HEALTH NEWS Briefing

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COMMUNITY HEALTH COUNCILS

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CONTRACTS FOR HEALTH CARE

MAKING THEM WORK FOR PATIENTS

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CONTRACTS FOR HEALTH CARE: MAKING THEM WORK FOR PATIENTS

C O N T E N T S

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S U M M A R Y

* CONTRACTS ARE TO BE THE MAIN VEHICLE FOR IMPLEMENTING THE REFORMS OUTLINED IN THE WHITE PAPER "WORKING FOR PATIENTS"

* ALL HEALTH AUTHORITIES WILL BE OPERATING CONTRACTS AFTER APRIL 1991

* COMMUNITY HEALTH COUNCILS HAVE A LEGITIMATE ROLE IN THE CONTRACTUAL PROCESS, REPRESENTING THE INTERESTS OF USERS OF THE HEALTH SERVICE AND ENSURING THAT QUALITY IS NOT NEGLECTED

* THE NEW ROLE OF DISTRICT HEALTH AUTHORITIES AS PURCHASERS OF HEALTH CARE CAN BE DIVIDED INTO SIX KEY ELEMENTS:

ASSESSING THE HEALTH NEEDS OF POPULATION
APPRAISING SERVICE OPTIONS
CHOOSING PATTERN OF DELIVERY
PLACING CONTRACTS
MONITORING CONTRACTS
RENEWING CONTRACTS

* CHCs WILL NEED TO BE INVOLVED AT EVERY STAGE OF THE CONTRACTUAL PROCESS

* PURCHASERS MUST BE CLEAR ABOUT THEIR QUALITY REQUIREMENTS, BEFORE CONTRACTS ARE NEGOTIATED

* THE SETTING OF QUALITY STANDARDS MUST BE A MULTIDISCIPLINARY EFFORT AND MUST INCLUDE A USER INPUT

* IN ORDER TO CONTRIBUTE TO THE CONTRACTUAL PROCESS, CHCs SHOULD FORMALISE CHECKLISTS OF QUALITY INDICATORS

* ACHCEW HAS BEGUN THIS PROCESS AND HAS PRODUCED 3 TYPES OF CHECKLIST FOR CHCs AND DHAs TO ADAPT TO LOCAL CIRCUMSTANCES:

STAGE 1 SETTING CONTRACTS: QUESTIONS & ISSUES WHICH USERS WOULD WISH TO SEE PURCHASERS ADDRESS BEFORE PLACING CONTRACTS: **CONSUMER QUALITY CHECKLISTS**

STAGE 2 MONITORING CONTRACTS: STANDARDS AGAINST WHICH SERVICES CAN BE EVALUATED: **CONSUMER STANDARDS IN CONTRACTS**

STAGE 3 EMPOWERING USERS: INFORMATION TO BE MADE AVAILABLE TO USERS TO ENABLE THEM TO BE MORE DEMANDING OF HEALTH SERVICES: **EMPOWERING SERVICE USERS**

* THESE GENERAL CHECKLISTS PROVIDE AN OUTLINE FOR CHCs AND DHAs TO ADAPT TO LOCAL CIRCUMSTANCES AND DIFFERENT SPECIALTIES. ACHCEW HAS ALREADY MODIFIED THE CHECKLISTS FOR MATERNITY SERVICES.

CONTRACTS FOR HEALTH CARE: MAKING THEM WORK FOR PATIENTS

INTRODUCTION

> **"A consistent and coherent framework of health and quality outcome objectives is needed to guide purchasing...consumers' needs must be considered at the beginning of the service process not the end."** [1]

The proposals for radical change in the organisation and management of health services contained in the 1989 White Paper "Working For Patients"[2] and the subsequent working papers[3] became law when the NHS and Community Care Act received Royal Assent in July 1990.

The declared intention of the reforms is to make the National Health Service more responsive to its users by promoting a more business like ethos, comparable to that in private service industries. Health managers are to adopt a more business-like approach, concentrating on increased efficiency, income generation, quality and consumer responsiveness.

The key mechanism for effecting this change is the introduction of an internal market within which different agencies will purchase and provide health care for the needs of defined populations. (This accompanies new funding arrangements, so that by 1992/93 all health districts will receive their main allocation on the basis of their population, weighted for age and morbidity.) Agreements between purchasers and providers on quantity, quality and cost will be articulated through contracts. These changes will affect **all** health districts from January 1991 and will be fully functional by 1994.

The Government's stated view is that consumers/patients/users are to be at the heart of the reformed NHS. It is therefore clear that the success of the internal market should be judged by the satisfaction of users. A pluralistic approach to service provision could mean services better able to meet the needs of users, but this is only likely if two key principles guide the reforms. The first is that users' views must be fully taken into account in the planning of new services, the second is that quality must be held to be as important as finance.

CHCs have already made known their concerns about the White Paper reforms[4]. This has been on the basis that they will lead to a fragmented health service which fails to meet the needs of users. Particular concern has been expressed at the hurried time scale for implementation, the absence of any pilot projects to test new ideas, the lack of consultation and the failure to address the issue of resources for the NHS. The intention of this paper is not to rehearse those arguments again, but rather to begin looking at how the reforms will work in practice and how the contractual process could be designed to reflect the interests of health service users in the planning and delivery of health care.

PART 1: THE INTERNAL MARKET WHAT WILL IT MEAN FOR PATIENTS?

"Contracting in all its many facets is the common focus and key element that links the many different strands embodied in the White Paper"[5]

The Purchasing Role From 1991 health authorities will switch emphasis from managing **institutions** to purchasing for **populations.** (The management of those hospitals and community health services which have not 'opted out' will be devolved to unit level, see The Provider Role below). The function of health authorities will be, therefore, to identify the total health needs of their resident population, to plan how best to meet those needs and to secure the best and most effective services within available resources. Purchasers will, therefore, have to be able to specify the nature and level of services they wish to buy, together with an indication of the quality issues they would expect any provider to address. They will then have responsibility for monitoring the level, cost, quality, appropriateness etc of those services they have purchased. Some GPs will also elect to take on a purchasing role and will be given a clinical budget from which to purchase a defined range of diagnostic procedures and treatments.

