What Seems to be the Matter:
Communication between Hospitals and Patients
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Preface

The Audit Commission is responsible for auditing the accounts of NHS bodies in England and Wales and examining the economy, efficiency and effectiveness with which resources are used. As part of its own strategy for driving improvements in the quality and effectiveness of services, the Commission is committed to developing greater understanding of the needs of service users, and of the impact of services upon them.

This report is about communication with patients in acute general hospitals. It is the first Audit Commission national report to assess a service entirely from the point of view of the user - in this case, the patient and his or her family, friends and carers. Over the coming year, the Commission's auditors will be following it up at local level, examining communication with patients in acute hospitals in England and Wales, and making recommendations on improvements to those responsible for running hospitals.

The study was carried out by Jocelyn Cornwell and Linda Jarrett, under the direction of Jonathan Boyce, with advice and guidance from a group of expert advisors. Appendix 3 lists the members of the advisory group, the hospitals that participated in the study, and the names of other individuals and organisations who contributed to the project. The Audit Commission is very grateful to them all.
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As health care processes and organisations become increasingly more complex, so the need to communicate with patients clearly about both the clinical and non-clinical aspects of their care grows. But provision has not kept up with the growing need, and lack of information and problems in communicating with health professionals usually come at the top of patients’ concerns.

The growth in consumerism, backed up by formal mechanisms such as The Patient’s Charter, has made these shortcomings more obvious, and is making health care providers re-examine the ways in which they communicate with patients. Moreover, there is a growing body of evidence to show that if providers improve communication they can in turn improve the effectiveness of care, increase the efficiency with which it is delivered, and improve their reputation locally with both patients and purchasers.

This report looks at communication with patients, relatives and carers in the acute hospital setting. It considers not only the giving of information, both general and clinical, but also the ways in which information is obtained from patients, either unsolicited (in the form of complaints) or solicited (by techniques such as surveys).

In all these areas, patients are experiencing difficulties both with the content of information and with the way that it is given or requested. A common complaint is that there is not enough information. Equally, information often exists, but the quality is poor - it is not clearly written, for example, or it is not what the patient wants.

Even when the information is adequate, the way in which it is communicated can diminish its usefulness. It may be given too late, or it may be given in too much of a rush. And sometimes it comes from a number of sources and is inconsistent or even contradictory. Sometimes there are physical barriers (particularly for patients with disabilities), and more help is needed for patients who do not speak English.

Although some hospitals have tried to make it easy to complain, many patients find that once they have complained they are not told what is going on, or they receive an unsatisfactory reply. A lot of the attempts to obtain patients’ opinions are inadequate because questionnaires are badly designed and the questions themselves are not the ones patients would have chosen to answer.

Underlying the difficulties patients experience are a few common causes:
— Staff not working well together, including:
  — professionals not talking to each other and therefore failing to co-ordinate patient care;
  — managers and clinicians not co-operating to improve the processes and systems;
  — poor communications between departments so that good ideas don’t spread.
— Shortage of skills and standards in a number of areas including writing information for the general public, and conducting surveys.

— Resource availability is often unclear. That is not to say there are insufficient resources. On the contrary, much staff time and effort is often invested in trying to improve communications. But finding money for relatively small things such as printing leaflets can be very difficult and there are often no budgetary arrangements. The time and effort of staff can be thwarted because of a lack of clarity about relatively minor levels of resources.

Some of these problems are rooted in long-held attitudes and practices, and cannot be solved in the short term. But there is much that managers and professionals can do to improve communication.

Minor changes can lead to improvements in the design and production of information leaflets, and signposting. It is more difficult, but still possible without significant expenditure, to change the way clinical staff work together, and developing guidelines on what to tell patients at each stage in their care, plus rules about recording what they have been told, will improve communication with health professionals. The difficulty, predictably, arises in ensuring that the rules are adopted in practice. And lastly there are some changes that can only be made with the investment of significant resources. Many of these involve making more staff time available, and employing new staff such as breast care nurses and interpreters.

Because these are new areas where there is relatively little good practice, and because staff lack the required skills, to make real progress hospital managers and professionals require support from outside organisations. Consumer groups and professional bodies can both provide a much needed impetus as well as practical help and advice. In future, the support of commissioning authorities and GP fund-holders will assume increasing importance in the drive to bring about the major goal of improving communication with patients.
1. Communication lies at the heart of health care delivery. To be effective it must be a two-way process: the service must give patients the information they want and need, and it must listen and respond to them. And it must do this, as far as possible, in a way that is tailored to the individual’s experience of health problems and to his or her unique blend of beliefs, understanding, expectations and ability to communicate.

2. At one time, the quality of communication depended very much on the person most concerned with the patient’s care, usually a doctor. But health care, especially in hospitals, has changed considerably in the last 25 years. It now involves large numbers of different staff and complex processes, and can no longer be left entirely to individuals or even individual departments. The organisation as a whole must create optimum conditions for good communication, and that necessarily entails clarifying responsibilities and establishing accountability. If these organisational issues are ignored, and professionals left to communicate as and when they like, the patient’s experience can include many of the negative features of the fictional case study overleaf.

3. There are compelling human reasons for making sure communication with patients works well. Good communication can transform the patient’s experience of hospital care, lessening the impact of what may be painful, difficult or anxiety provoking situations and decisions. The opposite is also true. Poor communication, with barriers between patients and the people they need to talk to, muddled and contradictory messages and missing information, creates avoidable anxiety and distress. It is, at least in part, in response to concerns about quality of communication in NHS services, that the Department of Health published The Patient’s Charter (see Appendix 1 for details of the relevant provisions) (Ref. 1).

4. The human reasons alone provide sufficient justification for a study of communication with patients, but there are others. Communication that works well can:

   — improve clinical outcomes;
   — increase efficiency; and
   — strengthen the hospital’s market position.

**IMPROVING OUTCOMES**

5. It is not easy to design studies that test the relationship between communication and clinical outcomes (Ref. 2), and the topic is both under-researched, and poorly researched. Nevertheless, there is increasing evidence of a positive relationship between communication and clinical outcomes across a range of clinical conditions and types of treatment. This applies to communication both between doctors and patients and between clinical teams and patients.
CASE STUDY

Mrs. Rogers had been referred to hospital by her GP and received a letter with the date and time of an out-patient appointment (1). She rang the hospital three times to find out if the consultation was for her eyes, or for her heavy periods. On each occasion the switchboard put her through to the appointments office which seemed to be permanently engaged (2). So she finally gave up, knowing she would find out on the day.

Arriving at the hospital she could see no signs for out-patients. Eventually a volunteer directed her to the Haldane Wing (3). After waiting for some time in the out-patient clinic, she overheard part of a conversation about cancer from a consulting room (4), but did not have time to feel too uncomfortable about it as a nurse called her into another room and told her to undress and wait on the couch (5).

The doctor arrived with Mrs. Rogers' medical notes and asked her what the matter seemed to be? Not without a sense of humour, she said she assumed she was there for her periods rather than her eyesight! The doctor did an internal examination, a cervical smear and said he would like her to have a 'scrape'. She heard the words 'routine' and 'nothing to worry about', but was also remembering the talk of cancer she had overheard. Had he taken a smear because he suspected cancer, she wondered? Although he asked if she had any questions, she did not know where to begin (6). What was a 'scrape'? Did it involve cutting? When would she get the smear result? She felt uncomfortable talking while she was still undressed, and was anxious to put her clothes back on.

On the day of the operation, a nurse told her off for bringing too much money and her expensive watch with her. As this was the first time she had been in hospital for an operation, she was worried about what else she had done wrong. On her bedside locker she found a booklet with all the information she needed. 'What a shame I didn't see this before,' she thought (7).

A doctor arrived with a consent form. He did not mention a 'scrape', but did talk about a 'D&C', the anaesthetic, and when she would get the results. Mrs. Rogers was startled - after her out-patient appointment she had concluded that the operation was to treat her periods - not that the 'scrape' was an investigation and that there was any question of results (8).

At home Mrs. Rogers received a questionnaire asking what she felt about the level of noise on the ward, and if the toilets were clean. As she ticked the boxes she thought, this was not really what she wanted to tell them about, but the three lines for other comments were not really enough (9) (10).
6. In 1991, after reviewing 'the most important facts' about the relationship between communication practices and outcomes, the international medical conference on doctor-patient communication published a consensus statement (Box A) (Ref. 3).

**Box A**

**THE TORONTO CONSSENSUS STATEMENT ON THE RELATIONSHIP BETWEEN COMMUNICATION PRACTICES AND OUTCOMES**

The quality of clinical communication is related to positive health outcomes. Reduction in blood pressure was significantly greater in patients who, during visits to the doctor, had been allowed to express their health concerns without interruptions.(4) Concordance between physician and patient in identifying the nature and seriousness of the clinical problem is related to improving or resolving the problem.(5)(6)(7) Explaining and understanding patient concerns, even when they cannot be resolved, results in a significant fall in anxiety.(8) Greater participation by the patient in the encounter improves satisfaction and compliance and outcome of treatment (for example control of diabetes and hypertension).(9) The level of psychological distress in patients with serious illness is less when they perceive themselves to have received adequate information.(10)(11)

Beneficial clinical communication is feasible routinely in clinical practice and can be achieved during normal clinical encounters, without unduly prolonging them, provided that the clinician has learned the relevant techniques.(12)(13)

7. The two main benefits of improved communication with patients identified elsewhere in the literature are:

— reduced anxiety and stress, leading in surgery to less pre-operative anxiety, reduced post-operative complications, and quicker and less stressful recovery (Refs. 2, 14, 15, 16, 17, 18, 19), and in radiotherapy, to greater treatment-related knowledge and less emotional distress (Ref. 20);

— increased compliance with medical instructions (Ref. 21) and prescribed medication (Refs. 22, 23) leading to improved functioning in everyday life, particularly for those with chronic illnesses.

**INCREASED EFFICIENCY**

8. The common-sense idea that good communication can create the 'expert' or efficient user, and reduce service costs, has not been rigorously researched. But it is supported by practical experience of staff and managers (Box B, overleaf).

**MARKET STRENGTH**

9. The reputation of the hospital with patients and purchasers, and therefore the strength of its market position, will almost certainly depend in part on how well it communicates with patients. There is overwhelming evidence that patients care more about communication than any other aspect of care. In surveys over the last 20 years, they have rated poor communication the number one cause of dissatisfaction with hospital care. And patients’ and consumers’ groups
are becoming increasingly vocal about perceived shortcomings in standards of communication in a variety of services, including services for cancer patients, obstetric care, accident and emergency, and children's services.

Box B

THE RELATIONSHIP BETWEEN COMMUNICATION AND EFFICIENCY IN THREE HOSPITALS

- At Leicester General Hospital, new and follow-up patients are given a choice of appointment times. New patients are contacted by telephone rather than sent a letter. After four months, the DNA (Did Not Attend) rates in 12 clinics have reduced dramatically from 11 to 1 per cent.

- Bristol hospitals give patients an indicative date for their admission to hospital, immediately after they have been seen in out-patients and recommended for surgery. This allows patients to plan well in advance for their admission, and gives them the flexibility to take into consideration their family and work commitments. There have been significant reductions in cancellations and non-attendances, and in telephone queries to medical records about admissions.

- At the Royal Oldham Hospital, a good language service may create additional costs of patient care but it also saves money by reducing the number of visits a patient has to make to the hospital. There are examples where a patient has been admitted for surgery and, at the last minute, has become so frightened and isolated, or has not understood the nature of the operation, that they have refused to go to theatre. The patient goes home and the whole episode has to be repeated at some future date. If a full explanation is given by medical staff in the out-patient department using a suitable interpreter, the patient comes into hospital as relaxed and confident as anybody can be under the circumstances.

Source: Personal communications from hospital managers

STRUCTURE OF THE REPORT

10. This report is written for acute hospital staff—both managers and health professionals, and for those in commissioning health authorities who set contracts with them. General managers can take independent action to improve general information and feedback successfully, but improvements in clinical communication can only come about through managers and clinicians working closely together. At the end of each chapter there is a summary of recommendations that can be used as check-lists by managers running the services or purchasing them, to monitor how well the hospital is communicating with patients.

11. The report refers throughout to 'patients', but makes the assumption that wherever possible, and in line with the patient's wishes, relatives, carers and friends should also be included in the communication. The three main chapters follow patients' progress through the acute hospital system, focusing on different aspects of communication.

— Chapter one looks at the general information hospitals give to patients, before they come to the hospital and once they are there, about all the practical aspects of how the service works.
— Chapter two is about the much more dynamic process of clinical communication involving patients and health professionals in an interchange of questions, thoughts and opinions, doubts and certainties.

— Chapter three on feedback, looks at how hospitals listen to what patients have to say, and allow their views to shape services.

— Chapter four considers the special problems involved in communicating with patients who do not speak English. The patients' needs for communication are like those of other patients, but the questions that arise in relation to providing and managing language services are complex and best dealt with in their own right.

— The final chapter on the way forward has recommendations for purchasers, and for other organisations and institutions, that affect the quality of communication with patients in hospital.

12. The report shows that standards of communication in most hospitals fall far short of the best. There is a great deal of work to do, but there is also a good base from which to start. There is an immense amount of interest in this area and a great desire amongst hospital staff to get it right. The aim of the report is to help them do that.
13. Everyone going to hospital for the first time, whether for an out-patient appointment or as an in-patient, needs the information in Box C. Practically this means they need information about how to find their way around without difficulty; how the system works; what is expected of them and who to ask if they need further information. When they leave, they need to know what they should do, what will happen next, who to contact with enquiries or problems, and about any support they will receive at home. Their relatives and friends also need information about visiting times, named contacts and whether they can accompany the patient to the clinic or ward.

