KING'S FUND CENTRE

INFORMATION FOR PURCHASERS ABOUT OBTAINING USER VIEWS

CONSUMER FEEDBACK RESOURCE

INFORMATION FOR PURCHASERS ABOUT OBTAINING USER VIEWS

CONTENTS

PREFACE

This leaflet is produced by the Consumer Feedback Resource which provides advice and information to health service staff on obtaining the views of service users.

Details of other leaflets and booklets produced by the Resource can be obtained from:

Shirley McIver
Consumer Feedback Resource
King's Fund Centre
126 Albert Street
London
NW1 7NF

Tel: 071-267 6111

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The King's Fund Centre has a reference library which holds many of the publications mentioned here. Photocopies of journal articles only (not books or reports) can be supplied at 20 pence a page plus postage and packing. However, you are advised to try your local library first.

ACKNOWLEDGEMENTS

I would like to thank Alison Frater, Tessa Brooks and Huw Jones for providing useful comments on a draft of this leaflet.

INTRODUCTION

Purchasers are faced with the prospect of collecting a range of information from service users, potential service users and the general public in their area. For example:

- Epidemiological information about rates and patterns of disease, disability and morbidity in the area.
- Socio-demographic information about patterns of age, social class, ethnicity and occupational status.
- Information about lifestyles: eating, smoking, alcohol and exercise habits.
- Local views about health priorities.
- Information about who needs current local health services but is not using them.
- Views about the adequacy and inadequacy of current patterns of local health service delivery.
- Views about the quality of local health services.
- Information from patients about the outcome of particular treatments/ services, in order to contribute to the assessment of the effectiveness of different treatments/services.

This range of topics can be usefully condensed into two main areas, which will inform the contracting process:

1. assessing and prioritising health needs;
2. monitoring current service standards.

The aim here is to cover the topic of assessing health need only briefly as advice and information are available elsewhere (1,2). Explicit prioritisation of need is relatively new, particularly the issue of public prioritisation; an introduction to the literature in this area is given. Ways of obtaining feedback from users in order to contribute to the monitoring of current service standards have developed over the last few years and have been extensively documented. The aim here is to mention some of the main texts available and summarise a number of key issues relating to user feedback techniques.

It is worth making two initial points about the process of obtaining information from service users.

1. Many methods

There is no one recommended way to obtain information from users. The methods available collect different types of information and so will answer different questions. Also the situation and the type of user concerned will influence choice of method. There are three general categories of method:

* quantitative	those that collect statistics, such as structured questionnaire surveys;
* qualitative	those that collect narrative, such as discussion groups;
* informal	those that encourage participation from users, such as public meetings.

It may help to place these different methods on a continuum which has been used to show different levels of participation by users in service delivery. This continuum is especially useful to those wishing to understand what is meant by terms like 'user participation' and 'dialogue with users'.

Information provision	**Consultation**	**Participation**	**Control**
(e.g. surveys, discussion groups, interviews)	(e.g. advisory groups, public meetings)	(e.g. membership of planning, review and evaluation committees/groups)	(user or community run services)

2. Who is the user?

There is confusion in some quarters as to who counts as a 'user'. Those familiar with total quality management will be aware of the importance of the internal user. Also purchasers will be concerned about proxy users, such as GPs. Although the views of all types of user may provide important feedback about service quality, it is necessary to separate 'end users' from those acting on their behalf and others in the chain.

In most circumstances it is also worth keeping the views of relatives/friends separate from those of patients. A picture of service quality drawn from a number of sources is the best aim. It may help to separate key levels of user view in the following way:

- The individual service user.
- Relatives and carers.
- Small groups of users and friends, such as self-help organisations, voluntary organisations, carers' groups.
- Umbrella voluntary organisations, such as community health councils, NCVO, and large voluntary groups like MIND, MENCAP.
- The 'local community' - that is a consensus of local views about particular health issues.

The literature overview which follows pays particular attention to issues of method and level of user view. Purchasers wishing to tackle the subject of obtaining user views in a thorough manner should realise that they will have to make decisions about which methods to choose in order to get the views of different 'levels of user'.

LITERATURE OVERVIEW

Assessing and prioritising health needs

The task of identifying a need for a particular service, a yet to be established service, or for particular health education advice, is a complex one because there is more than one source of definition. Need can be:

1. patient expressed;
2. professionally defined;
3. comparative.

There are limitations if any one definition is used on its own. *Patient-expressed need*, for example, rests on lay people having the knowledge to judge their own need fully.

Doctor/other professional-defined need is based upon specialised knowledge, but in most cases doctors rely on patients identifying a need themselves first and seeking help and advice from the doctor. This means that consultation rates/referral rates for a particular illness or disease may not fully reflect need.

