QUALITY IN CONTRACTS

– THE CURRENT POSITION

(JULY 1991)

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INTRODUCTION

In the autumn of 1989, the King's Fund Centre, in conjunction with NAHA, carried out a trawl of health authorities to establish the extent of work taking place in the area of contract specification. The picture at that time was one of apparent commitment to the task coupled with spasmodic activity and considerable apprehension. There was a genuine commitment by health authorities to tackle the specification of quality within the contract and in many instances to make it central to the contracting process. However, it was not clear how best to achieve this.

One year later we repeated the exercise not this time by approaching each of the 170 districts but by targeting three regional health authorities with acknowledged track records in quality (Trent, East Anglia and Wessex) and selected districts outside these regions.

The following outline gives a summary of the main points which emerged from this exercise and offers some practical advice about the development of contract specification.

While work is going on (and in some areas this is of a high standard) quality remains outside the mainstream of management concern. Furthermore, it remains tainted by association with 'value for money' as being in some way unacceptable and tawdry. Many units and districts are struggling and there is a very real concern that effective mechanisms for sharing and building upon information do not exist.

QUALITY BACKGROUND

A unit or district's own quality history and the approaches which it has used to handle and structure quality in the past have an obvious bearing upon the confidence with which it is tackling quality specification. A background in quality usually reflects a commitment of resources which is helpful in supporting and underpinning current quality initiatives. Furthermore, leadership in this area is paramount. While it is clear that the perception by management of its role in quality determination has been crucial and that where management has identified quality as a core issue this has strengthened its development, the role of professional groups is also of considerable importance. Examples of this include:

- standard setting approaches by the nursing profession;
- the promotion of medical audit and, more generally, the medical model of quality assurance;
- standard setting and audit by paramedical professions.

Also worthy of note is the impact of the Department of Health sponsored total quality management initiatives in a number of districts and units, which appear to have stimulated a multidisciplinary approach to quality.

MANAGING THE MARKET

The role played by regions in the specification and monitoring of quality is currently determined in part by their own track record in this field and in part by their relationship with districts within their patch. There is a lack of consensus about what this role should be, however, ranging from a hands off supportive relationship, to an expressed interest in one region, to interface directly with units.

Similarly, ambiguity and unhappiness exist at district and unit level focused on two main areas:

- The reluctance of some district officers who perceive themselves as operational managers to withdraw from this activity. There is a natural tendency on the part of many purchasers still uncertain about their new role to intervene in the delivery process and hence to over-specify.

- A reluctance at unit level to let go of responsibility for the community. This is entirely laudable and understandable but may get in the way of units acting as true providers.

HANDLING THE PROCESS

There is currently a lack of any robust model for handling quality and perhaps because of this there is a tendency to elevate advisory frameworks to the status of models. An example of this is the Department of Health's document EL(89)MB117 which quite clearly was never intended as other than guidance about those areas to be handled.

While ideally the commercial model of performance assessment by means of outcome would be applied to health care, this is not altogether possible. Because of the multivariate dimensions of 'standards of acceptance' in health care, and hence the difficulty in relying upon these as sound indicators, quality must be addressed both at the level of process and outcome. It would seem that the necessary balance of attention between the two is being increasingly acknowledged. There is a move away from the view that because outcomes are superior all effort should be focused upon them, and an accompanying acknowledgment that process issues must be handled but cannot be 'the be all and end all'.

Purchasers are increasingly developing two levels of specification:

- General service agreements These can be seen as establishing a provider's, 'fitness to trade' which should be specified prior to discussion of detailed business by the purchaser.

