The King's Fund
ORGANISATIONAL
Audit

PRIMARY HEALTH CARE COMMISSIONING

Organisational Standards and Criteria

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KING'S FUND ORGANISATIONAL AUDIT STANDARDS FOR PRIMARY HEALTH CARE COMMISSIONING

INTRODUCTION

This manual contains organisational standards for primary health care commissioning. It forms one part of the King's Fund Organisational Audit (KFOA) Project for Health Authorities and Primary Health Care Commissioners. The other part covers standards for health authorities which were issued in October 1995.

The standards apply to all primary health care commissioning organisations, whether these are GP fundholding practices, multi funds or non-fundholding practices that form part of a commissioning group. They provide the commissioning organisation with a 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 as health authorities and FHSAs are merging and as the primary health 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.

THE PILOT PROJECT

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

The health authorities and primary health care organisations participating in the project are:

- Coventry Health
- Doncaster Health
- Dorset Health Commission
- North Staffordshire Health Authority
- East London and the City Health Authority
- Sheffield Health Authority
- South and West Devon Health

- Bennetts End Surgery
- Birmingham Multi Fund
- Northumberland Health (White Medical Group and ABH Consortium)
- South and West Devon Total Fund.

During 1995 and 1996 the key steps are:

- standards development
- implementation of the standards by pilot organisations over six months
- external peer review of the pilot organisations
- development and review of the whole process.

In light of the above the process and standards will be adapted and refined to be introduced as King's Fund Organisational Audit programmes for all health authorities and primary health care commissioners during 1996.

KING'S FUND 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 combines an educational and developmental emphasis with standards compliance. It sets out to complement local and professional initiatives, recognise and spread good practice and support continuous organisational development.

THE KFOA PROCESS

The standards are the central element of the KFOA process around which three features are built: application of standards, self assessment and external peer review. Organisational Audit is only powerful when they combine.

Stage 1: Self Assessment and application of standards

Over a period of nine months to a year (five to six months for pilot sites) the health authority or primary health care commissioning organisation 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.

Initially the organisation completes a self assessment of its compliance with the KFOA standards and criteria. Staff at all levels should be involved in working with the criteria relevant to their area of work. This will encourage ownership of the process and group discussion. It will also facilitate 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 a manager completing the self assessment of the service against the criteria based only on their own perception of the situation.

This initial self assessment is for internal use and enables the organisation to identify those criteria that are not met and, from this, to identify priorities and to plan the action needed to implement criteria. Again, staff at all levels should be involved in planning and implementing the action to be taken.

This preparation and subsequent implementation period is supported by King's Fund Organisational Audit which advises the organisation throughout the process.

Six weeks prior to the survey, following a period of implementation, the organisation completes a second self assessment of its compliance with the standards and criteria. This is returned to King's Fund Organisational Audit with supporting background documentation including a profile of the organisation and will be used (a) by the surveyors to build up a picture of the organisation before the survey begins and (b) by King's Fund Organisational Audit to feed any comments on the criteria into the on-going revision process.

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 by King's Fund Organisational Audit and undergo training prior to taking part in surveys.
Surveyors receive the self assessment, organisation profile details and supporting documentation. This information provides the basis for the survey. The survey considers external links as well as internal processes. It involves a documentation review, individual meetings with staff and internal and external visits. The survey lasts 3 days for health authorities and between 2-3 days for primary health care commissioning organisations.

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 six to eight weeks later. This provides a comprehensive assessment of compliance with the organisational audit standards and criteria, recommendations for change as well as highlighting good practice and provides a basis for developing future action plans and monitoring progress.

STANDARDS DEVELOPMENT

1 *The Vision of a Primary Health Care Led NHS*

Two sets of standards have been developed:

For Primary health care Commissioners

Almost 100 general practices have undertaken the KFOA primary health care programme since the standards were published in January 1994. Since the publication of the original standards the role of primary health care organisations has grown and changed. One significant change has been the role of different configurations of primary health care organisations in commissioning.