<table>
<thead>
<tr>
<th>INFORMATION PATIENTS NEED FROM HOSPITALS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out-patients</strong></td>
</tr>
<tr>
<td>- Name of consultant, specialty and clinic</td>
</tr>
<tr>
<td>- Directions and transport details</td>
</tr>
<tr>
<td>- The amount of time to allow</td>
</tr>
<tr>
<td>- Whether they can travel home alone</td>
</tr>
<tr>
<td>- Name and number to contact to change appointments or get information</td>
</tr>
<tr>
<td>- Out-patient routines</td>
</tr>
<tr>
<td>- If students are likely to be present</td>
</tr>
<tr>
<td>- If companions are welcome</td>
</tr>
<tr>
<td>- Details of planned investigations/tests</td>
</tr>
<tr>
<td>- How results of tests will be given</td>
</tr>
<tr>
<td>- How to make suggestions/complain</td>
</tr>
</tbody>
</table>

Source: Audit Commission

14. Although the information is standard, hospitals need to vary their methods of communication if everyone - including people with impairments of vision, hearing and mobility, and people who cannot read or cannot speak English - is to have access to it. Most hospitals have a repertoire of methods that includes: staff speaking to patients both face to face and on the telephone; written information (letters, appointment cards, booklets, maps, leaflets and posters); information displays on sign-posts and notice-boards and, increasingly, television, video and electronic messages. Making sure that information reaches everyone means, for example, that hospitals must check to see that the size of print used in publications, and the size, position and lighting of signs and notices, are all such that patients with visual impairments can read them easily.

15. The relationship individual patients have with the hospital and with staff depends in part on the manner in which they come by basic information. If it is easy to obtain, they are more likely to feel the hospital is supportive which will improve their subsequent communication with clinical staff. If it is difficult or impossible to obtain, they are more likely to feel disadvantaged.
in a strange and even uncaring environment. The unintended message patients will receive is that their time and their capacity to be in charge of their own lives are of little consequence to the hospital.

**THE PROBLEMS PATIENTS EXPERIENCE**

16. Patients do not get all the information they need and some patients, for example those with disabilities, have particular difficulties. One hospital asked 1,000 of its ex-patients about the discharge process. Of the 555 who replied, 35% had not received any written or verbal advice or information when they were discharged. And a further 21% did not know who to contact if they experienced any problems (Ref. 24). At another hospital, 50 new out-patients were asked if they had been given written information: 91% had not, although 5% had been given a contact name or number informally.

17. Among the patients who face particular difficulties are:
- disabled patients using wheelchairs;
- patients with visual impairments;
- patients who are deaf or hard of hearing;
- patients who do not speak English (see Chapter 6);
- elderly patients who are mentally ill;
- patients with learning disabilities.

18. The reasons why patients do not receive general information are comparatively simple but they are linked to fundamental aspects of the hospital’s organisation (Exhibit 1).

**INFORMATION IS NOT AVAILABLE**

19. Sometimes information simply does not exist, either because nobody has thought to produce it, or it is not in a form that can be transmitted to patients. Some hospitals provide booklets, letters and maps, but a large number do not, or do so only in a limited way for particular groups of patients. And hospitals that do not have anything in writing are usually poor at giving information generally. For example, one hospital in the study sample had nothing in writing for new patients except standard letters. It had not produced an out-patient booklet and was out of stock of its booklets for in-patients. In the meantime, the switchboard and admissions office were inundated with telephone calls from patients asking for directions, information about public transport and parking, and what to do on arrival. Although the switchboard operators and admissions clerks were responding to the best of their ability, they had not been briefed and did not know all the answers.

20. In other instances information exists, but is badly distributed. Distribution often relies on a poorly designed system, or is left entirely to chance. In-patients, for example sometimes receive the information they need before they leave home, only after they have been admitted. And, in a number of hospitals, the information prepared for out-patients does not reach them, either because booklets are not distributed internally to the medical secretaries who make new out-patients’ appointments, or because they do not have envelopes of the right size in the
Exhibit 1

REASONS WHY PATIENTS DO NOT RECEIVE GENERAL INFORMATION

The reasons are linked to aspects of the hospital's organisation.

Source: Audit Commission

department. Notice-boards intended for patients are frequently covered over with other notices about staff social events, local raffles and sales (Exhibit 2), and leaflet racks stand empty because no-one is entirely sure who is responsible for filling them.

Exhibit 2

HOSPITAL NOTICE-BOARDS FOR PATIENTS

Notice-boards for patients can be poorly positioned and covered with notices for staff.

Source: Audit Commission
INFORMATION IS NOT ACCESSIBLE

21. There are physical barriers that get in the way of communication. Some make it more difficult for everyone; others affect particular patients. Physical barriers at reception desks inhibit easy communication and can put confidentiality at risk. Some, such as reception desks that are too high, affect people in wheelchairs, whilst glass barriers at reception in X-ray departments mean, for example, that female patients may have to raise their voice to tell the receptionist whether or not they are pregnant. Their answer may be more audible to people in the waiting area than it is to the person who asked. The function of physical barriers is to protect staff, but it is notable that banks and building societies are moving towards more open reception areas. Barriers at reception in Accident and Emergency and other departments may contribute towards aggressive outbursts from patients because of the frustration they cause.

22. Other ‘barriers’ exist. Unanswered switchboards affect everyone who tries to telephone a hospital. A recent survey of over one hundred hospitals found that telephone answering times were far worse than in commerce, industry or local authorities (Ref. 25). Only half the calls were answered within three rings and one in five callers rang off before receiving a reply. Noisy waiting areas affect patients who are hard-of-hearing by making it more difficult for them to hear when their name is called.

POOR QUALITY INFORMATION

23. The quality of printed documents, including maps, depends on design and lay-out, the spelling and language used in the text, and the size of print. Too many hospital-produced documents score badly on some or all of these counts and some are so poorly reproduced that they are impossible to read (Exhibit 3).

24. Sign-posts can be poorly positioned - too high, too low, hidden in the undergrowth - or badly lit. They can also be incomprehensible because they use jargon and acronyms (Exhibit 4).

UNDERLYING CAUSES

25. These failures to deliver good quality information to patients result from a number of underlying causes.

1. STAFF AND PATIENTS’ PERSPECTIVES DIFFER

26. To patients, the experience of going to the hospital for the first time, or even to a new department or ward in a hospital they know well, is often charged with anxieties about where to go, who to see, and what might happen. The sense the staff have of the hospital is quite different. They work there every day, they know it well, and go through the same routines hundreds of times with different patients. They easily lose all sense of what it feels like to be a patient and of what patients need to know.

2. POORLY CO-ORDINATED PRODUCTION AND DISTRIBUTION

27. In all hospitals a great many people are responsible for producing and distributing general information. Each one tends to do his or her own bit of the process without reference to (or even knowledge of) what the others are doing. As a result, the information patients get depends more on chance than design. In most hospitals, for example, each ward is free to compose and provide
Exhibit 3

PATIENT INFORMATION LEAFLETS
The poor quality of some documents makes them impossible to read
Source: Audit Commission

leaflets for patients and visitors. There is no common standard for the provision, appearance or content of such leaflets, and not surprisingly their usefulness varies.

28. Good practice in one part of a hospital is seldom picked up and shared elsewhere. In one hospital with a large non-English speaking population the breast screening unit had a leaflet that explained in eight languages how to get help with translation. In the same hospital the manager of the out-patient department wanted to find a way of giving non-English speaking patients information, but could not think of a good way of doing it at reasonable cost. She was not aware of the materials the breast screening unit used, and had not met the people who ran it. One of the more obvious outcomes of the lack of co-ordination in some hospitals is sign-posts that direct patients to wards and departments that no longer exist, or have changed their name or moved.

3. LACK OF SKILLS AND STANDARDS IN INFORMATION-GIVING

29. Outside the NHS, very few service organisations would think of producing information for consumers without first obtaining up to date and reliable data about them, including information about mother tongues, reading age and rates of sensory impairment, and without seeking professional advice on lay-out, design and content.

30. In a minority of hospitals, managers do understand that providing information successfully to a large and heterogeneous public requires considerable expertise, and in one way or another they manage to obtain advice and guidance. But in most, they either do not see the need for, or do not have access to, such expertise. They carry out tasks such as writing leaflets the best way they can, often at some personal cost.
4. IGNORANCE OF COSTS AND RESOURCES

31. No staff at the hospitals visited had any idea of the costs of providing general information to patients. Those that had commissioned someone outside the organisation for a particular task, such as designing a document or running a communication course, usually knew the cost. But on the whole, staff time spent developing, producing and distributing texts is absorbed in general staff costs, and the materials and equipment are unidentified elements of global or departmental printing, stationery and works budgets.

SOLUTIONS

32. Patients need high quality, timely general information. There is a number of steps hospitals can take to make sure they receive it:

— tailor the content and the medium to the patient;
— co-ordinate the production and distribution of information;
— develop skills and standards;
— develop cost awareness and invest resources.

1. TAILOR THE CONTENT AND THE MEDIUM TO THE PATIENT

33. The only reliable way of finding out what information patients and their relatives and friends need from the hospital is to ask them, and to include in the process patients who can tell them about the information needs of minority groups. Senior managers need to show a commitment to listening and responding to patients’ experiences and to demonstrate the importance of doing so by asking patients publicly what they think, and taking time to learn about what is happening day to day.

34. There is a variety of more or less structured and standardised ways of doing this, including surveys, walkabouts, inviting patient representatives into meetings, running focus groups, and consulting the local Community Health Council and patients’ self-help and voluntary groups. One publication for managers on obtaining the views of patients, recommends that even if resources are limited, they should be able to carry out ‘exit interviews’, asking a selection of out-patient users as they leave what they liked least and most about their experience that day (Ref. 26). If asked, patients will readily volunteer comments that can help managers improve information (Box D, overleaf). Commissioning authorities can ask general managers for details of how they intend to explore patients’ information needs.

35. Once the content is right, it is important to make sure it is communicated effectively. Written documents are not the only way of giving people information and many organisations use alternatives such as audio or video tapes which are particularly useful for groups that do not speak or read English or any other language. Again, individuals and groups of patients, including those representing patients with visual or aural impairments, can be asked to comment on style and clarity of new material whilst it is in draft and before it is finally produced.

36. Front-line staff should be sensitive to patients and responsive to their enquiries. This requires constant attention to training in awareness and attitudes, and many hospitals now run special courses. But they can be expensive and evaluating them should always be part of the process.
Box D

If asked, patients will readily volunteer comments that can help managers improve information. For example, when asked: 'Is there anything in particular you should have liked to be told before your appointment today?’, some patients wrote:

- 'What examinations to expect instead of a standard letter.'
- 'How long would I have to wait and where exactly I had to go.'
- 'What was likely to happen during my appointment.'
- 'If a translating facility was available.'
- 'How long I would wait and what would happen, i.e. possible procedures, investigations.'

and when asked 'what would you like to have been told before your admission?’ others wrote:

- 'I needed to guess about what I should take in.'
- 'The hospital booklet said bring a night-dress and dressing gown but this was not the case for a day patient.'
- 'Information about the routine of the ward, how to summon help or use the radio.'
- 'There was no information given to me about the ward nor the procedures of the ward.'

Source: Responses to Audit Commission questionnaires

2. CO-ORDINATE THE PRODUCTION AND DISTRIBUTION OF INFORMATION

37. The production and distribution of general information must be planned and organised. The first step is for hospitals to review the way they currently provide information. Some have done this by gathering together all the standard letters of appointment, and organising wider ‘trawls’ of every item of printed information they distribute to patients. The act of collecting information together often results in heads of departments first becoming aware of the poor quality of documents. They also need to find out:

— who decides the content of standard letters?
— who sends documents out?
— who tells patients when appointments and operations are cancelled?
— how patients know who to contact and how, when they need to make a cancellation?
— who patients speak to on the telephone?
— who makes the decisions about content and position of sign-posts, and how often they are reviewed?
— who gives patients information on discharge and in what form?
— whether patients receive the information intended for them?

38. Once the hospital has answers to all these questions, it can begin to take remedial action. The most important decision is who is to be responsible for production and distribution. Some hospitals have set up groups, usually of about six people with management responsibility for out-patients and wards, often including X-ray and therapists. The task of the group is to set standards, decide on contents and consider resources. Commissioning authorities can ask general managers to monitor the distribution system and such groups can be the focus of a monitoring activity.
39. Leicester General Hospital, where there is a working group of this kind, has taken
another step. All staff with whom patients and relatives have early contact, on the switchboard,
at reception desks, in car parks and in security — have been brought together under one manager.
The great advantage of this arrangement is that the manager has a number of different sources of
information about the most common questions patients ask and can make small but important
improvements to practice. She has, for example, had the sign-posting to the car parks and the
wording in standard out-patient letters changed as a result of getting feedback about the number
of patients getting lost on their way to out-patient clinics.

3. DEVELOP SKILLS AND STANDARDS

40. Hospitals need to develop skills and share them throughout the organisation. First of
all staff need to develop knowledge and expertise about the people who require information.
There are voluntary organisations that can help. For example, older patients are more likely to
be visually impaired and The Royal National Institute for the Blind (RNIB) shows that it is
possible to obtain a good estimate of the number of people with impaired vision from the
proportion of the population aged over 60 (Ref. 27). As well as obtaining this information, staff
need to become familiar with the standard methodologies for making text easier to read (Refs.
28,29,30).

41. Someone with expertise on standards of written English and presentation can be
responsible for approving all written information. If there is no-one with these skills in-house,
hospitals may need to go outside for advice and guidance on professional standards and methods
of communication. Other organisations can help hospitals communicate with specific patient
groups. The RNIB provides a service for transcribing documents on to tape and into braille. The
Royal National Institute for Deaf People's charter Louder than Words shows how written policy
can be used to enable equal access for deaf people (Ref. 31). They can also help with information
about adapted and text telephones. The Royal College of Physicians and the Prince of Wales's
Advisory Group on Disability have prepared a charter that managers can use to look at access for
disabled people (Ref. 32).

42. Some managers are aware of the need for skills and standards but have worries about
ownership and the potential conflict between centralised control and squashing the enthusiasm
of some staff for developing and owning information locally. There are different ways of
establishing minimum standards and involving staff and departmental managers: a model devel-
oped in one North American hospital shows a solution to some of the difficulties (Box E, overleaf).

4. DEVELOP COST AWARENESS AND INVEST RESOURCES

43. Hospitals need to begin to measure the large amounts of time and money they are
currently spending on producing and distributing general information: the time taken by staff to
produce and deliver information, and the costs of stationery and printing. They will then be
better placed to decide on the best use resources.

