Organisational Standards and a Monitoring Process for General Practices/Health Centres in the UK

Clare Deborah Blakeway-Phillips

M Phil, London School of Economics and Political Science
(University of London)

ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106-1346

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This thesis is based on a research project to test the feasibility of developing organisational standards and a means of assessing compliance with these standards for general practices/health centres to ensure robust systems and structures for quality service delivery are in place. Nine pilot sites, involving twelve practices, participated. A detailed account of the research project is given from the researcher's perspective as an involved observer. An 'accreditation' type approach has never previously been introduced to primary health care teams.

The background to this experiment is first discussed:- quality of health care as a public policy issue; the rise of primary health care on the health agenda, the shift from secondary to primary care and whether primary health care teams can bear this extra burden of expanded responsibilities. General practices are the least formal organisations within the NHS, relying on a system of organisation that has changed little since the NHS was established in 1948. However, practices are now structuring themselves into more formal organisations. The potential relevance of organisational audit in helping practices become formal organisations capable of delivering high quality primary health care is advanced.

The origins and rationale for organisational audit in primary health care are explored incorporating a review of the literature on accreditation.

There follows a description of the project. It begins with a chronological account of the development and implementation of the organisational standards and criteria by the pilot sites and how their compliance with the criteria was assessed. Problems that arose and how they were surmounted are highlighted.

Changes that took place in the organisation of the pilot sites while the project was occurring are described followed by a reflection of the validity of the whole exercise and implications for future policy.

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DEFINITION OF TERMS

ACCOUNTABILITY	The state of being answerable for one's decisions and actions. Accountability cannot be delegated.
APPRAISAL SYSTEM	The evaluation by colleagues of the performance of individuals or groups using established criteria.
ASSESSMENT	The collection and interpretation of data and the identification of patient/client problems.
BUSINESS PLAN	A plan of how to achieve the mission of the facility. The plan includes financial, personnel and other sub plans, as well as service development and a quality strategy.
CARER	Anyone who regularly and, in an unpaid capacity, helps a relative or friend with domestic, physical or personal care needed because of illness or disability.
CRITERION	A descriptive statement which is measurable and which reflects the intent of a standard in terms of performance, behaviour, circumstances or clinical states. A number of criteria may be developed for each standard.

EVALUATION	The process of determining the extent to which goals and objectives have been achieved. Actual performance or quality is compared with standards in order to provide a feedback mechanism which will facilitate continuing improvement.
FACILITY	The health centre, the general practice or any other site providing a primary health care service.
HEALTH PROFESSIONAL	A person qualified in a health discipline who is currently working in, or from, the facility (for example, a registered nurse or physiotherapist).
MISSION STATEMENT	A statement of values and beliefs which underpin the activities of the primary health care team.
MULTIDISCIPLINARY	The combination of several disciplines working towards a common goal.
OBJECTIVES	Hoped for results, goals or targets.
ORGANISATIONAL AUDIT	Setting and monitoring standards for the organisation of health care services.
ORGANISATIONAL CHART	A graphic representation of the responsibility, relationships and formal lines of communication within the

	facility.
PLANNING	The determination of priorities, expected outcomes and health care interventions
POLICY	A statement representing a course of action adopted by, or on behalf of, an organisation and its members.
PROCEDURE	A mode of action.
PROTOCOL	Guidelines or flow chart to guide staff.
PRACTICE	The partners, employed staff and their patients/clients.
PRIMARY HEALTH CARE TEAM	General practitioners, all staff employed by the practice and all other multidisciplinary professionals attached to the practice, for example, community nurses, dietitians, physiotherapists, counsellors, social workers, chiropodists, occupational therapists, speech and language therapists.
QUALITY	Defining and making explicit the service to be provided and ensuring that it is delivered in a consistent and continuous way.
QUALITY MANAGEMENT PLAN	A planned, systematic plan for the use of selected evaluation tools designed to

	measure and assess the structure, process and/or outcomes of practice against established standards, and to institute appropriate action to achieve and maintain quality.
REACCREDITATION	Concerned with quality of organisations (structure, process, outcome).
RECERTIFICATION	Concerned with quality of individuals (knowledge, skills, attitudes).
RESPONSIBILITY	The obligation that an individual assumes when undertaking delegated functions. The individual who authorises the delegated function retains accountability.
STAFF	All individuals working from or within the facility - full-time, part-time, casual or contract.
STAFF DEVELOPMENT	The formal or informal learning activities which contribute to personal and professional growth. It encompasses induction, in-service and continuing education programmes.
STANDARD	The desired and achievable level of performance corresponding with a criterion or criteria, against which actual performance is measured.

STRUCTURE	The organisational characteristics of the setting in which care is delivered.
USER	Someone who uses or could use the services provided by the facility.

CHAPTER 1

Quality of Health Care as a Public Policy Issue

Quality of health care is a public policy issue. In the past, policy has centred around quantity and equality of access to services (Day & Klein, BMJ Vol 1290, 1985). In the mid-1970's when resources were decreasing the concern shifted to increasing efficiency and quality of services. To improve quality overall requires balancing the forces of professionalism, regulation, market forces and competition. This chapter studies how these issues have shaped health care in the past and the forces that have introduced quality assurance into the health care of today.

Background to the medical profession

Until recently the public was prepared to accept that quality was a matter for the professions but now this is no longer the case (Griffiths 1983). The history of the medical profession sheds some light on how this has come about.

As a profession, the skill of healing arose out of medicine, religion and superstition with the oldest medical schools in the country founded by Augustinian monks in the 12th Century. When the practice of medicine became dissociated with the church, control over the profession was debated over the centuries (Gibson 1981; 18);from about the time of Henry VIII there was a persistent struggle between physicians and apothecarists. The Royal College of Physicians was founded in 1518; the General Medical Council was established in 1858; and the British Medical Association formed in 1832. The Royal College of General Practitioners was founded much later in 1952. British medical professionalism developed in the first half of the 19th Century around the Royal College of Surgeons and Physicians and the Society of

Apothecaries. Since then they have had a professional monopoly on the provision of health services (P Wilding 1982).

Rhodes (1976; Chapter 9) and Julian Tudor Hart (1988) discuss the expansion of knowledge associated with the practice of medicine and trends in the history of medical education. Twentieth century additions to the curriculum include psychology, sociology, community medicine, psychiatry and pharmacology. The present day doctor has the choice of specialising in many different fields of hospital practice as well as entering into general practice in the community. Despite the diversification within the profession, Watkins (1987; 212) argues that doctors remain the most powerful single group in the National Health Service (NHS) power structures.

Yet as in all professions, the lay public are challenging and disputing professional claims to a monopoly of knowledge or claims for more money without the accountability. In 1984, doctors were faced with a huge challenge to their professional status by the recommendations reflected in the Griffiths report. As Strong and Robinson describe (1990; 27) 'Whitehall was no longer willing to share power with the clinical trades, no longer content to leave matters to the doctors'. This, as it will be seen later, was to have a major impact on the management of medical practice.

The profession/semi-profession model

Health professionals, especially the medical profession have operated with great autonomy and clinical freedom. This has occurred because of the difficulty of supervising adequately their clinical work; the fact that only their fellow colleagues can understand and assess their work; and their argument that they need to be autonomous so that they cannot be involved in coercion by the state.

Paul Wilding argues that the professionals can be examined on the basis of four criteria; - their degree of self government; their measure of freedom in their work; their ability to ignore research findings and to reject or prevent evaluation; and finally

the degree of development of appeals and complaints procedures in their field of work.

Examining the medical profession under these criteria it is easily recognisable that the medical profession has secured a large measure of self government in the NHS. Indeed, Aneurin Bevan accepted this principle when the NHS was established.

Harding, Nettleton and Taylor (1990; 74) describe traits which most frequently have been identified as giving professional status. They also identify 'core' features which are possessed by all professions. These are summarised as:

(1) specialised knowledge and training

(2) service orientation

(3) monopoly of practice

(4) self regulations.

Friedson (1975) argues that the most strategic distinction between professions and other occupations lies in their legitimate autonomy.

Medicine has been recognised not just as having professional status, but as Goode (in Etzioni 1969) argues is one of 'the four great person professions' (the other three being law, the ministry and university teaching).

Etzioni (1969) invented a category he called semi-professions; those 'newer' professions whose 'claim to the status of doctors and lawyers is neither fully established or desired'. Etzioni argues that the semi-professions have shorter training, less legitimised status, less well established rights to privileged communication, less of a specialised body of knowledge, and less autonomy from supervision or societal control than 'the' professions. He focuses upon teaching,

nursing and social work as examples of semi-professionals.

The four traits described by Harding, Nettleton and Taylor are obviously fulfilled by doctors. Etzioni, when introducing the concept of the semi-professional, indicates that a true profession will have autonomy from supervision and societal control. Furthermore, he discusses the 'service organisations in which professionals are provided with the instruments, facilities and auxiliary staff required for the work. The professionals, however, are not employed by the organisation nor subordinated to its administrators' (1969; xiii). The application of this model to the profession of medicine gives a fairly accurate picture of the status and position of hospital doctors and general practitioners - at least up until the last decade.

Regulations of the NHS

When discussing the regulation of the NHS, the focus taken here will be on the mechanism of organisational and professional control rather than regulation through legal processes in the courts.

Since the conception of the NHS in 1948, successive governments have tried to tackle the problems of cost containment, resource allocation and the rationalisation of services through a variety of organisational reforms. Hughes & McGuire (in Dingmar & Fenn, 1992 Ch 5) state that the 1983 Griffiths Report and the 1990 Community Care Act represent the first steps towards fundamental change in the regulatory machinery that has shaped health care in the intervening years.

Social historians agree that the NHS emerged through evolution rather than social engineering or planning (Eckstein 1958; Pater 1981; Webster 1988). Hughes & McGuire (1992) argue that three characteristics of the 1948 NHS were to have special significance in shaping the service through to the 1980s. The meeting of a duty to provide care in a Minister accountable to Parliament, a unified hospital service managed through a single administrative hierarchy and the institutionalised recognition of professional autonomy. This has resulted in a bureaucratic regulation of the

administrative segment of the NHS (through powers vested in the Minister of Health and latterly, the Secretary of State for Health) while the professional segment was dependent on professional self regulation. The most important control mechanisms include the capacity of the General Medical Council (GMC) and other professional registration bodies to determine entry to the profession and punish misconduct, the powers of the Royal Colleges and the British Medical Association (BMA) to investigate allegations of improper behaviour, and the power of the defence societies to refuse to represent a member (Jacob 1988; 157).

Until recently bureaucratic regulation impinged on the activity of doctors in certain limited areas only such as complaints followed up by the Community Health Councils (CHCs) and investigations under the Department of Health's Circular HC81/5 (Health Service Complaints Procedure). Even in these cases, doctors have held power through sitting on advisory and executive committees or holding posts in the management hierarchy. Abel Smith highlighted the problem 'not the least of the difficulties to be overcome in improving standards of management and evaluating performance is that it has for so long been tacitly accepted within the NHS that the activities of the medical profession be outside management control (' (Abel-Smith 1973; 16). 'The consultant receives, in effect, a lifetime appointment ... The GP has independent contractor status but unlike most contractors his performance is not reviewed periodically ...' (Fox, 1978, p 10).

The return to centralisation

The 1980s were marked by a sharp reversal in government policy towards the NHS (Klein 1985) which was part of a general rise against the professions and trade unions and which to a large extent provides the explanation of performance review and indicators. Norman Fowler, the new Secretary of State in 1981, was in the process of introducing a new period of centralisation. This stressing of accountability to the centre, rather than delegation to the periphery resulted in the new system of performance review. The annual performance review was first launched in 1982 (D Allen in BMJ, Vol 285, 28 August 1982, pp 665-667). This involved a hierarchy of

review and accountability running from the individual hospital to the Secretary of State. The performance indicators were the latest in a series of experiments which included the Health Advisory Service (HAS) (1969), official encouragement of medical self audit by clinical teams (1970s) and the setting up of Community Health Councils (1974). These have been summarised by Klein (1982). The 1983 indicators were to be more comprehensive and more systematic than these previous experiments (Pollitt 1985). A review of the impact of HAS has found that 'remarkably little appears to have changed since 1969' (Day et al; 1988, p 10). Routine responses to instances of poor quality in the NHS have been handled by the CHCs and through complaints procedures. The incidence of malpractice and damage litigation in the UK is much lower than in the USA but it has been argued that this is as much to do with interprofessional solidarity between the legal and medical professions and lack of assertiveness of the British consumer as it has to do with quality of care or the adequacy of the complaints procedures (Pollitt, 1988).

Carter, Klein and Day (1992) state that performance indicators had been presented to parliamentary critics as an instrument of departmental control and as a way of reinforcing accountability to the centre. To NHS managers and members, they had tended to be presented more as a tool of self appraisal, as a way of seeing their own performance of their own district/practice within a national framework. This issue of whether evaluation, in whatever form is managerial or educational will be revisited later.

The first package of performance indicators was published by the DHSS in September 1983 (Pollitt 1985). Statistics which had been around for decades suddenly re-emerged and were re-named as performance indicators.

Performance indicators are a means of assisting responsible management to make efficient and effective decisions (P Jackson 1988). However, Carter, Klein and Day's interviews carried out at regional and district level found that performance indicators tend to be seen as a reference library rather than as a management tool. The performance indicators have been largely of historical interest by the time they were

published and therefore are not helpful in planning and managerial decisions (Carter, Klein and Day 1992).

Performance indicators grew out of the governments preoccupation with the value for money in the 1980s. 'For at least twenty years throughout the developed world annual increases in health care expenditures had consistently outstripped increases in national income' (Maxwell 1981, p 101). However, there were criticisms regarding their accuracy and the time taken between collecting data and presenting it as performance indicators. The complexity of the organisation of the NHS was also unhelpful in that the principle actors, the doctors, enjoy a high degree of autonomy, the structure of authority is complex and this resulted in data driven, slow and numerous performance indicators which were then used descriptively rather than prescriptively.

One of the main criticisms was the question of quality (for example Pollitt 1985). The emphasis had been on productivity and access (Day and Klein BMJ Vol 1290 1985), to the neglect of measures of quality outcome and consumer satisfaction; the patients perspective was scarcely acknowledged. Another criticism was that it was never clear whether they were intended to be an instrument of central control or managerial self examination. They also focused on activity in hospitals ignoring preventive based care and community services.

As the decade drew to a close, there was a definite preoccupation with 'accountability'. This was largely as a result of managerial efficiency and effectiveness being highlighted by the Auditor General and the National Audit Office following the 1983 National Audit Act (Garnett 1986).

General management

The implementation of the Griffiths Report in 1984 caused a departure from the 'old' NHS in which 'doctors were left free to run things in the way they wanted, and the power of the medical syndicalism meant that a rampant individualism reigned

throughout the length and breadth of the service' (Strong & Robinson, 1990; 32). A clear management structure was put in place, from the top to the bottom of the NHS, making individuals at all levels responsible for making things happen. The general managers had their pay and terms of service linked to their performance. With the disappearance of a consensus style of management, medical and nursing representatives lost their veto power (Klein 1989). The quotations for general managers collected by Strong & Robinson (1988) showed a readiness to challenge professionals, for example 'but it is the general manager responsible for a particular clinical area who has the task of discussing with the clinicians in that area what are reasonable standards for them to set'.

The review and performance indicators mentioned earlier also now allowed effective managers to challenge individual professionals such as the variation in waiting lists for operations (Yates 1987). In 1985, Paddy Ross, the then consultant's spokesman, said 'the concept of the NHS was to provide an administrative system within which doctors treated patients in the light of their professional judgement. The NHS is just the system that pays the bills and provides the hospitals and all that' (Strong & Robinson, 1990; 4). This may be an extreme view, but clearly the perceived threat by the hospital consultants to their autonomous state was evident.

However, this new managerial scrutiny persuaded the medical profession to examine its own practices, if only defensively (Klein 1989). One of the central arguments of the Griffiths Report was around delivering a good product to the consumer. Griffiths put the question of how to define and enforce standards on the managerial agenda. This new interest in quality resulted in jobs for the nurse managers who were now redundant as a result of the changes. Yet the first phase of general management did not solve the basic problems of resourcing and inefficiency. Progress in implementing management budget systems (Pollitt et al 1988) and quality assurance (Shaw 1986) had been disappointing. This was mainly as a result of managers having little control over the doctors. The perceived need to bring clinicians within the same framework of accountability as managers was a central issue in the Prime Ministerial Review of the NHS announced in February 1988. The central thrust of the reforms,

now incorporated in the National Health Service and the Community Care Act 1990, was to replace the bureaucratically regulated NHS planning and resource allocation system with an internal market in health care. So when the 1989 reforms were introduced, was the antagonism of hospital doctors to their greater accountability exacerbated, or had the consultants become more aware of the incompatibility of their autonomy with the resource limitations placed on the system as a whole?

Much of the conflict for the consultants centred on their role in management. 'Working for Patients' (DHSS, 1989; 8) aimed to ensure that hospital consultants 'are involved in the management of hospitals; are given responsibility for the use of resources; and are actively encouraged to use those resources more effectively'. However, Fitzgerald (1991; 26) argues that 'the culture within the medical profession has rarely acknowledged management experience to be useful ... subtle career and professional disincentives combine with pressures to do research and a lack of reward for managerial activity'.

Mumford & Riley (1991; 18) propose that the development of clinical management is particularly vulnerable in three areas; the acceptance by clinicians of the reality of contracts, the expectations by managers that doctors can and will influence their colleagues clinical practise and the quality of medical leadership.

If the consultants do suffer from what these and other writers describe as a lack of managerial skill and hostility to the management process, then perhaps one recommendation could be the introduction of management discipline into doctor's training. When considering the model of the true professional the trait theory includes specialised knowledge and monopoly of practise. Theoretically, the introduction of general management skills into medicine would therefore be a 'de-professionalising' factor.

Mumford & Riley also comment that 'autonomy is a crucial value in medical culture' and this contends with the notion of the accountability of clinicians both to their colleagues and their managers. This loss of autonomy is another possible de-

professionalising factor.

The pressure for cost containment within the system has led to the development of a variety of managerial responses. This has prompted the most profound displays of distaste for the new system by the hospital clinicians. For example, in 1991, Dr Nick Thatcher at the Christie Hospital near Manchester went to the national press with an emotive story of an elderly cancer victim who had been denied the chance of treatment with the extremely expressive new drug Interleukin, in protest against a system which denied the clinician the right to take unchallenged decisions about the treatment of his or her patient (BMJ, 1991).

Another area in which the status quo of the consultants has been disrupted is in their terms and conditions of service, particularly with respect to their merit awards (Department of Health 1989). Historically these were introduced in 1948 and given on the advice of an independent professional committee to reward clinical excellence. The reforms state that in future not only were awards only to be given to those who demonstrated 'a commitment to management and development of the service' as well as clinical skills, but also that there should be a stronger management influence on the choice of who was to receive awards in the future. Raftery (1989; 948) suggests that the impact upon clinical freedom arising from this change is such that 'it is difficult to see how they (the consultants) could remain aloof'.

Medical audit

The requirement of medical audit was included in the reforms to give consultants and general practitioners a means, by peer review to evaluate the quality of clinical practice. The issue of quality assurance was directly confronted. As a doctor led exercise, the process received a warm response (Beecham, 1989; Lancet, 1989). This is interesting to note in the light of the trait theory of the professional - that professionals should be a self-regulating body. However, it remains unclear how far quality issues overlap with cost-effectiveness issues and how managers will interpret their role in the process. (Hughes & McGuire, 1992)

General practice

General practice is the clinical discipline most affected by the Governments 1989 proposals for the NHS with GPs, due to their independent contractor status, being last in line in being made more accountable. In 1965, the Charter for the Family Doctor Service was constructed by members of the General Medical Services Committee (GMSC) of the British Medical Association (BMA). This took place at a time referred to by an editorial in the British Medical Journal as one of 'profound malaise and disorder within general practice' (BMJ, 1965). The Minister of State, Kenneth Robinson,. accepted the Charter as a basis of a new contract. The Charter enabled much-needed developments in practice structure, but the professions self-imposed standard setting (as pursued by the RCGP) was too slow in implementation. Therefore as a profession working in the public sector and charged with self-regulation but failing to establish and ensure its own standards, it should not be surprised that the Government seeks to do so for it (Willis, 1990).

The new 1990 contract (Department of Health, 1989b) takes a different approach to that of its predecessor, setting out specific objectives for general practices with regard to availability to patients, preventive medicine, the supply of information to patients, and the supply of information to Family Health Service Authorities for management purposes.

The NHS reforms state very clearly that it is not only hospital doctors for whom performance related remuneration is the way forward. Pre 1989, capitation fees formed an average 46% of the GP's income. 'Working for Patients' gives the interpretation of raising that proportion of a GP's income to at least 60% (NHS 1989; 54). The idea was to expose general practitioners to more competition by increasing the share of their pay which came from capitation payments. A further change was targeted incentive payments for immunisation and cervical smears. In addition, payments were introduced for preventive clinics such as anti-smoking clinics. GP's were also to become more responsible for their commitment to resources, with particular reference to their expenditure on prescribing. They were to have indicative

drug budgets, and the new Family Health Service Authorities (FHSA's) (previous Family Practitioner Committees (FPC's)) were to have a much greater role in monitoring this expenditure.

GP practices who became fundholders would be able to make their own contracts with the provider hospitals for care. The majority of GP's who remained directly managed would be expected to follow the contract patterns placed by the district health authority (DHA).

Strong opposition was voiced by the GP's to the plans of the reforms (Leathard 1991; 166); various opinion polls showed by far the majority of GP's were against the reforms, feeling that their independent contractor status and clinical freedom would be restricted. O'Dowd & Wilson (1991; 51), however, attempted to investigate what this philosophy of 'clinical freedom' actually means. They discuss a balance which should be drawn between clinical freedom and clinical responsibility; arguing that professional freedom carries with it social responsibilities, for example in the commitment of resources. Many GP's felt that the administrative upheaval of implementing the new systems and the increased workload which followed was underfunded and unjustified, in the same way as their colleagues in hospital had done. O'Dowd & Wilson (1991) however described the new contract as motivated by consumer demand and political expediency, and though unpopular with doctors, it had showed that linking remuneration to the screening targets had had its desired effect. The manager's power vis-a-vis the clinician was enhanced. Clinical management and medical audit, on the other hand seek to shift the focus of professional self-regulation to take account of quality issues and to assimilate doctors into a managerial culture.

One of the most dramatic developments within general practice was the progression of the GP fundholders. These GPs, who controlled their own resources and made their own decisions, suddenly became the 'wild cards' of the NHS reforms, able to dictate terms and conditions of service to hospitals eager for contracts.

One GP fundholder remarked (Tomlin, 1990) 'we have no steady state; we are

beginning to realise some hospitals offer better quality and we are making the changes' when it seemed that the Department of Health was becoming concerned at the power which fundholders could potentially have in the system and tried to issue guidance to control this. Another fundholder remarked; 'I am sure the Department would like to have it all tied up and neat, but it would be a rather unfortunate case of top down dictation'.

Etzioni (1969) argued that a true professional exhibits autonomy from supervision and societal control. It seems perhaps that these GP's who rather aggressively 'grasped the nettle' of fundholding saw this as the way to establish their own autonomy, and therefore professionalism, within the system.

The internal market

The idea of having an internal market by separating contractors and providers had been proposed in an influential paper by Alain Enthoven in 1985. Professor Maynard had also proposed in 1986 that general practitioners where best equipped to act as skilled buyers on behalf of their patients. The separation of demand (finance) from supply (provision) became the crux of the White Paper's (1989) proposals.

It was said in the past that a market in medical care was impossible because: professional monopoly was thought to be unavoidable; patients were too ignorant to exercise consumer powers and health insurance is flawed by moral hazard (Green 1986). Green argued that without competition, consumers would continue to be poorly served and second-class treatment would remain the NHS norm; competition would be better than a doctors' monopoly and the bureaucracy of the NHS.

In Alain Enthovens critical analysis of the NHS he identified several reasons for change. These included inefficiency (few incentives and consultants on life long contract); perverse incentives; overcentralisation; free capital (leading to waste space and capital asset); inefficient health facilities which may be difficult to close because of the public outcry that would arise; lack of accountability and a non-consumer

focused service. These points had been recognised by others (see Alford, 1975) and the model received much support (Institute of Health Services Management 1988, Robinson (1988). Enthovens solution of an internal market captured the imagination of many and a quasi market system was incorporated into the NHS Reforms of 1990. Under these reforms, hospitals are now allowed to opt out from health authority control; these and other independent hospitals and health clinics are able to tender for contracts with health authorities; and general practitioners with practices over a certain size can have budgets for each of their practices that they will be able to spend on hospitals and other treatments of their choice. Health authorities and GP's choose from competing independent institutions. The choice of care is not exercised by actual consumers but by the health authority or GP acting as their agent. The government decided to implement Enthovens solution as well as Alan Maynards idea of GP's acting as purchasers (due to their closer contact with the consumer). This General Practice Fundholding Scheme, with its bottom-up approach is well described by Glennerster et al (1992).

The introduction of competition is supposed to encourage a more economical use of resources thus improving service efficiency. More importantly the introduction of competing suppliers means that consumers or their agents, have an alternative. Accountability is also made more explicit. Contracts are drawn up detailing exactly what the providers will offer while purchasers (health authorities or GP fundholders) draw up their contract specification detailing the service and quality they want.

This switch from public monopoly provider to competitive private providers is often advocated on the grounds that it will reduce the costs of service delivery. Le Grand (1990) argues however that there are costs involved in setting up the infrastructure for markets to operate efficiently. Even if there are no cost savings, advocates of quasi-markets argue that at least there will be an expansion of consumer choice. This begs the question of who is the consumer; GP's and health authorities acting as agents for consumers might have increased choice but there is no requirement to involve consumers or CHC's in contract specification or monitoring (Pfeffer 1992, Pollitt 1988). In some areas, competition might be absent due to lack of competitors.

Measures of quality and outcome barely exist (Le Grand 1990, Pollitt 1988) making it difficult to assess services while needs assessment is yet another underdeveloped skill. These merits and difficulties of purchasing are described by Glennerster (1992).

This 'internal market' is recognised as being a real challenge to professional power and NHS integration (Hughes & McGuire 1992). Managers have greater freedom to manage but this will be accompanied by increased emphasis on accountability and performance review (Hughes & McGuire 1992 & Klein 1989).

Patient services contracts are now central to NHS management. Lessons from abroad and from the commercial sectors show that not only money cost, but also the quality and reliability of the service need to be taken into account. However the skills to do this are sadly lacking within the NHS (Best 1989). Hopkins & Maxwell (1990) highlight the central importance of proper attention to quality. They state that 'unless contractual relations take account of quality from the start they will be driven by financial considerations, with the false assumption that quality can look after itself' (BMJ Vol 300, P922). This includes how quality will be monitored, and provision for what to do if there is any suspicion of failure.

Context of quality in health care

The development of quality approaches in health care have been generally shaped by political, public and professional issues.

This chapter highlights some of the potential issues (structure of the NHS, resource constraints, management accountability) and some external pressures driving professionals to more overt accountability. Other political issues include; Britain's agreement with the World Health Organisation that 'by 1990 all member states should have built effective mechanisms for ensuring quality of patient care within their health care system' (WHO, 1985, Target 31); the growth of private medicine which has provided more scope for comparison - it has also encouraged the development of

explicit minimum standards for the purpose of registration (Shaw 1986).

Public issues have also been highlighted, namely the encouragement of the consumer as a legitimate judge of quality (Griffiths 1983). Information has become more available and consumer bodies are growing in number and influence, for example the Association of Community Health Councils of England and Wales (1986) the Patients Association and the College of Health. This has been strengthened by the introduction of the Patient's Charter and Charter Standards (DOH 1992) stating that the patient has certain rights to guaranteed standards of service. In the event of these standards not being met, the patient has the right of complaint or redress. Standards are set for the performance of delivery and performance against these standards is published.

Finally the professional issue of training and education has underlined the role of quality assurance. The clinical professions have shown determination in retaining the initiative in the evaluation of clinical practice and training in order to demonstrate effective self-regulation (Shaw 1986). For example, in general practice the 'What Sort of Doctor?' (RCGP 1985) sought to arrive at judgements about care using their own implicit standards. In this scheme GPs visit each other's practices on a voluntary and reciprocal basis. Visitors have guidelines in which it is suggested that they engage in observation and discussion; view video taped consultations; and inspect medical records. They are also recommended to bear professional values, accessibility, clinical competence and communication skills in mind. No more specific standards are suggested in these areas and they are expected to make their own minds up about appropriate levels of quality. This scheme, though popular with participants, has had limited success due to lack of resources.

Despite initial difficulties, improved quality models have developed. Management increasingly acknowledge the contribution which a quality centred approach to service delivery can offer and has assumed greater ownership of quality issues (Shaw & Brooks 1991). The health service has begun to develop its own definition of quality based upon principles borrowed from both industry and abroad (Coopers & Lybrand,

1986) but adapted to its own needs (Ellis & Whittington, 1993).

The 1990 Government NHS Reforms put quality on the agenda for the first time (DOH 1989). Medical audit (supported by central money) and the introduction of the internal markets were welcome initiatives. Above all, health care professionals are recognising that the freedom to develop their vision of health care will need to be earned by demonstrating accountability and value for money.

The quality of care provided by professionals is recognised as being of the highest importance yet the quality of care and services provided depends on the organisational context in which professionals operate. An individual such as a doctor or a nurse may be highly skilled but if they operate in an unsuitable environment, this is likely to affect the quality of service provided. This is particularly pertinent in primary health care where professionals work from variable practices or centres with differing organisational structures and staff profiles.

The organisation of primary health care is looked at specifically in the next chapter.

CHAPTER 2

A Lead Role for Primary Health Care and the Need for Organisational Clarity

Primary health care now plays a key role in the implementation of a national strategy for improving the nation's health. For example, primary health care teams have been given the responsibility for health promotion and preventive care and are therefore the lead agency in delivering the goals of the Health of the Nation. Some GPs now have important responsibilities in purchasing and hence improving the efficiency of secondary care through the GP fundholding scheme where, by holding budgets, they can dictate terms and conditions to hospitals for specific services. This scheme has been expanded to cover community and other services and on an experimental basis in 29 areas, to cover the whole of local secondary care. In other areas, 'locality' purchasing or commissioning is being developed. This too gives a larger role to GPs. Alongside this, primary health care teams are taking on more functions which were previously undertaken by the hospitals, such as minor surgery. As a result, primary health care is now high on the health agenda and much is being asked of it. Yet little attention has been given to the organisational capacity and capability needed to support these larger functions. This is of particular concern given that primary health care is the least formal organisation within the NHS. It relies largely on a system of informal organisation that has changed little since the NHS was established in 1948.

It is surprising that the planned shift of care to primary health care teams who are not formal organisations has not prompted academics, healthcare workers and policy makers to look at the organisation and management structure of practices who are taking on an expanded role within the health care field. Whether primary health care teams are capable of carrying the burden of such increased responsibilities needs to be considered. Research suggests that they are not. Practices are at various stages

of organisational development ranging from single handed general practitioners working from inadequate premises to large multidisciplinary practices who are computerised, employ managers and are based in purpose built premises. This is of particular significance when one considers Billis' argument that social policy and organisational form and structure are inextricably intertwined and that public policy must take account of the fundamental structural characteristics of different organisations (Billis 1993). If general practice as an organisational system is incapable of responding to these challenges the results for health policy will be serious. One way to ensure that general practice can undertake its new duties is to set in place organisational standards and possibly an accreditation system. This has been advocated by community managers and community staff who have experienced organisational audit in acute hospitals and felt such an approach would be of value to community and primary health care staff.

This thesis sets out to test the feasibility of developing organisational standards for general practices/health centres and developing an audit system to determine compliance with these standards. It also aims to evaluate the impact that compliance with these standards would have on the organisation of the primary health care team. A tool to help primary health care teams develop as an organisation is of great interest as most organisations within the NHS are highly organised and bureaucratic. However, general practices have been unusual health organisations as they do not fit into the traditional view of organisational or Weberian models described by many management writers.

'Bureaucracy' can be defined as a system of paid staff who are organised into hierarchical roles (Jacques 1976). Bureaucracies are bound together by concepts such as accountability and authority with a clear chain of command. General practices are not hierarchical nor do they have defined separate levels with spans of control or discretion. The way practices organise themselves does not fit the voluntary association model either. Voluntary associations may be defined as comprising groups of people who draw a boundary between themselves and others in order together to meet some problems, to 'do something'. The literature usually refers to

this as having an 'objective or purpose'. (Billis 1993). The voluntary association negotiates as a corporate entity. In general practice, staff come together not for self help but to carry out their professional roles, earn a wage and general practitioners (GPs) work as independent contractors who run their practice as a business. GPs form partnerships with each other within a practice. However, this is legally different to a limited liability company, a statutory organisation or a voluntary organisation. GPs are individuals, who as partners (and the partnerships may not be equal), have collective responsibility for their professional activity. Partnership agreements vary ranging from purely financial arrangements to work sharing agreements. In many cases both these elements are included.

General practice has developed since the days when it operated as a cottage industry. Now other health professionals and administrative staff work within general practice and although they do much of their work on their own with their individual patients, their activity is becoming more coordinated. A brief look at the developments in primary health care this century shows why this has come about.

The development of general practice this century

Doctors originally offered their services on an individual basis, seeing themselves as science-based, autonomous professionals forming individual contacts with the ill to relieve their sickness. For their services they charged a fee. The introduction of the National Health Insurance Act of 1911 (by David Lloyd George) was the states first entry into health care and the first step towards the provision of free health care, but only for those in employment. Doctors who participated in the new panel system gave medical attention free to the ill and there was weekly sickness benefit. The Act offered doctors power to intervene effectively in the course of acute illness in the working poor, and also increased and stabilised their incomes, but the profession bitterly opposed it at the time. This Act was instrumental in establishing the concept of primary care and the family doctor as its leader, responsible for the referral of patients to consultants. GPs worked from home, were available 24 hours a day and were supported by their wives and family. District nurses were employed by local

authorities and worked independently of GPs.

The National Health Service Act was passed in 1946, giving the British population free access to general medical services. It continued and developed the capitation basis for remuneration and within each district the Executive Council became the administration body. Doctors were paid irrespective of the standard of their general medical services. Therefore there was little incentive to practice good medicine, employ staff or improve their premises. Practices continued to be largely home based. Many GPs felt isolated and dissatisfied. They had few incentives to practice better medicine, no postgraduate education and no career structure.

The foundation of the College of General Practitioners in 1952 enhanced the status of the GP and became the Royal College of General Practitioners in 1967 when Prince Philip became the Royal Patron.

The first university Department of General Practice was formed in Edinburgh in the 1960s. General practice began to be included in medical schools' curriculum and to be involved in research.

In the 1960s, there was unrest in the medical profession over pay and conditions and it threatened to withdraw its services. After negotiations with the Government, a contract with better conditions was drawn up - the Charter for the Family Doctor Service of 1966. This Charter gave GPs more remuneration if they provided a standard service and defined much more clearly what the government expected of them (The Charter was taken to its logical conclusion in the 1990 GP contract).