To reflect recent changes the existing KFOA standards and framework for primary health care provision will be fully revised during 1995/1996. The result will be a modular package of standards for all forms of primary health care organisations which embrace provision and commissioning.

An early part of this revision has been expanding the existing standards through the development of a discrete module of standards for the organisational requirements that relate to primary health care commissioning. The commissioning standards cover:

* planning and development of services
* service level agreements
* management arrangements

* communication

* information

These standards can be applied to individual practices, in conjunction with existing KFOA standards for primary health care provision, or to multi-practice commissioning organisations on their own.

As there are some organisational elements that relate to both the providing and commissioning functions of general practice, there is some duplication of criteria required to meet both modules of standards. It is envisaged that opportunities for greater integration of these criteria will be identified during the pilot phase of the project.

For Health Authorities

In developing a framework for health authority standards we have been strongly influenced by the national direction set out in EL 94(79) and by the emerging roles being adopted by commissions across the country.

This vision, looking ahead to 1996 and beyond, is one where health authorities adopt a predominantly enabling role alongside performance management responsibilities while practitioners increasingly lead the commissioning of health services.

In Organisational Audit terms five of the eight standards - Strategy, Effective Partnerships and Alliances, Practitioner Services and Support of Primary health care Delivery, Support for GP Led Commissioning and Performance Management of Primary health care - reflect this vision.

Beside the vision is the reality of health authority responsibilities for contracting, primary, secondary and tertiary care and for 'required' functions which must be performed to a high standard. Two standards - Effective Purchasing and Required Functions - recognise these continuing responsibilities.

Underpinning this is the core organisational requirement 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.

All the standards were developed from a variety of source material including the Mawhinney Seven Steps for Effective Purchasing, the King's Fund Framework (1993) and other review frameworks. The emphasis has now shifted to reflect the primary health care led NHS and will shift again in the months ahead.

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

Workshops have provided the main fora for standards development. The workshop members have tried to ensure that standards and criteria have the following qualities:

measurability:	*the criteria should be measurable both by the staff implementing the criteria and by the surveyors measuring compliance against them*
achievability:	*whilst it is acknowledged that some organisations will find it more difficult to achieve the criteria than others, it is also recognised that there is little point in including criteria that are not achievable*
flexibility:	*the criteria should be flexible enough to be used by all types of primary health care commissioning organisations*
acceptability:	*the criteria should represent a consensus on currently accepted roles of responsibilities*
adaptability:	*the criteria should be non-prescriptive - they state what should be in place and not how something should be put in place. The criteria can then be implemented in accordance with local needs*
national applicability:	*the Organisational Audit process offers a common framework of standards and criteria against which all health authorities and primary health care commissioners within the UK can be assessed. It is therefore important to ensure that the criteria reflect national needs.*

2 ***Organisational Context***

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

For this reason the newly developed standards for primary health care commissioners should be relevant and useful to any primary health care structure be it a single practice, fundholding organisation, multi fund, commissioning group or total fundholding site.

INTERPRETATION

Guidance information is now shown in italics beneath a number 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

Where a criterion that is required to meet one standard is related to a criterion, or criteria, required to meet another standard, it is indicated in the manual.

DEFINITION OF TERMS USED

A glossary of terms is included at the end of the manual.

WEIGHTING

Existing KFOA criteria have been allocated a priority weighting. Participating health care organisations have found that this has helped them manage their workload by focusing on the more fundamental criteria and has proved useful for prioritising and action planning. Existing criteria are weighted according to the following classifications:

A **Essential practice**
If these criteria are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or the public will be created

(iii) the patient's rights, in term of The Patient's Charter, will be compromised.

B **Good practice**
Standard good practice, expected to be in place across the UK.

C **Desirable practice**
Good practice that is not yet standard across the UK

The new primary health care commissioning standards have not yet been given a priority weighting. It is envisaged that the pilot phase of the project and subsequent consultation exercises will inform the weighting given to each criterion.