The Provider Role Health authorities will be able to purchase services from a range of different providers: hospitals and community health units within their own district and from other districts, self-governing trust hospitals and private hospitals. Provider units will have to detail the range and quality of services they are prepared to offer to meet purchasers requirements. It is the Government's intention that under a system where money follows patient, 'popular' units with reputations for efficiency and high quality will be able to attract funding from a range of health authorities and so expand and develop their services. Health authorities will devolve responsibility for the running of those hospitals and community health services which are not self-governing to the unit level. These Directly Managed Units will have increasing freedom to manage the organisation and delivery of their services.

Contracts The provision of health services will become the subject of negotiation between purchasers and providers, on the basis of quantity, quality and cost. The result of this negotiation will be the contract itself. In essence, therefore, the internal market is about providers competing with one another for the contracts to be placed by purchasers. Purchasers will have to be able to compare providers in terms of efficiency, effectiveness, quality and cost if competition is to fulfill its role in raising standards and promoting consumer responsive services. Contracts will be the documents in which these elements will be specified, they will therefore be the means by which standards are articulated.

Guidance from the Department of Health[6] emphasises that establishing contracts should not be approached in a legalistic or adversarial exercise, that professional staff should be involved in assessing existing service delivery and setting standards and that the degree and level of change in service delivery can only be determined at a local level. The guidance also details three types of contract, to reflect different levels of available information, competition and administrative capability.

The CHC Role Supporters of the reforms claim they will champion "consumer rights", whilst critics, including CHCs have argued that the reforms do nothing to make health services more "user responsive". This contradiction is based on a difference in perception of what "consumerism" is all about. The government's own perception of well informed, articulate but disorganised, supermarket-style consumers is reflected in the role envisaged for users in the new style NHS. "Working for Patients" may represent a shift of power from professional groups to managers, but this does not necessarily imply any additional powers for users. Indeed the role that CHCs as users' representatives can play in planning and designing services has not been addressed by the Department of Health. It is the aim of this paper to fill that gap.

User representation in the health service takes place through Community Health Councils, which already have a number of statutory rights relating to consultation and access to information regarding health service planning and development. Clearly this relationship has now to be redefined so that CHCs' crucial independent monitoring role explicitly covers the part that DHAs play in the contractual process. Health authorities as purchasers will have responsibility for ensuring continuing health care for their population; it should therefore also fall to health authorities to ensure that the services they purchase are of the highest quality and meet users' expectations and needs. To do this HAs will need to familiarise themselves with users' views of existing and planned services. CHCs are the most obvious source of this information: "members are often well informed about what is actually going on in the service and are usually extremely well informed about what it feels like to be a user. This they ensure by their closer links with networks of service users' groups and local voluntary sector."[7] CHCs should, therefore, have a role at each stage in the contractual process.

Whilst CHCs have not been given any specific rights to involvement in the contractual process, neither have they been specifically excluded. CHCs as the representatives of local people have a legitimate role in the contractual process and will be able to offer management a great deal of experience and expertise. It is now for CHCs to demonstrate their credibility through the standard of their own work and their links with the local population. A number of CHCs are already sitting on DHA purchasing groups and are being asked to contribute to discussions on the quality issues to be addressed in service specifications.

The key role for CHCs will be in ensuring that issues of quality are not neglected as managers concentrate on cost and volume. In a recent simulation exercise to test the workings of the internal market, purchasers actually encouraged providers to **lower** quality in order to meet contracted caseloads and stay within budgets.[8] It is clear that a quality service can not be assumed to derive automatically from competition, (a point argued strongly by CHCs throughout the introduction of the White Paper). Indeed, explicit quality outcomes will have to be specified by purchasers and these quality standards will have to reflect users' own preferences, if contracting is to bring any benefits to users.

The danger for health authorities which do not involve users and their representatives in their new functions has already been recognised by one RHA:

> **"Distanced from local councillors they will be cast as remote, unrepresentative, bureaucratic bodies, interested more in finding the cheapest solution and doing the Government's bidding, than in meeting local people's health needs. DHAs must take active steps to ensure this does not happen. The new DHA must be able to present an image of a credible and responsible buyer of health services."**[9]

Purchasers: The New Role of District Health Authorities

This paper concentrates on the role District Health Authorities as purchasers of health care, will play in the Internal Market and the implications for CHCs. This is because not only is the role of DHAs central to the principle of contract funding, but also the performance of the new DHAs will be used by many to judge the success of the reforms in providing a high quality more consumer responsive service. In addition, DHAs as purchasers will have to show themselves accountable to health service users for the decisions they make on users' behalf.

For the purposes of this paper, the new role of DHAs as purchasers has been divided into six key elements, see Figure 1. The purpose of the following section is to make a case for active user involvement at each stage.

Figure 1

ASSESSING HEALTH NEEDS OF POPULATION
APPRAISING SERVICE OPTIONS
CHOOSING PATTERN OF DELIVERY
PLACING CONTRACTS
MONITORING CONTRACTS
RENEWING CONTRACTS

1. ASSESSMENT OF THE HEALTH NEEDS OF THE LOCAL POPULATION

"Working for Patients" could offer the potential of making a radical shift in the way that health services are planned. Instead of the ad hoc, finance-driven planning mechanisms which have dominated the 1980s and have led to conflicting and confusing priorities and unmet need; there is the possibility that future health service planning could be based on a rational public health strategy.

Until now health service delivery has not been as the result of long-term strategic planning. Despite being a signatory to the World Health Organisation's "Health For All by the Year 2000" and the publications of reports such as the "Black Report"[10], "The Health Divide"[11] and "The Nations' Health"[12], the UK has not adopted known targets for health promotion and translated these into policy. "Successive governments have supported the idea of promotion of health and the prevention of disease, but the emphasis has so far been on the more individualistic 'high risk' approach, rather than the 'population' approach." [13]

At the beginning of the contractual process, health authorities will need to assess the health status and health needs of the local population, including a more positive emphasis on the views of that population. This will, of course, need to be an on-going process, reflecting changes in health status and need over time. Health authorities will be able for the first time, to draw up locally based priorities and direct resources to meeting areas of need. The opportunity is there, for health authorities inclined so to do, to move away from existing, perhaps inappropriate patterns of service delivery, to ones which more appropriately meet the needs of the local community.

