Enabling clinical work

Proposals formulated at a workshop held in September 1984 about the organisational arrangements required to enable hospital clinical work, based on studies done in five districts

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Piloting Körner: the views of senior administrators from the four districts who piloted the interim reports of Working Groups A to E from 1981 to 1983

Making data credible: proposals formulated by members of a workshop held in February 1984 about the setting, achieving and monitoring of data standards with particular emphasis on standards for clinical activity data

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Enabling clinical work

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It must be considered that there is nothing more difficult to carry out, nor more doubtful of success, nor more dangerous to handle, than to initiate a new order of things. For the reformer has enemies in all those who profit by the old order and only lukewarmness arising partly from the incredulity of mankind who do not truly believe in anything new until they have actual experience of it.

Niccolo Machiavelli in *The Prince*

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Preface

A major aim of the Health Services Information Steering Group has been to promote good practice in the organisation of information production and the use of information technology.

Among the initiatives launched by the Steering Group was a study involving five districts to review the operational information required about doctor-patient contacts and to develop effective ways of collecting the data required. From this starting point the participants were inexorably drawn into a comprehensive review of the organisational arrangements which enable clinical work to be carried out.

The work is far from finished and some of the proposals made in the paper are as yet unproven. However, the analysis of the problems facing districts, as they prepare to implement both the recommendations of the Steering Group and the management philosophy outlined in the Griffiths report will, we hope, be useful to those involved in determining and setting up the new organisational structures and management arrangements.

We are grateful to all the contributors to the workshops, shown in Appendix A, and the staff in the participating districts for the time and effort they have expended.

Alastair Mason, Secretariat, NHS/DHSS Health Services Information Steering Group

Chapter 1: Introduction

Hospital clinical practice

1.1 Over the last ten years there have been major changes in hospital clinical practice. In particular these include:

a. An increase in the volume of doctor-patient contacts.

b. Changes in the content of contacts. Outpatient attendances, for example, may be the occasion for carrying out a variety of procedures previously requiring the use of a hospital bed.

c. An increase in the pace of work. Stays in hospital are shorter. Patients may use a hospital bed, attend an outpatient clinic and a day care facility all within a short period of time.

d. The dispersal of consultant work which means that doctors may see patients in a number of locations on a hospital site and outside hospital as well.

1.2 Not surprisingly, the changes in clinical practice have put a great strain on the arrangements for enabling clinical work in many districts. These arrangements have changed little since the 1960s. The purpose of this project was to find out how well existing arrangements work and to identify whether changes might improve the situation. The conduct of the studies is described in Chapter 2.

Enabling clinical work

1.3 The overall objective is simply stated. There should be arrangements that ensure that the patient, doctor and other health professionals are brought together at the right place and time with

appropriate up-to-date documentation. A planned doctor-patient contact is ineffective if:

a. the patient is not present in the required state (for example, fasting),

b. the doctor and relevant health professionals are not present,

c. the documentation is missing, or

d. crucial parts of the documentation are missing or cannot be found in disorganised records.

1.4 This objective which is simple to meet for one patient has to be achieved in each district for hundreds of thousands of planned contacts in each year in wards, operating theatres, outpatient clinics, day care facilities and in specialist departments such as radiotherapy.

1.5 The key tasks that need to be carried out are:

a. Scheduling of contacts.

b. Communication to patients and associated doctors and health professionals before and after the contact.

c. Maintenance of up-to-date documentation and its timely transmission to the location of the contact.

d. Production of management information, both to assist scheduling and also to allow feedback to doctors, managers and administrative support staff about how efficiently resources are being used to provide patient care.

The detailed tasks that must be done to achieve an effective out-patient attendance and an elective admission are noted in Chapter 3.

1.6 Despite the central importance of having effective administrative arrangements for enabling clinical work, little senior management

time is devoted to discussing them and few districts have information about how frequently the arrangements break down. A major purpose of this project was to collect data about ineffective doctor-patient contacts and the results of this work are included in Chapter 3 and Appendices C to E.

Management arrangements

1.7 In most hospitals the services involved in enabling clinical work have been centralised. Medical records departments and clinical secretariats have been established in which clerks and secretaries do a limited number of jobs. For example, staff are employed exclusively to make outpatient appointments, to file and retrieve case notes or to keep waiting lists. Many managers feel that these functional arrangements are cheap and efficient in the use of staff. There is no hard evidence to support these views and, indeed, many clinicians have complained that centralisation has led to an unacceptably high number of ineffective doctor-patient contacts.