44. The final example of good practice illustrates a number of different elements needed to
tackle the gaps in general information (Box F, overleaf). The Customer Care Course at Dudley
Road Hospital, has been designed to encourage staff to think of services from the patients' viewpoint. All staff are expected to attend the course; senior managers are committed and
Box E

WRITTEN INFORMATION - ANNE ARUNDEL MEDICAL CENTRE, ANNAPOLIS

The hospital values the information it produces very highly, because it wants patients to be impressed by the standard and - by inference - to transpose that sense into a favourable attitude towards the hospital generally.

- The hospital's External Relations department includes staff experienced in public relations and journalism; it holds the budget for all publications including leaflets, posters and booklets.
- Anyone in the hospital who wants to produce written information for patients, bids for budget allocation by submitting a proposal. All proposals are considered by the Board, which decides on the items to be produced that year.
- The External Relations staff work with the departments whose bids have been successful, helping their staff with content and presentation of documents without threatening their sense of ownership.

Source: Audit Commission site visit

Box F

CUSTOMER CARE COURSE - DUDLEY ROAD HOSPITAL

The course, in which a high proportion of the time is spent on role play, has shown not only that front-line staff can think about what it is like to be a patient, but also that they can tell supervisors and managers a great deal about the kinds of problems patients experience.

The course organiser suggests improvements that emerge out of the role play exercises, and these are sent to the general manager who forwards them to the appropriate manager for action. The involvement of senior managers underlines the priority the staff are expected to attach to the patient's point of view.

Most 'customer care' training is provided in-house and is uncosted, but Dudley Road Hospital measures its investment in this area. The course costs £10,000 per annum, or £30 per member of staff attending the course. Although costings are crude, based mainly on trainer's fees, the attempt to measure costs is a step ahead of most other hospitals.

Source: Audit Commission site visit

actively involved in receiving feedback; the costs have been calculated; and the hospital management have explicitly committed the resources required.

45. Patients and their relatives and friends are always appreciative when they get the information they need from a hospital, and their comments about people being kind and helpful show how much it gives them a feeling of support. Hospitals may not yet be in a position to say how much of their resources are going into producing and distributing information to patients, but it clearly accounts for a considerable amount of staff time, including senior and expensive members of staff, and the costs of materials. Despite the investment, there is room for improvement, and managers can begin by recognising and tackling the problems identified here.
**SUMMARY OF RECOMMENDATIONS**

**Commissioning authorities** can expect chief executives/general managers to:
- find out from patients what information they want;
- identify groups with particular information needs;
- monitor that patients receive the information intended for them.

**Chief executives/general managers** need to:
- review the general information the hospital currently gives to patients in writing, on television, using taped recordings, and on signs and notice-boards;
- audit the environment using the Royal College of Physicians and The Prince of Wales Advisory Group on Disability Charter for Disabled People Using Hospitals;
- assess the training needs of receptionists, switchboard operators and other front line staff;
- identify gaps in the expertise the hospital requires to produce and distribute information effectively;
- develop a plan that specifies:
  - the general information the hospital will produce and distribute;
  - the media it will use;
  - sources of expert advice or guidance and how they are to be brought in to the process;
  - quality standards;
  - delegated responsibilities for production and distribution, including responsibility for including patients and relatives in the process;
  - mechanisms for costing information-giving, including staff time and material resources;
  - alterations to the environment, signs and notices;
  - training for reception staff and others;
  - a mechanism for review and review dates.
2. Clinical Communication

"Many patients [......] are manifestly unhappy with much of the communication that takes place between them and their doctors. Lack of information about the diagnosis, prognosis and therapeutic options can cause anxiety, uncertainty, distress and dissatisfaction. These problems can also produce misunderstandings about the importance of different diagnostic tests, under-reporting of side-effects and symptoms, and they may negatively influence motivation to accept treatment. . . . . Such an unsatisfactory situation is disturbing for patients and their families, but it is also professionally and personally unrewarding for the doctor." (Ref. 33)

46. This quote comes from the handbook that accompanies a training video produced for oncologists by the Cancer Research Campaign Communication and Counselling Research Centre. It talks about cancer and does not mention health professionals apart from doctors, but the arguments it makes for the importance of communication apply to all clinical conditions and all health professionals.

47. Clinical communication between patients, their relatives and health professionals includes communication about any clinical matter: diagnosis and prognosis; results of tests and investigations; therapeutic procedures, risks and alternatives; and care and treatment following discharge from hospital. It embraces various media, from the spoken and written word to the use of audio and video cassettes, and can include non-professionals.

48. Some of the most imaginative solutions to communication problems are to be found in paediatric services. At Great Ormond Street Hospital, for example, clinical staff arrange for parents whose children have recovered from cardiac surgery to meet parents whose children are about to have the same operation. Both groups find the meetings help them support their children in hospital, and the 'new' parents ask and get answers to all kinds of questions which they do not feel able to ask the professionals.

49. The quality of clinical communication depends most obviously on the skills and manner of individual health professionals. Consultants in particular have a responsibility to ensure that patients are told their diagnosis and prognosis, and that treatment options and risks are fully explained. However, as the example from Great Ormond Street shows, other factors shaping the communication process are also important. These are the management and organisational factors that determine, for instance, who communicates with the patient, how much that person knows in advance about the patient's understanding of the problem, and where and when the communication takes place.

50. Where health professionals lack communication skills, the solutions lie with undergraduate and continuing education. This is largely outside the Audit Commission's remit in the health service and hence of this report, but the chapter on the way forward includes some
recommendations. The managerial and organisational problems that may prevent clinicians from communicating effectively fall well within the Commission's remit.

51. This chapter looks first at the difficulties patients and their relatives encounter, then at the organisational problems that cause them, and finally at some examples of what can be done to tackle these often very complex problems. It concentrates more on doctors than other health professionals because there is a natural tendency for patients to see them as influential and important. In many instances the consultant's approach to communication gives a lead that other staff working with the same patient respond to, whether positively or negatively.

52. The organisational aspects of clinical communication are more easily compared between hospitals if the content of the communication is held constant. To do this, four common clinical conditions have been selected, that, between them, cover many of the aspects of communication that both patients and staff find difficult. These include: giving and receiving bad news; discussing treatment options, risks, complications, and outcomes; communication with patients whose condition prevents them either understanding what is being said to them or responding to it; and involving relatives. The four conditions are: breast cancer, benign prostatic hyperplasia, stroke and rheumatoid arthritis.

53. Alongside the Commission's study of communication processes in hospital, the chapter draws on interviews conducted by the College of Health with patients with the four conditions in different settings: in self-help and voluntary groups, and in their own homes, both alone and with relatives. The purpose of the interviews was to find out patients' experiences of communication and their views on how it might be improved.

54. Before considering the organisational problems that shape communication practices in hospital, it is important to look at the patients' experience. They encounter difficulties in three areas:

— the amount and content of information;
— the communication process; and
— the environment.

THE PROBLEMS PATIENTS EXPERIENCE

AMOUNT AND CONTENT OF INFORMATION

55. Individual patients have different needs, preferences and expectations in relation to clinical information. Nevertheless, when they are asked about their experience in hospital, the theme that recurs most frequently is their desire for more information about clinical matters (Exhibit 5).

56. Relatives and carers sometimes want and need information as much or more than patients (Ref. 34). In some instances this is because the patient's treatment affects them directly, in others it is because they need help mastering a situation that feels out of control and potentially overwhelming. The patient's right to confidentiality is paramount, but it should not stand in the way of making sure relatives and carers are brought into the communication process. The partners of some prostate patients, for example, need to be told in advance that surgery may change their sexual relationship; and the relatives of patients who suffer a catastrophic event such as a stroke,
Exhibit 5

WHAT PATIENTS SAY IN INTERVIEWS
The common theme is a desire for more information about clinical matters

need to understand as much as possible about what has occurred, so that they can begin to work out how they will cope at home.

57. Patients and relatives want information about clinical matters, but they also need information about the aids and appliances, welfare benefits and informal supports that can help them adjust to new situations. There is not much relatives can do while the patient is in hospital, but finding more out about the condition - about its causes and what might be done to prevent a recurrence, about equipment and other kinds of support - is useful. From the relatives' point of view, as the hospital is the place where everything else is dealt with, it is logical to expect it to provide practical information about other kinds of support. Many clinical staff do not share this view and such information is not forthcoming.

58. Sometimes clinical departments and wards provide information, but in a style that is not helpful. They use medical terms, acronyms and abbreviations, forgetting that patients are not
familiar with them. And the standard of some leaflets containing clinical information - in terms of their readability, design, lay-out, size of print and quality of reproduction - is as poor as the standard of other written information (see Chapter 1).

THE COMMUNICATION PROCESS

59. There is a great deal more to clinical communication than giving information. Patients and relatives themselves need to be able to elicit information from professionals and to tell them what is on their minds, whether it is about treatment, symptoms, or anything else. A number of aspects of the way clinical communication is conducted can cause problems (Exhibit 6).

Exhibit 6
FACTORS IN CLINICAL COMMUNICATION
A number of aspects cause problems

Source: Audit Commission

(i) amount of time for discussion

60. There is a good deal of variation in the amount of time new out-patients have with consultants. The variation tends to be less in general surgical clinics, where there is some notion of a 'typical' length of consultation, than in medical ones. In surgical clinics, patients with solid breast lumps, for example, will have about ten minutes to discuss the diagnosis and options for treatment. In the majority of urology clinics, men with a prostate problem are put on to the surgical waiting list after a consultation that on average lasts seven minutes. In that time the
patient is examined and he hears everything he is going to hear about his condition, treatment, the surgical procedure, risks and outcomes before he is admitted as an in-patient. Patients are well aware of the pressures on professionals’ time and often feel inhibited about taking up too much of it.

61. The only opportunity in-patients and relatives usually have to talk to the consultant is on ward rounds. But some ward rounds happen too early in the morning for relatives to get to them, and patients and relatives are normally acutely aware of the need not to delay the round, because other patients are waiting to see the doctor.

(ii) timing

62. Patients need information at the right time, which is when it is useful to them and they can absorb it. Too often they get it too late, or at a moment that is not appropriate and they are either too shocked or stressed to absorb it. One of the benefits of using well-written leaflets to back up oral information about clinical matters is that it gives the patient something to refer to later.

63. Candidates for elective surgery should be told about the risks and complications of the operation before the decision to operate is made. But fifty percent of the urologists and surgeons in study hospitals who treat men with benign prostatic hyperplasia do not mention the risks and complications associated with transurethral resection of the prostate in the out-patient clinic unless the patient asks about them. Instead, they leave that discussion to the junior doctor who interviews the patient on the ward, to obtain his signed consent just before the operation. This means that the patient first hears of the risks after the decision to operate has been made, either the morning or the night before the operation.

64. Clinical staff working with breast patients describe the impact on most women of first hearing the diagnosis of breast cancer, in terms of shock and a numbness that makes it impossible to focus on anything else they are told. Consultants vary considerably in their practices in communicating with patients with breast lumps (Exhibit 7, overleaf). One records his consultation with the patient and gives them the audio-cassette to take home (some patients use the tape to help them with the very difficult task of breaking the bad news to members of the family) (Ref. 35); others provide information in writing or offer more than one opportunity to discuss treatment options in out-patients before they make any decisions. There are instances, however, where the only opportunity the patient has to discuss treatment with the consultant is immediately after she has been told the diagnosis.

65. Patients who have had a stroke, and their relatives, are often told the diagnosis and given an explanation of what it means shortly after admission to hospital, when the crisis is at its height. In hospitals that have computerised tomography, a great many stroke patients have CT scans to confirm the diagnosis, but staff seldom explain the purpose of the investigation to them, nor when they can expect results. Lay health knowledge does not necessarily distinguish between a stroke and a heart attack, but some stroke patients are discharged from hospital still not knowing much about stroke, how it differs from a heart attack, and what they can do to avoid a recurrence. Some also leave without understanding why they have been prescribed anti-coagulants, aspirin and other drugs (Ref. 34).
(iii) conduct of consultations

66. It is common for nurses in out-patients to 'prepare' patients by asking them to get undressed to be ready for examination as soon as the doctor arrives. In the surgical clinics which take referrals for breast lumps, medical staff often do not introduce themselves by name. They simply arrive, take the history, conduct the clinical examination and discuss reasons for referral and treatment options all with the patient undressed, sometimes with only a sheet to cover her, and still on the examination couch (Exhibit 7). This way of conducting the consultation strips patients of their dignity as well as their clothes, and because it increases their feelings of vulnerability, makes it even more difficult for them to focus on what is being said and questions to ask. As one patient put it: ‘Yes, I was able to ask [questions]; but not much came to mind at the time……the situation of being told half naked, lying down - I can’t speak to a strange man easily.’

(iv) support

67. Patients seldom have a relative or friend with them when they hear bad news. Letters offering appointments in out-patients do not, as a matter of course, mention to patients that they may bring someone with them, even when there is a high chance they will receive bad news. Most consultants say that if partners or relatives happen to be there, they make them welcome, but they do not tell patients in advance to bring someone. One consultant’s secretary had taken
it upon herself to tell patients to bring someone if she knew the consultation was likely to be distressing, but she did so without formal instruction from the medical team.

68. In a number of clinical areas, specialist nurses provide valuable support to patients who find them less intimidating and easier to talk to than doctors. The number of breast care nurse posts is increasing, but not all hospitals that have a breast service have a nurse, and some only have part-time posts. The chances of a patient with a suspected malignancy seeing a breast care nurse pre-operatively depend firstly on whether there is a nurse in post, if she is full or part-time, and if she has absence cover; and secondly on the policies and preferences of individual consultants (Exhibit 8).

