HEALTH NEWS BRIEFING

Quality Contracts

- Improving standards of patient care

December 1995

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Summary

Health commissioning authorities (purchasers) arrange the provision of health services for their resident populations through contracts with service providers. Contracts specify the quality, quantity and cost of hospital and community care services to be purchased. It is the responsibility of the health commissioning authority to arrange the appropriate range of services to ensure the best possible care for their population.

Whilst there is a great deal of work being carried out on issues of quality, a recent survey by the Greater London Association of Community Health Councils [1] looking at district health authority contracts found that the information available from London district health authorities (DHAs) on quality standards varied considerably. A CHC respondent to the survey said: *'I think the DHA would dispute this, but reporting on quality in [name of DHA] has involved heaps of paper/charts etc. which actually say very little about quality of services..'*.

Community Health Councils (CHCs), as independent representatives of the community, have an important role to play in the setting and monitoring of quality health care standards. This briefing looks at the development of quality in health care and considers how Community Health Councils intervene in the commissioning process to help to ensure that the public are being delivered a quality health service.

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Introduction

The NHS and Community Care Act 1990 introduced the 'internal market' into the NHS, separating responsibilities for the purchasing and the provision of health care. In the early days of the NHS reforms, public attention tended to focus on the provider units such as hospitals, which were undergoing dramatic change as they became self-governing NHS trusts. At the same time, early purchasing contracts for health care reflected a 'steady state' based on historical patterns of service, in a rapidly evolving health service.

During this period, debate focused on quality and the measurement of quality in the NHS. The White Paper preceding the 1990 Act, *Working For Patients*,[2] and subsequent working papers, set out a plan for what was then termed 'medical' audit, which evolved into 'clinical' audit, involving professions other than doctors. Medical audit was defined as 'the systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome and quality of life for the patient'[3].

Subsequent Government policy has focused on the importance of making services more responsive to the users of health care, and has emphasised the importance of 'quality' as an integral part of health service provision, the management responsibility for delivering high quality services and the need to move towards a service which is responsive to the needs and views of users.

> *'The move to a contract system and the funding of districts as purchasers from 1991 are above all aimed at improvement in the quality and responsiveness of patient care. The separation of purchasing from provision will require contracts to state in increasingly explicit terms the quality and standard of service which is to be provided'.* [4]

Increasingly, in more recent years, a variety of factors have helped to place quality issues firmly on the NHS agenda. They include:

- the 'contract culture' - setting service delivery levels on the basis of quantity, quality and cost
- the Patient's Charter and other national targets - setting national standards and raising public expectation for a quality health care service
- interest in 'quality management' within the academic and commercial sectors influencing and stimulating the 'quality in health care' debate
- medical malpractice liability - with the abolition of Crown Indemnity, the new arrangements mean that NHS trusts and health authorities need to detect and prevent incidents which could result in them bearing the costs of malpractice claims.

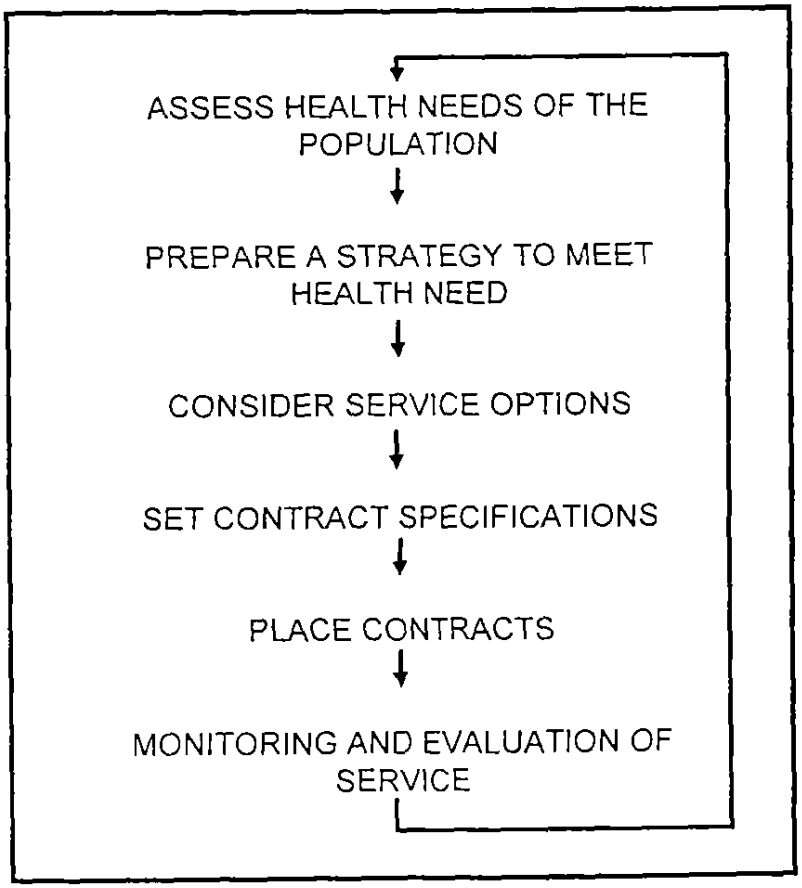
Quality in Contracts

Health commissioning authorities arrange for the provision of health care for their resident population through contracts with service providers. Contracts specify the service required, including the key elements of quality, cost and volume of service. On behalf of their population, the purchaser uses the contractual process to put mechanisms in place to set systematic quality standards, to scrutinise performance and to correct failure to meet standards.