NUMBERING

Each criterion in this manual has a unique number. This number is prefixed by a C which identifies it as a criterion specifically related to the organisational requirements of commissioning.

REVIEW AND REVISION

The first editions of both the standards for health authorities and the standards for primary health care commissioners will be used by pilot organisations and the early participants in the programme.

Especially during this critical phase in the development of health authorities and primary health care organisations updating the standards must be an ongoing process.

The first edition of the standards for health authorities was widely issued for consultation in early October 1995 and this feedback together with the experience of pilot organisations will be used to prepare the second edition which will be available in the second half of 1996. Standards for primary health care organisations will be used by pilot organisations from January 1996. Consultation will follow the revision of the existing standards for primary health care provision.

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COMMISSIONING

PLANNING AND DEVELOPMENT OF SERVICES

Standard C1

There is a commissioning plan which reflects the effective and efficient use of resources to achieve strategic objectives.

Criteria	*Comments*	*Please tick* *Yes*	*No*
C1.1 There is a written plan for the commissioning of services.		☐	☐
Guidance *This may form part of an annual plan, separate commissioning document or philosophy statement*			
C1.2 The written plan:		☐	☐
C1.2.1 is informed by a process of identifying local health care needs		☐	☐
Guidance *Health care needs should be defined by the commissioning organisation, stating what is included and excluded* *There should be an outline of how the assessment of health needs is made*			
C1.2.2 is developed with the involvement of primary care team members		☐	☐
C1.2.3 includes a strategic direction		☐	☐
C1.2.4 includes annual objectives		☐	☐
C1.2.5 includes national requirements		☐	☐
Guidance *Examples include:* * *Health of the Nation (or equivalent strategy for Northern Ireland/Scotland/Wales)* * *The Patient's Charter*			

C1.2.6 reflects national planning cycles. ☐ ☐

Guidance
For GP fundholders this forms part of the Framework for Accountability for GP fundholding

C1.3 The written plan reflects local strategies for the following:

C1.3.1 locality commissioning ☐ ☐

C1.3.2 health authorities (health boards/health and social services boards) ☐ ☐

C1.3.3 NHS trusts ☐ ☐

C1.3.4 community care ☐ ☐

C1.3.5 local authority services ☐ ☐

C1.3.6 shifts in care between the acute, primary and community health care sectors. ☐ ☐
(See Information, C5.4 and C5.9)

C1.4 The written plan is discussed with the following:

C1.4.1 the locality or area commissioning group ☐ ☐

C1.4.2 local health authorities (health boards/health and social services boards) ☐ ☐

C1.4.3 local NHS trusts ☐ ☐

C1.4.4 local community health councils ☐ ☐

C1.4.5 users ☐ ☐

C1.5 The written plan seeks to improve the quality of care by:

C1.5.1 continuous monitoring through audit ☐ ☐

C1.5.2 providing evidence based care. ☐ ☐

Guidance
Research findings are accessible and reflected in the commissioning plan

C1.6 The plan incorporates a statement detailing:

C1.6.1 how savings are to be achieved ☐ ☐

C1.6.2 proposals for the use of savings. ☐ ☐

(See Commissioning Management Arrangements C3.18)

Guidance
These should reflect up-to-date NHSE guidelines

The statement may include:

* *the volume and cost of changed activities which have reduced expenditure*

* *a rationale demonstrating how the use of savings will improve services to patients*

COMMISSIONING

SERVICE LEVEL AGREEMENTS

Standard C2

There are written agreements (contracts) for services provided by staff who are not employed directly by the commissioning organisation. These identify the quality and volume of services commissioned in order to achieve the goals of the commissioning organisation.