1.8 In a previous project, involving Brunel University, ten general administrative grade (clinical service coordinator) posts were funded in clinical departments. The object of the study was to identify what administrative tasks might best be carried out by an administrator working for a clinical team rather than by administrators and clerks organised on a functional basis and working within the administrative hierarchy. The results were not clear cut, but it was considered to be worth pursuing the general principle of organising the administrative support to enable clinical work on the basis of clinical teams and not on specific functions.

1.9 The districts participating in the present studies reviewed their administrative arrangements against this philosophy of relating support staff more closely to groups of clinicians. As a result of the work, a broad organisational framework for the effective organisation of clinical work has been developed and it is described in Chapter 4.

Chapter 2: The district studies

The districts

2.1 The work was carried out primarily in five districts, namely:

a. Bath,

b. Bromsgrove and Redditch,

c. Chester,

d. Newcastle,

e. Rochdale.

The districts vary considerably in size, facilities, workload and their previous experience and expertise in establishing management arrangements for enabling clinical work and for producing management information.

2.2 Bath Health District has 27 hospitals, 13 of which are acute units spread over a wide geographical area serving a population of 382,000. Annually there are approximately 46,000 inpatient admissions and 221,000 outpatient attendances. For many years there has been an active unit at district level producing management information. Before the study commenced a decision had already been made to appoint an orthopaedic coordinator. Two further appointments for general surgery and gynaecology have been made during the project.

2.3 Bromsgrove and Redditch Health District is situated on the outskirts of Birmingham and has seven hospitals serving a population of 159,000. Annually there are approximately 16,000

inpatient admissions and 73,000 outpatient attendances. During the course of the study the district has been the DHSS pilot site for implementing the recommendations in the Steering Group's reports to the Secretary of State. A new district general hospital will be opened in 1985/86 and much of the work has been aimed at planning arrangements for this new development.

2.4 Chester Health District has six hospitals serving a population of 178,000. Annually there are approximately 29,000 inpatient admissions and 160,000 outpatient attendances. Before the study it had been noted that there was a problem in transferring case notes speedily between sites and a need to rationalise case note and x-ray numbering systems.

2.5 Newcastle Health District comprises three major acute units and the work was carried out in only one, the Royal Victoria Infirmary. There are over 100 consultants and 50 clinical departments, and the hospital provides the majority of the regional services for the Northern Region. Annually there are approximately 27,000 inpatient admissions and 234,000 outpatient attendances. Staff at the Infirmary have been working on management information developments with John Yates from Birmingham University and on organisational issues with staff from Brunel University.

2.6 Rochdale Health District has five hospitals serving a population of 155,000. Annually there are approximately 20,000 inpatient admissions and 118,000 outpatient attendances. Rochdale was one of the sites for the original clinical service coordinator project (see paragraph 1.8).

Working methods

2.7 At the round of Körner Klub meetings in the Spring of 1983 the districts present were invited to participate in studies to examine

the administrative arrangements required to enable clinical work. Of the seven districts who initially expressed interest, two had to drop out before the work commenced.

2.8 In October 1983 a workshop was arranged in Bath involving staff from the five participating districts, members of the Körner Steering Group and Secretariat and members of BIOSS at Brunel University. The districts' representatives comprised a senior administrator, medical records manager and a clinician. At the two-day workshop there was a general discussion of the issues involved and each district formulated an action plan. During the course of their work, districts were offered expertise in medical records organisation, management information and organisational analysis as required.

2.9 Representatives from the districts reconvened in Chester in September 1984 to compare experiences and to see whether any general principles could be identified which might be of use to other districts. After the previous workshop, many of the districts had found that the original action plan was too limited, particularly when they had available the information gathered about ineffective doctor-patient contacts. Interest in improving the efficiency of clinical resource usage had also been heightened by the need to implement the proposals contained in the Griffiths report. Additional expertise at the workshop was provided by John Yates from Birmingham University.