Exhibit 8

BREAST CARE SERVICES
Not all hospitals provide a full-time breast care service and in those that do, not all cancer patients have access to it.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Breast care nurse post: full or part-time?</th>
<th>Who refers?</th>
<th>Which problems are referred?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Full</td>
<td>3 of 4 breast surgeons</td>
<td>All suspected malignancies</td>
</tr>
<tr>
<td>2</td>
<td>Full</td>
<td>1 of 2 breast surgeons and ward nurses</td>
<td>All suspected malignancies</td>
</tr>
<tr>
<td>3</td>
<td>Full</td>
<td>1 of 2 breast surgeons</td>
<td>All suspected malignancies</td>
</tr>
<tr>
<td>4</td>
<td>Full</td>
<td>2 of 2 breast surgeons</td>
<td>Mastectomies only</td>
</tr>
<tr>
<td>5</td>
<td>Part</td>
<td>2 of 5 breast surgeons</td>
<td>All suspected malignancies</td>
</tr>
<tr>
<td>6</td>
<td>Patt</td>
<td>Out-patient nurses</td>
<td>Mastectomies only</td>
</tr>
<tr>
<td>7</td>
<td>Part</td>
<td>Ward nurses</td>
<td>Mastectomies only</td>
</tr>
</tbody>
</table>

Source: Audit Commission site visits

69. In hospitals with low levels of provision and selective referral to the breast care nurse, different consultants' patients can be treated on the same wards. Ironically, both groups of patients can suffer - those that have seen the nurse as well as those that have not. Both groups wonder why they were or were not referred to the nurse, and can jump to mistaken conclusions about their diagnosis and prognosis.

(v) **contradictory messages**

70. Most hospital patients come into contact with staff from a number of professional backgrounds and in different departments, which creates a risk of them being given contradictory messages. Breast patients, for example, move from the care of the surgeon to the radiotherapist: the surgeon may have talked about the lump being 'nothing to worry about', whilst the radiotherapist mentions for the first time a 'risk of recurrence.'

71. The factual content may remain the same, but patients can be easily confused by a different gloss being put on the information. This is a common problem for stroke patients and their families: the general physician who admits the patient may believe in being optimistic and
encouraging, whilst the therapists who are also treating him or her take the view that it is mistake to encourage false hopes when there is only limited potential for recovery. (Sometimes it is the other way round, and it will be the doctor who believes in ‘frankness’ and ‘honesty’ and the therapists who feel it is important to keep patients spirits up and to be positive about even very small steps to recovery.) Either approach is reasonable in its own terms, but taken together, the combination only serves to confuse patients and relatives.

(vi) uncertainty about who to ask

72. Patients, particularly chronically ill patients who attend out-patients regularly, often want advice or information between appointments. Some doctors say patients know they can ring in and speak to a nurse, but only a minority tell patients routinely what the arrangements are for doing so. Only two of eight rheumatology departments, for example, give patients the name, number and availability of a nurse they can call with queries. In both, patients frequently call the nurse for advice about their drugs and possible side-effects, and medical staff believe this helps to keep down the number of follow-up out-patient appointments.

73. In general, in-patients and relatives are not given specific details about how to get hold of professionals, or who to contact if they have questions. Relatives usually want to talk to someone who knows the patient but the majority of wards had not, at the time of the study, succeeded in introducing a system that names the nurse in charge of the patient for the entire length of stay. Only one in five of the 38 general medical and surgical wards visited had prepared written information for relatives that told them who to ask for and how to call the ward.

74. Consultants say they are available to relatives on ward rounds and assume nurses tell the relatives. But nurses only tell relatives if they ask. And if the consultant is not available the doctor who comes may or may not know the patient and may or may not be able to answer their questions.

(vii) confidentiality and use of relatives to interpret

75. All hospitals surveyed use the relatives of patients who do not speak or understand English as interpreters (see Chapter 4) although some do not like doing so. In addition, most keep lists of bi-lingual members of staff, including people employed in the kitchens and laboratories and other non-clinical areas, who can be called upon to interpret. Arrangements such as these put confidentiality at risk. Some of the most worrying instances occur when children are called upon to interpret for parents in quite inappropriate situations like the breast clinic, and where the non-clinical members of staff called in to interpret come from the patient's own neighbourhood or community.

THE ENVIRONMENT

76. Where there is a lack of privacy, or the possibility of being overheard, patients may feel inhibited about asking questions. On wards, a great deal of clinical communication commonly takes place at the bedside, frequently behind only a screen or curtain, and there is rarely space for relatives to meet staff in private where they will not be disturbed. Lack of space means that conversations about clinical matters are often held on the open ward and in corridors.
77. Some spaces used for out-patient consultations are unsuitable. One consultant has used his own funds to buy a television to prevent people in the waiting area over-hearing the consultations taking place in cubicles that are not sound-proof. In one hospital, the ophthalmology clinic is conducted in an open room where four patients have their consultation with the doctor, without screens between them, and with other patients waiting. Surgical and gynaecological clinics in a number of hospitals are held in cubicles with nothing more than a curtain to separate patients having intimate examinations and private discussions. In one gynaecology clinic, staff find it so difficult to keep patients who are undressed and waiting for examination protected from view, that husbands and others accompanying the patients have to wait at the far end of the corridor.

UNDERLYING CAUSES

78. Patients and relatives often do not get enough information, the communication process is poorly handled and it is conducted in unsympathetic environments. Instead of their needs driving the process, it is shaped by underlying problems in the management and organisation of clinical services (Exhibit 9). These include:

— poor communication between clinical staff;
— an approach to communication based mainly on clinicians’ subjective views; and
— a gap between clinical work and general management.

Exhibit 9

PROBLEMS IN CLINICAL COMMUNICATION

Patients' experience of clinical communication is shaped by problems in the management and organisation of clinical services.
1. POOR COMMUNICATION BETWEEN CLINICAL STAFF

79. Poor communication results from services evolving over time rather than being planned. It is more likely to occur when the overall service has a number of separate and discrete elements, when departments and staff are professionally or geographically isolated, and when large numbers of disciplines work with the same patient. Poor communication in multi-disciplinary teams can result in breakdowns of service and failures of care, particularly in areas such as discharge planning.

80. The two models of breast care service (Exhibit 10) show how the level of integration achieved in a service can affect the quality of communication with patients. The compartmentalisation of departments and areas of the hospital, of out-patient and in-patient services, means staff in one place do not routinely know what those in other parts of the hospital are saying to the patient unless there is an explicit commitment to communicating this information. In several hospitals visited, for example, no one admitted responsibility for telling candidates for a transurethral resection of the prostate that they will wake up from the operation with a catheter in place; everyone thought someone else did it.

Exhibit 10
A COMPARISON BETWEEN BREAST CARE SERVICES IN TWO HOSPITALS
The level of integration of a service can affect the quality of clinical communication

<table>
<thead>
<tr>
<th>Hospital A: a typical general surgical breast service:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• patients are seen in any one of a number of general surgical clinics in the week making it difficult for the breast nurse (if there is one) to organise her time to see all the breast patients in clinic;</td>
</tr>
<tr>
<td>• there is no link between out-patients and the wards, and patients see the clinical oncologist at separate clinics on a different site;</td>
</tr>
<tr>
<td>• each group of professionals works in isolation from the others: the surgeons; the out-patient nurses; the nurses on the ward; the breast nurse and the radiotherapists meet within their own discipline, but not with each other. Contact between disciplines is informal, and communication between them is minimal.</td>
</tr>
<tr>
<td>Outcome: the staff do not know what the patient is told in other parts of the service and cannot avoid overlaps, gaps and contradictions in the messages they give her.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital B: a planned and integrated breast service:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• patients are referred to a specialist breast clinic which means the breast nurse can attend and she can sit in on 'bad news' consultations if necessary;</td>
</tr>
<tr>
<td>• 'link' nurses in out-patients also work on the wards, and are aware of how the communication with patients works in the two areas;</td>
</tr>
<tr>
<td>• the surgeons and oncologists are not based on the same site, but they have regular meetings to discuss referrals and follow-ups;</td>
</tr>
<tr>
<td>• the medical team meets regularly with the breast nurse and with nurses on the wards.</td>
</tr>
<tr>
<td>Outcome: there is more continuity and consistency in what patients are told, and opportunities for the clinical team to plan communication in the same way they plan other aspects of care.</td>
</tr>
</tbody>
</table>

Source: Audit Commission site visits
81. Communication suffers when staff working with the same patient belong to several clinical teams. This is particularly the case in the acute phase of care of stroke patients when a typical patient has contact with several of the following: a consultant physician plus medical team; a geriatrician or rehabilitation specialist plus medical team; nurses; a physiotherapist; an occupational therapist; a speech and language therapist; a continence advisor; a psychologist; a community liaison nurse; a discharge officer and a social worker. If the patient is admitted to a general medical ward, it is unlikely that all or even some of the clinical staff will meet together as a team. As they mostly keep their own records, there is also no common patient record to tell them who has said what to the patient, or what the patient knows.

82. On acute care of the elderly wards there is more of a tradition of multi-disciplinary working, but even so the working practices of the various disciplines often make it practically very difficult for individuals to work together in teams. Workloads are not planned on a multi-disciplinary basis, and staff working with the same patients are likely to be covering different combinations of patients and areas of the hospital. The physiotherapists, for example, may base their caseloads on consultant admissions, the speech therapists on patients’ age group, and the occupational therapists on groups of wards or specialties.

2. AN APPROACH TO COMMUNICATION BASED MAINLY ON CLINICIANS’ SUBJECTIVE VIEWS

83. Health professionals mostly have their own firmly held views about what and how they should communicate with patients, views they form over time and with experience, often based on personal reactions to the role models they have encountered in the course of their career. There is, however, a growing awareness in the professions about both the importance of communication and the need for training. Most professional courses now include training in communication skills as part of the original qualification. In the main, this means that junior and recently-trained staff have had more communication skills training than senior staff, particularly in the medical profession.

84. The majority of consultants and senior registrars currently in post have not attended courses in communication or had help with handling difficult and distressing situations. In a group of 40 senior consultants attending a recent course run by the Cancer Research Campaign’s Centre for Communication and Counselling, 90% had received no formal training in communication at under-graduate or post-graduate level, and 80% had not previously participated in any kind of communications training (Ref. 36).

85. Senior doctors express concern about particular aspects of clinical communication such as giving complex information, breaking bad news and talking to patients who do not speak English, but very few investigate their patients’ views or are familiar with the literature on communication. Yet in the absence of training, they have no other basis for deciding how to communicate than personal judgement. This accounts for some common misapprehensions, and for the kinds of variations evidenced in the communication practices of surgeons (Exhibit 7).

86. There is ample evidence that written information reinforces oral messages and that patients who receive it understand more about their condition and retain information that helps them manage their own care (Exhibit 11, overleaf). But consultants rarely produce or provide
written information for their patients as a matter of routine. Some approve of the idea in principle, but do not know how to overcome the administrative and financial obstacles in their way. A surprising number are convinced for whatever reason that their patients do not want it, do not read it, or will not understand it. Only two out of eight rheumatology departments give patients detailed information about drugs to take away with them.

Exhibit 11
THE BENEFITS OF WRITTEN INFORMATION
At follow-up, patients who are given written as well as oral information know more about their condition

Source: British Medical Journal (1979), vol. 1, 456. Ellis et. al.

3. THE GAP BETWEEN CLINICAL WORK AND GENERAL MANAGEMENT

87. Most health professionals attribute perceived problems in communication to their own lack of time and resources. There are instances where additional resources are needed - if medical staff do not have enough time with individual patients, the size of workloads may need to be reviewed, and some of the spatial problems in out-patient clinics can only be solved with capital investment. But the resource requirements are often not as great as imagined, and the reason problems persist may have more to do with the failure of clinical staff and managers to work together. Review of out-patient workloads is a case in point: reductions in work-loads can be achieved but only if managers and clinicians combine to work together with local GPs to make sure that the right patients are referred and followed-up as out-patients.

88. In some hospitals the gap between the clinical work and senior management is so wide that the managers do not know basic facts about the communication process. They do not know how much time on average consultants from different specialities spend with patients, what information patients are given at different stages of care and by whom, what they are told on discharge, whether they are given information in writing, and so on.

89. Out-patient appointment systems exemplify some of the problems. It is not unusual to find consultants, administrative staff and managers blaming each other for the way appointment systems work, and for the fact that patients wait too long and still do not have enough time with
the doctor. Although methodologies exist for tracking patient flows and tailoring appointment times to both individual consultants' working practices and actual and predictable differences between types of patient, they are not widely used. Clinical staff and managers continue to hold each other responsible for the rigidities of the systems. Often neither knows for sure who has the authority to change them, and staff and patients are needlessly frustrated by systems that do not work, but could be made to.

90. Some consultants, nurses and therapists are keen to improve information to patients with notice-board displays, leaflets and audio tapes, but they are thwarted by a perceived lack of funds to pay for them. Often the amounts involved are small, and as a proportion of cost per case, insignificant. The main difficulty is usually not cost, but the fact that there is either no budget ear-marked for it, or budget-holders have not had enough training in financial management to feel confident about spending the money. Ironically, some clinical directors and ward sisters responsible for very large sums of money do not feel able to authorise even small payments for booklets and leaflets that could help to ease patients’ and relatives’ anxieties, and save staff time.

SOLUTIONS

91. The gaps, overlaps, inconsistencies and contradictions in clinical communication only become clear when the hospital is examined from the patient's point of view. Some problems can be resolved comparatively easily because the changes required - such as re-wording standard letters of appointment to give disabled patients information about access, or making sure information about the national voluntary organisations that specialise in helping patients with particular conditions is posted - are comparatively simple.

92. Other problems are more difficult to resolve because they are linked to the culture of the hospital, to the organisation of care and to traditional relationships between professions. If prostate patients, for instance, are going to hear about retrograde ejaculation and other complications before agreeing to surgery, some consultants and clinical teams need to change their approach to communication. Some gaps in information for patients will only be filled when groups of staff that currently do not communicate with each other, begin to do so.

93. The most radical solutions to clinical communication problems are ones where someone other than the clinicians becomes involved in determining clinical processes and quality of communication. The mechanisms through which this can be done are variously called clinical pathways, clinical protocols and guidelines, managed care and case management. Usually managers have some involvement in bringing professionals who work with the same patients together to discuss and agree how they will organise the totality of the care process, opening the way to much more explicit arrangements for communicating with patients. There is no one right way of developing this kind of activity. The chapter ends with two case studies that demonstrate alternative approaches (Box G, page 36).