Criteria		*Comments*	*Please tick* *Yes*	*No*
C2.1	The service level agreements are used to implement the objectives of the commissioning plan.		☐	☐
C2.2	The service level agreements include the following dimensions:			
	C2.2.1 quality (clinical and non-clinical)		☐	☐
	C2.2.2 cost		☐	☐
	C2.2.3 volume/activity.		☐	☐
C2.3	The service to be provided is clearly defined in the written service agreement.		☐	☐

Guidance
This includes:

* *a description of the service to be provided*
* *the provision of services by people that are appropriately qualified and can demonstrate continuing professional development*
* *arrangements for the collection and delivery of specimens and results, including out of hours services*
* *specification of formal lines of communication between the commissioning organisation and the service provider*

* *arrangements for monitoring and reviewing compliance with specifications*

* *mechanisms for dealing with problems in service delivery*

* *specification of arbitration procedures in case of dispute*

C2.4 The following information is held centrally:

Guidance
'Centrally' may be in the practice, multifund headquarters or health authority for commissioning groups

C2.4.1 a list of providers with which the commissioning organisation has negotiated service level agreements ☐ ☐

C2.4.2 contact names for the above ☐ ☐

C2.4.3 a full set of signed and dated agreements for all the services purchased ☐ ☐

C2.4.4 a list of authorised signatories who can act on behalf of the commissioning organisation ☐ ☐

C2.4.5 copies of documents referred to in the service level agreements ☐ ☐

C2.4.6 purchaser plans for monitoring service provision ☐ ☐

C2.4.7 provider plans for monitoring service provision ☐ ☐

C2.4.8 the providers' complaints procedures. ☐ ☐

Guidance
This includes procedures for complaints from patients.

C2.5 Service level agreements are monitored. ☐ ☐

Guidance
Examples of monitoring are:

* *exception reporting on cost, quality and volume*
* *analysis of waiting list information and other targets*
* *analysis of ECR levels by practice and service or speed of system*
* *comparison of performance against clinical effectiveness specification*
* *evaluation of patient/carer satisfaction*
* *trends from complaints monitoring*
* *a process to share information with GPs including referral patterns.*

Monitoring procedures will explain how users (and providers) contribute to the monitoring of quality of services.

C2.6 Service agreement specifications and procedures are coordinated with those produced by the health authority/health board/health and social services board. ☐ ☐

Guidance
This may include:

* *common monitoring*
* *common documentation*
* *sharing of information*

COMMISSIONING

MANAGEMENT ARRANGEMENTS

Standard C3

There are management arrangements in place to ensure that the commissioning organisation can commission health services in the most efficient and effective manner.

Criteria		*Comments*	*Please tick* *Yes*	*No*
General				
C3.1	An organisational chart clearly defines the lines of accountability and specifies roles.		☐	☐
	Guidance *This includes accountability in the practice and in the commissioning organisation(s) with which the practice is involved*			
C3.2	Identified individuals are responsible for:			
	C3.2.1 the development of service level agreements		☐	☐
	C3.2.2 developing and implementing operational policies and procedures		☐	☐
	C3.2.3 organising the administrative functions of the service		☐	☐
	C3.2.4 consulting with other members of the primary health care team when developing and planning services		☐	☐
	C3.2.5 identifying the health needs of the population		☐	☐

C3.2.6 identifying the extent to which identified health needs have been met. ☐ ☐

Guidance
These individuals may be within a practice or external, for example, within a health authority or commissioning group

C3.3 In multiple practice organisations there is a formal agreement of constitution. ☐ ☐

C3.4 The constitutional agreement includes:

C3.4.1 clear indication of responsibility for the management of health service resources ☐ ☐

Guidance
This is a direct responsibility for fundholding practices for those services covered by the fundholding scheme and an indirect responsibility for all other services.

C3.4.2 the nature of representation by named individuals within the commissioning organisation. ☐ ☐

C3.5 There are clear channels of communication with:

C3.5.1 suppliers of service agreement monitoring and activity information ☐ ☐

C3.5.2 recipients of financial information ☐ ☐

Accountability

C3.6 Accountability arrangements include:

C3.6.1 the preparation of an annual commissioning plan (See C1, Planning and Development of Services) ☐ ☐

C3.6.2 a mechanism for signalling major shifts in purchasing intentions ☐ ☐

C3.6.3 the preparation of an annual performance report ☐ ☐

Guidance
These are mandatory for GP fundholders and good practice for non fundholding practices and commissioning groups.

