King's Fund

Organisational Audit

Health Authorities

Organisational standards

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Contents

Preface

A new model of 'commissioning' health authority was adopted on 1 April 1991. Since then, the process of commissioning, for which health authorities and their fundholder colleagues are responsible, has moved, albeit sometimes uncertainly, from infancy towards maturity. There have been growing pains. While early investment was made in developing the providers in their new role, the emergence of different models of commissioning left commissioners to learn largely for themselves.

The result has been a wide variation in organisational confidence and competence in carrying out what, by any standards, must be regarded as the demanding task of establishing the health needs of the local population, deciding priorities in respect of those needs and making appropriate commissioning decisions.

In 1991, the King's Fund introduced the concept of Organisational Audit for acute hospitals and trusts, with the specific purpose of helping acute providers to develop and demonstrate the fitness of their organisations. Since that time, both the standards and accompanying process have been extended to cover a wide range of service areas, including primary health care, nursing homes and also community, mental health and learning disabilities services.

It is not surprising that a similar demand has emerged for the development of standards and a peer review process for commissioning organisations. There is growing awareness that commissioners also need a form of structured organisational development such as that offered by King's Fund Organisational Audit, as well as an effective means by which to demonstrate their own fitness for purpose.

This manual has been produced by the King's Fund to meet that demand. It represents the culmination of several years' work by many individuals, some of whom we are able to acknowledge. The input of many will go unsung, but not unappreciated. We hope that the result offers an imaginative development in the application of standards relating to organisation and function. However, we have no doubt that, with further testing, they will require modification and updating to meet the rapidly changing organisations for which they are designed.

Tessa Brooks
Director

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- the health authorities who commented on the standards and criteria during the consultation phases
- the professional and consumer organisations who ensured that different perspectives were reflected in the standards and criteria
- the statutory organisations who provided specific expertise on the relevant regulations and guidelines.

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- the surveyors
- the members of the reference group and the following individuals who helped to shape the standards:

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Introduction

The publication of this manual of organisational standards and criteria for health authorities signals the end of the project for health authorities and primary care commissioners and the beginning of the Health Authority Programme.

These standards and criteria provide an organisation with the means to question practice and to stimulate development work. They provide a real opportunity for staff to question what they do, why they do it and whether it could be done better.

They have been introduced at a time when health authorities and family health services authorities are merging and when the primary care led NHS is adapting to new ways of working and thinking. Through these standards it is possible for organisations, whether new or existing, to prepare for the future.

Project for health authorities and primary care commissioners

King's Fund Organisational Audit set up the project to develop standards and an organisational audit process for health authorities early in 1995.

Six pilot sites were chosen to participate:

- Coventry Health
- Doncaster Health
- Dorset Health Commission
- North Staffordshire Health Authority
- Sheffield Health Authority
- South and West Devon Health.

Following the experience of the pilot organisations and an external consultation exercise, the standards and criteria have been revised and refined.

Separate standards and criteria for primary care commissioners have been developed following the pilot project, and are currently being evaluated.

Organisational audit

Organisational audit is an independent and voluntary audit of the whole organisation. It is based on a framework of explicit standards and criteria which are concerned with the systems and processes for the delivery of health care. It involves the evaluation of compliance with those standards by means of external peer review carried out by a team of senior health care professionals following a period of preparation and self-assessment. The King's Fund Organisational Audit programme complements local and professional initiatives, recognises and spreads good practice and supports continuous organisational development.

Application of the standards

Stage 1: Preparation, self-assessment and implementation

Over a period of nine months to a year the health authority works with standards and criteria in the Organisational Audit manual. The identification of a coordinator to lead the process and the establishment of a steering group are key to maximise success. An initial baseline assessment of compliance with the standards and criteria is carried out to identify priorities for action. Self-assessment questionnaires, contained in the manual, are completed for each department/ service. The preparation and implementation period is supported by King's Fund Organisational Audit, which advises the organisation throughout the process. A mock survey may be conducted two to three months before the survey by the organisation itself. Six weeks prior to the survey, self-assessment forms are completed and returned to King's Fund Organisational Audit with supporting background documentation. This includes a profile of the organisation.

Stage 2: Survey

An independent team of senior health professionals, chosen for their experience, knowledge, credibility and appropriateness for the organisation, undertake the peer review survey. Surveyors are selected and trained by King's Fund Organisational Audit. Surveyors receive the self-assessment, organisation profile details and supporting documentation in advance of the survey and this enables them to build up a picture of the organisation before the survey begins. The survey, which lasts for three days, involves a documentation review, meetings with staff and internal and external visits.

Stage 3: Report

A verbal debriefing is given to staff at the end of the survey summarising key themes and overall observations. A detailed written report follows eight weeks later. This includes a comprehensive assessment of compliance against the standards. It also highlights good practice and provides a basis for developing future action plans and monitoring progress.

Standards development

The development and subsequent revision of the standards and criteria have been led by health professionals from pilot organisations and invited individuals: GPs; chief executives; consultants in public health medicine; directors of commissioning, primary care, information, human resources and corporate development; managers for contracts, quality, planning, GP fundholders and many more.

Members have tried to ensure that standards and criteria are:

measurable	both by the staff implementing the criteria and by the surveyors measuring compliance against them
achievable	some organisations will find it more difficult to achieve the criteria than others, but there is little point in including criteria that are not achievable
flexible	so that they can be used by all types or sizes of health authorities
acceptable	representing a consensus on currently accepted roles and responsibilities
adaptable	non-prescriptive – stating what should be in place and not how something should be put in place – so they can be implemented in accordance with local needs
nationally applicable	a common framework against which all health authorities within the UK can be assessed – so it is important to ensure that they reflect national needs.

In developing a framework for the standards, attention has been paid to the national direction of health authorities as set out in EL(94)79 and by the emerging roles being adopted by health authorities across the country. In particular, we have attempted to reflect the challenge and new responsibilities in developing primary care led commissioning.

Five of the eight standards reflect their emerging role as 'enablers' of commissioning: Health strategy, Effective partnerships and alliances, Support for primary care led commissioning, Performance management of primary care and Practitioner services and support of primary care delivery.

Health authority responsibilities for contracting for primary, secondary and tertiary care and for statutory 'required' functions are included under two standards: Effective purchasing and Required functions.

Underpinning this is the core organisational standard which we describe as Organisational fitness and which embraces many features. Those that we have highlighted are general management, performance management, information, human resources, financial services, communication, and facilities and equipment.

Review and revision

It is a time of considerable change for health authorities across the UK. To ensure the King's Fund Organisational Audit standards and criteria reflect these changes and are representative of best practice, we will continue to review the standards and criteria on an ongoing basis.

To assist us in this process, there is a section at the end of each standard for comments to be recorded.

As part of this continual review process, we will be working with authorities in Northern Ireland and Scotland to ensure that future criteria reflect regional variations.

Organisational context

Organisational Audit does not prescribe or review organisational structures. There is no preferred structure for health authorities. The current and future scene is characterised by diversity.

The only assumption made about health authority structure and organisation is the move away from functional divisions and the increase of matrix working. Resources are used in flexible ways with an emphasis on project groups and on outputs. The standards do not therefore follow a functional, departmental pattern. In use, a single standard is likely to be applicable across the organisation.

Interpretation

Guidance information is shown in italics beneath some of the criteria in the manual. The aims of the guidance are threefold: first, to help staff interpret the criteria; secondly, to provide guidelines for meeting the criteria; and thirdly, to provide an indication of the areas that the surveyors will be assessing during the survey.

Cross-referencing

It is recognised that the sections of health authorities and primary care organisations do not operate as discrete entities. Indeed, one of the benefits of participating in the Organisational Audit process is that it encourages multidisciplinary working. For this reason many of the criteria have been cross-referenced to criteria relevant to different disciplines.

Working with the standards and criteria

The standards form the central element of Organisational Audit around which three features, previously described, are built:

- application of standards
- self-assessment
- external peer review.

Organisational Audit is only powerful when these are combined.

Staff at all levels should be involved in working with the criteria relevant to their area of work. This encourages ownership of the process and group discussion. It also facilitates the identification of weak and problem areas, bringing out into the open different staff members' perceptions of how well their service is complying with the criteria. There is limited value in managers completing the self-assessment of the service against the criteria based only on their own perception of the situation.

For health authorities in particular, peer review will need to look at the external links as much as the internal processes. We estimate that half of the survey process will involve review of Organisational Audit standards with the alliance partners of the health authority.

Weighting classifications

Each criterion has been allocated a priority weighting according to one of three predetermined classifications. This has been done to identify criteria which are fundamental to the way in which the organisation conducts its business, and to help prioritise the work. The classifications are:

A Essential practice

If these criteria are not in place then:

- legal and/or professional requirements will not be met
- a risk to staff and/or visitors will be created
- statutory, NHS Executive, employment or other contractual obligations will not be met.

B Good practice

Standard good practice one would expect to find in any health authority across the UK.

C Desirable practice

Good practice that is not yet standard across the UK.

Standard 1

Health strategy

The health authority has a long-term strategic vision for health contained in a clear, shared and comprehensive plan which describes health targets and how they are to be achieved.