2.10 The studies have not yet been completed. At the second workshop all the districts identified further work that they wished to do and issues that they would be pursuing. This publication is not therefore a definitive report of completed studies. However, it was felt that the results of collecting data about ineffective doctor-patient contacts would be of general interest and the organisational analysis carried out so far might be useful for other districts contemplating restructuring their arrangements for enabling clinical work.

Chapter 3: The work to be done

Introduction

3.1 The tasks that have to be done to enable clinical work comprise:

a. Arranging doctor-patient contacts such as outpatient appointments and elective admissions.

b. Ensuring that up-to-date documentation is present for doctor-patient contacts.

c. Producing data for operational and management purposes.

Arranging patient contacts

3.2 A variety of different types of doctor-patient contact may have to be arranged but the tasks to be done can be exemplified by the arrangements for:

a. referral for an outpatient appointment, and

b. elective admission.

3.3 The organisation of a referral for an outpatient appointment comprises four main stages:

a. On receipt of a referral letter. Identification details are checked in the master patient index. An appointment date is chosen in accordance with the consultant's policy. The patient is informed with appropriate instructions.

b. Before the clinic:

i. If the patient has not had contact with hospitals in the

district before, a case note is raised with appropriate documentation and pre-printed labels.

ii. If the patient has already had contact, the case note and, where appropriate, x-ray films are obtained. The documentation is checked and any missing information sought, for example, patient identification details. Supplies of pre-printed labels are checked.

c. At the clinic. The patient is received and details checked in the documentation before seeing the doctor. After the appointment arrangements are instituted for further care, for example, re-attendance or elective admission. Data about the activity of the clinic are recorded.

d. After the clinic. Arrangements for further care are made. A letter is sent to the general practitioner and other relevant health professionals.

3.4 The arrangement of an elective admission comprises six main stages:

a. At the time a decision to admit is made. The doctor may or may not give a date for admission and this information is recorded.

b. Sending for patients. If a specific date has not been given the consultant team choose which patients to send for. All patients are informed with appropriate instructions.

c. Before admission. Case notes and x-ray films are obtained. The documentation is checked to ensure that all diagnostic reports are included and any missing information about the patient is sought. Supplies of pre-printed labels are checked. Relevant personnel are informed of the impending admission.

d. At admission. Patients are received on the ward where there is the appropriate documentation.

e. During admission or at discharge. Arrangements are instituted for further care and those to be involved are contacted.

f. After discharge. Relevant personnel are contacted, documentation is updated and information abstracted from the case notes.

3.5 To improve the care given to patients, many doctors have instituted practices which place a premium on good scheduling and communication. These include:

a. Seeing patients at an outpatient clinic for the first time with initial investigations already completed.

b. Admitting patients electively with investigations and assessments done before the admission or with a booked plan of tests and assessments to be done during the admission.

c. Making arrangements for discharge at the outpatient appointment before admission or very early in the admission.

d. Discharging patients from hospitals with a view to reviewing investigation results at a subsequent outpatient clinic.

3.6 The more sophisticated the arrangements, the more important it is that the work is carried out by staff familiar with the clinical team and working closely with them. The clinical service coordinators set up in Bath, for example, carry out all the tasks outlined in paragraph 3.4, except the abstraction of clinical information from the case notes. The job description used in Bath is at Appendix B. Management arrangements to support clinical teams are discussed in detail in Chapter 4.

Maintaining documentation

3.7 At each patient contact a doctor expects to have available the complete, up-to-date history of the medical care delivered to that patient in hospitals in the district. The case note which should

contain the documentation for all previous contacts with all specialties must therefore be:

a. available at the location where the contact takes place, and

b. maintained so that the doctor can use it.

3.8 Case notes spend only a short time in use; for most of their existence they are in store or awaiting the completion of correspondence or documentation. To ensure that a case note is available for use when required there must be suitable arrangements to:

a. store case notes,

b. retrieve them either from store or the places where they are held in transit, and

c. transport them to the desired location.

3.9 A major feature of the centralisation of the medical records function has been to set up a central medical records library. In practice, however, although the library may be centrally controlled it is located in several places throughout the district, usually some distance from the clinical areas. The centralisation policy has often led to working arrangements aimed at keeping case notes in the library rather than speedy retrieval. As a consequence notes are retained with increasing frequency outside the central library in locations such as clinical team offices or wards. As this practice is common it is worth considering whether to use these areas not only as places for holding notes in transit but also as a permanent store for case notes of patients currently attending the hospital.

