detailed in the NHS Plan may impact positively upon **longitudinal** and **personal continuity** if one professional has the clinical capabilities and responsibility to oversee a greater proportion of an individual's care.

Implementation in practice

Objectives of reconfiguration

In all the seminars it was acknowledged that the overall aims behind the various policies for reconfiguration were reasonable and that the changes might prove beneficial for continuity of care in the longer term, assuming they are fully implemented and given sufficient time to settle down. For example, shifting the onus of decision making towards the local level was seen as sensible because those involved would have more insight into local needs and problems, and would also welcome the opportunities for greater influence on patient care.

> *I'm a lay person, so I'm putting words in clinicians' mouths, but I think what seems to motivate clinicians most is the chance to improve patient experience, because they obviously directly benefit from that. So making*

> *the decision making happen at a level where that interaction is constantly taking place is, I think, a driver. In the area I come from, a very deprived area, the GPs – loads of them are single-handers – are already beginning to say 'well, we could do this and we could do that', whereas before there's been complete disengagement. And so I do feel much more optimistic.*

At the same time, however, there was concern that if decision making were overly dominated by clinicians, patient-led priorities such as continuity of care would be more likely to get overlooked. This risk was felt to be increased by the loss of input from more strategic thinkers working at regional level, who were regarded as more open and less partisan. Plans for increased user participation in decision making were seen as important to rectify the balance.

The development of primary care trusts was particularly welcomed by participants in the cancer care seminar for providing an organisation in the community that has the potential to enable better integration across the acute and primary sectors.

> *Calman-Hine said that primary care is the focus of care. Full stop. And then didn't say what we should do about it. And I think we were all daunted by the thought, 'how do we get to 30,000 GPs, 11,000 practices and goodness knows how many community nurses?' Whereas the PCTs do give us a potential structure through which to do that.*

The need to work out how to use this structure positively had already led to greater integration across different services, as a result of staff from the various sectors and adjacent geographical areas relinquishing organisational and tribal rivalries and coming together to work out how to influence commissioning for cancer care. This shift towards greater collaboration was supported and reinforced by the development of cancer networks, which were seen as providing a valuable blueprint for similar developments in other areas of care.

On the other hand, the current preoccupation with reorganising services to improve access, for example by developing walk-in centres, was identified in the primary care seminar as a strand of reconfiguration policy which was more likely to undermine than enhance continuity of care, not least because such centres require additional staff to duplicate for some patients services that already exist for the whole population in general practice.

Human Resource Policies and Continuity of Care

Appropriateness and coherence

While seminar participants supported many of the aims behind the various plans for reorganisation, there was widespread agreement that reconfiguration, even where it is specifically aimed at improving integration, cannot succeed without a whole range of other changes also taking place in parallel. The perceived preoccupation with 'shuffling services around' was seen as misconceived because it proffered a structural solution to what were felt to be essentially functional problems. There were major concerns about the resources and expertise required to implement the new arrangements and participants warned against underestimating the cultural obstacles to introducing new philosophies of care.

> At practitioner level, working with people trying to develop those [outreach] teams, they ask very practical questions like, 'well does that mean that I take 12 of the people on my case load with me then, when I go into this outreach team? And what about the other 12 people I've been working with for the last five years? How do I deal with them?' So while, in theory, a lot of practitioners are signed up in terms of wanting to give really good-quality intensive care to the most vulnerable people, in practice there are some very hard practical difficulties, which really do highlight the clinician perspective of, 'I've known this person for 20 years'!

There was also concern about the 'lack of fit' between the various different policies which require rethinking of how services are organised. For example, participants in the mental health seminar drew attention to the problems of reconciling arrangements for trusts with the expectations in the various National Service Frameworks.

> You're getting a mental health trust, and you're getting a primary care trust with or without mental health. And then you get NSFs for mental health, for children and for older people. And when the NSF for mental health came out we sat down and said, 'well, what does this say about older people? Quite where do they fit?' And it's not really clear. And so, as the various NSFs come out, it requires individual organisations to extract different bits. A key issue for continuity in mental health is between child and adolescent mental health services and adult mental health services. And there are real discontinuities emerging there, where they are getting in one case into an acute trust, in other cases into a primary care trust. So some of the NSF stuff and NHS planned stuff is not quite fitting with some of the PCT and secondary care mental health care services. You have to do quite a lot of unpicking.

Process of reconfiguration

Participants in all the seminars commented on the many practical difficulties associated with any reconfiguration within a complex system. These include how to manage the handover, how to cope with 'planning blight' and how to keep hold of higher aims when preoccupied with operational issues.

> To give you a practical example, the mental health trust that we are developing involves bringing together seven bits of different organisations. But it's also within the context of arranging 20 organisations to be reconfigured throughout the county at the same time, on the same day.

Human Resource Policies and Continuity of Care

> *And we don't have a clearing house arrangement for what all that means for all these managers and so there is a lot of trauma out there, and nobody has really worked through what the fallout is going to be around that issue.*

There was also concern about how implementation of the various changes distorts the system, as new initiatives preceded change in other areas.

> *If you look at the NHS Plan, there are some very specific things in there about x number of early intervention services, and a larger number of crisis facilities. To deliver those in the way that is specified actually introduces significant discontinuities with the existing structure of services. I actually have quite a bit of sympathy with the plan, but I know many of my colleagues don't, because they see it as cutting across existing systems for promoting continuity. So we've got, at a kind of micro level, things coming up with very clear timescales attached to them that set up potentially significant discontinuities with the existing systems.*

Experience of reconfiguration

In all the seminars, discussion focused much more on the damaging effects of perpetual reorganisation than on what particular policies for a reconfigured service might ultimately achieve. There was a strong feeling that continuity within the system – both of people and of knowledge – was necessary to provide continuity of care for patients. For those involved in planning or providing care, the process of reconfiguration generated uncertainty, disrupted established links and undermined taken-for-granted assumptions about how the service worked. Thus any reconfiguration might be disruptive in the short term. With the present pace of change in the NHS, a major concern for all the participants was that disruption of this sort had become endemic and discontinuity had become a normal state. In these circumstances, each new change was perceived as contributing further to a general undermining of morale.

> *You can't go on changing everything. Because every change comes with a fanfare which says, 'this is much, much better than the last one, which was a load of rubbish!' And you can't go on destroying people's faith in the organisation that they are trying to optimise.*

Loss of personal relationships

A major consequence of reconfiguration is increased staff turnover among those whose jobs change or disappear. In addition, it was suggested in the seminars that the prospect of reconfiguration itself increased job mobility, because insecurity increased and people moved before they had to. The experience and anticipation of constant change were seen as undermining the development of informal links between staff in the health service, because investing in relationships on a personal level was no longer regarded as worthwhile. The loss of such links was identified as potentially damaging for continuity of care, insofar as the lack of informal contacts between staff might prevent important but sensitive information being shared.

Human Resource Policies and Continuity of Care

> *We've seen this in the context of domestic violence in pregnancy, where midwives are very wary about putting anything in writing. If they know the GP personally, then they will probably mention their suspicions. If they don't know them personally, then they won't.*

It was also observed that in circumstances of rapid change, where colleagues and systems become increasingly unfamiliar, people tended to gravitate towards old contacts, irrespective of whether they were still the most appropriate.

> *What you do if you're not sure what's going on around you, how things are being reconfigured or what's happening, is that you go back down to making those individual links and those individual sorts of referrals. It's about, 'who do I know in this patch that I can make a referral to for this patient?' You go back to what's known, rather than thinking around what's happening – what the potential is.*

It was suggested that one means to prevent this happening was for each service group to take active steps to ensure that all relevant parties were promptly informed of any personnel or structural changes. Meetings between those involved in caring for patients or clients at different points were also recognised as beneficial, if time and resources could be found to make this happen. In this connection, participants in the mental health seminar commented on the value of managed practitioner networks, which have been developed recently among those working with young offenders.

> *Networks are very common, everybody is engaged with networks. But what makes this different is the idea that resources will be put in to ensure that there is a manager of a network bringing together people from a much broader range of agencies than just health and social care.*

The perceived advantage of such networks was that they enabled links to be sustained between those with key roles and responsibilities, irrespective of how structures, individuals or job titles might change over time.

Loss of engagement with strategic thinking

Participants in all the seminars commented on how uncertainty about the future and unfamiliarity with changing systems led people to turn inwards and become less interested in engaging with strategic thinking or developing co-ordinated approaches for patient care beyond their individual areas.

> *I don't think anybody can insulate themselves totally from the changes that are taking place, but I think the strategy that many strong organisations will adopt will be one of, 'we'll just get on with it'. Because there's no point in making long-term plans to adapt to the environment when we don't know what that broader environment is. We don't even know what it is now. We certainly don't know what it's going to be in three years' time.*

Concern was also expressed about the loss of sustained leadership at management level in circumstances where shifting responsibilities and changing roles meant that nobody had established authority, individuals

doubted the legitimacy of their own decisions, and local knowledge and experience were not sustained.

> *I've been looking for the last six years for some kind of downward direction. Actually, as a person I favour grass-roots development, but nonetheless it would be nice to feel that there was someone at health authority level – or indeed, now, at PCG or PCT level – really driving forward some sort of co-ordinated approach to maternity services in terms of delivering continuity of care. But I haven't seen that in six years and I'm no more optimistic right now that I'm going to see it in the next six. I still feel that it's going to be down to individuals working as well as they can across the boundaries.*

Summary

Most of the policies for reconfiguration were seen as potentially beneficial for continuity of care, when and if they were fully implemented and allowed to settle down. However, there was some concern about the perceived preoccupation with structural change, when functional and cultural issues were equally important. Attention was also drawn to a lack of fit between the various different initiatives. Participants commented on the many practical difficulties associated with implementing change in such a complex system and the danger that multiple and rapid change distorted priorities and distracted attention from the fundamental objective of providing care. There was a strong view that some continuity within the system was necessary to provide continuity of care for patients. A major hazard of continuous reorganisation was that it damaged morale and those involved adapted by disengaging and continuing as far as possible down familiar paths, rather than actively participating in and taking advantage of new opportunities.

4.2 Information and information technology

Policy aims

Policies in this theme are concerned with improving the ways in which information is used, accessed, and transferred within the NHS and between health and social care services through system modernisation.

One key element is the development of an appropriate information infrastructure to facilitate evidence-based clinical practice. A second objective is to facilitate efficient and timely access to patient records through the harmonisation of information systems within the NHS and between health and social care. A third aim is to widen public access to usable, evidence-based, health-related information to assist in personal health maintenance and illness management.

Key documents

- *Our Healthier Nation: A Contract for Health* (1998)
- *Information for Health: An Information Strategy for the Modern NHS 1998-2005* (1998)
- *Saving Lives: Our Healthier Nation* (1999)
- *Working in Partnership: Developing a Whole Systems Approach* (2000)
- *A Health Service of All the Talents: Developing the NHS Workforce* (2000)
- *The NHS Plan* (2000)
- *Raising Standards for Patients: New Partnerships in Out-of-Hours Care* (2000)
- *Implementation Programme for the NHS Plan* (2000)
- Health and Social Care Bill (2001)
- *Changing Workforce Programme* (2001)
- *Building a Safer NHS for Patients: Implementing an Organisation with a Memory* (2001)

Potential implications for continuity

Systematic reference to evidence in clinical decision making has the potential to improve the consistency of treatment and **continuity of information** given to patients. Widespread access to better evidence may lead to greater standardisation of practice, leaving less scope for differences of opinion and approach which can limit the ability of staff to work together and share information in an effective manner. Greater cooperation and collaboration would enhance **cross-boundary and team continuity**.

Human Resource Policies and Continuity of Care

Systematic and standardised recording and effective access to patient information will help provide continuity across team and structural boundaries by enabling those providing care to access full clinical records where and when required. Electronic records are intended to aid integration of services and should therefore improve patients' experience of continuity.

Implementation in practice

Quality of relationships

Many participants, particularly in the maternity and primary care seminars, expressed concern that information systems such as NHS Direct, which substitute for personal contact between staff and patients, would have negative effects on the overall quality of patient care. Any loss of professional engagement with individual patients was regarded as potentially detrimental to continuity of care. The move away from a personal patient–clinician relationship was also identified as potentially damaging for staff recruitment and retention, since personal interaction with patients was regarded as a key element of job satisfaction for NHS staff. While it was generally agreed that NHS Direct might be useful for specific medical ailments, participants were less sure about the benefits of extending its remit into broader areas of health care.

> The sorts of things that are going to be possible are for somebody in NHS Direct to hold up a photograph of a rash and say, 'does it look like that?' It comes down the wire and in some ways that just turns me completely cold. It is brilliant, because it gives access to high-quality advice to people who are not mobile, all sorts of things like that. But, doing it through a television screen … I think if maternity care ever gets there then we really will have lost the plot.

In contrast, it was felt that electronic mail could play a useful role by providing an additional method of communication to help maintain links with patients and carers over time and between consultations. This was seen as valuable in establishing and sustaining both personal and longitudinal continuity.

> One thing I wouldn't like to lose is the contact with relatives. I've found email one of the most effective ways of contacting relatives who live miles away, and it's gradually building up. It's very informal, but actually I think that's going to be one of the keys for us, the contact with relatives. And there are lots of patients who go away for a while, but you can keep contact. It's not in terms of patient records, it's the communication.

Quality of information

The replacement of handwritten patient records by electronic records was regarded with anxiety, particularly by participants in the primary care seminar, who predicted that this would have negative consequences for the patient–professional relationship. Participants in all the seminars concurred with the view that present-day electronic

records were cumbersome, difficult to read and overloaded with inappropriate information. It was agreed that what was required was something multi-faceted, adaptable to a wide range of situations, illnesses and treatment programmes, and intelligible to a wide range of professional groups. The view was that such an optimal record did not yet exist even in paper form, and electronic systems were expected to face the same problems that had hindered the development of handwritten records.

Even imperfect paper records were regarded by most participants as supplying a range of information which could help clinicians to provide continuity by sparking memories of previous consultations and aiding early recognition of potential problems.

> *It's a subtle thing. For example, the length of the record, the style it's written in, handwriting, amendments … Is it a thick file? Is it a thin file? There's something more to reading a patient's record than what's written on a page. And [with electronic records] that's lost, you lose the early warning signs. You lose conveying the little things about a patient, where an exclamation mark means something, sometimes quite a lot.*

It was felt that standardised electronic records could undermine the capacity to provide appropriate care by limiting the nature of the information recorded, excluding idiosyncratic details that might be highly relevant for individual patients (such as the name of the patient's dog) and discouraging staff from recording information of a personal or sensitive nature.

> *What do you do when a patient doesn't want you to make the information widely available? In the written record you can sort of write around it. And we keep written records for that sort of thing.*

Accuracy and reliability of information

In all the seminars participants cautioned against over reliance on electronic records. As an example of the hazards, one participant told of a cancer nursing team which had noticed that the number of patients on its breast cancer register was considerably lower than expected, given the epidemiological profile of the catchment population. The team decided to do a hand trawl of patients' notes and found over one-third more patients who should have been entered onto the system. Participants in the primary care seminar also reported increased levels of incorrect information as a consequence of the shift to electronic records.

> *I think we're seeing more incorrect information, because when people see something in a [written] patient record that's wrong, they can correct it. But once they press the key and it's gone to the [electronic] record, people aren't as good at getting it back and correcting it. And the worst cases of loss of continuity and core communication involve computer-generated records, because for some reason, that bit of the screen hasn't come up!*

There was also concern about increased dependence on electronic systems of communication, however much they may improve efficiency

when they are working well, because of potentially greater problems when they fail.

There's been a lot of [test results back] and it has been a godsend to get them. But last surgery we had a power cut, so I actually had no records, no phone and no lights. And I thought, 'this is what electronic records mean. It means actually when the system breaks down, the whole thing goes'.

Professional access to information

A key benefit of the shift to electronic records was the speed and ease with which professional staff could access relevant information. As one participant in the cancer care seminar observed:

If you ring your consultant, or your husband's consultant, it is extremely handy if they can tap into a computer and just remind themselves, 'oh yes, 1997, laryngectomy'. Because, frankly, we can't all remember every patient all the time. What we won't have is your husband's notes sitting in front of us, the moment you happen to ring up. They will be 200 yards down the corridor. If we can have access to that medical information, on our desks, we can give you much more useful information when you do phone up with a query.

A number of participants also reported improved interprofessional and cross-boundary information sharing as a direct consequence of the introduction of electronic information systems. Furthermore it was agreed that better information collection and sharing had the potential to facilitate more efficient and effective utilisation of NHS resources, by assisting policymakers and commissioners to support effective service innovation, and to target services appropriately.

During the seminars many examples were cited of developments in information technology supporting a greater emphasis upon evidence-based decision making, through enabling more efficient and timely access to electronic databases and decision support. One example was of a pilot project in Solihull where district nurses had access to evidence-based information while visiting patients' homes, which enabled them to 'look up the latest on wound care, or whatever, and deliver the care there and then'. Both the enhanced capacity to deal promptly and appropriately with problems as they arose, and the more accurate, up-to-date and efficient record keeping which resulted were regarded as beneficial for continuity of care.

An added benefit of such technological developments was their capacity to free up staff time to deliver more personal care. One example was of a project where community midwives had piloted the use of hand-held remote-access systems enabling them to send information back to the unit and receive notification about new referrals without travelling backwards and forwards themselves. This project had, unfortunately, been curtailed because of the high cost of the equipment, but it was anticipated that such developments would become increasingly viable as prices fell in the future.

Human Resource Policies and Continuity of Care

There were also many examples of how IT and information policies were enabling practitioners to be increasingly flexible about where they deliver care.

> *If you have [cardiotocography] in a community setting, then you can easily fax through a CTG so the woman doesn't have to travel 20 miles in a rural area. If some sort of monitoring is felt to be necessary during the pregnancy she just goes to her local outpost.*

This helps build and maintain personal and longitudinal continuity, because patients can be treated by fewer professionals in their own communities. It also ensures greater continuity of information.