The main components of a contract are:

- Service specifications
- Quality specifications
- Information and monitoring requirements
- Levels of activity and prices
- Other terms and conditions

Contracts are the product of a purchasing, or health care commissioning process. The key steps in the health care commissioning process are:



What, then, does 'quality' mean in this context?

Although there is much debate about quality terminology, a widely accepted definition of quality in health care is a service that is:

- **Effective** - whether a procedure, treatment or process actually achieves what it sets out to do
- **Efficient** - value for money
- **Equitable** - that opportunity of access is fair and equitable for everybody
- **Accessible** - that appropriate information is available and easily accessible, that services are physically accessible, and culturally accessible to all
- **Appropriate** - treatment in the right setting, of the right sort, and administered by properly qualified professionals
- **Responsive** - a user-friendly service where patients are involved in decisions about their health and health care.

Whilst the definition of quality is straightforward, managers, professionals and patients can have very different views on how to achieve a quality service. Managers may focus on issues of cost and volume, and clinicians may value clinical audit processes and outcomes. Patients are more likely to measure a service by how they were treated and whether they feel better as a result.

The National Consumer Council in its report on quality standards in the NHS [5], identifies two basic requirements for developing a quality health service:

- Consumers must be involved in setting quality standards
- There must be openness in setting standards and in measuring how far services meet these standards.

In terms of health care, then, the pursuit of quality needs to be patient centred. Quality encompasses the patient's total experience of a service, from the environment in which care is delivered, through the appropriateness of treatment, the skill and care with which it is delivered, and the outcome.

The Role of the CHC in Quality Management

The Department of Health has said[6] that the concept behind the contracting for health care system is that such a system will improve the quality and responsiveness of patient care. Beyond this, there has been little national direction on the setting of quality standards, which has led to considerable variation in purchasers' approaches to quality issues. A recent study[7] of the 1994-95 quality specifications of district health authorities found that, of 32 DHAs which provided material, 19 had statements about what they believe quality means. Thirteen of the 32 purchasers reported that they had no definition of quality or a quality statement.

One of the factors which seems to limit the effectiveness of NHS quality initiatives is that quality assurance programmes have historically been modelled within the commercial and private sector, and do not necessarily transfer successfully to the NHS. For example, Total Quality Management (TQM) has been promoted as a solution to the problems of introducing quality assurance programmes within the NHS. TQM was developed for mass production industries, and is about adopting a comprehensive, organisation-wide approach to achieving quality. It has been described by the Department of Health as a 'corporate management approach which recognises that customer needs and business goals are inseparable'[8]. TQM and other quality initiatives have tended to focus on 'consumerism', with managers acting as 'champions' of consumers.

To achieve a quality, patient-centred service, it is not enough that NHS managers act as 'champions' of the people. It is in the nature of the job that managers are juggling with any number of conflicting pressures, not least financial restrictions. Similarly, it is not possible for any single user interest group to represent the community. Involving users in the purchasing process is time-consuming and difficult, and NHS managers have no real incentive to build patients' views into their decision making. Community Health Councils are in a unique position to act as a representative consumer voice. CHCs can help to ensure that a 'quality health service' truly reflects the desires and expectations of the public.

Community Health Councils were established in 1974 to provide a channel for local consumer concerns. They have developed links with the community and service user interest groups, and can feed the experiences of service users into the contract planning process. It is important that CHCs are credible representatives of the community and remain independent of the health authority structure. As statutory bodies, CHCs have rights to information from local NHS authorities, rights of access to certain NHS premises, to being consulted on variations in service and to hold meetings with their local NHS authority. The NHS Management Executive guidance [9] to health authority managers says that:

> *'The DHA has a duty to provide a CHC with such information about the planning and operation of health services in the district of that DHA as the Council may reasonably require in order to carry out its duties.'*

The guidance goes on to say:

'...consultation is the communication of a genuine invitation to give advice and a genuine receipt of that advice.'

Further guidance[10] clarifies the role of the CHC in the purchasing process:

*'7. **Purchasers** should invite CHCs to be involved in the purchasing process, focusing in particular on:*

- *needs assessment and priority setting within purchasing plans;*
- *strategy underlying decisions on the placing of contracts;*
- *the development of quality standards within contracts;*
- *monitoring services in co-ordination with health authorities;*
- *matching the services planned to the cultural, religious and other aspects of health needs in the community.'*

and that:

'12. Where GP fundholders are the purchasers, they should also provide (anonymised) information about major contracts to the CHCs, either directly or via the health authority, particularly where substantial changes are proposed.