C3.7 The following are made available to health service users:

C3.7.1 the annual commissioning plan ☐ ☐

C3.7.2 the annual performance report ☐ ☐

Guidance
These may be produced by the practice or by whatever commissioning organisation the practice is involved with.

C3.8 Financial administrative duties are split between, and undertaken by, different members of staff in line with audit requirements for probity and security. ☐ ☐

Guidance
These people may be within the practice or within whatever commissioning organisation the practice is involved with.

C3.9 Arrangements for accountability for finance include:

C3.9.1 ensuring the preparation of annual accounts for independent audit ☐ ☐

C3.9.2 stated planning contributions to local efficiency targets set by the NHS Executive. ☐ ☐

Waiting List Management

C3.10 There is a policy for the management of waiting lists. ☐ ☐

C3.11 An identified individual is responsible for the development, implementation and monitoring of waiting list policy. ☐ ☐

C3.12 Waiting lists are reviewed on a systematic basis. ☐ ☐

Guidance
The review should update the personal details of those on the waiting list and ensure that those on the list still need treatment.

Maximum waiting times should comply with national or local targets

Finance

C3.13 Responsibility for the commissioning budget is clearly defined. ☐ ☐

Guidance
For example:
* *the cash limit for Health Authorities*
* *the notional budget for commissioning GPs (including locality commissioners)*
* *the agreed fund for GP fundholders*

C3.14 The adequacy of budgets is assessed prior to acceptance. ☐ ☐

C3.15 Budget areas are: ☐ ☐

C3.15.1 monitored ☐ ☐

C3.15.2 reviewed regularly ☐ ☐

C3.16 There is planning for the apportionment of the budget between all service agreements. ☐ ☐

Guidance
A commissioning organisation should be aware of how its budget is determined in relation to other commissioning organisations.

C3.17 There is planning for the effects of financial risk and how those effects should be managed. ☐ ☐

C3.18 There is a plan to achieve and use savings. (See Planning and Development of Services, C1.6) ☐ ☐

C3.19 The plan includes securing an agreement for the proposed use of savings. ☐ ☐

Guidance
The use of savings for fundholders is governed by statutory instructions.

Commissioning groups may enter formal or informal savings arrangements with their Health Authority.

C3.20 There is a system for managing extra contractual referrals (ECR). ☐ ☐

Guidance
This system:

* *includes a mechanism for identifying and recording ECR costs*
* *monitors the ability to meet ECR costs from the budget*
* *monitors the source of costs (for example, tertiary referrals or elective referrals determined by patient/doctor choice)*

Training and development

C3.21 The skills and competencies required, and available, to implement the commissioning plan are identified. ☐ ☐

C3.22 There is a training and development plan to address training needs. ☐ ☐

Guidance
This is reviewed annually.

COMMISSIONING

COMMUNICATION

Standard C4

Excellence is pursued in all aspects of communication with colleagues, patients/clients, health agencies and the local community to ensure that the patient/client receives the best possible care.

Criteria		*Comment*	*Please tick* *Yes*	*No*
General				
C4.1	There is an up-to-date document that details communication links with key external organisations. *Guidance* *This includes the services provided by those organisations and the referral criteria that the facility must comply with.*		☐	☐
C4.2	There is an up to date document that details communication links in the organisation.		☐	☐
C4.3	These documents are made available to all members of the organisation.		☐	☐
Communication between Staff				
C4.4	Multidisciplinary meetings take place. *Guidance* *These meetings should take place on a regular basis.*		☐	☐
C4.5	Management meetings take place.		☐	☐
C4.6	The constituent members are informed of when meetings are taking place.		☐	☐

C4.7 Minutes of meetings are taken. ☐ ☐

Guidance
Minutes of meetings should:

* *be dated*
* *be available to all staff*
* *identify individuals responsible for action*
* *identify action points*
* *identify responibility for action*

Consideration should be given to any issues of confidentiality.