A basic practice allowance was paid in full for those doctors who had at least 1,000 patients, and pro rata payments for those with less patients. Capitation fees continued to be paid on top of this. Items of service fees were introduced to improve practice.

Doctors working week was shortened but they were till responsible for the provision of general medical services in their absences. This encouraged doctors to form

groups who could also now receive a group practice allowance. These group practices not only enabled the sharing of work but the sharing of premises, staff and equipment.

A postgraduate training allowance was introduced, and financial provisions were made for improvement of existing premises or for the purchase of new or purpose built premises. On top of this, payment was made for the employment of ancillary staff.

Despite this latter financial incentive, reports showed that the number of employed staff grew slowly. Ann Cartwrights survey in 1967 showed that only one quarter of doctors employed any staff.

Health visitors and district nurses were attached to some general practices. With the Health Service and the Public Health Act of 1968 district nurses became officially attached to practices rather than working on a geographical basis.

The Cumberledge Report

Julia Cumberledge's report on community nursing called for more control, with nursing managers and locality management. She raised queries about the attachment of nurses to surgeries, favouring locality management. This was followed by an increase in geographical or patch management. There are many convincing arguments on both sides, but for the primary health care team to operate with most effect, regard has to be given to some kind of named person/named practice attachment.

The report also states that practice nurses have little educational preparation for their work and have been taught procedures by doctors rather than nurses. These criticisms galvanized practice nurses into action, resulting in numerous courses for practice nurses.

Staffing

The provision of health centres by local authorities was encouraged from 1967, leading to some doctors working in groups. Many more doctors however formed group partnerships.

This resulted in primary health care being provided through different organisational structures. Variations included single handed GPs, salaried doctors and private partnerships between two and six or more GPs.

In 1952, 43% of practices were single handed GPs, 56% were group practices of between two and five GPs while 1% of practices had six or more GPs. By 1985 only 12% of practices were single handed GPs, 82% were group practices of between two and five GPs while 18% had six or more GPs (R Hobbs, 1990).

60% of doctors now own their surgery premises, 25% of GPs work from a health centres (60% in Northern Ireland) and only 15% rent accommodation.

The reimbursement of staff encouraged GPs to employ receptionists, practice managers and nurses. However, the reimbursement scheme was not fully taken up by all GPs. Staff employed varies. Community nurses attached to the practice may be housed in the practice or health authority premises. With the greater flexibility that fundholding allows, some GPs have employed or commissioned a whole range of staff including dietitians, physiotherapists, occupational therapists, orthoptists, counsellors, speech therapists, marriage guidance, continence services and special aids. Therefore primary health care teams can be structured and operate very differently.

The new contract

The 1990 contract and the NHS and Community Care Act of 1990 had great implications for the organisation and management of general practice. Central to the

contract was a shift in the methods of payment for services, with the intention of raising average remuneration accounted for by capitation fees from 46% to at least 60%. Payment would be received for regular health checks for children aged under five years and patients aged over 75, with financial rewards for health checks for newly registered patients, at risk groups, and patients with chronic conditions. Practices would provide an annual report, prescribing costs would be scrutinised, and larger practices would be free to apply for their own NHS budgets for a defined range of hospital services. Medical audit was introduced as a means of providing information about services and of improving the effectiveness of primary care.

Under the new contract there was an increase in workload. Business plans, annual reports and practice leaflets had to be produced, staff had to be properly qualified and trained and health promotion clinics had to be established. Targets had to be met for immunisations and cervical smears in order to receive payments and cash limiting of reimbursement for staff and drug budgets was introduced. This resulted in an increase in practice administration, workload and the more formal organisation of services. General practice was being pushed into a more business like structure.

Fundholding

The NHS and Community Care Act resulted in amongst other things an alteration in the flow of funds and the introduction of fundholding practices to day. Roughly a third of all practices now hold their own funds. GPs who chose to become fundholders took on the responsibility for handling government money and the responsibility of acting as their patients' purchasers of secondary health care. To facilitate this, these practices were given a management allowance which therefore encouraged them to become more managerially aware.

In order to meet the challenges of the new contract and for some practices, fundholding, practices have had to employ more staff including staff to manage the practice. The primary health care of today can only function effectively in a team setting. Working as a team in a coordinated way helps all those involved in primary

health care achieve their objectives more fully and economically. Yet primary health care teams are multidisciplinary with staff within the team having different employers. GPs cherish their independent contractor status, which allows them the freedom to work independently making their own clinical judgements and running their practice as they see fit. They employ their own staff for which they receive some financial reimbursement from the FHSA. Practice staff are clearly accountable to the GPs. Attached staff are usually employed and managed by the community unit/trust.

This century general practice has developed from the activity of a single handed doctor, often a family affair, to a multidisciplinary team often based under one roof offering a wide range of services to the local population. What has not been considered in detail is whether practices are organised to take on their enlarged role and increased workload and the steps they should take in order to offer their services to a high quality.

Organising primary health care teams

It is only since GPs have started working in partnerships and liaised with attached staff or have employed staff that they have formed an organisation - the primary health care team that we recognise today. The management level of general practice does not follow the traditional model described as 'hierarchical', 'bureaucratic' or 'authoritarian'. Nor does it follow the model described an non-hierarchical', 'antibureaucratic' 'responsive' and 'democratic'. It is usually a 'matrix organisation' involving several professions and lines of authority. Therefore primary health care teams are unusually complex organisations. In addition to the team members within or attached to the surgery of health centre, other people who play a key role in primary health care such as voluntary agencies, carers, patients and other professionals will form part of the team at various times.

A large proportion of health care provision is being shifted towards primary health care without an analysis of the organisation of primary health care teams. If primary health care teams are to succeed in delivering this care they will need to be organised

with stable structures.

Hierarchical structures persist within organisations on the grounds that there are different kinds of work carried out in organisations at higher and lower levels. The work stratum model described by Billis (1993) offers a concrete way in which organisations may be designed to react in various ways to their environment. The lowest stratum (i) is concerned with prescribed outputs (working towards objectives which can be completely specified before hand) to stratum 5 which is concerned with comprehensive field coverage. A stratum 5 organisation has a fully realised capability of self development and responds to a general field of need.

In general practice there are a variety of organisational structures which can fit into Billis' work stratum model. For instance the single handed GP will have few organisational problems. Where as the expanded primary health care team may have many. The single handed GP might have administrative staff to file and pull out notes. This is a level one task. Many practices now employ a manager who has wider responsibilities and span of control. Professionals within the team are carrying out professional tasks with a degree of discretion (level two). One partner may be the lead manager or fund manager (if fundholding) in duality with their role as a GP. This would entail systematic service provision (level three). Some practices join forces to form consortia. They then have responsibility for buying or commissioning certain services for their local populations. This responsibility for comprehensive service provision is a level four task. Those practices who become involved in locality purchasing are responsible for making comprehensive provision of services based on needs assessment of their local population. They are attempting to respond to a general 'field' of need (level five).

Alongside the primary health care teams, the community trust manager is managing a team of people working within a hierarchical structure, with defined roles and responsibilities and different stratifications of work ranging between levels one and five (community trust managers).

However, primary health care teams are all operating differently without a clear framework. Their responsibilities are expanding and yet beyond level two the work that is expected from each level is not clear.

With the expansion of the primary health care teams role to include health promotion and disease prevention and some care previously given by the acute sector, the team has expanded to cope with this increased workload. Practices have employed managers and are moving towards a more formal organisation, although they may be unwilling to recognise this. They are clearly in the transition zone similar to that described by Billis (1993). Transition zone ambiguity produces service malfunctions in voluntary organisations and could in general practice. Therefore it is of particular importance to think clearly about the organisational structure of primary health care teams.

For this transition to occur explicit and careful attention needs to be paid to organisational structures and responsibilities as well as issues of managerial authority and accountability, decision making, staff development, policies, procedures and job roles. As primary health care teams are not bureaucracies, they must take account of concepts of associations such as mission, informality and democracy. An underlying theory about what constitutes a primary health care team would help primary health care teams organise themselves to undertake their wide ranging and expanding tasks. Such a theory does not exist though resulting in each GP inventing his or her own.

Tensions are bound to arise in primary health care teams due to the ambiguous situations of some staff being part of a wider formal bureaucracy (for example a community unit) as well as being attached to practices, some staff being independent contractors (the GPs) and some staff being employed by the GPs. Tensions may arise between the leadership of the GPs or a charismatic GP and the authority-based community unit managers, the directly employed staff and the attached staff, democratic forms of organisation and bureaucratic forms.

To overcome these tensions and to create an effective organisation, there needs to be coordination of staff and services at all levels, clear job descriptions, a shared mission and clear boundaries.

Since the new GP contract and 1990 NHS and Community Care Act there has been low morale amongst primary health care teams and reported increased stress due to increased workload. This increased stress may in fact come though from their ambiguous roles and organisational incapability. It seems that primary health care teams are making the transition to becoming more formal organisations. Lessons are to be learnt from the organisational problems of government welfare bureaucracies which centre around boundary and role confusion. The distinctive problems of voluntary organisations centre around status ambiguity (the relationships between the political association, the bureaucracy of paid staff and the clients) and this must be acknowledged also.

Primary health care teams are therefore unusual health organisations which do not fit into the usual organisational models but are moving towards becoming more formal organisations and are in the zone of transition between 'formal associations' and 'formal organisations'.

In addition to the changes and developments in primary health care, the state wishes to make the professions more accountable. There has been a change in the organisational structure of health along with resource constraints. The lack of regulation in the past and the autonomy of the medical profession have given way to increased management accountability and more overt accountability amongst the professionals. GPs are in a unique situation as they are self employed and have been part of the NHS closest to self governing. With the increased emphasis on primary care, the issue of accountability has to be faced. The question is how to make GPs more accountable and how can GPs come to terms with the increased accountability forced upon them?

The issues of how to organise complex primary health care teams and also to make

GPs accountable to the state and to the public have not yet been resolved. The 1990 GP contract was an attempt by government to specify the services the GPs should provide. However, it did not specify the organisational means of achieving these services. In other areas of social provision such as universities and hospitals, the government has begun to specify organisational procedures and standards that are required to deliver a high quality service and to 'demonstrate fitness for purpose'. Organisational audit was seen by some as a way of getting primary health care teams to address these issues. The logic of the organisational audit approach as to what underpins fitness for purpose is that organisational standards concerned with all the systems and structures for the delivery of health care are in place. This starts with having clear goals, objectives and the systems and structures in place to enable each member of the organisation to achieve those goals. The approach is not based on any theoretical model but on practitioner's views on what should be in place to enable them to offer high quality service delivery. In taking part in organisational audit, an organisation puts in place the structures and systems to enable the development of a continuous quality improvement programme. Organisational audit can provide a framework to facilitate the development of the areas which can contribute to the overall goal of the 'pursuit of excellence'. Representatives (mainly managers) from primary and community services wondered whether organisational audit could address practice organisation and accountability to enable them to offer excellent primary health care services (C Pitt, unpublished).

Organisational Audit

Organisational Audit is a rational approach to setting and monitoring standards for the organisation of health care services. The standards are concerned with the systems and structures which must be in place in order to support high quality patient/client care. However, standards serve little purpose if there is no objective means of assessing or measuring whether compliance with these is achieved. Consequently, organisational audit also entails the evaluation of a health care organisation's compliance with the standards - the survey - which is undertaken by an external team of trained senior health care professionals.

The logic behind the approach is that if a sound organisational base can be achieved, those with responsibilities for delivering care or providing a service are free to concentrate on the delivery of high quality care or service. This model has been successful in the acute sector with over a third of acute hospitals participating in organisational audit to date. Acute hospitals have found organisational audit enabled them to ground their practice through the revision of procedures and documenting what they do, identifying weaknesses in systems, showing in a methodical way why they get the results that they do and in some cases revising their management structure or replacing staff who have been shown not to be fulfilling their roles and responsibilities. With the emphasis now on health care being increasingly delivered by primary health care services, would this model be a useful tool in developing and assessing the organisational capability of primary health care teams? This thesis sets out to assess whether organisational audit is applicable to primary health care.

Accreditation systems in other countries (US, Canada and Australia) have traditionally focused on the 'institutionalised' side of health care, although the US has recently developed standards for home-based care. There are no countries with accreditation systems in place which have primary health care services comparable to those in the UK. There was therefore little experience upon which to base this project.

As a result of organisational changes arising from the 1990 NHS and Community Care Act and the GP contract, primary health care services are under increasing pressure to meet standards (to ensure systems and structures are in place) and to develop systems for monitoring the quality of service offered. It is therefore an opportune time to test the feasibility and applicability of an 'accreditation' type approach (organisational audit) to primary health care services. Organisational audit was considered successful in hospitals where hierarchical structures exist with different kinds of work carried out at higher and lower levels. It is not clear what organisational structures and responsibilities are suitable for delivering primary health care. Through analysing their work and how to offer patient centred primary health care services, primary health care teams should be encouraged to think clearly about these issues which might have implications for the way they organise

themselves as well as for national policy.

Perceived difficulties

Primary health care teams are multidisciplinary with staff working for different employers. GPs have independent contractor status and employ their own practice staff for which they receive some financial reimbursement from the FHSA. Practice staff are clearly accountable to the GPs. Attached staff are usually employed and managed by the community unit/trust. Gaining agreement on standards, policies and procedures amongst staff and their employers could produce conflict and is more complicated than if there was only one employer.

GPs have always worked in an independent way. It will require a change in attitude to agree to the notion of standards. The standards, once developed, need to be robust to ensure credibility and a commitment to implementing them. Primary health care teams will need motivation in this implementation.

Primary health care teams vary according to the geographical area and the population served. Therefore the framework of standards needs to be flexible enough to be suitable for all primary health care teams. Since the introduction of the new GP contract, practices are feeling that their workload has increased whether fundholding or not. Devoting time to developing standards as well as implementing them and testing them out might be seen as an extra unwanted burden. Organisational audit must therefore be seen as tool worth developing and must fit in well with a primary health care teams working routine.

For consumers to be truly empowered they need to be involved in the setting and monitoring of standards. How to do this in a credible and constructive way requires careful planning.

Whether organisational audit is used as an educational tool or a management tool needs to be addressed.

Finally, my role as the project manager and an involved observer could influence the evaluation of the project. This is taken into account and discussed in the methodology chapter.

Perceived benefits

A detailed description of how primary health care teams develop and implement standards and the changes made in the organisation of practices/health centres as a result will provide useful information on whether a framework of standards benefits primary health care teams and if it does in what way. How best to provide objective feedback to primary health care teams in order to improve the organisation of primary health care teams is potentially important not only to the primary health care teams but to FHSAs and DHAs in their new role of monitoring quality in primary health care.

The study of this project in action should provide ideas for increasing the organisational capability of primary health care teams to deliver high quality care. It should also indicate how to increase accountability at primary health care level.

CHAPTER 3

Organisational Audit for Primary Health Care

Accreditation

In other countries (North America, Australia, Canada and New Zealand) the development of organisational audit has evolved through the accreditation process.

The word accreditation has different meanings in different settings. The Concise Oxford Dictionary defines it as 'recommending by documents' or 'a statement' or 'officially recognised' (Skyes Ed 1982). Accreditation is most commonly used to mean approval or assessment in relation to a person or recognised organisation. Approval carries connotations of rights to practice or the maintenance or loss of privileges.

Accreditation as developed in North America, Canada, Australia and New Zealand is a national approach to the setting and monitoring of standards.

Quality implies 'conforming to specified requirements' (Department of Trade and Industry 1987) which implies the design of standards against which measurement can take place.

Implicit in the development of standards for quality is the recognition that these standards must be desirable, achievable and measurable if they are to have any significance or credibility.

The history of accreditation dates back to the early 1900s. Surgeons in America and Canada concerned about the standard of patient care, as reflected in the poorly kept,

or more generally absent, medical records, (Roberts et al 1987 Stephenson 1978) formed the American College of Surgeons. One of the criteria for gaining fellowship to the College was the use of case notes to determine the applicants clinical competence. There was a 60% rejection rate. The College sought to improve the situation for developing standards for medical records; this was quickly followed by the establishment in 1917 of a hospital standardisation programme (McCleary, D 1977).

The College of Surgeons surveyed 692 hospitals of 100 beds or more and found that only 89% met with their standards. The names of all the hospitals surveyed were withheld and the results surreptitiously burned to prevent them falling into the hands of the press. The results, while disappointing and in some instances alarming, demonstrated the clear need for a formal programme of standard setting and monitoring, which rapidly gained national support. The College developed five official standards, known collectively as the Minimum Standard, which was one page in length, against which a hospital would voluntarily be assessed.

The value of the programme was demonstrated in the improvement in case records submitted to the College from approved hospitals, with an associated measurable improvement in the quality of care. The number of hospitals wishing to take part in the programme increased as tangible benefits were demonstrated, and by 1952 3,400 had been approved - over half of the hospitals in the United States. (Stephenson 1978).

This brief history of accreditation demonstrates three of the most important founding principles:

- a concern for the standard of care and service to the patient
- 'the concept that knowledgeable and experienced health care professionals should assess conditions in the hospital environment and work to achieve consensus on standards which would have the greatest positive effect on the quality of care provided to patients'

- confidentiality: the results and recommendations of the survey are known by the hospital concerned and the accrediting body only (although whether a hospital is accredited is widely known).

The College of Surgeons continued to run the programme until 1951, when it was then joined by the American College of Physicians, the American Hospital Association, the American Medical Association and the Canadian Medical Association to form the Joint Commission on Accreditation to Hospitals. (Affeld, T 1976)

The Canadians withdrew in 1959 to establish their own accreditation programme, which became known as the Canadian Council on Hospital Accreditation (Wrightman, C 1982). In 1974, Australia, working closely with the Canadians, established the Australian Council of Health Care Standards, (ACHCS 1986, McCue et al 1981 a and b) now renamed the Council on Health Care Standards (ACHCS). In 1989, after an extensive pilot study, New Zealand embarked upon a similar programme. (For further details of the various models see Ingrid Sketris, 'Health Service Accreditation - An International Overview' (1988).)

The initial one page 'minimum standard' has predictably expanded to more than 200 pages in all these models, reflecting the increasing complexity of health care. The standards cover all aspects of a hospital from an organisational perspective, the belief being that in striving to ensure an optimum environment for patients, and one within which health care professionals practise, the opportunity is created for the delivery of high quality health care. Accreditation cannot guarantee the quality of health care given; rather it is a measure of the hospitals capability to provide quality services.

The standards, the organisations and the approach to accreditation in each country are broadly similar:

(a) the standards relate to structure, systems and processes

(b) the organisations running the programme are:

- professional led
- independent
- non-profit making
- strongly educational (produce supporting literature and guidance on interpretation of standards; organise workshops and seminars; provide consultancy service)
- include consumer representation (with the exception of Canada)

The process to gain accreditation is voluntary and is essentially a national system of peer review. The steps involved are as follows:

The hospital applied for accreditation and following this, received copies of the standards manual and may request guidance on interpretation. The date for assessing compliance with the standards, known as the survey, is agreed at the beginning. The hospital prepares for the survey (approximately 12 month preparation period). Prior to the survey the hospital returns the hospital profile from, which indicates the size, complexity and range of services. Based on this information, the council staff put together an appropriate team to conduct the survey. This team (with the exception of the US) are comprised of senior practising health care professionals - consultant, manager, nurse. The survey is conducted over a 3-5 day period resulting in the team (with the exception of the US) recommending accreditation status (for 3, 2, 1 year or non-accreditation).

The council or commission vote on accreditation status of the hospital, based on the surveyors' report. The hospital then receives the report and the accreditation award. The results of the survey are confidential, although it is known if a hospital is or is not accredited (the US, however, has recently introduced conditional accreditation, which means the hospital has a number of problem areas and this information will be shared with the state and federal governments).

It is important to note that the US system is very different to the approach taken by Canada, Australia and New Zealand. The differences are evident in four main areas:

1 In the US a hospital must either be licensed or achieve accreditation status in order to receive reimbursement under the federal medicare, medicaid programme.

2 The Joint Commission employs full-time surveyors who are not current practising professionals. They do, however, use survey teams comprised of a doctor, nurse and administrator, but these are frequently retired professionals.

3 The survey team do not recommend accreditation status. This is calculated using a computer system and a complex scoring method.

4 The standards have become very detailed and are considered prescriptive.

The Joint Commission is beginning to address this latter point, together with a general review of its role, in a major research and development project known as the 'Agenda for Change'. The project is intended to 'improve the ability of the Joint Commission to evaluate health care organisations and stimulate greater attention to the quality of day-to-day patient care' by moving towards outcome based standards.

Therefore other countries over recent decades have moved to a system of accrediting organisations, not just practitioners. This had not happened in the UK prior to 1990.

Audit comes to the NHS

In 1987, the ministerial review established primarily to examine funding for health services, but later encompassing operational issues, considered the possibility of introducing an accreditation system into the UK health care system. Given that a limited internal market system was to be established through the separation of the purchasers of health care from the providers by means of formal contracts, (which were to have a clearly defined specification for the quality of service to be provided), the idea of an independent national agency to define and monitor standards (ie a

system of accreditation) seemed a likely possibility. This idea seemed to be well received by those working within the health service. However, when the White Paper which detailed the results of the review, was subsequently published in January 1989, accreditation had not been included; the responsibility for monitoring contracts was to be assumed by the purchasers of health care.

The White Paper has become the NHS and Community Care Act and managers now have some experience of drafting, assessing and complying with contracts but have no clear basis for how to judge between agencies providing services. There has been an increasing number of calls from general managers (independent and NHS) to establish some sort of independent agency to set and monitor standards for the health service. This view has been borne out by the level of support received for work in progress at the King's Fund to establish just such a scheme.

The origins of the Organisational Audit Programme

In spring 1989 the Quality Improvement Programme at the King's Fund Centre embarked upon a major study to look at the feasibility of introducing an accreditation-type approach within the UK health care system. The aims of the project were threefold:

1 to develop a comprehensive set of standards covering the range of services and disciplines within an acute unit, which could be applied nationally;

2 to develop a process to assess a hospital's progress towards meeting the standards (the survey); and

3 to assess the level of acceptance for a national programme of setting and monitoring standards.

The origins of the project go back to 1988, when the then recently established Quality Improvement Programme at the King's Fund Centre was looking for an appropriate

focus for activity. The Programme had set up a data base of published and unpublished quality assurance activities together with an enquiry service. The most frequent enquiry this service received concerned information on standards, how to set them, who had developed any and how to measure them. In response, the Quality Improvement Programme organised a one day conference, to look at the various categories of standards, and approaches to monitoring quality.

In considering the appropriate area for the development of national standards, standards can be conveniently divided into three main categories:

Professional/technical - which are considered the responsibility of the various professional bodies such as the Royal Colleges. Examples of these are the accreditation of teaching establishments and training posts (GMC 1967, JCPTGP 1976, RCGP 1990 and Lockie C Ed 1990).

Service Delivery - that is the patient/service interface. Examples of such standards are the waiting time in out-patients or A&E. Department of Health guidelines have been produced for out-patients which recommend that a patient should wait no longer than thirty minutes before being seen and this as we all know, is rarely achieved. It can be argued that there are too many variables at local level within this area to make the setting of national standards practical. That is not to say it is undesirable, but should be tackled locally.

The third category is organisational audit standards - and it is this area which has been the focus of national programmes - which are the various accreditation models developed by the US, Canada, Australia and New Zealand and in Europe, Spain and the Netherlands. These were discussed at the conference and support and enthusiasm was such that a number of districts volunteered to pilot some form of accreditation if the King's Fund was prepared to organise the necessary work.

About the same time, the Independent Hospital Association, understandably disgruntled with inspection procedures undertaken within the 1984 Registration and

Inspection of Homes Act, had set a working party to develop explicit standards against which the quality of their hospitals could be judged. They then heard about the King's Fund project and rather than duplicate effort, nominated two independent hospitals as pilot sites presenting an opportunity to develop standards which could be applied to both the NHS and the independent sector alike. For those within the NHS it was seen as an opportunity to tackle, at least in part, some of the issues around the quality specification within the proposed purchaser/provider contracts.

For the purposes of this thesis, key players representing consultants, managers and nurses from the original pilot sites were written to asking them why they took part in the organisational audit for acute hospitals project. Reasons cited that were common to each respondent centred around the desire for a credible system for assessing organisational 'fitness' of acute hospitals, objective measures of the hospitals quality of performance, especially management and development of tools to define and raise standards. Hospitals wanted bench marks against which to test their own local performance. All the respondents saw the value of organisational audit as a vehicle for organisational development: - it provided a comprehensive library of essential information, it propounded good practice and it enabled the quick formulation of action plans and by highlighting good practice, was a good motivator within the organisation.

Tessa Brooks was running the Quality Improvement Programme at the King's Fund Centre at the time. She stated that although quality initiatives in healthcare were proliferating, she found an absence of any notion of quality as a management concept or of quality as having contribution to make to the organisation itself. She also felt that there was no framework within which the growing number of initiatives could be structured and encouraged in order for them to contribute in a focused way to the overall effectiveness of the organisation.

Among the range of quality approaches current in the NHS at the time, the UK standard BS5750 was seen by some to have a place. The standard was developed for the industrial and manufacturing sectors and has largely been applied within that

context over the past twenty years, although in recent years its application has extended to the service sector and on a limited basis to the health care field in such areas as laundry, catering and estates.

The standard aims to offer a means by which the integrity, consistency, comprehensiveness and scope of quality management systems can be assessed and confirmed. It does not itself set standards of performance but establishes that those standards which are set by the organisation itself, can be consistently delivered. The standard requires that the procedures throughout the quality system are documented but it does not specify the complexity of this. BS5750 is usually applied incrementally within large organisations.

A national corpus of certification bodies accredited by the Government assess those organisations seeking registration under BS5750.

Because of the limitations of BS5750 its application has been restricted on an organisational wide basis. Whilst it is possible to assess the specification for technical quality in isolation, Tessa Brooks considered it hard to assess the quality of a service such as an out-patient service in isolation from the rest of a hospital.

At that time Total Quality Management (TQM) was fairly unknown in the NHS but was the dominant new model used in the private sector. In Tessa Brook's view TQM was an over ambitious concept for the average NHS hospital to handle. The principles underlying TQM are those developed by the US statistician Dr W Edwards Deming who convinced post world war II Japanese industrialists that by concentrating on quality they could capture markets world wide within five years. It took the americans another 30 years to adopt the approach themselves and their european counterparts a further decade. The principles of the TQM approach are that is management led, company wide, everyone is responsible for quality and the philosophy is prevention not detection. The standard is to get things right first time and the theme is one of continuous improvement.

In the late 1950s a number of hospitals began to experiment with the application of the TQM approach to quality investing in the development of a number of quality management sites. Initial findings suggested that the relatively youthful development of quality in the NHS coupled with the complexity of the organisational issues involved had made progress hesitant. Lessons learnt were also slow to disseminate.

A 1990 King's Fund study of the transferability of TQM principles in the NHS suggested further difficulties associated with: scale, political and managerial versus professional agendas, defining customers requirements, the pay-off versus the political timescale and work overload. The study concluded that nonetheless, the gradual and focused introduction of a continuous quality initiative approach would significantly improve the quality of care, empower staff, give a sense of purpose and identify to the NHS and increase the effectiveness and efficiency of the NHS (T Brooks, 1991).

She looked for another less sophisticated approach and lighted upon the accreditation model in North America and Australia. However, there were real problems with the systems which already existed in that they tended to be prescriptive and regulatory in their focus. She and the project manager conceived organisational audit as a developmental alternative which, while based on the accreditation model, incorporated additional developmental support, primarily in the shape of survey managers.

They argued that organisational audit would be an important step towards creating an environment where all staff are committed to a programme of continuous improvement. The steps involved would include the involvement of top management on a multidisciplinary basis, a strategy for implementation which involves the development of an overall mission statement and objectives for the hospital which is turned into action plans through the development of philosophies and objectives for all services. Implementation would involve a hospital-wide review of services against standards which focus on the consumer. Such a review should encourage the challenging of accepted practices. The evaluation by an external team would provide an organisational diagnosis. By taking part in organisational audit, a hospital would be putting all the structures in place to enable the development of a TQM approach.

Six district health authorities and two independent hospitals from across the UK volunteered as pilot sites giving a total of nine acute units - five district general hospitals, two teaching hospitals and two independent hospitals.

Developing the standards

A multidisciplinary steering group comprising senior representatives from each site was established. This group examined the various accreditation models and decided to use the Australian standards as a base from which to develop a UK model. The Australian standards were adapted by staff from the pilot sites and agreed by the steering group. The first draft of the manual was published in the Autumn of 1989. It included standards developed in an earlier King's Fund Centre project, and guidelines from the Department of Health and professional organisations where available and appropriate.

The standards covered management and support services, professional management and departmental management such as the accident and emergency service or the operating theatre service. The format of the standards covered philosophy and objectives, management and staffing, staff development and education, policies and procedures, facilities and equipment, patients' rights and special needs, patient care, evaluation and quality assurance.

Examples of standards included having an organisational chart that was regularly reviewed, heads of services being involved in budget preparations and holding their budgets, staff being adequately qualified and having contracts and appraisals and information being available such as on staff sickness, absence and turnover of staff.

Each hospital then established a programme to implement the standards which involved all groups and all levels of staff. Staff were also asked to assess the practicality of the standards.

Developing the survey process

Between February and April 1990, each hospital was visited by an external 'survey' team comprising a district general manager, consultant and nurse, all of whom had been trained for the task. An observer from the King's Fund Centre was also present during the survey. The principal objectives of the survey teams at this stage were both to assess the measurability of the standards and test the process of assessing compliance with standards.

Each survey concluded with a detailed verbal feedback to the hospital staff which was followed up by a written report. This described the findings already presented to the hospital by the survey team, and included recommendations for action and commendations of good practice in relation to the standards.

Evaluation

The various stages of the project were then subject to evaluation by the steering group and a range of staff from the pilot sites, and the necessary amendments made to the process and the standards. The results of this evaluation together with more detail about the feasibility study can be found in the first years report entitled 'The Quality Question' (1990). A second edition of the standards manual, Organisational Audit, was also published in Autumn 1990 and made widely available.

This project developed into the King's Fund Organisational Audit Programme in 1991 and is now the largest accreditation type approach in the UK, working with approximately 150 hospitals two years later. It is intended that the hospital will be revisited at three yearly intervals. Participation in the process is voluntary.Accreditation status is not awarded as the KFOA believed that the great advantage of the organisational audit approach was that it is viewed as a developmental activity by the participating hospitals and that any movement towards a system of rating, pass or fail, would inevitably shift the balance towards an inspectorial approach. However, hospitals are now asking for accreditation and

KFOA is therefore having to carry out research into its role as an accrediting body.

The project claimed that organisational audit offered:

- a useful framework for quality initiative activities
- validation and documentation of practice
- multidisciplinary review
- improved internal communication

as well as offering an independent mechanism for monitoring quality and confirmation to purchasers that robust systems and processes for quality delivery are in place.

It would appear that the agendas of the independent sector and for NHS were satisfied as there is no shortage of volunteer acute hospitals.

Amongst other similar approaches is that in South Western Regional Health Authority, which while based on similar principles works exclusively with community hospitals and offers accreditation status. A number of regional health authorities are also exploring a similar approach as part of their monitoring role, but the evidence suggests that an independent third party, its work endorsed by the professional bodies, will continue to prove more acceptable to the field.

To support the increasing level of activity, an advisory council, comprised of members of the King's Fund and the major professional and consumer bodies was established. Their role is to consider the long-term management of the programme and, together with the field, establish a programme for the continual development of the standards to ensure they are desirable, achievable and measurable. They have also been involved in debating the important question of whether the King's Fund 'accredits' hospitals.

The King's Fund became under increasing pressure to extend the work of the programme to primary and community health services. A steering group was

established to explore how this could be taken forward and a meeting was held at the end of November 1990. A subsequent meeting in March 1991 with representatives from primary and community care formed the steering group. The desirability and feasibility of extending the organisational audit approach into community services was discussed. It was agreed that the King's Fund should put forward a project proposal and seek funding to support an initiative which focused on the range of services provided by health centres and general practices. It was considered that primary care bases represent a microcosm of services provided within the community and, as such, would present an opportunity to tackle 'unchartered' waters.

Organisational audit is seen as a way of enabling organisations to be self aware and critical. Its success in the UK had been with hospitals who were already formal organisations albeit of a complex nature. The extension of organisational audit to GP practices and health centres was an interesting new development in that the audit model was being applied to a group that was in transition (Billis 1993) from non-formal organisations to ones that had formal organisational attributes. For example, they were employing staff including managers, holding budgets and buying services. Despite this transition in their structure and ways of working primary health care team members retained the belief that they were merely groups of practitioners collaborating under the same roof. It is difficult for primary health care teams to develop and apply standards when they are in this transition phase and there is no clear underlying model outlining what constitutes good organisational practice in primary health care. This explains the alternative approach undertaken in organisational audit where the professionals set standards by thinking about the organisational issues, analysing their ways of working and how best to offer patient focused services.

This chapter highlights how organisational audit developed from programmes that were initiated out of a need to accredit organisations. These accreditation schemes have been adapted and replicated by professionals to provide them with models to help them organise their services. Organisational audit is not based on a theoretical approach but on practical reasoning as to what should be in place for a health care

organisation to function well. Whether organisational audit could help primary health care teams organise themselves to enable them to deliver high quality care and the tensions that prevailed is explored in this thesis.

CHAPTER 4

Research Design

The first element in the research derives from a research project for which I (the project manager) was directly responsible but which the King's Fund financed and sponsored.

This research project, sponsored by the King's Fund, was established in January 1992, with the following aims:

- to test the feasibility of developing organisational standards for general practices/health centres and to develop an audit system to determine compliance with these standards; and

- to evaluate the impact that compliance with these standards would have on the organisation of the primary health care team.

Within these aims were specific objectives:

- to work with staff and users to develop organisational standards which focus on primary health care services;

- to develop a mechanism for monitoring progress towards meeting standards;

- to work with staff and users in nine volunteer pilot sites to test the standards and the monitoring process

- to identify and train health care professionals to conduct surveys of the pilot sites;

- to determine the input of users to the monitoring process;

- to determine the level of national support for the organisational audit of primary health care services; and

- to identify appropriate areas for the further extension of this work.

Developmental phase

Approximately 40 sites volunteered to take part in this exercise. They had heard about the project from members of the national steering group mentioned in the previous chapter, who were assessing whether to 'extend' organisational audit into the community. Nine pilot sites involving twelve practices were finally selected. They were:

Ballyowen Health Centre, Belfast, Northern Ireland
Bedgrove Health Centre, Aylesbury, Buckinghamshire
Bennetts End Surgery, Hemel Hempstead, Hertfordshire
Bridgegate Surgery, Retford, Nottinghamshire
Dunluce Health Centre, Belfast, Northern Ireland
Grove Medical Centre, Deptford, London
Lawson Street Health Centre, Stockton on Tees, Cleveland
Mount Surgery, Pontypool, Gwent
White Rose Surgery, South Elmsall, Yorkshire.