13. Each trust is responsible for developing its own relationship with local communities. Trusts should recognise the statutory role of CHCs in representing the interests of the public in this relationship and should agree arrangements for liaison and access (including monitoring visits for which there is statutory provision) with the CHC(s) concerned.'

A CHC Strategy for 'Quality in Contracts'

Why should CHCs have a strategy for 'Quality in Contracts' work?

Community Health Councils have a responsibility to represent the public interest in health service issues, and are well placed to contribute to improving the quality of health services, making them more responsive to the needs and preferences of those who use them. The ACHCEW document '*Performance Standards for CHCs - developing the framework*' [11] identifies the CHC core activities and recommends that CHCs develop clear objectives and standards to reflect local priorities. The core services are:

- acting as a voice for the community after actively seeking and listening to the views of local people
- acting as a watchdog for the community by monitoring local services
- helping local people and groups put forward their views to NHS managers, in particular seeking out people whose views are not normally represented and acting as an advocate for them
- providing information and advice to all people who phone, write or come to the offices
- assisting people to make and follow up a complaint

All of these core activities are relevant to CHC work in relation to the quality of health care. It is difficult for CHCs to juggle increasing demands on their time and resources. Having a 'quality strategy' allows the CHC to focus activity where it will prove most effective.

The suggested key elements of such a strategy are:

- **Timetable CHC work on quality issues around the purchasing authority's commissioning cycle**
- **Develop links with purchasers and providers to facilitate this work**
- **Set work priorities annually to focus activity on one stage of the health commissioning cycle or around specific service issues**

Timetable 'quality' work around the commissioning cycle

Health authorities plan their work around key dates in the purchasing year. The fixed dates (*italicised*) in the following diagram are taken from the NHS Executive 1996/97 Priorities and Planning Guidance[12]. The other time periods are taken from a local example.

THE PURCHASING CYCLE

Health needs assessment	18 month cycle (finishing in June)
Set purchasing strategy	*Publish initial purchasing plans and contracting intentions by 15 September.*
Specification of quality standards	*Finalise contracting intentions by 20 January.*
Placing contracts	*Agree all NHS contracts between purchasers and providers by 15 March.* *Sign all NHS contracts between purchasers and providers and make purchasing plans public by end March.*
Monitoring contracts and contract renewal	Annual contract renewal on 3 year review cycle, with one third of contracts reviewed each year.

Glossary of terms: *Purchasing Plan* - details the purchasing strategy for the next business year

Contracting Intention - identifies any significant contracting shifts as a result of the Purchasing Plan

The NHS Executive guidance, in line with its 'Local Voices' policy, which identifies the need for the on-going involvement of local people in purchasing activities, goes on to say that:

> *'Health Authorities should have a strategic plan for, and should be engaged in, systematic and continuing communication and consultation with local people, representative and voluntary groups (particularly Community Health Councils) in respect of the development of local services, purchasing plans, specific health issues and health promotion as appropriate.'*

Despite this guidance, purchasing authorities seem to have developed different timetables. CHCs may find it helpful to discuss local timescales with their purchasing authorities and use this information to plan their own annual timetable.

The table below is incomplete, but lays out the bare bones of a CHC/health authority strategic plan:

THE PURCHASING CYCLE AND THE WORK OF CHCS

	Health Authority Dates	CHC Dates
April		Implement annual plan
June	Draft purchasing plan out for consultation	CHC feeds comments into early draft of purchasing plan
September	Publish purchasing plan and contracting intentions	
November		CHC comments on draft contracts
December		CHC review day
January	Finalise contracting intentions	CHC drafts next annual plan and sends out for consultation
March	Place contracts with providers	
April		Agree CHC annual plan

Planning CHC work on quality issues systematically, allows the CHC to take a more proactive approach. Because of limited resources, it is unlikely that CHCs can keep up the same level of activity in quality issues throughout the year. Planning activity around the commissioning cycle will help the CHC to target activities by focusing on a particular stage of the commissioning process or on particular services.

Develop links with purchasers and providers.

CHCs are also hampered in their work by the statutory limitations placed upon them. Whilst CHCs have a right to information from health authorities, they do not have the same rights in respect of trusts and GP fundholders.

Historically, CHCs have had strong links with their local hospitals. More recently, CHCs have been formalising their relationships with provider units.

North Birmingham CHC have agreed a *Charter of Rights for the Community Health Council with Good Hope NHS Trust*[13] .This charter recognises that the CHC has a valid contribution to make as a representative of the community.

The CHC has the right to regular meetings with the Trust to find out about and to comment on the Trust's service delivery. An Executive Director is the lead contact with the CHC.

On quality monitoring, 'The Trust supports the Community Health Council role in quality monitoring in the following areas:

- To co-operate with the CHC in monitoring patient feedback on specific service delivery areas.
- The specific involvement of the CHC in the Trust's quality monitoring processes by mutual agreement.'

The relationship between a purchasing authority and the local CHC can also be strengthened to develop quality in health care programmes:

Oxfordshire CHC worked with Oxfordshire Health to develop a Quality and Care Standards Handbook[14] .