94. Three areas where changes can lead to improvements in the quality of communication are:

— structuring multi-disciplinary and team working;
— developing expertise in communication, and awareness of patients’ points of view; and
— closing the gap between clinical work and general management.
Commissioning authorities should expect hospitals to be able to demonstrate what they are doing in all three areas to improve clinical communication.

1. STRUCTURING MULTI-DISCIPLINARY AND TEAM WORKING

95. Comparatively minor changes in existing working arrangements can improve communication with patients. For example, explicit agreements that clinical communication will be on the agenda in existing multi-disciplinary forums, at weekly staff meetings or case conferences, and in clinical audit sessions, can result in information gaps being filled, and contradictions and mixed messages being ironed out.

96. Where there is no forum for staff from different disciplines to communicate with each other, the task is to create one. The acute phase of stroke care is an extreme example of communication with patients and relatives being hindered by a combination of a large number of staff groups with inadequate mechanisms for inter-professional communication, and admissions policies that scatter patients across a great many wards. But careful planning can resolve the problems:

— In a number of hospitals, the physical therapists who work with acute stroke patients have successfully established embryonic stroke teams. With support from their managers and recognition from medical and nursing staff, the teams can help to improve communication.

— At Western General Hospital in Edinburgh, a peripatetic multi-disciplinary team (made up of a general physician, physiotherapist and occupational therapist) assesses all acute stroke patients on the general wards. The team either advises other staff working with the patient, or it takes over the patient's care. In future, the hospital plans to centralise acute stroke admissions on one or two wards, which will strengthen the nursing input to the team. As a result of the much greater attention being paid to the communication needs of patients and relatives, the hospital provides stroke literature for patients and relatives and is taking steps to make sure patients know who is responsible for their care, and who they should talk to about any problems or worries.

97. Where it is not possible for staff working with the same patient to meet together, the patient record may be their only medium of communication. Wherever possible, there should be common records to which all the professions contribute (Ref. 37). If each discipline keeps its own records, it will help to keep the separate records together in one easily accessible place. All the records should have a designated space for writing down what patient and relatives want to know and what they have been told.

2. DEVELOPING EXPERTISE IN COMMUNICATION THROUGH AWARENESS OF PATIENTS' POINTS OF VIEW

98. One of the simplest and most effective things clinical staff can do to make themselves aware of what patients want to know, is to invite them to prepare for their next meeting by making a list of questions they want answered. This simple act gives patients permission to ask questions, and deals in a practical way with the problem they face of not being able to think clearly at the right moment.
99. Pre-admission clinics provide an opportunity for patients to ask questions and for staff to find out what worries them about admission to hospital. At Leicester General Hospital, when it became clear that patients were not well prepared for what would happen when they came in for surgery, the gynaecology ward sister organised pre-admissions evening sessions. Patients and their partners are shown around the ward, invited to ask questions, and given information, particularly about pain control. The sister is convinced that the sessions help reduce patients’ anxieties, and make the nursing task easier.

100. One of the obstacles that sometimes prevents patients being given information in writing is a lack of consensus about suitable content. A good way round the problem is to ask patients who have already been through the process what they would like to have been told. (Patients who have not been through the whole process will not know in advance everything they would like to be told.) As part of an exercise to evaluate compliance with drug regimes, the rheumatology department at Dudley Road Hospital asked patients how they felt about their treatment. They found out that they wanted more written information about drugs and possible side effects, produced attractive large-print leaflets on coloured paper, and discovered that patients began to manage their drugs more effectively.

3. CLOSING THE GAP BETWEEN CLINICAL WORK AND GENERAL MANAGEMENT

101. General managers can take two comparatively easy steps to improve clinical communication. First they can remove practical obstacles in the way of staff who want to provide patients with information on tape or in writing. And second they can clarify the formal arrangements for ordering and paying for supplies, and make expert advice available to clinicians who want to write their own documents.

102. They can also make sure that as part of their induction, new members of staff know where to find the accurate and up to date information patients need. Junior doctors - often the main point of contact for stroke patients and their relatives - will not know about local residential and nursing homes for example, and new members of staff will not be familiar with local self-help and support groups. But managers can make sure that wards and departments either possess standard directories of useful information, or that staff know where to go to get access to them.

103. More fundamentally, general managers may be able to make changes in the process of clinical care that will improve communication with patients. The terminology varies between hospitals, but the case studies illustrate two experiments of this kind with 'pathways' and 'case management' (Box G, overleaf).

104. The significance of pathways and other approaches is that all the disciplines involved with the same patients are brought together to talk about their part in the process of care, and often for the first time, professional staff see the process as a whole. Having got that far, they can make clear arrangements, delegating specific responsibilities for communication with patients and relatives to members of the clinical team.

105. Staff can then make sure patients are getting the information they need at the right time. They can identify occasions when patients are being confused by contradictory messages, and they can take steps to avoid it. When they make adjustments in the process, they can ask
patients about how the changes effect them. And they can include communication with patients in audit.

106. Not every condition or treatment is amenable to a pathway. Conditions are most suitable if treatment is usually routine and predictable. These tend to be surgical conditions, many of which involve a large number of patients. But the process of collective decision-making is one that can usefully be transferred to less predictable areas. Many hospitals in the United States are developing pathways for medical conditions. For example, staff at the Anne Arundel Medical Centre are working on a pathway for stroke patients which includes therapists who work in the community.

**Box G**

**CHANGING CARE PROCESSES**

**Case study A: critical pathways at Friarage Hospital and Community NHS Trust, Northallerton**

- Chief Executive appoints a Clinical Project Manager, who is an ex-nurse, to develop pathways. Objectives are to provide the right care efficiently, and to a high quality.
- The project begins with those clinicians who are most enthusiastic and interested, in this case gynaecologists. The procedure chosen was abdominal hysterectomy.
- Multi-disciplinary meetings take place with all relevant staff from out-patients and wards, together with therapists and medical staff. Responsibilities and working methods are discussed and clarified.
- The Project Manager, with assistance, develops a pathway that sets out in writing what happens at each step and who is responsible. A parallel patient information sheet is produced.
- The pathway is piloted and all patients going through it are asked for their views.

**Case study B: care protocols in the Patient Focused Hospital Project: Central Middlesex NHS Hospital Trust**

- Chief Executive appoints a Patient Focused Project Team to work on a number of pathways simultaneously. The objectives are to structure care by focusing delivery around the patient, and to ensure consistency and high quality.
- A Project Facilitator works alongside representatives of the multi-disciplinary team to develop pathways. The first two chosen in this case were for joint replacements and prostatectomy.
- The process is slightly lengthened because the Patient Focused Hospital Project aims to include cross-training to reduce the number of staff interacting with the patient.
- Patient evaluation is built in as they provide feedback via questionnaires.

*Source: Audit Commission site visits*
SUMMARY OF RECOMMENDATIONS
(see also Appendices 1-5)

**Commissioning authorities** can expect chief executives/general managers to:

— demonstrate what they are doing to find out patients’ views on clinical communication;

— have explicit arrangements in place for communicating with patients with particular conditions;

— provide patients with good quality written clinical information and the names and addresses of useful voluntary organisations;

— provide evidence that clinical communication is included in audit.

**Chief executives/general managers with senior clinicians** need to:

— establish mechanisms for obtaining feedback from patients and relatives about their information needs and their views of clinical communication in the hospital;

— introduce delegated responsibility within clinical teams for clinical communication;

— introduce systems for making sure patients and relatives know who they can talk to about clinical matters and how to contact them;

— review out-patient appointment systems so that consultations are spaced at intervals to allow clinical staff enough time for communication and patients to be dressed when they meet the doctor and discuss diagnosis and treatment;

— assess the degree of privacy and dignity afforded to patients, and plan improvements in out-patient clinics, X-ray departments and on wards;

— include clinical communication in medical audit and multi-disciplinary meetings;

— audit use of patient documentation to record information given to patients and relatives;

— provide new members of clinical staff with the information they need to pass on to patients and relatives;

— encourage patients to prepare themselves for consultations by preparing lists of questions in advance.
3. Feedback

INTRODUCTION

107. The previous chapters recommend that hospitals find out what it is like to be a patient, and encourage professionals and managers to obtain feedback about communication directly from patients. There are various routes for obtaining feedback: from oral comments to staff, thank you letters and cards; from the Community Health Councils and patients’ organisations they consult; via the complaints system; and by various data gathering and research exercises that can be grouped loosely together under the general heading of ‘eliciting patient views’.

108. This chapter is concerned with the last two of these: complaints and eliciting patient views. It examines the obstacles in the way of patients who want to let hospitals know their views and suggests ways in which staff might increase the amount of information coming to them and make better use of it. The aim is not to prescribe how much hospitals should invest in feedback, it is to establish sound principles for any investment they already make.

COMPLAINTS

RISING NUMBER OF COMPLAINTS

109. The number of complaints hospitals receive varies and may depend on where they are (in London and the south-east, hospitals generally receive more complaints than hospitals elsewhere), how big they are, and how well procedures are advertised. But all hospitals throughout the UK report an increase in complaints over the past three years (Exhibit 12, overleaf). The increase reflects a general rise in complaints throughout public services, attributed by commentators to: falling standards; easier access to complaints systems; a general rise in ‘consumerism’; a tendency of young people to be more critical and more assertive consumers; and publication of the Citizen’s and the Patient’s Charters. Whatever the reason, the rise in number of complaints can lower the morale of hospital staff.

110. Only a small number of patients and relatives make formal complaints. Do they complain because they have a worse experience than other people, or because they are a naturally more critical, more assertive and reactive group? The increase in hospital complaints has been matched in recent times by an increase in the proportion of complaints accepted for investigation by the Health Service Commissioner (Ombudsman). He considers that ‘patients are now better informed about how to complain and some are less ready to accept the outcome of a local health authority’s investigation’ (Ref. 38).

Litigation is outside the scope of this report. The great majority of cases that go to litigation do so directly. They open with a solicitor’s letter to the hospital, not with a letter of complaint.
EXHIBIT 12

INCREASES IN COMPLAINTS

All hospitals report rises in numbers of complaints

CHARACTERISTICS OF COMPLAINTS

111. All hospitals surveyed distinguish between formal and informal complaints, and count anything they receive in writing as formal. Characteristically, complaints from out-patients who say they have been waiting too long, or in-patients who say there is something wrong with their meal, but do not take the action further are classed as ‘informal’. Only a few hospitals keep a record of oral complaints and consider them also as formal.

112. Hospitals receive formal complaints about all manner of things, from lost property and dirty bathrooms, to delays and cancellations, attitudes of staff, mistakes, and inappropriate care. Complainants often raise a number of different points when they write. The complaint is not always made by the person who used the service; some complaints come from relatives and visitors, others from Members of Parliament and General Practitioners.

HOSPITAL COMPLAINTS SYSTEMS

113. Complaints systems have two main functions: to handle grievance, and to provide feedback for senior managers and professional staff about service quality and actual or potential problems (Ref. 39). The Ombudsman has recently commented critically on hospitals' performance in both areas. He charges some with insensitivity; failure to investigate complaints thoroughly and promptly; incomplete replies expressed in jargon; and failure to make apologies that are called for. He is also concerned that some Boards and senior managers are failing to shoulder responsibility for complaints, and to use the information they contain to improve services (Ref. 38).

114. NHS complaints systems are currently under review by the Department of Health. For the moment, hospitals handle complaints within the framework set out in the Hospital Complaints Procedure Act (1985) and the Patient's Charter (Box H). At the local level the system does not include an element of independence in the investigation of complaints. The Ombuds-
There is some variation in the way complaints systems operate. Most hospitals have evolved a system similar to that in Exhibit 13, overleaf. In some hospitals a business manager rather than a complaints officer is responsible for the administration and investigation of the complaint. Chief executives are usually involved at the end of the process. Sometimes complaints officers arrange meetings with complainants instead of, or as well as, writing to them at the end of the process. In all hospitals surveyed it is common for the complainant to be excluded from the investigation process and not to be asked for more information or contacted before the final response is sent out. In most systems, the manager and any health professional implicated in the complaint receive a copy of the final response sent to the complainant. In the hospitals where this does not happen, it is a cause for resentment and discourages staff from being open in respect of any future complaints.

**Box H**

<table>
<thead>
<tr>
<th>PROCEDURES FOR HANDLING COMPLAINTS IN HOSPITALS</th>
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<tbody>
<tr>
<td>1. Complainants have a right to have any complaint about NHS services investigated, and to receive a full and prompt written reply from the chief executive or general manager of the hospital.</td>
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<tr>
<td>2. A senior officer must be designated for each hospital, located in the hospital and responsible for:</td>
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<tr>
<td>— obtaining a full picture from the complainant of the events complained about</td>
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<tr>
<td>— circulating details of the complaint to the staff concerned for their comments</td>
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<tr>
<td>— agreeing a reply</td>
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<tr>
<td>— processing the complaint speedily and thoroughly</td>
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<td>— informing the complainant of progress</td>
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<td>— completing a report</td>
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<tr>
<td>— sending a letter detailing the results of the investigation to the complainant, to any person</td>
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<tr>
<td>— involved in the complaint and the manager of the department concerned.</td>
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<tr>
<td>3. Complaints must be monitored so that appropriate action can be taken.</td>
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<td>4. Summaries of complaints must be provided.</td>
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<td>5. Procedures must be publicised.</td>
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*Source: The Patient’s Charter (1991); Department of Health circular HC(88)37*
THE PROBLEMS COMPLAINANTS EXPERIENCE

116. Most complainants face a variety of hurdles in complaining. There are problems with access to the system, with complainants not being kept informed and with the tone of replies, all resulting from poor management systems (Exhibit 14). A recent NHS Management Executive survey of complainants in Scotland found that only one of 36 people surveyed was satisfied with the outcome of the process (Ref. 40).

COMPLAINANTS’ PROBLEMS AND THE UNDERLYING MANAGEMENT CAUSES

There are two main causes of the problems

Source: Audit Commission
ACCESS TO THE SYSTEM

117. Some hospitals go to great lengths to make the complaints system accessible, mainly through leaflets and posters. One goes as far as handing every in-patient a printed card with admissions information on one side, and an invitation to contact the chief executive with any comments or complaints, plus his name and telephone number, on the other. But some hospitals are not succeeding in getting information about the system to patients. Forty-five per cent of the wards the Audit Commission visited did not have any posted or written information about the system.