The criteria for selecting the pilot sites ensured that the range of organisational configurations were included. This was an important consideration as standards developed would be applied to any practice setting.

The criteria for selection included the following:

- demonstrable commitment

- geographical spread (including inner city, rural areas)
- different configurations (eg fundholding/non-fundholding practices, health centres)
- wide range of community services (to ensure representatives of all primary health care professionals were included.

The characteristics of the pilot sites can be seen in Figure 1.

FIGURE 1

Characteristics of the Pilot Sites

	STATUS	DEMOGRAPHY	LIST SIZE
Ballyowen Health Centre	Non-fundholders	Inner city (deprived)	30,000 (practice 9,000)
Bedgrove Health Centre	Fundholders	County town	8,500
Bennetts End Surgery	Fundholders	Suburban (mixed)	17,500
Bridgegate Surgery	Non-fundholders	Small town (affluent)	8,900
Dunluce Health Centre (4 practices)	1 Fundholding 3 Non-fundholding	Inner city (deprived)	23,000
Grove Medical Centre	Non-fundholding	Inner city (deprived)	6,400
Lawson Street Health Centre	Fundholding	Suburban (mixed)	31,361
Mount Surgery	Non-fundholding	Small town (mixed)	10,600
White Rose Surgery	Fundholding	Rural (mixed)	7,270

The GPs, the staff employed by them and the attached staff such as health visitors, district nurses, physiotherapists participated in the organisational audit project. The

attached staff were included even if they were based outside the surgery.

Three of the health centres (Ballyowen, Dunluce and Lawson Street) housed four practices each as well as community staff and pharmacies. In the case of Ballyowen and Lawson Street Health Centres, only one out of the four practices chose to participate in the organisational audit project. All the community staff in both health centres participated. In Dunluce Health Centre, all four practices were involved, along with their community services. Bedgrove Health Centre housed one practice only. Social workers were based in the Belfast health centres as health and social services are integrated in Northern Ireland.

No control group was used in this research project which has disadvantages. However a control group would have been expensive and not practical in this instance. Therefore this research was set up not as a randomised controlled study but as an exploratory study.

Local steering group

Each pilot site established a multidisciplinary working group which was responsible for coordinating the various stages of the project and taking forward the developmental work within the practice/health centre.

It was advised that the local steering groups:

- were multidisciplinary
- involved the FHSA and Health Authority
- involved consumers
- seconded expertise as required.

Central working group

A central working group was established to help plan each stage of the project. This group consisted of two people from each of the pilot sites and represented the different primary health care professions. This was a forum for sharing views, concerns and ideas of pilot site staff in relation to the development of standards and the monitoring process, and for securing agreement on the various stages of the project.

National advisory group

As a source of additional advice and support, a national advisory group was established comprising representatives of the key professional and consumer organisations such as the Royal College of Nursing, Health Visitors Association, RCGP, FHSA, Age Concern and the Carers Association. This group provided external and independent advice to the project.

Time frame

The project took place over 1.5 years. The table of activity can be seen in Figure 2.

FIGURE 2		
Table of Activity		
1992	January	Pilot sites identified
	February	Areas of development work allocated Standards developed by pilot sites
	May	Standards collated
	September	Draft manual of standards produced
	October - November	Manual distributed to pilot sites
	November	Baseline audit of practices undertaken
	November 92 - March 93	Standards implemented
1993	February	Pre-survey documentation completed
	March - May	Pilot site surveys
	June	Survey reports produced

Resources

The Gatsby Foundation, one of the Sainsbury Charitable Trusts, gave financial support to the project. Financial support was given also by either the FHSA, Community Trust or Regional Health Authority associated with the pilot site. This indicated the commitment of other agencies responsible for primary health care provision to the research project.

The financial support was used to cover the cost of meetings, printing, the surveys and publication of the final manual of standards with additional guidance booklet.

The pilot sites gave much of their time and bore the cost of photocopying within the practice.

I worked on the research project full time for two years, supported by a full time secretary.

Participant observation

The next phase of the research will involve a description of the project from my perspective as an involved observer. The purpose of this approach is to describe the activities that took place and the people who participated as well as to find out the views of the participants.

Having the status of an involved participant and one involved in making the project work involves the problems of bias, subjectivity and researcher led effects. (Patton 1987, Burgess 1984, Bryman 1989) Therefore I had to be aware of my role and alert to these issues. In making my observations I took account of the action and activities of a range of health care workers and consumers and practices/health centres in order to avoid bias and manipulation. All research methods have limitations and I consider that the problem of subjectivity is balanced by the richness of the detailed account gained by being closely involved in the research. I can reflect on the research critically and gain an insight into the day to day issues of practices undertaking organisational audit.

Strengths of the approach

Being an involved observer, I was able to observe and record in detail the views of the primary health care team members, the ways they worked together, the power structure within the teams, their anxieties, fears and successes and their plans for developing their service. In other words, I was able to collect data in the primary health care setting as it happened. I was able to do this informally when talking to team members in and out of the practice, for example in the car collecting me from the station or in their coffee rooms as well as formally in meetings.

Visiting the pilot sites helped me understand better the context within which the

organisational audit activities occurred. This is essential to a holistic perspective of vital importance when considering the possibility of extending the organisational audit approach more widely.

First hand experience of the project allowed me to be inductive. I could directly experience the project as an experience in itself, thereby making the most of an inductive, discovery-orientated approach.

Another strength of being an involved observer was that I was able to see things that may escape conscious awareness among the participants in the project due to their routines being taken for granted. I could also learn about things that the pilot site participants may be unwilling to talk about in an interview . In addition, I was able to gain access to all team members including those who might otherwise be sidelined such as community trust employed attached staff.

Most importantly, I was able to reflect on the direct experience of the project. First hand experience and observations ought to be especially valuable because they are grounded in direct understanding of realities and not abstract ideals; they are actual not hypothetical. This should yield therefore highly practical and relevant recommendations when evaluating the project.

Fieldwork procedures

When setting up the project, I had to build up trust and a rapport with the participants. Developing trust and establishing relationships was a crucial part of my involvement in the social scene of the primary health care team's I was working with.

Factual, descriptive notes were vital for the research methods. Minutes of formal meetings were recorded and notes taken of visits to the pilot sites and telephone conversations. Quotations were collected and views were captured in the participants own words where possible.

When writing up the project I had to be clear about separating descriptive accounts from personal interpretation and judgement. However my own thoughts, feelings and experiences will be found in the account of the project, making it a highly personal record.

Visits to the sites

Each pilot site was visited between five and seven times for meetings when formal and/or informal conversational interviews took place.

One and a half days were spent in each pilot site during their surveys.

Formal meetings at the King's Fund

Six meetings with the central working group and four meetings with the national advisory group took place during the project.

Potential surveyors were trained over a two and a half day period.

The pilot sites knew that they were participating in a research project. However they were not aware that I was undertaking a wider piece of research, observing in detail the changes that occurred within the teams, until the second year when I sent them questionnaires. As they were involved in a project, this did not appear to surprise them and they were extremely cooperative.

Evaluating organisational audit: sources of evidence

Formal discussions with observers

Evaluation of the project involved discussions with the central working group and the assessors of the pilot sites (surveyors), the results of which were recorded. These meetings followed a written agenda but were informal enough to allow all the members to feedback their or members of their practices/health centres views. Although this feedback was important and useful, it could be biased in favour of the members of the group and may not truly reflect the views of the rest of their teams.

Questionnaires (pilot sites)

To enable a fuller evaluation of the whole organisational audit process, a questionnaire was sent to each pilot site. The purpose of the questionnaire was to discover if the organisational audit was practical and suitable for practices to undertake. It was also a factual enquiry, to identify also changes that had taken place within the pilot sites as a result of organisational audit.

The content of the questionnaire covered the standards, the survey preparation, the survey and the report they received as a result (see Appendix 1).

When drawing up the survey, all aspects of organisational audit were asked about following the logical sequence of events of the research. Open ended questions were used in order to probe and obtain the respondents' own ideas as well as allowing them to relate, in full, the changes that had taken place. The questionnaire was piloted amongst health care professionals who were not from the pilot sites to check for clarity, full coverage of all aspects of organisational audit and biasness. As a result of this pilot, some questions were identified as leading and were re-worded. The questionnaire was sent to each pilot site with a covering letter explaining the purpose. When completing the questionnaire, the pilot sites were asked to involve all members of their primary health care teams to ensure their views were included. Some pilot

sites incorporated all their teams answers on to the one questionnaire. Others sent back several copies of the questionnaire, each filled in by the different groups of professionals. The questionnaires were anonymous but each site identified themselves on their reply. Each pilot site returned their questionnaire duly completed within a month.

Questionnaires (surveyors)

At the same time as questionnaires were sent to the pilot sites, questionnaires were sent to the surveyors who had assessed the pilot sites compliance with the standards. The purpose was to discover whether any improvements could be made to the survey from the surveyors perspective as well as discovering their views on being a surveyor.

The content of the questionnaire covered the survey timetable, composition of the survey team, surveyors support from the King's Fund and what they felt they had gained from being a surveyor. (See Appendix 2.) The questionnaire was drawn up in the same way as the questionnaires to the pilot sites using mainly open-ended questions.

The questionnaire was sent to every surveyor with a covering letter explaining the purpose. The majority of the surveyors were also involved in completing the pilot site questionnaire. The questionnaires were anonymised and each respondent completed the questionnaire fully within one month.

Baseline audit questionnaire

Each pilot site was also asked to fill in another questionnaire (to provide some indication of the level of activity that had taken place within the pilot sites while participating in organisational audit). They were asked to carry out a baseline audit of the standards their perceived they were meeting prior to implementing the standards. To do this, they were asked to go through the manual of draft standards

and indicate the standards they perceived they were already meeting. They were asked to do this as soon as they received the manual, to provide a snapshot view of their organisation before working with the standards. This baseline audit could then be compared with their self assessment forms indicating the standards they perceived they were meeting at the time of the survey, four to five months later. The limitations of this questionnaire are that it indicates the pilot sites perceptions of which standards they were meeting. It was therefore a subjective assessment on the part of the pilot site. Each pilot site completed and returned their baseline audit in less than one month.

Documentary evidence

Finally, documentation was gathered and analysed. Letters and minutes of practice meetings received from pilot sites provided useful information describing the organisational audit process. The pilot sites also gathered together their practice documentation to provide supplementary information for the surveyors on the surveys. The documentation that the pilot sites were advised would be useful for the surveyors to see is listed in Chapter 8. This documentation was to give a useful insight into the way the practices functioned and organised themselves. The dating of the documentation also indicated whether documentation such as objectives, policies, procedures or organisational charts had been developed as a result of working with organisational audit.

One of the outcomes of the surveys for the pilot sites was a written report giving feedback to each pilot site on where it stood against the standards. The reports provide a recording of each pilot sites position against the standards.

Analysis

The analysis proceeded in several stages. First, it was necessary to present a chronological account of the stages of implementation, drawing out the problems of implementation and how they were surmounted. This is done in chapters 5 to 8.

Secondly sources of evidence mentioned in this chapter were used to measure what practices thought about the process and the usefulness of organisational audit and whether there had been any observable change in the organisation of the pilot sites after the introduction of organisational audit. Also whether from observation or from the participants comments, any of these changes could be tied to organisational audit.

The research project did not set out to test whether actual service standards were improved or how this approach compared with other approaches. Rather, the project sought to explore the process of organisational audit in primary health care and if it could clarify thoughts on primary health care team's fitness for purpose.

This research unfortunately consists of some compromises such as the problems of bias, the 'Hawthorne Effect' and lack of control practices but, as has already been mentioned the richness of the detailed account should compensate for these limitations.

Finally, a more generalised analysis is undertaken reflecting on the feasibility of extending such an approach more widely.

CHAPTER 5

Developing Organisational Standards For Primary Health Care Teams

The first part of the project involved developing standards. Other institutions have standards and criteria stipulating systems and processes that need to be in place to ensure well run services. Having such standards is thought to encourage organisations to look at how they operate. Therefore, the philosophy underlying this approach came from previous examples such as organisational audit for acute hospitals and other accreditation schemes. It was hoped that developing the standards would clarify primary health care team members thinking about systems and processes that needed to be in place for them to provide desirable primary health care.

This chapter describes the eight months when the organisational standards for primary health care teams were developed. The main part of this work was undertaken by the pilot sites between February and May 1992. Between May and October 1992 the project manager worked further on the standards developed by the pilot sites, pulled their work into a structured manual of standards and circulated the draft manual widely for comments.

During this period, meetings were held with the central working group to guide the development work. The local steering group met regularly within the pilot sites to develop the standards on agreed topics. The national advisory group met four times during the project to hear progress and offer advice. Their role will be discussed in the final chapter.

How the standards were developed is described sequentially, followed by a reflection on the process and the role of the central working group.

The development phase

Once the nine pilot sites had been identified, they were written to asking them to form a multidisciplinary local steering group within the practice, to think about areas for which they thought standards should be developed and to send to the project manager the names of members of their staff who would be willing to represent them on the central working group. Out of these nominations two people per pilot site were selected, (except for the two health centres in Belfast where only one representative from each site was selected due to cost of attending meetings), ensuring that every professional group would be represented on the central working group.

First meeting of the central working group - 6 February 1992

The first central working group meeting was held in the Board Room of the King's Fund, London. It was important that as this was the first meeting, the members felt comfortable, the aims and objectives of the project were made very clear and an action plan was developed that was agreed by everyone.

The background to the project was given which included an outline of the development of organisational audit for acute hospitals and the interest in its expansion to primary health care. It was stressed that 'ready made' standards did not exist, unlike within the acute hospital project which had based their work on Australian standards, and that the pilot sites would be breaking new ground in the development of the standards and the monitoring tool. The importance of securing consumer involvement in each aspect of the development work so that the standards were patient focused was also stressed by the project manager. The reason for this was because the standards for acute hospitals were accused of not being patient focused.

A timetable for the project was tabled with the activity for the next two years described. The deadline for completing the first task (developing the first draft of standards) was set for May 1992.

A representative from each pilot site described the work undertaken to date within their respective health centre/practice. This included the composition of their local steering group, the number of meetings held, information gathered, areas of interest and the main issues/concerns that had arisen.

Significant progress had been made by each site in that they had established a multidisciplinary local steering group and had discussed the development of standards with their practices. There was a clear commitment to the project. Some GPs said that if standards were developed for general practice, they would rather have a role in their development instead of having standards imposed by Government or management.

There were some common concerns which centred around the workload involved and the level at which to pitch the standards.

It was acknowledged that it was difficult to determine the precise workload, but that it was likely to be greatest at the start of the project (ie developing the standards).

The level at which to pitch the standards was discussed at length. It was agreed that the standards should not be prescriptive, but written in a way which allows for interpretation at local level in order to reflect local variances and need. In addition, the standards should reflect good practice and be desirable, achievable and measurable.

As this was a new experience for everybody, the members agreed that details of each pilot site (for example, size and contact name) would be circulated to all the pilot sites. They could then obtain support and advice from each other as well as from the project manager.

The role of the central working group was stipulated. The key tasks of this group were to bring to a central forum:

(a) the views and concerns of each pilot site;

(b) to discuss and agree the stages involved in the project development; and

(c) to share experiences with the participants in the project.

It was stressed that all representatives should ensure that they were fully briefed by their local steering group in advance of central working group meetings.

The composition of their local steering group should:

(a) include consumer representation

(b) be multidisciplinary

(c) involve members of the FHSA, health authority and community unit

(d) be of manageable size (5-10). Individuals with specific expertise or experience should be seconded to the group as required.

The role of the local steering group was to:

(a) guide the development work at local level

(b) agree a timetable of activity

(c) share ideas

(d) ensure all staff working within the pilot site understood, were committed to and involved in the project.

The role of the project manager was to:

(a) coordinate and facilitate the development work undertaken by the pilot sites

(b) act as a resource to pilot sites (for example, information gathering, networking).

It was agreed that the project manager would develop and circulate written guidelines to support the work of the local steering groups. In addition, a list of dates when the project manager would be able to visit the pilot sites to support the development was circulated. It was agreed that the pilot sites would contact the project manager by the end of that week with preferred dates and times of these meetings.

At this point in the meeting, there was a break for a buffet lunch. It was encouraging to note how well the members mixed with colleagues beyond their own practice. The group was animated and clearly excited by the project.

After lunch, the group discussed the areas within the primary health care setting which require the development of standards. This was an open-ended session facilitated by the project manager. Although the group had seen the standards for acute hospitals, they had had no other guidance and were advised not to duplicate the acute work but to think of areas relevant to primary health care for which standards should be developed.

The group wanted standards for all the different health care workers including professionals such as the GPs, nurses, professions allied to medicine. Many practices in England do not think of social workers as part of their primary health care team but as social workers and health care workers work together in Northern Ireland, the Belfast representatives wanted standards for social workers included. Others agreed that although they didn't work closely enough with social workers, it was important to include them in light of the NHS and Community Care Act 1990. Grove Medical Centre employed an Alexander Technique teacher so they were interested in developing standards for complementary therapists.

There was some debate about whether to have different standards for the health visitors, district nurses and practice nurses. As the standards were organisational and not professional, the group decided to consider nurses as one group.

The dental manager on the group wished dentists to be included as dentists are sometimes based in health centres.

The importance of standards for general management and organisation of a practice were highlighted. These included reception, appointment systems, staffing, business plans.

The emphasis on health promotion in the new GP contract meant that it was pertinent to develop standards for health promotion/disease prevention and clinic organisation.

Dunluce Health Centre was interested in health records and especially computerised health records as the Professor of General Practice within the health centre had carried out research in this area.

If the standards were to be patient focused and to tie in with patient charter standards, the group thought standards for patient's rights and special needs (as called in the acute manual) were important. They suggested that the elderly, ethnic minority groups, children and the disabled were examples of patients with special needs. Ballyowen was especially interested in this area as they served a large travellers population and wanted to be sure they were providing travellers with a high quality service.

The fundholding practices were particularly interested in standards relating to management such as finance, skill mix of staff and contracts.

Other services offered by some primary health care teams were minor surgery and pharmacy. Minor surgery was considered important as this was in the main, a new

service offered by practices and there was controversy over the accreditation of practices to provide minor surgery and the quality of the service provided.

A lively brainstorming session took place resulting in flip chart paper stuck around the room listing areas for standard development. After much debate, some of the areas were amalgamated and were finally agreed.

The group also shared ideas for the internal format of the standards and with guidance from the project manager, a framework was constructed as follows:

Internal format for the standards

1 Mission and objectives
2 Management and staffing
3 Contract services/contract agreements
4 Communication
5 Information
6 Professional development and education
7 Policies, procedures and protocols
8 Facilities and equipment
9 Patient care
10 Audit and quality.

It was stressed that what had been agreed within the meeting was 'not written in tablets of stone' and any further suggestions or ideas from local steering groups should be communicated to the project manager.

Each pilot site agreed to take one or more of the areas according to where their interests lay, and to develop standards for these using the internal format. The areas were divided as follows:

Common areas	
Patient's Rights and Special Needs	Ballyowen
Overall Management/Organisation (including reception and appointment systems)	Bridgegate/Bedgrove/ Bennetts End
Clinical Organisation	Grove Medical Centre
Medical Record Content	Dunluce
Medical Record Management	Dunluce
Health Promotion/Disease Prevention (including screening, immunisation)	Mount Street
Professional areas	
Complementary Therapies	Grove Medical Centre
Dentistry	Mount Street
General Practitioners (including out-of-hours deputising and locum cover)	White Rose
Nursing	Lawson Street/Bennetts End
Professionals Allied to Medicine	Ballyowen
Social Workers	White Rose
Facilities	
Minor Surgery	Bedgrove
Pharmacy (to cover on-site facilities and dispensing doctors)	Lawson Street

Due to the short timescale, each representative was advised to ask their local steering group to put their expertise on paper and not to worry about the style or layout. The identified areas and internal format were intended to act as a catalyst to stimulate thinking/activity. The project manager wanted their ideas and she would formulate these into standards.

This first meeting was constructive, with all members exhibiting understanding of the task ahead and contributing their ideas. Their understanding was probably due to the

groundwork carried out by the project manager prior to the meeting. Each site had already been visited ensuring that the pilot sites had a good understanding of the project, any issues were clarified and concerns alleviated.

When debating the areas for standards development, the pilot sites tended to concentrate on areas pertinent to them ie if they had a pharmacy on site or for which they had a special interest. It was therefore useful that the pilot sites were varied and of different configurations. There was discussion about which areas for standards development could be amalgamated but there was general consensus about the areas finally agreed. The project manager was surprised by how quickly agreement was gained.

The fact that this was an innovative national project, new to primary health care seemed to be a motivating factor. It was made clear to the pilot sites that they would be acknowledged in the final published manual of standards.

This was the first time the majority of the members had met but the group was positive, friendly with the members sharing ideas both in the meeting, over lunch and at the end of the meeting.

Although there was excitement expressed at being involved in a new initiative, there was also some anxiety. The project appeared to them to be an enormous task which had to be completed to a tight timescale. As this work was new to all concerned, no one knew exactly how long it would take nor how complicated the task would be. No one seemed to have a clear idea as to what the standards would look like. This included how many would need to be developed and how detailed they should be.

The project manager wanted the pilot sites to feel confident in tackling this project. It proved useful to explain that she had greater experience of organisational standards and would fully support, facilitate and guide the pilot sites in this work. They however, were being relied upon for their primary health care knowledge and expertise.

A whole day was set aside for this meeting. This proved important as time spent explaining the project in detail ensured that everyone fully understood and felt comfortable with it and were ready to organise and develop action plans for their local steering groups to develop standards for primary health care.

Visits to the pilot sites by the project manager

Each pilot site identified a person within their team to act as the coordinator and contact point for the project. They were of mixed professional backgrounds:

Ballyowen Health Centre	Community Manager
Bedgrove Health Centre	Practice Manager
Bennetts End Surgery	Practice Manager
Bridgegate Surgery	Patient (employed to coordinate the project)
Dunluce Health Centre	Social Worker
Grove Medical Centre	GP
Lawson Street Health Centre	Health Centre Administrator
Mount Surgery	Community Dentist
White Rose Surgery	GP/Assistant Practice Manager

The pilot sites arranged dates for their local steering group meetings and decided ways of working. Dates were arranged for the project manager to visit each site between February and April. These visits were to facilitate the developmental work, reassure staff regarding their standard setting and to ensure each pilot site had a clear understanding of the task.

An example of a record of meetings to one of the pilot sites during this development phase follows. This is intended to provide a brief snapshot of how a pilot site embarked on this work.

Bennetts End Surgery

28 February 1992

Local steering group composition

GP, practice manager, district nurse, health visitor, practice nurse, deputy practice manager, director of patient services and nursing development, FHSA quality assurance manager.

Topics for standards development

Practice management and nursing.

Consumer involvement

A member of their patient participation group had been involved in their first meeting. The local steering group planned to involve consumers at a later date when they had developed the standards further. In the meantime, they had administered a questionnaire to patients to find out their health care needs and views on the service provided. The local steering group would take account of the results when developing standards.

Ways of working

The local steering group was chaired by the practice manager and was meeting regularly at lunch times. The practice manager was planning an 'awayday' for the local steering group and staff involved in the standards development work. Financial support was discussed and the project manger advised the practice to ask the FHSA and DHA for staff to cover those who took time out of their day for this development work. The practice thought this support would be forthcoming.

An 'Organisational Audit' shelf had been set up in the staff room. All literature relating to the project was stored there allowing easy access to staff.

Process

During the meeting there was obvious interest regarding facts that the team members did not know about each others work; for example, community nursing projects, polices and procedures developed by the practice nurse but not shared with the other nurses and the health visitor's research projects.

The nurses thought that an aim of this work should be to develop better teamwork. They also expressed a wish to involve their community managers as much as possible. The community managers would have ideas and expertise. Any standards the practice established would have an impact on the practice managers so it was decided it would be best to involve them from the beginning.

The nurses had arranged a working programme. They were going to work together initially and then divide up at a later date to develop further standards for their particular areas of work. During the meeting, they generated ideas and appeared extremely motivated. The project manager gave them further information on the administration of immunisations and vaccines and the Royal College of Nursing Guidelines for Practice Nurses in case the information was useful.

The practice manager was liaising with Bedgrove Health Centre and Bridgegate Surgery over the management standards as they were working on the same topic. The project manager gave them standards relating to telephones. Practice management was to be the topic discussed at the local steering group's awayday.

Problems

There was an initial misunderstanding as to the work they were meant to be doing.

The group thought they had to not only write standards but show how they as a practice would meet them, for example draw up a protocol. Once this was clarified, they were greatly relieved. The project manager had to spend some time explaining what the standards might look like and the form they might take.

8 April 1994

The practice manager chaired the meeting. She reported to the project manager that the local steering group had had an 'awayday' when they were joined by members of the FHSA and health authority. They had used the day to brainstorm ideas and to produce standards for overall management, for example, *the manager is involved in the preparation of the budget for the practice.*

The group showed the standards they had produced as a result of the awayday. They expressed difficulty in knowing how much detail was required for standards. The project manager advised them to draw up standards in broad terms relating to the audit cycle.

The project manager suggested that the standards relating to objectives and finance were weak in that there were few of them and they were vague so they were asked to concentrate on these two areas. The project manager gave copies of the standards Bridgegate surgery had produced so far on management to see where the overlaps and gaps were.

The nurses had difficulty in drawing up standards relating to nursing as they felt the standards would be the same as the management standards that they had written. They were therefore advised to look at the different nursing groups, ie practice nurses, health visitors, district nurses and midwives, and identify any differences between them for which standards should be developed. The project manager promised to ask Lawson Street Health Centre to share the work they had done on nursing standards with Bennetts End Surgery.

The visits to this pilot site were typical in that all the pilot sites had established local steering groups according to the guidelines given, they had already held meetings and more were planned for the future. Meetings were held over lunch time except in the Mount Surgery where they were held in the evening straight after work.

A number of practical general lesson were learnt in the course of the visits to pilot sites.

Group dynamics

The pilot sites embarked upon the task of developing standards for primary health care teams in various ways. This ranged from small groups of key players (Grove Medical Centre and White Rose Surgery) to involving all staff (Ballyowen and Dunluce Health Centre). This was probably indicative of the style of the different pilot sites.

In both Grove Medical Centre and White Rose Surgery, the practice managers had administrative roles rather than managerial roles. The GPs (central working group representatives) from these sites liked to be fully involved in and in control of practice activities. This might explain their smaller local steering groups.

The pilot sites had a broad representation of the primary health care team on their working groups and a team member other than a GP led the group (except in Grove Medical Centre and White Rose Surgery).

The three big health centres had the largest working groups. This probably reflected the larger number of different professionals housed in the health centres who wanted to be represented such as pharmacists and chiropodists.

The two largest health centres (Ballyowen and Dunluce) involved all staff (over 200 in each site) in discussions.

The project managers visits to the two Belfast pilot sites involved a programme of presentations to all staff planned by the local steering groups. This helped generate interest in the project throughout the two sites.

The meetings were usually chaired by one of their representatives who attended the central working group. Apart from the two GPs from Grove Medical Centre and White Rose Surgery, the only other GP who chaired the meetings was from Bedgrove Health Centre and she shared this responsibility with the practice manager with whom she worked closely.

The project manager observed that although GPs often lead meetings in the practices, this was not necessarily the case in this exercise. The task of developing standards was one which none of them had expertise in and so was a 'great leveller' as one pilot site said. In the Mount Surgery, the health visitor proved particularly good in developing standards, thinking clearly and ensuring good organisation within the group. These skills were later recognised by her managers resulting in her promotion. In Dunluce Health Centre, one receptionist was recognised as being particularly able and organised in developing standards relating to health records and so was given a great amount of responsibility in the developmental work. The professions allied to medicine played an important role in all the pilot sites as the majority of them had already been involved in their professional standards setting. Practice managers played a key role as organisational issues impinged on all aspects of their work.

However, in Bridgegate Surgery, the GPs must have not felt comfortable with the practice manager chairing the meetings. Although the project manager observed that they were well run, the GP's, once they became more confident in standard setting, declared that they would chair the meetings, rotating the task between the four of them. Once they were confident about the project, they wanted to lead and control the process. Their taking over of the meetings demoralised the practice manager as she could see no reason why she should not continue to chair the meetings especially as she was their representative on the central working group.

Multidisciplinary working

All the pilot sites set up multidisciplinary groups to develop the standards. However some pilot sites had difficulty engaging the involvement of all professionals.

The staff in Ballyowen Health Centre were motivated and enthusiastic but they were disappointed by the lack of involvement by the GPs.

In White Rose Surgery and Grove Medical Centre, the local steering group had difficulty in gaining the interest of the reception staff, whereas in Dunluce Health Centre, the reception and administrative staff were very vocal at meetings and had a large input in developing the standards. This could be because the topic (health records) was pertinent to their work. In the other two pilot sites, the receptionists were not so fully involved in practice planning and therefore distanced themselves from the development work, showing little interest. They were used to the GPs being involved in new projects which often meant more work for them, for example data collection for audit, and thought this project would have a similar impact on their workload without any benefit to themselves. They were not involved in the original project discussions which might have caused this view

Bennetts End Surgery involved the whole primary health care team except for the professions allied to medicine. This was not a deliberate decision but these professionals seemed not to have been considered. This is indicative of how the practice saw their team.

None of the pilot sites, except in Belfast, were successful in involving social workers in developing the standards. As White Rose Surgery agreed to develop organisational standards for social workers, they had invited their social worker team leader to participate. He attended a few local steering group meetings and put some ideas on paper but then due to the pressures of work (including a severe child abuse case) withdrew from the group.

The two health centres in Belfast fully involved their social workers. This they found easy to do as health and social services were under the same Board and they were housed in the same buildings as their health care colleagues. They appeared to be used to working together in Northern Ireland whereas some practices in England did not even know what their social worker looked like!

The other pilot sites had tried to involve their social workers but were disappointed by the lack of response. For example, Bridgegate Surgery sent letters inviting social services to attend each local steering group meeting and they sent them the minutes of meetings but they never received a reply.

The barriers to teamworking on a project like this appear to include whether a professional does not consider himself or herself to be part of a primary health care team; the work does not appear to have benefits for the individual; previous negative experiences of projects within the practice/health centre have been experienced.

Various staff working to different employers could have been seen as a potential problem for developing standards for primary health care teams. However, the pilot sites did not find this to be the case. In fact, they reported that they learnt a lot about each other and from each other; for example, standards various professional groups were already working to, new research projects community nurses were undertaking, protocols the community nurses and practice nurses were using as well as individual's areas of expertise.

The local steering groups said they found the involvement of the FHSA and community managers on the local steering groups particularly helpful. The FHSA for example, were helpful with standards relating to buildings, facilities and health and safety issues of which the primary health care team knew little. The community managers were helpful on management issues such as personnel and training; areas in which practices had little experience.

The local steering groups allowed the members to share their values, objectives, ways

of working and expertise. Meeting regularly to develop standards, having a topic to focus on and involving outsiders such as consumers, FHSA and community managers had helped develop multidisciplinary teamwork.

The commitment of the FHSA and community managers to the project was impressive. Three FHSAs funded awaydays for the primary health care team for this development work and two FHSAs offered to fund facilitators to lessen the workload for the primary health care team. Community managers were supportive in allowing their staff specific time to devote to the development work.

Consumer involvement

Each pilot site involved consumers and they achieved this in various ways. Two invited a member of their Patient Participation Group/League of Friends to attend the meetings while three invited representatives of the local CHC to participate. Grove Medical Centre involved a local voluntary worker who worked amongst people living in the local housing estates and knew the population well.

Patient questionnaires were a popular means of soliciting patients views on the services provided and what they would like from their practice/health centre. Ballyowen Health Centre embarked on a large patient survey using questionnaires before developing standards for patient's rights and special needs. The pilot sites found surveys were useful, not only in developing standards but in developing their own services.

Bridgegate Surgery employed a patient to work with them on the project. However, as she became an employee, it seemed her role was to coordinate the project rather than actively participate and put forward the consumer's perspective. The practice planned though to involve her in audits and patient surveys.

The pilot sites tapped into local networks with whom they were already familiar and had a relationship, such as the CHC. For all of the pilot sites except for Bennetts

End Surgery and Bedgrove Health Centre who had a Patient Participation Group/League of Friends, this was their first experience of involving consumers in developmental work. The consumers were vocal at meetings and were listened to although it was evident that sometimes they did not have a clear understanding of how primary health care teams worked and the constraints practices worked within. Despite this, the groups appeared to take note of their comments and involved them in developing standards, usually pairing them with a primary health care team member to work with.

The consumers were concerned about information to patients, access to services, carers and the building such as the layout and sign posting. They did not have the technical knowledge to contribute to many aspects of the standard setting. This did not seem to deter them as they found the work interesting but the limitations of their involvement in this sort of work must be acknowledged. Primary health care teams must remember not to use jargon as the consumers found some terms used difficult to understand.

Methods used

The local steering group meetings were generally informal but were given an allotted time and notes were taken. Usually a representative who attended the central working group led the local group. Brainstorming was the method used to generate ideas. The work was then divided up amongst smaller sub-groups. Not all members of the primary health care team were involved at this stage except in Belfast.

Many of the meetings formed part of the practice meetings. This had the advantage that this project work formed part of the normal working routine. 'Awaydays' seemed to be considered an important means of getting the primary health care team together to focus on the standard setting. Not only could time be devoted specifically to the project but the sessions were considered enjoyable as they were held in a venue outside the practice such as a hotel. They found the standard setting contributed to team building.

Development of standards

The pilot sites had similar problems when developing standards. These centred around drawing up standards that were flexible and broad, covering everything, and not being influenced by the acute manual of standards or by what they themselves had or had not in place within their practice/health centre. They had to concentrate on developing standards that would be applicable nationally and not just to their practice. Some of them found it difficult to write standards that they knew they did not meet but felt they should such as having an appraisal system for staff.

It was interesting that each of the pilot sites drew up standards covering similar topics no matter what area they were looking at. For example, each pilot site included standards for management arrangements, communication, information, equipment and so on. There was therefore a large amount of repetition in the work produced. This showed that each pilot site considered these topics important. For example, each pilot site wrote for the area they were working on that: *There must be multidisciplinary discussions to maintain good communication;* and *practises and policies, procedures and protocols must be developed by the primary health care team and relevant patient/support groups.*

Some of the work produced by the pilot sites was more structured than others and only three pilot sites wrote their work as standards. The other sites wrote statements and not in a consistent format. This indicated that they had no previous experience of setting standards. However, all the relevant information was there except for GPs, social workers and complementary therapists. Although Grove Medical Centre produced good standards for clinic organisation, they did not manage to produce anything for complementary therapists. They felt the standards would not be very different from those they had produced for clinic organisation. The project manager contacted the Department of Complementary Therapies at Exeter University who sent literature on policies, guidance and standards for complementary therapists. The project manager drew up organisational standards as a result of reading the material on which the Department of Complementary Therapists commented and hoped the

pilot sites would develop the standards further.