This handbook outlines a strategy for quality improvement that 'can be used locally to develop systems that assure the purchaser and the residents of Oxfordshire of the quality of their health services.'

CHCs have made less progress so far in their relationships with GP fundholders. A recent ACHCEW survey found that 25 per cent of the CHCs in the survey had no contact with fundholders. However, NHS Management Executive guidance (EL(92)11) to DHA managers says that 'DHAs should normally hold GP fundholders' contracts and should make these available to CHCs (anonymised to protect patient confidentiality)'.

Some health authorities are making efforts to work in partnership with GP fundholders. For example, encouraging GPs to put quality standards into contracts by setting up monitoring mechanisms for them.

There are no requirements for GP fundholders to consult the public, or even their own patients, about any substantial changes they wish to make either in the services they provide or services to which they refer patients. However, CHCs are working to develop links:

> North Clwyd CHC have been meeting with representatives of the North Clwyd GP Fundholding Consortium to discuss their purchasing intentions.
>
> Both parties have found the meetings helpful and a useful start to a developing working relationship.

CHCs are also developing relationships with social services. With the health service reforms and changes in social services responsibilities for providing long term community care, CHCs see the need to be involved in joint planning of local services.

> North Tees CHC works with social services and the purchaser to ensure that care standards are consistently high across the locality.
>
> The CHC is carrying out a joint project with social services on mental health. An earlier project identified a lack of understanding on the part of local people about care in the community. The report has been sent on to the Director of Education with a view to incorporating mental health awareness education into the curriculum.

Set annual work priorities which focus activity on one stage of the health commissioning cycle or around specific service issues

Traditionally, CHCs have focused monitoring work on visits to hospital premises. Whilst there is a valid role for this sort of monitoring, it is not the only area where CHCs can intervene in the health commissioning process.

Wakefield CHC has specified their quality monitoring priorities in their 1994/95 aims and objectives :

Objective

To monitor the quality and take-up of, and consumer satisfaction with, local health and health related services to identify the extent of unmet need for such services and to recommend improvements in services.

Action to Meet Objectives

a) Each Working Group (Acute Services, Primary Health Care & Community Services and Physically Disabled, Mental Health & Community Care) to undertake a programme of visits
b) Monitor complaints received
c) Undertake public surveys
d) Regular contact with Wakefield Healthcare in respect of quality, monitoring and health needs assessment
e) Consider ways of identifying health needs of public in Wakefield
f) Follow up public concerns about services from the trusts.

This provides a framework for project work.

CHCs have developed a variety of innovative projects around quality issues :

Needs Assessment

Health authorities have a duty to determine local health care needs and to involve local people in the commissioning process.

CHCs have an important role to play in making the purchasing authority aware of local needs, taking an advocacy role and seeking out the views of people who are under-represented. This work is in addition to public consultations which are being carried out by the health authority, or issues which are being addressed by a vocal interest group.

Good, credible links with the community require planning and perseverance. CHCs have developed various techniques for building links with the community. Some have adopted a 'seed bedding' approach - building relationships between the purchaser and groups within the community and then moving on. Others are involved with health forums, focus groups and consumer panels.

> The North Bedfordshire 500 consumer panel was set up as a CHC initiative with funding from Bedfordshire Health. The panel aims to be representative of the adult population and has so far considered local maternity services, the issue of out-of-hours health services and access to dental services.
>
> Results from these surveys are reported back to Bedfordshire Health for action. The survey on dental services[15] highlighted local concern about the lack of NHS dentists. Bedfordshire Health has responded with a range of initiatives, including contracting NHS dentists as an interim measure.

Determining local health needs within a restricted budget raises issues of prioritising and rationing. CHCs are increasingly being asked to participate in the priority-setting which NHS purchasers need to make to bridge the gap between available resources and health care need. CHCs respond to this in a variety of ways, bearing in mind what they consider to be in the best interests of the community. ACHCEW's submission to the Health Select Committee on this issue[16] concluded that:

> *'The responsibility for a decision is not automatically shared by consulting about it. The responsibility for rationing decisions will lie with the purchasing authorities which lay down ECR protocols or say that certain procedures will no longer be available. Responsibility will be ultimately with the Government for determining a level of resources within the NHS that requires the rationing decision to be made in the first place.'*

Contract Specification

CHCs can provide useful input into discussions about choice, quality and access and in defining specific service standards to be included in contracts.

> During discussions with Oxfordshire CHC on contract specifications for mental health services, Oxfordshire Health wanted to arrange a consultation with users. Oxfordshire CHC felt that they could facilitate the consultation by drawing up a list of standards that users and carers wanted.
>
> They used this to consult widely and succeeded in incorporating these into the mental health Trust contract.

Examples of specific standards, including the mental health service standards described above, are attached as an annexe to this paper.

Service specifications, including quality specifications, form the basis of monitoring and contract renewal. CHCs could find it useful to audit all contracts to ensure that they all contain the same standards. If a standard is included in one trust contract, why not in all? An exercise of this sort can also include contracts with voluntary and private sector trusts where they have been contracted for NHS services. Social services community care contracts may also contain more generally applicable quality standards.