Patient access to information

Participants in all the seminars felt that the general increase in patient access to medical and health-related information was empowering them to engage with professionals in a more meaningful manner about health matters and hence would help to ensure that they received the most appropriate treatment. However, there was some concern about the unaccredited nature of much of the available information and the unevaluated impact of information overload.

> *There are 1001 different sites for the future and next generations. How well does that strengthen patients' ability to self-care, or does it in fact actually increase concern and weaken it?*

There was also worry that the current orientation of IT and information policies favours those sectors of the population with access to electronic sources, thereby further exacerbating existing inequities.

> *You've got to think of the range of people and their ability or lack of ability to cope with whatever you want to give them. Some people will not be au fait with the web. Some people will not have the facilities and therefore you've got to think beyond that. It's alright for people that've got the facilities – they can log in and feel comfortable. For others, it's a frightening world.*

Furthermore, there was a concern that standardised information provision failed to address the needs of a culturally heterogeneous population and hence disadvantaged marginal groups.

> *In a city like Bradford, you've got 65 different dialects in the Bangladeshi community. And where there's not a word actually for 'spasm', which is a common type of pain, how can you translate that? So it's about access for information. Just having that information around doesn't sometimes help different types of populations.*

Conversely, IT developments were welcomed by some participants precisely because of their ability to facilitate greater access to accredited advice and information for traditionally excluded sectors of the population, such as those in remote or isolated communities or with limited mobility. However, all were agreed that information needed to be provided in the context of the population served.

Human Resource Policies and Continuity of Care

Issues of skills and competence

It was generally recognised that many, though not all, current problems with electronic systems were to do with unfamiliarity, lack of technical skills and a perception among NHS staff that they were more suited to financial or performance management than to assisting clinical care. This situation can be overcome to some extent by training and is likely to diminish over time as more user-friendly IT systems are developed and people become generally more adept at using them. However, it was noted that the quality of an IT system depends not only on the competence of its users, but also on how well it is supported and maintained. There were major doubts as to how the NHS could access such technical support without the capacity to pay competitive salaries.

> It's a human resources issue. People can earn twice as much with less hassle, better equipment, in the private sector. It's that straightforward. And a lot of our systems, they fail because they haven't got the infrastructure to support them, however good their concept is. And that seems to me a real, real problem with NHS IT. And if you haven't got that, the greatest desire in the world is not going to do anything. I think that is a real key issue for IT.

Legal and ethical issues

Considerable uncertainty was expressed about the legality of holding and transferring patient information electronically, given the provisions of the Data Protection Act. Although these issues are also pertinent to paper-held information, the introduction of new computerised record system has emphasised the potential legal implications of mismanaged data. Some participants felt these problems could be dealt with through the use of confidentiality codes and encryption of sensitive information but there was continuing concern about the lack of clear guidance about the legality of electronic records.

> We have our illustrious BMA suggesting that electronic records are nowhere near what we need. There are enormous confidentiality issues and there are loads of messages bombarding us down on the ground and saying email is bad, electronic communication is bad, and unless we encrypt everything we can't do it. For the average GP who is embracing computers at the moment, he feels a very real inhibition about taking it further.

Some participants also felt that developments in electronic record keeping were taking place without adequate consultation with or consideration of patients' views. There was a belief that many sectors of the population were uncomfortable with personal information being held centrally in an electronic format.

Summary

Policies capitalising on developments in information technology were recognised by all participants as having the potential to revolutionise

the use of information in the NHS. Generally, new developments which were seen as enhancing or supplementing traditional modes of communication were welcomed, while those perceived as aiming to substitute for personal interaction or paper records were viewed with greater scepticism. Even where IT policies were accepted as potentially beneficial for patient care, there were many obstacles to overcome before these benefits would be fully realised. These included orientation of existing systems, fear of and unwillingness to engage with IT, skills deficits, costs of adequately resourcing the necessary infrastructure, and concerns about the confidentiality, security, and dependability of IT systems.

4.3 Flexible workforce

Policy aims

The aim of policies within this theme is the creation of a skilled, flexible and integrated workforce capable of responding to the needs of patients.

A Health Service of All the Talents sets out a strategy for the development of a flexible workforce through multidisciplinary training, more flexible deployment of staff, and a more integrated approach to workforce planning and development. Although this document refers to the goal of continuity of care for patients, it is more focused on integrating the workforce than on patients' experience of an integrated service, so its effects on continuity are indirect. The same themes reappear in the *NHS Plan* and later implementation documents such as *Investment and Reform for NHS Staff – Taking forward the NHS Plan* and the *Changing Workforce Programme*, which promotes concepts such as integrated pathways and reconfiguration of jobs to combine tasks differently.

Key documents

- *Working Time Regulations, European Working Time Directive* (1998)
- *The NHS Performance Assessment Framework* (1999)
- *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare* (1999)
- *Patient and Public Involvement in the New NHS* (1999)
- *Supporting Doctors, Protecting Patients* (1999)
- *A Health Service of All the Talents: Developing the NHS Workforce* (2000)
- *The NHS Plan* (2000)
- *Human Resources Performance Framework* (2000)
- *Raising Standards for Patients: New Partnerships in Out-of-Hours Care* (2000)
- *Implementation Programme for the NHS Plan* (2000)
- *Investment and Reform for NHS Staff – Taking forward the NHS Plan* (2001)
- *NHS Professionals: Flexible Organisations, Flexible Staff* (2001)
- *Health and Social Care Bill* (2001)
- *Changing Workforce Programme* (2001).

Potential implications for continuity

The development of more flexible working roles such as nurse prescribers and nurse consultants could lead to greater **personal** and **longitudinal continuity** if it enables one professional to cover a wider range of a patient's care needs.

The development of a diversely skilled flexible workforce should enable the provision of **flexible continuity** in line with changing patient needs.

More fluid flexible working patterns may improve **cross-boundary and team continuity** by reducing communication barriers between professions.

Implementation in practice

Sharing skills

It was widely agreed that flexible working, whereby more staff acquire a wider range of skills, had the potential to increase longitudinal and personal continuity by enabling patients to remain in the care of fewer staff. However, participants in all the seminars were aware of situations in which flexible practices intended to increase continuity had, in practice, lead to role and skills drift, resulting in more fragmented care. One example cited was the reduction of medical involvement in maternity care and the concomitant extension of midwifery skills, which had led to a situation where doctors no longer saw certain tasks as belonging to them.

> *A skill which was somebody's becomes somebody else's, suturing the perineum is an example. There are some cases where that has now become the midwife skill and the junior doctors get cross if they have to do too much suturing, because it's actually meant to be the skill of the midwife. I can see it potentially happening with examination of the newborn, that skills transfer from paediatricians to midwives or from GPs to midwives, and then the other group of people no longer do it. And that actually makes no contribution to continuity at all. What would make a contribution to continuity is taking a skill and saying, 'these three different professionals could do it'. But we tend not to think like that.*

In the cancer care seminar similar examples were mentioned of role drift in relation to prescribing and administering chemotherapy.

> *We have a silly business because nurse specialists in palliative care are not hands on. So they're in the house ... and they're giving advice. Equally I [palliative care consultant] might be in the house, but we have to ask the GP to prescribe. So, actually, instead of the two of us sorting it, you've then got two other people, who might be having busier days, having to come back and do it and get the prescription and everything.*

A common view among participants was that the more specific clinical tasks were the ones most likely to get shared out. When such tasks were delegated outwards, for example from doctors to nurses and therapists, the less clinically definable aspects of care ran an increased

risk of 'falling off the end'. A bigger workforce was required to avoid things 'falling off' in this way and creating discontinuities for patients, who might have to look to other agencies or voluntary groups, or simply go without certain aspects of care.

Participants in all the seminars also drew attention to the danger that increasing the range of people who could undertake particular tasks might mean that those tasks were no longer specifically 'owned' by anyone.

> *It's sometimes confusing for [patients], knowing actually whose total responsibility it is for their care. If something goes wrong, who is it that they're actually relating to here? There still needs to be that clarity about accountability.*

An alternative approach to flexible working identified by participants was the development of collaborative initiatives which, rather than requiring that skills were shared, brought people with diverse skills to work together as a team. For example, in the mental health care seminar, the development of teamwork in areas such as assertive outreach was welcomed and seen as clearly preferable to the concept of generic mental health practitioners.

> *It is about the combination of skilful interventions. Certainly some of the learning for me around assertive outreach has been the teamwork approach, and the success of the teamwork approach is the health technology that comes with that, because you bring in psychiatrists, psychologists, other professionals, therapists, social workers, community psychiatric nurses. Yes, you look at some additional training for them, but the health technology is a combination of those very different, highly skilled disciplines. And that's what works. That's what is required. The mixing itself.*

Flexible services

Flexible working was also discussed in terms of challenging rigidities in the way that services are provided.

> *If everybody is cemented into their concept of what their role was for the next 20 years, then nothing will get done. The flexibility is not just about a flexible workforce in terms of pushing bodies around, it's also around constantly redefining the roles of the individuals within that workforce. I think that's what I understand by flexibility, it's that we're constantly rethinking either the necessity to do a certain activity, or the identity of the person who should be doing it.*

One example cited in the maternity care seminar was the rethinking of postnatal visiting, so that it was no longer automatically done on a daily basis up until a certain day, but could be adapted according to individual needs. It was noted that some of the most notorious instances of unhelpful rigidities, such as the distinction between 'health' and 'social' bathing for patients in the community, had previously been underpinned by the financial separation between health and social care. Participants welcomed the provision in the Health Act for pooling budgets across these boundaries, which they saw as

considerably increasing the potential for continuity and flexible provision for patients with needs for both health and social care.

Participants in the mental health seminar drew attention to the need to consider the interconnected nature of services, pointing out that successful innovation in one area may have detrimental effects elsewhere. An example presented was the introduction of crisis teams, which was shifting the pattern of acute admissions by reducing admission of patients with less severe problems and thereby bringing about a more 'disturbed' inpatient population. Concern was expressed that, as a consequence, inpatient services would become more difficult places, not just for staff, but for patients as well.

> *So you are getting an increasingly demoralised and marginalised workforce, because all the focus is on the interesting and exciting sort of outreach, crisis, early intervention stuff. And that's not inpatient focus. I don't know what the figures are for the percentage of agency staff in the inpatient setting, but I guess it's high. And that, in terms of continuity of care, is seriously bad news.*

Attempts have been made to close the gap between inpatient and community services by having the inpatient unit run by the community mental health team. This has had some success in one site but it was noted that elsewhere staff found it more difficult to take on the very different roles and clinical responsibilities required in the two different settings.

Specialised services

Alongside the move towards greater flexibility, a number of participants drew attention to the equal and opposite pressure across health care towards specialisation and a tightening of focus. The organisation of integrated care pathways around diagnostic groups was cited in the mental health seminar as a manifestation of this drive, resulting in specialist services for personality disorders, eating disorders, depression and a range of other categories.

The argument for this trend was that people with special skills could provide better treatment than generalists. Opportunities for increased specialisation are popular with health service staff, because specialisation is associated with career progression and higher status. However, it was pointed out that people might have a variety of diagnoses and multiple problems which did not fit into the integrated pathways set up around specific diagnostic categories. In these circumstances, specialisation could lead to greater discontinuity for patients if they were passed between specialists because of multiple symptoms.

> *There is nothing worse than presenting to the GP and saying, 'I feel anxious', and he sends you off to the anxiety clinic and the anxiety clinic says, 'well, actually it's an agitated depression really, it's a misdiagnosis, you need to go to the depression clinic.' And what happens on your second visit to explain your problem, you think, 'bugger it, I'm*

going back home', and I think it's at those points of transition between different assessment systems that people drop out.

In this sense, it was argued that interest in the specialist areas actually diminished the service's capability to deliver care to people who did not fit easily into specialist categories.

If you've just got a rather mixed affective state and feel anxious and miserable and aren't doing very much, then nobody might be that interested in you. How do you get taken up by the system?

A further problem, noted particularly in the maternity care seminar, was that once someone had progressed up a pathway into specialist care it was very easy to get stuck there, because less attention was paid to enabling them to move back down to 'normal' care. The concern was that this could lead to a loss of continuity if it prevented women from maintaining connections with those who might be better able to provide for their more general needs.

The mother might be trailing backwards and forwards to the referral hospital very frequently, and simply didn't have time to be seen anywhere else. And it was assumed that, 'oh yes, if she is going up to wherever it is, then she will be getting her antenatal care there', but actually she wasn't. A lot of these women ended up getting no care for themselves, as opposed to the monitoring of the baby, from that point onwards. The baby's needs were being prioritised.

Participants in the primary care seminar described the difficulties of maintaining the generalist role of general practice against the pressure towards greater specialisation. It was felt that dispensing with generalists would be 'disastrous' for continuity. In this respect, initiatives to improve access were seen as undermining continuity because it was thought that, if given the option, many patients would choose to go directly to a specialist.

Recruitment and retention

Participants in all the seminars questioned how the aims of flexible working, which frequently required time out for retraining as well as more staff in some areas, could ever be achieved within the current constraints of insufficient staff.

If you're going to have continuity of care and have patients having the right care at home, and going through the system seamlessly, there's got to be more staff. But where are we going to get them from if 100 are leaving and you only train 12 a year? It's only 12 that have gone through the system this year.

The problem of staff shortages was consistently forecast to become more acute. For example, participants in the maternity care seminar anticipated that the EU *Working Time Directive* would bring about a crisis because there would not be sufficient nursing and midwifery staff to take up the extra work resulting from further reduction of obstetrician time. In cancer care, many more district nurses were expected to leave, making it increasingly difficult to provide seamless care.

> *There are an awful lot of trained district nurses leaving the profession. I know many who have gone. I know loads that want to go. I'm in a job share, my job share vacancy has been vacant since November. We've advertised three times and we've only had one applicant. It's not just my area, it's right across the areas, there are so many. I don't know how we overcome that, because the future is ... a quarter of our trained district nurses will be leaving in the next two or three years.*

Summary

Policies for a more flexible and integrated workforce were seen as potentially beneficial in creating a more responsive service for patients. However, the blurring of boundaries within and between professional groups is hazardous in a professional culture where specialisation is highly valued. The danger is that skills that are shared with others become a low priority for individual practitioners. Equally, when staff are asked to extend their roles in the absence of additional resources, some aspects of care risk 'falling off the end' or no longer being seen as anyone's primary responsibility. Policies which focus on ensuring integrated teamwork may be more successful in avoiding these problems. Innovative ways of working which engage staff enthusiasm and help meet patients' needs were welcomed, but it was noted that their very success may lead to a draining of energy and resources from other less favoured aspects of care. Similarly, specialised services which increase the coherence of care for particular categories of patient or health need are beneficial for patients who fit within that framework, but are potentially detrimental to those with less coherent needs.

Working flexibly to provide continuity of care requires sufficient numbers of staff. If promoted in the context of a full staff complement working together as a team, it could help with recruitment and retention problems by making jobs more varied and interesting. In the present context of staff shortages, many of the strategies for flexible working will be very difficult to achieve and may exacerbate pressures on existing staff.

4.4 Quality, safety and standards

Policy aims

The aim of policies within this theme is to ensure delivery of a consistently high-quality, equitable service. Central strands of this policy theme are performance assessment, professional regulation, clinical governance, and National Service Frameworks.

The NHS Plan and the Health and Social Care Bill introduced such measures as quality-based contracts for GPs including annual appraisal and audit and revalidation every five years, the 'traffic light' performance assessment link to funding, and local authority overview and scrutiny committees.

The NHS Beacons Programme and the Modernisation Agency are part a learning strategy aimed at ensuring widespread adoption of good practice. *Building a Safer NHS: Implementing an Organisation with a Memory* promotes patient safety through improved reporting, recording and analysis of adverse events, and the development of a 'no blame, learning from mistakes' culture.

Key documents

- *A First Class Service: Quality in the New NHS* (1998)
- *The NHS Performance Assessment Framework* (1999)
- *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare* (1999)
- *Patient and Public Involvement in the New NHS* (1999)
- *Supporting Doctors, Protecting Patients* (1999)
- *A Health Service of All the Talents: Developing the NHS Workforce* (2000)
- *The NHS Plan* (2000)
- *Raising Standards for Patients: New Partnerships in Out-of-Hours Care* (2000)
- Health and Social Care Bill (2001)
- *Building a Safer NHS for Patients: Implementing an Organisation with a Memory* (2001)

Potential implications for continuity

The implementation of National Service Frameworks may assist in providing **continuity of information** and **cross-boundary and team continuity**. However, **personal** and/or **longitudinal continuity** could be compromised if rigid adherence to safety measures or protocols resulted in staff feeling unable or unwilling to do certain tasks.

Human Resource Policies and Continuity of Care

The development of more accountable, open and responsive professional regulation may improve **cross-boundary and team continuity** by facilitating better multidisciplinary working.

The introduction of patient assessment of clinical training and practice as outlined in *Patient and Public involvement in the New NHS* may facilitate the provision of greater continuity of care in all respects, if this is rated as a key priority by service users.

Implementation in practice

Value of guidelines

Guidelines and quality standards were recognised in all the seminars as potentially beneficial for continuity of care. For example, in areas like maternity services where care is provided on many different sites, guidelines were seen as an important means of ensuring cross-boundary and team continuity.

> *We are only as good as our guidelines. We must have confidence in knowing that, no matter what time of day or night it is, no matter where it is happening, a woman presenting with this problem is going to be dealt with in this way and is not going to have some completely maverick and dotty care.*

In the mental health seminar, an example was given of a guideline which had benefited continuity by enabling treatment to be managed in primary care.