White Rose Surgery produced few standards on social workers and general practitioners due to lack of time after their slow start.

The project manager wrote specific standards which were pertinent to social workers and general practitioners, drawing on standards already developed by the RCGP and individual social workers. The project manager felt it was particularly important to look at organisational standards for social workers considering the impact of the Community Care Act. However social workers and directors of social services were not willing to participate in this work although no reasons were ever given. The social workers in Belfast were relied upon to comment and add to any standards relating to social services and community care assessments which they ably did.

Motivating factors

The pilot sites appeared motivated in contributing to this project. They had regular meetings which were well attended and lively. Several motivating factors were identified by the project manager.

Many staff expressed a wish to be at the forefront of good primary health care. Being involved in a national project for which they would get recognition was therefore important to them. Even at this initial stage, some wanted to write articles about this work. GPs thought that standards would eventually be set for primary health care and they would therefore prefer to be involved in developing the standards rather than have them imposed from 'on high'.

Many professionals found that the standards should tie in well with other areas of their work such as their professional standard setting, clinical audit and team development. This was seen as beneficial as this work was then not a 'free-floating' extra activity.

In the local steering group discussions, many staff discovered new information about their colleagues work. For instance, the community nurses and practice nurses (working to different employers) found themselves discussing their various ways of working; something they had not done before. Learning from each other through these discussions was seen as beneficial and often led to more meetings, not necessarily to discuss standards, but to share protocols or other information.

There was a certain amount of competition amongst the pilot sites. They were interested to know how the others were progressing and to see the results of their work. They were willing to work with each other though and to share their work if they were working on the same topic. Competition existed between the two health centres in Belfast. Dunluce Health Centre considered itself at the forefront of primary care with its association with Queens University. It served a protestant population. Ballyowen Health Centre on the other hand served a deprived catholic population and felt they were under resourced. There was no communication between the two health centres although the project manager persuaded the two central working group representatives to liaise with each other on their journeys to the central working group in London. All the pilot sites wanted to perform well on what they perceived as an important project. This encouraged them to produce a large amount of work in a short time.

To enable the pilot sites to participate successfully and to achieve the project's aims, the project manager had to satisfy the pilot sites needs. Typical needs would be a need to belong and feel part of the project. Multidisciplinary team meetings within the practice as well as the central working group provided these conditions. The pilot sites would need to feel they had achieved something; therefore they were given full responsibility for the difficult task of developing the standards. They also needed to feel secure and confident; clear guidelines (verbal and written) provided by the project manager and through involving everyone within the practice, met this need.

Increasing employees accountability for their work (receptionist in Dunluce Health Centre), delegating complete units of work (practice and community nurses, Bennetts

End) and giving additional responsibilities within the practice/health centre (Social Worker, Dunluce, FHSA staff, Grove Medical Centre and Bedgrove Health Centre) were important. All of these relate to the higher levels in Maslow's hierarchy of need; belonging needs, esteem needs (self respect and respect for others) and self actualisation needs (the desire for self-fulfilment and the realisation of one's full potential).

Primarily, motivating a team of people is achieved through communicating clear objectives and defining the part each person can play in achieving it. The visits by the project manager to the pilot sites were crucial in achieving this.

Collation of standards

The pilot sites completed their task on time and returned their standards by the agreed deadline of May 1992.

The project manager collated all the work produced and edited the work so that there was some consistency but ensured nothing was deleted. The pilot sites had produced a huge amount of work, so the first rough draft was in two volumes. This was sent to all the pilot sites to comment on. Their central working group representatives were asked to feedback comments and ideas at the next meeting.

Second meeting of the central working group - 21 May 1992

This meeting allowed the pilot sites to share their experiences of writing the standards and their initial reactions to the first draft of standards.

The main themes were that the process had helped promote teamwork encouraging everyone to work on an equal basis, communication within the practices had been improved and the audit had encouraged staff to analyse their ways of working. Their meetings had been productive and the input from consumer groups and external agencies had proved useful. For instance the community managers had been able to

offer advice on personnel issues and the FHSA managers had been able to offer advice on statutory regulations relating to health and safety and building requirements. All the pilot sites had scheduled future meetings and some had arranged 'awaydays' for their local steering group to discuss the standards in more detail. The pilot sites were proactive, planning the work in advance.

Most of the meeting was spent discussing the standards. The pilot sites were congratulated on the impressive amount of work undertaken in a short timescale. The project manager stated that as this was the first draft, gaps, inconsistencies and repetitions remained but these would be addressed with each revision.

There were so many standards that the group felt swamped by the number. How to make the standards manageable was discussed at length. It was recognised that there was repetition. Areas that were covered in the management standards, such as communication, information, evaluation were repeated in other sections such as clinic organisation or in professional groups such as nurses. It was decided to pull the standards that were common to all staff into one core section. This would be followed by standards pertinent to members of the primary health care team defined as:

- general practitioners
- nursing
- professions allied to medicine
- social services
- pharmacy
- dentistry
- complementary therapies
- reception and administration
- practice/business management

Medical records, health promotion and minor surgery would form 'stand alone' sections as the groups felt they were particularly important to emphasise.

The project manager offered to restructure the standards so that there was less repetition and they were more manageable. The pilot sites could then comment on this next draft. The decision to restructure the standards in this way was a unanimous one. Detailed comments on the individual standards would be sent to the project manager.

The pilot sites were asked to:

- consider terms which should be included within a glossary
- consider terms to be used throughout the standards, for example patient/client/user; facility/centre/practice; in particular highlighting the different terms used in Northern Ireland and Wales
- provide lists of references used in developing the standards
- feedback comments on the standards.

Surveyor training

Although training people to assess the pilot sites compliance with the standards was nine months away, the project manager explained she was planning this already.

The training of potential surveyors would take place the first week in February 1993. Initially more surveyors than needed would be trained for the pilot stage so that surveyors were available if organisational audit was extended to other sites. The group was asked to consider who from their practice/centre/FHSA/health authority would be suitable surveyors, and how consumers could be involved in the process.

Nomination forms were issued which detailed criteria drawn up by the project manager for surveyor selection. The criteria the surveyors were required to have were:

- a wide range of experiences within health care and, in particular, primary health care

- up-to-date knowledge of developments within health care and, in particular, primary health care

- current employment and hold a senior post

- good interpersonal and communication skills

- good analytical and observation skills

- good physical and mental health.

The group planned to discuss this and the survey process at the next meeting when they had given it more thought.

The project manger outlined the next stages of the project which involved the pilot sites commenting in detail on the next draft so that a final draft could produced by September for all the pilot sites to implement and test.

Standards revision into second draft

The project manager restructured the standards as advised by the pilot sites into a core section of organisational standards, standards for the different primary health care team members (which were not suitable to be included in the core standards as they were specific to a particular profession), health promotion, health records (content and systems) and minor surgery. This was an enormous task as there were so many standards. It was important to redraft the standards in a systematic detailed way so as not to lose any of them in the process. The restructuring meant that the next draft could be contained in one volume rather than in two as had been the case initially.

As well as restructuring the standards, the project manager tried to ensure a consistent approach to the wording of the standards and to the format.

A definition of terms used in the standards and references was incorporated in this draft.

The new draft was sent to all the pilot sites. They were asked to send their comments back to the project manager within a month which they all did.

Third meeting of the central working group - 14 July 1992

Again this was a well attended, positive meeting.

The group discussed their initial response to the second draft. The main points were:

- it was a considerable improvement on the first draft
- an introduction was required to explain how the document should be used
- some sections, such as medical records, would require an explanatory introduction
- repetition still existed
- the standards should be checked for inconsistencies
- the use of over-long lists should be avoided
- the role expansion of nurses should be acknowledged; guidelines had just been produced by the UKCC.

During the meeting there seemed to be consensus on the standards. No tensions or

conflicts arose.

The deadline for further comments would be the end of July and the group was asked to pay particular attention to definition of terms, terminology and reference sources.

The definition of terms and the list of references was felt to be helpful. However, Bridgegate Surgery local steering group asked that there dissatisfaction with the term 'facility' to cover practice/health centre/clinic be minuted. Alternative terms for primary health care providers (bearing in mind that the delivery of primary health care services might alter in the future) were discussed and a vote taken. The majority felt 'facility' was the most appropriate term to use and this was accepted by the group.

The next stages of the project were described and discussed. This covered who to circulate the final draft of standards to for wider consultation and the standards implementation stage of the project.

The aims of the implementation phase were described as:

- working with the standards to achieve compliance with them; and

- testing whether the standards were achievable, measurable and desirable.

This stage would include the whole primary health care team so the pilot sites were advised to consider how this would be managed. Guidelines would be given to the pilot sites to support this work and the project manager would be available to launch this phase of the project within the practices and to facilitate the process.

There was concern about motivating members of their teams who had not been involved so far. It was felt that the launch would inform primary health care teams of the process, reassure them and motivate them. The group thought they would find it useful to read the benefits highlighted by the acute hospitals which had taken part

in an organisational audit.

This meeting was positive, constructive with no noticeable tensions between members. In fact the group was so supportive of each other that some members told the project manager after the meeting that they found it uncomfortable to comment on each others work in the meeting as they did not want to criticise their colleagues. This explained why detailed comments on the standards were not made during the meetings. However, specific comments were sent to the project manager.

Standards revision into final draft

In light of the comments made, the standards were redrafted, ensuring that there was no inconsistency nor repetition.

The draft manual of standards was desk-top published and well presented. The pilot sites expressed a sense of achievement and pride.

The manual was sent to all the pilot sites for them to test out the standards during the implementation phase.

The manual was also sent to the members of the national advisory group, the general managers, chief executives and relevant directors of the FHSAs and DHA and community units associated with the pilot sites, every regional health authority, the royal colleges, professional and voluntary organisations with an interest in primary care as well as to some other professionals who had shown an interest in the project. A covering letter was sent with the manual explaining the project and that these were draft standards which had not yet been tested but their comments on the standards would be welcomed. Approximately 130 manuals were distributed for comment.

Once the draft manual had been produced, the project manager drew up guidelines for the primary health care teams offering guidance on how to implement the standards in their practice and to prepare for a survey. A practice profile form was

also designed. It was envisaged that this would capture useful information about the practice for those eventually surveying the practice.

The circulation of the manual of draft standards in October 1994 heralded the end of the first phase of the project and the start of the implementation phase.

Reflections on the process

At this stage all the pilot sites had set up local steering groups, worked in a multidisciplinary way, developed standards for agreed topics and met the deadlines set by the project manager.

Support: These pilot sites were selected because they demonstrated motivational and innovative characteristics so they were expected to be creative. Even so, they all needed support. This was a new experience for everyone and the project manager observed how colleagues within teams were learning together and supportive of each other.

The pilot sites relied on the project manager for guidance and her visits and clear guidelines for each stage of the work seemed to allay fears and increase the primary health care team's confidence. Positive feedback given by the project manager at each visit and telephone call was considered important by her as she noticed how this encouraged the pilot sites to progress. Advice and examples of what standards look like increased the confidence of the pilot sites when developing standards and improved the work they produced.

Not everyone interested: Pilot sites were disappointed that some members of their primary health care team were not interested in this project and therefore not involved Reception/administrative staff often have an increased workload if the GP starts a new project. It could also be that there was not a clear understanding of the project.

It was important to find out why staff were not interested to see if their concerns

could be allayed. An outsider such as a project manager could play a useful role in these cases as it might be too threatening for some staff to disclose their fears to colleagues.

Positive feedback: Primary health care workers expertise in describing their work was necessary to develop the standards; no one could do this better than primary health care teams themselves. Providing the pilot sites with guidance and relevant literature supported their work. Although the standards produced were not well structured initially, positive feedback was given at each stage, backed up by constructive criticism and examples of standards. This was important in enabling the development of standards.

Meeting required standards: Before embarking on developing the standards, there was a fear amongst the pilot sites that they might not meet the standards. This caused difficulty in knowing at which level to pitch the standards initially. There was much debate over whether the standards were to be minimum standards or desirable standards. Practices often found it difficult to consider or write standards that they themselves were not meeting. They had to be reminded constantly that the standards had to be capable of being applied nationally, not just to their practice. This fear of not meeting standards was reduced once the practices became familiar with examples of organisational standards. While developing standards, their own inadequacies were highlighted, resulting in them implementing some systems and structures as they were developing the standards.

Difficulty structuring standards: The standards produced by the pilot sites covered a wealth of information. Developing the standards provided an opportunity for not being scientific but to analyse what primary health care teams do in a practical way. However the standards produced were not written in a consistent format, were written as long sentences or paragraphs and some read like shopping lists. This was probably because standards development was a new experience for the majority of staff. The project manager noted that the nurses and professions allied to medicine produced the best standards. This could be because these professionals had been already involved

in clinical standard setting.

It was difficult for the project manager to pull the standards together into a structured format due to the quantity of work produced, the varied way they had been written and the amount of repetition. It was important not to lose any information when drawing the standards together into a workable tool. Having some previous experience in working with standards proved helpful when carrying out this task. However, drawing the pilot sites work together into a manual of standards took longer than expected as it was not envisaged that the pilot sites would produce so much work. This amount of work could have been reduced by having fewer pilot sites but the wealth of information and expertise would have been reduced.

Questioning attitude: When carrying out this exercise, the primary health care teams questioned the ways they were working. Sometimes there were different viewpoints on how things should be done within the practice, reflecting different professional values. For some practices, this was their first opportunity to debate issues. Examples of discussions were: the role of the primary health care team in health promotion versus individual responsibility for health; whether doctors should say where they were on visits; the form of primary health care team meetings; how to sterilise and maintain equipment and how staff should be involved in budget setting.

Timetable: Target dates were set for completing the developmental work. These appeared to focus the mind of the local steering groups in developing action plans. The target dates, although tight, seemed appropriate in that they were met by everyone.

Central working group: The role of the central working group was an important ingredient in the success of this developmental stage.

The members of the central working group worked well together, resulting in informative, constructive meetings. This may have been because the members were

new to an organisational audit approach and were therefore learning together. They questioned each other and learnt how the different practices organised their services. The meetings were structured in such a way so as to allow time for debate and getting to know each other. This seemed to encourage a supportive atmosphere which the project manager felt was important to foster. Innovative thinking is more likely in a relaxed group.

The central working group was useful in providing feedback to the project manager as well as for taking messages back to their practices. This saved time for the project manager and was useful for reinforcing messages. The project manger found that if she managed to enthuse the members of the central working group, they would then spread that enthusiasm to their colleagues. Listening to positive ideas from their colleagues probably had more impact on the primary health care teams than receiving positive ideas from the project manager only.

The contents of the draft standards will be described in the next chapter.

CHAPTER 6

MANUAL OF DRAFT STANDARDS

This chapter describes the standards that were finally agreed by the pilot sites. It was recognised that some of them might be found to be unclear or inappropriate in particular settings. Therefore it was considered essential that those using the standards should give feedback to the project manager so that they could be amended as appropriate.

The manual of standards was based on the principles that the standards should:

- support the patient's expectations of quality care and personal dignity
- be desirable and measurable
- relate as directly as possible to the quality of care and to the quality of the environment in which care is provided
- emphasise an efficient and effective use of available resources
- represent a consensus on currently accepted professional practice
- state objectives rather than mechanisms for meeting objectives.

The standards within each section sought to establish that there was clear evidence of:

- a patient-centred service
- the effective and efficient overall management of resources
- the effective and efficient management of human resources
- continuous evaluation.

The structure of the manual

The manual of draft standards included:

Definition of terms
Introduction (describing the project)
How to use the manual
The standards with space for comments and self assessment tick boxes

Appendix 1	Relevant legislation and regulations
Appendix 2	Content of contract of employment
Appendix 3	Information to be used in practice leaflets
Appendix 4	Information to be provided in annual reports
Appendix 5	Membership of the central working group
Appendix 6	Membership of the national advisory group
Appendix 7	The KFOA acute hospital programme
Appendix 8	Circulation list for draft manual.

The standards were divided into four sections. The areas covered by these standards can be seen Figure 3.

Figure 3

Areas covered by the standards

SECTION 1 - THE PRIMARY HEALTH CARE TEAM (CORE ORGANISATIONAL STANDARDS)

Patient's/client's rights and special needs
    Patient's/client's rights
    Special needs
Mission and objectives
    Mission statement

Objectives

Contract agreements and contract for services (for which the facility is the purchaser)

Contract for services (for which the facility is a provider)

Management arrangements

Management structures

Finance

Staffing

Human resources

Staff development and education

Communication

Communication between staff

Communication with patients/clients

Communication - external

- Community Health Councils (CHCs)
- District Health Authority (DHA)/Health and Social Services Boards (Northern Ireland) and independent health care providers
- Family Health Services Authority (FHSA)
- Hospitals/wards
- Local medical, dental and pharmaceutical committees
- Social services

Written communication

Information collection and systems

Primary health care teams

Information for patients/clients

Policies, procedures and protocols

Policies and procedures

Protocols

Infection control

Health and safety

Fire safety

Clinic organisation

- Establishing a new clinic
- Management and staffing
- Referral and appointment systems

Near patient testing

Patient/client services

- Appointments
- Out of hours visits
- Waiting areas
- Consulting rooms

Patient/client care

- Community care assessments

Buildings, facilities and equipment

- Buildings and facilities
- Equipment

Audit and quality

SECTION 2 - PRIMARY HEALTH CARE TEAM MEMBERS

Complementary therapists

Dental practitioners

General practitioners

Nurses

Pharmacists/dispensing staff

Practice/business managers/administrators

Professions allied to medicine

Receptionists/administrative staff

Social workers

SECTION 3 - HEALTH PROMOTION

Definitions

Mission and objectives

Management arrangements

Staff development and education

Communication

Information

Policies, procedures and protocols

Access and barriers

Audit and quality

SECTION 4 - HEALTH RECORDS

Content

Data protection and ethical principles

Filing systems

Storage

Confidentiality

Access

Training

SECTION 5 - MINOR SURGERY

Staffing

Patient

Training

Records

Policies and procedures

Health and safety

Histology

Sterilisation

Facilities and equipment

Audit

Standards specified within each area

Core organisational standards

Section one related to the primary health care team, was the largest section and contained the core organisational standards that the whole primary health care team would work with. It was hoped that the whole primary health care team working together on core standards would foster multidisciplinary teamworking.

The standards started with patient's rights and special needs to emphasis the focus on a patient-centred approach. For example: *'There is a local charter which describes the rights of the patient/client. This charter (a) reflects the contents of the Patients' Charter and (b) is made known to the patient/client and his or her carer'* and *'Informed consent is obtained for participation in teaching exercises'*. The standards were then structured in a logical sequence starting with mission and objectives. These standards are shown at the end of this section. The first standard under management arrangements stated that *'There is a current written organisational chart which clearly defines the lines of accountability, specifies the roles of each member of the primary health care team and is understood by staff'*. The primary health care team would need to consider if the appropriate management arrangements were in place in order to meet the practice objectives. They would then consider if staff were adequately trained to fulfil their roles.

Systems that would need to be considered were broken down into communication, information, policies, procedures and protocols. These covered every aspect of primary health care. The pilot sites recognised also the importance of how they linked in with other agencies such as hospitals, health authorities and voluntary agencies. The standards therefore encouraged the primary health care teams to consider not only their internal ways of working but how they related to other organisations which had an impact on patient care.

Often primary health care teams suffer through other organisations poor systems and

processes. By stating explicit standards, for instance about lines of communication such as referral letters from hospitals, they felt that organisational audit would provide an opportunity to discuss other organisation's systems. This would then highlight how changes made by other organisations would help the primary health care team meet their own standards.

It was also hoped that these standards would encourage primary health care teams to look at how they interact with other services rather than being inward looking.

These general themes were followed by more specific patient services such as clinics and patient access to services (patient services).

The standards under patient care were written to ensure a systematic approach to the care of patients which is centred on the patient and his or her carer and maintain the rights of patients at all times. Many of the standards centred around patient care plans.

The standards relating to buildings, facilities and equipment were intended to ensure that the environment and equipment enabled the primary health care team to provide a quality service in accordance with their objectives and to achieve safe and effective care for all patients. Many of these standards covered statutory requirements as well as areas that the primary health care teams felt were important such as the ambience of the surgery.

The core standards finished with audit and quality stressing the importance of ensuring high quality care by being involved in evaluation activities in line with a practice quality management plan.

Where statutory requirements, standards or accepted national guidelines already existed, they were incorporated. Examples of references that helped formulate the standards were:- The Scope of Professional Practice, UKCC 1992; the NHS Statement of Fees and Allowances; Data Protection Act 1984; Caring for People:

Community Care in the Next Decade and Beyond, 1989 and Systemed - An Information System for General Practice, BMJ 1989.

Professional groups

The second section contained standards that were relevant to each respective professional group. These were standards that were considered important but were not included in the core standards as they were only pertinent to a specific professional group. For instance, standards that state that partners hold regular business meetings to discuss business planning or that there is a policy covering the equipment required for the GP's emergency bag are pertinent to GPs but not to all other team members. Therefore the primary health care team members were expected to comply with the standards relating to his or her professional group as well as with the core standards.

Health promotion

There had been much discussion over whether these standards should be in a stand alone section or not. The reasoning behind placing health promotion in its own separate section was that health promotion was sometimes offered as a discrete service and/or might be seen as the responsibility of each member of the primary health care team. An example of one of these standards was as follows: *'There is an agreed, minimum training requirement which is undertaken by all staff participating in health promotion work'.*

Health records

The health record was recognised in the manual as a composite of all data on a given patient. These standards were intended to help primary health care teams ensure that health records were maintained in a way which facilitated a high standard of 'seamless' patient care and evaluation of the care given. The standards related to both the content of the health records and the systems that should be in place to

ensure the health records were well maintained. These standards related to 'hard copy' health records but also to computer held records as the majority of practices now have computerised records. For example: *'Entries into the records, including alterations, are made only by authorised staff and are legible, dated and signed'.*

Minor surgery

As this was a new service provided by many practices, the pilot sites felt it was worth emphasising the standards by placing them in this separate section. They were not in the core standards as not all practices offer minor surgery procedures. The reasoning behind these standards was to ensure that the range of minor surgery procedures undertaken reflected the abilities of staff, the needs of the patient and that the facilities available were suitable for undertaking minor surgery. Examples were *'The practitioner undertaking minor surgery is suitably trained and competent to carry out the specified procedure and has written accreditation from the local FHSA'* and *'The patient is provided with information concerning alternative choices'.*

Each of the standard headings was organised around a principle which expressed the goals and underlying rationale for the standards in that section and was typed in bold. This was followed by a set of standards that define and describe what is required for quality and effectiveness. These standards would be used to assess a primary health care team's level of compliance. It was envisaged that these standards would also provide practical steps for service development.

An example of the first few standards relating to mission and objectives is given below.

2 Mission and objectives

The primary health care team work together to identify and meet the needs of the local community and its patients/clients in order to provide 'seamless care' and a quality service.

MISSION STATEMENT

2.1 There is a clearly worded statement which outlines the mission of the primary health care team.

2.2 The statement is developed by the members of the primary health care team.

2.3 The statement reflects the primary health care team's commitment to:

- 2.3.1 a 'user-centred' approach
- 2.3.2 identify the patient's/client's needs and concerns
- 2.3.4 carers
- 2.3.5 multidisciplinary teamworking
- 2.3.6 health promotion and disease prevention
- 2.3.7 health care for the community
- 2.3.8 continuity of care
- 2.3.9 working with other agencies in the community
- 2.3.10 equality of opportunity for the patient/client and staff.

2.4 The statement is made available to the patients/clients registered with the facility, the local community, the primary health care team members and other health and related organisations.

2.5 There is a mechanism to ensure that the mission statement is fully understood and implemented by all members of the primary health care team.

OBJECTIVES

2.6 Written objectives are developed by the primary health care team to achieve its mission. The objectives are used as a guide to planning, implementing and evaluating all aspects of the service.

2.7 There is a plan for the implementation of the objectives of the primary health care team. (This may be a business plan.)

2.8 In developing the objectives consideration is given to:

2.8.1 national and local health strategies, for example *Health of the Nation*, local public health report, regional health authority (RHA) strategy

2.8.2 conforming to statute and local government regulations.

Opposite the standards was a 'mirror image' page which included the main headings and numbers of each standard, a column for yes/no answers and a space for comments. This was to help each site indicate which standards were complied with.

Appendix 1 indicated relevant legislation and regulations that primary health care teams should be complying with and on which some of the standards were based.

Appendices 2, 3 and 4 contained relevant information with which practices should be complying. This was too detailed to incorporate into the core standards but was considered by the pilot sites to be useful guidance to practices to help them meet legal requirements and Government regulations.

Reflection on the standards

Content: Discussing patient's rights and special needs highlighted areas that the

practice should know about such as the Patients' Charter and the Children's Act 1989. It transpired that not all staff knew much about such issues or the impact on their working life. Therefore these standards should draw professionals attention to issues relating to patients rights and needs.

When discussing philosophy and objectives, values and points for consideration were indicated. These should encourage the primary health care team to think more broadly. For instance, to collaborate with other organisations in identifying local needs, to consult with patients and users and to evaluate the appropriateness of services offered. The way the standards were written encouraged each professional group to identify new objectives and then to share them with the rest of the primary health care team. This should help with the difficulties that arise from having different employers and lines of accountability.

The standards for management arrangements should clarify the practice managers role and management roles of other team members. They covered in detail personnel arrangements which should be in place. This is important as personnel arrangements are often poor in practices/health centres as frequently there is no human resource expertise available within the team. When working with these standards the different managers should identify common ground and ways of working that are consistent, whether they are NHS managers or practice managers. The standards should help them look at issues together to ensure consistency such as the existence of appraisal systems for NHS and practice employed staff.

The standards for staff development and training focused on the development of all staff and having planned programmes in place to support this development. This should encourage equity of access to training for staff. This is not the case at present.

Communication and information systems were outlined in some detail. These focused on lines of communication with patients and other organisations, not just within the team. Information technology is a new and important area for primary health care.

Some were disappointed that the standards did not detail guidance on information technology. The group considered this would be too detailed and prescriptive. The information standards should draw attention to issues to consider when establishing computer systems however.

The section on policies, procedures and protocols was very detailed. This section should encourage staff to discuss what they do and to document this. However, there is a risk that the process could become very paper orientated and bureaucratic. Many practices would probably find it difficult to produce all these policies and protocols due to their present workload.

The pilot sites had difficulty drawing up the standards for health and safety. The majority of staff were unaware of many of the regulations that should be in place. This could affect the health and safety of patients and staff. Having an outline of health and safety requirements should be a practical tool when establishing a safe environment.

Patient/client services covered access to services. With much health care now provided by primary health care teams, this is important to discuss and develop. These standards should promote discussion about how services are provided and how accessible they are.

Standards relating to community care assessment and social workers were not comprehensive. This is of concern as health and social services staff are having difficulty implementing the Community Care Act. These standards might have been weak because staff did not have suggestions for what should be in place or it might reflect a disinterest on the part of health care staff in community care assessments. The high workload of social workers coupled with a reorganisation of their services might have meant the standards for primary health care teams were not high on their agenda at this time. The fact that the pilot sites did not produce much on community care assessments indicates that systems were not in place in the field to implement the Community Care Act.

Audit and quality is being encouraged through the MAAGs. The audit and quality standards could tie in well with medical and clinical audit, underpinning this work. Some MAAGs are involved in auditing organisational issues in some practices. These standards could support that work.

The section containing standards for primary health care team members sometimes repeated core standards. There was also the danger that a primary health care team member would look at the standards relating to their profession and not at the core standards. They would then be using the standards out of context and without the framework provided in the core standards.

The health record standards were comprehensive and covered more areas than those already detailed in health record standards for GP training practices.

As there is much dispute about how to accredit practices who wish to undertake minor surgery, the project manager felt these standards would be difficult to clarify and gain agreement on. This was not the case as feedback from many organisations was most positive about this section. If FHSAs use these standards, once tested, as a basis for accrediting practices to provide this service, this might help ensure that all practices are assessed on the same grounds, unlike at present.

Comprehensiveness: The standards produced appeared to cover all aspects of how services are provided within and from a practice/health centre. This comprehensiveness was probably as a result of the large number of people involved in developing these standards. Staff were able to analyse and put down on paper exactly what they do. They were also able to recognise what would be useful and should be in place, even if they did not do it themselves. For example, having induction programmes in place for new staff or having formal lines of communication with the Community Health Council.

Seconding expertise as appropriate to help develop the standards ensured up to date relevant information was available. For instance, the health promotion managers in

the Community Trust helped clarify the primary health care teams thinking on health promotion and how this service should be provided. Likewise, GP trainers had a useful input to the staff education and development standards and the more experienced practice managers were vital in developing management standards as they had some background management theory.

As well as the expertise that was available within the primary health care teams, a wealth of background information was available to support the development of standards. These included professional and legal guidelines, Government circulars and practice management books.

The comprehensiveness of the standards was enhanced by trying to make the standards as flexible as possible so that the standards could be interpreted widely. For example the standard stating that *'all staff are qualified and competent to carry out their duties'* does not specify what staff should be employed and what their qualifications should be. The practice is required to assess whether they have the staff to meet the practice's objectives, define their roles and assess if they are qualified to fulfil these roles.

No specification of services: The standards did not specify what services should be provided by the primary health care team. Through working with the standards, the primary health care team should assess the needs of their population and then provide the appropriate services. Therefore, if they had a high asian population, they would be expected to supply information in the appropriate languages, use an interpreter service and provide screening for diabetes and coronary heart disease as there is a high incidence of these diseases amongst asians. This means the onus is on the primary health care team to work out what services should be provided and how. The standards stated what systems and structures should be in place but not how they should be implemented. Practices might therefore need guidance on how to implement the standards.

Some of the pilot sites wished specific services such as family planning to be

included. This would mean detailing every clinic and service which would have resulted in an unwieldy amount of information. This explains why standards were developed for clinic organisation. The standards in this section should apply to any clinic. This was agreed by the pilot sites yet they wanted minor surgery standards to be a separate section. This does not seem logical yet the argument for doing so was to highlight the importance of this service which was new to many practices. It was of particular concern to FHSAs who have responsibility for accrediting practices to provide this service, yet they had few criteria for doing so.

Prescriptiveness: There was a concern amongst the pilot sites that the standards would be too prescriptive, allowing little room for manoeuvre. Some of the standards produced were too detailed. Standards relating to health promotion were prescriptive and also overlapped with standards relating to information provided to patients. It seems that standards were likely to be more prescriptive when experts (such as the health promotion managers) worked on their specific topic only.

Differing values: Considering the different professions who were involved in this work, it is interesting to note that there was general consent and agreement on the standards. Where there was disagreement reflected different professional values. This was highlighted by discussing standards for minor surgery. It was generally felt that written consent should be obtained from patients before undergoing minor surgery. The GPs felt this was not necessary for minor procedures. Likewise, staff felt all tissue removed during minor surgery should be sent for histological examination. The GPs felt that this was unnecessary and that they should use own judgement as to what required histological examination. GPs wished to exercise their own professional judgements in these cases and not to have standards imposed upon them within which would decrease the use of their professional judgement. Other team members were concerned about mistakes being made, litigation and wanted the practice protected against these events.

Logic: The pilot sites did not look at the organisation of primary health care in any logical way. They analysed the areas they were given responsibility for and wrote

down systems and processes that they thought should be in place, looking at their work in practical terms.

The project manager had to pull the pilot sites work together into a logical format as described in this chapter. There was no theoretical model describing a well organised practice so the standards were developed using a bottom up approach, describing in practical terms what was required to provide a patient focused service, based on primary health care teams practical experience. This approach succeeded in producing a wealth of material if not in a logical form initially.

Primary health care professionals had documented what they thought should be in place to provide desirable primary health care services. The standards had yet to be tested and refined.

CHAPTER 7

Implementing the Organisational Standards

This chapter describes how the pilot sites implemented the standards between October 1992 and March 1993. For the purpose of this project, the main aim of implementing the standards was to test the standards to ensure they were achievable, measurable, desirable and covered all organisational and management issues relating to primary health care teams.

The timetable for the implementation phase was as follows:

1992

October - November	Each pilot site to receive standards
November	Pilot sites undertake baseline audits
November 92 - March 93	Pilot sites implement standards

1993

February - April	Pilot sites complete pre-survey documentation.

Before embarking on the task of implementing the standards, the pilot sites were advised to organise a visit by the project manager to launch the implementation phase within their pilot site. This was to ensure that every member of the team understood the project, the work involved, was motivated and was not threatened by the project.

A description of the visits, conversations and meetings is given in chronological order followed by a discussion of the implementation stage of the project.

Surveyor training took place in February 1993 but this will be discussed in the next chapter.

Coordinators

Before starting work on implementing the standards, three pilot sites identified that they would need extra help. They therefore employed coordinators. Grove Medical Centre identified a receptionist whose skills could be extended. She agreed to work part-time as a project coordinator. Bridgegate Surgery and White Rose Surgery made external appointments for part-time coordinators. These posts were agreed and funded by the pilot sites's FHSAs.

When these appointments were made, the project manager invited the three coordinators to a meeting to discuss the project and their roles facilitating the implementation of the standards within the pilot sites.

One coordinator could not attend the meeting as the GP refused to pay her fare. While speaking on the telephone, she asked the project manager if she had the time to 'pin her ears back' as she was not happy with her appointment. She had not had a meeting with the GP (project leader within the practice) as he was too busy. The practice was going through major changes as one GP had left (supposedly because new projects were established without prior discussion with the partners), the practice manager was leaving and deadlines had to be met in preparation for fundholding status.

She had a good understanding of organisational audit and had had a meeting with the practice on implementing the standards. However, she had met with resistance. The receptionists saw the project only as extra work. The coordinator admitted she had been very enthusiastic and might not have handled the meeting well and the staff

might have felt threatened by her.

The coordinator was advised not to start work on the standards until after the project manager visited the practice to explain the next stage of the project and to reassure the staff. In the meantime, she was advised to keep a low profile within the practice and to start identifying where standards were not being met within the pilot site.

The other two new coordinators met the project manager to discuss the implementation phase and their role within their pilot sites. The coordinator from Bridgegate felt well supported by the practice. The primary health care team were already embarking on developing policies, procedures and protocols. An 'awayday' in a hotel was planned for their team to work with the standards. The coordinator appeared confident in her role and reported that the practice manager was extremely enthusiastic about organisational audit. The only problem reported was that they had been unsuccessful in involving social services. Social services had been invited to every meeting and had been sent the minutes.

The coordinator from Grove Medical Centre had a clear understanding of the project. She perceived that it would be difficult to involve the reception staff as they could not see how the work would benefit them. She was concerned that her role as a part-time receptionist within the practice would diminish her authority as coordinator of the project.