3.10 The essential prerequisite of devolving the storage of records is an effective tracer system. Current manual systems have not been effective as they fail to detect the whereabouts of a case note once it has left the central library. Poor tracer systems have been an

important factor in the adoption of a custodial policy in many medical records libraries. Technology offers a potential solution to this problem and a number of medical records departments in the USA have successfully implemented tracer systems involving the electronic recognition of bar codes on the front of the case note folder. Such systems are used in many public libraries in this country.

3.11 It is *proposed*, therefore, that work be done to test the feasibility of:

a. Storing active case notes in locations adjacent to clinical areas, preferably those where notes are held in transit awaiting completion of documentation.

b. Equipping each of these sites with bar code readers so that case notes with bar codes can be logged in and out electronically.

c. Linking the data obtained from the bar code system with a computerised master patient index so that the last known location of a case note can be speedily identified by accessing the index.

3.12 Some districts, particularly those with a district general hospital on multiple sites, have considerable problems in transporting case notes to the appropriate location in the required timescale. In maternity services the patient has sometimes been used as the holder of the record and in this limited sphere the approach has been successful. However, a major problem arises with updating the record if the patient retains it. The introduction of a computerised patient record would allow the contents of the record to be transmitted between sites without the transfer of paper. This prospect is still some way off, but some parts of the record, such as laboratory and radiology results, can be successfully transmitted electronically from the originating departments to clinical areas. Chester District, which had particular problems with timely

transportation, found a detailed review of the current systems with consequent changes in the timing of procedures produced a significant improvement.

3.13 To ensure an effective doctor-patient contact, not only must the case note be present, but it must also be:

a. in good condition and contain accurate patient identification details,

b. updated, in that it contains all the results and correspondence, and

c. culled periodically to remove documentation not required.

3.14 The importance of maintaining accurate patient identification details, both in case notes and on the district master patient index, is emphasised in a previous publication in this series, *Making data credible*. The cost of holding inaccurate addresses is considerable in that instructions to attend the hospital go astray and ambulances are sent to the wrong address.

3.15 The updating and culling of case notes are crucial tasks. Unless they are carried out competently the case note may be available for the doctor-patient contact, but unusable because vital information is missing or irretrievable. To achieve the desired standard requires more than a cursory check just prior to the contact. In Bath the clinical service coordinators have this responsibility, for surgical firms in Bromsgrove the consultants' secretaries.

3.16 It is *proposed* that:

a. Each district have a specific policy about the culling of case notes, identifying those documents which are transient records and thus not to be retained and those which, though of a permanent nature, need not be kept in the case note as this is primarily for the use of doctors.

b. The culling and updating of case notes be carried out by staff familiar with the clinical team and their way of working. Arrangements for achieving this are discussed in Chapter 4.

Management information

3.17 The recommendations about data content made by the Steering Group are based on the premise that there is a minimum amount of data about health service activity which should be available to senior district managers. The data sets recommended for outpatient clinics and about the demand for elective admission both contain an item which measures one aspect of the effectiveness of doctor-patient contacts, that is, the failure of the patient to be present.

3.18 Operational managers require considerably more data than that contained in the minimum data sets. Part of this project has included the identification and production of data which managers responsible for enabling clinical work have thought necessary to carry out their work competently.

3.19 All the districts participating consider that data are essential about ineffective doctor-patient contacts in outpatient clinics. Surveys were carried out to determine:

a. the number of patients who did not attend,

b. the number of case notes which were missing, and

c. the number of essential bits of documentation which were missing.

The first two items are easily collected, but the third depends on the cooperation of medical staff. The most comprehensive survey was carried out in Newcastle and the results are shown in Appendix C.

3.20 If particular problems are identified from a survey of ineffective contacts, it may be necessary to collect more detailed information. The rate of non-attenders in medical outpatient clinics was particularly high in Rochdale and a special study was mounted to identify the factors responsible. This work is described in Appendix D.

3.21 Most districts already collect data about patients who, having been called for elective admission, fail to attend. It is rare for the case note or essential information in it to be missing. No special studies in this area were carried out by the participating districts.

