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Core health and race standards

Good practice paper

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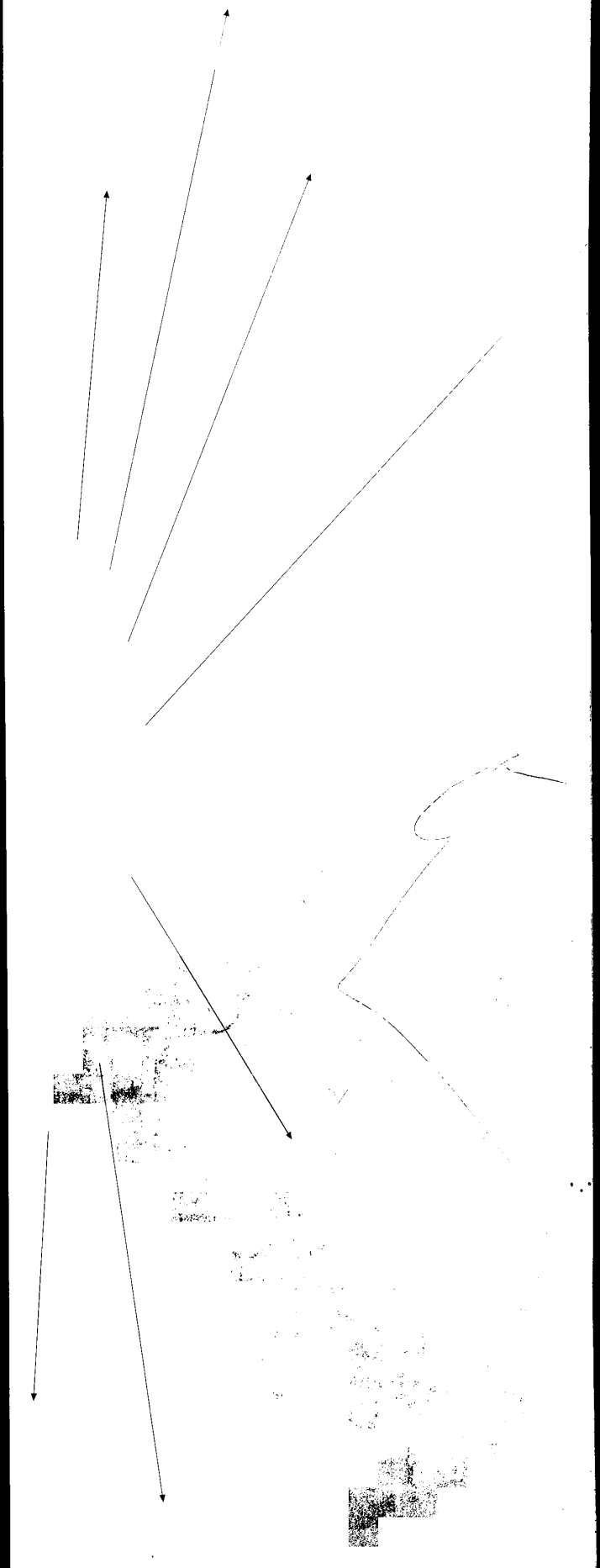
HEALTH & RACE
PURCHASERS FORUM



Introduction

The NHS reforms created opportunities for the newly established purchasing authorities and providers to refocus on the organisation, management and delivery of health services to Black and minority ethnic communities. For some ten years prior to the reforms and for some time afterwards, equal opportunities advisers were the key movers who undertook developmental work within district health authorities and established the foundations on which current work has been built.

The purpose of developing 'core' standards is to build on and consolidate experiences since introduction of the NHS reforms and to avoid reinventing the wheel for those health commissioning agencies (HCAs) and general practitioner fundholders (GPFHs) that have just begun or have yet to begin work in this area. We hope to promote consistency in the approach purchasers employ in specifying contract quality standards.

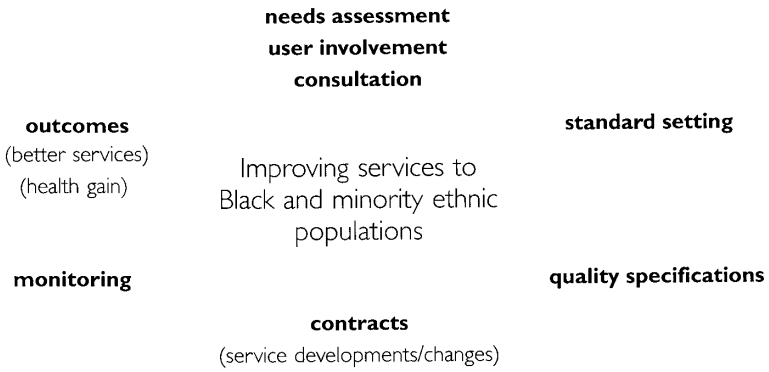
This paper offers HCAs and GPFHs a practical guide to developing and using health and race standards in their contract quality specifications. It draws on collective experiences of district health authorities over the past three years.