The 1988 Acheson Report into the future development of the public health function introduced Directors of Public Health, accountable to DGMs. It is these Directors of Public Health who will have the responsibility for providing epidemiological advice on the setting of priorities, planning services and evaluating outcomes. They will need to draw on a wide range of sources: factual information, research hypotheses, health economics, census data, health indices, prevalence of disability, current service usage etc and translate these into interpretations of unique local circumstances. Users' views will, obviously be as important as professionals: **"In doing so the DHA will clearly need to have regard to the perspective offered by the Community Health Council."**[14]

However, planning officers have already recognised that the readily available information does not coincide with health need. Current information is based almost wholly on mortality statistics and health activity statistics based around acute care.

Mortality figures may indicate what people are currently dying of, but not necessarily what they may have suffered from in previous years, causing distress and limiting functions.

Conditions such as mental illness and arthritis are not identifiable from mortality statistics. Output statistics indicating the activity level of health services, such as in-patient days, out-patient visits etc, are determined essentially by what is actually being provided. If a service is available, it is likely to be used. However, where services are not available, unmet needs will be hidden.

Community Health Councils have 15 years experience of highlighting the needs of vulnerable and sometimes hidden, NHS users, such as people with mental health problems or learning difficulties, elderly and disabled people and people from minority ethnic communities. They will therefore be able to make a valuable input to the work done by Directors of Public Health by:

* contributing to the assessment of unmet needs
* contributing an assessment of users' views of existing services in terms of range, level and quality
* reminding health authorities that assessment of health needs is far more than just the reports of Directors of Public Health
* asserting the significance of diversity in the local population, such as race culture etc.

2. APPRAISING SERVICE OPTIONS

After identifying the total health needs of its resident population, health authorities will begin the task of planning how these should be met. This will involve a process of describing each of the services required and their volume and identifying those service and those client groups for whom services need to be provided on a local basis.

In describing the range of services required, DHAs will have to devise a specification for each service covering the aims and objectives of the service, the populations to be served, the requirements of the service, its volume and the type of contract to be used. This will also be DHAs opportunity to specify the quality issues it would expect to be reflected in service delivery. These service specifications should, therefore, contribute to the way in which the contractual process provides a focus for raising standards. However, this is unlikely to happen if DHAs do not first identify what users expect from the delivery of services and take their views on the type and quality of services provided into account.

It would appear that the DoH expects providers rather than purchasers to take the lead in actually setting quality standards. From the user perspective this is totally the wrong emphasis. Health authorities with the responsibility for meeting the health needs of their population are met by the best and most effective services must also be responsible for setting the standards of the service.

Recent guidance from the DoH[15] reverses earlier guidance on the definition and importance of so-called "core services", that is those that should be provided on a local basis. "Core" or "designated" services will only apply in the context of Self-Governing Trusts. Therefore, DHAs will be under no obligation to provide any services on a local basis; decisions on the provision of services will be a matter for each DHA to determine.

Decisions to provide some or all of a service outside of the District should be capable of justification, based on the benefits that would accrue to the users of services set against any problems caused by the loss of geographical accessibility. In its 1989 paper "Core Services"[16], ACHCEW identified four groups of services:

(i) those whose effectiveness would suffer from any loss of accessibility
(ii) those whose effectiveness would not suffer but for which there would be no benefit to patients in an out-of-district service
(iii) those for which a loss of geographical accessibility could be traded off against other benefits
(iv) those whose effectiveness would suffer by attempting to provide local accessibility.

As it is users who will be affected by decisions on acceptable travelling arrangements, they too should be involved in discussions on the options for service provision. Similarly, as purchasers' decisions on volume will impact onto waiting times, users should contribute to the process of defining strategic options.

* CHCs should be involved in discussions about priorities in service planning
* CHCs should be consulted by DHAs on their service specification
* CHCs must remain vigorous in their insistence that quality indicators should be consumer-orientated. They should be fully involved in local attempts to define quality standards.
* CHCs will be able to make a contribution to the process of defining those services where local access is the priority factor.

3. CHOOSING PATTERN OF DELIVERY

The next stage for DHAs will be deciding on the placing and type of contract to be used to secure services.

As far as placing contracts are concerned, DHAs will have already distinguished those services where choice of provider will result in benefits to patients; that is, those services where local access is not a priority. At this point DHAs will begin to make a trade-off between cost, volume and quality; for example, longer travelling time but shorter waiting lists etc. It is the

Government's belief that this choice and the resulting competition between providers will improve quality and efficiency and lead to a more consumer-responsive service.

However, in many cases, as the DoH has admitted[17], there will be no real competition. In many areas outside the major conurbations there will be no choice for purchasers. Providers will be able to exert considerable monopoly and oligopoly power: restricting supply, driving up prices and inflating costs. Until information about quality and price is significantly improved; for example when the Resource Management Initiative is perfected, purchasers may find themselves in a weak position to make meaningful price and quality comparisons. In these cases it is even more important that DHAs should have prepared their own (consumer-orientated) service specifications rather than allowing monopoly providers to dictate terms.

Where competition does exist, DHAs will need to develop an understanding of their relationship and interdependence with Directly Managed Units, Self-Governing Trusts and other providers. DHAs have already been advised to discuss the placing of contracts with local GPs to take account of preferred referral patterns. This is <u>not</u> enough to ensure that users' views are represented and this process must be widened out to include users and their representatives. If a trade-off is to be made between cost, volume and quality, users must be included in this process.

The Department has already issued guidance on the types of contract HAs may want to use:
Block Contracts will cover a defined range of services at an all-in-price. For example: the provision of maternity care.
Cost & Volume Contracts will cover an agreed volume of a given service, agreed on the basis of an average price per case. For example: X hip operations.
Cost Per Case Contracts will cover individual referrals for individual patients.

Cost per case contracts are unlikely to be widely used, as to do so would interfere with DHA's planned expenditure and priorities. However, it is only in the use of these individual contracts that patients, as opposed to their proxies (GPs or DHAs), can have any real choice in where they are treated.