Fourth central working group meeting - 27/10/92

The three new coordinators attended this meeting along with the other pilot site representatives. The aims of this meeting were to update everyone on the project, receive feedback on the draft manual of standards, ensure the pilot sites were prepared for implementing the standards and to plan the survey format.

The primary health care teams were impressed by the draft manual of standards. They were looking forward to the next stage of the project but were anxious about

implementing the large number of standards and about involving all their staff. Despite these anxieties, they felt that the manual would provide a framework for developing quality initiatives and plans within the practice.

To support the pilot sites, guidelines on implementing the standards within the practice were distributed. These provided guidance on the communication of the project within the practice/health centre, using the standards, preparation for the survey and managing the results of the survey. These guidelines also included articles on managing change within the practice.

It was stressed that these guidelines were purely for guidance and that practices should feel free to develop their own action plan and ways of working.

Some initial guidelines were given on how to implement the standards. These were:

(a) Start planning how the practice would tackle organisational audit so that action plans could be discussed when the project manager visited the pilot site.

(b) Distribute the standards personally with an explanation and not through the post, to avoid overwhelming staff.

(c) Identify which standards were being met and which were not.

(d) Where standards were being met, identify what evidence there was to show this, eg protocols, guidelines. Where standards were not being met, prioritise and develop an action timetable.

The group was reminded that the main aim of this project was to test the standards, not the practices. They would not be expected to meet all the standards and the project manager would be available to support them as necessary. Although anxious initially, the pilot site representatives became less so in the meeting.

To ensure everyone understood the implementation phase dates to launch the next phase within the pilot sites were made.

Much of the meeting was taken up with discussing the form the survey should take and the types of people who would be suitable for this role.

Despite the fact that practices/health centres are small compared with hospitals, it was felt that a team of three would be appropriate (as on acute hospital survey teams). It would be difficult to meet all the staff and review the organisation of a practice/health centres with less than a team of three if the survey was to take place in two days.

There was some debate as to who should be on the survey team. On the acute hospital programme, the surveyors are high calibre professionals (chief executive, consultant and senior nurse). The group thought that the survey team visiting practices/health centres would need to have an in depth knowledge of the way primary health care teams worked and therefore professionals such as chief executives of FHSAs would be inappropriate as they are too far removed from practices with little inside knowledge of systems within practices. Therefore, such people would have little credibility with primary health care teams. To be credible, at least two of the surveyors on the team would need to be members of primary health care teams - one with a clinical and one with a managerial background. The surveyor with the managerial background would probably be a practice manager. There was some debate over the clinical surveyor. Some felt a GP should always be on the team. This would have resource implications. However, one GP pointed out that GPs did not necessarily have greater management, interviewing , organisational, observational and analytical skills than other clinicians such as nurses. This was agreed. Therefore the group decided the clinician need not necessarily be a GP but could be any primary health care clinician such as a nurse or physiotherapist. Some maintained however that a GP would have greater credibility as a surveyor, especially amongst other GPs.

It was decided that the third surveyor should have a managerial background and could be external to a primary health care team such as a manager from a community unit or from an FHSA. As an aim of the project was to be consumer focused, the group was asked whether they felt a consumer should form part of the team. The group were supportive of this idea and agreed to experiment with having a lay member on the team. However, it was felt that if they were going to be involved, they should form part of the team and not be tagged onto a team. It was decided that the third member of a survey team could be a manager external to a primary health care team or a consumer.

The structure of the survey was also discussed. Everyone agreed that all the staff and each area covered in the manual of standards should be visited and clinics sampled. It was also felt that a tour of the practice would be useful before the survey and that practice documentation should be reviewed at the beginning of the survey. There was some debate about when to visit reception and waiting areas. These areas are extremely busy in the mornings and some felt surveyors would hinder reception staff's work. However, everyone agreed that it was vital to observe these areas at their busiest times to observe how patients were treated and whether efficient appointment and reception systems were in place. Therefore it was planned to visit reception areas in the morning of the survey.

It was queried whether the surveyors would go to visit patients in their homes with community staff such as health visitors. Everyone decided that this would be difficult to organise. The community nurses also thought these visits would provide a limited and subjective view. However, they wanted the consumers perspective of the pilot site and decided this could be achieved through questionnaires to patients and by interviewing patients in the waiting areas.

Another way of gaining an external view of the practice could be by meeting external bodies who work with the primary health care team such as representatives of the FHSA, hospital and community trust.

To allow more time for the pilot sites to think about the structure of the survey, the project manager agreed to draw up a sample survey timetable to be commented on.

The group felt vulnerable about being assessed. As this was a new experience for everyone, they asked if the surveyors could be from the pilot sites and not outsiders who had not been involved in the project. The group felt quite strongly about this and were relieved once it was agreed that the surveyors would be people associated with the project. They felt 'safer' with colleagues from the pilot sites who they had become to know and trust and who understood the complexities of the project and what the project was trying to achieve. They wanted to ensure that they were not being tested but that the standards were.

Although there was some anxiety at the start of the meeting as to how to implement the standards and whether they would succeed in this, the group felt happier by the end of the meeting. Their confidence was increased by knowing the project manager would launch the implementation phase within their pilot sites, hopefully motivating other staff to implement the standards; the project manager would support them and offer them guidance; they did not have to implement all the standards but could set their own priorities; they could help define the form the survey should take and that the surveyors would be fellow project colleagues who would also experience being assessed.

Launches of the implementation phase

The launches of the implementation of the standards within the pilot sites took place in October and November 1992.

The pilot sites were asked to invite as many members of their primary health care teams as possible to their launch. The project manager gave a presentation which included the background to the project, guidance on how to use the manual of standards, what the survey would probably look like and the benefits of taking part in organisational audit. It was stressed that as this was a pilot project, the primary

health care teams were not being assessed at this stage but that the standards were. However, they would be given feedback on how they were complying with the standards.

The survey was described as being a two way sharing of information between the surveyor and the primary health care team and should not be threatening. Not only would the surveyors be asking them about their ways of working but the survey would provide an opportunity for the primary health care team to ask the surveyors for ideas on how to improve their ways of working. The importance of their role in this national project was highlighted and that their pilot site would be acknowledged in any arising publications.

The launches within each practice were seen as beneficial by the pilot sites. Not only were they attended by the whole primary health care team, but often community trust managers and in one case, CHC representatives attended. Although social workers were invited, they only attended at Lawson Street Health Centre. This was their first involvement despite having been invited at other times. They were interested and wished to be involved. It appeared their managers had not informed them before. They could see the benefits of participating such as working with the primary health care team to agree protocols and procedures for assessing clients in the community and improving lines of communication.

The launches allowed the project to be explained again to ensure everyone understood what was required of them. They gave an opportunity for staff to ask questions and for staff to be reassured if they had any concerns. However, there seemed to be a good understanding of the project and what was required of them. This would probably be due to the local steering group discussing the project within their practice/health centre.

The questionnaire sent to the pilot sites revealed various reasons for wishing to participate in this project. The main reason mentioned by them all was a desire to

improve standards generally and they welcomed the opportunity to review the quality of service offered to patients. They also valued the multidisciplinary aspect of the project and wanted teamwork to be improved by providing the whole primary health care team with a shared project. Some professionals wished to participate to influence the future of general practice.

Other reasons for participating were:

- the opportunity to involve consumers
- standardisation within the health centre (for example, records)
- purchasers are requiring standards
- professional interest in audit
- a seal of approval which would improve viability and increase saleability
- organisational audit was a challenge.

The primary health care teams had their own reasons for participating in the project and the launch was useful in rekindling their ambitions. For others, the project was quite new if they had not been involved by their local steering group until this point. It was important they had a clear understanding of their role. Confidence in implementing the standards within the practice was probably increased knowing that there was external support (the project manager and FHSA and Trust managers) and that there were clear guidelines.

The project was shown to be perceived as important by the pilot sites by their wish to publicise their launches. The launches were well attended with two practices inviting the press and holding photo sessions. Photos were taken of members of the local steering group, and the project manager with the manual of standards.

For the project manager the launches were useful in ensuring the high profile of the project, that everyone had a clear understanding of the process and that they were ready to start work implementing the standards.

The Implementation phase

By the time the pilot sites were ready to implement the standards, seven of the pilot sites had appointed coordinators. They were anxious about the short timescale and thought that having someone to coordinate and facilitate the work within the practice would be beneficial. Three of these coordinators worked within the pilot site and had time allocated to work on the project, two were FHSA employees who were allocated time to coordinate the project within the practice while two were outside appointments. All posts were funded by the FHSA or Health Board. The remaining two practices did not wish to appoint coordinators but wanted to manage the project themselves within their practice.

The following account of the implementation phase is drawn from the project managers observations and conversations and from the questionnaires sent to the pilot sites (Appendices 1 and 2).

Distributing the standards

Each local steering group photocopied the standards and distributed them to all their staff. Some pilot sites divided up the work giving sub-groups different standards to work with (for example Dunluce and Bedgrove Health Centres).

Dunluce Health Centre initially distributed the standards via professional groups but later found it more successful to distribute the standards via the individual practices within the health centre. They had originally wanted to implement the standards as one unit. This proved difficult as the four practices worked in different ways. They then implemented the standards as four practices which was far more successful as each practice could work as a manageable team.

Most sites were satisfied with the way they had distributed the standards. However, in some sites, not all staff had seen a complete copy of the manual, only the parts considered relevant to them. Health centres that had done this decided that next time

everyone should see a complete copy of standards, to promote a multidisciplinary approach.

Implementing the standards

The majority of practices established a series of team meetings to discuss the standards. Sometimes the routine primary health care team meetings were also used to discuss ways of working and whether the team compiled with standards. Often a topic was taken on which to base these discussions such as staff training or health and safety.

Some pilot sites divided the work amongst small multiprofessional groups (Bedgrove Health Centre) and uniprofessional groups (Dunluce Health Centre). They worked on the standards and then shared their work with the rest of the primary health care team for discussion and approval.

Two practices held seminars for staff and 'awaydays' were popular. These allowed the majority of the primary health care team to have time out of the practice to specifically work on the standards. These 'awaydays' were used to work on the core standards. One of the practices who ran seminars on the standards invited other practices within the town to attend even though they were not participating in the project.

The coordinators arranged these meetings, coordinated everyone's work, ensured the work was typed and shared.

Another method used was one-to-one discussions between the coordinator and team members. The coordinator then pulled together the work produced on the standards.

When implementing the standards, the self-assessment forms were considered a useful checklist. It was helpful having these opposite the standards as they encouraged the primary health care team members to document what they were doing to enable them

to tick that they were meeting the standards.

The manual of standards was found to be thorough, comprehensive and clear. The core standards provided a useful framework in which to work as well as a good benchmark for a quality service. The primary health care team's found the manual gave an overall picture of what progress needed to be made as well as re-enforcing what they were doing well. The glossary and appendices were appreciated.

However, it was generally felt that there could be less repetition of standards. Many of the standards in Section 2 (primary health care team members) were covered in the core standards. Also some of the health promotion standards were covered by the core standards.

Each pilot site felt that the standards were appropriate for primary health care. While two pilot sites described them as excellent, enabling them to improve their working environment, some sites considered some standards prescriptive and repetitive. Some standards were considered too ideal and several of the health promotion standards were considered vague and not measurable.

Benefits to the practice through implementing the standards

It was unanimously considered that working with standards had encouraged team work, enabled better multidisciplinary working and had provided the opportunity for getting to know each others roles better. Each pilot site found that the standards helped the practice identify what they had in place and highlighted their shortcomings.

Other benefits highlighted were:

- thinking about procedures
- involvement in writing procedures encouraged commitment
- documenting what they do
- staff now know the right way to carry out tasks

- priority assessment
- team meetings
- goal statements
- increased ownership of quality of service
- the first time reception/administrative staff have been involved in a quality initiative
- providing horizontal and vertical integration of staff
- consumer involvement
- induction course for receptionists
- production of a health and safety policy
- reference to levels to control the contracting process
- better supported delivery of care
- feeding back to GPs and staff about the service provided by particular disciplines.

Difficulties

The main problem associated with implementing the standards was shortage of time. For example, a considerable amount of time and effort was needed to bring together team members to discuss and examine standards.

To gain commitment from those implementing standards was sometimes also difficult.

The GPs in Ballyowen and the receptionists in White Rose Surgery and Grove Medical Centre did not participate initially as they could not see the relevance of the work to them or how it wold benefit them. They participated once they witnessed the work of the rest of their team (for example, the setting up of team meetings to discuss better ways of working, new protocols and closer liaison with other staff). The project manager's secretary made a large impact on the reception staff at White Rose Surgery when she explained why they should take part and how they could benefit (for example using organisational audit as a vehicle for discussing management issues such as poor personnel policies).

It appeared that the organisational barriers were so great that the majority of pilot sites failed to involve social services. This has implications for how Care in the Community will be implemented.

Although committed to the work, the nurse manager in Dunluce Health Centre was initially nervous about the possibility of the nurses being seen as not meeting the standards. This fear of staff being exposed in not meeting standards was not expressed by other sites. This may have been because Dunluce tackled the standards in a uniprofessional way initially instead of in a multidisciplinary way and so she felt nervous of how nurses would compare with other staff. When the staff worked with the standards in a multidisciplinary way, centred around the four practices, this fear was reduced.

White Rose Surgery had problems in that the GP (CWG representative) wanted the practice to meet all the standards. This was over-ambitious and put stress on the primary health care team. The project manager explained that this would not be possible within the short timescale.

With the exception of one health centre which had particular problems with liaison across four practices, most other difficulties were administrative or organisational:

- prioritising standards to work on
- involving 'fringe' members of the primary health care team
- referral for decisions to middle management
- limits placed on resources for improvements
- maintaining team enthusiasm.

Changes as a result of working with the standards

Each pilot site found that the standards and criteria helped the practice/health centre to identify the positive aspects of their services already in place but equally, highlighted their shortcomings. They also found that there was no longer an

'accepting atmosphere'; the standards had made staff think about what they were doing rather than take things for granted. Overall, there was greater critical evaluation of existing standards as well as a greater awareness of the importance of standards generally.

Examples of further benefits highlighted in the postal questionnaires returned by the pilot sites are listed below.

Strategy

- business planning and priority assessment undertaken
- a more 'marketable service' developed

Shared values

- increased ownership of the quality of the service
- attitude towards quality changed
- goal statements developed
- profile of health promotion raised
- a consumer involved in practice plans
- a desire for all staff to be aware of where the practice is going

Skills

- skill mix reviewed
- clinical audit worker appointed
- induction and ongoing training programmes established
- informative lectures by members of the primary health care team given to rest of team

Staff and Patients

- better supported delivery of care
- involvement of non-medical staff in the delivery of quality service
- awareness of roles increased and clarified
- staff awaydays organised for team development and planning

Structure

- new signs placed throughout buildings
- environment improved and made safe

Systems

- improved lines of communication
- procedure manuals reviewed
- new polices (including personnel policies), procedures and protocols produced
- newsletters written and practice leaflets updated to improve communication
- availability of health information improved
- suggestions/complaints box used
- unwritten understandings clarified and written down

After embarking on implementing the standards, each pilot site was asked to carry out a baseline audit. This would help identify any changes that had occurred within the pilot site as a result of organisational audit. To assist in this, each pilot site was given a copy of the self-assessment forms to record which standards were being complied with prior to the implementation phase. They were requested to complete the self-assessment forms and then return these straight away to the project manager. This would provide a snap shot of the systems and structures in place within the pilot site before working with the manual of standards.

Figure 4

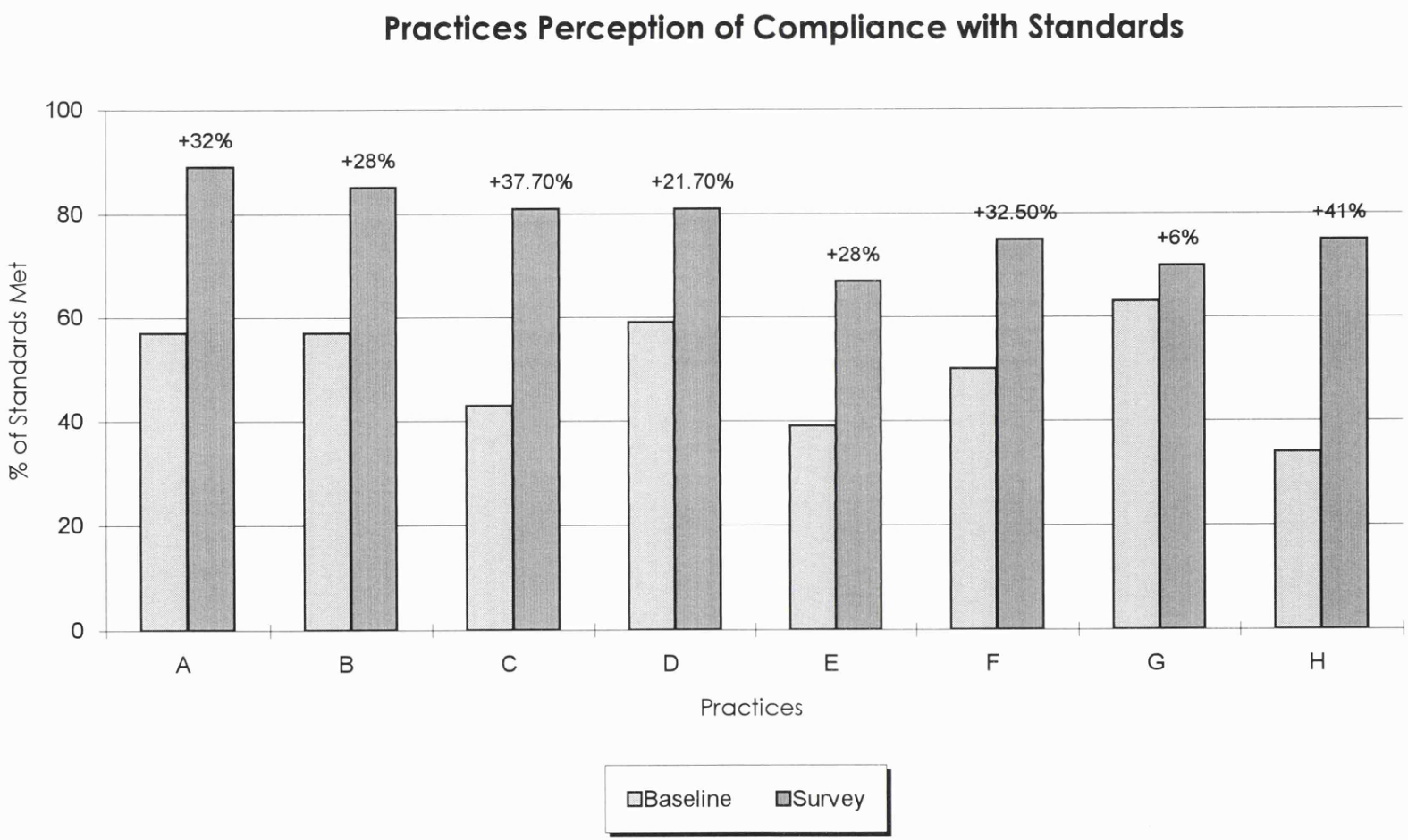

Practices Perception of Compliance with Standards
100
80
60
40
20
0
% of Standards Met
+32%
+28%
+37.70%
+21.70%
+28%
+32.50%
+6%
+41%
A
B
C
D
E
F
G
H
Practices
Baseline
Survey

Figure 4 shows that at the baseline audit, the pilot sites stated they were meeting between 34% and 63% of the standards. When completing their self-assessment forms for the survey, this had risen to between 67% and 89%. Although these pilot sites had only four or five months to work with the standards due to the time constraints of the project, this suggests that considerable activity had taken place. It is interesting to note that the pilot site who reported the highest level of compliance initially had the lowest increase in performance whereas the pilot site with the lowest reported level of compliance had a high rate of compliance at the survey. The three practices with the highest increase in perceived standards met were ones that had employed coordinators to support them in this activity.

5th central working group meeting - 2 March 1993

This meeting concentrated on the standards, how the pilot sites had implemented them and the planning of the surveys.

The standards

The comments received from external organisations and bodies such as the Royal Colleges had been extremely favourable. In fact, several organisations wished to use the standards but it was agreed that this should be discouraged until the formal publication of the manual. The group felt the standards on the whole were sufficiently robust and were encouraged by the positive response from organisations. However, they still felt that there was repetition within the standards which needed to be addressed.

Implementing the standards

Representatives from the different pilot sites were interested in sharing their experiences in implementing the standards and their different action plans for implementation. The main points were:

- the provision of a facilitator/coordinator and clerical support within the practice was extremely helpful;

- the two practices which had no such support had found the process rewarding but very hard work;

- some staff within the pilot sites saw the coordinator rather than the practice as owning the process; and

- some sites experienced difficulty in involving primary health care team members based outside the practice.

The pilot sites who had experienced the last two points looked to the rest of the group for advice. It was interesting to note that there was no competition between the pilot sites. Rather, there was mutual support. It had been stressed from the very beginning that this was a learning experience for everyone and it appeared this had helped create a safe environment for those participating to share their worries, concerns and successes. This openness was important for a full and honest feedback to be given on the whole organisational audit process.

Surveys

The group were reminded that the pre-survey documentation had to be with the King's Fund one month prior to their survey. The survey process was discussed to ensure everyone was confident about how to prepare for the survey.

As part of the survey process and to gain a patients perspective of the practice/health centre, the group were asked whether they would collect patient's views on the organisational aspects of the practice/health centre using a questionnaire designed by the College of Health. The College of Health would analyse the results which would then be available to the pilot site and to the survey team. Some pilot site representatives were very willing to do this, especially as they would receive the

results without having to do the analysis themselves. One pilot site expressed concern as it had already carried out several patient surveys and was concerned that patients might find yet another survey a nuisance.

It was agreed that in principle, patient questionnaires would add to the survey. If the pilot site had already carried out surveys, the results of these could be used instead. Eventually, each site agreed to return 100 completed questionnaires for evaluation prior to the survey. They were advised how to give out the questionnaire.

Everyone was in agreement about the survey process. However two issues were raised. The first concerned auditing a sample of medical records (to assess compliance with standards relating to the content of health records). The GPs in the group were worried about surveyors who were not GPs auditing the notes as this could be seen as a breach of confidentiality. After some debate, it was agreed that each pilot site could undertake a self audit of 20 notes picked at random. The project manager agreed to design a form to enable them to do this. The results of the audit would then be available to the surveyors.

The second issue related to the composition of the survey team. Some sites were not happy that a GP or a practice manager was not represented on the survey team visiting them. There had been full agreement on the composition of survey teams (clinician, manager and external manager/consumer) previously and when agreeing this it had never been stipulated that a GP or practice manager should be on the team. However some pilot sites felt that the team visiting them would not have a great insight into the management of a practice. For example one pilot site who was concerned had a team comprising a district nurse, community district nurse manager and a consumer. However, they did not realise that the community district nurse manager had previously been a practice manager. They were reassured once this was highlighted.

A GP did not think it was necessary to always have a GP on the survey team as GPs were not necessarily experts on organisational/management aspects of primary health

care. However, it appeared that the pilot sites who did not have GPs on their teams were disappointed. They believed having a GP present would increase the credibility of the survey.

The pilot sites agreed to accept their survey teams on the understanding that it was the standards and the survey process that were being tested and not the practice. It was concluded that in future, a practice manager or GP should be on the survey team and a short biography of the surveyors showing previous experience should be sent to the practice being surveyed.

This meeting highlighted how important the composition of the survey team was to the pilot sites. Although they agreed in principle to the composition of the survey teams, they criticised the team allocated to them, doubting their expertise to carry out the survey sufficiently. They wanted to achieve as much as possible from their survey and seemed to think GPs would enable this to happen despite usually having had little training in management/organisational issues. This could be because the GPs wanted to retain some control over the process while some primary health care team members felt that any feedback given to the practice would have greater credibility if it was given by another GP. If this proved to be the case, this would have implications for future surveys and surveyor training.

Survey preparation

Prior to the surveys, each pilot site was visited to ensure that they were prepared for the survey and to finalise the survey details.

The project manager ensured that they understood how the survey would be carried out and how the pre-survey documentation (practice profile, self-assessment forms and patient questionnaires) should be completed.

The timetable drawn up by the pilot site was discussed and amended if necessary. What practice documentation would be available and how it would be presented was

discussed and the project manager ensured that a room would be available for the surveyors to use as their base.

The form the feedback would take was discussed. Each pilot site wanted their whole primary health care team to be present.

As the report was to be confidential between the King's Fund and the pilot site, it was important to identify to whom the report should be sent. The pilot sites chose either the practice manager or a GP.

All the pilot sites were well prepared for their surveys. Some had even had 'mock' surveys to check out for themselves how well they were complying with the standards and to help staff feel comfortable when being questioned about their way of working. The practices felt this was particularly important for the receptionists who were not used to assessments and therefore might feel vulnerable. If a member of the primary health care team had been trained as a surveyor, they carried out the interviews. This was reported to have been successful as it allowed the surveyors to practice their interviewing and listening skills and increased the confidence of staff in describing their work. Although it was the standards which were being assessed and not the pilot site it appeared that each member of the primary health care team did not want to let their colleagues down; the primary health care teams wished to be seen as well organised practices/health centres.

Reflections on the process

Launches: The launches of the implementation of the standards within each pilot site proved successful in that they encouraged primary health care team members to be involved, helped ensure they understood the project and generated enthusiasm.

Approaches to implementation: This phase of the project identified the different ways the pilot sites approached implementing the standards. There was little previous experience on which to base this work but the ways these pilot sites approached

implementing the standards will be useful to share with future participants. The main lesson learnt was that health centres housing several practices should work with the standards as primary health care teams and not as professions across a whole health centre. This identifies how practices work as smaller multidisciplinary organisations within one large health centre and not as a corporate health centre, each with their unique way of working. One practice might implement a standard in a different way to another practice within a health centre or might not implement some at all depending on their priorities.

Time pressure: Shortage of time was reported by all pilot sites. Even if longer time is allowed in future, pressures on primary health care teams are such that this might always be considered a problem. Therefore appropriate support will need to be identified, be it administrative support or, as chosen eventually by six of the pilot sites, coordinators.

Coordinators: If coordinators are to be employed or staff are allocated time to act as a coordinator, this project highlights that they must have a clear role (ie as a facilitator/coordinator and not as implementing the standards for the primary health care team members), have credibility within the team and preferably be known to the primary health care team (ie have some knowledge of the practice/health centre). The two health centres who chose to run the project 'in house' were just as successful in implementing the standards. They achieved this by having an identified coordinator within their team, using a team approach to work with the standards (ie having 'awaydays' and primary health care team meetings) and dividing the work up amongst staff with clear action plans. Although it was hard work, they found it rewarding.

Having a coordinator seemed to be key to achieving the task of pulling the documentation together; whether they were a member of the primary health care team or someone employed specifically for the role.

Support: The support of senior management was important in maintaining enthusiasm amongst staff and it seemed useful for the project manager to keep them

informed of progress.

Involving staff: Involving all team members sometimes proved difficult. The project manager found that working with enthusiasts first resulted in other team members eventually contributing (in line with the theory of innovation). It was also important to highlight how the standards would fit in with their work. Interestingly the fundholding GPs were the most keen to participate (for example, only the fundholding GPs attended the launch at Dunluce Health Centre). This may be due to the fact that fundholding practices need good organisational and administrative systems in place to purchase health care services and they recognised organisational audit as a means of achieving this.

Involving social workers still proved difficult and this was frustrating for the primary health care teams. This could be because they did not see how organisational audit could benefit them. The social workers who attended the launch at Lawson Street saw the potential benefits by helping with planning services, policies on referrals, lines of communication and planning assessments of patients. Clearer marketing of organisational audit to social workers therefore needs to be explored. However, the social workers in Belfast provided useful feedback on organisational audit from a social workers perspective and were positive about the role of organisational audit in their work with health professional colleagues.

Robustness of standards: Although the standards were perceived as being sufficiently robust, useful comments were made which would help improve and refine the standards. The comments centred around some standards being too detailed, unclear and repetitive. Overall, judging by the hard work put into this exercise and the feedback received from the pilot sites, the exercise was perceived to be worthwhile. Some managers (for example the managers of the professions allied to medicine in Ballyowen Health Centre) involved all their staff in implementing the standards even though they were based in other health centres and not involved in this project.

This phase of the project supplied information on the achievability, measurability, desirability of the standards and whether they covered all organisational and management issues. The changes made to the standards will be described in the final chapter. In addition, lessons were learnt about how to implement the standards, what the primary health care teams found beneficial or difficult and the changes that took place within the practices/health centres as a result of working with the standards. Evidence of the changes that took place is limited as the project manager only had her visits, discussions with the working groups and the questionnaire to help build a picture of what was happening within the pilot sites. In retrospect, tracking a practice through the organisational audit process would have provided a more detailed analysis of the ways of working and the changes that occurred. However, this was not an option when the project was set up due to the timescale and resources that were available.

Implementing the standards also helped promote ideas and thoughts on how best to conduct the assessments (the surveys); the subject of the next chapter.

CHAPTER 8

Monitoring Compliance with the Standards

While the pilot sites were in the process of testing and implementing the standards, the project manager identified and trained 21 people to undertake the surveys. The surveyor training, the surveys and the results of the surveys will be described and discussed in this chapter.

The surveyors

In discussion with the working groups it was agreed that the survey team would comprise:

- a clinician with a primary health care background;
- a manager with a primary health care background;
- an external manager such as a member of an FHSA or DHA; and/or
- a consumer.

Their role would be to undertake the survey of each pilot site to determine compliance with the standards.

Each site nominated people to act as surveyors. Forty-five nominations were received and 21 were chosen for training. The following selection criteria were used when choosing prospective surveyors:

- a wide range of experience within healthcare and, in particular, primary health care
- up-to-date knowledge of developments within health care and, in particular,

primary health care

- current employment and a senior post
- good interpersonal and communication skills
- good analytical and observation skills
- good physical and mental health.

A broad range of nominations were received representing clinicians and managers. Some managers could fulfil the role of clinician or manager, for example community nurse managers. Only two nominations for consumers were received. Therefore a consumer representative from the national advisory group was asked to attend the training course as the project manager thought this would help provide the national advisory group with an insight to the whole process. A CHC member was also invited who had expressed interest although she was not associated with the pilot sites. Both accepted.

Each of the pilot sites had at least one person selected for surveyor training. These potential surveyors included eight clinicians (half of whom were GPs), five managers with primary health care backgrounds, four managers external to the primary health care team and four consumers.

Surveyor training

Training for surveyors was an intensive residential course of two and a half days in February 1993.

The training was prepared by the project manager and covered the background to organisational audit, the standards to be judged and took participants through each stage of the process. The course concentrated upon developing such skills as planning a survey, interviewing, listening, working as a team, time management, giving feedback and report writing. The course was participative using exercises and role plays. Course information included guidance notes, exercises, role plays, mock practice information and self assessment forms. The role plays covered interviews

with a GP on minor surgery, a receptionist on patient access to services and a practice nurse on clinic organisation.

(See Appendix 3 for the surveyor training programme.)

Although the course was difficult to plan as the project manager was not certain what the surveys would be like, the training course went according to plan and was successful. The evaluation forms identified that the participants had thought the course was well prepared, the guidance notes and the exercises, especially the role plays, were useful and their confidence had increased regarding the surveys. They felt they had a clearer idea of what the survey would be like which they could share with their practice/health centre. Some wished to do a mock survey within their practice/health centre to prepare staff for the real survey as well as to check out how they were complying with standards. One GP trainer planned to use the role plays in his GP training sessions and another GP said it was the best course she had ever been on.

As there were no experienced surveyors yet to speak on the course, a practice manager from another practice (not involved in the project) was invited to speak about her experiences of assessing training practices. In the future, surveyors will be able to speak at surveyor training course, sharing their experiences. This will be important as people like to hear peer's personal experiences.

The project manager found it difficult having consumers on the course. Information had to be presented at two levels, as more information had to be given to those who did not know in detail how primary health care teams function. Some of the consumers found some of the exercises harder to do, especially the exercise involving giving feedback to the primary health care team. They did not do this in a sensitive way and some participants felt these consumers would upset their team members if they surveyed their practice. However the consumer from the national advisory group was excellent, grasped the process well and carried out the exercises in a sensitive manner. The project manager felt the other consumers would have benefited

from having an introductory course on primary health care, organisational audit and to have responsibility for specific tasks such as observing the reception areas and checking information available to patients.

The course members were assessed for the suitability to the role of surveyor and, in total, nineteen course members were allocated to surveys. The two CHC members were felt not to be suitable for the role unless they had further training.

The survey schedule and content

All the surveys took place between March and May 1993. A team of three surveyors visited each site (four in the case of one large health centre). Their task was to test the measurability of the standards and to give detailed confidential feedback on each site's progress towards meeting them. The project manager facilitated the survey and ensured the surveyors carried out the role appropriately.

To help with the monitoring process a certain amount of documentation was required from the pilot site. This included:

- A practice profile of the practice (size, member of staff, patients, range of services and so on).
- A self-assessment of compliance with standards.
- A survey timetable (people to interview and areas to visit).
- The results of a patient-questionnaire (each pilot site was given questionnaires designed by the College of Health which asked questions about the organisational aspects of the practice/health centre).

These documents were sent to each member of the survey team. This information provided in advance of the survey, gave the team some indication of the primary health care team's progress towards meeting the standards and assisted them in planning the survey, such as the questions to ask.

The survey was carried out over two days. Typically, the survey teams met at the hotel on the evening prior to the survey, in conjunction with the project manager and a representative from the pilot site, to finalise the pre-survey documentation, check last minute changes to the timetable and to discuss the format of the survey itself.

The survey team then met with representatives of external organisations with an interest in the practice/health centre. Organisations represented, identified by the pilot sites and invited by KFOA, included the FHSA, the CHC, local hospitals the community unit and patient participation groups.

The purpose of this meeting was to enable the survey teams to gauge external opinions of the practice/health centre and background information on the local working arrangements and structures.

The project manager explained the organisational audit project and then each surveyor asked a small group questions. Examples of areas covered by the questions were:

- any particular areas on which the survey team should concentrate.
- relationship between the practice/health centre and FHSA/CHC/DHA/ hospitals/social services.
- level of communication between their organisation and the practice/health centre and form of communication.
- follow up of patients discharged from hospital.
- involvement of practice/health centre in the development of community care plans.

The meeting was given a time limit of an hour and then the findings of the meeting were discussed amongst the team and the survey approach finalised.

The following one and a half days were spent in the pilot site reviewing their documentation, observing and interviewing while ensuring that the routine of the pilot site continued as normally as possible during the survey.