Background

The establishment of quality standards within contracts is relatively new within the NHS. This approach has developed from a King's Fund Centre initiative in 1990 to fund purchasing agencies 'to improve services to Black and ethnic populations through the contracting process'. The thinking behind this approach is straightforward. Provider contracts are the main lever which commissioning agencies will use to influence the behaviour of health service providers or Trusts.

Using contract standards to influence change is only one dimension of a more comprehensive approach towards achieving greater equity within service provision for Black and minority ethnic services users.[1] Even where the core standards suggested are achieved, it is not a guarantee that the services are necessarily relevant or appropriate to users' needs. There are well-documented criticisms regarding the acceptability of health care provision for Black and minority ethnic service users.[2] Mental health provision is an example where many users argue that the Euro-centric bias in existing services prevents any amount of improvements from having positive long-term effect, and that a complete refocusing and remodelling around culture-specific needs is the best way to make services appropriate.[3]

The issues of improving health services to Black and minority ethnic populations cannot be effectively tackled by either purchasers or providers if they are divorced from the wider context of discrimination and racism. Purchasing agencies have a responsibility to ensure that their strategies, policies and, perhaps most importantly, practices reflect similar efforts to improve their operations; for example, ensuring that efforts are being taken to meet the Government's action programme for ethnic minority staff within the NHS.[4] The Forum takes the view that health and race contract quality standards should therefore complement a 'commissioning strategy' which actively uses needs assessment activities, user involvement initiatives and service developments to secure better services for Black and minority ethnic populations. The model below illustrates these links.



There are many areas, such as mental health, where service provision needs to be improved or changed to achieve basic standards which meet the Maxwell quality indicators.[5] The core standards presented in this document attempt to reflect these criteria.

Core Health and Race Standards for Acute and Community Providers

Standards specified in the contract quality schedule will generally combine local with regional and national performance areas, for example waiting time and *Patient's Charter* standards. Many of these standards are regarded as a baseline from which performance can be measured by health commissioning agencies. Using the contract in this way to specify local health and race standards indicates the commissioning agency's commitment to these issues, as well as signalling to providers the necessary action to ensure their services are relevant to the needs of Black and minority ethnic users.

The core standards presented below are selected from the standards used by Kensington & Chelsea & Westminster; Ealing & Hammersmith & Hounslow; Brent & Harrow; Camden & Islington; Merton, Sutton & Wandsworth; Redbridge & Waltham Forest; New River; Bradford; Sandwell and Walsall Health Authorities. (Bradford Health Authority is part of the Northern and Yorkshire Region and Sandwell and Walsall Health Authorities are part of the West Midlands Region.) They are in a format which is familiar to most health authorities. The three key columns are 'Core Standard', 'Target' and 'Monitoring Mechanism'. The intention is that they can be used with minor adaptations or be developed to reflect local circumstances, as general guidance, or as a checklist.

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Core Health & Race Standards for Acute and Community Providers

Core Standard	*Target*	*Monitoring Mechanism*
1. Ethnic Monitoring of Patients		
Ethnic monitoring of patients should be undertaken for *all services*.	**1.1** Ethnic monitoring of *all inpatients* should be undertaken in accordance with EL(94)(77).	**1.1** Activity report at agreed intervals by service area and ethnic origin accompanied by supporting text.
	1.2 Review the feasibility of providing ethnic monitoring for non-inpatient services. *or* Ethnic monitoring of outpatients, community and allied health services.	**1.2** Outcome of the review and report detailing timetable for full implementation including progress made.
	1.3 Providing information to the public regarding why the information is collected.	**1.3** Feedback from users and user groups on the introduction of ethnic monitoring.
2. Religion		
2.1 Ensure that cultural and religious beliefs are appropriately observed.	**2.1** Religion to be recorded in patient's notes.	**2.1** User survey and feedback from user groups.
2.2 Provision of multi-faith facilities for inpatients with information for patients about their availability, translated in required languages.	**2.2** Multi-faith facilities to be provided. Translated information made available to staff and patients in consultation with religious groups.	**2.2** Report providing evidence that multi-faith facilities are available. User survey and feedback from user groups.
	2.3 Protocols for death and bereavement should take into account cultural and religious beliefs and needs in accordance with national guidance.	Activity report at agreed intervals detailing inpatient activity by service area and religion accompanied by supporting text. **2.3** Equity report providing evidence that protocol for care of the dying has been reviewed.
		2.4 Analysis of patient complaints.