Placing of Contracts

In many areas providers will be operating from a position of virtual monopoly. In these circumstances, there is less incentive for providers to invest in improvements to their non-clinical services. CHCs, reflecting patients perceptions of the service, can put pressure on providers to improve standards in these areas.

For instance, issues of access are important to the general public. Access includes public transport and car parking, the hospital buildings and facilities including disabled access and signposting, and whether information about services is presented in appropriate language/languages with regard for cultural differences.

Monitoring and contract renewal

Purchasers are fast developing mechanisms for measuring how well providers are performing against contract standards. As these quality assessment procedures mushroom throughout the health service, CHCs are developing their own monitoring strategies to ensure that its monitoring activity is both effective and credible.

Darlington and Teesdale CHC have produced a working paper outlining their Quality Monitoring Strategy[17]. The key elements of the strategy are:

- The CHC will set out in its annual plan a programme of independent quality monitoring activities. The CHC will employ a range of methods to identify particular quality targets, and will select and put into practice appropriate methodologies for monitoring in each case. The CHC will visit health service units in accordance with its own protocols.
- The CHC will work in partnership with the purchaser and the providers in monitoring the quality of health care provision. The CHC will build and expand relationships with voluntary and community groups, with other CHCs and with the public to facilitate information exchange and joint quality monitoring where appropriate.
- The CHC will develop standards for its own quality performance and strive to integrate quality as a central strand through all CHC activities.

It is not possible for CHCs to engage in full monitoring of all the services being provided to their communities. A structured programme of selective visiting allows CHCs to assess the adequacy of the quality control procedures being followed by the provider units, and the monitoring arrangements being made by the purchasing authority.

This is likely to include a variety of monitoring activities:

'Dipstick' monitoring

'Dipstick' visiting to health care premises encompasses both planned visits such as Casualty Watch, and reactive visits which respond to changes in service provision, concerns raised by CHC members or through complaints monitoring. These visits can be used to gather information on change and improvements, and are also a useful training ground for new members.

It is important that this monitoring work fits within CHC strategic objectives and includes clear procedures for feeding recommendations for follow-up action to the appropriate person within the health authority and/or provider unit.

South Cumbria CHC has agreed monitoring objectives in their 1995/96 Annual Plan:

'The CHC will move away from its "rota" visits and visits will be linked to working groups, in order to facilitate tying some visits into the year's special areas for the working groups, to encourage continuity, and the building up a more detailed knowledge base. These visits will be organised much as before but attending members and locations to be visited will be less random.'

Audit and quality monitoring

This includes more formal monitoring in partnership with the purchaser or the provider. The value of this work is that the CHC will have a recognised advisory role and systems should be in place to follow up any recommendations for change coming from the monitoring exercises. The independence of the CHC should ensure that the public has confidence in the quality of the monitoring work.

Airedale CHC's Patient's Charter sub-committee wanted to develop a programme of quality audit to monitor the effectiveness of the Patient's Charter standards at the local trust hospital. Airedale NHS Trust wanted an independent assessment of their own standards and funded training for CHC members to enable them to carry out quality audits of Patient's Charter Standards to BS EN 150 9000 Standards.

These audits are very different from 'normal' visiting reports. The audit reports include a 'Corrective Action and Change Proposal Form' which identifies failures in the service. For example:

ACCESS TO HEALTH SERVICE RECORDS BY PATIENTS OF AIREDALE NHS TRUST HOSPITALS - QUALITY AUDIT REPORT.

Corrective Action and Change Proposal Form

Observation:

Patients' rights to access their medical record details are not included in the '*Information for Patients, Clients and Carers*' Document, nor is there an explanation as to the route by which this may be achieved.

Improvement Plan:

Passed to Chief Nurse who decides on action and agrees a timescale.

Review:

By CHC members, who then sign off the corrective action when it has been carried out to their satisfaction.

Independent surveys

Surveys commissioned and conducted by CHCs are a useful means of researching areas where purchaser or provider service monitoring is weak. CHCs are experienced in conducting surveys using both qualitative and quantitative survey methods. Surveys can be costly, and CHCs may want to explore opportunities for joint work with universities or other research establishments. CHCs also have a valid role in conducting surveys which are funded by, for example, the health authority. The results of surveys can feed into the commissioning process.

Complaints monitoring

Providing advice and representation for patients who wish to make a complaint about the NHS is an important part of CHC work. Although this is not part of the statutory role of CHCs, this area of work often takes up a substantial proportion of staff time, and currently, is probably the most time-consuming single activity for CHC staff. On average, a typical CHC is likely to deal with 120 complaints cases in a year, and will monitor complaints activity using the complaints database developed by ACHCEW and AMS Ltd.

Anonymised complaints information can be used for quality control purposes:

> Salford CHC uses complaints information during their annual review, to identify areas of concern. Alongside other information, the complaints report helps the CHC to identify projects for the coming year, which are written into their annual plan.
>
> Quarterly complaints reports are sent to both purchasers and providers, and Salford CHC is now discussing the standardisation of complaints logging with the provider, the purchaser and social services. They aim to develop common standards and categorisation for complaints handling, which will allow all parties to share information and to identify problem areas, particularly where the complaint crosses organisational boundaries.