118. Patients who have difficulty expressing themselves on paper, who cannot write or cannot write English are disadvantaged in most complaints systems. They will only be able to make complaints orally and most hospitals treat oral complaints less seriously than written ones. Very few hospitals make interpreters or advocates available to complainants.

BEING KEPT INFORMED

119. Complaints are normally acknowledged fairly speedily, often within two working days, but complainants are not told how the hospital will investigate the complaint, nor when to expect a full response. They typically hear nothing further until the final reply is received, even though there may be a gap of several months.

TONES OF REPLIES

120. The tone of the replies complainants finally receive varies (Exhibit 15). Many are excellent: they acknowledge the distress caused; explain what investigative action the hospital

Exhibit 15
ANALYSIS OF THE TONE OF REPLIES TO COMPLAINANTS IN 8 HOSPITALS
The tone of the replies complainants finally receive varies

Criteria for evaluating tone of hospital replies:
– thanks for drawing complaint to attention of hospital
– accepts complainant’s point of view
– covers all points raised by complainant
– mentions action taken (if appropriate)

Source: Audit Commission site visits

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has taken; express regret or apologise and spell out what the hospital is doing to make sure it does not happen again. But others are defensive and dismissive: they do not thank the complainant; they contain what the Ombudsman calls ‘weasel words’ and deny the complainant’s point of view. They ignore some of the points complainants raise and do not mention what action has been taken to avoid a recurrence.

UNDERLYING CAUSES

121. In some hospitals it is the grievance-handling aspect of the complaints system that is the main cause for concern; in others it is the poor retrieval and use of the information by managers.

1. POOR SYSTEMS FOR HANDLING GRIEVANCE

122. Grievance-handling is a sensitive and sometimes difficult task, requiring considerable skill and a great deal of support. It is often difficult for the individuals directly responsible for dealing with complaints to empathise with the complainant and maintain a sense of loyalty to their employer. And it can be personally difficult for the complaints officer to investigate the circumstances of the complaint, especially when he or she is junior to the people under investigation.

123. Most hospitals have a written policy or procedure that sets out the role of the complaints officer, but do not have formal mechanisms for making sure other staff are familiar with it. Some carry occasional articles in staff newsletters, and some heads of departments introduce new staff to the complaints procedure in their induction. Only one hospital routinely includes the complaints system in the formal induction of all staff.

124. The position of complaints officers and the degree to which they are integrated into the rest of the hospital management varies. At one extreme is the complaints officer as administrator: often out on a limb, geographically apart from managers, and mainly responsible for making sure files and papers are kept in order. At the other extreme is the complaints officer who is a member of the board, (in one hospital visited it was the medical director of the trust) who receives complaints, initiates thoroughgoing investigations, returns reports when not satisfied with them, and drafts final replies to complainants. Most hospitals have a complaints officer somewhere between the two.

125. Most complaints officers treat the first letter from the complainant as the final one and do not investigate further. Only a small number try to find out from complainants how they feel about the way their complaint has been handled. Some of the more junior and more isolated complaints officers have comparatively little support, and the standards they work to, particularly in drafting final replies to complainants, are often ones they have developed for themselves.

2. POOR SYSTEMS FOR RETRIEVING INFORMATION FROM COMPLAINTS

126. There is no regulation requiring hospitals to build an element of independence into their investigations of complaints. Indeed, in most hospitals it would be inappropriate to describe the way complaints are processed as an investigation. Normal practice is for the complaints officer to request reports from the manager of the department and from the consultant involved, and to draft a reply to the complainant based on the reports. Occasionally the chief executive or another
senior manager redrafts the response to the complainant to alter the tone, but they often do so without having seen the complete contents of the relevant file.

127. Hospitals are obliged to report numbers of complaints to the Department of Health and to their own boards. But managers and board members seldom receive information about causes and trends, or reports on areas of service or individuals that persistently generate large numbers of complaints. Too often, they are simply told that complaints have been resolved but nothing about any action taken to prevent problems recurring, or whether complainants are satisfied. Senior managers and professionals often know very little about the generality of complaints about their hospital. They only know about the ones they are involved in personally.

128. The solutions to these causes of patients’ problems with complaints systems are considered below, following an examination of the problems found in the second major source of feedback, eliciting patients’ views.

ELICITING PATIENTS’ VIEWS

129. Complaints are a valuable management tool and source of information, but cannot be obtained to order. On the other hand, when hospitals initiate their own research they can control the sample and the timing. Instead of waiting to find out what patients have to say, they can ask the questions they want. Complaints and research are complementary, not alternatives.

THE PROBLEMS PATIENTS EXPERIENCE

130. Although there is a great deal of interest amongst hospital staff in exploring patients’ opinions and incorporating their views into the running of the service, management problems lead to a less than adequate experience for patients (Exhibit 16).

Exhibit 16
ELICITING PATIENTS’ VIEWS
Management problems lead to less than adequate experience for patients
COVERAGE

131. The vast majority of patients are not asked their views at all in spite of the fact that hospitals are increasingly carrying out surveys. Some hospitals use standard questionnaires but they do not usually distribute them throughout the hospital. Others have suggestion boxes and comment cards. Sometimes the retrieval boxes are positioned in such a way that people feel embarrassed to use them, especially if their comments are critical or negative. Often it is a matter of chance who sees the boxes and cards, and people are not always sure what kind of comments are appropriate.

POOR RESEARCH METHODS

132. The most common method of obtaining feedback is the questionnaire-based survey. Unfortunately many of the questionnaires in use suffer from problems such as wrong print size, and poor design and layout, identified in Chapter 2. People who do not read English for any reason are unable to respond to them, so the hospital does not hear their point of view. Some of the questions are poorly designed and ambiguous, and the questionnaires poorly structured (too many closed questions, yes/no answers where a graded answer is needed etc.). But more important, the questionnaire is used when another research tool, such as a telephone survey, or face to face interview, would be more appropriate to the research aims.

IRRELEVANT QUESTIONS

133. Patients are not often given the opportunity to say which aspects of service they care most about. They are asked specifically about their opinion of hotel services (for example bathrooms and food) and about waiting times; but their opinions of their clinical care or the communication with individual health professionals about clinical matters are not sought. Occasionally they are asked whether or not they were ‘satisfied’ with communication with entire groups of staff, such as doctors or nurses.

FEEDBACK

134. Like complainants, patients who take part in research, or who fill out comment cards and make suggestions are rarely told what has happened or what will happen as a result of their efforts. The guarantees of confidentiality researchers and managers must provide when they elicit patients’ views can make it more difficult to give feedback to individuals. But this does not explain the dearth of general reports to patients and patients’ representatives on the results of patient opinion studies.

UNDERLYING CAUSES

1. POOR STANDARDS

135. Research into patients’ views is often undertaken by individual heads of department and ward sisters on their own initiative, or by students as part of their training. The staff who instigate the work often have no previous research experience, and are not aware of the possible pitfalls.

136. There is much reinventing of the wheel, with research projects that do not draw on previous published work in the area. Instead of exploring the variety of methodologies available,
including group discussions, patient interviews and shadowing patients in the hospital, researchers tend to plump for questionnaire based surveys and quantitative measures of patient satisfaction. And despite the emphasis on measurement, most studies happen only once; they are not repeated and there are no benchmarks to compare findings.

137. Projects often start before the aims and objectives have been clarified, and before anyone has decided what they will do with the results. Consequently, they frequently produce findings that are of no practical use. Often there are no reporting arrangements and staff and patients who have taken part in the work are not told the findings. Nor does anyone monitor change resulting from the findings.

2. LACK OF DIRECTION AND POOR CO-ORDINATION

138. In most hospitals the Audit Commission visited it proved impossible to find anyone who knew about all the work on patients’ views. Most of it had evolved without central direction or hospital-wide co-ordination, and with very little support for those doing the work. It was not unusual to find surveys carried out in the same area of the hospital that had been designed and organised separately, by different people.

139. Medical or clinical audit on the one hand and research into patients’ views on the other are usually seen as separate activities. But despite the fact that there is much potential synergy, hardly any hospitals are attempting to integrate these activities, either with each other or into a broader quality strategy.

140. Some hospitals commission outside researchers to undertake surveys on their behalf, and consequently know the costs associated with this work. On the whole, however, despite the fact that senior members of staff sometimes devote a considerable amount of their costly time to patient opinion projects, there is little cost awareness.

SOLUTIONS

141. The problems with handling complaints and with eliciting patients’ views have a great deal in common. With both, it is useful to distinguish between the processes of handling grievance and eliciting patients’ views, and the overall management framework within which they are accomplished. It is possible to make piecemeal changes in processes that are useful and will benefit complainants and patients, but there are limits to what this can achieve. It will not solve the problem of hospitals missing out on valuable feedback, and failing to use the results to improve services.

1. IMPROVING PROCESSES

142. Hospitals can do a great deal to improve complaints handling by making changes at a procedural level. Specifically they should:

— ensure everyone has ready access to the system;
— take oral complaints as seriously as written ones;
— make someone senior responsible for publicising and monitoring access, especially for people who might have difficulties;
— set standards for response times and tone of replies;
— monitor the standards;
— feed the results back to staff;
— elicit the views of complainants about the complaints system itself (Exhibit 17).

Exhibit 17
FINDING OUT WHAT COMPLAINANTS THINK
Some hospitals ask complainants their opinion of the system

Thank you for informing us of problems in the services provided by the trust. I hope you find our response prompt, comprehensive and easily understood.

To help us give a better service, please answer the questions below and return this card to us - no stamp required. Thank you for your assistance.

How do you rate the letter you have just received for...

1. **Speed of Response?**
   - Excellent
   - Good
   - Satisfactory
   - Poor
   - Very Poor

2. **Coverage of the issues you raised?**
   - Excellent
   - Good
   - Satisfactory
   - Poor
   - Very Poor

3. **Clarity?**
   - Excellent
   - Good
   - Satisfactory
   - Poor
   - Very Poor

4. **Explanation?**
   - Excellent
   - Good
   - Satisfactory
   - Poor
   - Very Poor

Have you any other comments you would like to make?

Source: Central Middlesex Hospital

143. The rising number of complaints, and a more public approach to handling them can be threatening to staff, and demoralise them. Managers need to be acknowledge this problem and develop staff training aimed at repositioning complaints in a positive and helpful light.

144. Patient opinion research in hospitals needs to be put on a more expert footing. People doing the work need access to guidance and support at every stage of the process, from clarifying the aims, to choosing appropriate methods and developing research instruments.

145. It is helpful to develop some basic rules for the conduct of research in order to avoid wasting time and scarce resources, and to make sure the results genuinely reflect the concerns of patients. Studies should not start without a literature review of previous work in the same area. The purpose of the work should be clear, as should the handling of the results, including the mechanisms and timescales for feeding them back to patients and staff. Patients or consumer organisations should be involved in drafting and testing research instruments, and study methods must be piloted.

2. THE MANAGEMENT FRAMEWORK

146. Commissioning authorities can ask hospitals for detailed reports about the complaints they receive. They can expect managers to have systems in place that ensure complaints are
handled well, and that research is relevant and properly carried out. They can also ask for evidence that information from complaints and opinion research has been used to improve services.

147. The case studies in Boxes 1 and J overleaf describe approaches for managing complaints and eliciting patients’ views in two hospitals that have succeeded in overcoming a great many problems. Both have established frameworks for managing the work of grievance handling and eliciting patients’ views that include reports to the trust board and senior managers on both the volume and the outcome of the work. Both have formal mechanisms that link information from patient sources to quality assessment and medical and clinical audit.

148. They identify individuals responsible for overseeing and co-ordinating the work, and the relationship they are to have with other staff. In the complaints case study, for example, the consumer relations officer has overall responsibility for the complaints system, but much of her work is done through advising, supporting and supervising other managers (Box 1). In the other

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**CASE STUDY A: THE COMPLAINTS SYSTEM AT HASTINGS AND ROTHER NHS TRUST**

**The trust board:**
- Gives the lead on complaints, makes clear it views them as important, and sets out timescales and standards for handling them according to the Ombudsman’s criteria (‘courteous, critical and thorough investigation’).
- Deals with oral complaints in the same way as written ones. Telephone calls are written up and acknowledgements are sent with a note asking complainants to check the accuracy.
- Receives quarterly reports from the consumer relations officer who presents her report to the board in person and keeps members of the board well-informed and up to date on users’ views.
- Has set up a Complaints Panel that meets quarterly under the chairmanship of a non-executive member of the board. It includes a GP, a hospital consultant, the director of quality and nursing, a member of the Community Health Council and the consumer relations officer. The panel reviews trends and the handling of individual complaints. Prior to panel meetings the CHC member examines a selection of files on complaints received in the previous quarter.
- Links information coming from complaints into the audit programme and provides copies of quarterly reports to clinical directors, business and nurse managers.
- Has appointed a consumer relations officer to co-ordinate the handling of complaints and patient enquiries.

**The consumer relations officer:**
- Meets with quality assurance staff on consumer quality issues including complaints handling, to make clear the relationship between complaints and quality.
- Produces information explaining the complaints procedure and how to access it.
- Has developed a written procedure for managers handling complaints.
- Participates in staff training on consumer relations and complaints handling.
- Maintains the complaints register.
- Helps managers handle complaints according to the standards set by the board.
- Meets complainants, at home if necessary, to discuss their concerns.
- Investigates complainants’ views on how their complaints were handled.

*Source: Hastings and Rother NHS Trust*
hospital, the audit/research staff in the trust have overall responsibility for co-ordinating the work on patients’ views, and to avoid duplication of effort all other staff are asked to liaise with their department (Box J).