FIGURE 5

EXAMPLE OF A SURVEY TIMETABLE

	Clinical	**Practice Manager**	**Community Manager**
Day 1			
08.30	Introductions and review of documentation		
09.30	Health promotion nurse	Practice Manager	CPN
10.00	↓	↓	Waiting room/ patients
10.30	Patient notes	Reception staff appointment system\admin	↓
11.15	Practice nurses	Nurse unit/ receptionist and systems	→
12.00	PAMs	Secretarial	Cleaning staff
12.30	Lunch with the primary health care team		
14.00	GPs	GPs	Building/facilities equipment
15.00	Minor surgery	Assistant Manager	Acupuncture
15.30	↓	↓	Health Visitor
16.00	Review	Review	Review
16.30	Midwife	Computer Manager	District Nurse
17.00	Practice Manager	Waiting room	Revisits

Day 2			
08.15		Practice Manger (follow ups)	→
09.00	REVIEW IF REQUIRED		
10.00	WRITING UP		
13.00	LUNCH AND FEEDBACK SESSION		
14.00	FINISH		

Day One

Natural variations in work schedules on the particular day of the survey led to differing arrangements over the introduction of the survey teams to the practice/health centre staff. Whilst one pilot site used their early morning primary health care team meeting to launch the survey, many of the sites busy schedules meant informal introductions during the team's initial tour of the premises.

Documentation

The working base/meeting room for the surveyors also acted as the reference point for all the requisite documents by the primary health care team. Information the project manager suggested should be available comprised:

Professional structures

- management organisation
- nursing structures and advisory committees
- full lists of advisory groups/committees

Plans

- strategic practice/health centre plan
- business plan
- service contracts and objectives
- quality assurance plan
- annual report
- annual financial review

Policies and procedures

- policy for continuity of care

- standing financial instructions
- personnel policies including statistics for staff absence and turnover)
- internal incident plans (evacuation, drugs etc)
- last three fire reports
- complaints procedure, recent reports and action taken
- administrative procedures for letters, reports, results

Committee minutes

- partners' management
- primary health care team
- clinical audit
- quality assurance
- medical records
- nursing advisory
- health and safety
- infection control
- patients' participation group

Appointments

- diary formats
- appointment availability, time spent with patients, effective time monitoring
- urgent versus routine appointment systems
- arrangements for emergency calls

Rosters

- medical and nursing on-call rotas
- practice/health centre weekly timetable in outline

Information

- practice/health centre profile
- population profile
- age/sex profile/register
- disease register
- agencies file
- standard letters for patients
- samples of information for patients/carers
- staff communications (newsletters or team briefing notes)
- public health annual report
- practice/health centre leaflet
- practice/health centre charters and standards

Audit

- the results of, for example, clinical; work load; management systems; referral rates;

quality; patient satisfaction audits.

Not all these examples were made available to the surveyors but the list gave an indication of the evidence the surveyors would be looking for. The pilot sites presented examples of this documentation but three pilot sites who had business plans refused to make these available. This was accepted. Only recent copies of meeting minutes were asked for, such as minutes of the last three primary health care team meetings.

Much of this information was already available within the pilot sites so it was not too problematic for them to present it. Documentation that was missing usually related to policies, procedures and plans.

The documentation produced varied in quality and quantity. Usually an adequate amount of documentation was in evidence. One pilot site had very little and some of this had been quickly put together for the survey. Another pilot site had produced

so much that the amount was overwhelming and it was impossible for the surveyors to review it all. This was disappointing when staff had put so much effort into this.

The comprehensive nature of the documentation gathered, however, together with that from the pre-survey phase, helped to build a clear picture of each pilot site, provided evidence to support compliance with standards capable of being tested with staff, clearly identified the workings of the site and alerted the teams to potential areas of focus for the survey.

Interviews; as a general rule, survey team members interviewed staff on a one-to-one basis, although exceptions were made where groups of staff performed similar functions.

The surveyors sought compliance with the standards and evidence of patient-centred, user friendly services. The assessment involved interviews not only with staff, but also with patients and users of the services; observation of the practice/health centre in operation, its facilities and equipment; and checked that practices/health centres put into practice the policies, procedures and protocols as previously expressed in the documentation review. Areas covered by the questions included lines of management, services offered to patients, ways of working, training and development of staff, how emergencies were dealt with and the evaluation of activities. Examples of questions were :

May I see the written objectives and organisation chart for the service?

How is advice provided to the patients?

What sort of statistics are collected by the practice?

How do you deal with accidents/incidents/complaints?

While interviewing staff, the surveyor would check the facilities such as the

storeroom for cleanliness, safety and security or the refrigerators for cleanliness, safety and storage.

The survey team met throughout the day to compare notes, test points of view, flag-up perceived problems or to highlight those areas demonstrating good compliance with standards. Further discussion took place at the end of the day, with initial survey notes being written up by the surveyors using a proforma. Those areas of the practice/health centre requiring additional investigation were also identified.

Day Two

Any outstanding interviews or visits were made during the second morning, together with those return visits identified the previous day and those needed to verify certain findings.

The rest of the morning was set aside for compiling notes for the draft written report and for the preliminary verbal report to the primary health care team. Full discussion between the surveyors ensured that all were in agreement with the conclusions and recommendations that each would make.

The verbal report was presented to the primary health care team the same day, with as many of the team present as possible. Each surveyor reported the findings of their own elements of the complete survey, outlining both recommendations for change or improvement and examples of good progress towards compliance.

The objective of such immediate feedback was to give an on the spot impression, enabling primary health care teams to respond with their views of the survey and its findings.

The Report

The surveyors gave their individual reports to the project manager who then wrote

up the report.

The full survey report on each pilot site was produced within six weeks of each survey. It took the form of a confidential commentary giving a comprehensive assessment of the progress being made towards meeting the standards (Appendix 3). The report highlighted good practice and also gave recommendations for change. It was written in the form of an action plan, which provided a basis for each pilot site to set its own targets for future development.

The sample of the anonymised report in Appendix 4 provides an example of some the survey team's findings when assessing a practice. This was an innovative practice which took on board many projects without periods of consolidation. Although there was a practice manager, her role was really one of an administrator and the practice had poor management arrangements.

The surveys resulted in common findings. Often there were poor or unclear management arrangements in the practices. Only two practices had excellent management arrangements. Generally however there were no organisational charts with clear lines of accountability. Management roles were not clearly defined with some GPs holding on to some management roles without letting the practice manager have full management responsibilities.

Criteria relating to human resources were often not met, for example, personnel records were not complete (no contracts, job descriptions or valid nursing personnel identification numbers recorded) or appraisal systems were not in place.

Lines of communication were often not clear nor regularly reviewed as well as information for patients not being clear or accessible.

Although much work had been carried out prior to the survey on developing policies, procedures and protocols, more needed to be drawn up. This would make explicit the way the primary health care team worked.

None of the sites met all of the criteria relating to health and safety. Prior to working with the manual, they were generally unaware of the Health and Safety at Work Act 1974, the Control of Substances Hazardous to Health Regulations 1988 and new EC regulations.

The regular checking of equipment, especially emergency resuscitation equipment was not always adequate or recorded with poor planning programmes for upgrading and replacing equipment.

Audit/evaluation of activities was often poor and none of the sites had developed a quality management plan.

Minor surgery is a new service within many practices. All of the pilot sites were carrying out minor surgery procedures yet none complied with the majority of criteria. In particular, none of them contained written consent from the patients or evaluated minor surgery activities. Few policies and procedures for minor surgery existed such as identifying tissue removed during minor surgery which requires histological examination.

In summary, the areas common to all pilot sites where criteria were least complied with were management arrangements, personnel issues, policies, procedures and protocols, health and safety and audit/evaluation of activities.

Evaluation of the surveys

The survey was evaluated through discussions with the pilot sites and surveyors as well as by questionnaires completed by pilot sites and surveyors. The findings were as follows.

Length of preparatory phase and length of the survey

These pilot sites had only four months to work with the standards due to the time

constraints of the project. They considered that six to nine months was an appropriate length of time to work with the standards. Six months was considered the minimum period needed, although some pilot sites would have liked a year including the large health centre with four practices.

Generally it was felt that the one and a half days spent with the practice was about right. The surveyors felt that adequate time must be allowed for writing up and preparing feedback to the practice/health centre.

Larger practices and health centres needed a longer survey. Despite having four surveyors on the team in Dunluce Health Centre, the staff and surveyors felt they would have benefited from more time and could then have carried out the survey in more depth.

Timetable

Primary health care teams and the surveyors felt that sufficient time was allocated for the interviews. In some cases, it was perceived that a longer time would have given a more indepth picture.

Some pilot sites and surveyors said they would have liked longer time for revisits and the surveyors would have liked more time for reviewing the practice documentation. The surveyors would have liked more opportunities to cross-check and discuss findings with their fellow surveyors during the day. Having lunch by themselves, instead of with the primary health care team, would have allowed this and they thought this a better use of time.

Changes individual pilot sites would make in future were:

- allocating more interviewing time to individuals
- including social services and professions allied to medicine
- persuading more team members to spend time with the surveyors so that a

more overall picture could be recognised.

- Allowing access to junior primary health care team members.

Although the practices were anxious about the survey, they enjoyed it when the time came. Wishing they had involved more staff in the survey indicates they found the survey supportive and beneficial. As one pilot site said 'the primary health care team enjoyed the actual survey - they did not find it as intimidating as they feared it would be!'.

Professions allied to medicine had told their representatives on the national advisory group that being involved on the survey helped them feel part of their primary health care teams.

Survey teams

The pilot sites were generally satisfied with their survey teams and thought they had been well balanced. This view was held by the surveyors. However, the pilot sites and the surveyors felt that either a GP or a practice manager should be included in the team as they would have an indepth view of general practice. Two of the sites who did not have a GP on their team would have preferred one.

One surveyor commented that the expectations of a surveyor was not always equal which showed in the feedback and reports. However, if the criteria are used correctly the level of subjectivity should be decreased.

'All the surveyors were very professional and approachable making staff feel comfortable' (pilot site's comment on questionnaire).

External support

The surveyors felt well supported in their role by the project manager although the two consumers would have liked more training.

Some surveyors would have liked longer than two weeks to review the pre-survey documentation. Past experience with surveyors on the acute hospital programme however highlights that most surveyors do not look at the pre-survey documentation until just before the survey.

This was a new role for all the surveyors and they stated that a debriefing after the survey with feedback on their performance from the project manager (some felt even from the practice being surveyed) would be beneficial and confidence boosting. On the later surveys the project manager did feedback on the surveys and was able to offer constructive criticism.

Verbal feedback

The verbal feedback to the primary health care team seemed to be the aspect of the process the practices were the least happy with and responses were mixed.

Some pilot sites found the feedback to be a natural rounding off of the survey, relieving suspense and providing the feeling that everyone was 'working on organisational audit together'. The primary health care teams liked hearing what they were doing well and thought the feedback provided a starting point for planning improvements. The feedback also provided the primary health care teams with an opportunity to discuss and question the findings with the surveyors and prevented losing the momentum generated by the survey.

However, although the majority of the pilot sites felt there were no disadvantages from receiving the feedback at the end of the survey, some felt there was a sense of 'let-down' - the feedback lacked depth, being brief and not specific. On the other hand, another pilot site felt the feedback was handled insensitively and was very prescriptive.

The primary health care teams appeared to have different expectations of the feedback. The project manager, when observing the feedback sessions, was

impressed by how confidently and competently the majority of surveyors gave feedback. Afterwards all admitted to being nervous though. It was clear that the pilot sites did not like hearing the recommendations (constructive criticism). Interestingly, the primary health care team members who complained of the surveyors being too prescriptive were just as prescriptive when they gave feedback.

Many recommendations about a service had to be handled sensitively as, unlike in hospitals, only one person offers that service (such as one physiotherapist rather than a team of physiotherapists). Therefore individuals could feel singled out. The project manager had to advise the surveyors how to handle this.

If a strong recommendation had to be made, this was often made to the appropriate staff before the feedback session so that there were not nasty surprises at the feedback.
Two of the surveyors would have liked more advice on giving structured feedback.

The project manager felt the feedback sessions were well structured, gave an idea of what would be in the report and related purely to the standards and criteria. It must be recognised that those receiving feedback often perceive the sessions differently. The feedback on the last survey was the most successful. The surveyors had themselves been on the receiving end of a survey and had complained of prescriptive, insensitive feedback. They therefore spent much time on planning the feedback. They wanted to ensure that when they highlighted good practice they did not sound condescending and when they made recommendations, they were not prescriptive but constructive. The GP making recommendations succeeded in doing this by adding comments such as 'I don't know how best to implement this recommendation as we haven't tackled it yet in my practice' or 'we had a similar problem and tackled it by .... - I am not suggesting this is the way you should do it, but it may be worth considering'. She made the recommendations in a softer way than some of the other surveyors who made straight recommendations such as 'The Community Trust have an appraisal system but the practice employed staff do not. We recommend that you establish an appraisal system for all staff'.

Receiving feedback is difficult unless it is positive. Maybe this part of the survey process will always be the most difficult part. The questionnaires highlighted that these sessions will need further development with more emphasis placed on practising giving feedback during surveyor training.

The report

The reports took the form of exception reporting and were written in an action plan format (Appendix 4). The format was popular with the practices as they found it clear, quick to read and practical for planning further action. Apart from one practice who felt there were a couple of inaccuracies, the pilot sites thought the report gave an accurate reflection of their practice/health centre. A couple of sites thought the recommendations a little prescriptive and concerned with fine detail.

The surveyors

The questionnaire results showed that without exception each surveyor found that the survey was an enjoyable and valuable learning experience. The surveys provided a valuable insight into the various workings of a wide range of general practices/health centres. The experience helped broaden the surveyors knowledge of primary health care. In addition, the interviewing skills of the surveyors were improved as was their team working.

One surveyor commented that the training had been thorough but was different to the 'actual experience' of the survey. These surveyors personal experiences will be useful to share with potential surveyors on future training programmes to ensure they are appropriately prepared.

When asked if the surveyors would like to be involved in future surveys, all replied positively confirming that they found the survey an enjoyable learning experience. The only problem noted was that for some, (especially those from Belfast), travelling a long distance to carry out a survey involved an increased time commitment.

Changes within the pilot sites as a result of the surveys

All the pilot sites continued their multidisciplinary working group meetings after the surveys and action plans were developed, based on the survey results. This was encouraging as it indicated that although their role in the project was over, the organisational audit was something they wanted to continue.

The immediate changes that took place after the survey were varied and were in direct response to the recommendations in their reports.

Many of the specific changes made were to the environment. Outsiders reviewing the practice for the first time often highlighted environmental features that the primary health care team were so used to and took for granted. The survey encouraged them it appeared to reassess their premises from a users perspective.

Two of the pilot sites placed new signs throughout the buildings, identifying more clearly where health professionals could be found and when rooms were engaged. One health centre placed a sign outside the building indicating the health centre while another cut back bushes which were hiding signs indicating the premises. All of the pilot sites reviewed their waiting/reception areas. Three reassessed their waiting rooms and changed them to more informal, comfortable layouts. One pilot site re-positioned the patient library so that it was more accessible to patients and therefore more likely to be used. How information was given to patients was discussed by the pilot sites which resulted in reviewing the use of notice boards in the waiting rooms. One practice had an electronic display sign in the reception area. They had put a request for patients to pick up toys from the waiting room floor after use on the display sign after the danger of having toys scattered across the floor was highlighted on their survey.

Locks were immediately put on doors and cupboards containing drugs, lotions and cleaning fluids in the pilot sites where they were found to be lacking.

A new chair had been bought for one computer operator which was more ergonomically suitable.

Access to the premises was considered by all the pilot sites when implementing the standards. One pilot site invited the Royal Society for the Blind to assess their practice for access to the blind immediately after the survey. This was not a recommendation by the surveyors but was something the practice had thought of as a result of working with the standards and assessing the needs of their population.

Systems were also reviewed or established. New protocols and policies were developed in all the sites. Some of these were clinical protocols but the majority were management policies and procedures such as the transportation of specimens by the porters, personnel policies, referral procedures and out of hours visits to patients. Four pilot sites updated their procedure manuals.

Health and safety issues were raised on all the surveys. This promoted discussion about health and safety in all the practices resulting in policies, tighter security and asking others for specific advice, such as infection control nurses.

One pilot site reviewed its system of receiving vaccines. Their survey highlighted that the vaccines were not kept at the correct temperature consistently during delivery. The system was changed so that all vaccines were delivered more rapidly to the pilot site by courier.

Equipment was found to be adequate in the pilot sites but was not always adequately checked to ensure it was in working order. Three pilot sites established systems for checking resuscitation equipment and refrigerator temperatures where vaccines were stored.

Two pilot sites set up more effective systems for monitoring clinic times to assess whether appointment times were adequate and appropriate.

Many of these changes that took place immediately after the survey were in response to the recommendations in the report that were simple to organise and respond to and were somewhat short-term in nature.

However, when asked about future action planned as a result of the survey, the primary area for future planning was a focus upon the re-evaluation of the roles of the primary health care team members and management structures.

All the pilot sites reviewed their management arrangements which in three sites involved the GPs devolving some management responsibility.

In the pilot site where a GP managed the practice with the support of an administrator, the surveyors had recommended that a practice manager was employed. This GP's workload was too great and as he held all the practice information, problems arose if he was unavailable. Although the GP enjoyed the management role, he recognised these problems and after discussion with his partners they decided to appoint a practice manager. They agreed to employ a management consultant to help them review their management structure and to identify the skills required for the practice manager post.

The other site where a GP made all the management decisions also planned to act on the recommendations regarding their management arrangements. Although one GP enjoyed managing the practice and making the decisions, he considered the management arrangements with the rest of the primary health care team after the survey, resulting in identifying management roles. Instead of having a practice manager, management responsibilities were to be given to three staff, building upon their expertise. The three management roles would cover fundholding, personnel and reception. Job descriptions were drawn up and training needs identified to enable staff to fulfil their roles. The management roles of the GPs were also being defined.

The GPs who employed a practice manager who was only allowed to act in an administrative role decided to devolve greater responsibility to her and to look at their

primary health care team meetings to review how decisions were made and implemented.

Other practice plans included defining roles and identifying responsibilities, evaluating the organisational structure of administrative staff and establishing management meetings.

Two pilot sites wished to encourage the community trust staff to be more involved with the practice. For example, the site who had not thought to include the professions allied to medicine in their organisational audit regretted this and felt it would be useful to include them in this and other projects or discussions in the future, thus broadening their primary health care team to provide a more integrated service.

One practice survey highlighted how their dietitian had no administrative support within the practice. Her time was limited within the practice and she felt that finding and filing her patient notes was not good use of her time. The practice was therefore going to consider the community trust's staff who worked in and from the practice to consider what were the best systems to establish to support these staffs work.

All of the pilot sites planned to evaluate the organisational structure of their administration staff, defining the staff's roles more clearly and giving individual responsibilities to staff. One pilot site planned to develop the reception team further, while another pilot site's reception staff planned to write their own standards.

A review of the team meetings featured in three of the pilot site's action plans. One planned to involve practice nurses in the community nurses team meetings, one wished to involve the chiropodist in the primary health care team meetings and another planned to involve the GPs more in the primary health care team meetings.

Another long-term plan common to all the pilot sites was to regularly review their policies, procedures and protocols. Much work had been put into developing these for the survey. This had been a useful exercise as it had encouraged discussion about

ways of working, what to do in emergency situations and the quality of care provided. The pilot sites appeared to consider the effort put into policies, procedures and protocols should not be wasted but that they should be regularly reviewed and checked to see if they were being followed.

Some pilot sites considered some of their systems, resulting in plans for a communication strategy in two practices and improving and developing the clinics run within two other practices.

Other plans included setting up a patient participation group to enable the local community to become more involved in supporting and providing feedback to the primary health care team and establishing a library of staff to enable their own education and development.

Audit and evaluation of activities which were found to have been poorly developed in the pilot sites were being reassessed. Some staff were studying ways to evaluate their work on a personal basis such as minor surgery while other pilot sites were discussing topics for evaluating as a team such as access to services. One pilot site planned to establish a quality management plan.

Additional comments

The pilot sites were asked if they had additional comments about the organisational audit. All gave positive responses highlighting that it had been an extremely useful exercise and they would recommend other practices to take part. Two practices, while acknowledging the benefits, stated that it had been a time consuming process.

Other specific comments were:

'organisational audit raised the profile of health promotion'
'we felt we had ownership of the manual'
'organisational audit enabled us focus on what we were doing and to involve the

consumer'
'it enabled networking with other centres'.

The majority of practices/health centres expressed a wish to be accredited.

'It was a very worthwhile process. I feel privileged to have had the opportunity to take part.'

'organisational audit was a time consuming process which generated a lot of work. However, it was well worth the effort in terms of confirming/establishing a comprehensive organisational base for service delivery and closer team working between disciplines.'

'We would not have missed it for anything!'

The majority of the pilot sites, once they had completed the organisational audit expressed a wish to be accredited. Not only was this mentioned in the questionnaires but also in the central working group. They wished to have some formal recognition of the level of service they provided. Although they were each given a King's Fund Organisational Audit Certificate of Participation, this did not seem to fulfil their requirements. They felt that some system of formal accreditation of primary health care teams to mark their achievements should be considered.

Reflections on the process

Surveyor training: Although the project manager found training potential surveyors problematic in that there was little previous experience of surveys, other than assessments of general practices for training purposes and the acute hospital surveys, the training was well received. The evaluation forms completed by the participants indicated that the course was well-planned, structured, allowed the practising of skills and increased the confidence of the potential surveyors. Future surveyor training courses will benefit from the experience of surveyors and practices who have

undergone surveys.

Training consumers as surveyors: The most difficult aspect for the project manager was training consumers to be surveyors. The consumers who did carry out surveys made useful contributions and it was felt by the project manager and the pilot sites that the involvement of consumers should continue. It should be possible to refine the surveyor training programme in such a way as to provide tailored information to meet their needs. This would need to include an introductory programme on primary health care. In this project, the project manager probably assumed too much knowledge on the part of the consumers.

Composition of the survey team: Initially the general view was that the survey team should comprise a clinician, practice manager and a community manager or consumer. Although this was agreed by everyone, the pilot sites who had no GP or practice manager on the team surveying them felt aggrieved. This is important to note if the survey teams in the future are to be credible. Although the surveyors are looking for systems and processes which should be present in any well-run organisation, general practice differs from many organisations as has been discussed in the first chapter. GPs and practice managers have the greatest knowledge of running general practices so the project manager feels that their inside knowledge is vital on a survey if the survey is to be more than a superficial assessment. There are other quality assessments methods such as BS 5750 in operation. Where the organisational audit approach differs is that it is patient centred, has been developed by health care professionals specifically for primary health care and offers recommendations. To achieve these three aims, especially the last two, the involvement of a GP or a practice manager would probably be an important ingredient to the success of the survey, especially as many of the issues discussed are management issues. If recommendations are to be well-received they must come from a credible sources. The pilot site questionnaire responses indicated they consider GPs and practice managers increase the credibility of a survey team. This must therefore be noted if future surveys are to be successful. It is also indicative of the rising importance of the role of practice management in general practice and the

importance to GPs of quality assessments being professionally led.

Survey format: A survey format was planned beforehand and interestingly, changed little from the original design. The project manger's feelings backed up by the central working group and questionnaire results was that the survey format is appropriate. The only change requested was for the surveyors to have more time to discuss their findings. This should be simple to incorporate into future timetables.

Documentation: The project manager was surprised that there were no complaints made about the amount of documentation that was asked to be made available for the survey. This might have been because they were not specifically asked about the documentation in the questionnaire. The project manger suspected that much of the documentation requested was already available or was documentation that the primary health care teams thought they should produce. It would be useful to discuss this with future participants and surveyors as the organisational audit should be useful not a burden to primary health care teams who already suffer from having to produce large amounts of paper work. It would be counter-productive if the process became too bureaucratic and time-consuming.

Feedback: The verbal feedback of the survey findings was identified in the questionnaire responses as being the least popular part of the survey. It would be worth spending more time during the surveyor training on practising ways of feeding back survey findings. Other useful ways of preparing surveyors for this role might be to video or tape record surveyors who are perceived by primary health care teams as providing feedback in a constructive way.

These tapes could then be used to initiate discussions on how to feedback survey findings appropriately.

Low compliance with standards: The main aim of the survey was to test the standards and the survey process. In future, consideration will need to be paid to how to deal with practices with low compliance with the standards. The view of the

pilot sites was that practices/health centres with low compliance with the standards should be recommended to continue to work with the standards and to undertake a re-survey within twelve months. This would seem a reasonable approach which hopefully would not need to be put into action often.

Action plans: All nine pilot sites implemented short-term action plans as a result of their survey reports which gave rise to a number of immediate changes. Future action plans were also described but some of these were short-term in nature. Unfortunately, the pilot sites were asked about changes that had been made as a result of the survey soon after the survey. This did not allow them much time to consider the report and develop long-term action plans.

However, all the pilot sites said that they wished to continue with organisational audit and requested to be re-surveyed in two years time. A clearer picture of recommendations that have been implemented, changes that have taken place and the impact of organisational audit on practices will then be available.

The changes made to the standards as a result of the pilot sites working with them and testing them during the surveys as well as the changes to the organisational audit process that would seem desirable will be discussed in the final chapter.

CHAPTER 9

Project to Programme and Beyond

As a result of testing the feasibility of developing organisational standards for primary health care and a monitoring system, those involved in the project decided the process was beneficial and in light of the evaluation of the project, the standards should be revised. This final chapter describes the revision of the standards, the transition from project to programme and then discusses the lessons learnt from this exercise of developing and implementing standards and monitoring practices/health centres compliance against standards. The role of the national advisory group is also discussed, highlighting the importance of sympathetic experts overseeing a project of this nature. This is followed by a reflection of the validity of the approach taken in this project and the implications for future policy.

Standards revision

One of the main objectives of this project was to develop standards that covered all organisational aspects of a general practice/health centre. Practices/health centres could then work towards meeting these standards and be assessed against them in order to receive an organisational diagnosis.

Therefore, when the draft manual of standards was implemented and tested by the pilot sites, it was also circulated widely for consultation. The manual was sent to every regional health authority, FHSAs and DHAs associated with the pilot sites, the royal colleges, every organisation/association with an interest in primary health care as well as to some voluntary organisations and others who had expressed interest in the project. They were asked to send their comments on the manual.

Feedback varied from general comments simply complimenting on the manual to detailed comments on individual standards. For instance, the Royal College of Anaesthetists wanted some additions to standards relating to general anaesthetics and the pathologist pointed out that under the standards relating to near patient testing, an accredited pathology laboratory should be involved but not necessarily a Clinical Pathology Accreditation (CPA) accredited clinical pathology department as stated. The standard was advertising one form of accredited clinical pathology department which was not appropriate.

Not everyone sent comments but those received were positive and constructive. All the comments were written by the project manager onto a master copy of the draft manual.

In the same way, the pilot sites returned their detailed comments on the standards. They did this when sending in their baseline audit and also when sending in their self-assessment forms with their pre-survey documentation. Their comments were similar to that of the surveyors and highlighted where there was repetition which they found frustrating and standards which were unclear. During the surveys, there were debates over the minor surgery standards (often a new service only recently provided). Although the standards stated that written consent should be received prior to minor surgical procedures being undertaken, this was never done. The GPs thought this was unnecessary in most cases. However, after much discussion, it was agreed that in the long-term, it would be safer to receive written consent and so the standard remained. There were similar debates over whether all removed tissue should be sent for histology tests. It was finally agreed that the standard should indicate that the practice decides a protocol stating which tissue should be sent to the histology department. The standards were tested also when the project manager was writing up the reports. There were occasions when the surveyors had wished to make a recommendation which they felt was important. However there was no relevant standard so the recommendation could not be made. When this occurred, the recommendation was written as a suggestion in the report and the relevant standard was added to the mastercopy.

As a result of testing the standards and receiving comments on the standards the basic manual format remained but the standards were restructured into a more logical sequence and the following changes were made:

- the standards were restructured into standards and criteria. A GP had previously pointed out that many of the standards were not standards but criteria (descriptive statements which are measurable and reflect the intent of the standard in terms of performance, behaviour, circumstances or clinical states)

- repetitions or unmeasurable criteria were deleted. Many criteria in Section 2 were also found in Section 1 - core standards)

- unclear criteria were rewritten

- health promotion criteria (Section 3) were incorporated into the core standards. This was to reduce repetition and because health promotion was considered to be a core service offered by the primary health care team

- some sections of the manual appeared as long lists which the pilot sites found difficult to follow, for example, the standards for patient's rights and special needs. These lists were rewritten so that they were shorter and clearer to understand

- the criteria were weighted. This was to help practices prioritise their work, something the pilot sites had found difficult to do. The criteria were weighted by 40 people (the surveyors, representatives from the pilot sites with members of the national advisory group). The criteria were weighted into three categories:

  * *Essential practice* - if these criteria are not in place: staff, patients or visitors will be at risk (that is, on the grounds of health and safety or

legal liability); patients rights will be compromised; or statutory requirements will not be met.

* *Good practice* - the criteria in this category relate to standard good practice which you would expect to see in any surgery or service.

* *Desirable practice* - these criteria relate to desirable service provision or the means of advancing or improving practice.

These weightings will need to be tested by future practices/health centres working with the manual of standards.

♦ the standards, criteria, self-assessment boxes and space for comments were printed on the same page. This should make the manual more practical and reduce photocopying by the practice. The manual was more clearly indexed.

The revised manual of organisational standards and criteria for primary health care can be seen in Appendix 5. Advice on using the manual, the standards and criteria, appendices, definitions and further reading are included. This manual of standards and criteria was endorsed by all the royal colleges, professional and voluntary organisations prior to publication in January 1994. The standards reflect current thinking on what constitutes good practice in organisational terms for primary health care teams from different angles.

Project to programme

Conference

On 30 June 1993, the experiences of those involved in developing organisational audit for primary health care were shared with a wider audience at a conference 'Organising for Success; a framework for quality in primary health care'.

This conference was held at Regents College, Regents Park. Interest in the conference was such that the conference was over-subscribed; 250 delegates attended representing chief executives, members of FHSAs and community units, regional health authorities, GPs and other members of primary health care teams, MAAG and community health councils. Representatives from the pilot sites also attended and were identified by colour coded badges so that delegates could discuss with them their personal experiences of organisational audit.

Judging by the enthusiastic response from the audience and the results of the evaluation forms, the day proved to be interesting, informative and generated much interest in organisational audit. A large proportion of practices/health centres signed up to participate in the next round of organisational audit were as a result of this conference.

In November 1993 the King's Fund Organisational Audit Primary Health Care Programme was launched. Sixty practices/health centres signed up to participate in the first year. It was stipulated that the programme could only accommodate practices in geographical groups with a minimum of five practices in a geographical area.

The cost of taking part in the programme is £6,500 + VAT per practice. This cost includes:

- support of a survey manager
- guidelines
- manual of standards and criteria
- survey
- report
- certificate of participation in the King's Fund organisational audit.

The funding for this next wave of practices taking part is being provided by their commissioning agency, RHA, FHSA, with in some instances, the community trust

and practices making a contribution. Two FHSAs in London are funding 16 practices to participate using Tomlinson money.

Practices/health centres will be encouraged to participate in organisational audit every three years in order to keep the process a dynamic one. There will be a reduced fee for practices undergoing re-surveys. All the original pilot sites have signed up for re-surveys.

These practices will be able to comment on and update the standards in response to changing requirements for the standards must remain in the vanguard of good practice. They will also be able to test whether the weighting of the criteria is appropriate.

Some single handed GPs are participating. This will help identify whether organisational audit is a useful tool to them.

A programme manager, three survey managers and an administrator run the programme from the King's Fund supported by other members of the KFOA staff.

As a result of this project, a manual of standards was created and a model for implementing the standards and assessing a primary health care team's compliance with the standards developed. Evaluating the project highlighted many issues which would be worth considering by people developing standards and monitoring systems in the future. The evaluation also suggested changes to the process which would seem desirable. These are discussed in the following section.

Developing standards - lessons learnt about the process

Drawing on previous experience: Before embarking on the task, it is important to review what guidelines and standards are available , both locally and nationally. Developing standards is a time consuming task so it is important to prevent 'reinventing the wheel'. Incorporating guidelines and standards developed by experts,

such as the Institute of Medical Laboratory Sciences (standards for near-patient testing) or the General Medical Services Committee, RCGP and Royal College of Surgeons (standards for minor surgery) would seem sensible. The result is also a framework with coordinates well with other national initiatives. The danger of reviewing other work is that those developing standards can be influenced easily by previous styles. A few members in one pilot site studied the manual of organisational standards for acute hospitals and just adapted sections of it for primary care. This resulted in a not very innovative piece of work. The acute manual of standards was the only kind of example available to show the pilot sites when offering guidance so it was hard to prevent them being influenced by it. It seems though that the time spent emphasising the importance of not replicating the style and content of the manual but to produce a product that is tailor-made for primary health care was worth while as the final product differed in style to the acute manual. It is more manageable in size and structured in such a way as to encourage a multidisciplinary teamwork approach.

Flexible criteria: This project highlights the importance of flexible rather than prescriptive criteria. Some pilot sites produced criteria that applied to them but found that they did not apply to other practices. These pilot sites with their different configurations demonstrated the diversity of primary health care teams and hence the need for flexible criteria.

It is important to ensure standards and criteria are measurable, achievable and desirable and cover all aspects of primary health care. Consulting all professional organisations, associations an voluntary organisations associated with primary health care, although costly in time and resources, proved useful in this exercise. Those consulted provided reassurance where the criteria were appropriate, identified omissions and offered constructive criticism. Taking time to identify who to consult and to consult widely is a recommendation of this project. Gaining the backing of professional organisations also helps gain credibility.

Involving all disciplines: Ensuring that the working groups are truly

multidisciplinary probably accounted for the wide range of criteria produced. Given the traditional view of the primary health care team, it was surprising that standards were produced for complementary therapists, dentists, pharmacists and social workers. It is excellent that criteria have been produced for these groups considering how the membership of many primary health care teams is expanding to incorporate other professionals.

Involving stakeholders: It is also important to ensure that all stakeholders are involved in the process, especially in primary health care where team members work to different employers. The involvement of managers was identified by the pilot sites as useful in ensuring the support they required. This also resulted in discussions on differing objectives and ways of working.

Size of working groups: It seems that a local steering group of about eight people is a suitable size for carrying out the research and writing the standards. The three health centres which had much larger local steering groups found they needed to divide their groups up into smaller units for the developmental work.

Seconding expert help: Seconding expertise to the local steering group as required proved an effective way of keeping groups manageable and yet gaining expertise. The FHSA staff were particularly useful to second when discussing areas such as buildings, and facilities where the community trust unit could provide information on health and safety; both issues of which the primary health care team had little knowledge previously.

Involving consumers: The pilot sites said they benefited from involving consumers when developing standards. They helped the primary health care team retain a consumer focused approach. Involving consumers was new to the majority of people and some looked uncomfortable at first about how best to work together. From observing these local working groups, it seems important to be clear before hand why the consumers are involved, how they will be involved and to make that explicit. It is also important to avoid using medical jargon as some of the consumers on this

project found this inhibiting. The consumers contributed well on this project. If their role had not been clarified, their membership could have become a token gesture to consumerism without great benefit.