> *The guideline that we've had most success with has been around the toxicology issue with Lithium. It's the only thing I do that allows clinicians to sleep safely in their beds at night. From a patient point of view, they achieve stability, they achieve independence because their medication is handled at the GP surgery. In terms of a guideline, a protocol, a process as standard, the kind of security of treatment in terms of people's safety taking a very difficult drug, it works very well and it's auditable and even the audit's been tolerated.*

However, it was agreed that such success is relatively exceptional, and that developing, implementing and monitoring guidelines can often be an unrewarding process. Problems were identified with the amount of work needed to get the evidence together and reach agreement on content as well as obtaining co-operation for subsequent audits of practice. The unco-ordinated proliferation of guidelines at all levels from local groups to the National Institute for Clinical Excellence was seen as problematic, because of the potential for different recommendations to undermine and cut across each other. It was also noted that guidance designed to ensure one component of quality such as safety might be directly detrimental to other desirable aspects of care, such as continuity.

> *Some of the things around safety standards say, 'this person cannot do this because they are not trained to do it, it's not safe'. So you get this separating out, that only this person can do this and that person can do*

that. I think that's one way in which insistence on safety standards, even though it should be good news for safety, might be bad news for continuity."

At a time when other strands of policy are encouraging the development of a service more responsive to individual patients' needs, participants were worried that guidelines and quality standards, unless handled very carefully, were likely to pull in the opposite direction towards greater uniformity. One example discussed was the danger of producing inflexible guidelines for aspects of care where most patients might have similar requirements, but some wanted something different.

Two patients had gone for the same treatment for breast cancer, and there had been a month in which the journey was completed, from diagnosis to treatment. And that, in the textbook, was a big tick. And one of the patients was really happy with that – they felt reassured that it was completed and they could move on. But the other patient said that they needed about a month after the diagnosis, to just think about it. And there's no flexibility to build that in. Everything was pushed by the two-week wait."

Continuity of care as an objective

Continuity of care was identified as being an 'apple pie' concept, whose obvious desirability tended to disguise the fact that the evidence for benefits in terms of improved outcomes, as opposed to greater patient satisfaction, was not extensive. In an era where robust evidence is regarded as a driving force for quality, it was thought that continuity of care would easily lose out as an objective against 'harder' and more measurable goals. There was concern that, if attention was specifically given to promoting continuity of care, efforts would tend to focus on the most obvious and easily defined aspects such as continuity of carer, which might not always be the most important. It was suggested that with major new initiatives, such as the development of National Service Frameworks, the multidimensional nature of continuity of care should be specifically acknowledged and incorporated in the guidance.

What I hope is that [the NSF] picks up all the different dimensions of continuity. Certainly, in maternity services, people tend to think it's just continuity of carer, which tends to link mainly to the personal continuity. That's what would be really refreshing, if the NSF emphasised that there's lots of different ways of achieving continuity which may be appropriate in different areas.

It was agreed, however, that guidelines would be of little use in defining standards for some of the more elusive factors that influenced the quality of care, such as empathy with patients or staff morale, which might be crucial to supporting personal continuity.

In all the seminars participants pointed out that continuity should not automatically be regarded as a central tenet of high-quality care. In some circumstances, continuity might not particularly matter to the patient and in cases where the care itself was poor or inappropriate, continuity might be positively damaging.

Human Resource Policies and Continuity of Care

> *It depends what condition you're suffering from. If you're suffering from something which requires a short programme of expert help, after which you will be cured, the benefit of having continuity is probably outweighed by the benefit of things that help deal with you quickly. Whereas if you need ongoing support over a long period, continuity will be much more at a premium. And I think we have to think about the outcomes from continuity – they're not always good. Sometimes it just leads to a decline in performance and a stagnated relationship and poor outcomes. It depends on what the impact is on the person receiving care, and on those giving it.*

Participants described a number of circumstances where discontinuity might even be preferable for patients, for example enabling them to move on from a particular episode of illness or to obtain an alternative opinion. One example cited, where lack of continuity appeared to have been experienced as beneficial, concerned an evaluation of a midwifery development unit in which the care of women who had a known midwife during labour was compared with those who did not. No differences had apparently been found between the two groups except on the measure which asked, 'do you feel you were treated as an individual?'. The women who were looked after in labour by a midwife they did not know were more likely to say they had been treated as an individual.

Continuity of care as an agent of quality

While reservations were expressed about assuming that continuity of care equated with quality, it was agreed that continuity of contact with patients could help staff know whether they were providing good care and encourage them to do so. For example, participants in the primary care seminar raised the point made by some GPs that the opportunity to provide longitudinal continuity enabled them to learn from how their patients progressed and find out when they made mistakes. It was suggested that such feedback would be equally important in all aspects of the health service.

> *We've got to have feedback. The consultant who looks after the patient on the ward needs to have feedback over what happens to the patient when they come out to the community. The NHS Direct nurse needs to know what happens to the chest pain she triaged a month ago.*

Pressures on staff morale

In all the seminars, participants stressed the pressure that the increasing emphasis on clinical governance and implementing and monitoring guidelines and quality standards was putting upon staff. There was resentment both at the huge amount of time that was taken up 'feeding the beast' and at the damaging effects on staff morale of continued implicit questioning of their competence. This was perceived as exacerbating all the other problems in the health service by increasing the difficulties of retaining staff.

> *Why keep struggling against the tide? If I haven't got the confidence anymore, because I'm not sure that I'm delivering according to this or that, it's just easier to go and get another job somewhere else, or to retire.*

It was also seen as undermining the commitment of those who stayed in post.

The problems are actually much worse than people realise, because the numbers leaving are only the tip of the iceberg. It's the people who are staying that are completely changing their attitude. I'm seeing more and more people clock-watching, just not interested in going the extra yard, let alone the extra mile. And the health service has always relied, because of its underfunding and undermanning, on people doing more than they are expected to do. They're not doing it any more, and they're never going to do it any more. I don't think this health service can ever go back to the goodwill it had 10 years ago from its own staff.

Effects of blaming culture

The pressure of increasing evaluation together with the threat of complaints in a system generally under pressure and facing widespread criticism were seen as inspiring the growth of a defensive culture that militated against high-quality care and was slowing down the service as a whole.

You only need the majority of consultants to dig their heels in about the number of patients that they see in a clinic on the basis of, 'I'm not going to see another patient at all, because the net result is that my clinic will run late, complaints against me will increase, I will therefore get a black mark that will be filed in some folder that will be seen by somebody'. So you will find that clinics will slow down. Consultants are increasingly spending more time with patients, not because they necessarily need to or the consultation is any better. One of the true sadnesses about what's happened in the last three or four years is that previously there was a kind of unrealised understanding between the patients and the doctors, the nurses and the midwives within the NHS that most, if not everything that was done, was done with the best of intentions. And therefore it didn't have to be questioned. Now that has moved on. There is a great deal of uncertainty about why things are recommended and the net result is that all interfaces are now taking longer with patients. That's fine, except there is no slack in the system.

The effect on practitioners is that the quality of their working lives can feel under threat.

It feels punitive at the moment, working within the NHS. It feels as if you're walking over glass all the time, that you're waiting to make a mistake. And if you make a mistake your name will be across the headlines and your life will be wrecked.

In these circumstances, current policy exhortations to adopt a no-blame approach and greater openness in learning from mistakes were seen as unlikely to have much effect.

Summary

Policies which ensure the achievement and maintenance of high-quality care were regarded as fundamentally important for continuity, not least because continuity could not be advocated as desirable unless the competence of those providing care were guaranteed. However, concern was expressed about how the present policies in this area

were working out in practice. In the right circumstances, guidelines and standards might be extremely helpful in ensuring continuity, but too many guidelines applied inflexibly might have the opposite effect, increasing uniformity and undermining the ability of the service to be responsive to different patients' needs. Participants were anxious that continuity of care might be ignored as a marker of quality, because of measurement difficulties and the lack of strong evidence of its benefits. At the same time, there was concern that continuity should not be valued indiscriminately, or automatically associated with high-quality care, because in some circumstances it might be neither necessary nor beneficial. There was general agreement that the increasing emphasis on quality and accountability had led to serious problems of poor morale, lost goodwill and increasing defensive practice which must inevitably be damaging for patient care.

4.5 Better working lives

Policy aims

The aim of policies within this theme is to provide a better service for patients by increasing staff recruitment and retention. This is to be achieved by restructuring terms and conditions of employment for NHS staff and enabling staff to strike a better work–life balance, thereby making the health service a more attractive place to work.

Central strands of this policy theme are concerned with developing roles, improving pay, providing return to practice and career break schemes and offering more education and training opportunities. Policy documents stemming from the NHS Plan propose improved childcare provision, housing assistance, flexible working and retirement schemes. Some of the new Human Resources Beacons are focusing on providing healthy and supportive workplaces. The document *NHS Professionals: Flexible Organisations, Flexible Staff* outlines the development of an NHS-run staffing agency to become the primary provider of temporary staff, thereby providing greater access to flexible working patterns for NHS staff.

Key documents

- *Working Time Regulations, European Working Time Directive* (1998)

- *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare* (1999)

- *Caring about Carers* (1999)

- *A Health Service of all the Talents: Developing the NHS Workforce* (2000)

- *The NHS Plan* (2000)

- *Human Resources Performance Framework* (2000)

- *Raising Standards for Patients: New Partnerships in Out-of-Hours Care* (2000)

- *Implementation Programme for the NHS Plan* (2000)

- *Investment and Reform for NHS Staff – Taking forward the NHS Plan* (2001)

- *NHS Professionals: Flexible Organisations, Flexible Staff* (2001)

- *Changing Workforce Programme* (2001)

Potential implications for continuity

Increased recruitment and retention levels within the NHS should result in improvements to the overall quality of care, and enhanced continuity of care as experienced by patients.

Human Resource Policies and Continuity of Care

Adequate staffing levels are a precondition for delivering continuity of care, as understaffing has been shown to lead to a routinisation of clinical tasks at the expense of continuity. More part-time opportunities may help to attract and retain staff; however, this may also impact negatively on **longitudinal** and **personal continuity** if staff are not available at the times required by the patient.

The restructuring of services to suit the needs of patients and staff as detailed in the *Human Resources Performance Framework* may have a positive impact on **longitudinal** and **personal continuity** if these are identified as important factors for patient and staff satisfaction. However, patient and staff needs could be contradictory.

Implementation in practice

Reduced working hours

A key element within this theme is the reduction in junior doctors' hours. A number of participants agreed that decreased dependence on junior medical staff could, in theory, result in a more integrated package of nursing and medical care. A more streamlined service, provided by senior medical staff and nursing/midwifery practitioners with extended roles enabling them to provide a greater range of care, should potentially have a positive impact upon continuity of care. However, this had not been the experience of many of the participants to date. On the contrary, the reduction in junior doctors' working hours was more likely to be perceived as directly undermining the capacity to provide continuity.

> At the moment, junior doctors' hours is, in the acute sector, chaos. You come in acutely ill, you're seen by one doctor until midnight. Then another doctor covers until 8 in the morning and the third doctor picks up with a consultant that's never seen any of it before. And they don't even know where the patients are, they weren't there to see whether you're better or worse. And it goes on like that.

One of the central problems identified as preventing continuity was the lack of medical handover. This reflected the fact that, while there had been substantial changes to medical working hours and patterns of working, there had been little adjustment in the ways in which this work was carried out.

> One of the key things that doctors don't have built in and nurses implicitly do, at the start and end of every shift, is hand over. There is no doctor hand over. There is only a bleep. And you might say you may as well go there first, but sometimes you can pick up a bleep and just have no idea. Sometimes it's much better than that, but it's just not a routine part of what you do.

In addition to these concerns, participants in the maternity care seminar raised the question of possible structural changes which might occur as a consequence of the EU *Working Time Directive*. It was feared that the safety implications of a reduced medical workforce

could result in the amalgamation or dissolution of small-scale units, which would make access to services more difficult for some women.

Flexible working

The potential for flexible working policies to enhance continuity by improving retention, increasing staffing numbers, and reducing reliance on agency staff was universally recognised. Many participants felt that an improved work–life balance for NHS staff should result in higher morale levels and would consequently be beneficial for patients. It was also suggested by participants in the primary care seminar that part-time workers might have higher energy levels and therefore be more efficient than full-time staff.

Participants in the mental health seminar were troubled by the impact of high levels of absenteeism on the capacity of the service to deliver continuity.

> *We have absences in mental health that you don't have in other parts of the health service. Then we use agency and bank staff and that creates a whole set of problems for the permanent staff. And continuity certainly is lost.*

Consequently, they welcomed both the actual and anticipated impact of flexible working patterns on attendance rates. One participant illustrated how annualised hours had significantly reduced levels of absenteeism in their Trust.

> *We tracked what was happening in the disability service – there were huge absences at certain times of the year. It was the school holidays. So we gave managers discretion around the hours their staff worked, and [absences] have been reduced almost to nil. Staff do generally want to be at work, but their domestic circumstances take them away. You have to deal with that.*

However, there were many concerns about the implementation of flexible working strategies, including the difficulties involved in providing appropriate cover for part-time workers and considering the implications for succession planning.

> *There's also not much emphasis on succession planning for the posts. A lot of posts have been expanded and a lot of people have very general and broad-shouldered job descriptions that don't actually reflect the amount of care and expertise within them, and the projects they can do. So, when they leave, of course there is a huge gap and people have to start from the beginning again.*

Concern was also expressed about the clinical competence of part-time staff, the impact of flexible working policies on the ability to provide personal continuity, and the impact upon workforce stability. Participants in the primary care seminar were concerned that measures to increase career flexibility, which are designed to make long-term careers in health care more attractive, would instead lead to instability and increased mobility in the workforce. One example was the

introduction of salaried doctors in general practice, which was seen as having resulted in a faster turnover in staff.

One participant in the cancer care seminar suggested an imaginative solution to minimise the negative impact of part-time working on continuity. A group of district nurses, who were unable to physically hand over cases due to their part-time working structure, used audio recordings of their case details to ensure their job-share partner was up to date. Such an approach could also be utilised for medical handover.

> *If we don't see each other we leave tapes covering everything that's happened. Not just the main things, but everything, so that hopefully nothing gets missed.*

Career pathways

The development of clearer career pathways throughout the NHS was regarded by all participants as crucial for attracting and retaining staff. There was a specific emphasis on the need to develop career pathways in nursing which continued to incorporate clinical practice, since career progression in nursing had traditionally been synonymous with a move away from practice.

> *You [nurses] need to feel you've got status, you're moving up a system, you're respected. But you're not actually then involved in patient care. And then the message I guess for junior staff is that actually being with patients is not that important. The way to get on and get status is to leave patients behind.*

Participants in the mental health seminar welcomed the introduction of additional incremental points for nurses, which they felt would not only ensure greater retention of nursing staff, but also encourage highly skilled nurses to remain in clinical practice. But although this was seen as a positive step to improving continuity, it was recognised that the discretionary nature of such an initiative could be viewed as inequitable and might be difficult to implement. The introduction of nurse consultant posts was welcomed in all the seminars as a step in the right direction, but there were concerns that there would not be sufficient posts to have a significant impact on recruitment and retention in nursing.

Finance

Finance was recognised as a key barrier to improving recruitment and retention rates. Although the NHS could endeavour to provide additional benefits similar to those available in the private sector, there was a concern that the gap in salaries would prove insurmountable, particularly in urban areas, where high housing and living costs were a key factor.

> *I work in an area where all the nurses live elsewhere. Nobody can afford to live in central London, so you add that on to your day. And they're talking about housing assistance. They'd have to offer a lot of money to*

> *get people to where they need to work, because inner city areas need people most.*

Organisational culture

Participants in all the seminars felt there was discontinuity between the policy agenda and NHS culture, which manifested itself in organisational resistance to many of the initiatives encapsulated in the theme of better working lives. Factors cited as barriers included the low status of part-time work and resentment towards part-time workers, which was attributed in part to excessive emphasis on the rhetoric of commitment in the NHS. Participants acknowledged that these attitudes were beginning to change, particularly in primary care through the feminisation of general practice. It was agreed that a more general shift in professional and management thinking would be needed if the policies for better working lives were to be successful. At the same time, it was regarded as important to accept that the service required high levels of commitment from at least some of the staff, for safe and efficient functioning.

> *The bottom line is, you've got to have someone there to make sure that things happen. If you're all part-time, or partially committed to – if there is an end to your commitment – then something has to be done.*

Societal factors

A number of macro-societal factors were cited as obstructing the recruitment and retention of staff in the NHS. These included labour market competition from private industry, repeated press attention to the low pay and morale levels of NHS staff, and increasingly negative attitudes to careers in the public sector. Public attitudes were regarded as particularly problematic for recruiting staff to work in mental health services.

> *There is a huge stigma about mental illness. What can be done about it, I don't know. I think it's very good that the [first National Service Framework] was a mental health NSF and that it's one of the priority areas in the national plan. Good on the government for doing that. But one shouldn't forget how pervasive the stigma is, within medicine itself really. If you go to a casualty department it's: 'Oh, there's another nutter just come in'. That sort of thing. It's as endemic as racism.*

Participants welcomed the increased recognition of the need to tailor strategies for flexible working to address the needs of a predominantly female workforce. However it was seen as important to retain a sufficiently flexible and broad approach to ensure that other needs of the many diverse groups involved in working in health and social care were also taken into account.

> *For some parts of the country, issues about family-friendly services and so on are going to be very important; they are going to be crucial in retention and to bringing people back in. But, In other parts of the country, the things that matter to people are going to be quite different. For example [the youth worker service] is built around, not quite a youth*

culture, but you need a slightly different approach to get people in and get them to stick there. If you can get a 22-year-old for five years, working in a city mental health service, that's very good going. That's long service.

Quality agenda

The emphasis on flexible working inherent in the theme of better working lives was seen as potentially incompatible with the requirements of policies within the theme of quality, safety and standards. In particular, the employment of very part-time staff was seen as problematic for trusts seeking to meet expectations about training, accreditation and clinical governance.