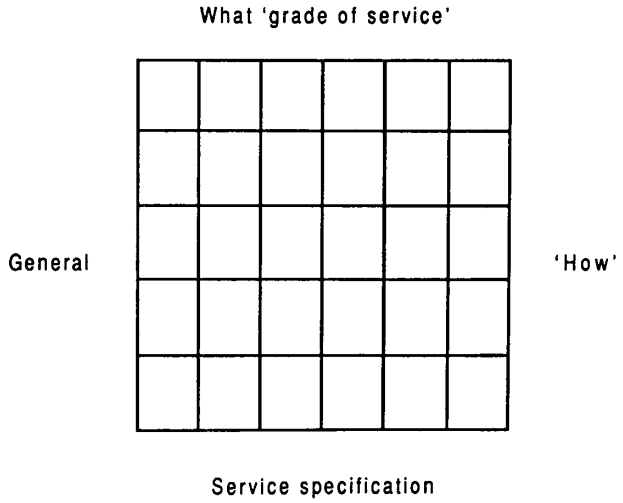
- Individual service agreements These are specifications for specialties or services (for example, gynaecology, mental handicap, support services).

In addition to the need to distinguish between the general and service specification, some contract documentation is making a clear distinction between:

- the 'what' - the type and 'standard' of service to be provided;

- the 'how' - the systems/processes by which the service specification is to be provided. The first is clearly the remit of the purchaser; the latter of the provider.

The following matrix offers a useful starting point to approaching quality:



MONITORING

There is still a notable absence of reference to the potentially negative aspects of the purchaser/provider relationship and a lack of clarity about how sanctions or incentives might work. Yet purchasers must be aware that the more they specify the more they will be required to monitor, and potentially respond to, by way of penalties.

Approaches to monitoring can be grouped under the following headings:

➢ purchaser-led inspection (including organisational audit). The issue of organisational audit was raised by a number of districts and is clearly an issue which needs to be faced up to nationally. In some instances, embryonic organisational audit systems have been developed within districts while others have adopted a regional approach (for example, East Anglia and South Western Regions or a national approach with the King's Fund);

➢ partnership/liaison arrangements;

➢ exception reporting, unit led.

Where districts contract with NHS units outside their boundaries, many appear prepared to let the host district undertake the monitoring on their behalf, although this is not relevant to all or agreed by all.

In addressing monitoring issues, the following questions are pertinent to the quality indicators included:

➢ are they measurable?

➢ do they matter?

➢ do they convince those who need to be convinced?

➢ are they relevant to the relationship between the provider and purchaser?

➢ are they achievable?