3.22 Operating theatre usage was a particular concern in Chester. Not only may theatre sessions be cancelled, but also the surgeon, anaesthetist, patient and documentation may fail to be brought together as planned and the case has to be cancelled. The recording of the former is a mandatory requirement in the minimum data set for operating theatres. The study done in Chester is described in Appendix E.

3.23 In none of the studies carried out was it difficult to collect or collate the data. With the exception of the Chester theatre study, no extra staff were required. At the second workshop, medical records managers and unit administrators agreed that information about ineffective doctor-patient contacts is essential if patient care services are to be managed rather than be allowed to lurch from crisis to crisis. It is thus *proposed* that unit general managers and those responsible for enabling clinical work should have available to them on a regular basis information about the level of ineffective doctor-patient contacts for:

a. outpatient clinics,

b. operating theatres, and

c. patients planned to be admitted electively.

Chapter 4: Management arrangements

Introduction

4.1 Participants in the project found that, having started by collecting information about the effectiveness of enabling clinical work, they were inevitably drawn to a consideration of major organisational issues. Before considering specific arrangements to facilitate doctor-patient contacts it was found that it is essential that there is explicit agreement on wider organisational issues such as:

a. The respective interests and responsibilities of NHS management (the DHSS, regional and district authorities and the officers acting for them) and of a consultant.

b. The appropriate structure of the organisation to be set up to get the work done. This must include:

i. a clear sense of what the work is,

ii. how responsibilities are to be arranged, and

iii. within what relationships people are to act.

Without such agreement it is not feasible to arrange effectively for clinical work to be carried out and, indeed, attempts to act without resolving these basic issues will make matters worse rather than better.

4.2 The appropriate relationship between a district health authority and each of the consultants drawing on its resources is one of continual negotiation. The negotiation reflects the need for a balance to be found between the authority's responsibility for

ensuring that services match the needs of the population served and each consultant's responsibility to carry out and develop his practice to the best advantage of his patients. The negotiation is requisitely continual because changes in direction and emphasis will occur on each side.

4.3 Representative mechanisms in which one consultant represents his peers cannot deal with the degree of detail necessary for realistic negotiation. The setting up of processes which establish appropriate relationships between an authority and the consultants working in it is a major task. It may well occupy an authority and the district and unit general managers for some two years or more.

4.4 If effective arrangements are to be found and established, the work which requires them needs to be described and understood in sufficient detail. Terms such as 'administration' or 'medical management' carry at best no meaning; at worst they carry the illusion of meaning to the point when they go unquestioned and merely add to rather than resolve the problem.

4.5 What is required is a grasp of the kinds of work involved which will help to answer such straightforward questions as:

a. What sort of people are needed to do it well?

b. What will be their career expectations?

c. Who should be responsible for seeing it properly done?

d. What should be the relationships among those doing the work?

4.6 Once the differences in kinds of work are understood, organisational arrangements can be constructed to fit them. Accountability can be made real since many of the difficulties in getting proper delegation and properly accountable behaviour stem from an incorrect perception of the type of work to be done. A

manager and subordinate may be working too closely in that they are both carrying out the same type of work. Or they may be too distant, leading to difficulties in communication because there are no shared assumptions about their respective jobs.

4.7 The key element in managing the work of others is undertaking responsibility for their work. In addition to certain requisite personal skills, successful managers require an organisational framework which makes it possible for their abilities to be put to use. It needs to be explicitly agreed that a manager must:

a. be free to refuse to accept or retain subordinates judged by the manager to be unacceptable,

b. be free to decide what work subordinates should do, and

c. make the formal assessment of subordinates.

These elements of authority are essential to make a manager's responsibility real and, indeed, distinguish the role of the manager from other kinds of role.

4.8 The arrangements for enabling clinical work must form part of the total set of procedures adopted in the district and be in tune with the general approach taken by senior managers to consultants. This means that such an approach has to exist and it has to be explicitly stated. Once a general context has been set it is possible to develop specific arrangements for:

a. Managing clinical areas such as wards, outpatient clinics and operating theatres.

b. Organising the work of a clinical team.

c. Ensuring that up-to-date documentation is available for doctor-patient contacts.

d. Ensuring that operational and management information is produced.

. The five districts in the project have been looking at different parts of the overall problem; no one district has yet tackled the whole. From the work carried out, however, it is possible to draw a number of general conclusions which may assist other districts reviewing their arrangements for clinical work.