Comparative need is obtained by studying the characteristics of the population in receipt of a particular service and those who are not in receipt of the service. Those not in receipt who have key characteristics similar to those who do can be said to be in need. A difficulty lies in identifying key characteristics.

A fourth definition seems to be encouraged by the reorganisation of the NHS into purchaser and providers. This is *'organisationally defined need'* - a definition arrived at through the collaboration of professionals and managers in different organisations (FHSAs, local authorities, GPs, DHAs, units), patients and the local community.

Identifying need is only one part of the problem. The second part lies in deciding which needs to satisfy, given resource constraints. In the past, limitations have been imposed by a variety of largely covert processes, for example, doctors making individual judgements about type of treatment, when and where to refer, and by the management of waiting lists and booking policies. Change to a contracting system between purchasers and providers enables more explicit decision-making processes to be developed.

In order to identify health needs, purchasers can expect to use a variety of different methods. Some local information should be already available, for example, epidemiological information (public health/community medicine), and socio-demographic information about percentages of people of different ages, races, housing status, occupational group (planning department/local authority) (3,4); also rates of service use.

Some information is available through national studies and so does not need to be replicated, for example information on inequalities in health and health and lifestyle (5-10). Links have already been established between poor health, low income and poor housing. Also, information already exists on eating, alcohol, smoking and exercise trends among different social groups. A well-constructed population survey to elicit this kind of information would be expensive and may not deliver any new useful information unless the questions are thought out clearly and checked against what has already been found out.

When local socio-demographic and epidemiological information is examined in the light of the national studies on inequalities, lifestyle and so on, it will enable purchasers to make inferences about the numbers of people who may need a particular service (now or in the future) or better health education. Guides to public health priorities, such as *The Nation's Health* (11), also provide a valuable framework for this information.

A further way that professionals can identify need, without asking individuals directly if they require a particular service, is for them to ask questions about their health status. This can be done in a number of ways and will need to be linked to an appropriate database (12).

Well known examples of health status measures are the Nottingham health profile (13,14) and the general health questionnaire (15). Other measures are examined in 16, 17, 18 and 19. These examples mainly use the self- completion questionnaire survey method and rely on professional judgements about service need. Questionnaires can also be designed which ask people directly whether or not they need or would use a particular service. But this must be done carefully because behaviour does not always follow opinion. If people are asked if they think such and such a service should be more widely available (e.g. a well-person service) they might tick the 'yes' box without any feeling of personal need. Lack of knowledge about service choice may also prevent people from expressing opinions.

An approach which tries to overcome some of these problems by involving the local community and building upon existing knowledge is described by Ong *et al* (20). This used a research approach called rapid appraisal to assess health need and develop health priorities in a socially deprived ward in South Sefton. It involved a team of professionals who designed an interview schedule which they used to interview key informants in the local community. This locally obtained information was put together with the more usual epidemiological and socio-economic information to develop local priorities. The combination of information from different sources was important and the researchers comment 'we do not advocate taking the community's word as gospel'. At the very least the community dialogue should be ongoing because issues can be overlooked the first time. For example, the respondents in the community did not mention the vaccination and immunisation of children as important, yet it is well known that childhood immunisation has important benefits for child health.

The South Sefton study was rooted in a community health development approach which is more usual in the developing world. In the UK such projects have mainly originated outside mainstream NHS provision. However, this picture is changing; for example, community development workers have been employed to work from health centres or with specific service users. The theme of the fourth Annual Healthy Cities Symposium in 1989 was that of strengthening community action (21) and a body of work about the organisation of effective community participation has been developed in this area and could be useful to purchasers (22). The National Community Health Resource is producing an information pack on this subject (23).

Prioritisation: the Oregon project

Information about the health values and priorities of the local community also can be gathered using a questionnaire method and/or public meetings. A combination of these methods was used by the Oregon Health Services Commission in the USA. The aim of the Oregon project is to provide a list of health services ranked by priority from the most important to the least important, representing the comparative benefits of each service to the entire population served. There are two main components to the research: treatment outcome and public values and priorities.

The treatment outcome information has been obtained by:

a) soliciting outcome of treatment information from 54 panels of specialist health care providers; and

b) conducting a telephone survey based upon the quality of well-being scale (24) in which Oregon residents were asked to assign numeric scores to various sets of health symptoms and functional improvement.

The survey information and the information from the specialist panels was combined into a cost-benefit ratio formula, which provided a single index for each condition-treatment pair; these index values were used to establish a rank order among the items (25).