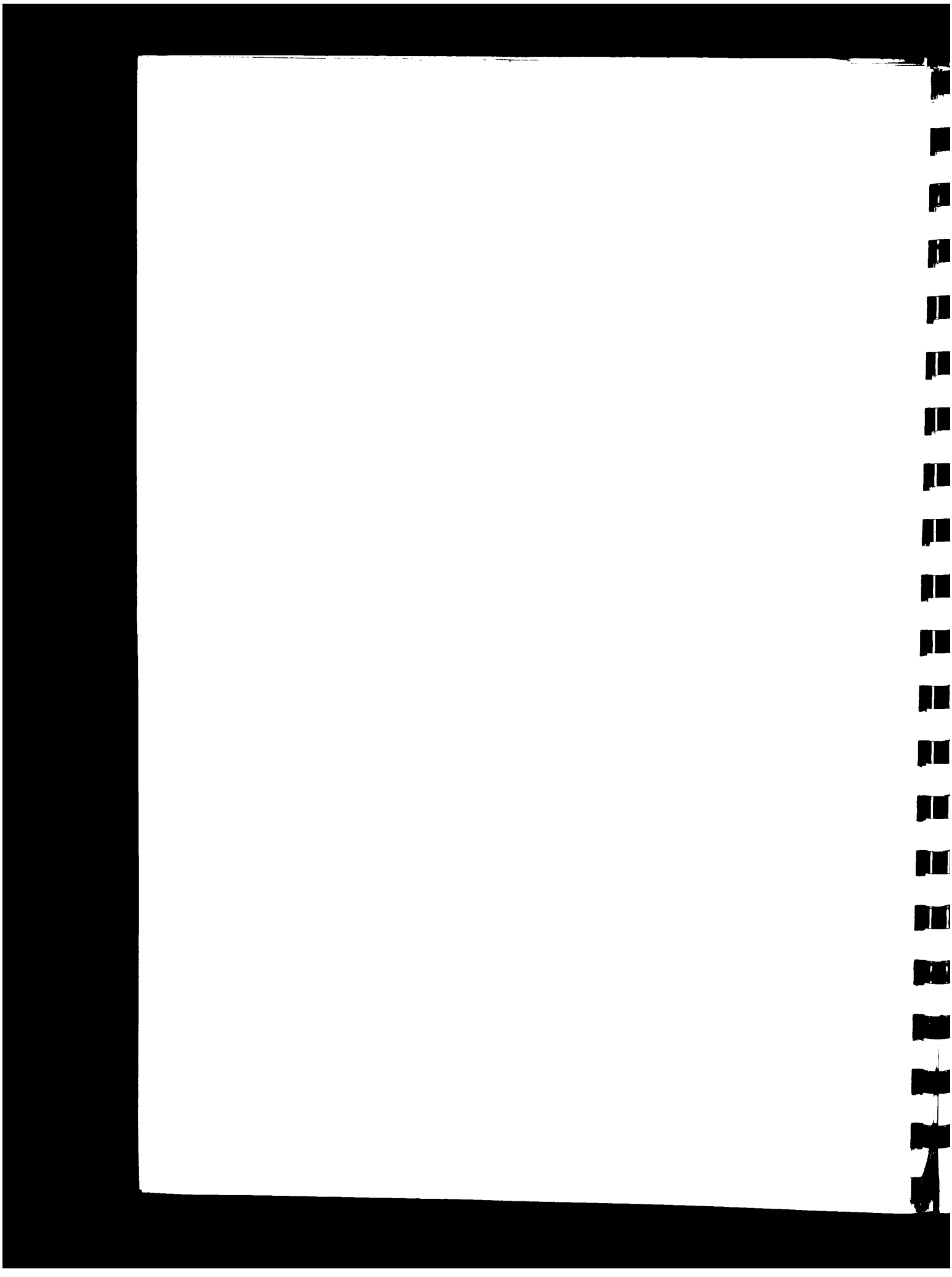
GENERAL PRACTITIONERS AND CONSUMERS

Many districts have undertaken a survey to establish general practitioners' viewpoints on the contracting process and to identify their quality requirements. GPs are identifying detailed quality requirements and have a major contribution to make to the specification of these in contracts. An increasing number of districts and FHSAs are carrying out joint contracting exercises. Reference to the involvement of community health councils and other consumer organisations in the contract development process is very limited. In one or two instances, the CHC has been actively involved in the team developing the contracts. However, in the main this is not the case and the indications are that this reflects either that draft documents are not sufficiently developed for consultation or that there are concerns about the usefulness and level of regard of the CHC's contribution.

CONCLUSION

A number of elements which need to be taken into account in developing quality specification in contracts have been highlighted by the review; these are summarised in the following checklist.

CHECKLIST FOR DEVELOPMENT OF QUALITY IN CONTRACTS.	
CONTEXT	Explore the planning context: ✎ health needs of the population ✎ strategic framework – targets and priorities ✎ health investment plan.
COMMITMENT	Ensure and encourage ownership of quality at both purchaser and provider level: ✎ general management – responsibility and leadership ✎ all staff are involved.
CONTENT OF QUALITY SPECIFICATION	Establish a clear and realistic framework and approach which allows and encourages further development. Covering: ✎ purchaser's philosophy and objectives ✎ organisational practice ✎ national and statutory requirements ✎ key indicators ✎ information requirements ✎ monitoring requirments.
CONSULTATION	Establish a timetable and process for consultation and ensure the following are involved: ✎ providers; including medical staff ✎ community health council ✎ other consumer bodies ✎ FHSA ✎ GPs ✎ social services.
CO-OPERATION	Encourage an ongoing spirit of co-operation in relation to the development of quality with ✎ providers ✎ other purchasers.
REGULAR REVIEW AND APPRAISAL WILL BE ESSENTIAL	