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA		YES	NO		PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
1.1	There is a written health strategy in place.	☐	☐	A	
1.2	The health strategy reflects:				
1.2.1	the assessment of health and health needs of the local population	☐	☐	A	
1.2.2	national planning guidance and targets	☐	☐	A	
1.2.3	locally determined priorities and specific health targets	☐	☐	A	
1.2.4	epidemiological and demographic evidence	☐	☐	B	
1.2.5	a response to national and supra-district issues	☐	☐	B	
1.2.6	proposals for implementation including milestones to measure progress	☐	☐	B	
1.2.7	plans which extend to five years	☐	☐	B	
1.2.8	the values of the organisation	☐	☐	B	
1.2.9	the availability of resources	☐	☐	B	
1.2.10	an approach to quality management	☐	☐	C	
1.2.11	the configuration of health services	☐	☐	C	

↓

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA		YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
1.2.12	knowledge of the internal market.	☐☐ C	
	GUIDANCE *The health strategy will have been issued or reviewed within the last 12–18 months.*		
1.3	The health strategy is:		
1.3.1	developed with and agreed by GPs	☐☐ B	
	GUIDANCE *This consent may have been reached through consultation with GP forums as well as individual GPs.*		
1.3.2	developed with local authorities	☐☐ B	
	GUIDANCE *Especially for strategies concerned with continuing health needs for elderly, disabled, vulnerable people and children and with mental health services.*		
1.3.3	broadly supported by NHS providers.	☐☐ B	
	GUIDANCE *Especially in relation to configuration of health services.*		
1.4	The health strategy is developed through consultation with and contributions from:		
1.4.1	local people	☐☐ A	
1.4.2	representatives of health professions	☐☐ B	
1.4.3	local alliance partners.	☐☐ B	
	GUIDANCE *Local people should include:* • *users*		

↓

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA	YES	NO		PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
• *carers* • *patient associations* • *community representatives* • *minority groups.* *Consultation should take into account the requirements of the Code of Practice on Openness in the NHS (1995).* *Representatives of health professions should include:* • *independent contractors* • *GPs, general dental practitioners (GDPs), opticians and pharmacists* • *professions allied to medicine* • *clinical representatives in community and acute trusts.* *Local alliance partners should include:* • *local authorities: social services, housing, environmental health, education* • *community health councils* • *voluntary organisations* • *statutory or independent providers* • *local employer and employee organisations.*				
1.5 The health strategy is widely accessible and understandable, especially to local people. *GUIDANCE* *The strategy should be written in clear English and translated to reflect the ethnic minority population.*	☐	☐	B	
1.6 There is a mechanism to review and update the health strategy.	☐	☐	B	
1.7 Progress against milestones is monitored.	☐	☐	A	

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA

YES NO

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

1.8 There is an annual commissioning plan which sets out how the health strategy is to be achieved. ☐☐ A

GUIDANCE

The commissioning plan may be known as a purchasing plan, purchasing intentions plan etc.

The annual commissioning plan should:

- *reflect the annual report of the director of public health*
- *reflect the five year strategy*
- *be joint or coordinated with fundholder commissioning plans*
- *give a clear direction to providers about purchasing intentions*
- *contain a financial context which includes an investment programme for primary care*
- *reflect the community care plan*
- *reflect agreed clinical audit priorities*
- *reflect the health needs of the local population.*

COMMENTS

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

If you think that any of the criteria should be weighted differently, please indicate how and why.

Standard 2

Effective partnerships and alliances

The health authority has effective strategies and mechanisms to promote alliances throughout the community to deliver the local health strategy and actual health improvement.

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA		YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
2.1	There are working arrangements to enable the following local people to influence and contribute to the work of the health authority:		
2.1.1	users	☐☐ B	
	GUIDANCE *These should include physically disabled people, people with mental health problems, parents of children with disabilities etc.*		
2.1.2	patient associations	☐☐ B	
2.1.3	community representatives	☐☐ B	
	GUIDANCE *These should include minority groups.*		
2.1.4	carers.	☐☐ C	
	GUIDANCE (FOR ALL ABOVE) *Evidence should include:* • *the use of focus groups or equivalent* • *the use of citizens' juries* • *the use of patients' forums*		

↓

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA		YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
	• *regular meetings, agendas, minutes and action plans (see Communication, page 45).*		
	Areas for public debate include: • *priority setting* • *service shifts* • *purchasing plans* • *promoting healthy lifestyles.*		
2.2	There are working arrangements to enable the following alliance partners to influence and contribute to the work of the health authority:		
2.2.1	local authorities: social services, housing, environmental health, education	☐☐ A	
2.2.2	community health councils	☐☐ A	
2.2.3	local professional organisations	☐☐ A	
	GUIDANCE *These will include local medical committee, local dental committee, local pharmaceutical committee, local opticians' committee.*		
2.2.4	statutory providers	☐☐ B	
2.2.5	(other) local commissioning organisations and agencies	☐☐ B	
2.2.6	voluntary organisations	☐☐ C	
2.2.7	independent providers	☐☐ C	
2.2.8	local employer and employee organisations.	☐☐ C	
	GUIDANCE *For example:* • *trade unions* • *trade councils.*		

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA	YES	NO		PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
2.3 There is a framework to promote joint working between alliance partners.	☐	☐	A	
GUIDANCE *Evidence will include:* • *alliance partners' strategies and plans clearly influence and are reflected in health priorities and plans* • *the identification of overlaps and gaps in services provided by alliance partners with agreed action plans which make the best use of resources* • *clear agreement between partners on:* - *delivery of Health of the Nation targets* - *Care in the Community* - *Health for All 2000* - *children's services* - *health promotion/education.*				
2.4 Health authorities work with local authorities in joint commissioning.	☐	☐	B	
GUIDANCE *Joint commissioning primarily involves social services departments but may also include education departments. It requires the involvement of GPs, other health providers and representatives of users and carers in key aspects such as setting of continuing care policies and eligibility criteria.*				
2.5 There is local agreement on:				
2.5.1 policies for continuing health care needs	☐	☐	A	
2.5.2 eligibility criteria for continuing health care needs	☐	☐	A	
2.5.3 the level and range of services to be invested in and future priorities	☐	☐	A	

↓

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA		YES NO	
2.5.4	operational procedures for continuing care	☐☐	A
	GUIDANCE *These should include:* • *review procedures on hospital discharge decisions* • *contingency plans* • *dispute procedures between statutory agencies (reference: HSG/(95)8/LAC (95)5 NHS Responsibilities for Meeting Continuing Health Care Needs).*		
2.5.5	major changes in pattern of services	☐☐	A
2.5.6	monitoring of continuing care requirements.	☐☐	A
2.6	The health authority publishes the local policies and eligibility criteria for continuing health care needs.	☐☐	A
2.7	Benefits of joint commissioning are assessed.	☐☐	C
2.8	There is contact between alliance partners at all levels of each organisation.	☐☐	C

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

COMMENTS

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

If you think that any of the criteria should be weighted differently, please indicate how and why.

Standard 3

Effective purchasing

The health authority is organised to purchase health care services which maximise health gain for the population based on the best use of evidence on health, clinical effectiveness and resource use.

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA

YES NO

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Evidence based purchasing

3.1 There is an integrated approach to purchasing by the health authority and by primary care practitioners which makes use of:

3.1.1 public health input ☐☐ A

GUIDANCE
For example, use of health needs assessment of the local population.

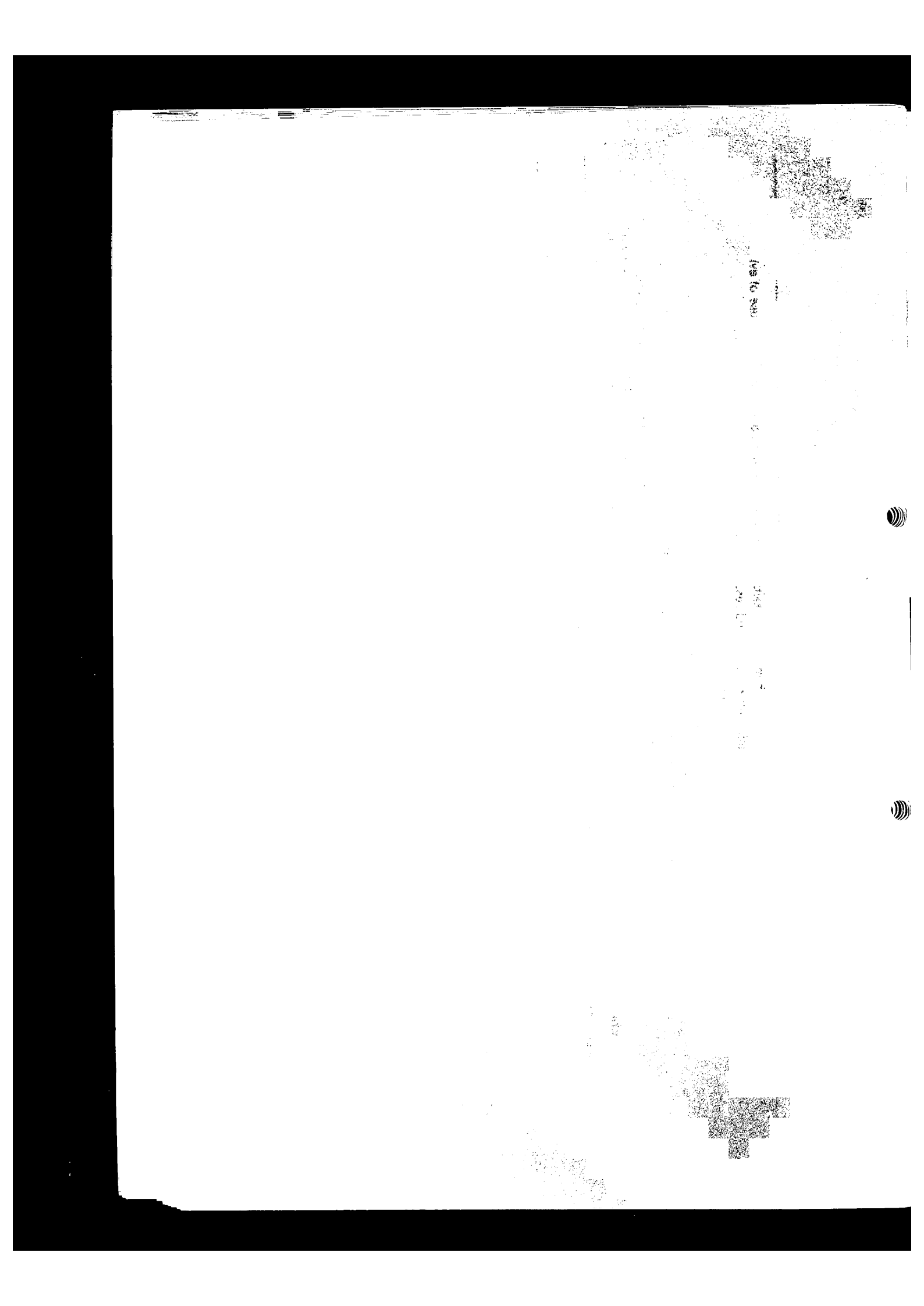
3.1.2 links with contractor professions ☐☐ A

3.1.3 local advisory networks ☐☐ B

3.1.4 independent professional advice. ☐☐ C

3.2 Information required to determine the health status of the local population is identified and readily available. ☐☐ B

GUIDANCE
Information should be available to planning and contracting functions and to alliance partners. Information about practice populations should be gathered and assessed.



Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA		YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
3.3	Information on effectiveness of interventions is available to:		
3.3.1	the health authority	☐☐ A	
3.3.2	general practices	☐☐ B	
3.3.3	other providers	☐☐ B	
3.3.4	the public.	☐☐ C	
	GUIDANCE *Identified clinical, cost effectiveness and local resource usage issues should inform:* • *communications with the public* • *investment and disinvestment* • *priorities* • *prescribing.*		
3.4	Information on effectiveness of interventions is reflected in purchasing plans and contracts.	☐☐ B	
	GUIDANCE *Local programmes of action on clinical effectiveness should make best use of the resources identified in Promoting Clinical Effectiveness (1996).*		
3.5	The following are available:		
3.5.1	a service which holds essential publications	☐☐ C	
3.5.2	literature reviews	☐☐ C	
3.5.3	access to on-line databases.	☐☐ C	
3.6	The uptake of these services is monitored.	☐☐ C	
3.7	There is a clinical audit programme.	☐☐ A	

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA		YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
3.8	The clinical audit programme:		
3.8.1	informs the contracting process	☐☐ A	
3.8.2	is agreed with provider clinicians and GPs	☐☐ B	
3.8.3	defines objectives	☐☐ B	
3.8.4	monitors performance against these objectives	☐☐ B	
3.8.5	is reflected in the health strategy	☐☐ B	
3.8.6	indicates the links between primary and secondary care audit.	☐☐ C	
	GUIDANCE *The clinical audit programme should inform interventions purchased, quality standards and service requirements.*		
3.9	There are clinical practice guidelines/protocols for selected interventions.	☐☐ B	
	GUIDANCE *Health authorities should demonstrate that protocols are in use/under development and that interventions are linked to purchasing plans and contracts (see 3.4).*		

Research and development

3.10	Use is made of national and international research and development (see 3.3).	☐☐ B	
3.11	A research and development strategy is in place which includes arrangements to commission local research and development.	☐☐ B	
	GUIDANCE *This should include multidisciplinary research and development in primary care, and build on the NHS R & D Strategy and Culyer Report (EL(96)47).*		

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA

YES NO

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Effective contracting

3.12 Responsibility for contract management and negotiation is clearly assigned. ☐☐ B

3.13 Strategic aims and priorities are reflected in contract specifications and in the majority of specific contracts. ☐☐ B

3.14 Specifications are drawn up for:

3.14.1 service requirements ☐☐ B

3.14.2 quality standards. ☐☐ B

GUIDANCE
In drawing up specifications the following should be covered in some form:
- *timeliness*
- *involvement of key stakeholders*
- *national and local targets*
- *tertiary referrals*
- *protocols*
- *clinical audit*
- *evidence based purchasing.*

Completed specifications should be made available to users, users' representatives and alliance partners as appropriate.

3.15 GPs are involved in the:

3.15.1 contract specification ☐☐ B

3.15.2 contract decision making. ☐☐ B

GUIDANCE
The level of involvement of GPs will vary. The key stages in the process are:
- *strategic development*

↓

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA

YES NO

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

- *needs assessment*
- *contract specification*
- *contract decision making.*

3.16 Relevant health care professionals in provider units are involved in contract negotiations on service levels and quality specifications. ☐☐ B

GUIDANCE
There should be evidence of liaison between health authority clinical or contracting staff and clinical staff in the provider organisation, especially clinical directors. Clinical audit and evidence based purchasing should feed into the contracting process.

3.17 There is evidence that the health authority is working with providers to develop contracting based on health care resource groups (HRGs). ☐☐ A

3.18 Different forms of contracting are used. ☐☐ B

GUIDANCE
The health authority should consider the following:
- *use of performance measures to include health outcomes*
- *use of appropriate contract currency*
- *moves to longer term contracts*
- *use of case mix information.*

3.19 There is a systematic contract monitoring procedure. ☐☐ A

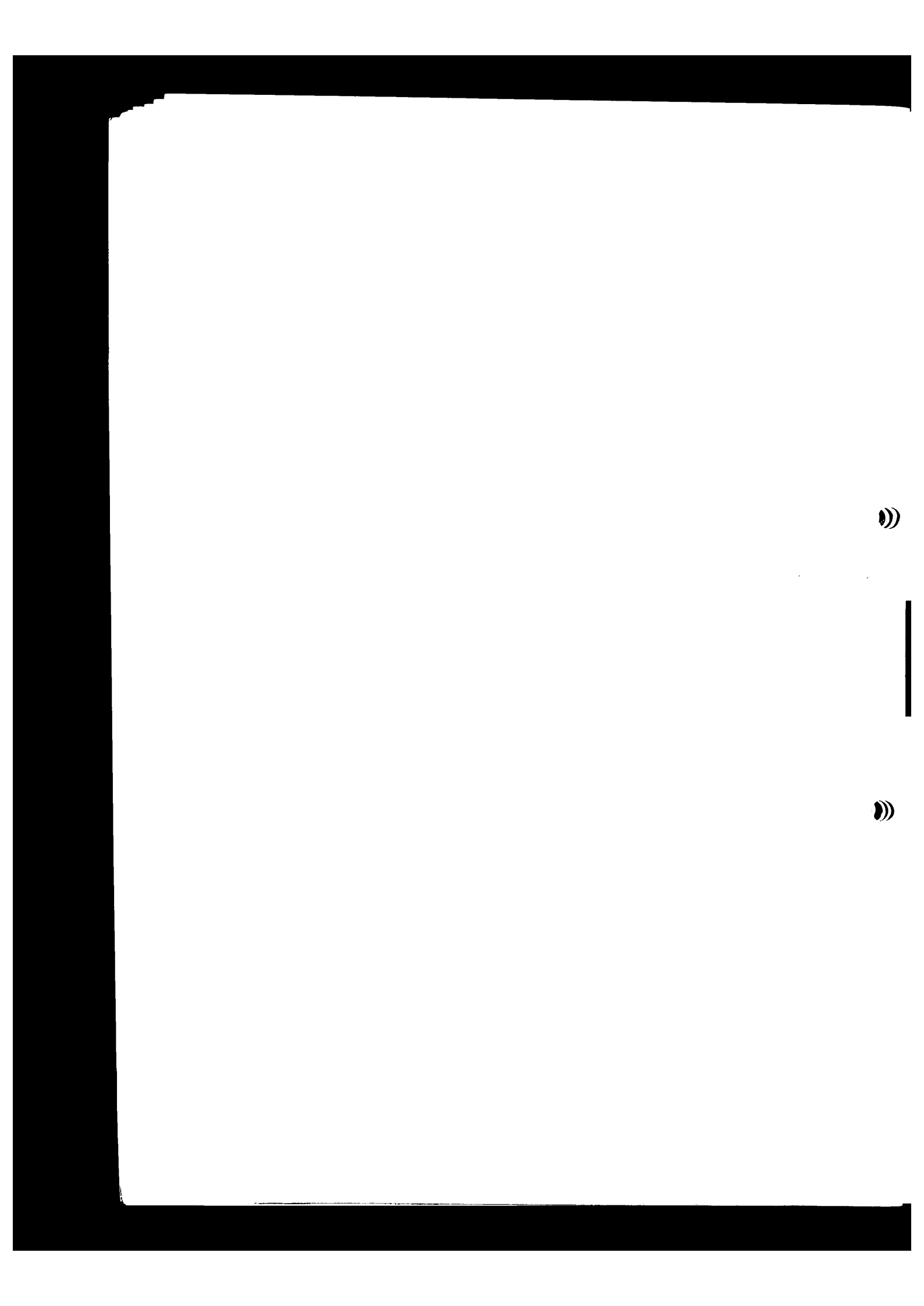
GUIDANCE
Examples of monitoring may be:
- *exception reporting on cost, quality and volume*
- *analysis of waiting list information and other targets*
- *analysis of extra-contractual referral levels by practice and service or speed of system*

↓

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA	YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
• *comparison of performance against clinical effectiveness specification* • *evaluation of patient/carer satisfaction* • *trends from complaints monitoring* • *an explicit policy to manage variations in performance against contract* • *clear links back to the strategy and priorities* • *a process to share information, including referral patterns, with GPs* • *a process to involve representatives from local commissioning organisations* • *comparison with appropriate benchmarks.* *Monitoring procedures should explain how users and users' representatives, especially the community health councils and providers, contribute to the monitoring of quality of services.*		
3.20 Contract specifications and procedures are coordinated with those produced by GP fundholders. *GUIDANCE* *Indicators may include:* • *common monitoring* • *common documentation* • *sharing of information.*	☐☐ A	
3.21 Contract specifications and procedures take into account advice from, and evidence produced by, other local commissioning organisations.	☐☐ C	
Influencing the market		
3.22 There is a plan which links knowledge of the internal market to the health strategy and purchasing intentions (see 1.2.12, 1.8). *GUIDANCE* *Information and analysis of the current market should inform:* • *comparison of current provision with health needs*	☐☐ C	

↓



Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA

YES NO

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

- *strengths and weaknesses of providers*
- *level of risk associated with loss of contracts by providers*
- *identification of alternative providers, e.g. independent sector*
- *priorities for market influence*
- *pricing and understanding of the way costs differ.*

Knowledge of the market should include all the key players, for example GP fundholders, providers, GPs, social services departments, other purchasers.

3.23 Procedures exist for the health authority to monitor trends in provider performance and viability. ☐☐ A

GUIDANCE
Methods may include:
- *scenario planning*
- *sensitivity analysis*
- *monitoring of provider reports*
- *monitoring of purchasing intentions/referral patterns, including fundholding and other commissioning agencies*
- *analysis of private finance initiative business cases.*

3.24 The information collected is analysed and reported to the health authority on a routine basis. ☐☐ B

3.25 Reviews of the market are undertaken. ☐☐ C


COMMENTS

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

If you think that any of the criteria should be weighted differently, please indicate how and why.