The ranked list of conditions/treatments was also related to information about community values and priorities gathered at public meetings. Over 45 meetings were held, involving over 1,000 citizens (26). They involved a slide-show, the collection of demographic information, the involvement of individuals in ranking health services in priority order, the exploration of the values that guided their priorities and whether a consensus could be reached (27). More meetings with the aim of consensus building are planned. (25, 28). A list of the top ten and bottom ten health priorities in Oregon is given in the BMJ (29). An appraisal of the Oregon project is given in Klein (30).

Prioritisation: other projects

A British project asked individuals to indicate the relative value they placed upon various human lives. This survey of 719 residents of Cardiff used an interview schedule, part of which asked respondents to consider 15 situations, in each of which they were required to choose between two hypothetical individuals who differed by only one characteristic (e.g. elderly adult vs child, employed vs unemployed).

The researchers found that the results gave:

> '. . . clear indications that the public may have a value system which considers lives to be of unequal worth, and that this system is relatively stable across a number of relevant control variables' (31)

Further results of UK surveys in which patients or members of the public were asked to rate states of ill health are given in 32 and 33.

Prioritisation: summary

It seems from recently completed work that it is possible to take a number of approaches when asking members of the public about health priorities. They can be asked about service preferences (34), about the relative worth of different types of individuals (31), or about outcome preferences (25). Hadorn (35) recommends the outcomes approach as superior. That is, an approach which asks people about their preferences concerning the benefits and harms produced by health care services and then maps these outcome preferences onto the outcomes expected with the use of specific health care services. He states that the advantages of the outcomes approach helps explain why outcome preference literature predominates in the health care arena and comments:

> '. . . once outcome research findings are translated into practice guidelines, payers (especially public payers) will likely provide coverage for services only for clinical conditions which have been found to derive significant benefit from treatment.' (35)

In the USA, health insurance companies are obviously generating great interest in outcomes research, but purchasers in the UK will be concerned with treatment outcomes so that they can commission the most cost-effective treatment for the local population. Outcome research is also one part of the process of assessing the quality of current service provision.

Monitoring current service standards

Outcomes are the end results of medical care and form one part of the classic triad used to define quality of care: structure, process, outcome. The patients' view of the quality of service is an important component (some might say the most important) although lack of knowledge about what to expect from health services makes it difficult for service users to make assessments. The number of publications on obtaining user views about service quality has increased over the last few years (36-43).

Most of the work on user assessments of service quality has concentrated on process, but there are recent examples of projects which have obtained views on both process and outcome. One example used self-completion questionnaires to patients attending a rheumatology outpatient clinic in Leeds. Part of the questionnaire asked patients about the usefulness of the aids supplied. Questions about the helpfulness of different types of patient education about the illness were also included (44).

Another project developed a systematic and comprehensive assessment of treatment provided by a community mental health team. This was based on a pilot using consumer surveys assessing accessibility, expectations, information given, acceptability of interventions offered, quality of the environment, and outcome at discharge and at follow-up. The final format combined different types of data collection, including input, process and outcome variables, and a standardised letter requesting information from clients, sent out within a week of discharge. The letter asks a series of questions about whether the user considers that improvements to his or her condition have occurred as a result of using the service (45).

It is important to make clear that the patient's view of the outcome of treatment is only one possible outcome measure. Other measurements, such as those of the patient's health status, are also needed for an accurate picture (46-48). There are also the traditional measures of mortality and morbidity (49). The process of measuring outcome is complicated and there are many different instruments, methodologies and taxonomies. Roberts (50) provides a classification of approaches according to what is measured (e.g. mortality rates, clinical indicators and measures of health status or patient satisfaction).

Service providers will be mainly concerned with service monitoring, but purchasers will need to know whether the user-monitoring methods employed by providers are capable of accurately and reliably assessing quality. To this end they should bear in mind the following points:

1. Self-completion questionnaires with fixed responses are not appropriate in every case. They are not sensitive to complex issues such as explanations about why service quality is or is not satisfactory. Also they will not record the views of those who do not read English, who cannot use their hands, or who have impaired eyesight.

2. In all questionnaires or interviews, questions asked should be based upon the service users' agenda of importance with regard to quality issues and not just those issues considered to be important by service providers.

3. Regularly used questionnaires should have been checked for validity and reliability, that is, whether they measure what they are supposed to measure and are consistent over time.

4. Response rate is very important. Purchasers should make sure that numbers of total possible respondents, people approached, and responses received, are all reported. In some cases service providers have been guilty of selecting out patients before beginning to count (e.g. those too ill, demented, and so on) and not making this clear. Large sections of people can be overlooked in this way and these people may have very relevant views about quality issues.

5. If a survey aims to give a representative view of the majority of service users, an appropriate sample size and at least a 75 per cent response rate is the ideal. If a survey is for explorative purposes - that is, to find out why users are or are not satisfied with a particular service - then much smaller numbers of respondents are acceptable. Much qualitative research of this kind involves between 15 and 75 people.