* CHCs should be consulted on planned patterns for referral and contract placement to ensure that a user perspective is included in discussions on cost, volume and quality issues.
* CHCs will want to comment on the level of uncommitted funding set aside for cost per case treatments

4. PLACING CONTRACTS

The determination of the standards to be included in each contract is to be the subject of negotiation between purchasers and providers, based on the purchaser's specification and the provider's response. Guidance from the Department of Health gives providers the primary responsibility for detailing the manner in which services are to be provided and quality addressed. This will in effect mean that it will be providers which define the quality standards to be included in contracts. The DoH will expect purchasers to decide between providers not just on the basis of cost but also on the basis of the quality being offered.

However, in many areas providers will be operating in a virtual monopoly position and purchasers will have no real choice. If patients' interests are to be protected service specifications must be as detailed as possible; placing the onus on providers rather than purchasers to specify standards is likely to result in patients' interests being marginalised at the expense of consultants. Consultants working in Directly Managed Units and Self-Governing Trusts will be in a powerful position in relation to determining the manner in which services are provided. The evidence of CHCs over many years is that the health service is often organised for the convenience of those working in it rather than those who use it. A powerful counterbalance will be needed to ensure that the placing of contracts truly reflects users' needs and preferences, if the Government's intentions concerning 'choice' are to be a reality.

Once contracts are agreed, it will be extremely difficult to resolve concerns about the quality of service unless the provider actually breaches a contract term. It is therefore important that the standards set are widely accepted by Community Health Councils and other organisations representing service users. Similarly, it is essential that there is proper consultation about the standards to be specified in NHS contracts.

The drawing up of standards has to be a multi-disciplinary effort and must include a user input, for users' expectations of what constitutes a good service are likely to differ widely from clinicians, nurses or management view. There is a need to introduce a social dimension to the contractual process, to, protect, empower and represent users' views. Charters and checklists aimed at service users can be a good way of giving information and raising expectations.

CHCs working with other users' groups have 15 years experience of contributing to the service planning process, a users' perspective of what constitutes a good quality service. CHCs' surveys of the quality of service being provided in local hospitals, clinics and community health units provide an independent assessment of how these services meet the needs of users. To date, little has been done to develop formal consumer standards and CHCs have used very general criteria to define a user-led quality service, such as

- access: does the community know about the service, can users reach the service?
- adequacy: does the quantity of service meet demand?
- appropriateness: does the service meet the needs and circumstances of users?
- acceptability: are users as "consumers" satisfied with he service?

Although there is a certain amount of agreement on abstract criteria of "quality", such as those outlined above, the challenge for CHCs and health authorities committed to providing a quality service will now be to make these concrete in relation to specific areas of service provision.

CHCs will need to be well informed and well prepared if they are to make a positive contribution to the contract placing process. Part Two of this paper begins the process of defining a tool for CHCs to use in raising quality issues in contracts. Not only is it important for CHCs to be well informed, users themselves need support in articulating their own preferences and needs. CHCs have an important role to play in empowering users of services to monitor service provision and demand improvements.

* CHCs should be involved in discussions on the range of quality issues that purchasers will want addressed
* CHCs should contribute consumer-orientated criteria, checklists or standards for inclusion in contracts
* CHCs should be consulted on the quality standards defined in contracts.

5. MONITORING CONTRACTS

Once contracts are in place, purchasers will monitor how well the standards required are being met. Initiatives to monitor quality of service will have to be independently monitored. A management led monitoring methodology is likely to omit the key issues as far as the service users are concerned. An independent input into monitoring the quality of contracts would ensure not only that the right questions are asked, but also that solutions make as much sense to users as they do to managers and clinicians.

CHCs have a key role to play in this process. CHC members are often extremely well informed about what is actually going on in the service. The strength of CHCs lies in their diversity, their comprehensive local knowledge, their links with the local community via voluntary and other groups and their statutory rights in relation to management. Their independence from the health authority structure means that they can provide external validation, based on a knowledge and understanding of the concerns of users, and this has to be the essential underpinning of any good quality management.

Users themselves also have a vital role to play in monitoring services. Voluntary organisations, CHCs and indeed purchasers should all have a responsibility to provide users with

information on the range, nature and quality of services available. Users may need checklists of their own and advice on how to complain if services do not meet their expectations.

* Contracts should specify that CHCs shall have a right to relevant information
* Contracts should specify that CHCs should have a right to visit all facilities to which patients from their district have been sent under a contract placed by their DHA
* CHCs should be consulted on any organisational changes proposed by agencies supplying services under contract to their DHA

6. RENEWING CONTRACTS

As contracts expire, purchasers will be able to take the opportunity to consolidate good practices and improve any aspects of service provision or delivery found to be unsatisfactory. The credibility of a quality service rests in a genuine commitment to making improvements. In the past health authorities have experienced difficulty in acting upon the findings of patient satisfaction surveys. As independent bodies, CHCs, are often able to emphasise those issues which management may be reticent to pursue. Renewing contracts provides excellent occassion for acting on the views of users

* CHCs should be formally consulted when contracts are renegotiated, rolled-forward or renewed.

PART 2: CONSUMER STANDARDS FOR CONTRACTS

INTRODUCTION

In order to make a positive contribution to the standard setting process, it will be helpful for CHCs to formalise checklists of the quality indicators they would wish to see in contracts.

Some work in this area has already been completed. ACHCEW's "Patients' Charter" outlines basic principles which users' representatives consider underpin the provision of a quality service. The Charter has been adopted and adapted by many health authorities working with their CHC as a public commitment to good practice. ACHCEW is currently working with the Royal College of Nursing to develop the Charter into a series of checklists for managers, nurses and patients, to use in assessing service provision.

The National Association for the Welfare of Children in Hospital has developed a comprehensive set of quality indicators for the care of children in hospital. Starting with a a ten point charter, NAWCH later developed a Quality Checklist to give health authorities, CHCs and parents a tool to assess the quality of hospital services. In 1989 NAWCH published it's "Quality Review" which aims to aid the development of basic standards with which to monitor services by providing DHAs with a tool to draw up a profile of existing services for children. Specific quality checklists have now been developed to cover a range of services.