C4.8 There is an agreement on sharing information. ☐ ☐

Guidance
This includes:
* *identifying persons or organisations with whom information is shared*
* *the frequency with which information is shared*

C4.9 The effectiveness of internal communication mechanisms is audited. ☐ ☐

Guidance
This includes:
* *access to general practitioners' computers by other health professionals*
* *circulation of reports, circulars and guidelines.*

Communication with Public/Patients

C4.10 The organisation has a policy for communicating its activities to the public and/or patients. ☐ ☐

C4.11 The views of the public, patients and carers regarding commissioning intentions are actively sought. ☐ ☐

C4.12 The views of the public/patients/carers are:

C4.12.1 assessed ☐ ☐

C4.12.2 acted upon where necessary ☐ ☐

C4.13 There is a written policy for dealing with complaints arising from purchasing decisions. ☐ ☐

C4.14 Records of complaints are maintained. ☐ ☐

C4.15 Each complaint is investigated. ☐ ☐

C4.16 Action is taken following the investigation of a complaint. ☐ ☐

C4.17 The effectiveness of communication with public/patients is audited. ☐ ☐

C4.18 All staff are given the opportunity to train in comunication skills and customer care. ☐ ☐

External communications

C4.19 There is regular and ongoing communication between the organisation and the following external agencies:

C4.19.1 community health council ☐ ☐

C4.19.2 local health authority (health board/health and social services board) ☐ ☐

C4.19.3	social services		☐	☐
C4.19.4	local trusts		☐	☐
C4.19.5	local medical committee		☐	☐
C4.19.6	local dental committee		☐	☐
C4.19.7	local pharmaceutical committee		☐	☐
C4.19.8	voluntary organisations		☐	☐
C4.19.9	user and carer groups.		☐	☐
C4.20	Minutes of meetings between the organisation and external agencies are:			
C4.20.1	kept		☐	☐
C4.20.2	actioned		☐	☐
C4.20.3	filed.		☐	☐
C4.21	Proposed changes in the patterns of service provision are discussed with the relevant agencies. *Guidance* *Relevant agencies include external agencies detailed in C4.19*		☐	☐
C4.22	The organisation provides all agencies with an up to date contact list.		☐	☐
C4.23	The organisation will has a policy for dealing with the media.		☐	☐

COMMISSIONING

INFORMATION

Standard C5

Appropriate and accurate information is accessed and used to support purchasing and commissioning, monitor contracts and meet reporting requirements.

Criteria	*Comment*	*Please tick* Yes	No
Demographic/epidemiological data			
C5.1 The following statistics are collected:			
C5.1.1 population profile		☐	☐
C5.1.2 morbidity		☐	☐
C5.1.3 mortality		☐	☐
C5.1.4 immunisation status of population		☐	☐
C5.1.5 cervical cytology		☐	☐
C5.1.6 lifestyle data		☐	☐
C5.1.7 referrals		☐	☐
C5.1.8 patient/client contacts		☐	☐
Guidance *Statistics may be obtained from public health departments, practices or other sources.*			

C5.2 The organisation obtains a broad range of other statistics relating to the local population. ☐ ☐

Guidance
These may include:

* *local unemployment rates*
* *uptake of income support*
* *number of residential and nursing home residents*
* *percentage of patients with private health insurance*

C5.3 Statistics are:

C5.3.1 analysed ☐ ☐

Guidance
This may include analysis carried out by the local public health department or other statistical services carried out by the local Health Authority

C5.3.2 used to inform service provision ☐ ☐

Guidance
The organisation should demonstrate how it uses data. For example, OPCS data could be used to monitor trends.