On the other hand, it was suggested that, with imagination, strategies for monitoring and evaluation could be designed which would satisfy both agendas. One example described in the maternity care seminar was of a trust which had made continuity of care a criterion for monitoring, thereby reinforcing the importance of an aspect of work which was known to enhance job satisfaction.

In setting up teams of midwives, who are specifically geared to give personal continuity of care to women, we have said, 'we care much less about things like when you arrive at work and when you finish at work than whether or not you were able to be at the labour of the women you care for'. So we've sort of changed our monitoring focus and made it on the achievement of continuity.

Summary

Policies to improve recruitment and retention of staff were identified in the seminars as central to achieving continuity of care. Participants repeatedly emphasised the severity of the staffing crisis and the detrimental effect this had on the ability of the service to function effectively. Staffing shortages were seen as the key obstacle to the implementation of a wide range of policies in other themes which had the potential to enhance continuity.

One major recent change in working patterns, the reduction in junior doctors' hours, had been experienced as largely negative to date, although it was acknowledged that there could potentially be benefits for continuity of care, once the system was reoriented to accommodate this change. The general focus on more flexible working, both day to day and throughout careers, was widely welcomed, but this endorsement was qualified by concerns about the impact of part-time working on the ability to provide personal continuity and on organisational and workforce stability. It was agreed that the policies needed sensitive and imaginative implementation that took account of local circumstances. Participants were concerned that the capacity of the various 'better working lives' policies to produce results would continue to be undermined by financial, organisational and societal factors which were largely beyond the control of NHS policy.

4.6 Patient-centred care

Policy aims

This theme captures those policies that emphasise reforming the NHS as an organisation built around the needs of patients. It includes a commitment to prioritising the experience of patients at an individual level as well as achieving a more equitable and fairer service for the wider population.

Patient and Public Involvement in the New NHS sets out an agenda for developing a patient-led service through involving patients in the planning, development and monitoring of services. *Caring about Carers* defines a national strategy for carers which includes the need for them to be involved in planning and providing services.

The aim of achieving greater continuity of care across geographical and social boundaries, and reducing socially related disease incidence and variations in treatment as outlined in *Saving Lives: Our Healthier Nation*, is a key component of delivering a patient-centred service. The *NHS Performance Assessment Framework* aims to promote fair access and improvements to reduce inequalities, while at the same time ensuring that the NHS is sensitive to individual needs.

Key documents

- *Our Healthier Nation: A Contract for Health* (1998)
- *A First Class Service: Quality in the New NHS* (1998)
- *Saving Lives: Our Healthier Nation* (1999)
- *The NHS Performance Assessment Framework* (1999)
- *Patient and Public Involvement in the New NHS* (1999)
- *Supporting Doctors, Protecting Patients* (1999)
- *Caring about Carers* (1999)
- *The NHS Plan* (2000)
- *Raising Standards for Patients: New Partnerships in Out-of-Hours Care* (2000)
- Health and Social Care Bill (2001)
- *Building a Safer NHS for Patients: Implementing an Organisation with a Memory* (2001)

Potential implications for continuity

A service which is led by the principle of 'patient as expert' and public consultation should be better equipped to provide **flexible continuity**. It is possible that patients would place greater emphasis upon issues other than continuity of care, such as safety, or emphasise one dimension of continuity over another, such as **personal** or **longitudinal continuity** over **team continuity**.

Human Resource Policies and Continuity of Care

Greater emphasis upon clinical communication skills as outlined in *Patient and Public Partnership in the NHS* should improve **continuity of information** and may have a positive impact upon **cross-boundary and team continuity** if it leads to improved communication between professionals.

Implementation in practice

Defining patient-centred care

Seminar participants identified a variety of possible interpretations of the concept of patient-centred care. These included, 'providing, as far as possible, what the woman in front of you wants in terms of her care', consulting and developing the service with user input, and organising care around the ways in which patients move through the service, rather than by specialty. It was agreed that, whichever definition was intended, there were major barriers to achieving genuinely patient-centred care to do with NHS culture, professional attitudes and also, sometimes, patient expectations. The policies in this theme were welcomed as helpful in promoting the principles of patient centred care, but the required shift in values was regarded as something unlikely to be achieved by policy initiatives alone.

Involving patients in decisions about their care

Empowering patients to increase their role in making decisions and choices about their own care was identified in the seminars as a key element in the philosophy of patient-centred care, and participants raised a variety of issues from their experiences in trying to support this approach. It was agreed that patients needed good information, time, space and support to consider options and make decisions, and personal continuity was likely to facilitate acceptable decisions. Ensuring these requirements could be met required careful planning of services and sufficient staff resources, which were not necessarily available. Patient-centred care also depended on commitment from providers, and it was acknowledged that staff might be resistant to engaging patients more actively in decision making because of professional protectionism and reluctance to deal with the consequences of relinquishing control. Other factors such as social and knowledge inequalities were also identified as liable to undermine equal partnership in decision making. It was noted that patient centred-care demanded a lot from patients, and some patients were unable or unwilling to take an active part in their own health care.

Resistance to change was perceived as greatest among medical staff, who were more likely to challenge the validity of the new philosophy of care.

> *What did you go to medical school for umpteen years for, and all the rest of it, if you're no better qualified to make a decision than the woman is?*

Human Resource Policies and Continuity of Care

However, there was optimism that medical students were being offered more training in this area than in previous generations and, perhaps because of this, younger doctors were often less emphatic about privileging clinical knowledge.

> *The new generation are more respectful to patients. It's a way of life that the new generation of doctors are beginning to grasp, which is that you preface virtually everything you say to a patient by saying, 'I don't know what the answer is, but here are some suggestions and I'll tell you what I think might be the best idea, if you want me to.'*

It was noted that recent changes in the access arrangements which give a greater role for nurses as gatekeepers to care appear to be supporting a greater element of patient choice.

> *Some very interesting data are coming out of our NHS Direct site – the NHS Direct nurses are actually becoming patient advocates and are steering the patients to the level of care that the patients want, rather than what the GPs and their co-operatives have decided they should get. Last year this caused a bit of an issue. But this year, I'm pleased to say, we have all accepted it and it's all very good.*

Involving patients in service planning

It was suggested that involving patients in developing services should be seen as something broader than just finding out and responding to what was wanted in terms of clinical care. If services are to be designed around what patients say they want, this means taking account of all aspects of the experience of using them. An example cited in the primary care seminar was the introduction of a one-stop clinic.

> *And when the patients evaluate their experience, it's not just that they can get their result, get it that day, but it's also that the whole thing is organised to suit them. So they're phoned up the week before just to remind them. They're sent appropriate information well before, told all the details of where to park and that there's coffee … and there's a nurse who introduces them and takes them through, every step of the way. And it's absolutely terrific, it's the way it should be. People say that, who've been through it.*

In the mental health seminar it was suggested that consultation with users was valuable in defining the principles that should underpin a service, even where their expectations could not be met completely.

> *Initially, you ask a service user what they want. They will say, 'basically I want somebody that I can ring up whenever I'm distressed, 24 hours a day'. And of course that's completely impossible because health workers have lives of their own, they go on holiday, etc. So how do you get round that? You say, we're going to have to have a relationship to a team. You don't have one key worker, you get to know the whole team and the whole team gets to know you. And although service users initially expressed reservations about that, because everybody is very used to the idea of a key worker, in fact the evaluation was very positive."*

Human Resource Policies and Continuity of Care

Designing services around patient needs

A major problem with the concept of patient-centred care, which was raised in all the seminars, is that patients have different requirements which are not necessarily compatible. So a service which attempts to be responsive to such needs is likely to find its resources pulled in conflicting directions. Sometimes priorities are clear: for example a patient arriving in a surgery with a problem requiring immediate treatment will be given precedence over others who then wait longer to be seen. But beyond such obvious examples, participants observed how the commitment to patient-centred care intensified the difficulty of reconciling the needs of different individuals. There was discussion of the dilemma of dealing fairly with particularly articulate and informed patients, whose needs might be no greater than others but who are particularly competent at arguing their case. At the same time, concerns were raised about the implications of focusing extra effort on patients who did require a great deal of care.

> *If you go out on a limb for one patient, that sets a precedent and you have to justify your decision. And that's very difficult as a practitioner, because you want to advocate for patients' wishes, families' wishes. But for people who need very complicated care for a cancer problem or whatever, funding them means there will be 20 others, who have minimal needs, who don't get a resource because there's only a finite pot of money. The justice of that is very difficult.*

The problem of reconciling the needs of different groups of patients was identified in the primary care seminar as equally problematic. It was suggested that efforts at promoting patient-centred care often led to care centred on only some of the patients and this, in turn, might become care that suits nobody, because patients and their requirements changed over time.

> *Where we have tried to do patient-centred care, it's worked for a subset of patients and then it has stopped working, because that subset have moved on. Things like Saturday morning clinics, you might get a particularly interested lot of working parents who would use it and then it would dwindle off. Or we've done antenatal care for teenagers, and you might get a particularly interested, vociferous group of teenagers and then they stop. So it's actually quite difficult sometimes making clear that the care you're giving is centred on patients in general, when, as we've been discussing, there aren't general patients.*

It was noted in the cancer care seminar that patient-centred care was more easily provided where services had already been designed around particular disease trajectories and the clinical problems were familiar and predictable to staff. Thus, for example, palliative care provided an individualised, responsive service that was predicated on knowledge of the needs of cancer patients. It was for that very reason less adaptable to the requirements of people suffering from other conditions.

> *Over 90 per cent of our patients are cancer patients, so we've got the feel of it. We kind of look at the thing and think, 'hmm, lung cancer – looking*

like that – yes, days [to live]. Breast cancer, looking like that, no, they've got a way to go'. Give me one set of patients, I know what I'm doing. Give me another set and I'm all at sea really, because the normal markers aren't there.

Population-centred care

An alternative way of conceptualising patient centred-care discussed in several of the seminars was to move the focus away from diagnostic categories or users of particular services and look instead at the global needs of people in particular social groups. It was suggested that if needs were perceived in these wider terms, then continuity of care should no longer be considered in terms of health alone. One example of an initiative which has taken this wider view was a project in one health action zone in a deprived community which attempted to meet the needs of people who had problems accessing care, by bringing a range of 'ordinary services' – general practice, social care, dentist, police and play group – together on the same premises.

It was also suggested that efforts at improving continuity of care might be more productive if they were selectively addressed towards those groups who, for social reasons, were least likely to be getting it at present.

If you take one extreme, refugees and asylum seekers, for whom there is absolutely no continuity of care … It's almost an oxymoron to talk about continuity of care for those groups but, focusing on them, you may actually make much bigger gains than if you try thinking in a general way about continuity for the large mass of patients.

Summary

There was consensus that a health service genuinely based on the principles of patient-centred care would take more account of users' perspectives on continuity of care. This might lead to a broader view which goes beyond the present focus on individual patients, clinical services and health-defined needs to consider how continuity of care in general may be provided for different populations or social groups. However, participants emphasised the cultural and professional obstacles to achieving such a fundamental shift and the difficulty of influencing these through policy alone. It was also noted that patients differed and might have conflicting needs. Some patients have greater expectations and are better able to express them; some patient groups are already better provided for by the existing structure of services. For such reasons it was felt that a commitment to patient-centred care made the difficulties of providing a fair and equitable service if anything more acute.

Section 5 Discussion and recommendations

5.1 Continuity of care in NHS policy and practice

The NCCSDO listening exercise identified continuity of care as an important priority for health service users. During the present study, continuity was acknowledged as a significant issue by all the providers, users, policymakers and managers who were consulted or approached as possible seminar participants. However, in the policy documents analysed for this study, continuity of care did not generally stand out as a clear goal or priority. While the concept of continuity was sometimes mentioned as an issue in the general aims, it was certainly not defined as a key driver and rarely featured in the more detailed objectives. In most of the documents it was not explicitly considered at all, but remained concealed as an implicit component of the wider goals of integrated care or patient-centredness. It appears that, while continuity of care is accepted as important by people involved in receiving and providing care, at the national policy level it tends to remains largely at the level of an unelaborated 'good idea'.

Nevertheless, despite its relative invisibility in policy, during the initial document analysis undertaken for this study it was possible to identify clear potential gains for continuity of care within the intended goals of all six policy themes. These potential benefits were acknowledged and appreciated in all the seminar groups, albeit with caveats about some particular aspects of the policy objectives. And yet the overall tenor of the seminar discussions was much less positive than these assessments might imply. The main reason for this is that many of the policy objectives are still some way off being realised, the process of implementation is often difficult and painful, and in some cases there are doubts about whether the long-term aims are actually achievable. In the meantime, some genuine opportunities for improving continuity have already emerged, but in other respects the ability of staff to provide continuity of care appears to have been more compromised than enhanced by the changes underway.

The impact of policy on continuity of care

At the beginning of this report, it was suggested that both the deployment and attitudes of the NHS workforce were likely to be important in determining whether patients experience continuity of care. During the seminar discussions, one factor that emerged as being of key importance in determining both the capacity and motivation of staff to provide continuity for patients was the extent of continuity in the system over both space and time. This includes continuity of people, places, roles, knowledge and information. To the extent that

Human Resource Policies and Continuity of Care

current policies affecting human resources in the NHS enhance or reinforce such system continuities, they were perceived as increasing the potential for providing continuity of care. Where they create discontinuity, or exacerbate existing problems, that potential was seen as being diminished and less likely to be realised.

Impact on continuity in the system

The following boxes draw together a range of examples, cited in the seminars, of ways in which the policies discussed are perceived to be impacting on system continuity. In broad terms, developments in respect of information and IT were perceived as playing the most positive role to date, whereas policies involving reconfiguration were more consistently experienced as having negative effects. Many policy initiatives in all the themes were recognised as having a mixed impact, with the balance of beneficial and undesirable consequences varying for different groups of patients.

Box 5.1 Ways in which system continuity is seen as being enhanced

Increased continuity of information

- staff contact with patients and carers between consultations enhanced by use of email

- remote access to information about patients improved by availability of electronic records

- patient access to information improved by availability of internet, especially beneficial for some groups such as people with disabilities or in remote communities

Increased consistency of practice

- consistent and more evidence-based management of patient care in different settings facilitated by staff having electronic access to guidelines

---

Human Resource Policies and Continuity of Care

Increased continuity of place for patient care

- increased ability to provide patient care promptly in the community, because electronic systems provide community-based staff with remote access to information

- diminished need for patients to travel to central facilities, because tests can be undertaken at remote sites

- guidelines increasing the ability of patients to be cared for in general practice, without the need for specialist supervision

Increased continuity of staff

- absenteeism being reduced by greater flexibility in working hours

- staff remaining in clinical practice because of introduction of new career pathways

Increased collaboration between staff

- organisational and tribal rivalries between staff groups being relinquished in order to co-ordinate strategies for working with primary care trusts

- people with a range of skills working more closely together through the development of team working

- greater collaboration between staff caring for the same patients at different stages through the introduction of integrated care pathways for particular conditions

Increased flexibility of practice

- more critical consideration of the need for particular tasks to be done in particular ways, and greater flexibility to adapt to individual patient needs

- greater flexibility for providing integrated care across the boundary between health and social care because of pooled budgets

- greater flexibility for patients to access care by different routes and through different staff, for example by the use of NHS Direct

---

Box 5.2 Ways in which system continuity is seen as being undermined

Exacerbated effects of staff shortages

- new services which duplicate existing provision demanding additional staff

- job satisfaction reduced by move away from personal patient–clinician relationships, for example through introduction of NHS Direct

- loss of confidence in staff and between staff and patients, slowing everything down

- reduced working hours for junior doctors creating a need for more staff

More fragmented care

- expanded roles leading to skill transfer rather than multi-skilled staff

- greater role flexibility increasing the risk that some tasks are not owned by anyone and may not be carried out at all

- safety standards limiting what tasks can be done by which staff

Decreased collaboration between staff

- anticipation of change decreasing motivation to establish informal links, and reducing familiarity with other staff

- opportunities for flexible hours creating resentment between different staff groups

Diminished continuity of staff

- constant reconfiguration increasing job mobility

- reduced working hours resulting in more shift changes with poor handover

- part-time working diminishing capacity for personal continuity

- faster turnover of salaried doctors associated with increased support for portfolio careers

Decreased continuity of knowledge

- unfamiliarity with people and systems because both change

- loss of insights into patients with loss of paper records

- less reliable and accurate data in electronic records

Human Resource Policies and Continuity of Care

(continued)

Loss of leadership

- loss of people with local knowledge, experience and legitimacy to take a strategic view

- loss of region-level strategic thinking

Increased inequity between different patient groups

- variation in patient resources and ability to use and access electronic information

- reduced commitment of staff to inpatient care in mental health resulting from improved outreach care

- emphasis on integrated care pathways creating problems for people with problems that do not fit within the definitions

- guidelines diminishing flexibility for patients who need something different

- patients better at articulating their demands get more from patient-centred care

- patient-centred care easier to provide for those with known clinical problems

---

Impact on staff attitudes and values

In addition to the effects of policies on continuity within the system, it was made clear in the seminars that policies might also affect the capacity of staff to provide continuity of care by influencing how they felt and thought about themselves and about their patients. In this respect also, there was clear recognition that the majority of the policies discussed were aimed in the right direction and would, if realised, have beneficial effects. For example, it was acknowledged that greater engagement of clinicians in decision making should in theory raise morale and enable the service to become more responsive to patients. It was also agreed that the general commitment to increase involvement of patients in the design and evaluation of services and to take the perspective of users seriously should encourage staff to extend their thinking beyond clinical aspects of continuity of care for individual patients and to take a wider view.