Standard 4

Support for primary care led commissioning

The health authority meets its obligations to commissioning practices and has policies supporting the expansion of primary care led purchasing.

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA		YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
4.1	An information service is available to support commissioning decision making.	☐☐ B	
4.2	A wide range of information is available which includes:		
4.2.1	demographic trends	☐☐ B	
4.2.2	health needs assessment	☐☐ B	
4.2.3	historic use of secondary care services	☐☐ B	
	GUIDANCE *This will include referral patterns and trends.*		
4.2.4	contracts	☐☐ B	
4.2.5	performance data relating to providers	☐☐ B	
4.2.6	clinical effectiveness	☐☐ B	
	GUIDANCE *This information should include systematic reviews of research findings, clinical guidelines and health bulletins.*		
4.2.7	examples of purchasing practice.	☐☐ C	

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA	YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
4.3 All practices are informed of:		
4.3.1 the information and advice available	☐☐ B	
4.3.2 how to comment on the information service.	☐☐ C	
4.4 There is a policy regarding the development of primary care led commissioning.	☐☐ A	
4.5 This policy:		
4.5.1 is communicated to all practices	☐☐ A	
4.5.2 includes a statement on the expansion of direct purchasing	☐☐ A	
GUIDANCE *The health authority should inform practices about the benefits, disadvantages and responsibilities of increasing levels of direct purchasing. Information should be available on the range of current models for the involvement of GPs and primary health care teams.*		
4.5.3 enables all GPs to become involved in commissioning.	☐☐ B	
4.6 The health authority establishes communication links with all primary care practitioners and/or practices.	☐☐ B	
GUIDANCE *This may be to individual GPs or through practices.*		

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA

YES NO

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

4.7 There are equitable arrangements for allocating resources to commissioning GPs. ☐☐ A

GUIDANCE
This should include all the different types of fundholding commissioning organisations and/or locality purchasing groups. The setting of budgets may be notional or actual.

These arrangements should refer to:
- *the GP accountability framework*
- *clear timetabling*
- *information to and advice from GPs.*

4.8 The arrangements are:

4.8.1 agreed locally ☐☐ B

4.8.2 clear. ☐☐ B

4.9 Practices are assisted in developing their commissioning skills and capacity. ☐☐ C

GUIDANCE
Support should include:
- *development needs*
- *information*
- *advice*
- *secondment*
- *monitoring of staff development and training plans.*

The system used should include a clear picture of expressed needs of the primary health care team and how the health authority could help.

COMMENTS

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

If you think that any of the criteria should be weighted differently, please indicate how and why.

Standard 5

Performance management of primary care

The health authority is organised to carry out assessment and monitoring to ensure that practitioners meet contractual obligations and accountability responsibilities.

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA	YES NO		PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
5.1 The health authority has a clear system in place to enable potential fundholding or total fundholding practices to meet eligibility criteria.	☐☐	A	
5.2 Arrangements are in place to ensure that the fundholding accountability framework is implemented.	☐☐	A	
GUIDANCE *See summary in Accountability Framework for GP Fundholding (England and Wales only).*			
5.3 Action is taken following regular review meetings between the health authority and fundholding practices.	☐☐	A	
5.4 A business planning cycle for general practice is in operation.	☐☐	A	
5.5 The business planning cycle is agreed locally.	☐☐	B	
5.6 The health authority monitors:			
5.6.1 the GP contract	☐☐	A	
5.6.2 the development of services	☐☐	A	
↓			

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA		YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
5.6.3	the application of GP fundholder regulations	☐☐ A	
5.6.4	the work of other local commissioning organisations.	☐☐ B	

GUIDANCE
Monitoring may cover:
- *prescribing*
- *administration of complaints*
- *practice leaflets*
- *referral patterns*
- *patient satisfaction*
- *premises*
- *staffing arrangements*
- *computing*
- *accountability.*

5.7 There are arrangements for regular reporting on the delivery of primary care. ☐☐ A

GUIDANCE
For example, through practice plans and annual reports. Reports should include a review of performance against agreed plans.

COMMENTS

Please comment on the standards and criteria in the space below.
This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

If you think that any of the criteria should be weighted differently, please indicate how and why.

Standard 6

Practitioner services and support of primary care delivery

The health authority meets its statutory obligations to practitioners in primary care and has policies supporting the improvement of primary care delivery.

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA		YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Policies and guidelines			
6.1	Written policies/guidelines are developed for the following:		
6.1.1	provision of secondary care	☐☐ A	
	GUIDANCE *Reference: A National Framework for the Provision of Secondary Care within General Practice (HSG(96)31).*		
6.1.2	complaints procedures (see 6.13)	☐☐ A	
6.1.3	prescribing, including incentive schemes	☐☐ B	
6.1.4	premises	☐☐ B	
6.1.5	practice staff training	☐☐ B	
6.1.6	IT development	☐☐ B	
6.1.7	approval of additional principals	☐☐ B	
6.1.8	branch surgeries and practice boundaries	☐☐ B	
6.1.9	allocation of patients	☐☐ B	
6.1.10	practice charter	☐☐ B	

↓

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA		YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
6.1.11	an extended range of general medical services	☐☐ B	
	GUIDANCE *These services may include:* • *health promotion* • *child health surveillance* • *family planning* • *minor surgery.*		
6.1.12	dispensing practices	☐☐ B	
6.1.13	primary health care team development	☐☐ B	
6.1.14	additional practice staff	☐☐ B	
6.1.15	access to NHS dentistry	☐☐ B	
6.1.16	partnership agreements.	☐☐ C	
6.2	Policies are reviewed annually or upon red book update, whichever is sooner.	☐☐ C	
6.3	All practitioners for which the health authority is responsible:		
6.3.1	are made aware of the existence of these policies and their updates	☐☐ B	
6.3.2	have access to them on request.	☐☐ B	
6.4	Policies/guidelines are drawn up in consultation with:		
6.4.1	local medical committees	☐☐ C	
6.4.2	local dental committees	☐☐ C	
6.4.3	local pharmaceutical committees	☐☐ C	
6.4.4	local opticians' committees	☐☐ C	

↓

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA		YES	NO		PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
6.4.5	community health councils	☐	☐	C	
6.4.6	regional consortia (where present).	☐	☐	C	
6.5	There is evidence that decisions are informed by these policies.	☐	☐	C	

GUIDANCE
For example, an audit trail.

National regulations

6.6	All practitioners for which the health authority is responsible:				
6.6.1	are made aware of the existence of national regulations and their update	☐	☐	A	
6.6.2	have access to them on request.	☐	☐	A	

GUIDANCE
National regulations include:
- *terms and conditions of service*
- *statement of fees and allowances.*

Payment

6.7	Payments to primary care are:				
6.7.1	accurate	☐	☐	A	
6.7.2	made within a defined timescale.	☐	☐	A	
6.8	All payments are accompanied by clear remittance advice.	☐	☐	A	

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA	YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Advice		
6.9 Up-to-date and accurate advice is provided for:		
6.9.1 interpretation of policies in discretionary areas (see 6.1)	☐☐ B	
6.9.2 interpretation of national regulations (see 6.6)	☐☐ B	
6.9.3 matters relating to prescribing	☐☐ B	
6.9.4 demography	☐☐ B	
6.9.5 research findings	☐☐ B	
6.9.6 secondary care policies.	☐☐ B	
GUIDANCE *For example, extra-contractual referral exclusions.*		
6.10 The method for accessing this advice is communicated to all practitioners.	☐☐ B	
Patient registration		
6.11 The database of patients registered with practices is updated and regularly validated in consultation with the practice.	☐☐ A	
6.12 The transfer of patients' notes meets national and local charter standards.	☐☐ A	
Complaints		
6.13 The health authority ensures the following:		
6.13.1 there is a system for patients to register complaints regarding practitioner services	☐☐ A	
6.13.2 each practice has a written policy and procedure for handling complaints	☐☐ A	

↓

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA	YES	NO		PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
6.13.3 a written explanation of the complaints procedure is available to the public	☐	☐	A	
6.13.4 there are conciliation and advocacy services available.	☐	☐	A	
6.14 There is an appeals mechanism.	☐	☐	A	
6.15 The health authority monitors the number of complaints received.	☐	☐	A	

GUIDANCE
Monitoring is in accordance with national guidance (Directions to health authorities on dealing with complaints about family health services practitioners SI 1996 Nos 702 & 704).

COMMENTS

Please comment on the standards and criteria in the space below.
This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

If you think that any of the criteria should be weighted differently, please indicate how and why.

Standard 7

Organisational fitness

The health authority is led, organised and managed so as to ensure that its principal objective (i.e. Standards 1 – 6) can be met. Specifically, there are effective arrangements for general management, performance management, communications, finance, information, human resources and facilities.