6. The ideal way to assess user views is to use a combination of methods: qualitative research (e.g. interviews, discussion groups) with a small number of respondents to find out the users' agenda of importance and in what way they feel a service is satisfactory or not; and quantitative methods (surveys) to find out how many users feel this way.

7. User views can change over time, as can service delivery, and so an ongoing programme of user-feedback work is advisable.

8. Purchasers should check what encouragement providers are giving to users to take part in user-feedback opportunities. Users are more likely to respond to surveys if they feel that their views are important and have some influence. This can be encouraged by providers giving feedback about the results of surveys to users. Another method is to invite users on to planning committees and/or set up user forums and patients' councils where users can discuss issues and take part in decision-making processes. If these initiatives are made known to users it will encourage a feeling of participation. A further, more simple way is for providers to promote suggestion boxes, and

to make it easier for users to make complaints by providing clear information about procedure. This is likely to increase the number of complaints but this can be a positive sign. The efficient handling of complaints is also important and a complaints officer who contacts complainants swiftly to discuss their problem is also recommended.

9. The process of obtaining feedback is a waste of time unless changes are made to improve service quality in response to user views. Without this, users are likely to be discouraged from giving their views on future occasions. This has happened to users from black populations in particular and purchasers should check on action resulting from user feedback. If the area has a high proportion of black users, purchasers should be particularly concerned about how providers are overcoming any communication gap.

10. Good information provision is a prerequisite for informed user feedback. Without some idea of what to expect from a service, the user will be unable to make a judgement about service quality. In the absence of relevant information, the 'gratitude factor' is likely to lead the user to say they are satisfied. Users should be given basic information about service standards and what they can reasonably expect from a service. It is advisable for purchasers to check on the quality of information provision (e.g. content, whether it is understandable, if it is given out at the most appropriate time, if arrangements are made for those who cannot read) as part of the process of monitoring user feedback.

Purchasers may also want to carry out their own monitoring visits to assess the quality of particular services. If this is the case, they will need to devise a checklist of quality indicators which are considered important from both the user and professional viewpoint and which relate to the quality specifications written into contracts.

Joint purchasing

At the heart of the relationship between the DHA and the local community is the ability of the authority effectively to purchase health care to satisfy health care needs. Many DHAs are engaging in joint purchasing as a way of fulfilling this demand.

In their review of joint purchasing, Ham and Heginbotham (51) found the following reasons for joint purchasing:

* some DHAs too small to form viable purchasing organisations;
* shortage of people with skills in purchasing;
* achieves economies of scale;
* greater financial leverage will be available;
* increases the potential competition among providers;
* makes it easier to form healthy alliances with FHSAs and local authorities;
* assists in the integrated purchasing and provision of primary care, community care and secondary care.

The participants in joint purchasing have principally been DHAs, but FHSAs are also becoming partners.

At the 1991 National Family Health Services Conference, the NHS Chief

Executive, Duncan Nichol, made it clear that FHSAs and health authorities should work together:

> 'It is illogical that they should continue to have separate health strategies and different health priorities, often pointing in different directions.' (52)

Instead he advocated that FHSAs and HAs should develop joint health profiles of local populations and joint health needs assessments. These should be developed into joint health priorities, strategies and targets.

This will not be an easy task because the two organisations have different histories with separate structures, cultures and ways of working. Therefore, bridges between the two are necessary, although some pioneering collaborative projects began while FPCs were still in existence (53).

More recently, North West Thames RHA decided to try and bridge the gap in understanding between senior managers and general practitioners by organising a project where managers shadowed GPs as they worked and then met up for a joint workshop. All participants were enthusiastic about the project at the end and:

> '. . . most of the participants asked for another opportunity to meet again as a group to discuss the issues that had emerged more thoroughly'. (54)

Ham and Heginbotham (51) found a number of different joint FHSA/DHA initiatives. These included joint appointments in public health and planning, and collaborative work in areas such as health promotion and the development of a common information base.

In Ealing Health Authority, collaboration between the DHA and FHSA began with the appointment of a director of public health to serve both authorities. There is now a proposal to create a single chief executive responsible to both authorities. This is an appointment which has already been agreed between Doncaster DHA and FHSA.

Local authorities are also potential joint purchasers but, to date, they have been much less involved. East Sussex has a history of collaborative projects between DHA and LA and joint contracting by DHAs and social services is now being explored.

Those considering joint purchasing may find the insights gained from the Ham and Heginbotham study useful:

* joint purchasing covers a variety of approaches;
* time is needed to develop trust and understanding;
* it is essential to win local ownership and commitment;
* key players must be identified and their contribution agreed;
* flexibility is important - learning by doing;
* project management is a key ingredient of success;
* steering groups involving representatives of constituent authorities can make an important contribution;
* an investment in organisation development is needed to build new purchasing organisations;
* a locality focus has an important contribution to make.