Gaining commitment: Some primary health care members were disappointed that they failed in gaining commitment from all members of their team. This project showed that it is important to work with enthusiasts first. By the time of the surveys, even the most uninterested professionals were involved once they saw the changes that were happening in their practice. A good example of this was Ballyowen Health Centre. Only one practice took part and those GPs only participated towards the end. When they finally did, they worked hard on the project. During the survey, the two other practices within the health centres were asking why there were not involved.

Explaining tasks: It is important to give a clear explanation of the task when developing a new tool. Drawing up organisational standards proved to be a difficult concept to grasp for the pilot sites. They were slow in starting and asked for reassurance. Now that primary health care teams have succeeded in developing organisational standards, the expertise is available in primary health care. Since this work, the Association of Managers in General Practice have developed standards and ways of using criteria to assess practices using the expertise of the practice managers involved in this project. These organisational audit standards should provide a useful building block for other work.

Practical tool: The standards produced had to be suitable and practical for primary health care teams. That is why those working in the field were asked to develop them. This worked well in this project in that a broad spectrum of standards were developed in a short time-scale. This bottom up approach is vital if a practical tool is to be produced.

Central guidance: The central working group was successful in agreeing the development of the various stages of the project. All the pilot sites and every profession were represented on this group which coordinated the views, concerns and

ideas of the local groups in the development of standards as well as the monitoring process. The reason this group worked well could be because all the pilot sites had been visited and the staff met by the project manager, before selecting the membership from the nominations. Personalities and their likely contribution to the group were therefore assessed beforehand. The central working group saved the project manager making multiple individual visits to the sites as the group provided a conduit for information. They also succeeded in motivating their colleagues within their practices. For this type of exercise it seems important that the project manager is involved in the selection of the group to ensure they are not only be able to contribute to the meetings, but that they also have the interpersonal skills to ensure ideas are implemented within the pilot sites.

The central working group played an important role during the project which might have implications for practices taking part in such a process in the future. A multidisciplinary group of interested staff could be useful in identifying how best to guide and support practices undertaking organisational audit locally. The lessons learnt from this project could be applied to such a group locally.

Timescale: The pilot sites found developing standards time consuming. Only three to four months were allocated to this task. Some might argue a longer timescale would have been more suitable. However, the short timescale in this project resulted in action plans being established quickly within the pilot sites and the involvement of many staff in the task.

Little spare time is available in general practice so it is worth considering working to a short timescale in order to concentrate minds on the task involved and to ensure that the project does not encroach into the practice workload for too long. This approach worked well in this project.

Workload: An enormous amount of work was produced by the pilot sites; far greater than the project manager envisaged. This resulted in a large amount of standards for the project manager to refine and draw together. There was also

repetition in the work produced. This work could have been reduced if there had been fewer pilot sites and if clearer guidelines had been given on the internal format of the manual. The large number of sites though produced many ideas and demonstrated varieties of expertise. Clear guidelines on internal formats might have stifled innovations. It was only through trying various formats that the idea of core standards emerged. When designing a project such as this, it is worth considering the number of pilot sites involved. In retrospect, the project would have been less time consuming to coordinate if there were a couple of sites fewer. Travel time would have been reduced as would the amount of raw material to deal with. However, less expertise would have been available. Weighing up the costs and benefits of having a large number of pilot sites should be carried out before embarking on similar projects involving the production of large amounts of written work.

By products: Involving all members of a team in a completely new task has many benefits which are useful to identify. For those developing the standards, the benefits experienced included: increased multidisciplinary teamworking; newly identified leadership skills; management and professionals working together to achieve a common goal; consumer involvement in the ways practices function and the discovery of different ways of working.

Many of those involved in the development of these organisational standards are using their new experiences to help develop local standards or professional standards. These pilot sites' expertise will be useful when amending the manual in the future.

Dynamic standards: It is important that the standards remain dynamic. Therefore it is advised that this manual is published in small numbers to allow for continual updating of the standards and criteria.

Implementing the standards - lessons learnt about the process

Launches: Launching any project can help raise awareness in the topic presented.

The launches of organisational audit in the pilot sites were successful in doing this as well as motivating staff and allaying concerns. Future sites taking part in organisational audit would probably also find a launch of the process beneficial. To be successful, these launches need to be held at a time when most staff are available and to be well advertised. The whole organisational audit needs to be described allowing for plenty of time for discussion and questions. NHS management attended the launches within the pilot sites. These managers were supportive of the project so it would seem desirable to invite management to future launches.

Implement as a primary health care team: All the pilot sites approached the organisational audit in different ways. An important lesson learnt in this project is that organisational audit has to be implemented by a primary health care team and not by a health centre as a whole (including several teams), unless of course the health centre contains only one practice. This highlights how primary health care teams centre around the GPs.

Time out: Not all the pilot sites could afford the luxury of an 'awayday' for the team to discuss their implementation of the standards. However, this seems a useful exercise and 'awaydays' are becoming more popular with practices. Organisational audit could be useful tool on which to base an 'awayday' or teambuilding workshop. Such workshops are run throughout most of the country, usually supported by the FHSAs and would provide a useful opportunity for practices to look at their systems and processes for delivering care.

Prioritising work: The pilot sites found it hard to prioritise the criteria to work with, often tackling the easiest criteria first. Now that the criteria have been weighted it should be easier for practices to develop action plans for implementing the criteria. However the weightings will need to be evaluated by the first practices working with them and amended accordingly.

Single handed practices: Single handed practices did not participate in this project. It had been suggested that they might find the manual daunting due to the number of

criteria. The weighted criteria should help single handed practices identify the essential criteria to meet. Single handed practices need to be encouraged to take part in organisational audit so that the relevance of the manual of standards to them can be assessed.

Written evidence: When implementing the standards, much of the work centred around writing up policies, procedures and protocols and providing written evidence of systems. Relying on written evidence needs to be reviewed to prevent the process becoming mechanistic and bureaucratic. If organisational audit becomes bureaucratic it will lose its appeal of being a helpful tool when general practice is suffering from large amounts of bureaucratic paperwork already.

Support: These pilot sites identified that practices require support when participating in organisational audit. This support was provided by the project manager during this study. It is envisaged that future participating practices will require guidance, support and advice in implementing the standards as well as preparing for the survey. This support could be provided by staff especially employed by the King's Fund to undertake this role with practices participating around the country. This model is used with hospitals undertaking organisational audit and is planned for the primary health care programme. The benefits of the King's Fund running organisational audit are that they are independent, have expertise in organisational audit and a structure in place to support the development of organisational audit. The disadvantages are their lack of manpower to support practices, lack of local knowledge and high costs. Running organisational audit centrally is costly however, and high costs will prevent practices participating. Training development agencies/professionals locally (such as FHSAs Medical Audit Advisory Groups (MAAGs) and facilitators) to support practices in organisational audit would be cheaper as this work could sit alongside their existing work. Local staff managing the process would also have knowledge of local networks who could support the practices such as the MAAGs, GP tutors and post graduate courses. For example, if a study day on minor surgery was run in a district, the organisational audit support manager could ensure that the organisational standards were linked into the course. Knowledge of local networks would help

provide a coordinated approach to organisational audit across a geographical area.

To support practices participating in the future, written guidelines have been produced, built upon the experiences of this project. These guidelines encourage the practice/health centre to nominate a team member to coordinate the implementation of the standards and the planning of the survey timetable. Future coordinators will have to ensure that practices see organisational audit as a team effort and not solely the role of the coordinator.

Uninterested staff: Some pilot sites were disappointed if colleagues showed little interest in participating in organisational audit. However, all staff invited (except social services) participated by the time of the survey. Future practices will need to be encouraged to involve the interested staff first of all. Other staff will follow if they see benefits. Further discussions with social services need to take place to discover whether it is feasible for them to be involved due to their time constraints and how to gain their commitment. Fundholding GPs appeared to be the most interested GPs in this exercise. This could be because they recognise the need to have efficient systems in place to purchase health care. If and how organisational audit helps fundholding practices would be a useful area to study further.

Timescale: The practices/health centres involved in this study only had four-five months to prepare for the survey. This was found to be too short. It is envisaged that eight months to one year will be adequate time to prepare for the survey. If the time allowed is any longer, practices might not focus their minds on the audit in a concentrated way and the impetus might be lost. Future practices will be able to confirm if the time allowed for implementing the standards is adequate.

Monitoring compliance - lessons learnt from the process

As a result of observing surveys and gaining feedback from the surveyors and pilot sites the following changes would seem desirable.

Team composition: The survey teams should include GPs and/or practice managers. These should be balanced with consumers and health care professionals who formed the majority of the pilot site surveyors. Involving GPs or practice managers on all future survey teams will mean that they will need to be specifically targeted for training. The credibility of the survey team is critical to the success of organisational audit. A large pool of surveyors will need to be trained around the country. Much effort and planning will be required to ensure the availability of high calibre individuals to undertake the surveys of practices.

Surveyor training: The training of surveyors should include a longer time for practising the feedback of findings to primary health care teams. The pilot sites found the feedback the least satisfactory part of the process. Videos or tapes of sensitive and not so sensitive feedbacks to practices might provide useful discussion points in future training sessions.

Consumers as surveyors: Consumers should have additional training programmes providing background to primary health care and how it is delivered. This would help the trainer when training consumers for their surveyor role as well as increasing confidence of surveyors. Gaining advice on consumer involvement from organisations who work with consumers such as the College of Health might prove useful.

Self development: Surveying a practice/health centre is a valuable learning experience. For surveyors to develop their expertise they should be provided with an individual performance appraisal as part of their personal development.

To ensure high calibre, credible surveyors, it would be useful to establish a system which allows the practices being surveyed to evaluate their surveyors. The pilot sites and surveyors in this project indicated they would welcome this.

Survey format: As the survey format did not need to change during the project, the survey length should remain at two days, with one and a half days spent in the

practice/health centres. However, survey timetables should allow more time for surveyors to discuss findings with each other.

Report: In this project, the written report of the survey findings was confidential between the practices and the King's Fund Organisational Audit. However, practices were advised to share the report with their FHSA and community trust managers. All of them did so willingly. This might be because the managers had been involved in the process. It is vital that confidentiality should be maintained between the monitoring organisation and the client to encourage open, honest responses. It is recognised though that commissioners may wish to negotiate access to the organisational audit reports as part of their performance review. Who has access to the report will need to be negotiated and agreed prior to each survey.

Surveys will be able to highlight examples of exceptionally good practice throughout the UK. Therefore consideration needs to be given to how to capture good practice in a form that is accessible to those working in primary health care.

Follow up support: No subsequent support was available to practices once they had received their reports. The pilot sites were not asked whether they required support so their views on this are not available. Support following a survey might be desirable. If organisational audit is run centrally this would be difficult due to large resource implications. If organisational audit was run locally, suitable support would be easier to identify and mobilise to enable primary health care teams to implement the recommendations.

Approach: A developmental approach was taken when implementing organisational audit in primary health care. It is not a pass/fail system but provides recommendations for developing as an organisation. However, it is becoming increasingly clear (as highlighted in the pilot site's questionnaire responses and central working group meetings) that primary health care teams want more than a certificate of participation; they want to show that they have achieved certain quality standards. This issue of accreditation therefore needs to be rapidly addressed. This

will be discussed later in this chapter.

National advisory group - lessons learnt

The national advisory group was chosen for the project manager by the King's Fund. The members were intended to represent the leading primary health care organisations as well as professional and voluntary associations.

The role of the national advisory group was to provide external and independent advice to the development work entailed within the project. The role was also to inform the project manager of any national developments/projects which might have an impact on the project. The group met four times during the project.

The national advisory group meetings were very different from the central working group meetings in that there was much scepticism about the project. For instance, one of the group was reported to have once said that organisational audit could not be introduced for primary health care. She made it clear that she was not interested in the project by reading other paperwork while the project manager was speaking and by making side comments to her neighbour during the first meeting. She seemed to have a negative affect on the rest of the group.

The two members representing voluntary associations were very concerned that consumers should be involved in the process. Although it was explained how consumers would be involved at each stage of the project, this did not seem to wholly satisfy these two members and the negative person. When asked for ideas for involving consumers, no on came up with any practical ideas.

The majority of members were of high seniority and each appeared to want to have their say, even though many of the points made did not add to the debate. When the discussions became slightly negative or off the point, a chief executive, who was a surveyor for the acute hospital's organisational audit programme and experienced in this process spoke positively bringing the discussion back to the aims of the project.

The group was concerned that its brief should not be too broad but should have a clear focus for its activity. This might have been because the group did not have a clear knowledge of organisational standards nor an understanding of how the project would work. Members of the group appeared to want to impress other members by their comments and yet they might have felt insecure about their knowledge base and how they were expected to contribute to the project.

Constructive advice was limited as was information proffered about other national initiatives which might have had an impact on the project. For example, representatives of the Royal College of General Practitioners (RCGP) did not share or offer information on the RCGP's quality initiatives. The project manager discovered these independently.

This lack of constructive advice and support may not have been intentional, as members might have felt inhibited by the vocal negative members of the group. For instance, one member of the group asked to see the project manager after the meeting as he had some ideas that might by helpful, but felt he could not say them in the meeting.

However, members of the national advisory group did send constructive comments individually on the standards to the project manager. Interestingly, the comments received from the disruptive members were the least helpful. They were often prescriptive or not entirely relevant to primary health care teams. One member was from a public health background and some of her comments were relevant to public health and not to primary health care workers.

The national advisory group perceived the organisational structure of practices to be an obstacle to developing organisational audit yet this was not the perception of the pilot sites; rather the pilot sites saw this project as an opportunity to strengthen their teamwork.

The national advisory group was therefore found to be negative initially, offering little

constructive feedback. This appeared to be because they did not have a clear understanding of the project, concentrated on the role of consumers which could have been because they thought this was politically correct and they did not have a clear understanding of their role. They were all experts in their field and wished to demonstrate this rather than work together. They were also used to leading organisations and may have felt powerless in an advisory role.

The meetings did improve once the manual of standards was produced and the members had a clearer understanding of what the monitoring process might look like. Many were complimentary about the standards once produced, and were more positive.

The project manager did not choose all the members of this group. Some of them were nominated by the King's Fund because of their work with the King's Fund or on other projects. In retrospect, it would have been better to have had clearer criteria for inviting people onto the group which would include a positive approach to innovations and an interest in quality primary health care. Any project needs to be overseen by sympathetic experts. The project manager should have a say in the membership so as to identify the appropriate support required.

Although the aims of the project and how it would work were explained at their first meeting, longer time should have spent on this and their understanding checked. Too much knowledge of an organisational audit approach and of primary health care was assumed.

Clearer role definition of the group might have increased the group's confidence. They wanted to steer the work rather than advise. As their role was not clear in the early stages, they appeared to feel ill at ease.

Likewise a clearer role for consumers would have been helpful, recognising the constraints of involving consumers.

One of the consumers on the national advisory group who was sceptical of the whole process was invited to be trained as a surveyor. She made an excellent surveyor and she gained a greater understanding of organisational audit. This was useful as she then became more constructive in the national advisory group meetings. Her enthusiasm influenced the other members of the group. Involving sceptical people in the process being tested can help increase their understanding of the project.

It was found that difficult or angry members are best tackled individually after the meeting to find out their concerns and to identify how they can contribute productively.

Conversely, recognising supportive members of the group who are clear thinking about the task in hand and referring to them in the meeting can help balance the meeting and encourage the group to refocus on the tasks to be achieved.

The project manager felt there was still role for experts to oversee organisational audit once it became a programme. This was discussed with the national advisory group who agreed that a small advisory group would be appropriate. A member of the group suggested that a new group should be established once new staff were in post to run the organisational audit programme. These staff could then identify the external support that would be beneficial to them. The group agreed that this would be a good policy. Lessons learnt from the projects' national advisory group would be worth remembering when setting up this new advisory group to ensure constructive, sympathetic, expert external advice.

Validity of the approach

The beginning of this thesis highlighted how primary health care now plays a key role in the implementation of a national strategy for improving the nation's health. The question raised was how to ensure primary health care teams had the organisational capacity and capability to deliver this shift from acute to primary care and whether organisational audit could give guidance on organisational means of delivering

services.

It was agreed that for the transition from an informal to a more formal organisation to take place, capable of reacting to these changes in health care delivery, attention needed to be paid to managerial authority and accountability, decision making, staff development, policies, procedures and job roles. As primary health care teams are not bureaucracies they would need to take account of concepts of associations such as mission informality and democracy.

The pilot sites in this project tackled the problem of how best to organise primary health care teams using a bottom up approach. On reflection, this was a difficult task as they were given no 'usable theory' (Billis, 1984) and were working without any conceptual map to guide and inform them. The approach used was one of practitioners identifying what is important to enable primary health care teams to function. Practitioners did this by using their common sense in clarifying their thinking about how they work, practical experience and by adapting an accreditation model.

Therefore this project has only made a first step, though an important one, by identifying the organisational problems and the key issues that need to be addressed by primary health care teams. The pilot sites by using a multidisciplinary approach were successful in analysing their objectives, ways of working and what needed to be in place to help them achieve their objectives successfully.

This project indicates that organisational audit can help primary health care teams consider these complex organisational issues and can also provide a means of increasing accountability by stating the standards they meet.

They managed to develop standards that cover every part of a primary health care team that primary health care teams and FHSAs considered should be monitored. The primary health care teams who took part in this exercise found that the standards provided a practical means of seeing whether systems and structures are in place

which are believed to be necessary to deliver high quality health care. They reported many changes within their teams as a result of working with organisational audit. These centred around the issues discussed in the first chapter to ensure the transition to more formal organisations. Examples of these include a shared vision, clear job roles and boundaries, reorganisation of management structures, policies, procedures, evaluation activities; complex issues with working together but under different management and pay structures. The standards encouraged GPs to delegate and modify their practice which should enable them to meet the increased burden of their expanding responsibilities. Reviewing systems such as maintenance of equipment and health and safety issues also contributes to managing risks. This is of importance to GPs who wish to secure effective medical defense through risk avoidance.

The pilot sites were therefore able to identify and consider organisational problems by working with the standards. Yet organisational audit gives no guidance to primary health care teams on how best to meet the standards. For instance, criterion 6.1 states that: '*There is a current, written organisational chart which clearly defines the lines of accountability, specifies the roles of each member of the primary health care team and is understood by staff*'. This is clearly an important criterion to implement but organisational audit does not give guidance on what is the best organisational structure for primary health care teams. Organisational audit provides a tool based on practitioners experiences to analyse what should be in place which is comprehensive, practical and raises key questions for a primary health care team. It can help primary health care teams cope with the complexity of their service but would benefit from theoretical underpinning. Organisational audit helps primary health care teams identify what should be in place in order for them to offer high quality care/services but does not state how best to organise themselves. They have no theory on which to base this. Billis' theory identifying distinctive organisational features of welfare agencies in the public and voluntary sectors tackles different problems but here are analogies. Using a theory such as Billis' might help primary health care teams cope with their complex organisational features how best to offer primary health care services in an 'organised' way. For example, fundholding practices are moving towards level 4-5 using Billis' model. What organisational audit

does not clarify in organisational terms is whether all practices could benefit to moving to level 4 or 5 and what systems and structures would need to be in place to support practices working at that particular level (eg staff, training). Practitioners were capable of identifying what needs to be in place but the project did not produce clear ideas of how best to organise primary health care teams. This is important to consider for further research.

Many difficulties in implementing this scheme were initially envisaged.

There are well-recognised problems associated with the fragmentation and lack of coordination of services provided in the community, which are exacerbated by the variety of agencies responsible for providing such a service, a large part of which is provided by primary health care teams. The key objectives of the NHS and Community Care Act are to clarify the responsibilities of these agencies, to promote coordination of services and to ensure that each is responsible for the maintenance of quality in the provision of their services. There is the potential for considerable duplication of effort across the country. This could be avoided if agreement were reached between the various agencies about areas of responsibility and the sort of standards which need to be in place.

Multidisciplinary staff working to different employers in different agencies was seen as problematic. Involving everyone from the beginning, including the various managers, dispelled this fear. In fact, the organisational aims were so common amongst staff that the project resulted in core standards for them all to work with. This was not considered before embarking on the project. This was helped by focusing on the main objective of providing high quality patient focused care; a common objective. Although staff agreed on the standards, the different management structures might hinder the implementation of them in the future.

The independent way GPs worked was considered a potential problem; they might not agree to the notion of standards they have to comply with. The GPs in this project participated along with other team members and made a valuable contribution to both

developing and implementing the standards. As has been previously discussed, this was probably influenced by their desire to have some control over the standards developed.

There was a fear that the standards might increase practice workload and might be seen as an extra unwanted burden. Developing the standards was definitely time consuming for the pilot sites. Now though there is a framework of standards to build upon which will make standard development easier in future.

These pilot sites spent time implementing the standards but recognised that this was time well spent and would save time in the future. For instance, policies, procedures and protocols developed will now only need to be reviewed periodically. It has been argued earlier in this chapter the importance of not letting organisational audit become bureaucratic and paper orientated but that it must support and fit in with a primary health care team's routine.

It was stated at the beginning how important it is to involve consumers in the setting and monitoring of standards. Consumers were involved at each stage of this project. They made a valuable contribution. The project highlighted the difficulties in involving consumers appropriately and that further planning for how best to involve consumers in the surveys is required.

Many of the perceived difficulties did not occur. However, whether organisational audit is used as an educational tool or a management tool still needs to be addressed. At present it is an educational tool to help develop primary health care teams as organisations. What was important to the pilot sites was that organisational audit also provided a means for the primary health care team to show their commitment to quality services. They all wanted to display their certificate of participation and some wished for a formal accreditation of their practice. This display of achievement would presumably help practices in a competitive market. If organisational audit forms the basis of an accreditation scheme, it will also be a management tool. This will change the focus of the approach. To retain their professionalism, GPs are likely

to wish to retain some control over that process.

This was the first time primary health care teams had been involved in a project to develop standards and a monitoring system that could be applied nationally. Therefore the approach taken was to describe the activities that took place chronologically and to record the views of the participants so that lessons could be learned. The process of developing organisational audit has been recorded but outcomes have only been reported anecdotally. This project has not shown in a rigorous way how effective assessing practices is in improving practice organisation. This needs to be the next step.

The problems of bias, subjectivity and researcher led effects were highlighted in Chapter 4 outlining the research design. However the problem of subjectivity is outweighed by the insight gained into the everyday issues of practices undertaking organisational audit. The project has resulted in a record of the whole process, backed by the views of the participants captured in the questionnaires and formal discussions with the central working group and local steering groups.

It is essential that the criteria developed have a high degree of validity. The criteria developed have been based on available evidence, professional opinion and consultation with other groups including consumers and therefore reflect current thinking. They will need to be continually validated by professionals and future participants in the scheme. This will ensure that assessments are measuring what is important, not just making important those things that can be measured.

Surveyors were trained in objectively assessing practices against the criteria. If a national system is developed, it will be necessary to ensure that the assessments reached in different parts of the country are comparable, even though the levels of performance that may be required may vary. The project managers presence at each of the surveys helped in ensuring reliability and that the assessment did not discriminate against any particular practices.

The methods used resulted in practical and relevant recommendations for the future. The comparison of the baseline audit questionnaire with the questionnaire indicating the standards the pilot sites perceived they were meeting at the time of the survey indicated that activity had taken place within the pilot sites. The postal questionnaires provided some evidence of what this activity was. However, a detailed picture of the organisational changes was not provided. Tracking a practice through the organisational audit process would have given a clearer insight of what these changes were and how they took place. This should be considered for the future to inform policy makers and primary health care teams on how primary health care services are best organised.

Many changes were reported to have taken place as a result of organisational audit by the pilot sites. There may have been other outside influences that effected these changes that have not been recognised in this project. The changes described though related directly to the criteria. Tracking in detail a practice through the process would help prove if action taken was as a result of organisational audit and how the standards were implemented.

Each of these pilot sites will be re-surveyed in two years time. This will indicate whether changes have been sustained and whether action plans as a result of their first survey were implemented.

Despite potential difficulties, a robust framework of organisational standards and criteria has been developed to enable practices/health centres to analyse themselves. In the absence of an underpinning theory, standards have been developed that reflect current thinking from all different angles identifying organisational features of general practices/health centres. The weighting of the criteria should ensure that primary health care teams focus on meeting criteria to ensure patient's rights are not compromised, statutory requirements are met and that staff, patients or visitors are not at risk. In other words that the environment is safe. At present, there is no other way to ensure this.

The idea was to develop a sound organisational base and to cope with the transition to becoming more formal organisations. The pre-survey preparation provides an opportunity for a systematic self-review and for development. The survey provides the primary health care team with the unique experience of receiving an organisational diagnosis. Many excellent initiatives are taking place in primary health care which unfortunately are often unrecognised. The survey report provides a validation of good practice as well as providing recommendations for change. Primary health care teams have indicated that this process is useful in developing and organising themselves yet organisational audit gives no indication of what is the best form of organisation for primary health care teams. Outside help based on organisational theory would help underpin this model. The organisational audit programme should therefore consider employing a member of staff with a grounding in organisational theory who can support practices in how best to implement the standards.

With the rise in the consumer movement, patients expect to be told what is being provided for them and to have redress if the service falls below standard. Higher standards of education and awareness have led consumers in all sectors to be more vocal and articulate in the expression of preference.

This has been endorsed by government policy and the introduction of the Patient's Charter in 1992 clarifying individual rights to care in the NHS, setting targets for service delivery and requiring health authorities to publish data on performance against these standards. The Department of Health is now putting pressure on FHSAs to encourage primary health care teams to develop their own local charters.

Patients are encouraged to 'shop around' when looking for primary health care services but they have little information available to them to make an informed choice. They require evidence of a consumer-focused quality service instead of anecdotal stories on a practice's performance.

Many improvements made by the pilot sites to the quality of services provided to users have already been mentioned. While it is too early to assess outcomes of

organisational audit in primary health care, the pilot sites will be re-surveyed in two years and surveys of a large number of practices over the next year will provide more information. It should also be possible to capture examples of good practice to share amongst primary health care teams as well as providing greater insight as how best to organise these teams.

As Government, purchasers, providers, professionals and consumers all have potentially a stake in ensuring organisational standards are appropriately developed and met by primary health care teams, consideration needs to be given as to how all practices/health centres can benefit from this approach if they wish.

Where next?

Standard setting has now spread to general practice. Alongside this FHSAs are looking for ways of measuring individual practices' performance in order to improve accountability for the public expenditure under their control. The majority of GPs also agree a system of reaccreditation is necessary and wish the process and content of reaccreditation to remain their responsibility and under their control (Sylvester 1993).

The RCGP now has considerable experience of the assessment of doctors in their own practices, starting with the first 'What Sort of Doctor' working party (RCGP 1985), the application of this method to the assessment of training practices (Schofield and Hasler 1984) and more recently Fellowship by Assessment (RCGP 1990). Organisational audit has identified systems and structures which should be in place and developed a means of assessing the whole primary health care team.

Each of these approaches had a different purpose and therefore adopted a different focus and method of assessment.

One feature in common, however, has been the way that their approaches have been evaluated. In each case the process of developing the method has been carefully

recorded and the experience of the visitors conducting the visits has been described. However, the outcomes in terms of changes in practices as a result of these assessments, have only been reported anecdotally. No rigorous study has been conducted on the effectiveness of assessment in practices in producing change, either in practice organisation or patient care.

There are now however systems in place which can be built upon and adapted. The challenge remains to accredit the whole primary health care team. Practice accreditation would provide a framework for supporting and identifying ways of developing primary health care teams as well as introducing some of the accountability for use of NHS resources that is currently absent. The RCGP has convened a working party to examine practice assessment and accreditation. The organisational audit project manager has been invited to join this working party. The aim of this practice accreditation working party is to examine methods of assessing the performance of primary health care teams in practice and to make recommendations on the accreditation and reaccreditation of practices. Organisational Audit should help inform the debate about practice based accreditation and reaccreditation and to produce recommendations for the development of accreditation.

Organisational audit is based on professional's common sense. Professionals were able to identify what systems and structures should be in place to support them in the delivery of primary health care services. They lack though the knowledge of organisational theory of how to implement these criteria in the best way. Organisational audit has made the first step in identifying what needs to be in place to ensure primary health care teams are organisationally capable of delivering high quality primary health care services. What is now needed are some outcome measures to inform how best to organise primary health care to cope with the complexity of delivering services and a 'usable theory' to help primary health care teams organise themselves in a complex environment. There is much research in general practice but little on general practice. A balanced portfolio of research in general practice and research on general practice is essential if primary health care is to progress at both clinical and organisational levels. Also, when studying the

organisation of primary health care teams, the wider organisational context within which they work can not be ignored. It must be recognised that there are wider organisational issues that need to be addressed nationally if primary health care teams are to be the lead agency in health care provision. For example the need for a national primary health care strategy, the introduction of contracts with primary health care teams for the provision of core services and a change in management arrangements and pay structures which are more conducive to teamwork. There is a sense of threat amongst the professions by the ideas of change too. These wider organisational issues also have to be addressed if primary health care professionals are to succeed in delivering high quality care/services.

APPENDIX 1

Evaluation Questionnaire for the Primary Health Care Project

How did you hear about Organisational Audit?

What were your reasons for taking part in Organisational Audit?

How appropriate were the standards?

How did you distribute the standards?

Would you distribute them differently another time?

How could the manual be made more useful?

What were its most helpful features?

List the things that were beneficial to the practice through implementing the standards.

List the things that were difficult when implementing the standards.

What changes have taken place in the practice as a result of working with the standards?

How many months do you think would be appropriate for the preparatory phase leading up to the survey?

What are your thoughts on the length of the survey?

Was sufficient time allocated to the primary health care team members during the survey?

What differences would you make to the timetable another time?

Please comment on the composition of the survey team.

What was most helpful in the support you received?

How could support from the King's Fund be improved?

What were the benefits from receiving feedback at the end of the survey?

What were the disadvantages from receiving feedback at the end of the survey?

What immediate changes have taken place as a result of the survey?

Was the report a clear and an accurate reflection of the practice?

What future action have you been able to plan as a result of the survey?

Do you have any other comments regarding Organisational Audit?

APPENDIX 2

Surveyor Questionnaire

Would you prefer to meet:

(a) the evening prior to the survey (as in the pilot surveys) ie two nights away; or

(b) 10.00 the morning of the survey, with the survey starting after lunch and finish the end of day two as opposed to lunch time of day two; ie one night away?

What are your thoughts on the length of the survey?

Please comment on the time allocated for interviews/visits during the survey.

What changes would you make to the timetable?

Please comment on the composition of the survey team.

How could support to surveyors be improved by the King's Fund?

Have you any other comments on the survey?

What did you gain from being a surveyor?

Would you like to be included in future surveys?

APPENDIX 3

Surveyor Training Programme

Primary Health Care Project

Tuesday 9th February 1993

18.00	Course information
	Arrangements for the course
	Primary Health Care Project and the future
19.00	Questions
19.15	Game - teambuilding
20.15	Drinks and dinner

Surveyor Training Programme

Primary Health Care Project

Wednesday 10th February 1993

09.00	The survey process General questions
09.30	What is a surveyor?
10.00	Experiences of a practice manager on general practice assessment visits.
10.30	Coffee
10.45	Setting the scene for interviews
11.00	Exercise 1 - Using the pre-survey documentation Objectives * to identify areas of concern to focus on * to identify points to raise at the evening meeting with the representatives external to the primary health care team * to plan the session * to plan the feedback to the course
13.00	Lunch

14.00 Feedback from each group

14.45 Standards

* background and development
* the internal format

15.15 Tea

15.30 Interviewing skills

Questions

16.00 Exercise 2 - Being a surveyor

Objectives

* to identify key areas for discussion
* to structure interviews
* to receive information
* to conclude the interview

Divide into groups of three and allocate role plays

16.15 Ground rules for role play

16.30 Preparing for role plays

Surveyor Training Programme

Primary Health Care Project

Thursday 11th February 1993

09.00 Exercise 2 (continued) - Conducting interviews (role plays)

10.15 Coffee

10.30 Exercise 2 (continued) - Conducting interviews (role plays)

11.15 General discussion

11.45 Video (on interviewing skills)

12.15 Reports

* what King's Fund Organisational Audit expects
* what makes a good report
* content and format

12.35 Exercise 3 - Report writing

Objective

* to collate the information gathered from Exercise 2 and to produce a comprehensive, well-balanced report

13.00 Lunch

14.00 Report writing (continued)

14.30 Feedback - how to avoid a disaster

14.45 Exercise 4 - Feedback to primary health care team

Objectives

* to identify main themes

* to give clear, well balanced feedback

15.45 Tea

16.00 Discussion

16.30 General questions

17.00 Finish

APPENDIX 4

Report sample

****

The ********** is a fundholding surgery situated in an urban area with a high unemployment rate. It is also a training practice.

The following report is based on the survey of the practice in relation to the King's Fund Organisational Audit Draft Standards For Primary Health Care. Prior to the survey, the practice completed a self-assessment questionnaire designed to give an accurate reflection of its compliance with the standards. As the standards are in their draft form the main exercise of the survey was to test the standards, not the practice.

This report reflects the findings of the survey team. An overview of the practice is provided, together with specific commendations for good practice and comments against the Organisational Audit standards. Comments are made on an exception reporting basis. Recommendations are referenced to specific standards and set out to provide an action plan format for the use of the primary health care team. The report is divided into four sections relating to the primary health care team; core standards, health promotion, health records and minor surgery.

OVERVIEW

The ********** is a highly innovative, forward looking practice with an average list size and has extremely hard working, dedicated, enthusiastic staff. This has enabled the practice to break new frontiers in primary health care and provide a very caring service to a deprived practice population. However, the survey team found ample evidence that this very strength is causing problems within the primary health care team at all levels resulting in 'organisational burn out'. 'Organisational burn out' has been classified into four stages. Stage one is when the practice begins to feel the stresses. The second stage is when action is taken to deal with the stresses and returns occur. The practice appears to be at stage three which is where the primary health care team is trying very hard to react to various stresses in the practice and the returns are not occurring. If urgent steps are not taken to deal with this effectively, the practice will reach stage four which is exhaustion and apathy.

The practice needs to look at where they are now, where they want to go and how to get there. This process needs to be undertaken by all members of the primary health care team.

Roles, responsibilities and workload of all the team members need to be analysed and then rationalised. This will involve developing effective delegation.

The key process to bring about this assessment and change is for the practice to understand the difference between administration and management. At present the practice is very well and efficiently administered. However, over the past few years the practice has put in much work into developing primary health care without being effectively rewarded. It is suggested that a management role is defined and created and that family health service authority (FHSA) support is sought. A suggestion is that the practice might consider using the Department of Trade and Industry (DTI) enterprise initiative for management consultancy. The DTI will pay 70% of the costs for this.

The survey team is optimistic that the practice can manage this change. They feel strongly that the recommendations contained within this report should not be acted upon until the above process has taken place. Failure to do so will result in increased stress within the practice.

COMMENDATIONS

The primary health care team members are caring, friendly and motivated.