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA	YES	NO		PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
General management				
Leadership				
7.1 There is an explicit mission and values statement.	☐	☐	B	
7.2 The mission statement is:				
7.2.1 linked to a coherent set of priorities	☐	☐	B	
7.2.2 understood by the whole organisation.	☐	☐	B	
7.3 Information on the role of the board, particularly non-executives, is available throughout the organisation.	☐	☐	B	
GUIDANCE *Evidence may be demonstration that the chairman and chief executive work to a coherent set of priorities which are understood by the whole organisation.*				
Management structure				
7.4 There is a written organisational chart which is updated to reflect any changes.	☐	☐	B	

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA

YES NO

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Organisational development

7.5 There is an organisational development strategy in place. ☐☐ C

GUIDANCE
The organisational development strategy should:
- *be developed with regular staff involvement*
- *include effective methods for implementation and monitoring progress*
- *coordinate with other initiatives/strategies such as information, quality, personal development, value for money.*

Corporate governance

7.6 There is a document(s) which states the constitutional arrangements of the health authority. ☐☐ A

7.7 The document has regard to central statute and national guidelines on corporate governance. ☐☐ A

GUIDANCE
The document should include:
- *a description of the power and duties of the board of directors*
- *a scheme of delegation*
- *standing orders*
- *standing financial instructions*
- *policies and procedures*
- *reference to a register of board members' interests*
- *responsibilities of registration and inspection of nursing homes*
- *compliance with the Codes of Conduct and Accountability Guidance NHSE 1994 (EL(94)40) and Code of Practice on Openness in the NHS (EL(95)42).*

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA	YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
7.8 The power and the duties of the board of directors and the standing orders are made accessible to:		
7.8.1 all staff	☐☐ A	
7.8.2 members of the public.	☐☐ A	
7.9 The standing orders specify those decisions which must be made by the board.	☐☐ A	
7.10 There are committees with terms of reference setting out membership, limits to powers and reporting arrangements to the board for:		
7.10.1 remuneration and terms of service	☐☐ A	
7.10.2 audit (see 7.41).	☐☐ A	

Board administration

7.11 There are clear arrangements to ensure the proper functioning of the board. ☐☐ A

GUIDANCE
These arrangements may include:
- *regular, minuted meetings of the management board of the health authority*
- *communicating to staff key issues arising from board and other meetings*
- *mechanisms for seeking professional advice in the development of health authority policy.*

7.12 There is a designated secretary to the board with defined responsibilities. ☐☐ A

GUIDANCE
These responsibilities should include:
- *maintaining standing orders*
- *maintaining standing financial instructions in liaison with the director of finance*
- *retaining the corporate seal and its application*
- *keeping a register of members' interests.*

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA	YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
7.13 The board:		
7.13.1 publishes an annual report and annual accounts	☐☐ A	
7.13.2 makes the annual report and annual accounts available to the public.	☐☐ A	
Performance management **(relating to a health authority's internal performance management)**		
7.14 There is a corporate plan (contract).	☐☐ A	
7.15 The corporate plan (contract):		
7.15.1 is time specific	☐☐ A	
7.15.2 is regularly reviewed	☐☐ A	
7.15.3 is monitored by routine information collection	☐☐ A	
7.15.4 contains measurable objectives.	☐☐ A	
GUIDANCE *The corporate plan (contract) should have key measures including the Patient's Charter and the efficiency index by which the health authority can judge itself and by which it is judged. It should show how responsibilities are assigned and how the strategic plan should be put into action.*		
7.16 There is a purchasing plan (see 1.8) supported by a mechanism to give feedback on performance to the public, patients, providers and other alliance partners.	☐☐ A	
7.17 Key milestones and deadlines are identified and monitored.	☐☐ B	
7.18 The responsibility and accountability for carrying out the corporate plan are clearly assigned.	☐☐ B	

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA	YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
7.19 The performance of staff is monitored against this.	☐☐ B	

Communication

7.20 There is a written communication strategy for the health authority. ☐☐ B

GUIDANCE
The strategy should indicate what, with whom, how, when and why. It should make reference to and/or reflect recommendations contained in the Efficiency Scrutiny Reports into the burdens of paperwork in trusts and health authorities. The strategy should refer to particular priorities and needs, for example communication with ethnic minorities and the importance of two way dialogue.

7.21 There are policies and procedures to support the communication strategy. ☐☐ B

GUIDANCE
These may include:
- *consultation on major health documents*
- *publication of, and access to, information and communication*
- *code of conduct on openness*
- *policy for whistleblowing*
- *responsiveness (telephone, letters) and reception of visitors*
- *handling patients' complaints and/or comments*
- *mechanisms for providing information for people whose first language is not English.*

7.22 There are mechanisms for communication with:

7.22.1 the community health council ☐☐ A

7.22.2 the local community ☐☐ B

7.22.3 health authority staff ☐☐ B

↓

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA		YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
7.22.4	alliance partners (see Standard 2)	☐☐ B	
7.22.5	the media	☐☐ B	
7.22.6	the NHS Executive.	☐☐ B	

GUIDANCE
The local community: this should reflect requirements under the Health Information Service initiative and include freephone information (HSG(95)44). Mechanisms should be developed to communicate with those who do not have access to NHS services.

7.23	The following information is published:		
7.23.1	Patient's Charter standards	☐☐ A	
7.23.2	waiting times and local health targets	☐☐ A	
7.23.3	service changes	☐☐ A	
7.23.4	complaints procedure	☐☐ A	
7.23.5	health strategy	☐☐ A	
7.23.6	health promotion literature.	☐☐ B	
7.24	There is a team briefing or equivalent process accessible to all staff.	☐☐ B	
7.25	The team briefing process is linked to key meetings of the health authority.	☐☐ B	
7.26	There is clear internal and external signposting.	☐☐ B	
7.27	There is an effective internal and external telephone system in operation.	☐☐ B	

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA	YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
7.28 The effectiveness of communications is systematically audited.	☐☐ B	
GUIDANCE *Communications with the public should reflect guidance and monitoring arrangements under HSG(95)44.*		
Finance		
7.29 There is a written financial strategy.	☐☐ A	
7.30 The financial strategy:		
7.30.1 covers forecast pay/price inflation	☐☐ A	
7.30.2 covers future uncertainty	☐☐ A	
7.30.3 addresses the management of prescribing costs	☐☐ A	
7.30.4 addresses recurring over commitments.	☐☐ B	
GUIDANCE *This should include the reporting arrangements to the health authority of over commitments funded through non-recurring monies.*		
7.30.5 supports joint commissioning	☐☐ B	
7.30.6 supports primary care development	☐☐ B	
7.30.7 supports other service developments.	☐☐ B	
7.31 Budgets are developed (as part of the business plan) with the participation of appropriate staff.	☐☐ B	
7.32 Budget holders receive financial training/guidance.	☐☐ B	

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA	YES NO		PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
7.33 The budget statement provides information relevant to the management of the department.	☐☐	B	
7.34 Budget statements are distributed to all managers and budget holders no later than 21 days after the accounting period.	☐☐	C	
7.35 Budget holders are held accountable for their financial performance.	☐☐	B	
7.36 There is a mechanism for establishing the reasons for budget variation in either income or expenditure.	☐☐	B	
7.37 A report is produced monthly for the executive management team and the health authority.	☐☐	A	
7.38 This report:			
7.38.1 sets out the financial position to date	☐☐	B	
7.38.2 reports on the performance of cash spend against profile	☐☐	B	
7.38.3 forecasts forward to the year end	☐☐	B	
7.38.4 identifies areas requiring action.	☐☐	B	
GUIDANCE *There should be a formal mechanism agreed by the director of finance for the release of development monies and other reserves during the year.*			
7.39 The report is in a format approved by the health authority.	☐☐	B	
7.40 Annual accounts are produced by 15 June.	☐☐	A	
7.41 There is an established audit committee (see 7.10.2).	☐☐	A	

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA	YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
7.42 All audit reports are considered by the audit committee. *GUIDANCE* *This should include the annual management letters.*	☐☐ B	
7.43 The findings of the audit committee are acted upon.	☐☐ B	
7.44 User friendly extracts from standing orders and standing financial instructions are issued to all budget holders.	☐☐ C	
7.45 There are written and up-to-date policies and procedures for all accounting functions.	☐☐ B	
7.46 There is a system for managing the following within specified targets:		
7.46.1 creditors	☐☐ A	
7.46.2 debtors.	☐☐ B	
7.47 There is an up-to-date capital asset register.	☐☐ A	
7.48 The capital asset register is routinely maintained.	☐☐ A	
7.49 There is a capital asset replacement programme.	☐☐ B	
7.50 There is an up-to-date inventory of 'attractive' items costing less than £5000 per item. *GUIDANCE* *For example, computers, calculators, mobile telephones, slide projectors.*	☐☐ C	

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA | YES NO | PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Information

7.51 There is a written information management/technology strategy for the health authority. ☐☐ A

7.52 The information strategy takes into account:

7.52.1 electronic links between health authorities and GP ☐☐ A

7.52.2 information from and to alliance partners ☐☐ B

7.52.3 use of information by GPs, other providers and health authority staff ☐☐ B

7.52.4 the need to monitor key milestones and deadlines in the strategy. ☐☐ B

GUIDANCE
The information strategy should:
- *define how the health authority's needs over three to five years will be provided for*
- *be derived from, and be linked to, the health strategy*
- *reflect the national information management and technology strategy (Strategy for Information Management & Technology (IM &T) in the NHS 1992)*
- *be in line with the recommendations in the NHS Executive Efficiency Scrutiny Reports 'Patients not Paper' (1995) and 'Seeing the Wood, Sparing the Trees' (1996).*

7.53 The effectiveness of information systems is reviewed on a systematic basis. ☐☐ B

7.54 Confidentiality is maintained in accordance with the Data Protection Act 1984. ☐☐ A

7.55 Unauthorised access to information systems is prevented. ☐☐ A

GUIDANCE
Guidance for health authorities given in Protection and Use of Patient Information (HSG(96)18) should also be considered.