Developing a range of consumer standards across specific areas of service provision will be an exacting task. Based on discussions with CHCs and users' groups, ACHCEW has attempted to begin designing quality checklists which could be used by purchasers, CHCs and other users' groups and indeed users themselves, to articulate demands for high quality responsive services. Based on the existing consumer criteria of ACCESS, INFORMATION, CHOICE, SAFETY and REDRESS the checklists have been designed in three stages:
STAGE 1: Setting Contracts: Questions and issues which users would wish to see purchasers address before placing contracts.
STAGE 2: Monitoring Contracts: Standards against which services can be evaluated.
STAGE 3: Empowering Users: Information to be made available to users to enable them to be more demanding of health services.

Two sets of checklists have been devised, the first raise general issues which could be applied to contracts for all services, the second build on this general base and apply them to the provision of maternity services. The checklists do not claim to be comprehensive, nor do they address the issue of how standards are to be reached - that is the prerogative of providers. Rather they are an outline on which CHCs, users' groups and purchasers can build and adapt to meet local circumstances. The aim being to ensure that the contractual process does produce more responsive health services.

PLACING CONTRACTS FOR HEALTH SERVICES

STAGE 1: CONSUMER QUALITY CHECKLISTS

Before placing contracts, purchasers will need to assure themselves that prospective providers are able to deliver high quality services which meet the needs of service users. The CONSUMER QUALITY CHECKLISTS offer consumer-led criteria of quality and indicate those areas on which purchasers will need to seek assurances from providers. District Health Authorities will need to work with their local CHCs to adapt these checklists to local circumstances.

STAGE 2: CONSUMER STANDARDS IN CONTRACTS

Unless contracts are to be long detailed documents, issues of quality will have to be specified in general terms, based on agreements made during Stage 1 between purchasers and providers. Contracts could contain statements of principle, or CONSUMER STANDARDS against which DHAs and CHCs will be able to monitor patient satisfaction.

STAGE 3: EMPOWERING SERVICE USERS

Users of health services require information on the basis of which they can make choices about their treatment and care. They need information about the range of services available and the type of care they should reasonably expect. Patients' Charters and other checklists aimed at users held to empower service users to be more demanding of and get the best from the health service.

ACHCEW is currently working with the Royal College of Nursing to update its own charter, which has been adopted by many health authorities. Until this is completed, it is worth restating both the aim of the 1986 Charter and the points of 'good practice' contained therein. DHAS will need to work with CHCs to provide information at a local level to empower service users.

CONSUMER CHECKLIST: **ACCESS** TO HEALTH SERVICES

ORGANISATIONAL ACCESS TO SERVICES:

Is there a waiting list for access to the service?

* how does it compare to national norms
* how does it compare to DoH guidance
* how is need determined

Is the service itself running efficiently?

* what are waiting times within clinics
* is a block booking procedure used
* are reception arrangements easy to follow
* how is time allocated for each patient
* how are patients called for consultation/ examination within clinics etc
* how are patients informed of delay/ cancellation of their appointment/examination/ admission

Is the service able to meet special needs?

* are interpreting services provided
* is there a self-advocacy scheme
* is there a citizen-advocacy scheme

Does the service promote awareness and sensitivity to special needs?

* staff training on serving cultural differences
* equal opportunities training
* meeting needs of children
* NAWCH Charter and Checklist

Is the environment in which the service is provided, conducive to making users relaxed and comfortable?

* privacy of consultation
* adequate seating
* availability of refreshments
* availability of reading material
* adequate heating and ventilation
* health promotion materials
* adequate toilets (well signposted)

PHYSICAL ACCESS TO SERVICES:

How easy is it to get to the service in terms of?

- distance from local centres of population
  * acceptable travelling time
- service of public transport
  * acceptable travel costs
- meeting the needs of vulnerable groups

  * provision of hospital transport
- facilities for private transport
  * adequate car parking
- arrangements for relatives/carers to stay near by

How accessible is the unit in terms of?

- sign posting
  * appropriate languages/symbols
  * suitable positioning
- meeting special needs
  * disabled access
  * adaptations for elderly people
  * facilities for parents with children
- social areas for patients and visitors

CONSUMER CHECKLIST: **INFORMATION** IN HEALTH SERVICES

Is information made available in clear, unambiguous and appropriate languages relating to diagnosis and possible treatment options?

Is pre-admission information available in clear, unambiguous and appropriate languages?

* explanation of referral date and any waiting list
* adequate notice of admission date
* leaflets explaining the service
  - plan of the hospital/clinic
  - details of transport routes
  - eligibility of non-emergency ambulance service
  - claiming hospital travel costs
* verbal explanations from staff
* self-health promotional information
* role and location of CHCs and other support groups
* appropriate clinical conditions
* Patients' Charter
* Patients' Rights
  - provisions of Mental Health Act 1983
* opportunity to visit unit

Is information provided during treatment/care in clear, unambiguous and appropriate languages?

* consent to examination and treatment
* explanation of consultation
* time to ask questions of doctors
* ease of seeking advice and help from nurses
* information for carers/ relatives
* inpatient/outpatient handbooks
* professionals easily identifiable (name tags)
* access to medical records

Are counselling services, in appropriate languages, available for support of patients in distress or discomfort?

* pre/post screening counselling eg antenatal
  cervical
  breast
  HIV
  diabetes
* pre/post abortion, miscarriage and stillbirth counselling
* bereavement
* victims of violence
* terminal/chronic illnesses
* traumatic injury

Is information, in clear unambiguous and appropriate languages, available covering discharge arrangements and procedures?

* discharge leaflet for patients appropriate to different patient groups
* discharge leaflet for carers/relatives
* continuing care arrangements, including notification of GP prior to discharge

Is public information made available on the operational policy and impending developments at the unit?

CONSUMER CHECKLIST: CHOICE IN HEALTH SERVICES

In planning care/treatment can individuals exercise choice?

* Choice of admission dates
* Evening clinics
* Local service provision
* choice of female consultant
* Opportunities for discussion of diagnosis and treatment options

In the delivery of care/treatment can individuals exercise choice?