Managing clinical areas

4.9 A unit general manager will deal with general features of the work and not the concrete details of each aspect involved. Thus no particular background or profession is requisite for this post and a person of the right calibre in such a job should experience no difficulty in managing people of different professions and occupations.

4.10 Within a unit a number of clinical areas can be identified. For example, in an acute hospital there will be wards, an outpatient department and a suite of operating theatres. Each of these areas should be managed by subordinates of the unit general manager. The clinical area managers need to be knowledgeable and expert in the concrete details of the work being carried out. It is *proposed* that a clinical area manager should:

a. manage all the staff who work solely in the clinical area, and

b. have a budgetary allocation within which to provide the service.

A clinical area manager is also responsible for the production of information (see paragraph 4.19).

Organising clinical teams

4.11 In previous chapters the work needed to ensure the scheduling

and communication which are essential to effective clinical work are identified. It is concerned with the scheduling of patients and the linking of these schedules to the activities of individual doctors. It thus demands an ability to deal with awkward and unexpected situations and is firmly tied to the type of practice carried out by particular doctors. The work should therefore be carried out by someone who will:

a. stay in the post for some time,

b. develop a detailed knowledge of the doctors' ways of working and the local scene, and

c. through use of this knowledge enable the work of the clinical team.

4.12 The original project (see paragraph 1.8) involved instituting special posts to do this work and further experience has been gained from the three posts set up in Bath. Different titles have been attached to such posts but the most appropriate is probably service coordinator. It is *proposed* that, when clinical teams have explicit policies requiring effective scheduling and communication, consideration be given to the appointment of a service coordinator to the clinical team to be responsible for organising these tasks.

4.13 The tasks that might be organised by a service coordinator can be identified by analysing the work that needs to be done as outlined in paragraphs 3.3 and 3.4. A service coordinator might, for example, be responsible for:

a. Arranging outpatient contacts by:

i. receiving referral letters and arranging appointments,

ii. raising case notes and obtaining documentation before the appointment, and

iii. making arrangements for further care and communicating to appropriate personnel after the appointment.

b. Arranging elective admissions by:

i. keeping and maintaining elective admission lists,

ii. sending for patients,

iii. ensuring case notes and x-rays are available before admission, and,

iv. making arrangements for further care and communicating with appropriate personnel during or after the admission.

These tasks may be done by the service coordinator or other staff organised by the coordinator.

4.14 The need for a service coordinator to be managed by a consultant has been well expressed by Professor Vickers in an article in *Health Trends* (58, *16*, 1984) describing the experience of one of the posts set up in the original project. He writes:

> '. . . much of the antagonism which exists between administration and medical staff arises because of the physical distances separating their respective places of work and the consequent mutual lack of understanding of what each group is doing and the problems they encounter, at the time they encounter them . . . An "in-house" administrator, who is both at, and on, the side of the clinician, and is seen to be helping actively in the day-to-day running of the department is, we find, readily accepted as a friend and colleague. Nor does the creation of such a post necessarily add to the cohort of administrators, as he takes over many of the functions of "remote" administrators, as well as freeing clinicians from inappropriate administrative tasks.'

4.15 Service coordinators with clinical teams not only facilitate the organisation of clinical work but they may also carry out other administrative tasks on behalf of the consultants. In the original project, service coordinators also:

a. Prepared duty rotas, coordinated requests for annual and study leave and initiated procedures for arranging locums.

b. Maintained records of work done and produced statistics.

c. Assisted consultants in carrying out their committee responsibilities.

Documentation

4.16 As noted in Chapter 3, at each patient contact the doctor expects to have available an updated case note. This entails:

a. ensuring the case note is available, and

b. maintaining the documentation so that the doctor can use it.

4.17 The appointment of a service coordinator to a clinical team would allow much of this work to be devolved from the medical records staff who currently do it. It is *proposed* that a service coordinator could:

a. take responsibility for storing notes of patients currently seeing members of the clinical team and for ensuring that they are available when required, and

b. be responsible for culling and updating case notes within agreed district policies.