However, for every instance cited of such positive developments, there were many more counter examples where policies were seen as damaging morale. The general consensus seemed to be that, in the short term at least, the effect of many of the policies discussed had been to diminish motivation and undermine constructive commitment to considering how continuity of care can be assured. In this respect, the most negative views were again expressed about the policies involving reconfiguration and also about those concerned with quality, safety and standards. In respect of the first theme, the experience of perpetual change was seen as leading staff to disengage from strategic

thinking beyond their immediate responsibilities and to cling to the familiar, even when this might be inappropriate. It was also widely acknowledged that the preoccupation with practical problems of implementing change distracted from providing patient care. In respect of the quality agenda, the main anxiety was that loss of confidence associated with an environment of constant monitoring and implicit criticism was resulting in more defensive practice, loss of goodwill, and increasing unwillingness to 'go the extra yard'. There was also concern that the increasing preoccupation with measurable aspects of quality, based on hard evidence of benefit, would draw attention away from more complex issues like continuity, which were harder to define and measure.

Reasons for the problems

In the seminars it was fully acknowledged that change was necessary for the health service to develop and progress, and that even the most desirable changes would inevitably generate some disruption. However, it was also widely agreed that some of the problems in the present case were exacerbated by weaknesses in the policies themselves, while others reflected potentially intractable difficulties associated with their implementation.

Problems with policies

The overarching concern in relation to current NHS policy was that there was simply too much happening, too fast, with unrealistic time frames for implementation. In addition, doubts were expressed about the apparent lack of joined-up thinking both within and between the various policy areas. This was reflected, for example, in the poor 'fit' between various components of reconfiguration, in the potential contradiction between strategies for increasing flexibility for staff and those aimed at creating a more responsive service for patients, and in the desire for a patient-centred service which was also equitable and of a consistent standard. A third area of concern was that, despite the overall excess of change, some aspects of policy remained too limited in extent or too narrowly framed to have the desired effects. This concern applied particularly to some of the initiatives within the theme of better working lives.

Problems with implementation

The most fundamental barrier identified to the successful implementation of policies in all six policy themes was the chronic and continuing shortage of staff. While the various strategies for improved recruitment and retention were widely welcomed, they were seen as unlikely to be sufficient to counter the adverse effects of wider social, demographic and economic factors which were largely beyond the control of policymakers in the NHS. The problem of insufficient staff pervaded all the seminar discussions, but other problems of

implementation were more closely linked to particular policy themes. Regarding reconfiguration, for example, the temporary distortions and discontinuities generated by the incremental adoption of specific new initiatives were seen as inevitable effects of introducing change in a complex system. In respect of information and IT, barriers to implementation were identified both in respect of staff scepticism, skills deficits and lack of familiarity with the relevant technology, and in the unreliability and imperfections of the information systems currently available. Both of these were acknowledged as having the potential to improve over time assuming there was adequate investment in both training and resources. With regard to developing genuinely patient-centred care, many of the problems were seen as linked to deep-rooted cultural assumptions which might be modified over time by education and example, but were unlikely to be overturned in the short term by policy initiatives alone.

5.2 Recommendations

The general conclusion from this study is that if and when current policies affecting human resources in the NHS are fully implemented, the capacity of staff to provide continuity of care for patients is likely to be enhanced in a number of ways. In the meantime, however, the impact of the various policies on this aspect of care appears to be rather more equivocal, because of the damaging effects of the process of policy implementation on continuity within the system and on staff attitudes and values. If continuity of care is accepted as an important element of quality in health care, attention must be given to developing strategies which support system continuity and to developing a better understanding of the role that continuity of care can play in improving patient care.

Supporting continuity in the system

Possible strategies for reinforcing continuity in the system include:

- making the most of opportunities for strengthening and reinforcing system continuity by identifying and disseminating examples of successful strategies for increasing continuity of people, place, roles, knowledge and information (some of those suggested during this study are listed in Appendix E)

- being alert to the potential hazards to continuity generated by system changes and developing active policies to anticipate such hazards and minimise their impact

- where possible, diminishing the pressure on staff and systems by slowing down the rate of change and allowing realistic time for consolidation

- supporting the development of resilient systems such as managed practitioner networks that can sustain connections irrespective of how structures may be changing underneath

- considering how service innovation in one area may impact upon another and ensuring that any potentially detrimental consequences are anticipated and addressed

- when designing new guidelines or safety standards, ensuring that their effects on aspects of care such as continuity are considered and addressed

- when redesigning services with patient input, ensuring that account is taken of the user's whole experience, not just the aspects perceived as clinically relevant.

Reinforcing continuity of care as an objective

As mentioned earlier, while continuity of care is an important priority for health service users and is recognised as such by many of those involved in providing care, it tends not to stand out as a key priority in national policy documents. One reason for this relative lack of visibility may be that continuity of care is an 'apple pie' concept – its desirability is taken for granted and it is not therefore seen as needing special mention or defence. As was suggested in the seminars, such status can be both a strength and a limitation. On the one hand, few people are likely to argue against the benefits of continuity. On the other, few may see the need to define its strengths or actively defend it as a concept. Without such critical analysis, continuity of care runs the risk of being over-simplified as an idea, with insufficient attention given to the less obvious or measurable dimensions. It may be valued indiscriminately as a necessary good, despite the fact that the evidence for its clinical benefits is fairly limited and, in some circumstances, it may be relatively unimportant to patients or even undesirable. Alternatively it may be undervalued as something important only to patients, ignoring its role in providing satisfaction to staff or as a means of ensuring or measuring quality.

To avoid such distortions, and ensure that continuity of care is appropriately valued by staff and strengthened as a policy objective, it will be important to:

- undertake robust research to establish the value of continuity on patient outcomes

- ensure that all concerned in providing or planning patient care appreciate the various dimensions of continuity of care, including its potential significance as something which goes beyond health care and beyond the care of individual patients

- acknowledge that continuity of care has different resonances for different patients and in different areas of care and understand when it is likely to be most important or most inappropriate

Human Resource Policies and Continuity of Care

- develop measurable criteria and targets for all dimensions of continuity and include these as elements in staff and systems appraisal

- identify aspects of working practices that support continuity of care and provide satisfaction to staff, and use these as criteria for evaluation

- identify ways in which continuity of care may act as an agent of quality, for example by enabling staff to see the consequences of the care they provide.

References

Brandon, D. and Jack, R. 1997. Struggling with services. In I. Norman, I. and Redfern, S. (eds), *Mental Health for Elderly People*. Edinburgh: Churchill Livingstone

Buchan, J. 2000. Health sector reform and human resources: lessons from the United Kingdom. *Health Policy and Planning* 15(3): 319–25.

Department of Health. 1993. *Changing Childbirth Part 1: Report of the Expert Maternity Group.* London: HMSO

Department of Health. 1997. *The New NHS: Modern, Dependable*. London: Stationery Office

Department of Health. 2000. *A Health Service of All the Talents: Developing the NHS workforce.* London: Department of Health

Department of Health. 2001. *Shifting the Balance of Power – Securing Delivery.* London: Department of Health

Freeman, G., Shepperd, S., Robinson, I., Ehrich, K. and Richards, S. 2001. *Continuity of Care. Report of a Scoping Exercise for the National Co-ordinating Centre for NHS Service, Delivery and Organisation R & D.* London: NCCSDO

Glendinning, C, Halliwell, S, Jacobs, S, Rummery, K. and Tyrer J. 2000. New kinds of care, new kinds of relationships: how purchasing services affects relationships in giving and receiving personal assistance. *Health & Social Care in the Community* 8(3): 201–11

HM Government. 1999. Health Act 1999, Chapter 8. London: Stationery Office

Ham, C. 1999. Improving NHS performance: human behaviour and health policy. *British Medical Journal* 319: 1490–2

Heslop, L., Elsom, S. and Parker, N. 2000. Improving continuity of care across psychiatric and emergency services: combining patient data within a participatory action research framework. *Journal of Advanced Nursing* 31(1): 135–43

Howie, J.G.R., Heaney, D.J., Maxwell, M., Walker, J.J., Freeman, G.K. and Rai, H. 1999. Quality at general practice consultations: cross-sectional survey. *British Medical Journal* 319: 738–43

Luker, K.A., Austin, L., Caress, A. and Hallett, C.E. 2000. The importance of 'knowing the patient': community nurses' constructions of quality in providing palliative care. *Journal of Advanced Nursing* 31(4): 775–82

Marks, I. 1994. *Seamless Care as Patchwork Quilt*. London: King's Fund

Martinez, J. and Martineau, T. 1998. Rethinking human resources: An agenda for the millennium. *Health Policy and Planning* 13(4): 345–58

NHS Executive. 1998. *Working Together – Securing a Quality Workforce for the NHS*. London: Department of Health

NHS Executive. 1999. *Agenda for Change – Modernising the NHS Pay System*, Health Service Circulars 1999/035 and 1999/227

NHS Executive. 2000. *The Vital Connection: An Equalities Framework for the NHS.* Health Service Circular 2000/014.

NHS Service Delivery and Organisation National R & D Programme. 2000. *National Listening Exercise: Report of the Findings.* London: NCCSDO

Ritchie, J. and Spencer, L. 1994. Qualitative data analysis for applied policy research. In Bryman, A. and Burgess, R.G. (eds) *Analysing Qualitative Data.* London: Routledge

Sandall, J. 1998. Occupational burnout in midwives: new ways of working and the relationship between organizational factors and psychological health and wellbeing. *Risk, Decision & Policy* 3(3): 213–32

Appendix A

List of identified policy documents

The following is a chronological list of NHS policy documents published between 1 May 1997 and 1 June 2001 which were identified as potentially relevant to the study.

Note: The documents marked in bold are those included in the subset selected for more detailed analysis.

September 1997	NHS Executive *Priorities and Planning Guidance for the NHS: 1998/99* Department of Health 97PP0132
December 1997	Department of Health *The New NHS: Modern, Dependable* The Stationery Office Cm3807
February 1998	**Department of Health** ***Our Healthier Nation: A Contract for Health. A consultation paper*** **The Stationery Office CM3852**
December 1998	NHS Executive *The New NHS: Modern, Dependable: a national framework for assessing performance: a consultation document* Department of Health
April 1998	*NHS Executive* The New NHS: Commissioning Specialised Services Consultation NHS Executive, http://www.doh.gov.uk/nhsexec/csscpack.htm
July 1998	NHS Executive The New NHS: Guidance on Out of Area Treatment – consultation paper NHS Executive. http://www.doh.gov.uk/nhsexec/ecr.htm
September 1998	NHS Executive *Nurse Consultants* NHS Executive, Health Service Circular HSC 1998/161 http://www.open.gov.uk/doh/coinh.htm
September 1998	Department of Health *Partnership in Action (New Opportunities for Joint Working between Health and Social Services) A discussion document* Department of Health, http://www.doh.gov.uk/pia.htm
September **1998**	**Department of Health** ***A First Class Service: Quality in the new NHS*** **Department of Health,** **http://www.open.gov.uk/doh/newnhs/quality.htm**
September 1998	NHS Executive *Working Together: Securing a Quality Workforce for the NHS* Department of Health, http://www.open.gov.uk.doh/newnhs/hrstrat.htm

Human Resource Policies and Continuity of Care

September 1998	Department of Health *Information for Health: An Information Strategy for the Modern NHS 1998-2005* Department of Health, http://www.nhsia.nhs.uk/strategy/full/contents.htm
October 1998	**Working Time Regulations, European Working Time Directive** **Department of Trade and Industry Information Sheet**
November 1998	Home Office *Supporting Families: A consultation document* The Stationery Office
December 1998	NHS Executive *Working Together with Health Information – A Partnership Strategy for Education, Training and Development* Department of Health, http://www.doh.gov.uk/nhsexipu/develop/nip/together.htm
December 1998	NHS Executive *Electronic Health Records options – a discussion paper* Department of Health, http://www.doh.gov.uk/nhsexipu
January 1999	HM Treasury *Public Services for the Future: Modernization, Reform, Accountability* http://www.official-documents.co.uk/document/cm41/4181/ psa-00.htm
February 1999	**Department of Health** **Caring about Carers** **Department of Health**
February 1999	House of Commons *National Minimum Wage* House of Commons Research Paper 99/18
March 1999	House of Commons Health Committee *Future NHS Staffing Requirements* House of Commons Health Committee Press Notice No. 6 of Session 1998-99, http://www.parliament.uk/commons/selcom/hlthpnt6.htm
March 1999	**NHS Executive** **The NHS Performance Assessment Framework** **Department of Health 16431**
March 1999	NHS Executive *Clinical Governance: Quality in the new NHS* Department of Health
April 1999	House of Commons *The Health Bill [HL] Bill 77 of 1998–99* House of Commons Research paper 99/39
May 1999	Department of Health *The new NHS information pack* Department of Health
June 1999	Department of Health *Future Staffing Requirements: The Government's Response to the Health Committee's Report on Future Staffing Requirements* The Stationery Office Cm 4379
June 1999	Health Act 1999, Chapter 8 The Stationery Office
July 1999	**Department of Health** **Saving Lives: Our Healthier Nation** **The Stationery Office Cm 4386**

Human Resource Policies and Continuity of Care

July 1999	**Department of Health** ***Making a Difference: Strengthening the nursing, midwifery and health visiting contribution to health and healthcare*** **Department of Health, http://www.doh.gov.uk/nurstrat.htm**
July 1999	NHS Executive *Report of the NHS Taskforce on Staff Involvement* Department of Health, http://www.doh.gov.uk/nhsexec/staffinv.htm
September 1999	Department of Health *Explanatory Notes, Health Act 1999* The Stationery Office
September 1999	**Department of Health** ***Patient and Public Involvement in the New NHS*** **Department of Health**
September 1999	NHS Executive *Nurse, midwife and health visitor consultants* NHS Executive, Health Service Circular HSC 1999/217
November 1999	**Department of Health** ***Supporting doctors, protecting patients: A consultation paper on preventing, recognizing and dealing with poor clinical performance of doctors in the NHS in England*** **Department of Health, http://doh.gov.uk/cmoconsult1.htm**
2000	NHS Learning Network *The NHS Beacons Programme: Selection of New Beacons for 2000/2001* Department of Health, http://www.nhs.uk/beacons
2000	Department of Health *An organization with a memory: Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer* The Stationery Office
January 2000	Department of Health *Modernising Health and Social Services: National Priorities Guidance 2000/01 – 2002/03* Department of Health
March 2000	**Public Services Productivity Panel** ***Working in partnership: Developing a Whole Systems Approach*** **Department of Health**
April 2000	**NHS Executive** ***A Health Service of All the Talents: Developing the NHS Workforce – Consultation Document on the Review of Workforce Planning*** **Department of Health**
April 2000	NHS Executive *Partnership in Action: The Action Plan to implement the recommendations of the NHS Taskforce on Staff Involvement* Department of Health
April 2000	NHS Executive *The Vital Connection: An equalities framework for the NHS: Working together for quality and equality* NHS Executive, Health Service Circular HSC 2000/014
July 2000	**Department of Health** ***The NHS Plan: A Plan for Investment, A Plan for Reform*** **The Stationery Office Cm4818-I**

Human Resource Policies and Continuity of Care

October **NHS Executive**
2000 ***Human Resources Performance Framework***
NHS Executive, Health Service Circular HSC2000/030

October Department of Health
2000 *Improving Working Lives Standard: NHS Employers Committed to Improving the Working Lives of People who Work in the NHS*
Department of Health

October **Department of Health**
2000 ***Raising Standards for Patients: New Partnerships in Out-of-Hours Care, An Independent Review of GP Out-of-Hours Services in England***
Department of Health

November Department for Education and Employment
2000 *Work–Life Balance 2000: Baseline Study of Work-Life Balance Practices in Great Britain*
http://www.dfee.gov.uk/work-lifebalance/case.htm

December **NHS Executive**
2000 ***NHS Plan Implementation Programme***
Department of Health,
http://www.doh.gov.uk/nhsplanimpprogramme/ forward.htm

January House of Commons
2001 *Improving NHS Performance, Protecting Patients, Modernising Pharmacy and Prescribing Services: the Health and Social Care Bill*
House of Commons Research Paper 01/01

January Department of Health
2001 *The NHS Plan – Implementing the Performance Improvement Agenda: A Policy Position Statement and Consultation Document*
Department of Health, http://www.doh.gsi.gov.uk

February NHS Executive
2001 *Making the Change: A Strategy for the Professions in Healthcare Science*
Department of Health

February **NHS Executive**
2001 ***Investment and Reform for NHS Staff – Taking Forward the NHS Plan***
Department of Health, http://www.doh.gov.uk/invandreform

February **NHS Executive**
2001 ***Workforce Planning Review: A Health Service of all the Talents: Results of Consultation***
NHS Executive, http://www.doh.gov.uk/wfprconsult/results.htm

February **NHS Executive**
2001 ***NHS Professionals: Flexible Organisations, Flexible Staff***
NHS Executive Health Service Circular HSC 2001/02

February **Health and Social Care Bill [HL] Bill 47**
2001 **The Stationery Office**

February *Explanatory Notes: Health and Social Care Bill HL Bill 39-EN*
2001 The Stationery Office

February Department of Health
2001 *The Report of the Chief Medical Officer's Project to Strengthen the Public Health Function*
Department of Health

February 2001	Department of Health *The Essence of Care: Patient-focused benchmarking for health care practitioners* Department of Health, http://www.doh.gov.uk/essenceofcare/
March 2001	House of Commons *Educating and Training the Future Health Professional Workforce in England* The Stationery Office, HC277 Session 2000–2001
March 2001	Audit Commission *Hidden Talents: Education, Training and Development for Healthcare Staff in NHS Trusts* Audit Commission
March 2001	**NHS Executive** ***Changing Workforce Programme*** **NHS Executive, HR Directors' Bulletin,** **http://www.doh.gov.uk/hrbulletin/hr9cwp.htm**
March 2001	NHS Executive *Electronic Booking Systems Strategic Outline Case, National Patient Access Team* http://www.doh.gov.uk/pdfs/nhsplanbookingsystemssoc.pdf
April 2001	NHS Executive *Implementing the NHS Plan – Modern Matrons: Strengthening the role of ward sisters and introducing senior sisters* NHS Executive, Health Service Circular HSC 2001/010
April 2001	**Department of Health** ***Building a Safer NHS for Patients: Implementing an Organisation with a Memory*** **Department of Health, http://www.doh.gov.uk/buildsafenhs**

Appendix B

Analysis sheets for documents reviewed

These analysis sheets provide summaries of the policy documents rather than any evaluation of how the policies work in practice. The summaries are intended to point to areas where there may be some kind of significant impact on continuity of care and to raise issues rather than making judgements about the effect of policies in terms of constituting barriers or having a more positive effect on the provision of continuity of care as defined by *Continuity of Care: Report of a Scoping Exercise for the SDO Programme of the NHS R & D.*

Analysis Sheet: *Our Healthier Nation: A Contract for Health*

Reference number	3
Date and origin	February 1998, Stationery Office
Title	*Our Healthier Nation: A Contract for Health*
Aims/general content	Introduced overall government health policy. Two stated central aims are (1) to improve health of the population as a whole, increase length of people's lives, number of years free from illness and (2) to improve health of worst off in society. Specified four priority areas with detailed targets for 2010, CHD and Stroke, Accidents, Cancer, Mental Health.
Document status	DoH Consultation Paper
Linked to future/past document?	*The New NHS: Modern, Dependable* (1997)
Group/instruments/ future plan initiated	HIMPs, HAZ, Wired for Health, PCG, Healthy Living Centres, Healthy Settings (Schools, Workplaces, Neighbourhoods)
Policy strands	2, 6
Impact on C of C and what dimension	Difficult to assess as places emphasis on targeting specific diseases rather than method of delivering care.