* continuity of care
* Support for refusal of treatment
* Discussion of results of investigations etc
* Promotion of informed consent
  - research trials
  - treatment by students
* Information and support of the right to a second opinion
* Support of a relative or friend at all times
  - visiting times
  - restrictions on numbers visiting
  - restrictions on children visiting
  - adequate accommodation for parents wishing to stay with children in hospital
* Privacy
  - bed spaces and numbers
  - privacy of examination
  - privacy of visiting
  - sufficient changing accommodation
  - appropriate dressing gowns etc
* Respect for dignity, personal needs, religious and philosophical beliefs
  - sensitivity to how patients wish to be addressed
* Personalised clothing
* Hospital food
  - patients with special dietary needs
* Ward routine
  - access to relevant social facilities eg telephones
    refreshments
    post
    newspapers
* Participation
  - birth plans
  - parental involvement in care of children
* Dealing with death in hospital
  - facilities for privacy for dying patient and their family/carers/friends
  - staff training in different cultural attitudes and traditions surrounding death
  - access to spiritual advisors

CONSUMER CHECKLIST: **SAFETY** IN HEALTH SERVICES

Is there evidence of the provision of formal quality assurance systems covering:

* medical audit
  - monitoring of peri-operative mortality
  - monitoring of peri-natal mortality
* infection control procedures
* Health & Safety at Work Act
* Fire Precautions, exits and equipment
* Environmental Health Regulations
* Cleaning services
* maintenance of medical equipment
* staffing levels
* co-operation in epidemiological work
* District Ethic Committees

Other good practice

CONSUMER CHECKLIST: **REDRESS** IN HEALTH SERVICES

Information on complaints procedures:

* leaflets
* posters
* suggestion boxes
* users' forums

Recording complaints:

* designated Complaints Officer
* recording of complaints resolved at ward/clinic level
* assessment of substantial complaints
* record of outcomes of complaints
* reports of action taken
* provision for further investigation by contracting authority if complainant is not satisfied

Testing public opinion:

* patient satisfaction surveys
* users' groups and discussion forums

Public representation:

* CHC visits: impromptu
  report back to purchaser
* CHC surveys
* lay membership of committees: Maternity Services
  Liaison Committees
  Ethics Committees
* CHCs should have access to all appropriate information
* CHCs should have observer status on all board meetings

CONSUMER STANDARDS FOR INCLUSION IN CONTRACTS FOR HEALTH SERVICES

ACCESS:

1. The diversity of culture, language social and economic circumstances of residents will be recognised and appropriate provision will be made for special groups.

2. The total time elapsing between in-patient admission and placing on the waiting list shall not exceed 12 months for non-emergency treatment.

3. The first out-patient appointment for a non-urgent criteria shall be no later than 9 weeks for any specialty.

4. Urgent conditions shall be seen within two weeks.

5. Out-patient and other clinics will be held at times and places convenient to patients.

6. A booked appointment time should operate in all out-patient clinics. Patients will be able to change their appointment if necessary.

7. No patients should wait more than 30 minutes for an appointment without an explanation from a senior clinician.

INFORMATION:

8. Proposed admissions will be explained clearly to patients and the GP will be notified promptly.

9. Information in clear unambiguous and appropriate languages will be offered to all patients, this to include:

* pre-admission information
* information on the nature of illness and course of diagnosis, treatment and care
* pre-discharge information

CHOICE :

10. All services will be sensitive to the needs of users and their families/carers and will demonstrate respect and compassion. The particular needs and wishes of each patient will be met wherever possible and made known to all staff.

11. The dignity, privacy and individual choice of each patient will be upheld at all times.

12. Appropriate and convenient arrangements will be made for in-patients to have access to their families/carers/friends.

SAFETY:

13. Agreed operational policies and sound inter-professional communication will be established for all aspects of the service and reviewed regularly.

14. A system of medical and clinical audit will be established.

15. Information will be collected to allow national and regional comparisons of local service outcomes.

16. All care will be provided in an environment which is clean, safe, comfortable and sensitive to users needs.

17. All statutory requirements will be met, for example, Health & safety, Environmental Health and Employment legislation.

REDRESS:

18. Representatives from purchasing authorities and their CHCs shall have access to all premises where care is provided under contract.

19. The views of users will be sought regularly on all aspects of the care they have received and the environment in which it is provided.

20. A mechanism will be established for dealing with users' complaints based on the Hospital Complaints Act 1985, other relevant guidance and after discussion with the relevant CHC.

P A T I E N T S ' C H A R T E R - GUIDELINES FOR GOOD PRACTICE

(first published by ACHCEW in 1986)

"The Charter reminds everyone that we have the right to be treated as customers of the NHS. Many of these principles are already practiced in the NHS and the Charter has the support of many staff and professionals as well as users. We hope the Charter will further promote these good practices and the dialogue between health service users and providers."

All persons have a right to:

1. health services, appropriate to their needs, regardless of financial means or where they live and without delay *;

2. be treated with reasonable skill care and consideration *;

3. written information about health services, including hospitals, community and general Practitioner services;

4. register with a General Practitioner with ease and to be able to change without adverse concequences;

5. be informed about all aspects of their condition and proposed care (including the alternatives available), unless they express a wish to the contrary;

6. accept or refuse treatment (including diagnostic procedures), without affecting the standard of alternative care given;

7. a second opinion;

8. the support of a relative or friend at any time;

9. advocacy and interpreting services;

10. choose whether to participate or not in research trials and be free to withdraw at any time without affecting the standard of alternative care given;

11. only be discharged from hospital after adequate arrangements have been made for their continuing care;

12. privacy for all consultations;

13. be treated at all times with respect for their dignity,

personal needs and religious and philosophic beliefs;

14. confidentiality of all records relating to their care *;

15. have access to their own health care records;

16. make a complaint and have it investigated thoroughly, speedily and impartially and be informed of the result;

17. an independent investigation into all serious medical or other mishaps whilst in NHS care, whether or not a complaint is made, and, where appropriate, adequate redress

* Already an established legal right

PLACING CONTRACTS FOR MATERNITY SERVICES

The preceding checklists and standards contain general consumer-led criteria of quality which could be used in the process of setting contracts for almost all health services. However, the real value of the checklists and standards is that they are flexible enough to be adapted across specific service provision. Specimen contracts for maternity services were amongst the first to appear, and prove an ideal testing ground for ACHCEW's consumer approach to contracting. These checklists have been formulated in discussion with CHCs, professional and user groups concerned with the provision of maternity care.

STAGE 1: CONSUMER QUALITY CHECKLISTS

Detailed quality issues which purchasers will need to assure themselves that providers of maternity services can address.