From the point of view of service users and the local community, joint purchasing would be an advantage if it meant there was less duplication of information collection, canvassing of views and research. Many users find it confusing to be surveyed by different authorities asking similar questions. They would also benefit if the care they received was better coordinated by the different authorities involved. Many users have difficulty understanding which authority provides which service.

The role of community health councils (CHCs)

It has been reported that the shock waves raised by the White Paper *Working for Patients* gave CHCs the opportunity to examine their work and possible future role in the new NHS structure (55). Officially their role is not made explicit in the White Paper where it states:

> '. . . the interests of the local community will continue to be represented by Community Health Councils, which act as a channel for consumer views to health authorities and FPCs' (56).

This is only a mandate to continue as before, but as this varied considerably from CHC to CHC (57) it did not satisfy many CHCs or the national association (ACHCEW). Community health councils in Oxford and North West Thames commissioned outside consultants to review their role and function and to make proposals for adapting to the new environment (55) and ACHCEW has produced a briefing document which gives guidance to CHCs on how they should be involved in the contracting process (58). Purchasers may also find the document useful because it contains three general checklists:

1. *consumer quality checklists* - questions and issues which users would wish to see purchasers address before placing contracts;

2. *consumer standards in contracts* - standards against which services can be evaluated;

3. *empowering service users* - information to be made available to users to enable them to be more demanding of health services.

A series of checklists adapted to maternity services is also included. ACHCEW is compiling information about arrangements made by HAs to involve the CHC in the specification and monitoring of service contracts. For example Rochdale CHC and Basildon and Thurrock CHC have representatives on the HA purchaser group. Brighton HA has said that contracts with out-of-district providers will stipulate that CHCs should have visiting rights. Medway, Bromley, North West Surrey, Southampton, South West Hants and North Staffordshire HAs have all agreed that the CHCs will have an important role in specifying and/or monitoring contracts.

Walsall CHC has compiled a report of quality assurance for acute and community services which is based on checklists for service standards, including national guidelines, information from members, visits to health premises and views received by the CHC from users of the services. The result is a critical overview of acute and community services in Walsall.

It is clear that CHCs could be a useful resource for purchasers aiming to contact the local community at a number of different levels. Firstly, though, it is important that DHAs, RHAs and CHCs, separately and then jointly, work out how the CHC can provide a quality service and then how they can productively work together.

What can the CHC be reasonably expected to do? What should the DHA expect? A basic working contract is necessary in order that the relationship is satisfactory on both sides. Some of the valuable tasks the CHC could carry out are:

- providing information to purchasers about gaps in service provision across service boundaries;
- facilitating the process of linking purchasers to voluntary and community networks and establishing what good links might look like;
- raising quality issues which users feel are important;
- piloting survey questionnaires;
- facilitating user forums;
- helping in the production and distribution of all types of health information.

CONCLUSION

The role purchasers have been given is one which has the potential to empower users of health services for the first time in the history of the NHS. When it was established in 1948, public participation was not a major feature of the organisation. In fact, a structure enabling the views of the public to be conveyed to health authorities was not introduced until 1974, when community health councils were established. Since that time there has gradually been a move away from the original paternalistic philosophy.

If the potential is to be realised, purchasers will have to experiment with ways of creating a dialogue between themselves, other authorities, patients, and the local community. Two very important steps are necessary before this can be achieved.

The first is to provide service users and their carers with better information. This means improving information in a number of different ways. For example, some of the relevant factors are that any information produced should be:

- given at the right time and place;
- understandable;
- comprehensive;
- use a number of media (verbal information should not be neglected);
- include provision for those who do not read English (translations, advocates);
- up to date;
- provide the opportunity to get further information or support (e.g. self help groups, information help line);
- relevant from the patient's point of view;
- provide the patient with the opportunity to make comments about adequacy and relevance, so that improvement can be continual.

The second step is to establish organisational structures which allow users and user representatives to take part in decision-making: membership of committees, consultation exercises, advisory groups etc. There will need to be a variety of different mechanisms to obtain user views and to enable users to take part in the planning and review of services.

As a recent publication about the consumer view of quality suggests, there is no shortage of evidence that the public is concerned about what kind of health services they are getting, not just the quantity (59). What is needed is the development of ways to 'cultivate and sustain the active support of the public'.

CURRENT PROJECTS

These projects are ones that are funded to develop good practice in the field of user involvement in purchasing health care.