**Box J**

**CASE STUDY B: THE STRATEGY FOR ELICITING PATIENTS’ VIEWS AT LEWISHAM HOSPITAL NHS TRUST**

- The trust has demonstrated its commitment to patients’ views by forming a group to devise and implement a strategy for the hospital, made up of representatives of clinical staff, management, the research/audit unit, the Community Health Council and the medical school.
- The group reviewed all existing methods of obtaining patients’ views in the hospital, including comment cards, satisfaction surveys, complaints, clinical audit and research projects.
- The group has agreed three strategic aims which it implements through the research/audit unit:
  1. To establish a system to co-ordinate patient survey activity throughout the trust. Anyone undertaking a project is expected to liaise with the research/audit unit. Summary reports of all projects eliciting patients’ views are made available to staff through the library or the research/audit unit.
  2. To facilitate the development of good quality patient - involvement initiatives. The research/audit unit has developed a resource pack for staff undertaking their own patient surveys which includes information on all aspects of survey methodology, confidentiality and guidance on ethical considerations.
  3. To develop a co-ordinated response to the ‘patient satisfaction’ demands of outside agencies. The research/audit unit has designed a satisfaction questionnaire for its main purchasers. The questionnaire is accompanied by a message in the most frequently occurring foreign languages so that non-English speakers know how to request help from interpreters when completing the questionnaire.

*Source: Lewisham Hospital NHS Trust*

149. Both hospitals have set standards for performance and clarified the training and support that are to be made available. They have agreed policies at board level that set out the main aims and principles to be followed, as well as the board’s view of complaints and patients’ opinions. Significantly, the two boards demonstrate their commitment to patients' views by inviting Community Health Council members on to the panels and working groups that direct and oversee the work, and by appointing senior managers and staff to these bodies. In the Lewisham Trust, the Health Service Research and Evaluation team, together with a business manager and a trainer, oversee the work on patients’ views.
**SUMMARY OF RECOMMENDATIONS**

**Commissioning authorities** can ask hospitals to provide:

— detailed reports on complaints received and research into patient's views; and
— evidence that the information is used to improve services for patients.

**Chief executives and general managers** need to make sure that:

— hospitals have written complaints policies and procedures that are publicised to all staff, in all areas of the hospital, and in writing for out-patients and in-patients;
— help is available for people who have any sort of difficulty registering their complaint;
— standards for the tone and content of letters to complainants are set and monitored;
— training in the complaints policy and procedures is available for all staff, and specialised training is available for those involved in handling complaints;
— feedback is obtained from complainants on their views of how their complaints were handled;
— they receive regular reports on serious complaints, numbers and trends and action taken as a result of specific complaints;
— they review recent research into patients' views and bring together the findings;
— they develop a plan for research that covers all services and all patient groups;
— they set standards for research and monitor them;
— they provide researchers with access to expert advice on research methods and report writing.

**And generally** to make sure that the views of patients and relatives are included in the overall assessment of service quality, managers need to bring information from complaints and patient opinion research together with that from audit and quality programmes.
4. Communication with Non-English Speaking Patients

INTRODUCTION

150. The adverse effects of poor communication are greatly exacerbated for those patients who do not speak English. This chapter is specifically about language services - i.e. interpreting and translation services for non-English speaking patients. It is not about the broader management agenda of making services responsive to the needs of black and ethnic minority patients, and meeting the cultural and religious requirements of patients from different communities. The degree to which hospitals are successful in helping minority patients feel at home is a topic that is too important and too large to be covered as a side issue in a report that is principally about communication.

151. It is in the hospital's interest to communicate well with patients who do not speak English, for the same reasons that it is in its interest to communicate well generally. Language difficulties can force patients to seek help elsewhere, as well as detracting from the efficiency and effectiveness of services. In hospitals where significant numbers of patients do not speak English, clinical staff spend more time in out-patient consultations and on ward rounds, and there is a much greater potential for medical errors.

152. The Audit Commission investigated non-English speaking patients' experiences at three hospitals where they accounted for a large proportion of the patient population. These data were supplemented with results from a telephone survey of twenty hospitals in local authorities that the 1991 Census records as having the highest proportions of ethnic minority residents, the best indicator available of likely language difficulty.

153. The aim in this chapter is to help hospitals meet the communication needs of patients who do not speak English. It rehearses briefly the difficulties of such patients and the variations in special provision, and then identifies some underlying causes and possible solutions.

THE PROBLEMS PATIENTS EXPERIENCE

154. There is very little research into the views of patients who do not speak English. That which has been carried out, together with observation in hospitals with high proportions of non-English speakers, shows that in addition to all the problems faced by patients who speak English, this group have particular problems in respect of access to services, confidentiality and the feedback process. All three have underlying management causes (Exhibit 18).
ACCESS

155. One study in the South of England demonstrated that access to hospital services can be much reduced for people who do not speak English, either because they do not know the service exists or because they feel in some way that it is not intended for them (Ref. 41). One hospital manager thought there were no patients in his catchment area who did not speak English, and yet the survey reported an estimated 8,000 people in this group locally.

156. If and when they do have contact with the hospital, non-English speakers may have significant problems. One patient in the same study described her experience in these terms: "I was in hospital for one week. I couldn't communicate with anyone. Although they tried to be helpful, I felt very alienated and isolated. I was scared." A great many non-English speakers have to rely on relatives or friends to accompany them to hospital, which can be inconvenient. Parents do not like having to take children out of school, and they feel uncomfortable about children translating for them. An Indian woman said: 'I don't always tell the doctor everything, because I have to tell my daughter what it is. I feel it is very embarrassing.' Whilst a Chinese girl who interprets for her family said: 'I feel embarrassed sometimes to have to explain to my mum what the doctor is saying. Sometimes there are terms I don't know how to translate, so I explain it in a roundabout way.'

157. When interpreting services do exist, access to them can be difficult because they are not well-publicised. Only a few hospitals include information about interpreting services in the main booklets and leaflets for out-patients and in-patients, or have posters advertising them in 'main' languages.
CONFIDENTIALITY

158. In Chapter 3 this report talks of breaches in confidentiality undermining communication about clinical matters. It is open to question how far bringing members of the patient's family into consultations, or involving other patients or non-clinically trained staff in confidential discussions, contravenes professional codes of conduct. These practices are common with patients who do not speak English and the normal rules of privacy and confidentiality that govern the interactions between patients and health professionals are frequently broken.

FEEDBACK

159. Patients who do not speak English find it hard to talk to professional staff and managers about their experience of a hospital, or to make suggestions or to voice complaints. Very few hospitals advertise complaints procedures in anything other than English, and most obtain feedback in ways that only accommodate people who can read English.

UNDERLYING CAUSES

160. There are several different models for providing interpreting and translation services in hospitals, including the use of one or a number of interpreters employed by the hospital and buying a service in from Family Health Services or Local Authorities. But on the whole they are not succeeding in meeting the communication needs and there are common problems in relation to planning, management and quality of services.

1. LACK OF PLANNING

161. Most language services in hospital have developed as a result of political battles and the enthusiasm of key individuals, rather than careful planning. Needs assessment is rare, funding is inadequate and service provision patchy.

(i) no needs assessment

162. Some hospitals are beginning to establish formal methods of assessing need. One has conducted a literacy survey; others collect figures on use of language services by language group, or are piloting methods for ethnic monitoring. The Audit Commission telephone survey found that in most, the person nominally responsible for language services was able to describe local ethnic communities in only general terms. They referred questions about community size, numbers, language differences within communities and literacy either to someone else in the hospital, to purchasers or to the public health department. Most hospitals do not have formal links with the local community and only ad hoc contact with community leaders. The information they get is not detailed or accurate enough for planning purposes.

(ii) poor funding arrangements

163. Sources of funding vary - some services are funded from main hospital budgets, but many rely on grants and ad hoc funds (Box K, overleaf). Uncertain arrangements affect the way people see the service and its status within the hospital. They make it easy to treat the service as an add-on, rather than an integral part of the organisation. The sense of it being peripheral is often reinforced by temporary and poor quality accommodation for interpreters.
(iii) patchy coverage

164. All hospitals with non-English speaking patients use members of staff and the patient's family as interpreters; a quarter of hospitals in the survey have no other alternative. Two of the survey hospitals do not approve of these arrangements and only resort to them in emergencies. Over half employ their own interpreters, but they vary between a hospital with one part-time interpreter in the maternity service who may be called to other areas of the hospital, and a hospital with eleven full-time 'liaison officers' working on two sites. Some hospitals use the telephone interpreting service offered by Language Line, others buy a service on contract from another organisation such as the local council or the Family Health Services Authority. But the dominant characteristic is patchy coverage. Hours may be limited, or the service may be confined to only certain kinds of provision, such as maternity or paediatric services.

165. Most hospitals in the survey translate booklets for out-patients and in-patients into other 'main' languages but very little of the clinical information is available in languages other than English.

2. POOR MANAGEMENT

166. Most interpreting services are under-managed. Less than half have a dedicated manager. Others lodge with a variety of departments, from customer relations, to operations, patient services and personnel. Interpreters are frequently based in departments such as maternity or out-patients, where they are supervised by the professional manager or head of department, who may or may not understand their role and be supportive. They go by various titles - interpreter, advocate, link worker, liaison officer - and it is not unusual to find some or all of these titles in the same hospital. The end result for managers, staff and patients is confusion about what kind of service is on offer. The language service staff and others need more clarity about their role.

167. Interpreters need training not only in interpreting but also in medical matters. They are brought in to consultations and expected to communicate clinical information, a task that doctors themselves often find difficult. Without training, they inevitably piece together their own understanding of medical procedures and medical jargon, and it is that understanding that they translate for patients. Almost half the survey hospitals offer some kind of training, but the context varies from a short induction course to a 33 week course on advocacy and interpreting. Only one hospital offers training specific to health care settings.
3. POOR QUALITY ASSESSMENT

168. The quality of language services is variable but there is almost no routine evaluation. The uncertainty and confusion that surrounds the definition of the role, the type of service the hospital offers and the peripheral nature of many services makes it difficult or impossible to evaluate the service. In those hospitals where managers recognise the need to evaluate what they are doing, they are often at a loss as to how they might go about it.

SOLUTIONS

169. A number of structural and organisational problems in developing language services are identified in this Chapter. To overcome them, hospitals must define the need for a service, use the information to plan and manage the service and ensure its quality. Efforts made at the Royal Oldham Hospital and Community NHS Trust to assess needs, allocate resources, ensure quality and establish strong community links demonstrate that it is possible to provide a high standard of service (Box L).

Box L

Royal Oldham Hospital and Community NHS Trust: characteristics of language services
- Ethnic Health Advisor funded by the trust
- Top management support for quality service
- Local authority ethnic information team provides information about population
- Hospital and community interpreting service is co-ordinated by one manager
- Interpreters work full-time, are qualified and trained in health and clinical topics
- Interpreting service has clerical support
- Use of family members to interpret is discouraged
- Interpreting and translating services are advertised
- Use of the service is monitored
- Strong community links used to get feedback
- Staff are trained to use the service and attend cultural awareness courses
- Links with other hospital and community interpreting services

Source: Audit Commission telephone survey

1. DEFINE NEED

170. Before planning an interpreting or translation service, hospitals must systematically investigate needs. There are several ways of doing this. From April 1994, providers will be expected to monitor the ethnic origins of patients. They are not required to gather data on mother tongue, spoken English and literacy, but if they can add on questions about these areas they can compile their first set of useful data. Some hospitals, anticipating the requirement, have started to pilot ethnic monitoring in particular areas or services. It is important to do so in advance because the administrative process is complex. One hospital piloted ethnic monitoring and found that on the day the pilot started the computer centre was not equipped to handle the new forms.
Hospitals need first hand information about the services non-English speaking patients use, the difficulties they encounter and the sort of help they would prefer. They need to find out:

- which patients do not speak English?
- what language(s) they do speak?
- whether they can read at all, and which scripts?
- if they use all parts of the service, or only some and how often?

They should also consider it their business to find out whether there are potential patients in the community who are prevented from using services by real or supposed language difficulties. They can begin to find out the answers by developing formal links and consulting with community groups who will be able to tell them whether, and how well, they are meeting the needs of patients.

2. PLAN AND MANAGE SERVICES

Armed with information about the extent and variety of needs, managers will be in a position to make plans and identify areas of the hospital they need to cover, the hours required, the costs and the resources. The aim of the service should be to reduce reliance on family members and untrained staff. It is important to decide in advance if it is to be an interpreting or an advocacy service. Extending the service to patients who wish to make a suggestion or complaint is an obvious step if the hospital is serious about obtaining the views and opinions of all patients. Staff, as well as patients, should be made aware of the service and how it operates. Working through interpreters is different from being able to communicate directly and clinical staff may need training in how best to communicate through interpreters.

3. ENSURE QUALITY

The service plan should include mechanisms for maintaining a high quality service. As with any other planned service, audit and evaluation need to be built into the way the service operates. Hospitals need to monitor up-take and set and monitor minimum standards for recruitment, training and supervision. Some hospitals have found targeting recruitment on local ethnic minority groups particularly helpful, and others have produced a written Code of Practice which sets out the aims of the service and offers guidance on how to cope with racism, confidentiality, and methods of working (Ref. 42).

Part of ensuring quality should be an on-going evaluation of the service and one way hospitals can go about it is simply to ask patients their views. They can do it through translated questionnaires or interviews, or by including community representatives in a feedback programme using such methods as focus groups.

Providing language services is a new area for many hospitals. They tend to develop their own solutions to the immense problems staff and patients face when they do not speak a common language. This Chapter has highlighted the problem for patients, indicated organisational reasons that underlie them and offered solutions to overcome them.
Commissioning authorities should work with chief executives/general managers to assess the need for interpreting and translating services and should expect them to provide information about:

- what they are doing to meet the needs of non-English speaking patients; and
- the standards they have set and how they monitor them.

Chief executives/general managers need to:

- find out from patients who do not speak English the extent and nature of the problems they face in the hospital;
- establish systems for monitoring use of services by patients who do not speak English;
- formalise links with local community groups;
- use the information to plan language services to meet their needs, and to decide on the role of the service; including decisions about coverage within the hospital; staffing; funding; and arrangements for publicising the service;
- set and monitor standards for recruitment and training;
- agree and implement a Code of Practice for interpreters and professionals using the language service.
177. The most important message in this report is that senior professionals and hospital managers must develop an understanding of what it is like being a patient in their hospital, so that they can tailor communication more accurately to patients' wants and needs. There is a number of ways of acquiring insight into patients' experiences, including accompanying individuals through the system, listening to complainants, consulting voluntary organisations and local self-help groups, and initiating research.