Contract Renewal

As contracts are renewed, purchasers will be able to take the opportunity to consolidate good practice and to improve any aspects of service provision or delivery which are unsatisfactory. The credibility of a good service rests in a genuine commitment to building on good practice.

Purchasers are still learning how to use the contracting process to improve quality. A seminar held in 1992 at the Health Services Management Centre in Birmingham, identified key issues about quality, which included:

- many quality standards were included in contracts but there was little point on incorporating these if effective monitoring systems did not exist
- effective contract monitoring would not be possible until deficiencies in information systems were tackled
- that little use of incentives and penalties in contracts had been made.

A follow-up workshop in 1994, which included representatives from CHCs as well as purchasers and providers, sought to look in more depth at these issues, and to identify examples of good practice that purchasers and providers could consider in the next round of contracting. The report of this workshop[18] provides a summary of current trends, and CHCs may find some of these ideas applicable to their local circumstances. Amongst others, these issues were identified:

- That monitoring arrangements still need to be strengthened. Purchasers and providers need to collaborate at an early stage to agree and develop meaningful monitoring arrangements. For example, the development of a key set of core standards across a number of neighbouring purchasing organisations.

A project group in South Yorkshire, the South Yorkshire Quality Network, involving Doncaster, Rotherham, Barnsley and Sheffield health authorities have developed 20-30 core common quality standards in contracts with their providers. The intention is that by limiting the number of core standards, they can be monitored effectively, and purchasers can make meaningful comparisons of providers performance.

- There is still insufficient use made of sanctions and incentives in contracts. Both are tools which purchasers can use to force improvements in provider performance, for example by withholding money for failures to achieve standards (sanctions).

Almost all incentives and sanctions are financial - a fixed percentage or amount agreed within a contract:

National Standard	Service Response - Current Service Level	Contract Agreement	Penalty
Outpatients should be given individual appointment times and should not wait longer than 30 minutes after the appointment time, this should be monitored for consultant and non-consultant clinics.	General Surgery - current performance 64% Renal - current performance 78%	Under-performing specialties are expected to make substantial progress towards a target of 90% by (date)	Any deterioration of performance, penalty of £1,000 per specialty

Incentives can be applied to encourage good performance, such as improvements in the timing and quality of monitoring data.

The NHS Executive national review of contracting in 1994[19], reported that 33 per cent of DHAs used incentive schemes in their contracts, and 52 per cent were enforcing sanctions. The workshop view was that purchasers need to concentrate on incentives or the absence of incentives, rather than sanctions, and that incentives did not need to be confined to bonus payments, but could also take the form of support for a capital project or equipment.

Finally, there is evidence that the contracting cycle is changing, and that purchasers and providers are developing more stable and long term relationships:

- It is important to develop longer term collaborative relationships between purchasers and providers. These more mature relationships could lead to, for example, contracts being renewed on a three yearly rather than an annual cycle, allowing service planning to fit into a longer and more stable time frame

The workshop concluded that quality is likely to become, and remain, central to the contracting process. CHCs may well feel that a lot of work is required to ensure that this is the case.

Conclusion

Government health policy emphasises the importance of making services more responsive to the users of health care:

> *'The move to a contract system and the funding of districts as purchasers from 1991 are above all aimed at improvement in the quality and responsiveness of patient care. The separation of purchasing from provision will require contracts to state in increasingly explicit terms the quality and standard of service which is to be provided'.*[20]

There have, however, been concerns that health authorities and their providers have not yet achieved a quality, patient-centred service.

Community Health Councils, as independent representatives of the community, have an important role to play in the setting and monitoring of quality health care standards. They are well placed to contribute to the improvement of health services, making them more responsive to the needs and preferences of those who use them.

It is difficult for CHCs to juggle increasing demands on their time and resources. Developing a 'quality strategy' allows the CHC to focus activity where this will prove most effective.

Roselyn Wilkinson
December 1995

Annexe

There is a great diversity between the quality documentation produced by purchasers. A quality standards strategy is likely to include the following aims:

- That all service users, their carers or representatives as appropriate, have access to relevant information and that procedures enable them to actively participate in their health care
- That all patients receive individual care which is relevant to them
- That the provider actively engages patients and service users in monitoring services provided and to ensure that complaints are dealt with efficiently, in order to satisfy the complainant and that the provider has a commitment to learning from complaints
- That all service users receive care which respects their privacy, dignity, religious and cultural beliefs
- That all patients receive high quality professional care
- That all service users receive the right service at the right time
- To provide continuity of care between primary, secondary and tertiary services
- That every patient experiences good standard procedures for their discharge from hospital
- To achieve the best health for patients, staff and visitors through health promotion and disease prevention
- That all facilities are accessible and that the health, safety and security of patients, visitors and staff is ensured

(Adapted from *Camden & Islington Health Authority Quality Standards Schedule* 1994/95)

Making these aims relevant, making a difference to the standards of care for patients, requires systems which define, describe and monitor health services.