Human Resource Policies and Continuity of Care

Analysis Sheet: *A First Class Service: Quality in the New NHS*

Reference number	9
Date and origin	September 1998, NHS Executive
Title	*A First Class Service: Quality in the New NHS*
Aims/general content	Quality improvement, equitable service delivery
Document status	Department of Health Consultation Document
Linked to future/past document?	*The New NHS: Modern, Dependable* (1997)
	The NHS Performance Assessment Framework (1999)
	Clinical Governance: Quality in the New NHS (1999)
Group/instruments/ future plan initiated	Proposed National Institute for Clinical Excellence (NICE), Commission for Health Improvement (CHI) National Service Frameworks (NSFs), Performance Assessment, National Survey of Patient and User Experience, and Clinical Governance as a means of guaranteeing the delivery of standardised evidence based care.
Policy strands	4, 6
Impact on C of C and what dimension	1, 2
	Provides a framework for ensuring the provision of standardised/equitable/harmonised care across social, geographical, organisational, and professional boundaries, through provision of detailed care pathways and monitoring of services to ensure they meet set clinical indicators. Therefore inadvertently promoting continuity of information (1) and cross-boundary and team continuity (2).

Human Resource Policies and Continuity of Care

Analysis Sheet: *Working Time Regulations, European Working Time Directive*

Reference number	12
Date and origin	October 1998, Council of the European Union
Title	*Working Time Regulations, European Working Time Directive*
Aims/general content	Horizontal Amending Directive to bring Junior Doctors into line with WTD by 2012. Implementation of 48-hour maximum working week for junior medical staff.
Document status	Department of Trade and Industry Consultation Document
Linked to future/past document?	*Working Time Regulations*
Group/instruments/ future plan initiated	
Policy strands	3, 5
Impact on C of C and what dimension	2: May improve team continuity if there are fewer professional groups involved in delivery of care.
	4: Possibly greater longitudinal continuity if permanent staff take on greater responsibility for work previously carried out by junior doctors, e.g. increased consultant or nursing cover on wards; however currently difficult to assess.

Human Resource Policies and Continuity of Care

Analysis sheet: *Caring about Carers*

Reference number	16
Date and origin	February 1999, Department of Health
Title	*Caring about Carers*
Aims/general content	To clarify the government's objectives for carers and to set out an integrated strategy for future action. Aim was to support people who choose to be carers in three ways: improved information – wider and better sources of information about help and services available; support – involvement of carers in planning and providing services and in the development of workplace policies to help them combine employment with caring; care – to help carers make choices, maintain their health, exercise independence, and be recognised by policymakers and the statutory services.
Document status	National strategy document
Linked to future/past documents?	
Group/instruments/ future plan initiated	Plan to establish a local carer support service. New special ring-fenced grant to local authorities to enable carers to take a break from caring. Good practice checklist on involving carers. Policy and Practice Guidance on Fair Access to Care. Carers' Assessments.
Policy strands	5, 6
Impact on C of C and what dimension	3

Human Resource Policies and Continuity of Care

Analysis sheet: *The NHS Performance Assessment Framework*

Reference number	19
Date and origin	March 1999, NHS Executive
Title	*The NHS Performance Assessment Framework*
Aims/general content	Six aspects for performance assessment: patient/carer experience, effective delivery of appropriate healthcare, efficiency, fair access, health outcomes of NHS care, health improvement.
Document status	For action from April 1999
Linked to future/past documents?	*A First Class Service*, July 1998 (NICE, Clinical Governance, Commission for Health Improvement, National Survey of Patient and User Experience) Human Resources Strategic Framework, Oct. 2000
Group/instruments/ future plan initiated	7th area, human resources, to be addressed in its own Human Resources Strategic Framework, High Level Performance Indicators (HSPIs)
Policy strands	4, 6
Impact on C of C and what dimension	Fair access strand could influence continuity of care in the equalities sense but this is not in our dimensions. Patient/carer experience covers 1, 3.

Human Resource Policies and Continuity of Care

Analysis Sheet: *Saving Lives: Our Healthier Nation*

Reference number	26
Date and origin	July 1999, The Stationery Office
Title	*Saving Lives: Our Healthier Nation*
Aims/general content	Outcome of Our Healthier Nation consultation process details the government public health strategy.
	Focused on four key diseases, target areas outlined in Green Paper: CHD & stroke, accidents, cancer, mental health.
	Targeting inequalities through range of initiatives on education, welfare-to-work, housing, neighbourhoods, transport and the environment.
Document status	Public Health White Paper
Linked to future/past document?	Follows on from *Our Healthier Nation* (1998)
Group/instruments/ future plan initiated	Regional Public Health Observatories (monitor progress on reducing inequalities)
	Healthy Citizens Programme
	Health Development Agency (replaces HEA, public health equivalent of NICE)
	Skills Audit and Workforce Plan
	Public Health Development Fund.
	National Development Plan
Policy strands	2, 6
Impact on C of C, and what dimension	Difficult to assess as places emphasis on targeting specific diseases rather than method of delivering care.
	2

Human Resource Policies and Continuity of Care

Analysis Sheet: *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare*

Reference number	27
Date and origin	July 1999, Department of Health
Title	*Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare*
Aims/general content	Introduction of new career framework incl. consultant roles; development of range of nursing roles, e.g. school nurses, nurse prescribing; focus on professional self-regulation; planning local services, inc. primary care organization; commitment to fund extra 6000 student places and increase qualified staff; improving working lives, e.g. better pay, return to practice and career break schemes.
Document status	Strategy document
Linked to future/past document?	*Clinical Governance: Quality in the New NHS* (1999) National Service Frameworks *Essence of Care* (2001)
Group/instruments/ future plan initiated	
Policy strands	1, 3, 4, 5
Impact on C of C, and what dimension	More flexible working arrangements could have an impact but hard to predict, e.g. a nurse practitioner working part-time could offer longitudinal or personal continuity on an appointment basis, but not in urgent care situations. 2, 3, 4, 5

Human Resource Policies and Continuity of Care

Analysis Sheet: *Patient and Public Involvement in the New NHS*

Reference number	29
Date and origin	September 1999, Department of Health
Title	*Patient and Public Involvement in the New NHS*
Aims/general content	**Aims:** Improve quality responsiveness of services, reduce health inequalities; improve public confidence in NHS; encourage more appropriate use of services, and facilitate greater public understanding of need for service changes through user and community involvement in the planning and development of patient-led equitable health services.
	Content: Facilitation of local decision making re service needs; development of patient, user, carer, public partnership; reorganization of services around patients; emphasis upon clinical communication and participatory skills in training and evaluation; individual patient-determined care (through information provision and informed choice); integration of marginalised and previously under-represented groups; statement of principles of good practice.
Document status	Strategy document
Linked to future/past document?	*The New NHS: Modern, Dependable* (1997)
	A First Class Service: Quality in the New NHS (1998)
	Clinical Governance – Quality in the New NHS (1999)
	Caring for Carers (1999)
	Information for Health: An Information Strategy for the Modern NHS (1998)
Group/instruments/ future plan initiated	Good Practice Guide
Policy strands	4, 6
Impact on C of C and what dimension	1, 2, 3,

Analysis Sheet: *Supporting Doctors, Protecting Patients: A consultation paper on preventing, recognising and dealing with poor clinical performance of doctors in the NHS in England*

Reference number	31
Date and origin	November 1999, Department of Health
Title	*Supporting doctors, protecting patients: A consultation paper on preventing, recognising and dealing with poor clinical performance of doctors in the NHS in England*
Aims/general content	**Aims:** Reduce problems associated with poorly performing medical staff in the NHS; develop wider, more comprehensive and more efficient framework for managing poor performance in the NHS.
	Content: Modernization of professional self-regulation; identified elements required to improve accountability, openness and responsiveness of the bodies involved in the regulation of the medical profession: provide HAs with power to suspend GPs; establish criteria by which to measure success of new strategy (reduction of incidence of mis/maltreatment as a consequence of poor performing doctors, early recognition of problems).
Document status	DoH Consultation Document
Linked to future/past document?	*A First Class Service: Quality in the New NHS*
	Clinical Governance – Quality in the New NHS
Group/instruments/ future plan initiated	Assessment and Support Centres: provide impartial support to doctors undergoing assessment and the local employer/health authority. Streamline process of professional regulation.
Policy strands	4, 6
Impact on C of C and what dimension	2: possibly greater interprofessional team working as a consequence of more open, accountable regulation structure.

Human Resource Policies and Continuity of Care

Analysis Sheet: *Working in partnership: Developing a Whole Systems Approach*

Reference number	35
Date and origin	March 2000, Department of Health
Title	*Working in partnership: Developing a Whole Systems Approach*, Executive Summary
Aims/general content	To capture examples of good joint working practice; to identify critical factors for joint working to succeed; to develop a self-assessment tool for use by local health communities to assess readiness for joint working. Focus was on Information for Health, but whole systems approach advocated for wider organizational change (e.g. PCTs); detailed seven key recommendations for successful joint working.
Document status	Project report
Linked to future/past document?	*The New NHS: Modern, Dependable* (1997)
	Information for Health: An Information Strategy for the Modern NHS (1998)
	Public Services Productivity Panel (Established 1999)
Group/instruments/ future plan initiated	Self-assessment tool and Good Practice Guide
Policy strands	Development of local 'health communities' relevant to 1, and IT focus, 2
Impact on C of C, and what dimension	1, 2

Human Resource Policies and Continuity of Care

Analysis Sheet: *A Health Service of All the Talents: Developing the NHS Workforce –*
Consultation Document on the Review of Workforce Planning

Reference number	36
Date and origin	April 2000, Department of Health
Title	*A Health Service of All the Talents: Developing the NHS Workforce – Consultation Document on the Review of Workforce Planning*
Aims/general content	Made proposals to develop the NHS workforce to create more integrated, flexible service and sensitive to patient needs. Emphasis on multidisciplinary training, education and working, to be responsive to patients. Four main areas of concern: fragmentation of planning and lack of technical skills; lack of management ownership; training and education weaknesses; career structure and workforce numbers issues.
Document status	Department of Health Consultation Document
Linked to future/past document?	House of Commons Health Select Committee Report on Future NHS Staffing Requirements recommended a major review of workforce planning in NHS.
Group/instruments/ future plan initiated	Proposes National Workforce Development Board, and local Workforce Development Confederations
Policy strands	3, 4, 5
Impact on C of C, and what dimension	Introduction refers to C of C, but little linkage to main report. Integration in terms of workforce but not directly from patient's point of view. Coherence of workforce strategy rather than of service delivery. 2, 3

Human Resource Policies and Continuity of Care

Analysis Sheet: *The NHS Plan*

Reference number	39
Date and origin	July 2000, The Stationery Office
Title	*The NHS Plan*
Aims/general content	Investment, reform, modernization, a health service designed around the needs of patients. Extensive document but includes policy for: more staff; Modernisation Agency to spread best practice; quality-based contracts for GPs, GPs required to participate in annual appraisal and audit, revalidation (5 years); new terms for consultant contracts, new consultant nurse roles and increased prescribing role; improved working lives; patient involvement.
	NHS Direct as one-stop gateway to healthcare by 2004.
	Reduced waiting time targets by end of 2005.
	Traffic lights (performance assessment link to funding).
	Pharmacy and NHS Direct links
	Commission for Health Improvement to work with Audit Commission inspecting every NHS organization every 4 years. Following Health Act 1999, which introduced PCTs, further development of joint working of local councils and NHS, introduction of Care Trusts bringing together health and social care: co-location of services, joint assessment of needs, integrated home care teams. Taskforces on cancer, mental health, workforce etc. (12)
Document status	Department of Health Policy Document
Linked to future/past document?	The NHS Plan feeds into the Health and Social Care Bill (see summary), National Service Frameworks, Performance Assessment Framework, National Institute for Clinical Excellence, Performance Framework for Human Resources, Improved Working Lives Standard, Health Act 1999.
Group/instruments/ future plan initiated	Modernisation Agency
Policy strands	1, 2, 3, 4, 5, 6
Impact on C of C, and what dimension	Main impacts on C of C will be from NHS Direct becoming main gateway to NHS, expanded responsibility of nurses, and joint working of social and health care, but hard to say in which direction it will go because it is such a broad policy document and C of C is more context specific.
	1, 2, 4, 5

Human Resource Policies and Continuity of Care

Analysis Sheet: *Human Resources Performance Framework*

Reference number	40
Date and origin	October 2000
Title	*Human Resources Performance Framework* (HRPF), NHS Executive
Aims/general content	**Aim:** Permanent improvements in NHS human resource management.
	Content:
	Update on original Working Together priority action areas. Provides detailed guidance on measuring and maintaining progress on the three strategic aims of *Working Together: Securing a Quality Workforce for the NHS*: adequately resourced quality workforce (appropriate skill-mix, diversity, and organisation); improvement to working life of staff; appropriately managed HR.
	Details three key national NHS targets: improving working lives (IWL), working together, developing the workforce, with interim (2001) and completion (2003) dates for organisational adherence to targets.
	Flexible NHS organisations employing staff flexibly.
Document status	Health Service Circular
Linked to future/past document?	*The NHS Plan: A plan for investment, A plan for reform* (2000)
	Working Together: Securing a Quality Workforce for the NHS (2000)
	Modernising Health and Social Services; Developing the Workforce (1998)
	Comprehensive new IWL Standard published concurrently.
Group/instruments/ future plan initiated	Strategic Human Resource Intelligence Networks (SHRINE) – support sharing of good practice and benchmarking
	Annual education and training guidance and targets
	Regional Taskforces established to facilitate implementation of IWL.
Policy strands	3, 5
Impact on C of C and what dimension	2: if effective in improving integration of professional and organisational groups.
	4, 5: if emphasis on improving working conditions/patterns to suit staff/users is realised may or may not result in more one-to-one care.

Human Resource Policies and Continuity of Care

Analysis sheet: *Raising Standards for Patients: New Partnerships in Out of Hours Care, An Independent Review of GP Out-of-Hours Services in England*

Reference number	42
Date and origin	October 2000, Department of Health
Title	*Raising Standards for Patients: New Partnerships in Out of Hours Care, An Independent Review of GP Out-of-Hours Services in England*
Aims/general content	Integration of out-of-hours provision (broadly defined) to streamline patient access experience. Follows on from fundamental changes in the organisation of general practice, and development of other areas of primary care, i.e. NHS Direct and nurse triage, primary care centres and walk-in centres, pharmacy. Integration with other service providers, recruitment and retention of staff. Information flows and development of electronic records. Quality standards and local accountability
Document status	Independent review commissioned by the DoH
Linked to future/past document?	Out-of-Hours Development Fund, Clinical Governance, PCT formation
Group/instruments/ future plan initiated	Convert Out-of-Hours Development Fund to Out-of-Hours Quality Fund and Out-of-Hours Implementation Fund
Policy strands	1, 2, 3, 4, 5, 6
Impact on C of C, and what dimension	This area of change has potential impact on continuity of care in all our dimensions (see above). 1, 2, 3, 4, 5

Human Resource Policies and Continuity of Care

Analysis sheet: *Implementation Programme for the NHS Plan*

Reference number	44
Date and origin	December 2000, Department of Health
Title	Implementation Programme for the NHS Plan
Aims/general content	Identified priorities for expansion and reform, provided guidance to the NHS and social care on priorities for 2001/2002 following NHS Plan. Approved by the Modernisation Board.
	Set out plans to meet targets and planning milestones, e.g. modernise primary care infrastructure so that by 2004 '500 one-stop centres will have been established, bringing primary and community services – and where possible social services – together under one roof to make access more convenient for patients'.
	Targets and planning milestones for reduction in mortality rates including cancer and suicide, and reduction of waiting times for diagnostic tests for cancer.
	Workforce targets followed NHS Plan and Improving Working Lives.
	Information systems targets included electronic booking and electronic health and patient records.
	Taskforces created to implement policy in ten functional areas including cancer, mental health, and workforce.
Document status	Planning document
Linked to future/past document?	The NHS Plan, Improving Working Lives, Health Improvement Plans
Group/instruments/ future plan initiated	Taskforces
Policy strands	1, 2, 3, 5
Impact on C of C, and what dimension	Aim of less variation in services and quality could create geographical continuity, but not one of our dimensions. Faster and easier access could have implications either way for dimensions 1, 3, 4, 5 unless continuity is a built-in factor.
	Workforce targets should provide more staff and improve recruitment and retention, indirectly contributing to 3, 4, 5.