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA	YES	NO		PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
7.56 Monitoring information integrates financial, contract and performance information.	☐	☐	B	
7.57 There are written procedures for disaster recovery of computing and network services.	☐	☐	B	
7.58 Data on screening and other clinically related services are:				
7.58.1 accurate	☐	☐	A	
7.58.2 timely	☐	☐	A	
7.58.3 complete.	☐	☐	A	
7.59 For all other data, quality is assured with regard to:				
7.59.1 accuracy	☐	☐	B	
7.59.2 timeliness	☐	☐	B	
7.59.3 completeness.	☐	☐	B	
7.60 There is a comprehensive range of information accessible to:				
7.60.1 health authority staff	☐	☐	C	
7.60.2 alliance partners.	☐	☐	C	

GUIDANCE
This may include information on:
- *secondary and primary care*
- *demography*
- *mortality*
- *morbidity*
- *quality indicators (e.g. survey results)*
- *finance*

↓

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA	YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
• *comparative performance.* *Advantage may be taken of opportunities to identify and exploit new data sources.*		
7.61 Central returns on plans, forecasts and out turns are completed.	☐☐ A	
7.62 The health authority assesses the skills required and available at executive level to analyse, model, interpret and present information.	☐☐ B	
Human resources **(includes health and safety)**		
7.63 There is a written human resource strategy for the health authority.	☐☐ C	
7.64 The strategy is in evidence at operational level.	☐☐ C	
GUIDANCE *The strategy should:* • *be reviewed on a systematic basis* • *identify an individual at senior management level with overall responsibility for developing, implementing and evaluating the strategy* • *include a rewards strategy.*		
7.65 There are documented human resource policies and procedures in operation for:		
7.65.1 employee relations	☐☐ A	
7.65.2 equal opportunities	☐☐ A	
7.65.3 recruitment and selection	☐☐ B	
7.65.4 orientation and induction	☐☐ B	
7.65.5 training and development	☐☐ B	

↓

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA		YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
7.65.6	performance review.	☐☐ B	
	GUIDANCE *Policies and procedures should:* • *comply with legislation* • *be made known to staff, and be understood by them.* • *take into account Opportunity 2000 and other relevant initiatives* • *take into account forthcoming guidance on employment law and in particular the Disability Discrimination Act 1995 and Employment Rights Act 1996.* *As part of recruitment, checks should be made of qualifications, references and health status.* *A staff appraisal system should identify:* • *objectives, strengths and weaknesses in performance* • *areas for personal development and training* • *the connection between personal and organisational objectives.*		
7.66	The health authority monitors the ethnicity of its staff.	☐☐ B	
7.67	Terms and conditions of service are:		
7.67.1	written and available to all employees	☐☐ A	
7.67.2	incorporated into individual staff contracts/letters of engagement	☐☐ A	
7.67.3	dated and signed	☐☐ A	
7.67.4	reviewed periodically	☐☐ B	
7.67.5	revised as necessary.	☐☐ B	

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA		YES NO		PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
7.68	Personnel records are maintained and include:			
7.68.1	up-to-date job descriptions	☐☐	B	
7.68.2	study leave	☐☐	B	
7.68.3	sickness/absence	☐☐	B	
7.68.4	a record of training plans and courses undertaken and completed	☐☐	C	
7.68.5	agreed job descriptions.	☐☐	C	
7.69	There is an organisation-wide health and safety policy which conforms to the requirements of Section 2(3) of the Health and Safety at Work etc. Act 1974.	☐☐	A	

GUIDANCE

The policy should ensure that:

- *the health authority/board has access to competent advice on health and safety matters (which need not be provided in-house) as required under the Management of Health and Safety at Work Regulations 1992*
- *there is a senior manager(s) with overall responsibility for ensuring that the health and safety policy is formulated, developed and implemented and that health and safety issues are properly dealt with*
- *there are first aid arrangements in place which are in accordance with the Health and Safety (First Aid) Regulations 1981*
- *there is a clear reporting procedure in place (including the reporting of accidents as required under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995, and the Control of Substances Hazardous to Health Regulations (COSHH) 1988) for recording, investigating, reporting and taking action on accidents, incidents, hazards and defects*
- *the requirements of the following regulations are taken into consideration:*
  - *Management of Health and Safety at Work Regulations 1992*
  - *Workplace (Health, Safety and Welfare) Regulations 1992*
  - *Health and Safety (Display Screen Equipment) Regulations 1992*
  - *Provision and Use of Work Equipment Regulations 1992.*

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA	YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
7.70 The health and safety policy is:		
7.70.1 regularly updated and reviewed where necessary	☐☐ A	
7.70.2 widely distributed throughout the organisation.	☐☐ C	
7.71 There is evidence that within this policy:		
7.71.1 responsibility for implementation is clearly assigned	☐☐ A	
7.71.2 there is a health and safety management plan.	☐☐ A	
GUIDANCE *The plan should clearly set out how the policy is to be implemented.*		
7.72 Staff are involved in health and safety matters.	☐☐ B	
GUIDANCE *For example, through a formal safety committee or sub committee of the staff consultative committee.*		
Facilities and equipment **(includes fire safety)**		
7.73 There are documented fire safety procedures in place which comply with legislation.	☐☐ A	
7.74 Procedures include:		
7.74.1 a documented response to recommendations made by the local fire authority	☐☐ A	
7.74.2 the provision of fire fighting equipment as appropriate which conforms to relevant standards	☐☐ A	

↓

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA		YES NO	
7.74.3	recorded evidence of the testing and maintenance of fire systems and equipment on a systematic basis by a qualified person	☐☐	A
7.74.4	prominent display of fire procedures and exit signs	☐☐	A
7.74.5	regular fire drills.	☐☐	A
7.75	There are designated individuals responsible for:		
7.75.1	ensuring the provision of all facilities and equipment	☐☐	B
7.75.2	maintenance of facilities and equipment	☐☐	B
7.75.3	security of all facilities and equipment.	☐☐	B
7.76	There is evidence that provision is made for:		
7.76.1	wheelchair access inside and outside the health authority's building	☐☐	B
7.76.2	visitors or staff with sensory or physical impairments	☐☐	B
7.76.3	car parking for disabled people	☐☐	B
7.76.4	reception of visitors.	☐☐	B
7.77	All equipment and facilities conform to existing statutory health and safety requirements.	☐☐	A

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

COMMENTS

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

If you think that any of the criteria should be weighted differently, please indicate how and why.

Standard 8

Required functions

The health authority has clear policies, procedures and organisational arrangements to fulfil specific functions delegated by the Secretary of State and required by the NHS Executive.

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA	YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Public health		
8.1 The following systems and procedures to meet statutory requirements for communicable disease surveillance are in place:		
8.1.1 a consultant with authority for communicable disease surveillance and the medical aspects of chemical incidents within telephone contact 24 hours per day	☐☐ A	
8.1.2 communicable disease surveillance procedures which are written into provider contracts where necessary.	☐☐ A	
GUIDANCE *The following should be considered:* • *the level of support for communicable disease surveillance provided by microbiology laboratory* • *the links with infection control procedures and staff in provider units* • *the procedure for the notification of infections from provider units to the health authority.*		
8.1.3 procedures to monitor vaccination and immunisation coverage	☐☐ A	
8.1.4 requirements under the Port Authorities Act.	☐☐ A	

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA	YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
8.2 The health authority has clear policies and procedures which cover:		
8.2.1 cervical screening	☐☐ A	
8.2.2 breast screening	☐☐ A	
8.2.3 child health surveillance	☐☐ A	
8.2.4 child protection.	☐☐ B	
8.3 The health authority satisfies statutory or required functions with regard to the following:		
8.3.1 AIDS Control Act 1987	☐☐ A	
8.3.2 emergency planning including arrangements to deal with chemical and nuclear incidents	☐☐ A	
8.3.3 ethnic monitoring of all inpatients.	☐☐ A	
8.4 The report of the director of public health is:		
8.4.1 published annually	☐☐ A	
8.4.2 communicated widely to alliance partners	☐☐ B	
8.4.3 used to formulate health strategy and plans.	☐☐ B	
Nursing home responsibilities		
8.5 The health authority is organised to carry out statutory requirements under the Registered Homes Act 1984.	☐☐ A	
8.6 The following are in place:		
8.6.1 specific quality standards	☐☐ A	
8.6.2 operational policies.	☐☐ A	

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA	YES NO	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
8.7 These standards and operational policies are:		
8.7.1 widely distributed and consulted upon	☐☐ B	
8.7.2 regularly reviewed.	☐☐ B	
8.8 The health authority reviews patient care plans and treatment regimens.	☐☐ C	
GUIDANCE *Reviews need to be undertaken by relevant health professionals. Evidence may include:* • *review of clinical protocols and procedures for the prevention of pressure sores* • *the promotion of continence* • *the assessment of nutritional status.*		
8.9 There is an ongoing and independent formal inspection process in place.	☐☐ A	
8.10 The formal inspection process is supplemented by ad hoc informal visits.	☐☐ B	
8.11 The health authority promotes a collaborative approach to its inspection role through:		
8.11.1 selection and training of inspectors	☐☐ A	
8.11.2 multidisciplinary teams	☐☐ B	
8.11.3 close liaison with local authorities and other regulatory bodies	☐☐ B	
GUIDANCE *Such as the Health and Safety Executive and environmental health.*		
8.11.4 inclusion of lay people in the process	☐☐ C	
8.11.5 the involvement of residents and patients' advocates.	☐☐ C	

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA	YES	NO		PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
8.12 The health authority has access to legal advice.	☐	☐	B	
Clinical negligence and personal injury litigation				
8.13 There is a clear written policy on the handling of clinical negligence and personal injury claims.	☐	☐	A	
8.14 This policy:				
8.14.1 is approved by the board	☐	☐	A	
8.14.2 conforms to the standards outlined in Clinical Negligence and Personal Injury Litigation (EL(96)11 annex B)	☐	☐	A	
8.14.3 is audited on a regular basis under the supervision of the health authority's audit committee (see 7.10.2 and 7.41).	☐	☐	A	
GUIDANCE *Under EL(96)11 the following should be in place:* • *a designated board member with responsibilities for clinical negligence* • *a designated claims manager* • *access to legal advice in accordance with NHS litigation authority* • *a database with information on all claims* • *agreed delegated financial limits for approval of settlements.*				
Complaints				
8.15 There is a clear written policy and procedure for the handling of complaints relating to:				
8.15.1 family health services practitioners (see 6.13)	☐	☐	A	

↓

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA

YES NO

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

8.15.2 purchasing decisions. ☐☐ A

GUIDANCE
These should comply with national guidance; the NHS (Functions of Health Authorities) (Complaints) Regulations 1996 (FHSL(96)18) and the directions to health authorities on dealing with complaints about practitioners.

Procedures should:
- *be easily accessible and well publicised*
- *simple to use*
- *have established time limits/performance targets for action*
- *ensure confidentiality.*

8.16 There is a designated complaints manager. ☐☐ A

8.17 The health authority ensures that all family health services practitioners have practice based systems for handling complaints (see 6.13). ☐☐ A

GUIDANCE
These systems should reflect national criteria (SI 1996 No. 702).