This annexe contains specific examples of good quality standards, which describe service expectations. It is not possible to produce a comprehensive checklist of quality standards here. Instead, the following are examples of good practice which can be developed by CHCs to fit local circumstances, and can form the basis of monitoring work.

The examples have been grouped into three classifications: Essential, common and specialty-specific quality requirements. These classifications do not necessarily reflect the layout of a contract, but are commonly used to describe groups of standards.

Essential Quality Requirements

These are standards which apply to all services and are based on legislation, national and regional guidance. Statutory and legal requirements cover all relevant legislation such as:
Health and Safety Regulations
NHS and Community Care Act 1990
Children Act 1989 & Education Act 1993
The Mental Health Act 1983

These standards also include those required by the National Charters. All health care contracts will include national and local charter standards, and Patient's Charter monitoring should be well established. However, these standards can be expanded:

You can expect the NHS to respect your privacy, dignity and religious and cultural beliefs at all times and in all places. For example, meals should suit your dietary and religious needs.

Target indicators demonstrating service improvements will be -

- Patients will have access to appropriate faith leaders.
- Quiet rooms will be available for prayer.
- Menus will include a range of non-European diets.
- Staff awareness of ethnic issues will be raised through training.

Essential quality requirements can include standards which are to be a priority for the contract year. For example:

Patient and Consumer Focus: Involvement of, and responsiveness to patients and carers.

Emphasis this year will be on:

- Patients and carers will have access to information about treatment and services regardless of any physical/sensory disability and/or ethnic background.
- 'Think Carer' initiatives will be developed.
- Patient participation groups - especially the Patient Quality Group.
- Linking inpatients to the advocacy service and/or the CHC where thought necessary.

- Ensuring that relatives and carers have access to clinicians in order to discuss diagnosis and prognosis (with the agreement of the patient).
- The named nurse should take responsibility for ascertaining whether patients, relatives and/or carers wish to talk to clinicians, particularly consultants, and should make arrangements where necessary.

(Taken from *Isle of Wight Health Commission Quality Specifications* 1995/96)

Common Quality Requirements (Service Standards)

These apply to groups of specialties and services. They include standard good practice and guidance, and 'soft' standards. Monitoring methods will vary:

Outpatient Services

Monitoring by Provider:

- Patients will be offered an outpatient appointment within the agreed maximum and target waiting times, the degree of urgency being determined by the referring doctor, i.e.
  Urgent - 2 weeks
  Soon - 4 weeks
  Routine - 13 weeks
  These times are to be measured from receipt of the referral by the provider.

- Patients will be seen at initial referral by a consultant, associate specialist or registrar (unless agreed alternative protocols exist locally).

- All patients who have special needs e.g. sensory impairment, must be consulted about having their specific requirement met, e.g. they will be asked if their notes can be marked to ensure all staff take the appropriate action.

Monitoring by GP/Practice Manager:

- Prior to any redefinition of the patient (urgent, soon, routine) the GP will be consulted within 48 hours if urgent and within 1 week for soon and routine.

- All urgent appointments will be issued within 2 working days of receipt of GP referral by the trust.

- A letter will be sent to the referring GP within 7 working days of the consultation for all patients.

- Copies of any test results (Path, X-ray, Imaging) ordered by the hospital clinician **must** be provided to the GP concerned but the primary responsibility for acting on results remains with the consultant, except in the case of open access referrals.

Monitoring by Visits and Spot Checks:

- The trust will undertake to make information about help with travel costs readily available and on display to patients.

- Information will be readily available in the Department about health, social and voluntary services.

Day Surgical Services

Monitoring by Provider:

- The trust will work towards all patients having the opportunity of a pre-admission discussion on their treatment.

- All patients should receive, prior to admission, a comprehensive information booklet.

- All patients will receive information on restrictions on work and life style post-discharge. They will be informed of what to do in the event of feeling unwell.

- All patients will be asked if they feel ready to go home prior to discharge.

- The trust will submit information to the purchaser on the percentage of day case patients who stay overnight.

- The trust will submit information to the purchaser on the re-admission rate following day surgery.

- Arrangements for support after discharge are evaluated before admission and discharge plans are made accordingly.

- All patients in need of pain relief will receive analgesics within 15 minutes of the need for them becoming apparent.

Discharge Arrangements

Monitoring by Provider:

- A clear and explicit discharge policy will be applied which takes into account the Community Care Act and the Care Programme Approach as appropriate. Operational staff must be aware of the policy and the procedure details.

- On discharge, nursing assessments/summaries will accompany those patients who require follow-up nursing care.

Monitoring by GP/ Practice Manager:

- The trust will pay particular attention to ensuring that patients are not sent home with severe constipation.

- The top copy of SPELL summaries are to be sent to the GP practice within one working day of discharge, must be legible, and not contain abbreviations. If information is urgent, it must be faxed.