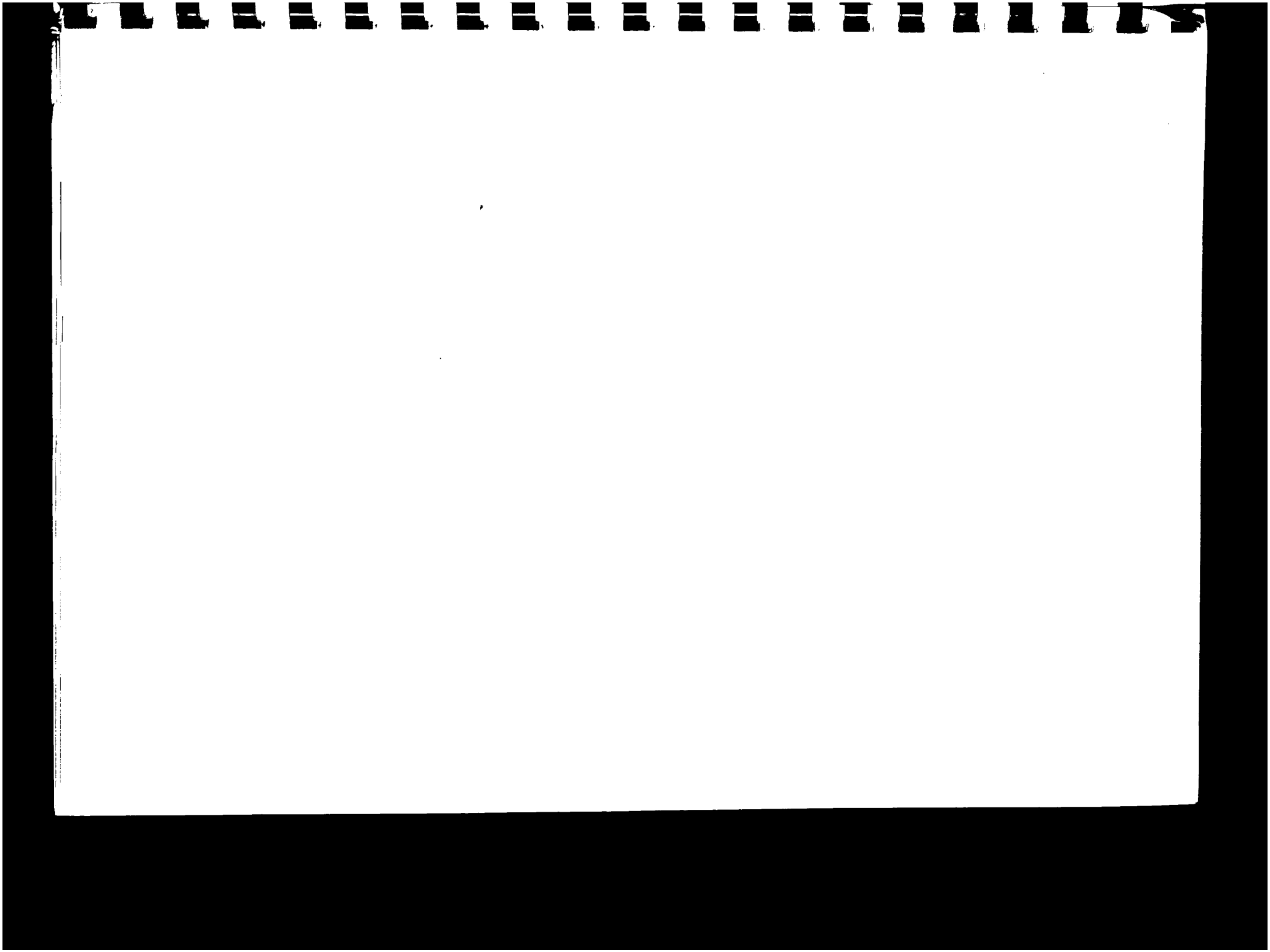
Content of Quality Specifications

1. From a variety of approaches to the content and format of quality requirements detailed in service agreements and specifications, a number of key headings have emerged. These are listed in the chart below together with indications of the content included under such sections.