178. Once senior professionals and managers understand the patient's experience of communication, they can take action at a number of levels to make sure it is satisfactory. The first step is to develop hospital-wide policies allocating responsibility for the aspects of communication examined in this report. Communication is not an 'add on', it is at the heart of patient care, and the responsibilities of all professionals, and of consultants in particular, need to be clarified and underlined.

179. Training staff, setting standards and monitoring effectiveness need to go hand in hand with allocating resources to this crucial aspect of service delivery. In the majority of instances it will be necessary to make changes to current practice. It should be possible to make significant improvements in communication by diverting the substantial amount of time and money already invested, to better ends. However there may be some areas where additional resources are needed.

180. The recommendations of the report are intended for managers of acute provider units and commissioning authorities. Over the next year, the Audit Commission will conduct audits in hospitals throughout England and Wales, where the main aim will be to help local managers implement the report's recommendations. There are also other important players who have key roles in helping hospitals improve communication with patients, not least patients themselves.

181. Patients are not just passive recipients of information. Individually and collectively, through organisations such as Community Health Councils and the many voluntary organisations that campaign on their behalf, they have an important role to play in letting hospitals know their views.

182. Some professionals interested in communication processes are working with individual patients, helping them to plan for clinical consultations, what they want to ask and how to get the information they want (Ref. 43). Patient groups, together with hospitals, could encourage the development of more such schemes locally.

183. The Royal Colleges and other professional bodies. The report has not focused directly on the communication skills of individuals or on skills training, but both are important. Nurses' and therapists' training includes communication skills as does undergraduate medical education (Ref. 44). And the General Medical Council now expects students and pre-registration house officers to develop communication skills and to be able to tailor their approach to individual patients (Ref. 45). The majority of newly qualified doctors have some experience of role play and
feedback on their own strengths and weaknesses, which will in the long-term benefit their approach to communication. Most senior doctors and professionals have not had these opportunities and yet they are the role models and mentors of junior members of staff. They need time and opportunities to examine their own practice and to develop communication skills.

184. The Royal Colleges and other professional bodies have an important role to play in setting standards of professional conduct and qualification. The Royal College of Physicians currently instructs examiners to 'devise ways of testing the ability of young doctors to communicate with patients' (Ref. 46) and the Royal College of Surgeons is encouraging its members to include investigation of patient satisfaction in medical audit. If the Colleges were publicly to endorse the value of communication skills training, and to invest in courses, conferences and seminars for their own members, they would make a valuable contribution to improving patients’ experiences in hospitals.

185. The Department of Health. The Patient's Charter is a step in the right direction. It has raised the profile of many aspects of communication and spurred managers into action on some of them.

— This report has pointed managers towards outside sources of expertise in areas such as design, layout and production of documents, research methods and the assessment of the communication needs of patients in minority groups. A central register of national bodies and organisations, and a reference list of reliable sources and methods would provide helpful short cuts to improving communication processes in hospitals.

— Funding arrangements for professional bi-lingual language services should be reviewed. The NHS reforms commit health authorities to providing sensitive and flexible services for ethnic minority patients, but language services create additional costs. Authorities with substantial non-English speaking patient populations need help with resources, and guidance on whether purchasers or providers are to meet the additional costs.

— The Patient's Charter standard on information about treatment is exceptionally difficult to implement and monitor, and in any case it is not part of routine Charter monitoring. It would be useful for managers and professionals if the Department of Health could give guidance on this Charter requirement.

— The Charter also requires hospital chief executives to reply to letters of complaint. The Health Service Commissioner has suggested that this is leading to dishonest practice on the part of some chief executives who sign letters of response without having seen original letters of complaint, and with little knowledge of the investigation or its outcome. It would be helpful if the Department of Health would clarify the purpose of the standard and make clear to chief executives that whilst they must keep in overall touch with complaints, and with responses, they may delegate specific operational responsibility to other managers.

— The classification used for reporting complaints to the Department of Health needs attention. The current system of classifying complaints as clinical or non-clinical is too crude to be meaningful. It would be more useful to develop a classification system that includes specialty, department and content, to help managers identify areas where there are particular problems and analyse trends.

186. The complaints process would be strengthened by having an element of independence in the investigation of individual complaints at hospital level. In some trusts non-executive
directors are beginning to fulfil this role. The national review of complaints procedures should consider the practical options that can be set out in new guidance.

187. **Commissioning authorities** will increasingly determine not just the type and amount of service provided in hospital, but the quality of services. The sooner contracts become more condition specific and detailed the better. The Audit Commission recommends that purchasers work towards contract specifications for standards in these areas: general information, clinical information, access to information for patients in minority groups, complaints handling and feedback. Communication with patients is not part of some vague 'quality umbrella'; there is good evidence that a more efficient service can be provided and more effective outcomes obtained when communication works well. Including communication specifications - and not only about written documents - may prove a challenge. But it is a challenge that must be heeded.
Appendices

Appendix 1
THE PROVISIONS OF THE PATIENT'S CHARTER RELEVANT TO
COMMUNICATION
Hospitals must:
— give general information about services, and specific information about quality;
— provide a named nurse for every patient;
— enable patients to find their way around and improve sign-posting;
— identify all staff with name badges;
— give patients full information about treatments and alternatives sufficiently in advance of
decisions having to be made;
— keep relatives informed, according to patients’ wishes;
— find out what patients think;
— respond speedily, and from the top, to people who complain.

Source: Patient's Charter (1991)
Appendix 2

This Appendix contains information about the tracer conditions that were used to investigate clinical communication. Each condition presents its own problems for patients and these are described, together with good practice that has helped to overcome them.

There is a dearth of written clinical information and even where it does exist, there are rarely mechanisms to ensure patients get it. Good practice in the production and distribution of written information is described separately.

(i) BENIGN PROSTATE HYPERPLASIA

PROBLEMS FOR PATIENTS

<table>
<thead>
<tr>
<th>Patients:</th>
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<tbody>
<tr>
<td>• are put at a disadvantage in consultations if they are undressed when they meet the doctor for the first time and when they discuss treatment</td>
</tr>
<tr>
<td>• are not encouraged to bring their partners to consultations</td>
</tr>
<tr>
<td>• do not know what to ask or have enough time to discuss the condition, treatment and outcome</td>
</tr>
<tr>
<td>• do not receive written information they can take away about the condition, procedures and post-operative care</td>
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<tr>
<td>• do not receive routine test results</td>
</tr>
<tr>
<td>• receive important information about risks of surgery just before the operation</td>
</tr>
<tr>
<td>• miss out on information they would find useful because the professionals looking after them do not communicate with each other about what they say to patients</td>
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</table>

GOOD PRACTICE

<table>
<thead>
<tr>
<th>Clinical staff and general managers should work together to:</th>
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<tbody>
<tr>
<td>• organise out-patient clinics so that the patient is dressed to meet the doctor and to discuss treatment</td>
</tr>
<tr>
<td>• give patients the opportunity to bring partners to the consultation</td>
</tr>
<tr>
<td>• give patients full information before a decision about surgery is made</td>
</tr>
<tr>
<td>• allow time for discussion, not necessarily with a doctor - a clinical nurse specialist can perform this function</td>
</tr>
<tr>
<td>• link out-patient clinics and wards in such a way that staff know what patients are told</td>
</tr>
<tr>
<td>• provide written information (See Box at the end of this Appendix)</td>
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(ii) **BREAST CANCER**

**PROBLEMS FOR PATIENTS**

<table>
<thead>
<tr>
<th>Patients:</th>
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<tbody>
<tr>
<td>• are put at a disadvantage in consultations if they are undressed when they meet the doctor for the first time and when they discuss treatment</td>
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</tr>
<tr>
<td>• are not encouraged to bring someone with them when they are told their diagnosis</td>
<td></td>
</tr>
<tr>
<td>• do not receive written information they can take away about the condition, treatment and outcome</td>
<td></td>
</tr>
<tr>
<td>• discuss treatment options, only once, immediately after they have been told they have cancer</td>
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<tr>
<td>• are not supported through the process of diagnosis and treatment</td>
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<tr>
<td>• miss out on information and are given confusing or even contradictory advice</td>
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<tr>
<td>• are kept waiting for results that are available</td>
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**GOOD PRACTICE**

<table>
<thead>
<tr>
<th>Clinical staff and general managers should work together to:</th>
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</thead>
<tbody>
<tr>
<td>• organise out-patient clinics so that the patient is dressed to meet the doctor and to discuss treatment</td>
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<tr>
<td>• give patients the opportunity to bring a friend or relative to the consultation</td>
<td></td>
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<tr>
<td>• introduce a trained breast nurse who works as part of the clinical team offering information, support and advice to all breast cancer patients who want it</td>
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<tr>
<td>• establish a link between the breast nurse and ward nurses to assist continuity</td>
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<tr>
<td>• establish closer links between surgeons and clinical oncologists</td>
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<tr>
<td>• make sure patients receive information about local self-help and support groups</td>
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<tr>
<td>• provide written information (See Box at the end of this Appendix)</td>
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</tbody>
</table>
(iii) RHEUMATOID ARTHRITIS

PROBLEMS FOR PATIENTS AND RELATIVES

Patients:
- do not receive information about access for disabled people at the hospital
- do not receive written information about drugs and their side effects
- have difficulty finding out about aids, appliances and voluntary organisation and support groups
- need, but do not get, access to out of hours advice about changes in their condition or side effects of drugs
- see different doctors, (who do not know what they have been told before) each time they come to out-patients

Relatives:
- lack all the information that patients lack
- do not get the support they need

GOOD PRACTICE

Clinical staff and general managers should work together to:
- agree a standard letter which gives patients details about access to the hospital
- arrange for a named contact to be available for patients and advise them of their number and hours
- organise and advertise relatives support/patient education groups
- provide written information especially on details of drugs and side effects (See Box at the end of this Appendix)
(iv) **STROKE**

**PROBLEMS FOR PATIENTS AND RELATIVES**

<table>
<thead>
<tr>
<th>Patients:</th>
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<tbody>
<tr>
<td>• do not receive written information about the condition, treatment and care after discharge</td>
<td></td>
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<tr>
<td>• are not told about aids, equipment, support groups and benefits</td>
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<tr>
<td>• are isolated on acute wards where staff understandably give priority to patients with more urgent medical conditions</td>
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<tr>
<td>• may receive contradictory messages from different clinical staff</td>
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<tr>
<td>• are uncertain who to ask for information</td>
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<tr>
<td>Relatives:</td>
<td></td>
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<tr>
<td>• do not know how to get access to doctors</td>
<td></td>
</tr>
<tr>
<td>• do not receive written information about the condition, treatment and care after discharge</td>
<td></td>
</tr>
<tr>
<td>• in charge of patients for information are given no advice about support groups</td>
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**GOOD PRACTICE**

<table>
<thead>
<tr>
<th>Clinical staff and general managers should work together to:</th>
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<tbody>
<tr>
<td>• develop an admissions policy for stroke patients</td>
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<tr>
<td>• improve communication between professionals by establishing team meetings</td>
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<tr>
<td>• include relatives at all stages of care and not just at discharge</td>
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<tr>
<td>• advertise set times when doctors are available to meet relatives</td>
<td></td>
</tr>
<tr>
<td>• delegate responsibility for informing patients and relatives about support groups, and other post-discharge help</td>
<td></td>
</tr>
<tr>
<td>• provide written information (See Box at the end of this Appendix)</td>
<td></td>
</tr>
</tbody>
</table>
(v) WRITTEN INFORMATION

PROBLEMS FOR PATIENTS AND RELATIVES

Patients:
• do not get written information about the condition, treatment, procedures and post-operative care
• get poor quality information
• get information too late to be of use

Patients and their relatives:
• do not get written information about aids, equipment, and people who can help

GOOD PRACTICE

Clinical staff and general managers work together to:
• review the written information currently distributed and the distribution mechanisms
• find out what kind of information patients and relatives would like
• provide written information about conditions, procedures and post-operative care
• make written information from national organisations available
• allocate resources to the production or purchase of written information
• make clear arrangements for distributing written information at the right time - for example before a decision is made about surgery or before discharge from hospital - and check at regular intervals that they work
Appendix 3

Project advisors

— Professor Judy Allsop, Head of Health and Social Policy Division, South Bank University
— Dr Tony Bradlow, Consultant Rheumatologist, Battle Hospital, Reading
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— Havering Hospitals NHS Trust
— Central Middlesex Hospitals NHS Trust
— Milton Keynes General Hospital NHS Trust
— Northallerton Health Services NHS Trust
— Dudley Road Hospital, Birmingham
— Bridgend and District NHS Trust
— Leicester General Hospital NHS Trust
— Kent and Canterbury Hospitals NHS Trust

SHORT VISITS

— Anne Arundel Medical Centre, Annapolis
— Western General Hospital, Edinburgh
— Sully Hospital, Llandough NHS Trust Hospital
— The Royal London NHS Trust
— Frenchay Healthcare NHS Trust
— Stoke Mandeville Hospital
— Velindre Hospital
— Royal Berkshire and Battle Hospitals NHS Trust

COMMENTATORS ON THE DRAFT REPORT
— Department of Health
— National Association of Health Authorities and Trusts
— Welsh Office
— Institute of Health Services Management
— The Patient’s Association
— NHS Trust Federation
— Association of Community Health Councils for England and Wales
— College of Health
— British Medical Association
— National Audit Office
— College of Anaesthetists
— Royal College of Physicians
— Royal College of Surgeons
— Royal College of Nursing
— National Consumer Council
— Health Service Commissioner
— Royal National Institute for the Blind
— Royal National Institute for the Deaf
— Stroke Association
— Arthritis Care
— BACUP (British Association of Cancer United Patients)
— Cancer Relief Macmillan Fund
— Marie Curie Cancer Care
— Health Services Research and Evaluation Unit, Lewisham Hospital NHS Trust
— College of Speech and Language Therapists
— British Association of Occupational Therapists
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43. P Morris, research fellow in communication skills, Cambridge Medical School (personal communication). See also Open University and BBC TV programme on 'the doctor — patient relationship' for OU course U205 'Health and Disease.'


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