Lucy Moore
Researcher
London School of Hygiene and Tropical Medicine
Keppel Street
LONDON
WC1

Tel: 071-636 8636

A project examining the role that consumers of health care can play in the decision-making process that will take place within purchasing organisations in the reconciliation between health care needs and limited resources, and as a result of the NHS review.

Sue Sullivan
Organisational Development Facilitator
East Dyfed Health Authority
Starling Park House
Johnstown
Carmarthen
DYFED
SA31 3HL

Tel: 0267 234501

As part of the new emphasis on consulting service users, a series of public meetings about cancer was organised in June 1991 by East Dyfed Health Authority together with Dyfed Family Health Services Authority, Dyfed Social Services and Ceredigion, Llanelli and Carmarthen Community Health Councils. Report available August 1991.

Helen Whitmore
Quality Manager
South Bedfordshire Health Authority
Bute House
7 Dunstable Road
LUTON
Bedfordshire
LU1 1BB

Tel: 0582 37121

A project aimed at eliciting the views of general practitioners about their priorities with regard to the quality of service provided by the health authority. Meetings with GPs were organised in different localities, followed by a questionnaire survey. Results to be included in a newsletter.

Safder Mohammed
Development Worker
Primary Care Programme
King's Fund Centre
126 Albert Street
LONDON
NW1 7NF

Tel: 071-267 6111

A project to improve services to black populations through the contracting process. A series of workshops with purchasers is taking place during 1991.

Huw Jones
Development Officer
Future of Acute Services
Coventry Health Authority
Christchurch House
Greyfriars Lane
COVENTRY
CV1 2GQ

Tel: 0203 224055

A series of eight public forums about the future of acute services have been convened. These informed the development of a questionnaire which has been distributed to 1000 randomly chosen people in Coventry. Report available October 1991.

Alison Frater
Development Worker
Acute Programme
King's Fund Centre
126 Albert Street
LONDON
NW1 7NF

Tel: 071-267 6111

Also:
Public Health Directorate
North West Thames Regional Health Authority

Tel: 071-262 8011

A project exploring the use of outcome measurement in assessing and improving the quality of medical care. A report being compiled to describe methods under review in the UK and USA emphasises particularly the use of functional health status measures. A number of workshops are taking place with the aim of bringing together key managers and chairmen from both purchaser and provider units to explore the constellation of issues which need to be resolved before outcomes can become a key tool for running health services.

Michael Powell

Michael Powell
Development Officer
Acute Programme
King's Fund Centre
126 Albert Street
LONDON
NW1 7NF

The project is concerned with the development of practical and monitorable measures of clinical quality suitable for use in service contracts. The emphasis is on clinical effectiveness and outcomes rather than measures of clinical process. The early stages concentrated on work with clinicians and managers within provider units in order to gain their commitment to developing clinical quality measures and to determine what is feasible using existing information systems. The next phase is building on this work by working closely with purchasers to identify measures of clinical effectiveness which will be useful in developing contracts which begin to focus on key health outcomes. It is intended that this will include the use of health and functional status data derived from patients.

Janet Fullforth
Assistant to the DGM
Frenchay Health Authority
Beckspool Road
BRISTOL
BS16 IND

Tel: 0272 701070

A research project studying the ways in which health authorities are tackling the issues of integrating different perspectives on health needs and deciding health priorities. Completed as part of a masters in policy studies at Bristol University.

Gilly Lutton
Research Associate
Public Health Department
Mid-Essex Health Authority
Collingwood Road
WITHAM
Essex
CM8

A project involving a series of public health forums attended by members of voluntary organisations, the community health council and representatives of the health authority. Other forums were held with general practitioners. Participants were asked to complete one of the questionnaires used in the Oregon, USA, project. They completed it individually and then formed small groups and attempted to reach a consensus within the groups. The Public Health Department is deciding how to link these feedback mechanisms to the formal managerial and public health input into contracts with reference to priorities. Report available.

Bill Fleming
Sounding's Research
377 Health Road South
Northfield
Bimingham
B31 2BA

Tel: 021-475 3919

A project with Shropshire Health Authority (Department of Planning and Quality Assurance) which has the aim of developing non-survey methods, particularly discussion groups, as a way of understanding user views. A manual, *Developing service quality through understanding users' experience* will be available in spring 1992.

Ingrid Barker,
Contract Manager For Mental Health Services
Carole Craddock,
Research Assistant to the Contracts Department
Newcastle Health Authority
Scottish Life House
2-10 Earthbound Terrace
NEWCASTLE-UPON-TYNE
NE2 1EF

Tel: 091-281 5011

A project developing ways of working with the Newcastle Mental Health Service Consumer Group so that user views are incorporated into the contracting process.