Information from health authorities (health boards/health and social services boards)

C5.4 The following information is sought from health authorities (health boards/health and social services boards). ☐ ☐

C5.4.1 the business plan ☐ ☐

C5.4.2 corporate objectives ☐ ☐

C5.4.3 policy statements ☐ ☐

C5.4.4 local interpretation of national objectives ☐ ☐

C5.4.5 information on local health needs ☐ ☐

C5.4.6 plans for service provision ☐ ☐

C5.4.7 a list of provider units with which agreements have been negotiated ☐ ☐

C5.4.8 service quality specifications ☐ ☐

C5.4.9 plans for monitoring service provision ☐ ☐

Effectiveness data

C5.5 The organisation has access to effectiveness data. ☐ ☐

Guidance
This data may be held by the organisation or by external sources, for example, the local health authority

Sources include:
* *Bandolier*
* *Cochrane Trust*
* *Effective Health Purchasing*

C5.6 Effectiveness data is used to inform commissioning decisions. ☐ ☐

Information from service providers

C5.7 The following information is obtained from service providers: ☐ ☐

C5.7.1 consultants and speciality ☐ ☐

C5.7.2 waiting time for referral to consultants ☐ ☐

C5.7.3 waiting time for admission ☐ ☐

C5.7.4 investigations undertaken (for example - microbiological, haematological) ☐ ☐

C5.7.5 waiting time for results ☐ ☐

C5.7.6 quality indicators ☐ ☐

Guidance
This includes information about:
infection rates
readmission times
percentage of referrals responded to within two weeks
quality measures
length of stay
time between GP referral and consultation
failed discharges

C5.7.7 evidence that quality standards state in service agreements have been achieved. ☐ ☐

C5.7.8 pricing structure ☐ ☐

C5.7.9 agreed minimum data set ☐ ☐

Guidance
This should be at a level appropriate to the commissioning organisation

The minimum data set national guidelines should be referred to ☐ ☐

C5.7.10 contract currencies ☐ ☐

Guidance
This could include finished consultant episodes (FCEs), health related groups (HRGs), community contacts, admissions or bed days ☐ ☐

C5.7.11 activity data ☐ ☐

C5.8 The information received from service providers is:

C5.8.1 recorded ☐ ☐

C5.8.2 monitored ☐ ☐

C5.8.3 reported. ☐ ☐

Guidance
Reconciliation between the information received and internal data sources should be carried out

DEFINITION OF TERMS USED

Agreement of constitution

A written agreement of the framework and principles of an organisation.

Aims

The overall purpose of an organisation or service.

Audit

The process of setting or adopting standards and measuring performance against those standards with the aim of identifying both good and bad practice.

Commissioning

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

Commissioning organisation

An organisation that has involvement in commissioning primary, secondary and tertiary care services. The term embraces all forms of primary health care organisations, be they single practices, multi funds, non-fundholding commissioning groups or total fundholding sites.

Criteria

The evidence upon which the judgement is made as to whether or not a standard is met.

Evidence based care

Patient care that has been demonstrated, by research, to be effective.

Minimum data sets

A group of statistics or other information that together comprise the minimum amount of information required to inform any management process, for example, monitoring.

Monitoring

The systematic process of collecting information on clinical and non-clinical performance. Monitoring may be intermittent or continuous. It may also be undertaken in relation to specific incidents of concern or to check key performance areas.

Objectives

Specific and measurable statements that set out how overall aims are to be achieved.

Organisational chart

A diagrammatic representation of an organisations responsibilities, relationships and formal lines of communication.

Policy

A statement representing a course of action adopted by or on behalf of an organisation and its members.

Primary health care team members

All professional, managerial and administrative staff working in primary health care settings, whether employed by a general practice or other health care organisation.

Procedure

The steps taken to fulfil a policy.

Quality indicator

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

Service level agreement

A document agreed between providers of health care and the purchasers of health care detailing the service to be provided. This includes activity, financial and quality levels to be achieved.

Specification

A specified requirement determined by the commissioning organisation for the provision of a given health or support service.

Standard

An agreed and authoritative performance objective reflecting the optimal requirements against which measurement can be made. Standards are a prerequisite of audit and organisational audit.

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