- The GP practice will be notified within 24 hours of all cases where a patient self-discharges against medical advice

- Patients who need drugs and dressings on discharge will be given supplies as follows:
  Drugs - 14 days, except where differently indicated
  Dressings - 3 days. Dressings should either be available on the drug tariff or the trust should provide a 14 day supply. (Includes other essential supplies such as catheter bags).

(Taken from *Isle of Wight Health Commission Quality Specifications* 1995/96)

Specialty Specific Quality Requirements

These standards are additional to the essential and common service standards and are relevant to a particular specialty of the service.

Standards for Mental Health Services.

These are based on work carried out by Oxfordshire CHC, Oxfordshire Health and Oxfordshire Social Services, and are based on users and carers views. These standards are now included in the service contract of the Oxfordshire Mental Healthcare NHS Trust.

Users and Carers have a right to be involved in decisions about their treatment and care programmes.

- Users and carers should know who is responsible for co-ordinating their care and treatment programmes and have regular contact with that individual.
- Information about a wide range of matters should be freely and readily available in a variety of forms and at appropriate times to enable informed decisions to be made.
- Users' and carers' needs may differ and this should be taken into account in the making of treatment and care programmes.

Users - People as Partners

- The user has a right to have their own insight into their illness acknowledged.
- The user has the right to be an equal partner in their assessment and to be offered the full range and choice of possible care and treatments including personal hygiene and general physical health, at the appropriate time.
- The user will have any procedures explained to them in a hospital setting by a named nurse, and in a community setting by a member of the community team.
- In particular circumstances, all efforts will be made to accommodate the user's preference with regard to the sex of the doctor or worker.
- There should be the opportunity for the user to meet the consultant/senior registrar at least once during the period of treatment or stay in the hospital.
- Users should be given the names of the consultant, junior doctor, named nurse, key worker and all other relevant staff, and information on how/when to contact them.

- The user's hospital-community link should be a named known person with whom regular contact is held.

- Hospital and community staff should hold up-to-date information on community facilities; this information should be discussed with the user and be available in written form on discharge.

- Users should be made aware of advocacy services and encouraged to use them when appropriate.

- There should be a clear, straightforward and well-publicised procedure for being able to see medical and social care notes.

- There should be a clear, straightforward and well-publicised procedure for making comments and or complaints. All comments and complaints should receive a prompt response.

Carers - People as Partners

- The role of carers as providers of care should be acknowledged. They should be offered help and support in their role.

- The carer will have any procedures explained to them in a hospital setting by a named nurse, and in a community setting by a member of the community team.

- New doctors and other members of staff should introduce themselves to carers.

- There should be an opportunity for the carer to meet the consultant/senior registrar at least once during the period of treatment or stay in hospital.

- Carers should be given the names of the consultant, junior doctor, named nurse,, key worker and all other relevant staff, and information on how/when to contact them.

- The carer/closest relative should be informed of the planned date of discharge or transfer to another facility, or will be notified of discharge if the user discharges themselves prior to this date.

- Hospital and community staff should hold up-to-date information on community health facilities; this information should be discussed with the carer and be available in a written form on discharge.

- If needed, the carer should be offered appropriate support and/or treatment.

- Carers should be made aware of advocacy services and encouraged to access them when appropriate.

- For parents of children under the age of 16 there should be a clear, straightforward and well-publicised procedure for making comments and or complaints. All comments should receive a prompt response.

Care and Treatment

- Jargon-free information on drugs should be provided before they are prescribed.
- Care plans should be followed through, monitored and updated. They should be checked in a regular review. The date of the next review should be agreed as part of the review process.
- Provision should be made to cover gaps caused by holiday/sick leave so there is a responsible person available over 24 hours.
- Plans for discharge should be initiated on admission and will include appointments in the community to be set up in advance.
- Discharge and transfer plans should be discussed with the carer/closest relative as well as the user.
- Timescales and action plans should be written into discharge plans, including the first review date.
- All plans for care and treatment should acknowledge the user's right to privacy and personal safety.

Groups and Activities

- Mental health staff should be able to demonstrate active links with, and show how they make use of, wider community services - statutory, voluntary and recreational.
- Notice boards should hold up-to-date posters advertising user and carer support groups and services, which mental health staff should support and publicise.
- Groups in assertiveness training, problem-solving, anger-management and self-help groups should be publicised and numbers monitored.
- Advocacy services should be encouraged and publicised.
- Befriending schemes to support people in activities should be publicised.
- Assertiveness training should be incorporated into care planning where appropriate.
- Occupational therapists should be widely available to work with people in hospital and at home.

Staff Quality and Ability to Deliver Services

- Skilled workers (i.e. CPNs, mental health care managers/social workers) should be dedicated to the "hard end" of mental illness in the community.
- Response to callers should be prompt and clear in its direction.
- All professionals working in mental health should receive training in treating users and carers as partners, and in communication skills.
- Staff should be appropriately trained and informed to take gender, cultural and religious differences into account.
- There should be a handover period if the key worker or named person changes.

The trust will itemise those standards which can be checked and report on these to the authority.

The 'soft' standards will be shared with staff at workshops which will be held at various times of the year.

The trust has agreed to consider ways of involving users and carers in the process.

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