Ann Bowling
Senior Lecturer in Public Health and Primary Care
Head of Needs Assessment Unit
St Bartholomew's Hospital Medical College
West Smithfield
LONDON
EC1A 7BE

Tel: 071-601 8888

A project set up to test the validity of the consumer values exercises used in Oregon and with voluntary and professional groups in Essex, in a multi-culture area of East London. The best method of organising public participation to facilitate maximum participation will also be tested. The survey will be extended to hospital clinicians and general practitioners in order to assess the degree of overlap of the consumers' views and values with those of the medical profession.

ORGANISATION CONTACT LIST

This is a list of organisations offering advice and assistance to purchasers seeking to obtain information from users. This list is not comprehensive and inclusion does not imply endorsement by the King's Fund Centre.

School of Advanced Urban Science
University of Bristol
Rodney Lodge
Grange Road
BRISTOL
BS8 4EA

Health Services Management Unit
Manchester University
Devonshire House
Precinct Centre
Oxford Road
MANCHESTER
M13 9PL

Tel: 061-275 2908

Centre For Health Economics
University of York
Heslington
YORK
YO1 5DD

Tel: 0904 433648/433646

Centre for Health Planning and Management
University of Keele
Science Park
Keele
STAFFORDSHIRE
ST5 5SP

Tel: 0782 621111

The King's Fund College Programme on Purchasing and Providing
2 Palace Court
LONDON
W2 4HS

Tel: 071-727 0581

Q-Aid
Quality Support System
Initiative Software Application Ltd
10 The Square
MARKET HARBOROUGH
Leceistershire
LE16 7PA

Tel: 0858 464622

Priority Search Ltd
Sheffield Science Park
Arundel Street
SHEFFIELD
S1 2NS

Tel: 072 701006

Research Associates
The Radfords
Stone
STAFFORDSHIRE
ST15 8DJ

Tel: 0785 813164

London Research Centre
Parliament House
81 Black Prince Road
LONDON
SE1 75Z

Tel: 071-627 9695

REFERENCES

1. Centre for Health Economics. Future role of the district health authority: assessing needs for services and setting priorities. York: University of York, 1991.

2. Purchasing for patients. NHS Managerial Executive, Room G14A, Richmond House, London SW1A 2NS. Paper on listening to user views also available.

3. Charlton JRH, Vauer R, Lakhani A. Outcome measures for district and regional health care planners. Community Medicine, 1984 (6): 306-15.

4. Lakhani A. Application of outcome indicators in the NHS — a conceptual framework. Working Towards Health, London: DHSS, 1985.

5. Townsend P, Davies N. Inequalities in Health: the Black Report. Harmondsworth: Penguin, 1982.

6. Smith GD, Partly M, Plane D. The Black report on socioeconomic inequalities in health ten years on. British Medical Journal, 1990, 301: 373-7.

7. Tudor Hart J. The inverse care law. Lancet, 1971, (1):405-12.

8. Whitehead M. The health divide: inequalities in health in the 1980s. London: Health Education Council, 1987.

9. Cox BD. The Health and Lifestyle Survey, London: Health Promotion Research Trust, 1987.

10. Rathwell, Phillips (ed). Health, race and ethnicity, 1986.

11. Jacobson B, Smith A, Whitehead M (eds). The nation's health: a strategy for the 1990s. London: King Edward's Hospital Fund for London, 1991.

12. Eskin F, Bull A. Squaring a difficult circle. The Health Service Journal, 1991 (10 January).

13. Hunt S M, McEwen J. The development of a subjective health indicator, Sociology of Health and Illness, 1980, 2(3): 231-46.

14. Hunt S M, McEwen J, McKenna S P. Measuring health status: a new tool for clinicians and epidemiologists, Journal of the College of General Practice, 1985, 35: 185-8.

15. Goldberg D. Detection of psychiatric illness by questionnaire. Oxford: Oxford University Press, 1972.

16. Seigman A E. A classification of sociomedical health indicators: perspectives for health administrators and health planners, International Journal of Health Services, 1976, (6): 521-38.

17. Ware J, Brook R, Davies-Avery A, Lohr KN. Choosing measures of health status for individuals in general populations. American Journal of Public Health, 1981, (71): 620-25.

18. Balinsky W, Berger R. A review of the research on general health status indexes. Medical Care, 1975 (13): 283-93.

19. Bowling A. Measuring Health: A review of quality of life measurement scales, Buckingham: Open University Press, 1991.

20. Ong BN, Humphris G, Annett H and Rifkin S. Rapid Appraisal in an urban setting, an example from the developed world. Social Science and Medicine 1991, 32(8): 909-15.

21. Tsouros A. Healthy cities means community action. Health Promotion International, 1990, 5(3): 177-78. See also other articles in same issue.

22. Spearman J. Healthy cities network conference: information needs 2000. Community Health Action, 1990/1: No.8 (winter). See also reference 21.