8.18 The health authority monitors the numbers of complaints handled by medical and dental practitioners. ☐☐ A

8.19 The health authority provides an up-to-date information leaflet on all local complaints procedures. ☐☐ A

8.20 The procedure on how to make a complaint is:

8.20.1 publicised ☐☐ A

8.20.2 made available to the public. ☐☐ A

Weighting: Essential practice A, Good practice B, Desirable practice C

CRITERIA

YES NO

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Disciplinary arrangements for family health services practitioners

8.21 There are clear written arrangements for hearing disciplinary matters relating to family health services practitioners and other authorities (or consortia). ☐☐ A

8.22 These meet the requirements of the NHS Committees and Tribunal Amendment Regulations 1996. ☐☐ A

GUIDANCE
Arrangements should include:
- *appointment of a reference committee*
- *establishment of a disciplinary committee for each of the practitioner services in accordance with guidelines referred to above.*

8.23 The arrangements are monitored against set time limits/targets. ☐☐ B

COMMENTS

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

If you think that any of the criteria should be weighted differently, please indicate how and why.

Appendix 1

Relevant legislation, regulations and guidance

A National Framework for the Provision of Secondary Care within General Practice (HSG/(96)31)

Accountability Framework for GP Fundholding

Clarifies and streamlines the accountability arrangements for GP fundholding. The principles which underpin it are of relevance to all GPs and are part of the wider strategy for the development of a primary care led NHS. The framework deals primarily with GPs' management accountability (and accountability to patients and the public).

AIDS Control Act 1987

Annual report to be submitted to the Department of Health (DoH) by health authorities. Guidance on the completion and return of reports is issued each year.

Children Act 1989

Provides the foundation for law on children in Britain. The Act requires collaboration between agencies in the provision of services to, and the protection of, children deemed to be in need. The Act emphasises the rights of the child to make informed decisions in relation to his or her own medical care.

Children's (Northern Ireland) Order 1995

Replaces the provisions of the Children and Young Persons Act (Northern Ireland) 1968 and amends the law relating to illegitimacy and guardianship.

Clinical Negligence and Personal Injury Litigation (EL(96)11)

First of a linked series of guidance notes which sets out the action required by trusts and health authorities in claims handling.

Codes of Conduct and Accountability Guidance NHSE 1994 (EL(94)40)

Concerned with the conduct and account of NHS boards and their members. Standing orders should reflect the guidance which deals mainly with exchequer funds. Areas covered include annual reports, remuneration and terms of service committees and declaration of interests and register of interests.

Code of Practice on Openness in the NHS (EL(95)42)

Sets out the basic principles underlying public access to information about the NHS. It complements the code of access to information which applies to the DoH/NHS Executive and builds upon the progress made by the Patient's Charter

in this area. Requests for information should be responded to positively except in certain circumstances, such as patients' records, which must be kept safe and confidential.

Collection of Ethnic Group Data for Admitted Patients (EL(94)DO11)

The introduction of ethnic monitoring systems in hospitals became mandatory from April 1995.

Control of Substances Hazardous to Health Regulations (COSHH) 1988

Commonly referred to as the 'COSHH requirements'.

Creation of the New Health Authorities (EL(95)24) and Accompanying Guidance on Transitional Issues

Sets out the proposed role of the new health authorities and their relationships with patients, the centre, the primary care professions, local authorities and other organisations. Three key areas are highlighted: effective purchasing, the public health role and accountability.

Culyer Report (EL(96)47)

Made a variety of recommendations about the R&D funding systems in the NHS and related topics. An implementation plan was issued by the NHS Executive in April 1995.

Data Protection Act 1984

Brings Britain into line with other Western countries in terms of the rights, duties and obligations of all persons and organisations concerned with computers and computerised data. The Act recognises the specific importance of personal data and the individual citizen's rights. The Act allows individuals right of access to information about themselves held on computer.

Developing NHS Purchasing and GP Fundholding (EL(94)79)

Sets out proposals for the development of purchasing and primary care led NHS with particular emphasis on the expansion of GP fundholding and the role of the health authority in strategy development, monitoring and support.

Directions to health authorities on dealing with complaints about family health services practitioners

Apply to any complaint made on or after 1 April 1996 and the arrangements health authorities need to have in place.

Disability Discrimination Act 1995

Makes it unlawful to discriminate against disabled persons in connection with employment, the provision of goods, facilities and services for the disposal or management of premises. It makes provisions with regard to the employment of disabled persons. This Act is applicable to Great Britain.

Emergency Planning in the NHS (Executive Handbook)

Employment Rights Act 1996

Ethnic Monitoring of Staff in the NHS: a programme of action (EL(94)12)

The aim of this programme is to achieve the equitable representation of minority ethnic groups at all levels in the NHS, reflecting the ethnic composition of the local population.

General Practice Fundholding: a primary care-led NHS (DoH 1995)

Outlines the principles behind the GP fundholding scheme. The information has been revised to take into account specific changes within the NHS from 1 April 1996.

GP Practice Charters

The Patient's Charter and Primary Health Care (EL(92)88) sets out the requirement for family health services authorities to set specific charter standards and targets. It also clarifies how primary health care teams and/or individual practices can facilitate the development of charters.

Health and Safety at Work etc. Act 1974

Sets out the relevant responsibilities of employers and people at work. The legal obligations ensure, as far as is reasonably possible, that employees and members of the public are not exposed to unacceptable risk as a result of their organisation's activities.

Health and Safety (Display Screen Equipment) Regulations 1992

States the minimum requirements for workstations with display screen equipment (in line with EEC directive 90/770 EEC).

Health and Safety (First Aid) Regulations 1981

Identifies the necessary requirements to ensure first aid can be provided in the workplace.

Health Authorities Act 1995 (transitional provisions): Order 1996

Makes transitional provision in connection with the abolition, by the Health Authorities Act 1995 on 1 April 1996, of regional health authorities, district health authorities and family health services authorities, and the establishment of health authorities. It refers to the transfer of staff and specific functions including the investigation of complaints and continuation of the community health councils.

Health for All by the Year 2000

Global strategy to improve health of the population and provide universal health care, first enunciated at the WHO/UNICEF meeting in Alma Alta in 1978.

Health of the Nation: a strategy for health in England

Sets 15 targets for the reduction of deaths caused by coronary heart disease, stroke, cancer and accidents, and the improvement of mental and sexual health (HMSO, 1992).

Health Service and Public Health Act 1968

Lays down the regulations for informing about notifiable diseases. The Public Health (Control of Diseases) Act 1984 extended the 1968 Act. It does not apply to Scotland or Northern Ireland.

Hospital Infection Control: guidance on the control of infections in hospitals (HSG(95)10)

Contains a number of recommendations for health authorities regarding the surveillance, prevention and control of hospital infection.

Management of Health and Safety at Work Regulations 1992

Set out broad general duties which apply to almost all work activities.

NHS and Community Care Act 1990

Provides for the establishment of NHS trusts; the financing of the practices of medical practitioners; the provision of accommodation and other welfare services by local authorities; and the establishment of the Clinical Standards Advisory Group.

NHS Complaints Procedure

The new complaints procedure arising out of the recommendations of the Wilson Report, 'Being Heard', came into force on 1 April 1996.

NHS Executive Efficiency Scrutiny Reports 'Patients not Paper' (1995) and 'Seeing the Wood, Sparing the Trees' (1996)

Concerned with bureaucracy in general practice and the burdens of paperwork in NHS trusts and health authorities.

NHS (Functions of Health Authorities and Administrative Arrangements) Regulations 1996

Make provision for the Secretary of State's functions relating to the health service to be exercised by health authorities, restrictions on these functions and arrangements for these functions to be exercised jointly or on their behalf by other bodies and/or committees.

NHS (Functions of Health Authorities) (Complaints) Regulations 1996 (FHSL(96)18)

Confer on health authorities the function of establishing and operating procedures for dealing with complaints about family health services practitioners.

NHS (Fundholding Practices) Regulations 1996 (No. 706)

Contain the legal requirements governing GP fundholding with effect from 1 April 1996. In addition to consolidating the 1993 regulations and subsequent amendments, they take into account the introduction of the new health authorities and regional offices, devolvement of management functions to the new health authorities and recent changes made to fundholding schemes.

NHS (General Medical Services Regulations) 1992

Consolidate and amend the NHS (General Medical Services Regulations) 1974, which relate to general medical services. They regulate the terms on which GMS are provided under the NHS Act 1977. The Amendment Regulations (No. 540) outline information to be contained in annual reports and the manner in which the information is to be presented.

NHS (Pharmaceutical Services) Regulations 1992

Consolidate and amend the NHS (General Medical and Pharmaceutical Services) Regulations 1974. They regulate the terms on which general pharmaceutical services are provided under the NHS Act 1977.

NHS Responsibilities for Meeting Continuing Health Care Needs (HSG(95)8/LAC(95)5) and Current Progress and Future Priorities (EL(96)8/CI(96)5)

Sets out guidance and monitoring arrangements for meeting continuing health care needs. Monitoring has confirmed the importance of joint working between health and local authorities in this area.

NHS (Service Committees and Tribunal) Amendment Regulations 1996

Amend the 1992 regulations and are concerned with the establishment of new complaints made against practitioners. The regulations reflect the new role of health authorities.

Operation of Community Health Councils from April 1996 (EL(96)17)

Provides guidance on the operation of community health councils following the new establishing arrangements from 1996.

Patient's Charter

The new patient's charter was launched in April 1995. The expanded charter sets out new rights and standards and aims to reduce waiting times. It also aims to promote the respect of dignity, privacy and patient choice.

Patient's Charter Monitoring Guide: key standards – April 1996

Covers key Patient's Charter standards which need to be monitored nationally and guidance on monitoring local patient's charter rights and standards.

Port Authorities Act

Priorities and Planning Guidance for the NHS: 1997/98

Identifies the national priorities for the NHS in 1997/98 and the years ahead. It builds upon previous guidance issued to health authorities. The document distinguishes between baseline requirements and objectives and medium term priorities (DoH, 1996).

Promoting Clinical Effectiveness (1996)

Describes sources of information of clinical effectiveness, suggests ways in which changes to services can be encouraged (based on well-founded information about effectiveness) and describes how changes can be assessed to see whether improvements have resulted.