4.18 Medical records managers would then be responsible for:

a. developing policies for patient documentation including those concerning the maintenance of confidentiality of patient data,

b. developing systems, particularly those involving information technology to improve record handling,

c. training all staff, including service coordinators with clinical teams, in operating the systems and procedures,

d. monitoring that all staff handling patient documentation comply with policies,

e. maintaining a library of case notes not being used currently and microfilming, and

f. organising procedures for disclosing information about patients to approved parties.

Information production

4.19 Management arrangements for ensuring the production of information have been discussed in previous papers in the series, namely *Converting data into information* and *Making data credible.* The general principles outlined in these documents have been confirmed in this project, namely:

a. Each authority should set district wide standards for data accuracy, completeness and timeliness. The detailed work of setting data standards should be carried out by staff of the district information service.

b. Managers should be responsible for the quality of data produced by their subordinates. Thus, managers of clinical areas (such as an operating theatres' manager) or managers of a clinical service (such as a chief physiotherapist) are responsible for ensuring that data are collected by their staff to the standard required.

c. Managers should be responsible for ensuring that their staff are trained to collect data. The training would normally be carried out by staff expert in data production.

d. For each information system in the district a specified individual should be responsible for monitoring whether standards are being maintained. If the data produced are outside prescribed limits, the monitor should inform the manager of the clinical area or service and ensure that advice and help are available to make the necessary improvements.

4.20 Two particular tasks which might be carried out by service coordinators with clinical teams are:

a. inputting data to a computerised master patient index, and

b. abstracting and coding clinical information from case notes.

Both these tasks require special skills and it is *proposed* that if they were to be taken on by service coordinators not only should they be trained but they should also pass a formal test of competence. It should be noted, however, that there will be greater consistency of coding if this task is confined to a specially trained small group of coders.

Conclusion

4.21 The implementation of the recommendations of the Information Steering Group and the adoption of the management philosophy outlined in the Griffiths report have major organisational consequences. In particular, districts will have to review their arrangements for enabling clinical work. No magic blueprint exists and it will be some time before the most effective organisational structures emerge. This paper contains preliminary observations, from a project involving five districts, which it is hoped are a useful contribution to resolving one of the most important management problems facing the NHS over the next five years.

Appendix A

WORKSHOPS HELD IN BATH 17-18 OCTOBER 1983 AND IN CHESTER 4-5 SEPTEMBER 1984

Attenders

The following attended at least one of the workshops:

Mr P Barrow	Unit Administrator, Chester DHA
Mr G Barnes	Medical Records Officer, Newcastle DHA
Dr R Bullough	Specialist in Community Medicine, Rochdale DHA
Mr S Cang	Chairman, Institute of Organisation and Social Studies, Brunel University
Dr C Davies	Consultant Psychiatrist, Bath DHA
Mr B Dowdeswell	Unit Administrator, Newcastle DHA
Mrs L Ellis	District Medical Records Officer, Rochdale DHA
Mr J Farndon	Consultant Surgeon, Newcastle DHA
Mr F Graves	Consultant Surgeon, Bromsgrove & Redditch DHA
Mrs J Ingram	Medical Records Officer, Bromsgrove & Redditch DHA
Dr A Jennings	Consultant Anaesthetist, Northampton DHA
Dr A Mason	Secretariat of Information Steering Group
Mr J Ovretveit	Research Fellow, Brunel University
Mr A Pearce	Service Development Adminstrator, Bath DHA
Mr M Pickering	Unit Administrator, Bromsgrove & Redditch DHA
Dr J Robinson	Consultant Anaesthetist, Chester DHA
Mrs A Slater	Patient Services Officer, Rochdale DHA
Miss D Shone	Medical Records Officer, Chester DHA
Mr S Taylor	District Projects and Information Officer, Bath DHA
Mrs L Wainwright	Secretariat of Information Steering Group
Mr M Warner	Assistant District Administrator, Bromsgrove & Redditch DHA
Mr J Yates	Research Associate, Health Services Management Centre, University of Birmingham.

Appendix B

JOB DESCRIPTION FOR A SERVICE COORDINATOR IN THE ROYAL UNITED HOSPITAL, BATH

Job Title — Service Coordinator

Job summary

i To promote and assist in the effective management of resources in Bath.

ii To obtain and maintain a comprehensive data base for patients on the waiting list.