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Core Health & Race Standards for Acute and Community Providers

Core Standard	*Target*	*Monitoring Mechanism*
3. COMMUNICATION		
3.1 Patients should be able to communicate with health workers in the language they feel comfortable with.	**3.1** Produce a communications policy covering all aspects of patient care.	**3.1** Report providing evidence that communication policy is available and operational.
	Language to be recorded on the patient record and as part of any assessment process.	Audit of patient records.
3.2 Services which patients may need to use should be clearly sign posted, enquiry points clearly marked, and essential written information regarding the services made available, in thecommunity languages specified by the purchaser.	Inform users who speak little or no English that interpreters are available and should be provided on request.	User survey and feedback from user groups.
	3.2 Essential written material should be translated in the required community languages – must include what services are available, how and where to obtain them, how to complain and procedure for complaining.	**3.2** Audit of patient information.
	3.3 Each provider must have a contract with a professional language service. There should be a protocol in operation regarding its use.	**3.3** Report providing evidence that a contract with appropriate service is operational and a protocol is available and in use. Audit of operational policy to include data on requests for and use of service by service area.
		3.4 Analysis of patient complaints.

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Core Health & Race Standards for Acute and Community Providers

Core Standard	*Target*	*Monitoring Mechanism*
4. PATIENT CHOICE		
4.1 Patients should have the choice of a female clinician and information made readily available regarding this option.	**4.1** Review current arrangements to ensure that the male/female staffing ratio is appropriate for the relevant service areas. (Exact ratios to be negotiated)	**4.1** Report identifying problem areas and actions taken. User survey and user group feedback.
4.2 Single sex facilities to be provided wherever feasible.	**4.2** Review mixed wards and facilities and agree timetable to address the effective separation of the sexes.	**4.2** Report detailing the outcome of the review of mixed facilities, plans to address, implementation programme and progress made. **4.3** User survey and feedback from user groups.
5. DIET		
5.1 Meals should meet the cultural requirements of service users and be authenticated by the relevant community leaders.	**5.1** Develop standards for providing culturally appropriate diets in consultation with local communities.	**5.1** Samples of menus available to be provided. **5.2** User survey and user group feedback.
5.2 Dietary information should be available to suit differing local community cultural requirements both in hospitals and in the community.	**5.2** Record dietary requirements for all inpatients in patient's notes. **5.3** Protocol in place to ensure that staff are aware of culturally appropriate dietary provision and clients know how to utilise the service.	**5.3** Report showing how needs of different of local groups are met to includeaudit of patient's notes and numbers of meals provided by type. **5.4** Analysis of patient complaints. **5.5** Menu tasting sessions with representatives from relevant communities

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Core Standard	*Target*	*Monitoring Mechanism*
6. STAFFING		
6.1 Ethnic monitoring of all staff to be undertaken.	**6.1** Implement and maintain systems for ethnic monitoring of staff.	**6.1** Activity information on current staffing position by staff grade, with supporting text.
6.2 All staff involved in providing services should be fully aware of how the Health & Race Standards relate to their areas of work.	**6.2** Develop and execute a rolling programme of training for key staff involved in implementing Health & Race Standards.	**6.2** Report detailing progress with implementing health & race training programme including numbers of staff trained.
7. PATIENT COMPLAINTS		
Ethnic monitoring of complaints should be introduced and maintained.	**7.1** Ethnic monitoring to be undertaken for all patient complaints.	**7.1** Analysis of patient complaints with supporting text.
	7.2 Information on complaints procedures to be translated.	

Targets and monitoring mechanisms

While the standards are likely to remain much the same, the targets and monitoring mechanisms may differ to reflect the individual Trust's circumstances and the starting position negotiated with Trusts by health commissioning agencies. Specifying clear and realistic targets and monitoring mechanisms ensures that both purchaser and provider understand and agree what actions are to be taken, what methods will be used to measure and assess performance and the format and time intervals in which reports are expected from providers. Experience has highlighted a need for greater clarity in relation to these areas, and the following notes explain how the terms 'target' and 'monitoring mechanism' are used in this paper.