STAGE 2: CONSUMER STANDARDS IN CONTRACTS

Broad principles of quality which purchasers will need to specify in contracts and against which quality can be monitored.

STAGE 3: EMPOWERING USERS OF MATERNITY SERVICES

Information for users of maternity services to help them judge the quality of their local service.

CONSUMER CHECKLIST: ACCESS TO MATERNITY SERVICES

ORGANISATIONAL ACCESS TO SERVICES:

At what stage do women normally make their first attendance for hospital antenatal care and how long do they wait for an appointment?

* how does it compare to national norms
* how does it compare to DoH guidance
* how is need determined

Do women have access to a full range of antenatal, intrapartum, postnatal and neonatal care?

* are midwives used to the full extent of their professional expertise
* is the role of midwives publicised locally
* are midwives readily identifiable
* are home births catered for
* is domino delivery offered
* are Health Visitors used to act as a link between hospital and community services

Is the service itself running efficiently?

* what are waiting times within clinics
* is a block booking procedure used
* are reception arrangements easy to follow
* are a woman's records immediately available on admission
* how is time allocated for each patient
* how are patients called for consultation/ examination within clinics etc
* how are patients informed of delay/ cancellation of their appointment/examination/ admission
* are women assured continuity of care
  - contact with minimum different professionals
  - regular case conferences for all staff

Is the service able to meet special needs?

* are interpreting services provided
* is there a self-advocacy scheme
* is there specialist care for women at risk
* is there co-ordination with social/welfare rights workers
* women admitted to hospital during pregnancy due to complications
* care of women with disabilities
* care of babies with disabilities
* care of women with emotional/psychological needs
* care of babies to be fostered/adopted
* care of women with problems breast feeding

Does the service promote awareness and sensitivity to special needs?

* staff training on serving cultural differences
* equal opportunities training

Is the environment in which the service is provided, conducive to making women relaxed and comfortable?

* privacy of consultation/examination
* adequate seating
* availability of refreshments
* availability of reading material
* adequate heating and ventilation
* health promotion materials
* adequate toilets (well signposted)
* play area for accompanying children
* security for personal belongings

PHYSICAL ACCESS TO SERVICES:

How easy is it to get to the service in terms of?

* distance from local centres of population
  e.g. acceptable travelling time
* service of public transport
  e.g. acceptable travel costs
* meeting the needs of vulnerable groups
* provision of hospital transport
* facilities for private transport
  e.g. adequate car parking
* arrangements for relatives/carers to stay near by

How accessible is the unit in terms of?

* sign posting
  e.g. appropriate languages/symbols
  e.g. suitable positioning
* meeting special needs
  e.g. disabled access
  e.g. facilities for parents with children
* social areas for patients and visitors

CONSUMER CHECKLIST: **INFORMATION** IN MATERNITY SERVICES

In the antenatal period is information available in clear, unambiguous and appropriate languages?

* explanation of appointment date
  - adequate notice of appointment date
* leaflets explaining the service
  - plan of the hospital/clinic
  - details of transport routes
  - eligibility of non-emergency ambulance service
  - claiming hospital travel costs
* verbal explanations from staff
* self-health promotional information
  - importance of early confirmation of pregnancy
  - smoking
  - nutrition
  - exercise
  - parentcraft classes
  - infant feeding
  - screening
* role and location of CHCs and other support groups
* information leaflets by voluntary organisations
* Patients' Charter
* Patients' Rights
* opportunity to visit unit

Is information provided during treatment/care in clear, unambiguous and appropriate languages?

* consent to examination and screening
* explanation of consultation
* time to ask questions of doctors
* ease of seeking advice and help from nurses
* information for carers/ relatives
* inpatient/outpatient handbooks
* professionals easily identifiable (name tags)
* access to medical records
  e.g. pregnancy card

Are counselling services, in appropriate languages, available for support of patients in distress or discomfort?

* pre/post screening counselling
* pre/post abortion, miscarriage and stillbirth counselling
* bereavement counselling

In the intrapartum period is information, in clear unambiguous and appropriate languages available:

* written information on recognising early symptoms of labour
* explanation of all procedures
  - full discussion with women admitted due to

complications in pregnancy
- full discussion with women experiencing complications during childbirth

If mother and baby are separated are parents kept fully informed of treatment and progress:

* leaflets about the neonatal unit
* photographs of baby sent periodically to parents

Is information, in clear unambiguous and appropriate languages, available covering discharge arrangements and procedures?

* discharge leaflet for women
* discharge leaflet for carers/relatives
* continuing care arrangements
  - prior notification to GP
  - prior notification to midwive
* explanation of hand over from hospital to community
* practical advice on all aspects of mothercraft
* how to register the baby's birth

Is public information made available on the operational policy and impending developments at the unit?

CONSUMER CHECKLIST: CHOICE IN MATERNITY SERVICES

In planning care/treatment can women exercise choice?

* avoidance of unnecessary visits
* involvement of partner/friend
* screening facilities
* home visits from midwives/health visitors
* Choice of admission dates
* Evening clinics
* Local service provision
* Information in written and verbal form on diagnosis and treatment options
* discussion on options for labour
* preferred length of post natal stay
* choice of female consultant
* opportunity to visit maternity unit/SCBU etc

In the delivery of care/treatment can individuals exercise choice?