Grade — Higher clerical officer

Principal duties

1 To maintain and update waiting lists and to obtain and to disseminate as appropriate information about changes.

2 To maintain a daily 'bed board' and, in conjunction with the appropriate nursing officer and doctors, plan admissions.

3 To call in waiting list admissions as agreed with each consultant.

4 To obtain information about possible discharges and arrange transfers, informing nursing officer, general practitioner and community nurses as appropriate.

5 To deal with enquiries or complaints regarding admissions from patients, relatives and general practitioners.

6 To maintain a list of medical staff absences (including anaesthetists).

7 To keep records of bed and theatre use (including district computer program on waiting lists) and to report to each divisional meeting.

8 To review the efficiency of working practices and initiate consultations on improvements.

Appendix C

OUTPATIENT CLINIC SURVEY AT ROYAL VICTORIA INFIRMARY, NEWCASTLE

In November 1983, following the first workshop, a survey was carried out of all outpatient clinics held during the month. Data were recorded mainly by clerical staff with some input from nurses. The aim of the study was to identify patients with appointments who did not attend, case notes which were missing and attendances at which the clinician considered that vital information was missing. The results for the specialties with the greatest number of outpatient attendances are shown in the Table. The unit management group has decided to repeat the survey regularly each six months.

Table: Outcome of 22,645 planned outpatient attendances

Specialty	**Patients did not attend*	*Patients did attend*		
		Missing documents		*Documents correct*
		Case Notes	*Reports*	
Dermatology	256 (4.9%)	4	33	4959
Ophthalmology	250 (7.5%)	1	0	3093
General medicine	324 (12.8%)	3	0	2194
Orthopaedics	126 (5.3%)	0	0	2228
ENT	152 (8.6%)	2	0	1608
General surgery	177 (10.8%)	1	0	1458
Others	554 (8.8%)	17	1	5204
All	1839 (8.1%)	28	34	20744

*The percentage refers to the patients who did not attend as a proportion of the total planned attendances.

Appendix D

REVIEW OF OUTPATIENT NON-ATTENDERS IN GENERAL MEDICINE CLINICS IN ROCHDALE

A survey of non-attendances at outpatient clinics in the district showed that general medicine clinics had on average a non-attendance rate of 17 per cent with a variation between consultants of 6-29 per cent. It was decided to investigate the reasons for this high level of non-attendance with a view to taking remedial action where appropriate. Four one-month surveys were carried out to identify the characteristics of non-attendance. The last survey has just been completed and the results are being evaluated. For each non-attendance information was obtained about the following:

a. *The patient:*

i. age,
ii. sex,
iii. address, and
iv. ethnic origin.

b. *The appointment:*

v. initiator of the appointment, and
vi. first visit or re-attendance.

c. *Previous appointments (if applicable):*

vii. number of previous appointments,
viii. grade of doctor seen at last visit,
ix. number of previous non-attendances since starting attending the clinic, and
x. interval since last appointment.

d. *Clinical details:*

xi. consultant responsible for the patient,
xii. broad diagnostic category, and
xiii. whether or not consultant had a 'special' interest in the case.

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Appendix E

OPERATING THEATRE SURVEY IN CHESTER HEALTH DISTRICT

A management services team was commissioned to review the utilisation and efficiency of the eight general operating theatres in the district. The survey was carried out over a seven week period in March-April. Some of the key results of the study are shown below:

Theatre sessions

i. Maximum number of sessions which could be made available, assuming 9 sessions/theatre/week = 72 sessions.

ii. Number of sessions planned to take place = 61 or 62 sessions alternate weeks.

iii. Average number of sessions held = 57.7 sessions/week (range 53-61).

Operating theatre time

iv. Maximum time which could be made available in planned sessions, assuming 9 sessions/theatre/week and 3½ hours for each session = 252 hours.

v. Average number of hours theatres used for planned sessions = 198 hours/week (range 181-215).

vi. Average number of hours theatres used outside planned sessions = 38 hours/week (range 28-47).

vii. Percentage of planned sessions which lasted less than two hours = 10%.

Cancellations

viii. Theatre lists are provisionally drawn up one week before they take place. It was not possible to calculate the number of patients who failed to attend or were cancelled following preparation of the provisional list.

ix. Theatre lists are typed one day before they take place. Of the 1175 patients on the definitive theatre lists, only 15 (0.7%) did not have an operation as planned.

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