Human Resource Policies and Continuity of Care

Analysis sheet: *Investment and Reform for NHS Staff – Taking Forward the NHS Plan*

Reference number	48
Date and origin	February 2001, Department of Health
Title	*Investment and Reform for NHS Staff – Taking Forward the NHS Plan*
Aims/general content	To increase the number of staff in the NHS and change the way in which staff work to benefit patient care.
	To increase numbers of doctors, nurses, midwives, scientific, therapeutic and technical staff. Improve training and education, attracting new staff, improving pay, help with housing, improving childcare provision, flexible working arrangements, flexible retirement.
	Extending nurse prescribing, GP specialists, e.g. minor surgery, management of chronic disorders.
	Set up Workforce Development Confederations to replace education consortia and the Local Medical Workforce Advisory Groups.
	Established National Workforce Development Board, Care Group Workforce Teams.
	Integrated care pathways and protocols.
Document status	Planning document
Linked to future/past documents	*The NHS Plan*, *A Health Service of All the Talents*, *Making A Difference*
Group/instruments/ future plan initiated	Changing Workforce Programme, Workforce Development Confederations, National Workforce Development Board, Care Group Workforce Teams and Workforce Numbers Advisory Board from April 2001
Policy strands	3, 5
Impact on C of C, and what dimension	More flexible working should create opportunities for continuity but need to be specific: e.g. could provide continuity in circumstances where patients can book in advance, but will make it more difficult in urgent care situation.
	2, 3, 4, 5

Human Resource Policies and Continuity of Care

Analysis Sheet: *NHS Professionals: Flexible Organisations, Flexible Staff*

Reference number	50
Date and origin	February 2001, Department of Health
Title	*NHS Professionals: Flexible Organisations, Flexible Staff*
Aims/general content	Announcing the NHS Professionals initiative, a new approach to providing temporary staffing services.
	NHS-run staffing agency to become primary provider of temporary staffing by 2003 to help alleviate staff shortages.
	Extends IWP standards to staff working in temporary, locum, or bank capacity, thereby providing more opportunities for flexible working.
	Responsibility on Trusts and Regional Offices to work collaboratively to implement NHS Professionals by: developing more flexible, family-friendly working arrangements; reviewing current temporary staffing arrangements; removing any anomalies between pay and conditions of bank and permanent staff.
Document status	Health Service Circular
Linked to future/past document?	*The NHS Plan: A Plan for Investment, A Plan for Reform* (2000)
	Working Together – Securing a Quality Workforce for the NHS (2000)
	Modernising Health and Social Services; Developing the Workforce (1998)
	Human Resources Performance Framework (2001)
Group/instruments/ future plan initiated	NHS Professionals
Policy strands	3, 5
Impact on C of C and what dimension	2: Standarised pay and conditions for NHS permanent and temporary staff, more stable agency usage, may assist in development of closer working relationship between agency and NHS staff.
	3: Flexible workforce may provide more opportunities to adjust service to user needs.

Human Resource Policies and Continuity of Care

Analysis Sheet: Health and Social Care Bill and *Explanatory Notes*

Reference Number	51
Date and origin	February 2001, The Stationery Office
Title	Health and Social Care Bill and *Explanatory Notes*
Aims/general content	Provided mechanisms for the Secretary of State to allocate more money to 'under-doctored' areas by taking into account Part II non-cash-limited expenditure on GMS when allocating Part I money to health authorities and PCTs; make performance-related payments (relates to new Modernisation Agency); make supplementary payments to NHS trusts and PCTS; provide for public-private partnerships.
	Patients' Forums and Councils (to monitor NHS Trusts and PCTs), non-statutory Patient Advocacy & Liaison Services (PALS) and Independent Local Advisory Forums (ILAFs) to replace CHCs. Local authority overview and scrutiny committees (OSCs) with remit for reviewing, reporting on and advising on health and social care services.
	Gave Secretary of State intervention powers; abolition of Medical Practices Committee and NHS Tribunal; health authorities to have power to suspend or remove GPs from HA list, subject to appeal to FHSAA.
	Following Health Act 1999 setting up of Primary Care Trusts, this bill makes provision for establishment of Care Trusts to integrate health and local authority services to provide seamless care.
	Extension of prescribing rights. Changes to data protection.
	Accreditation of out-of-hours service providers.
	NHS to take responsibility for nursing care, local authorities will no longer purchase, therefore not means tested. But local authorities can recoup through charge on property. Cross-border placements 'deregulatory'.
Document Status	Parliamentary Bill
Linked to future/past document?	*The NHS Plan*, The Health Act 1999
	The *Explanatory Notes* contain an outline of existing law in Annex
Group/instruments/ future plan initiated	Provides for establishment of Care Trusts
Policy strands	1, 2, 3, 4, 6

Impact of C of C and what dimension?	Important but indirect links. Resources for 'under-doctored' areas should provide more GPs, facilitating C of C in theory, but PCTs emphasize wider professional primary care base. Care could be more fragmented, or continuity could be achieved but with other health professionals. Patients to have more prominent role in monitoring services, so if continuity. is important they may influence change, but will sufficient numbers get involved?
	Local authorities and health services to work more closely together to provide 'seamless care', addressing continuity types 1, 2, 3.
	Extension of prescribing rights so patients may get prescriptions from wider range of health professionals, and across boundaries, e.g. 'e-pharmacy' could mean fragmentation of care, and not having to be reviewed to get repeats?
	1, 4, 5

Analysis Sheet: *Changing Workforce Programme*

Reference number	57
Date and origin	March 2001, NHS Executive
Title	*Changing Workforce Programme*
Aims/general content	To increase staff numbers by improving job satisfaction.

1. Pilot test sites – to try new ways of working: moving tasks up or down the traditional unidisciplinary ladder; expanding breadth and depth of jobs; new jobs combining tasks differently. Use of care systems, pathways and protocols; evidence of good practice. Produce replicable models and good practice database.

2. Removing blocks to change – anxiety, history, territorial and protectionist behaviour, education and training, information systems, disjointed initiatives etc.

3. Support to all in NHS to achieve change.

The Toolkit – facilitates problem analysis and solutions.

Document status	Human Resources Directors' Bulletin
Linked to future/past document?	NHS Plan, Clinical Governance, Beacon Sites, Primary Care Development Team, Agenda for Change, Improving Working Lives, Modernisation Programme
Group/instruments/ future plan initiated	
Policy strands	2, 3, 5
Impact on C of C, and what dimension	Success to be measured by improved patient care, e.g. decreased patient handovers, greater staff retention and reduced turnover.
	2, 3, 4, 5

Analysis Sheet: *Building a Safer NHS for Patients: Implementing an Organisation with a Memory*

Reference number	60
Date and origin	April 2001, Department of Health
Title	*Building a Safer NHS for Patients: Implementing an Organisation with a Memory*
Aims/general content	Promoting patient safety through improved reporting, recording and analysis of adverse events; no blame culture; learning from mistakes.
	Specific targets: suicides among mental health in-patients; maladministration of spinally injected cancer drugs, harm in the field of obstetrics and gynaecology; medication errors.
	Generic: promoting a 'culture' of reporting and patient safety across whole NHS system; integrating and making more consistent responses to adverse events.
Document status	For implementation
Linked to future/past document?	*An Organisation with a Memory*; *A First Class Service* (clinical governance)
Group/instruments/ future plan initiated	National Patient Safety Agency; National Clinical Assessment Authority; a 'minimum data set' for adverse event and near-miss reporting; 'standardised root cause analysis methodologies'
Policy strands	2, 4, 6
Impact on C of C, and what dimension	If adverse events are analysed systematically, lack of C of C may be cited in same way as lack of communication. But if a learning culture is established, continuity could improve.
	1, 2 especially, but could include more.

Appendix C

Briefing paper for expert seminars
Policies affecting human resource management in the
NHS and their implications for continuity of care

Aim of the briefing paper

This briefing paper is being circulated in advance to all participants in
the four expert seminars on maternity care, primary care, mental health
and cancer care, which will take place during the next few weeks as
part of this research study. Our task in the study is to explore policies
affecting human resource management in the NHS and their implications
for continuity of care. In each seminar we will consider the impact of
these generic policies in a different area of care. We chose these four
areas as exemplars of the service as a whole, because each one raises
a slightly different range of problems in relation to achieving continuity
of care.

The paper explains how we have approached our task so far. It
contains a brief summary of the range of relevant policy initiatives
since 1997 and some preliminary ideas about their possible effects on
continuity of care. It is intended to provide a stimulus for thinking and
a framework for discussion. During the seminars, for each strand of
policy identified, we will be asking participants to consider:

- whether and how it may enhance or support continuity of care

- whether it generates new problems for continuity, and what these
  are

- what can be done to optimise the benefits and minimise the
  problems.

While reading the briefing paper in advance, we would ask you to
reflect on these same questions.

Structure of the briefing paper

The paper comprises:

1   an explanation of how policy documents were identified and selected for analysis

2   a framework grouping different policy themes

3   a summary of the different dimensions of continuity of care

4   a preliminary analysis of key strands of policy and their possible effects on continuity of care.

The accompanying appendices (which have been emailed to you as a separate document) contain:

A   a chronological list of all potentially relevant policy documents since 1997

B   a set of analysis sheets for each of the documents reviewed to date.

Note on terminology

We have used the term 'patient' to refer to people who are currently using health services, because this reflects the language of most of the policy documents included in this study.

Selection of policies for inclusion

In deciding which recent policy initiatives are relevant to this study we took a pragmatic rather than a theoretically driven approach and chose to throw the net quite wide. We defined as 'policy' any proposals emanating from the Department of Health or the NHS Executive since 1997 which appear to have implications for significant change in the health service and some possibility of being implemented. We defined as 'relevant' not only policies that specifically address issues of human resource management, but also those relating to major developments in other aspects of the health service which seem likely to impact upon where, how or by whom patients are cared for and how health professionals do their work.

Policy documents were identified via government and other health-related websites, and through consultation with librarians and other colleagues. (All the documents collected are listed in the accompanying appendix.)

We then selected a subset of documents for detailed analysis by applying the following criteria:

1   contains generic policy with service-wide implications, rather than relating to specific areas of care

2   has not been superseded by more recent initiatives

3   contains proposals which may have significant implications for continuity of care.

Categorisation of policy strands

We devised our own system for analysing different strands of policy, grouping together the various different issues that feature in the documents under six thematic headings (Box C1), which reflect broader trends evident in wider health policy and related literature over the past four years. The themes emerged as the analysis proceeded, and may be refined further as the study progresses.

Box C1 Policy themes

1 Reconfiguration of services
(e.g. PCTs, redrawn organisational boundaries, service links)

2 Information and IT
(e.g. electronic patient records, data protection)

3 Flexible workforce
(e.g. skills, skill mix, flexible deployment, education, training)

4 **Quality, safety and standards**
(e.g. performance assessment, learning from errors, guidelines and standards)

5 Better working lives
(e.g. flexible hours, improved career paths)

6 Patient-centred care
(e.g. care pathways, user-oriented service)

Dimensions of continuity of care

We adopted the multi-aspect definition of continuity of care proposed in the *Report of the Scoping Exercise for the SDO Programme of NHS R & D* [1], which led to the commissioning of the present study. In this definition, continuity is seen as 'the experience of a co-ordinated and smooth progression of care from the patient's point of view'. To

---

[1] Freeman, G., Shepperd, S., Robinson, I., Ehrich, K. and Richards, S. (2001) *Continuity of Care. Report of a Scoping Exercise for the SDO programme of NHS R & D*. Available from NCCSDO. Email: sdo@lshtm.ac.uk

achieve this experience, the report suggests that five different dimensions of continuity must be present (Box C2).

Box C2 Dimensions of continuity

1 Continuity of information
Effective information transfer following the patient; consistency of information given to patients; harmonisation of common data management

2 Cross-boundary and team continuity
Effective communication between professionals and services across team and organisational boundaries; smooth transition between care settings and health care professionals

3 Flexible continuity
Flexibility within the service to enable adjustment of provision to the needs of the individual as they change over time

4 Longitudinal continuity
Care from as few professionals as possible, consistent with other needs

5 Personal continuity
Provision of one or more named individual health care professionals with whom the patient can establish and maintain a therapeutic relationship

---

Process of analysis

Each document initially selected was then analysed to:

- generate a summary description of its main policy aims

- establish its status (e.g. consultation document, parliamentary bill)

- identify links to other earlier and more recent policy initiatives

- identify which of the various policy themes it addresses

- consider which of the five elements of continuity of care it might affect.

Appendix B contains summaries of this information for each document included.

Box C3 shows all the selected documents, listed in chronological order and mapped by policy theme. The ticks in the column below each thematic heading indicate which policy documents address the strands within that theme. The preliminary analysis which follows contains a brief summary of the main elements of each policy theme, incorporating examples from the relevant documents. For each policy theme we have made some provisional suggestions as to how policies of this sort, if implemented as planned, might be expected to affect continuity of care.

It should be stressed that this is, at present, an oversimplified and highly speculative exercise, based on looking at what has been written rather than what is actually taking place. We have taken the aims of the various initiatives as set out in the documents at face value

without, for the moment, considering any evidence as to how they are actually turning out in practice. We have looked at each policy theme in isolation from the others, without addressing the ways in which different themes may interact or even conflict with one another. We have not attempted to be comprehensive in looking at the implications for each area. Above all, we are aware of having made some considerable and probably unjustified leaps of the imagination, particularly in respect of policies that were not explicitly intended to have effects on human resources or continuity of care and those whose goals are outlined only in the most general terms. But our purpose at this stage is not to offer a definitive analysis. Our aim, rather, with this briefing paper, is to provide some common starting points for seminar participants to reflect upon beforehand and to set up a framework for our discussions on the day.

Box C3 Map of the selected documents in chronological order analysed according to six policy themes and five dimensions of continuity of care (each of the documents analysed on the sheets in Appendix B has been entered into the map)

Ref. No.	Title and date of document (in chronological order)	Dimensions of Continuity of Care	1 Reconfiguration of Services	2 Information and IT	3 Flexible Workforce	4 Quality, safety, and standards	5 Better working lives	6 Patient-centred care
3	*Our Healthier Nation: A Contract for Health*, 1998			4				4
9	*A First Class Service: Quality in the New NHS*, 1998	1, 2				4		4
12	*Working Time Regulations, European Working Time Directive*, 1998	2, 4			4		4	
16	*Caring about Carers*, 1999	3					4	4
19	*The NHS Performance Assessment Framework*, 1999	1, 3				4		4
26	*Saving Lives: Our Healthier Nation*, 1999	2		4				4
27	*Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare*, 1999	2, 3, 4, 5	4		4	4	4	
29	*Patient and Public Involvement in the New NHS*, 1999	1, 2, 3				4		4
31	*Supporting Doctors, Protecting Patients*, 1999	2				4		4
35	*Working in Partnership: Developing a Whole Systems Approach*, 2000	1, 2	4	4				

Box C3 (continued)

Ref. No.	Title and date of document (in chronological order)	Dimensions of Continuity of Care	1 Reconfiguration of Services	2 Information and IT	3 Flexible Workforce	4 Quality, safety, and standards	5 Better working lives	6 Patient-centred care
36	*A Health Service of all the Talents: Developing the NHS Workforce, 2000*	2, 3			4	4	4	
39	*The NHS Plan, 2000*	1, 2, 4, 5	4	4	4	4	4	4
40	*Human Resources Performance Framework, 2000*	2, 4, 5			4		4	
42	*Raising Standards for Patients: New Partnerships in Out-of-Hours Care, 2000*	1, 2, 3, 4, 5	4	4	4	4	4	4
44	*Implementation Programme for the NHS Plan, 2000*	1, 3, 4, 5	4	4	4		4	
48	*Investment and Reform for NHS Staff – Taking Forward the NHS Plan, 2001*	2, 3, 4, 5			4		4	
50	*NHS Professionals: Flexible Organisations, Flexible Staff, 2001*	2, 3			4		4	
51	Health and Social Care Bill *and Explanatory Notes, 2001*	1, 2, 3, 4, 5	4	4	4	4		4
57	*Changing Workforce Programme, 2001*	2, 3, 4, 5		4	4		4	
60	*Building a Safer NHS for Patients: Implementing an Organisation with a Memory, 2001*	1, 2		4		4		4

Analysis of selected policies and possible effects on continuity of care

1 Reconfiguration of services

This policy theme centres on the reconfiguration of health services to create a more integrated, seamless service. This includes the development of a primary care-led service and the facilitation of joint working between health and social care.

Key strands of this policy are the development of Primary Care Groups/Trusts, Care Trusts and NHS Direct as the gateway to health care.

Possible effects on continuity of care

Joint working between health and social care providers is intended to increase **cross-boundary and team continuity,** and could affect **flexible continuity** as well as **continuity of information**.

The NHS Direct gateway to the NHS is intended to create a streamlined experience for patients, but may be perceived as a barrier to **longitudinal** and **personal continuity** if patients lose direct contact with particular professionals with whom they have had a personal and/or long-term relationship.

The development of an integrated primary care service may have a positive impact upon **cross-boundary and team continuity** as a consequence of more effective and integrated multidisciplinary working.

Expanded clinical responsibility for specific professional groups such as nurses and consultants as detailed in the NHS Plan may impact positively upon **longitudinal** and **personal continuity** if one professional has the clinical capabilities and responsibility to oversee a greater proportion of an individual's care.

Key policies

- *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare* (1999)
- *Working in Partnership: Developing a Whole Systems Approach* (2000)
- *The NHS Plan* (2000)
- R*aising Standards for Patients: New Partnerships in Out-of-Hours Care* (2000)
- *Implementation Programme for the NHS Plan* (2000)
- *Health and Social Care Bill* (2001)

2 Information and IT

The main element of this policy theme is the modernisation of information technology within the NHS, to provide a harmonised system which facilitates the effective transfer of information both within the NHS and between health and social care systems. The development of electronic patient records, electronic booking systems, and computer-assisted decision support for NHS Direct are key components of this theme.