HEADING	SUMMARY OF CONTENT/EXAMPLE
PHILOSOPHY AND OBJECTIVES	Aims of authority to secure provision of a comprehensive range of high quality, value for money services for its resident population. Philosophy in relation to quality to respect the needs and preferences fo service users in providing services which are equitable, effective, efficient, accessible, acceptable and appropriate to local needs. These values to be understood by all those who provide, manage and use the services.
ORGANISATIONAL PRACTICE	Demonstration of 'fitness to trade' accreditation/ organsiational audit either through national pilot or locally developed regional or district system which covers extensive general quality assurance standards relating to the organisation. To be viewed as a minimum requirement for trading.
NATIONAL AND STATUTORY REQUIREMENTS	Comprehensive or summary list of included and adherence required to all statutory and national requirements. Covering employment, health and safety, fire precautions, environmental health, food hygiene, lifting of crown immunity, COSHH.
KEY INDICATORS	Both clinical and non-clinical ranging from a small number to quite an extensive list in some instances. Wide variety of indicators and standards specified in the contracts reviewed. The following chart illustrates some of the topics and common themes.
INFORMATION REQUIREMENTS	Korner minimum data sets, complaints reports, quarterly reports and implementation of quality programmes (information required quarterly or annually).
MONITORING	In addition to information requirements, examples given above, requirements range from exception reports through to detailed information obtained from auditing visits or regular monitoring reports supplied by provider.

2. The following chart, referred to above illustrates some of the topics and common themes included against the key indicators of quality:

HEADING	EXAMPLES
ACCESS	Waiting lists and times Admission rates
CLINICAL CARE	Medical audit Clinical audit Paramedical audit Goals for health outcomes Postoperative infection rates Care plans Immunisation uptake rates Untoward incidents/accidents
CONTINUITY OF CARE	Discharge procedures Transfer arrangements
FACILITIES AND ENVIRONMENT	Health and safety regulations Facilities for children Facilities for the disabled Hotel services Catering standards
CUSTOMER CARE	Patient satisfaction surveys Information to patients Patients' charters Cultural minorities Complaints
STAFF	Staff satisfaction surveys Personnel policies and procedures Staff/patient ratios and skill mix



KEY MESSAGES

The key messages and conclusions to come out of the review are as follows:

- The reluctance to share information must be addressed, along with the concern expressed by certain authorities to protect the confidentiality of some contract documentation.

- Clarification is needed of the differing roles of regions and districts in determining and monitoring quality in contracts and, similarly, between district and units. Confusion is currently evident.

- Training and support for quality assurance programmes for both purchasers and providers is lacking. Attention needs to be given to enable co-operative/consortium approaches to training.

- For 1991/92 contracts the frameworks provided by regions were in many cases produced too late to assist districts in the development of the next year's contracts. Clear guidance and frameworks need to be issued by the beginning of the next financial year to assist in structuring contracts, and these need to link to the health investment plan and to the contracting intentions of the purchaser - a link which is currently lacking in much of the documentation.

- The purpose of 1991/92 contracts in establishing the existing baseline must be made explicit in the contract: over-ambitious schedules are evident which are not timely or appropriate for achievement in the current year. A distinction between next year's requirements and agendas for future developments must be made.

- Different leadership bids in establishing quality in contracts are apparent: the process of who does what and where needs to be defined in each district. Variations in approach should be acknowledged as legitimate.

- The content and presentation of quality in contracts is not always clear. Simplicity is essential and many contracts need to be revisited in order to reduce the number of indicators included to those which are key rather than trying to define everything that moves. Purchasers need to be clear about what should be included in their specifications as compared with the content of providers' prospectuses.

- The monitoring of contracts requires further detailed thought. Co-ordinated approaches to monitoring need to be established and consideration given to measures to be taken if quality requirements are not met.

- This review clearly reinforces the need for a national framework for organisational audit in order to pool resources and expertise and to set a common baseline or "licence to trade".

- Timeframes are not always stated: these need to be made explicit, including the deadlines for the achievement of targets.

- Further work is necessary to establish GPs' quality requirements and to ensure that they are involved in the specification of quality requirements in contracts.

- Strategies for the involvement of consumers in the contract development and monitoring process must be established. There is confusion between the roles of consumer organisations (such as CHCs), purchasers and providers in this.