Definitions and examples

Targets

To be negotiated and agreed with Trusts. They must be specific and should reflect *minimum* performance requirements or a negotiated agreement for provider performance against the standard. Examples of the targets/actions are as follows.

- Actions in accordance with relevant Executive Letters
- Review and update of existing policies
- Production of new policies
- Development of protocols
- Production of information including translations
- Review of existing provision
- Development of new facilities
- New management/operational systems

Monitoring mechanisms

The monitoring mechanisms are the systems used by the provider to measure their performance against the standards. The purchaser should agree that these systems are able to provide an appropriate amount of data which can be validated and are reliable. Unless specified elsewhere, the timescale for reporting against the standard must also be indicated and agreed with the provider. Examples of the monitoring mechanisms used are as follows.

- Activity reports [quarterly/six-monthly]
- Exception reports [quarterly/six-monthly/annually]
- Copies of policy documentation
- Copies of information produced
- Copies of ad hoc reports
- Copies of surveys/audit
- User feedback
- Trend analysis

General principles

There are a number of general principles worth keeping in mind about developing and implementing health and race standards. The main areas are:

- Named purchaser lead
- Provider ownership
- Contract compliance
- Feedback to providers on their performance
- Feedback to and from local communities

Named purchaser lead

Purchasers should have a named senior manager lead for health and race and ensure that health and race standards are a core component of any contract with providers.

Provider ownership

Providers should have a named senior manager lead for health and race. Improvements in the delivery of health care for Black and minority ethnic groups should be achieved through close co-operation between providers and purchasers. Providers are at different stages of development, and in acknowledgement of this, both provider and purchaser should agree an implementation programme (including timetable) for health and race work at the start of the contract year.

Contract compliance

It is important that purchasers satisfy themselves that providers are making their best efforts to meet contract quality standards and must decide on what contract penalties or sanctions, if any, they wish to impose for non-compliance. Decisions to use purchasing powers in this way should be done considerately and to achieve the best results for patients.

Community support

The health and race standards should be supported by and reflect concerns of local communities. Core standards have been identified by the Forum but individual health commissioning agencies should complement this with additional work with local populations to fine tune the information to reflect local needs. For example, where reference is made to 'relevant community languages' purchasers will need to define these locally.

Feedback to local communities

In order to obtain support from local communities some form of flexible mechanisms must exist. The same mechanisms can be used for developing a two way dialogue with local communities. In many instances the mechanisms do not exist and agencies will have to initiate these, which will have substantial time and resource implications. This should form part of the agency's agenda for 'listening to local voices'.

Feedback to providers on their performance

Purchasers should ensure that providers receive regular feedback on the information they provide. It is recommended that both parties meet on a quarterly basis to review progress.

Conclusions

This paper has attempted to show how those commissioning health care can ensure that their contracts begin to reflect standards which address the needs of diverse and multi-ethnic communities. The Forum believes the core standards represent a baseline, which all providers should be achieving. The information presented will be used at its best to inform and provide a basis from which to develop standards locally. It is perhaps important to reflect that 'health commissioning' is still rapidly developing and this document reflects a reasonably accurate picture of the current state of affairs. However, as the development continues, the processes and content will be reviewed and updated as necessary.

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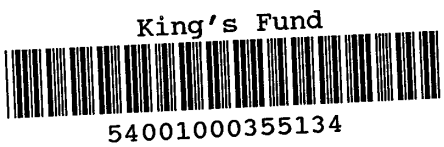

Acknowledgements

We would like to acknowledge the feedback and comments received about this paper from all members of the Forum, as well as the feedback received from colleagues who are not members of the Forum but support our work and the relevance of sharing good practice and developing better ways of working.

Note on terminology

The term 'Black and minority ethnic groups/populations/communities' as used in this paper refers to heterogeneous groups of people who share common experiences of discrimination because of their racial backgrounds.

The Forum

The London Health and Race Purchasers Forum was established in March 1993 by a group of individuals improving access to health care for Black and minority ethnic communities through the commissioning process. Our remit is to prevent duplication of effort through shared experiences and learning; to undertake collaborative work based on our combined expertise and knowledge; and to produce working documents and models for use mainly by health commissioning agencies, but also for health Trusts, across London. Our priorities over the past year have been ethnic monitoring, interpreting and translation services and contract standards on health and race.

Share

Share is a King's Fund Development Centre project with funding from the Department of Health. If you would like further information regarding any of the Share publications or have any queries relating to health and the Black populations please contact us.

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