23. Peter Watson, National Community Health Resource, 57 Chalton Street, London NW1 1HU (071-383 3841).

24. Kaplan RM, Anderson JP. A general health policy model: update and applications. Health Services Research, 1988, 23: 203-17.

25. Klevit H D, et al. Prioritisation of health care services. A progress report by the Oregon Health Services Commission. Archives of Internal Medicine, 1991, 151: 912-16.

26. Hasnain R, Garland M. Health care in common: report of the Oregon Health Decisions Community Meetings Process. Portland, Oregon: Oregon Health Decisions, 1990.

27. Garland M, Hasnain R. Health care in common: setting priorities in Oregon. Hastings Center Report, 1990, 20: 16-18.

28. Garland MM. Setting limits on health care: the Oregon experience. Center for Ethics in Health Care, Oregon Health Sciences University, 1991.

29. McBride G. Oregon revises health care priorities. British Medical Journal, 1991, 302 (March): 549.

30. Klein R. On the Oregon trail. Rationing health care: more politics than science. British Medicine Journal, 1991, 302: 1-2.

31. Charny M C, Lewis P A, Farrow S C. Choosing who shall not be treated in the NHS. Social Science and Medicine, 1989, 28 (12): 1331-38.

32. Ebrahamim S, Brittis S, Wu A. The valuation of states of ill-health: the impact of age and disability. Age and Ageing, 1991, 20: 37-40.

33. Vetter N, Lewis P, Farrow S, Charny M. Who would you choose to save? The Health Service Journal, 1989, 10 August: 976-77.

34. Raferty J, Skingsley R, Carr J. Preferential Insights. The Health Service Journal, 1990, 22 November.

35. Hadorn D. The role of public values in setting health care priorities. Social Science and Medicine, 1991, 32(7): 771-81.

36. McIver S. An introduction to obtaining the views of users of health services. London: King's Fund Centre, 1991.

37. McIver S. Obtaining the views of outpatients. London: King's Fund Centre, 1991.

38. McIver S. Obtaining views of users of mental health services. London: King's Fund Centre, 1991.

39. Luck M, Lawrence B, Pocock B, Reilly K. Consumer and market research in health care. London: Chapman and Hall, 1988.

40. Cartwright A. Health surveys in practice and in potential. London: King Edward's Hospital Fund For London, 1988.

41. International Hospital Federation. And what would they know about it?, 1988. 2 St Andrew's Place, London NW1 4LB.

42. National Consumer Council. Consulting consumers in the NHS: a guideline study, 1990. 20 Grosvenor Gardens, London SW1 ODH.

43. Carr-Hill R, McIver S, Dixon P. The NHS and its customers. University of York: Centre for Health Economics, 1989.

44. Hill J. Patient evaluation of a rheumatology clinic. Nursing Times, 1986: 2 July 42-3.

45. Burbach FR, Quarry A. Quality and outcome in a community mental health team. International Journal of Health Care Quality Assurance, 1991, 4(2): 18-26.

46. Fallowfield L. The quality of life: the missing measurement in health care. London: Souvenir Press, 1990.

47. Najman J M, Levine S. Evaluating the impact of medical care and technologies on the quality of life: a review and critique. Social Science and Medicine, 1981, 15: 107-15.

48. Scrivens E, Cunningham D, Charlton J, Holland W. Measuring the impact of health interventions: a review of available instruments. Effective Health Care 1985, 2 (6): 247-60.

49. Lohr K. Outcome measurement: concepts and questions. Inquiry, 1988, 25 (spring): 37-50.

50. Roberts HM. Outcome and performance in health care. London: Public Finance Foundation, 1990.

51. Ham C, Heginbotham C. Purchasing together. London. King's Fund College, 1991.

52. Glasman D. Partnership aims at a new balance. The Health Service Journal,

1991, 28 February: 16.

53. Marks L. Planning primary care: forging links between family practitioner committees and district health authorities. London: King's Fund Centre, 1989.

54. Beardow R, Styles B. A good day's practice. The Health Service Journal, 1991, 18 April: 14.

55. Hogg C, Winkler F. Community Health Councils: their role after the NHS white paper. Health Services Management, 1990 (August): 171-3.

56. Department of Health. Working for patients. HMSO, London, 1989.

57. Levitt R. The people's voice in the NHS — CHCs after five years. London: King's Fund Centre, 1980.

58. ACHCEW. Contracts for health care: making them work for patients, 1990. 30 Drayton Park, London, N5 1PB.

59. Pfeffer N, Coote A. Is quality good for you? A critical review of quality in welfare services, 1991. London, Institute for Public Policy Research. 30-32, Southampton Street, London, WC2E 7RA.

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