Possible effects on continuity of care

Plans for electronic health and patient records are intended to aid integration of services and streamline patients' experience of continuity. However, such measures may diminish patients' experiences of **longitudinal** and **personal continuity** by emphasising continuity of information over personal continuity.

The introduction of primary care centres, walk-in centres, NHS Direct nurse triage and advice, and closer working partnerships with pharmacies may, if properly integrated, deliver more convenient access to a wider range of services for patients. However, if integration and communication between these providers fails, the patient may receive a more fragmented service than before. These systems could therefore have a negative effect on **continuity of information**, **cross-boundary and team continuity**, **longitudinal** and **personal continuity**.

The *Health and Social Care Bill* proposes that health authorities can make arrangements for provision of services such as pharmacy by 'remote' (i.e. electronic) means. This may offer patients convenience and choice, but it could equally damage **longitudinal continuity** with the local pharmacist.

Key policies

- *Our Healthier Nation: A Contract for Health* (1998)

- *Saving Lives: Our Healthier Nation* (1999)

- *Working in Partnership: Developing a Whole Systems Approach* (2000)

- *A Health Service of all the Talents: Developing the NHS Workforce* (2000)

- *The NHS Plan* (2000)

- *Raising Standards for Patients: New Partnerships in Out-of-Hours Care* (2000)

- *Implementation Programme for the NHS Plan* (2000)

- *Health and Social Care Bill* (2001)

- *Changing Workforce Programme* (2001)

- *Building a Safer NHS for Patients: Implementing an Organisation with a Memory* (2001)

3 Flexible workforce

The main aim of this policy theme is the creation of a skilled, flexible and integrated workforce capable of responding to the needs of patients.

A Health Service of All the Talents sets out a strategy for the development of a flexible workforce through multidisciplinary training, more flexible deployment of staff, and a more integrated approach to workforce planning and development. Although this document refers to the goal of continuity of care for patients, it is more focused on integrating the workforce than on patients' experience of an integrated service, so its effects are indirect. These themes reappear in the *NHS Plan* and later implementation documents such as *Investment and Reform for NHS Staff – Taking forward the NHS Plan* and the *Changing Workforce Programme*, which promotes concepts such as integrated pathways and reconfiguration of jobs to combine tasks differently.

Possible effects on continuity of care

The reduction in junior doctors' working hours may have a positive impact upon **continuity of information** and **cross-boundary and team continuity** if it leads to greater dependency on permanent rather than rotating staff and if there are fewer professional groups involved in the delivery of care to an individual.

The development of more flexible working roles such as nurse prescribers and consultant nurses could lead to greater **personal** and **longitudinal continuity** if it enables one professional to cover a wider range of a patients' care needs.

The development of an NHS-run agency for provision of temporary staffing services may facilitate **cross-boundary and team continuity** if it facilitates more stable patterns of agency usage and closer working relationships between agency and permanent NHS staff.

The development of a diversely skilled flexible workforce should enable the provision of **flexible continuity** in line with changing patient needs.

More fluid flexible working patterns may improve **cross-boundary and team continuity** by reducing traditional professional communication barriers.

Human Resource Policies and Continuity of Care

Key policies

- *Working Time Regulations, European Working Time Directive* (1998)

- *The NHS Performance Assessment Framework* (1999)

- *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare* (1999)

- *Patient and Public Involvement in the New NHS* (1999)

- *Supporting Doctors, Protecting Patients* (1999)

- *A Health Service of all the Talents: Developing the NHS Workforce* (2000)

- *The NHS Plan* (2000)

- *Human Resources Performance Framework* (2000)

- *Raising Standards for Patients: New Partnerships in Out-of-Hours Care* (2000)

- *Implementation Programme for the NHS Plan* (2000)

- *Investment and Reform for NHS Staff – Taking forward the NHS Plan* (2001)

- *NHS Professionals: Flexible Organisations, Flexible Staff* (2001)

- *Health and Social Care Bill* (2001)

- *Changing Workforce Programme* (2001)

4 Quality, safety and standards

The main aim of this policy theme is the delivery of a consistently high-quality equitable service. Central strands of this policy theme are performance assessment, professional regulation, clinical governance, and National Service Frameworks.

The *NHS Plan* and the *Health and Social Care Bill* introduced such measures as quality-based contracts for GPs including annual appraisal and audit and revalidation every five years, the 'traffic light' performance assessment link to funding, and local authority overview and scrutiny committees.

The NHS Beacons Programme and the Modernisation Agency are part a learning strategy aimed at ensuring widespread adoption of good practice. *Building a Safer NHS: Implementing an Organisation with a Memory* promotes patient safety through improved reporting, recording and analysis of adverse events, and the development of a 'no blame, learning from mistakes' culture.

Possible effects on continuity of care

The implementation of national service frameworks may assist in providing **continuity of information** and **cross-boundary and team continuity**. However, **personal** and/or **longitudinal continuity** could be compromised if rigid adherence to safety measures or protocols resulted in staff feeling unable or unwilling to do certain tasks.

Human Resource Policies and Continuity of Care

The development of more accountable, open and responsive professional regulation may improve **cross-boundary and team continuity** by facilitating better multidisciplinary working.

The introduction of patient assessment of clinical training and practice as outlined in *Patient and Public involvement in the New NHS* may facilitate the provision of greater continuity of care in all respects, if this is rated as a key priority by service users.

Key policies

- *A First Class Service: Quality in the New NHS* (1998)

- *The NHS Performance Assessment Framework* (1999)

- *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare* (1999)

- *Patient and Public Involvement in the New NHS* (1999)

- *Supporting Doctors, Protecting Patients* (1999)

- *A Health Service of all the Talents: Developing the NHS Workforce* (2000)

- *The NHS Plan* (2000)

- *Raising Standards for Patients: New Partnerships in Out-of-Hours Care* (2000)

- *Health and Social Care Bill* (2001)

- *Building a Safer NHS for Patients: Implementing an Organisation with a Memory* (2001)

5 Better working lives

The main aim of this policy theme is to provide a better service for patients by increasing staff recruitment and retention through a restructuring of NHS working terms and conditions.

Central strands of this policy theme are staff recruitment and retention, improved working terms and conditions, developing job roles, improving pay, providing return to practice and career break schemes, and offering more education and training opportunities. Policy documents stemming from the *NHS Plan* propose improved childcare provision, housing assistance, flexible working and retirement schemes. Furthermore, some of the new Human Resources Beacons are focusing on providing healthy and supportive workplaces. *NHS Professionals: Flexible Organisations, Flexible Staff* outlines the development of an NHS run staffing agency to become the primary provider of temporary staff thereby providing greater access to flexible working patterns for NHS staff.

Possible effects on continuity of care

Adequate staffing levels are a precursor to the delivery of continuity of care, as understaffing has been shown to lead to a routinisation of clinical tasks at the expense of continuity. More part-time opportunities may help to attract and retain staff however this may also impact

negatively on **longitudinal** and **personal continuity** if staff are not available at the times required by the patient.

The restructuring of services to suit the needs of patients and staff as detailed in *Human Resources Performance Framework* may have a positive impact on delivery of **longitudinal** and **personal continuity** if this is identified as an important factor for patient and staff satisfaction. However, patient and staff needs could be contradictory.

Key policies

- *Working Time Regulations, European Working Time Directive* (1998)

- *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare* (1999)

- *Caring about Carers* (1999)

- *A Health Service of all the Talents: Developing the NHS Workforce* (2000)

- *The NHS Plan* (2000)

- *Human Resources Performance Framework* (2000)

- *Raising Standards for Patients: New Partnerships in Out-of-Hours Care* (2000)

- *Implementation Programme for the NHS Plan* (2000)

- *Investment and Reform for NHS Staff – Taking forward the NHS Plan* (2001)

- *NHS Professionals: Flexible Organisations, Flexible Staff* (2001)

- *Changing Workforce Programme* (2001)

6 Patient-centred care

This theme captures those policies that emphasise reforming the NHS as an organisation built around the needs of patients. It includes policy that is about creating a service that delivers or intends to enhance continuity of care as experienced by individual patients, and reflects a more general aim of promoting or appealing to ideas about choice, convenience and the voting power of 'consumers'.

Patient and Public Involvement in the New NHS sets out an agenda for developing a patient-led service, through the involvement of patients in the planning, development and monitoring of services. *Caring about Carers* defines a national strategy for carers which includes the need for them to be involved in planning and providing services. The aim of achieving greater continuity of care across geographical and social boundaries, and reducing socially related disease incidence and variations in treatment as outlined in *Saving Lives: Our Healthier Nation* is a key component of delivering a patient-centred service.

Possible effects on continuity of care

The effects of policies aimed at reducing inequalities at the generic level may be experienced by patients as conflicting with the effects of other

aspects of policy that are intended to create the experience of continuity of care on an individual level. An example could be the *NHS Performance Assessment Framework* which aims to promote fair access and improvements to reduce inequalities, while at the same time ensuring that the NHS is sensitive to individual needs.

The effect of these policies on continuity of care will be partially determined by the significance which patients place on continuity in the planning process. Hence, it is possible that patients could place greater emphasis upon issues other than continuity of care such as safety, or emphasise one dimension of continuity over another, e.g. **longitudinal continuity** over **team continuity** if they wish to have continual care from a named professional.

Greater emphasis upon clinical communication skills as outlined in *Patient and Public Partnership in the NHS* should improve **continuity of information** and may inadvertently have a positive impact upon **cross-boundary and team continuity** if it leads to improved communication between professionals.

A service which is led by the principle of 'patient as expert' and public consultation should be better equipped to provide **flexible continuity**.

Key policies

Our Healthier Nation: A Contract for Health (1998)

A First Class Service: Quality in the New NHS (1998)

Saving Lives: Our Healthier Nation (1999)

The NHS Performance Assessment Framework (1999)

Patient and Public Involvement in the New NHS (1999)

Supporting Doctors, Protecting Patients (1999)

Caring about Carers (1999)

The NHS Plan (2000)

Raising Standards for Patients: New Partnerships in Out-of-Hours Care (2000)

Health and Social Care Bill (2001)

Building a Safer NHS for Patients: Implementing an Organisation with a Memory (2001)

Appendix D

Expert seminar participants

Name	Job title
Jo Allen	Macmillan Project Officer for User Involvement, Avon, Somerset and Wiltshire Cancer Services
Richard Baker	Director of the Clinical Governance Research & Development Unit and Professor of Quality in Health Care, Department of General Practice & Primary Health Care, University of Leicester
Tom Bass	Carer and Member of Avon, Somerset and Wiltshire Cancer Services User Involvement Group
Maggie Bisset	Consultant Nurse Palliative Care, Camden & Islington Community Health Services NHS Trust
Elisabeth Buggins	Chair, Walsall Maternity Services Liaison Committee; Chair, Walsall Community Health NHS Trust; West Midlands Lead, NHS Confederation
Clare Gerada	General Practitioner, Lambeth; Project Director, RCGP National Drugs Primary Care Training Agenda
Stephen Gillam	Director of the Primary Care Programme, King's Fund, London; General Practitioner, Luton; Honorary Senior Lecturer, Royal Free and University College Medical School, University College London
Jo Green	Research Psychologist and Senior Lecturer, Mother & Infant Research Unit, University of Leeds
Jeremy Holmes	Consultant Psychiatrist and Psychotherapist, North Devon; Senior Lecturer in Psychotherapy, University of Exeter; Chair, Psychotherapy Faculty, Royal College of Psychiatrists; Chair, Psychotherapy Advisory Group, Department of Health
Eileen Hutton	Chair, Patients' Liaison Group, Royal College of General Practitioners
Jill Ireland	Nurse Consultant Cancer Care, Whittington Hospital NHS Trust
Jessica Linskill	Director of Nursing, Children's and Older People's Services, North Herts and Stevenage Primary Care Trust
David Lloyd	General Practitioner, North Harrow
Andrew McCulloch	Head of Policy, The Sainsbury Centre for Mental Health; Chair, Mental Health Media
Chantal Meystre	Clinical Director, Warwickshire Integrated Service Directorate for Palliative Care
Mary Newington	Practice Nurse, Islington; Practice Nurse Trainer, Camden & Islington Health Authority

Human Resource Policies and Continuity of Care

Kate Phipps	Project Director (Mental Health), Leicestershire Health Authority
Steve Pilling	Clinical Psychologist and Director, British Psychological Society Clinical Effectiveness Unit (CORE); Co-Director of the National Collaborating Centre for Mental Health; Head of Mental Health Psychology Services, Camden & Islington Mental Health Trust
Richard Porter	Consultant Obstetrician and Director of Maternity Services, Royal United Hospital Bath NHS Trust; Chair, Association for Community-Based Maternity Care
Mike Richards	National Cancer Director and Professor of Palliative Medicine, GKT School of Medicine, King's College London
Jenny Secker	Senior Research Fellow, Institute for Applied Health & Social Policy, King's College London
Jim Sikorski	General Practitioner, Sydenham; Research Fellow and Honorary Senior Lecturer, GKT School of Medicine, King's College London
Helen Stevenson	Executive Director, The Guild Community NHS Trust, Preston; Member, Preston PCG Project Steering Group and Lancashire Mental Health Trust Project Team
Cathy Warwick	General Manager, Women's & Children's Services and Director of Midwifery, King's College Hospital
Judy Withers	Team Leader, District Nursing Team, Oxfordshire; Vice-Chair, Oxfordshire Cancer Services Advisory Group

Appendix E

Examples of how people have used ingenuity to provide continuity of care

A one-stop clinic

When a new one-stop clinic was proposed for women with menstrual problems, discussions were held with staff and patients to design the service around what patients wanted. Women now have a service organised to suit them. They are given a reminder of their appointment by telephone, sent appropriate information well before their appointment and details of where to park. When they arrive they meet a nurse who takes them through the whole service. They get test results on the same day.

Health and social care for people in discontinuous circumstances

Some groups of people, or people in particular circumstances, are especially likely to experience discontinuities in their access to services, e.g. refugees and asylum seekers, children in care, prisoners. Similarly, some people in very deprived areas need access to a range of services to help them overcome the effects of social and health inequalities. In one health action zone, a single-handed GP joined up with other service providers – social care, policy, a dentist and a playgroup – to meet the needs of the local community all on one site.

Using technology to keep patient access local

Continuity of care is often linked to access when providing patient-centred care, and both of these factors can be facilitated by keeping services local. Technology can be used to transfer information, rather than patients having to travel to larger centres of care. In maternity services, if cardiotocography is available in a community setting, women who need monitoring during a pregnancy and who live in a rural area can go to a local outpost, and have the results relayed electronically back to the central site. This saves women with pregnancy-related risk from making additional journeys. Such use of technology can help build and maintain personal and longitudinal continuity, as patients can be treated in their own locality by fewer professionals, which also helps ensure greater continuity of information.

A team who knows me

An extended-hours crisis prevention service tried using a team approach as a new way of working with service users. The one-to-one keyworker-to-user relationship had been thought to be important and everyone was used to this way of working, and consequently the proposed change was not welcomed by all users or professionals. However, when the project was evaluated, users reported that when they had met the whole team and telephoned the service it was good to talk to someone who already knew them. The team approach also improved access because users didn't have to wait for their keyworker to be available.

Making sense of data

Continuity of care sometimes means ensuring that people do not 'slip through the net' and services do not lose contact with them. A cancer nursing team, using their epidemiological knowledge, noticed that the number of patients on their breast cancer register for the year was much lower than expected according to the normal incidence in their catchment population. They decided to do a hand trawl of patients' notes and found over one-third more patients who had not been entered onto their system. Information and IT systems are being modernised to facilitate the effective use of information, and electronic patient records and booking systems are part of this drive. But there will always be a need for individuals to use their knowledge and initiative to ensure that the data produced by such systems makes sense.

Minding the gap

Job sharing and part-time working can help staff remain in health care jobs while meeting other responsibilities outside of work, and increasing such opportunities may help recruitment. Yet continuity of information, team continuity, longitudinal and personal continuity can all suffer with a greater number of staff covering an area of work. Some job-sharing district nurses devised a system of tape-recording information about their patients and events so that the district nurse next on duty would have all the details and 'nothing would get missed'.

Using technology to deliver community services

Delivering continuity of care in maternity services has been interpreted in terms of team continuity in hospital services, and continuity of carer in community-based services. To preserve the option for women to receive community-based midwifery and for midwives to work in this way, time-consuming activities such as travel need to be kept to a minimum. Hand-held computers enable community midwives to save a lot of time by picking up new referrals and sending information back to the main unit without going there themselves.

Delivering information

District nurses are using hand-held computers to access evidence-based information and treatment guidelines while in patients' homes. This means they can share and discuss the information with patients, and deliver the care there and then, rather than having to refer patients elsewhere to discuss the information or having to come back at another time to implement the care.

Disclaimer

This report presents independent research commissioned by the National Institute for Health Research (NIHR). The views and opinions expressed by authors in this publication are those of the authors and do not necessarily reflect those of the NHS, the NIHR, the NIHR SDO programme or the Department of Health. The views and opinions expressed by the interviewees in this publication are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, the NIHR SDO programme or the Department of Health

Addendum

This document was published by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) research programme, managed by the London School of Hygiene & Tropical Medicine.

The management of the Service Delivery and Organisation (SDO) programme has now transferred to the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Prior to April 2009, NETSCC had no involvement in the commissioning or production of this document and therefore we may not be able to comment on the background or technical detail of this document. Should you have any queries please contact sdo@southampton.ac.uk.

Addendum:

This report was amended on 29th September 2011 to update the correct copyright statement and/or correct the publication date. The content of the report has not been changed.