Protection and Use of Patient Information (HSG(96)18)

Offers guidance on the protection and use of patient information and builds upon existing legislation and guidance such as the Data Protection Act and Code of Practice on openness in the NHS.

Provision and Use of Work Equipment Regulations 1992

Govern equipment used at work and list minimum requirements for work equipment to deal with selected hazards, whatever the industry.

Provision of the National Free Phone Health Information Service (HSG(95)44)

Responsibility for providing the health information service (HIS) was devolved to health authorities from 1 April 1996. Health authorities are required to have in place a contract with a HIS provider which reflects the requirements of the guidance under HSG(95)44. The aim of the HIS is to provide information to the public, as a means of enabling them to become more active in relation to issues concerning their own health care and treatment and in matters relating to the development of health care policies and services. In addition, there is a Patient's Charter commitment to the provision of a national HIS through the provision of a national freephone service which will form part of the contractual arrangements.

Public Health: responsibilities of the NHS and the roles of others 1993 (HSG(93)56)

Specific responsibilities include arrangements for dealing with the control of communicable diseases and infection as well as health aspects of non-communicable environmental hazards. Summarises the responsibilities of health authorities regarding the public health function.

Race Relations Act 1976

Aims to eliminate racial discrimination and to remedy individual grievances. It makes unlawful direct or indirect discrimination on the grounds of race, ethnicity or nationality in the fields of, for example, employment, education or housing. It also makes it illegal for employees, professional bodies and trade unions to discriminate either directly or indirectly on the grounds of sex or marital status, except where marital status or a particular sex can be shown to be bona fide requirements.

Raising the Standard: management standards for the registration and inspection units of health authorities

Provides a series of standards and criteria enabling health authorities and their managers to judge the appropriateness of their managerial arrangements in the work of registration and inspection under the provision of the legislation (NAHAT, 1995).

Registered Homes Act 1984

Primary legislation governing the registration and inspection of nursing homes in England and Wales.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995

Identifies the injuries, diseases and dangerous occurrences that must be reported, and the relevant authorities to which they should be reported (HMSO, 1995).

Strategy for Information Management and Technology (IM & T) in the NHS 1992

Describes a common way forward for information management and technology for all sectors of the health service in England. 'Information management' includes both computer and paper based systems.

Workplace (Health, Safety and Welfare) Regulations 1992

Cover the working environment, safety, facilities and housekeeping.

Appendix 2

Glossary

Advocate

An individual acting on behalf of, and in the interests of, a person who may feel unable to represent himself/herself when dealing with health care, or other, professionals.

Alliance partner

See Health Alliance

Appraisal system

The evaluation of the performance of individuals or groups using established criteria.

Business plan

A plan which sets out how the strategic aims of the organisation or part of an organisation are to be achieved.

Clinical guidelines

Also referred to as protocols. Procedures and practices for clinical treatment, care and management and agreed between health professionals.

Commissioning

The strategic activity of assessing needs, resources and current services, and developing a strategy to make best use of available resources.

Commissioning plan

Also known as a purchasing plan. A detailed plan for a given period which indicates how the health strategy and other objectives of a health authority are to be put into practice.

Contractors

Also referred to as contractor professions; include general practitioners, general dental practitioners, pharmacists, opticians and chiropodists.

Contract currencies

Agreed units of measurement for contracting, for example finished consultant episodes (FCEs).

Corporate contract

The monitoring arrangements between the regional office and the health authority.

Criterion

A measurable component of performance. A number of criteria need to be met in order to achieve the desired standard.

Eligibility criteria

The policies that set out who is entitled to services.

Epidemiology

The study of the occurrence, transmission and control of disease.

Evaluation

The study of the performance of a service with the aim of identifying successful and problem areas of activity.

Evidence based purchasing

The purchase of health services that have, on the basis of clinical evidence, been demonstrated to be effective.

Extra-contractual referral

The referral of an individual for health services that are not covered in the contracts that exist between the purchaser and providers of services.

Health alliance

All organisations – statutory, non-statutory and voluntary – involved in development and implementation of the strategy to improve a population's health. Also referred to as alliance partners.

Health gain

Quantifiable improvement to the health of a population, for example lower mortality rates, improved quality of life.

Health needs assessment

The investigation and evaluation of the state of people's health in a community, client group or other sector.

Health status

The outcome of health needs assessment expressed in terms of a variety of indicators, for example nutrition or the risk of becoming ill.

Health target

A specific measurable goal, as in the Health of the Nation.

Joint commissioning

A process through which the assessment of need, resources and current services, and the development of a strategy to make use of available resources, is shared between two or more agencies/alliance partners.

Organisational chart

A graphic representation of the responsibility, relationships and formal lines of communication.

Organisational fitness

The capacity of an organisation expressed in terms of knowledge, skills, policies, plans and procedures to achieve its overall purpose and objectives.

Outcome

The end result of treatment, which can be used to measure the effectiveness of care.

Performance management

The overall approach to implementation of plans and objectives by scheduling, assigning tasks and responsibilities, setting priorities, monitoring and evaluating.

Performance review

The systematic check on the achievement of organisations and individuals compared to set objectives.

Philosophy

The values of a service or department. A philosophy is characterised by statements such as 'we believe...' and 'our values are...'

Policy

An operational statement of intent in a given situation.

Primary care commissioners

General practitioners and primary health care team members who have responsibilities for purchasing, and involvement in commissioning of primary, secondary and tertiary care. The term embraces all forms of fundholders and GP commissioning groups.

Procedure

The steps taken to fulfil a policy.

Purchasing

An operational activity, set within the context of commissioning, of applying resources to buy services in order to meet needs, either at a macro/ population level or at a micro/individual level.

Quality indicator

A standard of service which acts as a measure of quality. Examples could include the evidence of infection as a likely indicator of the quality of care, or readmission rates as an indicator of the quality of discharge arrangements.

Required functions

Specific activities which are the statutory or delegated responsibilities of health authorities which fall outside of strategic, commissioning, enabling and performance management responsibilities.

Service level agreement

This term is used generically to describe a document, agreed between organisations that will provide and receive a service, which sets out in detail how the service will be provided.

Specification

Specified requirements laid down by a health authority or primary care commissioner for the provision of a given health or support service.

Standard

An overall statement of the desired performance.

Team briefing

A method of two way communication within an organisation by cascade of information and feedback within a given timescale.

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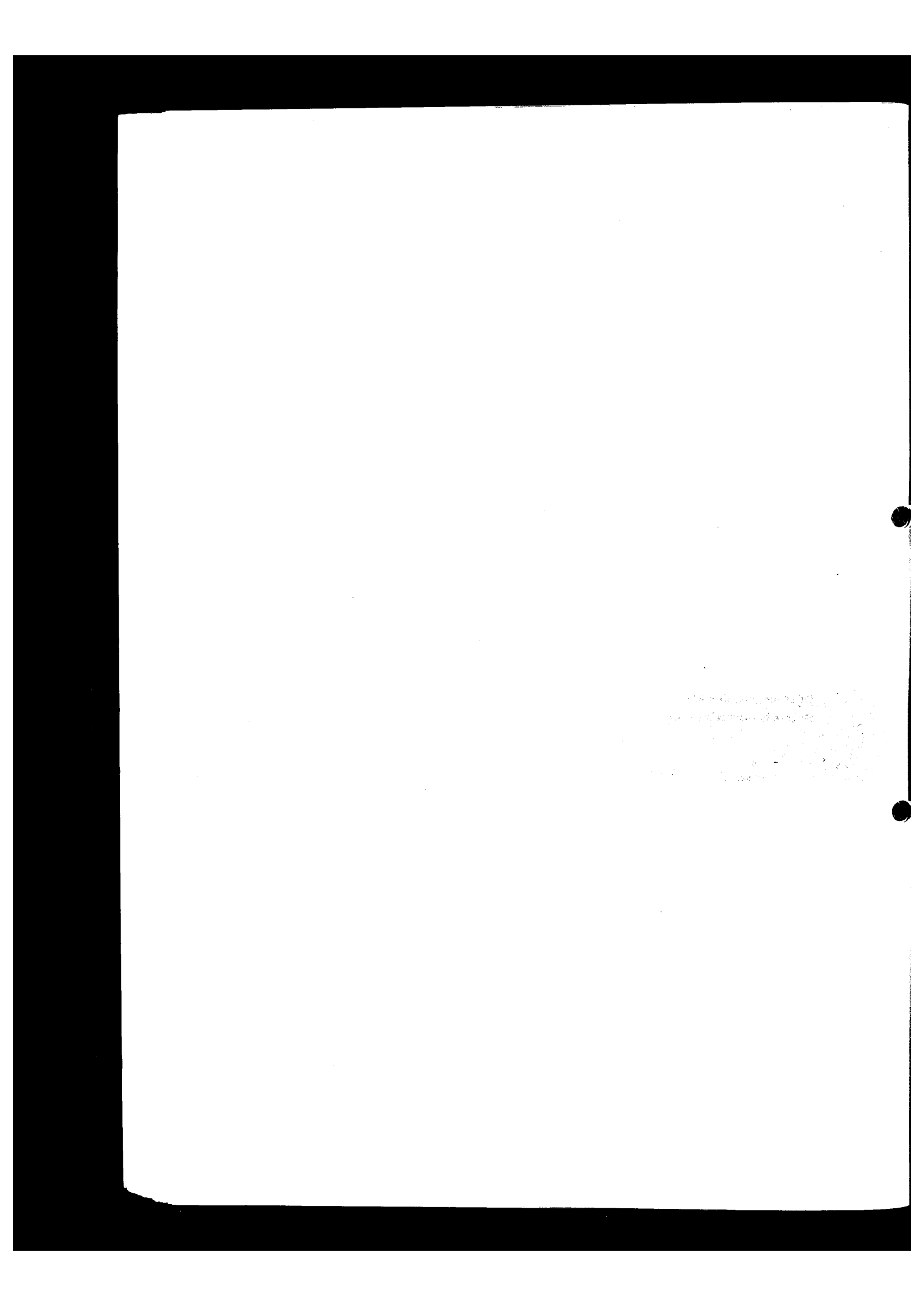

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