* continuity of care
* Support for refusal of treatment
* Promotion of informed consent
  - research trials
  - treatment by students
* Information and support of the right to a second opinion
* Support of a relative or friend at all times
  - visiting times
  - restrictions on numbers visiting
  - restrictions on children visiting
* Privacy
  - bed spaces and numbers
  - privacy of examination
  - privacy of visiting
  - sufficient changing accommodation
  - appropriate dressing gowns etc
  - privacy in period after birth
* Respect for dignity, personal needs, religious and philosophical beliefs
* Personalised clothing
* Hospital food
  - patients with special dietary needs
* Ward routine
  - access to relevant social facilities eg telephones
    refreshments
    post
    newspapers
* Encouragement of formally recorded birth plans covering:
  - role of partner/friend
  - pain relief
  - fetal monitoring
  - delivery position
  - use of episiotomies
  - use of oxytoxic drugs

- first contact with baby
- procedures in cases of emergency
- feeding

* Dealing with death in hospital
  - facilities for privacy for dying patient and their family/carers/friends
  - staff training in different cultural attitudes and traditions surrounding death
  - access to spiritual advisors

CONSUMER CHECKLIST: **SAFETY** IN MATERNITY SERVICES

Is there evidence of the provision of formal quality assurance systems covering:

* agreed procedures for initial assessment of pregnancy
  - known and understood by all professionals
* agreed routine of information to be sought and tests undertaken at first assessment
  - estimated date of delivery
  - previous obstetric and infant history
  - relevant medical condition
  - haematological investigation
  - smoking, eating, drinking
  - age, height, weight
  - occupation
  - home circumstances
* agreed procedures for following up non attenders
* clear instructions for emergency admissions
* written operational procedures, updated regularly outlining clear roles and responsibilities of all staff
* facilities for maintaining electronic monitoring equipment
* written operational procedures for dealing with different types of complication, understood by all staff
* clearly defined arrangements between maternity unit and ambulance service
* written operational policies dealing with small or ill babies
* access to regional Perinatal Centre
* medical audit
  - monitoring of peri-operative mortality
  - monitoring of peri-natal mortality
  - neonatal unit daily census
  - monitoring of perinatal morbidity
  - monitoring of use of caesarian section
  - monitoring of use of forceps delivery
* infection control procedures
* Health & Safety at Work Act
* Fire Precautions, exits and equipment
* Environmental Health Regulations
* Cleaning services
* maintenance of medical equipment
* staffing levels
* co-operation in epidemiological work
* District Ethic Committees

Other good practice

CONSUMER CHECKLIST: **REDRESS** IN MATERNITY SERVICES

Information on complaints procedures:

* leaflets
* posters
* suggestion boxes
* users' forums

Recording complaints:

* recording of complaints resolved at ward/clinic level
* assessment of substantial complaints
* record of outcomes of complaints
* reports of action taken
* provision for further investigation by contracting authority if complainant is not satisfied

Testing public opinion:

* Maternity Service Liaison Committees
* patient satisfaction surveys
* users' groups and discussion forums

Public representation:

* CHCs should have access to all premises where care is provided within a contract
* CHC visits: impromptu
  report back to purchaser
* CHC surveys
* CHCs should have access to all appropriate information
* CHCs should have observer status on all board meetings

CONSUMER STANDARDS FOR INCLUSION IN CONTRACTS FOR MATERNITY SERVICES

Aim of the maternity service

> "To provide a full range of antenatal, intrapartum, postnatal and neonatal care, comprising an integrated community and hospital based maternity service, offering a flexible approach to womens' needs, close to where she normally resides."

This is the general criteria against which the maternity service will be measured more specifically monitoring will cover:

ACCESS:

1. The diversity of culture, language social and economic circumstances of residents will be recognized and appropriate provision will be made for special groups.

2. All women who so request will be examined by a woman doctor.

3. All women will carry their own individual and complete case notes.

4. Each woman will be seen within 3 weeks of referral and before 18 weeks gestation and women requiring urgent referral will be seen without delay.

5. All women attending out patients departments will be given an appointment time. No woman will wait more than 45 minutes for an appointment without an explanation from the senior clinician.

INFORMATION

6. Information, in clear unambiguous and appropriate languages, on the availability and content of antenatal services will be offered to all women.

7. Counselling services, in appropriate languages, will be available for all women in distress and discomfort.

8. Information, in clear unambiguous and appropriate languages, on the availability and content of facilities to meet any problems during childbirth will be offered to all women.

9. Information, in clear unambiguous and appropriate languages, on procedures for discharge and continuing care will be readily available.

CHOICE

10. All women will have an opportunity to visit maternity and

neonatal facilities and discuss care during labour with staff, before confinement.

11. The particular needs and wishes of each woman will be met, wherever possible and made known to all staff involved.

12. The dignity, privacy and individual choice of each woman will be upheld at all times.

13. The special needs of women with ill babies or women who have lost their babies will be catered for.

SAFETY

14. Agreed operational policies and sound inter-professional communication will be established for all aspects of maternity care and reviewed regularly.

15. A system of medical and midwifery audit will be established.

16. Information will be collected to allow national and regional comparison of local services outcomes.

REDRESS

17. Representatives from purchasing authorities and their CHCs shall have access to all premises where care is provided.

18. Forums such as Maternity Services Liaison Committees will be used to discuss the provision of maternity services with users' representatives.

19. Regular sampling of users' views will be reported to purchasing authorities and their CHCs.

20. Women's complaints and dissatisfactions will be dealt with promptly.

EMPOWERING USERS OF MATERNITY SERVICES

INFORMATION TO BE PROVIDED FOR USERS OF MATERNITY SERVICES

ACCESS

1. You have a right to maternity services which meet your needs, regardless of your race, background, beliefs, where you live or whether you can pay.

2. You should expect a full range of maternity services within a reasonable travelling distance of your home.

3. You should expect clinic and surgery times which suit you.

4. You have a right to the cost of fares if you are on a low income.

INFORMATION

5. You should expect clear verbal explanations and written material covering all aspects of your maternity care.

6. You should expect to be offered information on where to go for help and support, such as details of local self-help groups and Community Health Councils.

8. You should expect clear verbal explanations and written material on keeping healthy during pregnancy and care for you and your baby.

CHOICE

9. You should expect to be able to make choices about the pattern of care you receive during pregnancy, such as:

* who cares for you and examines you
* where and how you give birth
* the role of your partner or friend
* what to do in cases of emergency
* when you leave hospital

10. You have the right to receive information to allow you to consent to any tests or treatments.

11. You should expect to have your dignity, personal needs, religious and philosophical beliefs respected at all times.

SAFETY

12. You should expect a high quality safe maternity service.

REDRESS

13. If you feel that the maternity service you have received does not meet the above criteria you have the right to comment or complain.

* Free confidential and independent advice and support is always available from your local Community Health Council. (Find them in the yellow pages)

* Other local groups such as National Childbirth Trust may also be able to give you advice.

14. You have a right to raise any queries you have with the manager of the maternity service, especially if you feel that the care you have received does not meet your needs.

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