Good working relationships exist between attached staff and practice staff.

The chairman for the primary health care team meetings is nominated by the team every two years.

Links with external organisations such as the FHSA, district health authority (DHA), local hospital, community trust and the patient participation group appear to be strong.

The practice has developed some very good protocols and procedures - for example, the diabetic protocol and the interruption to power and water supplies procedure.

The practice drug formulary is an excellent initiative.

The practice questionnaire to identify carers will be useful.

The health visitors are profiling their caseloads and have developed standards of care. These standards are being used as a tool for auditing their work.

Clerical support is provided for the health visitors.

The district nurses are introducing client held records.

The district nurses are involved in joint assessments with social services for home care workers for the elderly.

The practice has discussed health promotion issues on a population basis with the Department of Public Health.

The collection of information for fundholding purposes is efficiently and effectively carried out - for example, the waiting list information.

The data base to identify self-help groups is innovative and access to it by patients will be of great value.

The waiting areas although small, are compact and comfortable.

The consulting rooms are of a good standard.

There is a tidy and good storage system for records.

All medical records are in chronological order.

Patient's/Client's Rights and Special Needs

A practice 'Patient's Charter' has been drafted. This needs to be developed further and displayed to staff and patients.

The section relating to patient's/clients's rights needs further work as many of the standards were not responded to in the pre-survey documentation. During the survey, it was clear that some team members had implemented some of the standards but this had not been shared with the rest of the primary health care team.

Access for disabled patients is a problem within the building - for example access to the baby clinic. To overcome this, disabled patients are usually seen in the treatment room.

It is recommended that:

1 The whole primary health care team develops standards referring to the right of all patients/clients. (Standards 1.1, 1.2.1-1.2.11, 1.2.26-1.2.28, 1.2.34)

2 There is an agreed written policy on access for disabled patients that all staff are aware of. (Standard 1.33)

Action	Timescale	Responsibility

Mission and objectives

The practice has produced a clear mission statement. Four staff were involved in drafting the mission statement. Although all staff have read it, it is not seen as important to a number of staff.

The objectives reflect the mission statement but are not shared with and understood by all staff.

It is recommended that:

1 The mission statement is shared with and implemented by all members of the primary health care team. (Standard 2.5)

2 Written objectives are developed by the primary health care team to achieve its mission statement. (Standard 2.6)

Action	Timescale	Responsibility

Management arrangements

There is a general awareness of team member's roles and their lines of accountability. However, some staff require clarification.

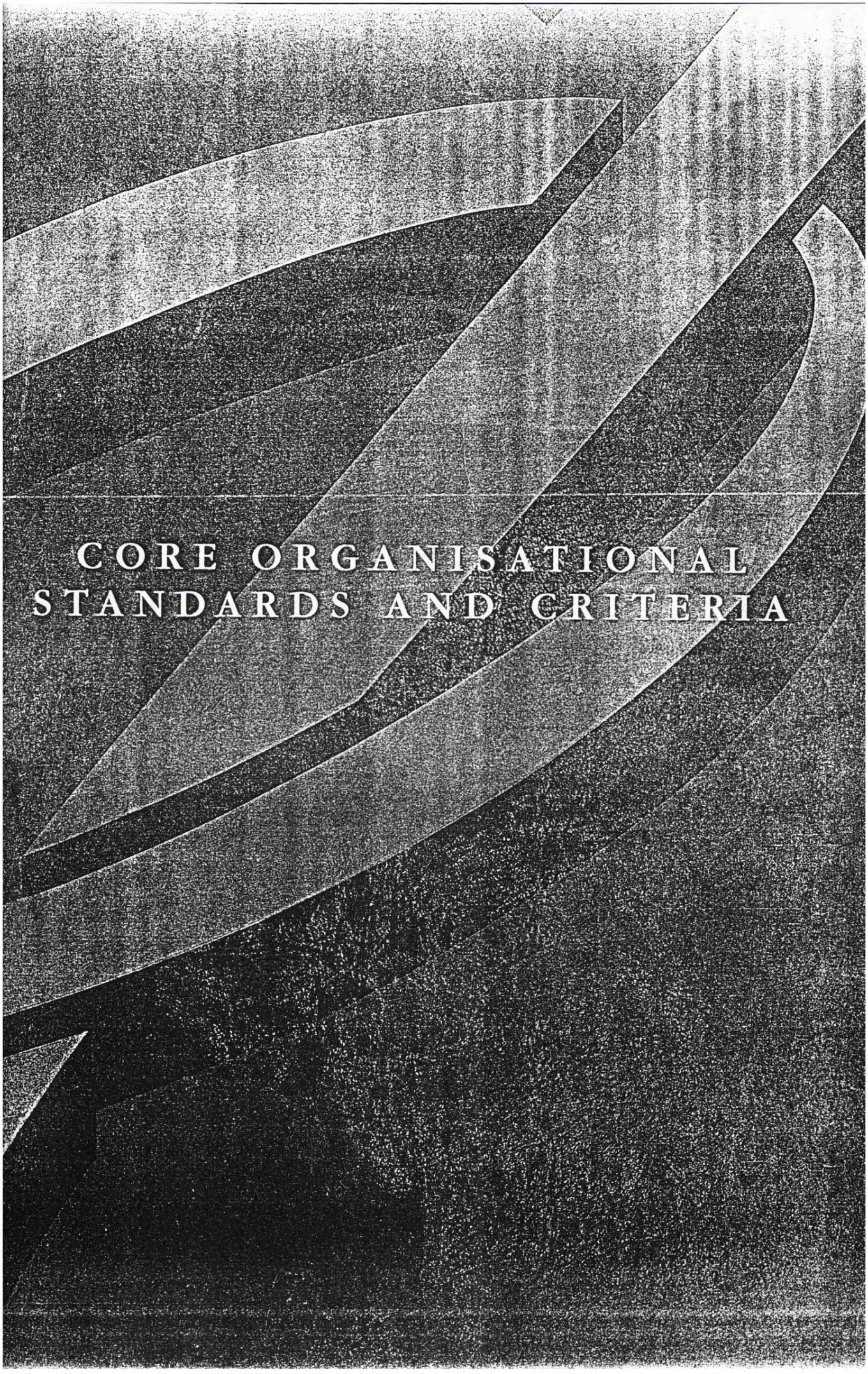
Staff have written job descriptions and contracts. However these are not signed, dated or reviewed.

Work is sometimes duplicated or not delegated appropriately - for example, four different team members are involved with the baby clinic.

There is no staff appraisal for staff. An appraisal system would help set objectives and identify areas requiring further development and educational/training needs.

APPENDIX 5

Manual of organisational standards and criteria for primary health care


CORE ORGANISATIONAL
STANDARDS AND CRITERIA

PREFACE

The organisation and management of health services are undergoing enormous change. Significant amongst these are:

- the shifting balance of provision between primary and secondary care
- the blurring boundaries between primary and community health care, as well as between health and social care
- the evolution of new organisational roles in the shape of commissioners providers and fundholders
- the changing nature of the responsibilities of both the statutory and non- statutory agencies.

Against this teeming backdrop, the need to provide high quality customer focused care remains unaltered. We hope that the publication of these standards for primary health care will be of real assistance in that process, by offering a yard stick against which the organisation, the service and the professionals delivering that service can measure and improve upon their performance. The standards are dynamic and will themselves develop over time to reflect the evolving environment within which they are applied. Our experience in the acute sector suggests that this change will be more rapid than we envisage as the standards continue to contribute to the development of both organisation and staff.

ACKNOWLEDGEMENTS

We would like to acknowledge the enormous support that we have received in developing the standards and criteria and the survey approach.

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Aylesbury Vale Community Healthcare NHS Trust
Bassetlaw Hospital and Community Services
Bennetts End Surgery, Hemel Hempstead
Eastern Health and Social Services Board, Northern Ireland
Hertfordshire Family Health Services Authority
Lambeth, Southwark and Lewisham Family Health Services Authority
North Tees NHS Trust
North West Hertfordshire Health Authority
The Welsh Office
Yorkshire Regional Health Authority

The pilot sites all of whom have worked tirelessly and enthusiastically over the last eighteen months.

Ballyowen Health Centre, Belfast, Northern Ireland
Bedgrove Health Centre, Aylesbury, Buckinghamshire
Bennetts End Surgery, Hemel Hempstead, Hertfordshire
Bridgegate Surgery, Retford, Nottinghamshire
Dunluce Health Centre, Belfast, Northern Ireland
Grove Medical Centre, Deptford, London
Lawson Street Health Centre, Stockton-on-Tees, Cleveland
Mount Surgery, Pontypool, Gwent
White Rose Surgery, South Elmsall, Yorkshire

The surveyors - Joan Bakewell, Senior District Nurse, Bridgegate Surgery, Retford; Kath Bergmanski, Health Visitor, The Mount Surgery, Pontypool, Gwent; Anne Bibbings, Carers National Association; Richard Crooks, GP, Bridgegate Surgery, Retford, Nottinghamshire; Joan Ella, Patch Nurse Manager, White Rose Surgery, South Elmsall; Sandra Gower, Practice Development Manager, Bennetts End Surgery; Janet Hamilton, Health Centre Manager, Lawson Street Health Centre; John Harley, GP, Lawson Street Health Centre, Stockton on Tees; Gill Jones, Senior Dental Officer, Gwent Health; Margaret Kelly, Nurse Manager, Dunluce Health Centre, Belfast; John Kitson, Cleveland Family Health Services Authority; Barbara McCreesh, Unit Speech & Language Therapist, Ballyowen Health Centre, Belfast; Frances Martin, Social Worker, Dunluce Health Centre; Jackie Maun, Practice Manager, Bedgrove Health Centre; Akber Mohamedali, GP, Grove Medical Centre, Deptford, London; Wendy Moody, Audit Co-ordinator, Bridgegate Surgery, Retford; Pat Preece, Nurse Manager - District Nursing, North Tees Health Trust; Thelma Sackman,Clinical General Manager - Community Services, Aylesbury Vale Community Healthcare NHS Trust; Audrey Walters, GP, Bedgrove Health Centre, Aylesbury - all of whom have contributed a large part to the success of the first phase of the project.

The many professional and consumer organisations for their comments and suggestions on the draft of the manual which have been incorporated in this edition.

Clare Blakeway-Phillips, the project manager, who has facilitated the development process and worked extremely hard to pull together and shape this manual.

Ann Patrick, the project secretary, for both typing the manual and exercising such patience when faced with 'yet another set of amendments and changes'.

Lee Braithwaite, for designing and producing the manual.

Tessa Brooks
Director
King's Fund Organisational Audit

December 1993

INTRODUCTION

The publication of this manual of organisational standards and criteria signals the end of the Primary Health Care Project and the beginning of the Primary Health Care Programme.

WHAT IS ORGANISATIONAL AUDIT?

Organisational Audit is a national approach to setting and monitoring standards for the organisation of health care services. The standards are concerned with the systems and structures which must be in place in order to support high quality patient/client care. However, standards serve little purpose if there is no objective means of assessing or measuring whether compliance with these is achieved. Consequently, organisational audit also entails the evaluation of a health care facility's compliance with standards - the survey - which is undertaken by an external team of trained senior health care professionals.

The logic behind the approach is that if a sound organisational base can be achieved, those with responsibility for delivering care or providing a service are free to concentrate on the delivery of high quality care or service. The approach was developed by the King's Fund over a two-year period (1989 and 1990) working with nine acute hospitals (full details of the project phase can be found in The Quality Question [Reference 1, Further Reading]). Considerable progress has been made since 1989. King's Fund Organisational Audit (KFOA) is now an established programme within the King's Fund, working with acute and primary health care and is developing Organisational Audit for community hospitals and nursing and residential homes. KFOA is also working with Wessex Regional Health Authority to develop Organisational Audit for learning disability services.

THE PRIMARY HEALTH CARE PROJECT

As a natural and necessary extension of the acute programme, a project was set up to develop organisational standards, criteria and a monitoring process for primary health care.

THE PILOT SITES

Support for this project was considerable; over 40 sites volunteered to take part and nine pilot sites were finally chosen based on predetermined selection criteria. These were:

Ballyowen Health Centre, Belfast, Northern Ireland
Bedgrove Health Centre, Aylesbury, Buckinghamshire
Bennetts End Surgery, Hemel Hempstead, Hertfordshire
Bridgegate Surgery, Retford, Nottinghamshire
Dunluce Health Centre, Belfast, Northern Ireland
Grove Medical Centre, Deptford, London
Lawson Street Health Centre, Stockton-on-Tees, Cleveland
Mount Surgery, Pontypool, Gwent
White Rose Surgery, South Elmsall, Yorkshire

They encompassed a variety of organisational arrangements and social settings and collectively provided a range of services including chiropody, community psychiatric nursing, dentistry, district nursing, health visiting and social work. Each pilot site included general practitioners.

THE AIMS

The aims of the project were:

- to test the feasibility of developing organisational standards and criteria for health centres/practices and to develop a monitoring system to determine compliance with these criteria;
- to evaluate the impact that compliance with these standards and criteria would have on the quality of service provided to users.

The specific objectives of the project were:

- to work with staff and users to develop organisational standards and criteria which focus on primary health care services;
- to develop a mechanism for monitoring progress towards meeting standards and criteria;
- to work with staff and users in nine health centres/practices to pilot the criteria and the monitoring process;
- to identify and train health care professionals to conduct surveys of the pilot sites;
- to determine the input of users to the monitoring process;
- to determine the level of national support for the organisational audit of primary health care services;
- to identify appropriate areas for the further extension of this work.

THE METHOD

When embarking on the acute hospital project, the KFOA was able to use and adapt existing organisational standards (used in the Australian Healthcare Accreditation Programme) as a starting point. This was not the case with the primary health care project - we were effectively 'breaking new ground' in the development of the standards, the criteria and the monitoring process. In addition, the project had a very clear consumer focus.

To take forward the necessary development work, each pilot site set up a multidisciplinary working or steering group which was responsible for coordinating the various stages of the project at local level. The overall composition of this group varied from site to site, but each had medical, nursing, management and consumer representation as a minimum.

Two representatives from each pilot site were selected to join a central working party comprising the different staff groups. It was this group which, in consultation with colleagues at local level, agreed the various stages of the developmental work.

As a source of additional advice and support, a national advisory group was established comprising representatives of professional and consumer organisations which have an interest and expertise in this area. This group provided external and independent advice to the project.

(The membership of the central working group and the national advisory group can be found in Appendices 6 and 7).

DEVELOPING THE STANDARDS

The areas to be covered and the format of the standards and criteria were the subject of extensive debate and discussion within the pilot sites and the various working groups. Once agreement had been reached, each of the pilot sites volunteered to work on one or two of the areas identified. Then, working to an agreed set format, the members of the local steering groups developed the standards and criteria in consultation with additional colleagues and consumer groups.

The KFOA pulled all the standards and criteria together into one manual. This was then circulated to all the pilot sites so that staff and consumers could comment on all the areas covered. These comments and views were shared with the central working group and the national advisory group.

As a result of this process, consensus was reached on the standards and criteria to be piloted within the project. The draft manual of standards and criteria addressed the key aspects of service provision within and from a general practice or health centre as well as issues such as risk management.

The draft manual of standards and criteria was circulated to every regional health authority, a wide range of health care staff and professional and consumer organisations for comment.

IMPLEMENTING THE STANDARDS AND CRITERIA

Between November 1992 and March 1993 the pilot sites established a programme to implement the standards and criteria. This involved identifying the criteria that were being met, as well as those that they intended to meet, and the development of a clear action plan in order to achieve compliance. In essence, the various aspects of the primary health care service were subject to a comprehensive 'spring clean'. It was a time when staff, in consultation with users, looked critically at how services and care were delivered in relation to the standards and criteria, identifying areas for improvement. This work was supported and facilitated by the KFOA.

Prior to their survey, each pilot site completed the self-assessment forms in the manual, indicated the criteria they were meeting and made comments against the criteria they were not meeting. This enabled the pilot sites to assess their own progress towards meeting the standards. The forms also provided an opportunity for the primary health care teams to feed back comments to the KFOA on the value of the standards.

THE SURVEY

While the pilot sites were implementing and testing the criteria, the KFOA identified and trained health care professionals from the primary health care setting (the surveyors) to undertake the audit of compliance with the criteria (the survey). A team of three surveyors visited each site (four surveyors in the case of one large health centre). The teams comprised a clinician and manager from a primary health care background and the third person was either a consumer or manager external to the primary health care team, such as a member of a family health services authority or district health authority. The surveyors' task was to test the measurability of the criteria and to give detailed confidential feedback on each site's progress towards meeting these.

The surveyors sought compliance with the criteria and evidence of a user-friendly, patient- centred service. The assessment involved interviews with staff, patients and users of the service, observation of the environment, documentation review and that policies, procedures and protocols were followed in practice.

A report was sent to the practice/health centre following the survey. This gave a comprehensive assessment of progress towards meeting the criteria and included recommendations for change as well as highlighting good practice. The report provided a basis for developing future action plans within the health centre or practice.

EVALUATION

The pilot sites worked on the project with great enthusiasm. They found that organisational audit enhanced multidisciplinary teamwork and, most importantly, that working with the criteria helped each health centre/practice to develop as an organisation.

The evaluation of the project can be found in the primary health care project report. As a result of the Primary Health Care Project, the KFOA has extended its work to include a Primary Health Care Programme and is looking forward to working with other primary health care teams throughout the UK.

Clare Blakeway-Phillips
Project Manager
Primary Health Care Project
King's Fund Organisational Audit

October 1993

USING THE MANUAL

The manual is to be used by all members of the primary health care team in order to prepare for the survey. No health centre/practice is expected to meet all the criteria. However, the survey team will look for clear evidence that the health centre/practice is meeting or working towards complying with the majority of criteria.

The guiding principles are that the criteria should:

* support the patient's/client's expectations of quality care and personal dignity;
* be desirable and measurable;
* relate as directly as possible to the quality of care and to the quality of the environment in which care is provided;
* emphasise an efficient and effective use of available resources;
* represent a consensus on currently accepted professional practice;
* state objectives rather than mechanisms for meeting objectives.

The criteria within each section seek to establish clear evidence of:

* a patient/client-centred service;
* the effective and efficient overall management of resources;
* the effective and efficient management of human resources;
* continuous evaluation.

WEIGHTING

To help primary health care teams prioritise their work, the criteria have been weighted and fall into three categories:

* essential practice ■
* good practice ◨
* desirable practice □

The criteria have been marked accordingly.

ESSENTIAL PRACTICE

It is essential that the primary health care team complies with criteria which relate to key service provision. If these criteria are not in place:

1 staff, patients or visitors will be at risk (that is, on the grounds of health and safety or legal liability);
2 patient's rights will be compromised; or
3 statutory requirements will not be met.

GOOD PRACTICE

The criteria in this category relate to standard good practice which you would expect to see in any surgery or service.

DESIRABLE PRACTICE

These criteria relate to desirable service provision or the means of advancing and improving practice.

Each member of the primary health care team will work with the core organisational standards and criteria detailed in Section 1 - Core Organisational Standards and Criteria. In addition, each member will be expected to comply with any criteria relating to his or her respective professional group (Section 2 - Primary Health Care Team Members) and the standards and criteria for health records (Section 3). The standards and criteria for minor surgery (Section 4) are relevant to staff involved in any aspect of supporting or performing minor surgical procedures.

SELF ASSESSMENT

This manual also contains self-assessment tick boxes and spaces for comments. These enable the health centre/practice to assess its own progress towards meeting the criteria and also provide an opportunity for staff to feed back comments to the KFOA on the value or otherwise of the criteria.

Each site is asked:

* to indicate whether each criterion is being complied with;
* if the criterion is not being met, to state the reason in the comments column;
* to comment on the criteria in general.

Completion of this document serves two purposes:

1 A copy of the completed document will be sent to each member of the survey team. This will provide the team, in advance of the survey, with some indication of the facility's progress towards meeting the criteria and will assist them in planning the survey.

2 It will greatly assist the KFOA in the task of developing and improving the criteria. The comments will be included in future revisions of the Organisational Audit Manual for Primary Health Care.

The completed form must be returned to the KFOA six weeks before the survey date for each facility.

SUPPORTING DOCUMENTATION

A definition of the terms and references used by the pilot sites in the formulation of the standards and criteria can be found at the end of the manual.

Appendices give the content of the Patient's Charter, relevant legislation, content of contract of employment, information to be provided in annual reports and practice leaflets and membership of the central working group and the national advisory group.

KFOA Guidance for Primary Health Care Teams is available from the KFOA. These guidelines provide advice and suggestions for the steering group responsible for managing organisational audit and will enable the primary health care team to make the most of participation in the KFOA.

CORE ORGANISATIONAL STANDARDS AND CRITERIA

These standards and criteria relate to all members of the primary health care team

DEFINITIONS

The practice refers to the partners, employed staff and their patients.

The primary health care team refers to general practitioners, all staff employed by the practice and all other multidisciplinary professionals attached to the practice (for example community nurses, dietitians, physiotherapists, community psychiatric nurses, counsellors, complementary therapists, social workers, Macmillan nurses, occupational therapists, and so on).

The facility refers to the health centre, the general practice or any other site providing a primary health care service.

The following 'core' standards and criteria apply to all members of the primary health care team. In addition there are supplementary criteria relevant to individual members of the primary health care team. Please refer to the introduction on how to use the standards and criteria.

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

PATIENT'S/CLIENT'S RIGHTS & SPECIAL NEEDS

Patient's/Client's Rights

Standard 1

The rights of all patients/clients and their carers, regardless of their age,disability,race, gender or sexual orientation are recognised, respected and complied with by all staff involved in their care.

Comments

Criteria

please tick
Y N

1.1 There is a local charter which describes the rights of the patient/client. This charter ☐☐◨■

(a) reflects the content of the Patient's Charter (Appendix 5); and
(b) is made known to the patient/client and his or her carer.

1.2 The primary health care team is aware of and respects the following:

1.2.1 the right of the patient/client attending the facility to be treated with courtesy and consideration by all staff ☐☐■

1.2.2 the right of the patient/client attending the facility to be treated as an individual with individual needs ☐☐■

1.2.3 the right of the patient/client attending the facility to be treated with respect for personal privacy and dignity ☐☐■

1.2.4 the right to equality of access to the services offered by the facility ☐☐■

1.2.5 the patient's/client's decision to refuse treatment ☐☐■

1.2.6 the patient's/client's right to choose ☐☐■

1.2.7 the determinants of health that are beyond the individual's control ☐☐■

1.2.8 the patient's/client's right to appeal when denied a service ☐☐■

1.2.9 the right to receive treatment/care from a female/male member of staff ☐☐◨■

1.2.10 the culture and traditions of ethnic groups within the population served. ☐☐◨■

1.3 Informed consent is obtained for:

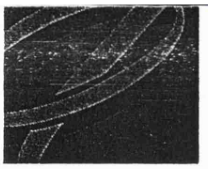
1.3.1 surgical procedures ☐☐■

1.3.2 participation in teaching exercises (Patient's Charter) ☐☐■

1.3.3 participation in any research project (Patient's Charter) ☐☐■

1.3.4 photographic and audiovisual recording ☐☐■

1.3.5 other procedures where consent is required by law. ☐☐■



SPECIAL NEEDS

Weighting ☐

Essential practice ■

Good practice ◧

Desirable practice ☐

Comments

please tick
Y N

Ethnic groups

2.10 Inservice education is available to ensure that staff are aware of the particular needs and culture of ethnic groups. ☐☐☐

2.11 Interpreter services are available and are made known to patients/clients and staff. ☐☐◧

2.12 Where the primary health care team are of a different culture and linguistic background to the local population served, bilingual advocates are available. ☐☐◧

2.13 The language used by a patient (if non-English speaking) is prominently recorded on the patient's record. ☐☐◧

2.14 Translated health promotion material and primary health care information are available and used where required. ☐☐☐

Travellers

2.15 Travellers have access to primary health care services. ☐☐■

2.16 Inservice education is available to ensure that staff are aware of the particular needs and culture of travellers. ☐☐☐

2.17 All families are provided with parent/guardian-held child health records. ☐☐☐

2.18 Health promotion material is available to meet the needs of travellers. ☐☐☐

Patients/clients with a disability

2.19 The patient/client and/or carer are informed of the relevant services provided by other agencies. ☐☐◧

2.20 Interpreter services are available when appropriate. ☐☐◧

2.21 Tape/braille information is available when appropriate. ☐☐◧

2.22 There is ease of access to the facility and services for those with a visual or physical difficulty. ☐☐◧

Carers

2.23 Staff are aware of, and support, the key role carers play in assisting disabled or infirm people living at home. ☐☐◧

2.24 There is a mechanism to assess the needs of carers. ☐☐☐

2.25 Information is provided about support services available to carers. ☐☐◧

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

Standard 3

There is a written mission statement, a philosophy and a set of objectives which act as a guide to planning, implementing and evaluating all aspects of the service.

Comments	*Criteria*	please tick Y	N
	3.1 The mission statement and philosophy are developed by the members of the primary health care team.		■
	3.2 The following values are reflected in the philosophy statement:		
	3.2.1 courtesy and consideration is given to patients/clients and their carers at all times		■
	3.2.2 patient's/client's privacy and dignity and that of their carers is respected		■
	3.2.3 cultural differences are responded to		■
	3.2.4 support requirements of the patients/clients and carers are identified.		■
	3.3 The philosophy statement reflects the primary health care team's commitment to:		
	3.3.1 a 'user-centred' approach		■
	3.3.2 identifying the patient's/client's needs and concerns		■
	3.3.3 providing care related to the patient's/client's needs and concerns		■
	3.3.4 carers		■
	3.3.5 multidisciplinary teamworking		
	3.3.6 health promotion and disease prevention		■
	3.3.7 health care for the community		■
	3.3.8 continuity of care		■
	3.3.9 working with other agencies in the community		■
	3.3.10 equality of opportunity for the patient/client and staff.		■
	3.4 The statement is made available to the patients/clients registered with the facility, the local community, the primary health care team members and other health and related organisations.		■
	3.5 There is a mechanism to ensure that the mission statement and philosophy are fully understood and implemented by all members of the primary health care team.		■

MISSION AND OBJECTIVES

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

Comments

Objectives

please tick
Y N

3.6 There is a plan for the implementation of the objectives of the primary health care team. (This may be a business plan.) ◨

3.7 In developing the objectives consideration is given to:

3.7.1 national and local health strategies (for example, Health of the Nation, local public health report, regional health authority (RHA) strategy) ■

3.7.2 conforming to statute and local government regulations. ■

3.8 The objectives consider at least the following:

3.8.1 to provide the patient/client with a service which is based on professional standards ■

3.8.2 to identify the health care needs in collaboration with other organisations (for example, RHA, district health authority (DHA), health boards, family health services authority (FHSA), other primary health care facilities, public environmental health and social services and community health councils (CHCs)). (Central Services Agency, health and social services boards and councils for health and social services in Northern Ireland.) ◨

3.8.3 to consult users and patients in order to establish the needs of the population ☐

3.8.4 to evaluate the appropriateness of the service offered (for example, opening hours, scope of services, availability of staff) ◨

3.8.5 to provide and maintain high standards of health promotion in all activities through analysis, review and evaluation ◨

3.8.6 to optimise the social, mental and physical health of all people registered with the facility ◨

3.8.7 to enable individuals to take responsibility for their own and their family's health ◨

3.8.8 to provide consistent information to patients/clients ◨

3.8.9 to provide an accessible, responsive and safe service to patients/clients ■

MISSION AND OBJECTIVES

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

please tick
Y N

Comments

3.8.10 to establish and maintain effective communication within the primary health care team and with appropriate agencies to:

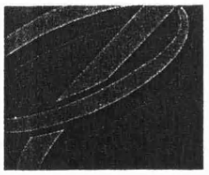
(a) meet patient's/client's needs; and
(b) facilitate coordination of services

3.8.11 to provide educational opportunities to further develop knowledge and skills in the interest of effective and efficient delivery of care.

3.9 Individual services develop specific written objectives which are shared with the rest of the primary health care team (see section for Primary Health Care Team Members).

3.10 All staff are aware of the objectives of the service.

3.11 These objectives are reviewed regularly and revised to reflect changes.



Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

CONTRACT AGREEMENTS AND CONTRACT FOR SERVICES

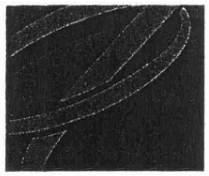
(For which the facility is the purchaser)

Contracts may, for example, cover domestic services, security, pathology services, specialist clinics, nursing services.

Standard 4

There are written agreements/contracts for all health care provided by external agencies. These are monitored and reviewed regularly.

Comments	*Criteria*	*please tick* Y N
	4.1 The partners develop written agreements/contracts in consultation with service providers.	☐ ☐ ■
	4.2 Contracts and service agreements include quality specifications.	☐ ☐ ■
	4.3 There is a system of recording unmet need which is used to inform the purchasing and planning of services.	☐ ☐ ■
	4.4 Documentation of contract services addresses at least the following:	
	4.4.1 specification of formal lines of communication and responsibility between the service provider and the facility	☐ ☐ ■
	4.4.2 mechanisms for monitoring the quality of service	☐ ☐ ■
	4.4.3 provision of services by people appropriately qualified to perform their duties	☐ ☐ ■
	4.4.4 adequate pick-up and delivery arrangements (for example, pathology, specimens and results)	☐ ☐ ■
	4.4.5 participation of the service provider in relevant facility meetings (for example, domestic manager involved in control of infection meetings)	☐ ☐ ■
	4.4.6 arrangements for after hours and emergency services	☐ ☐ ■
	4.4.7 mechanisms for dealing with problems in service delivery	☐ ☐ ■
	4.4.8 adequacy of facilities and equipment for the service being provided at the facility and at the site of external services	☐ ☐ ■
	4.4.9 facility policies and procedures, in particular emergency procedures.	☐ ☐ ■
	4.5 Compliance with contract specifications is monitored and reviewed regularly.	☐ ☐ ■
	4.6 Fundholding partners are involved in meeting with service providers, at least annually.	☐ ☐ ■



Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

CONTRACTS FOR SERVICES

(for which the facility is a provider)

Standard 5

There are written, signed agreements for all health care services provided by the facility.

Comments

Criteria

please tick

		Y	N
5.1	There is evidence of a structured and systematic approach to developing and negotiating service agreements.	☐	◨
5.2	These agreements include at least the following dimensions:		
5.2.1	quality (clinical and non-clinical)	☐	■
5.2.2	cost	◨	◨
5.2.3	volume/activity.	◨	◨
5.3	Medical, nursing and other staff are involved in the contract negotiation, the determination of activity targets and quality indicators.	☐	☐
5.4	All contracts for health care provided by the facility include:		
5.4.1	a description of the service to be provided	☐	■
5.4.2	a commitment to providing integrated care	◨	◨
5.4.3	health education	◨	◨
5.4.4	a statement of provision of aids and equipment	◨	◨
5.4.5	specialist services	◨	◨
5.4.6	specification of formal lines of communication and responsibility between the service provider and service purchaser	☐	■
5.4.7	a requirement for the provision of services by appropriately trained and qualified staff	☐	■
5.4.8	regular review	◨	◨
5.4.9	mechanisms for identifying and remedying problems in service delivery	☐	■
5.4.10	protocols of care which indicate the different responsibilities of staff.	◨	◨

Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

MANAGEMENT ARRANGEMENTS

The term manager is used generically and relates to the manager of the facility or of any service.

Standard 6

The facility is organised, managed and staffed to provide safe, efficient and effective care to its patients/clients, to achieve its objectives, and to ensure high quality professional practice.

Comments

please tick

Y N

Management structure

Criteria

6.1 There is a current, written organisational chart which clearly defines the lines of accountability, specifies the roles of each member of the primary health care team and is understood by staff. ☐☐■

6.2 The organisational chart is reviewed annually and/or when there is a change in the management arrangements, revised and dated. ☐☐■

6.3 There is a named manager for each aspect of the health care service provided. ☐☐■

6.4 Each manager has a clearly defined role. ☐☐■

6.5 The manager is qualified by education/training and experience appropriate to the responsibilities of the position. ☐☐■

6.6 There is a designated deputy to act in the absence of the manager to provide direction at all times to the facility/department/professional group. ☐☐■

6.7 The responsibilities of the manager include:

6.7.1 involvement in the development of service agreements/contracts where applicable ☐☐■

6.7.2 ensuring compliance with contract specification and business plans ☐☐■

6.7.3 the application and implementation of operational policies/procedures ☐☐■

6.7.4 the organisation of the administrative functions of the service and the delegation of duties ☐☐■

6.7.5 facilitating service and interdepartmental meetings ☐☐■

6.7.6 consulting with other health care professionals when developing new service policies ☐☐■

6.7.7 ensuring services are provided in line with current professional guidelines. ☐☐■

Finance

6.8 The manager is involved in the preparation of the budget for the facility/service. ☐☐■

MANAGEMENT ARRANGEMENTS

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

please tick

	Y	N

Comments

6.9 The manager is responsible for the efficient and effective management of the budget. ◨

6.10 All statutory regulations are implemented and records held (for example, national insurance, PAYE, statutory sick pay). ■

6.11 There are clear and effective channels of communication between manager and suppliers of financial information. ◨

6.12 Reports of income, expenditure and cash flow statements are communicated to budget holders at regular intervals throughout the year. ◨

6.13 The financial reports are clear, accurate and timely. ◨

6.14 The financial reports and recommendations are communicated to the partners, FHSA/health authority as appropriate at set intervals throughout the year. ■

6.15 The financial information system is flexible and allows ad hoc information to be retrieved as required. ◨

Staffing

6.16 All staff are qualified and competent to carry out their duties. ■

6.17 When employing staff, consideration is given to:

6.17.1 academic and vocational qualifications ◨

6.17.2 training and experience in employment. ◨

6.18 Staff are state registered or are members of a professional organisation where applicable. ■

6.19 Staff, patients and clients are covered by insurance policies. ■

6.20 All staff are aware of the roles of each member of the primary health care team. ◨

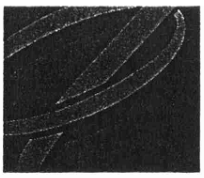
6.21 Staff do not work outside their designated role. ■

6.22 Staff are appointed and deployed on the basis of workload and population served within given resources. ☐

6.23 Workload requirements are assessed before the appointment of new staff. ◨

6.24 The additional requirements of teaching, supervising and assessing are reflected in the numbers of staff on duty. ☐

6.25 All students and unqualified staff working within the facility are under the supervision of an appropriately qualified professional. ■



MANAGEMENT ARRANGEMENTS

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

please tick
Y N

Comments

6.26 Staff are supported in the delivery of care by the following personnel:

6.26.1 administrative ☐☐◨■

6.26.2 ancillary (for example, domestic staff, works and maintenance, transport, caretaking) ☐☐◨■

6.26.3 reception ☐☐◨■

6.26.4 colleagues. ☐☐◨■

6.27 The numbers and mix of professional and technical staff are organised to achieve the objectives of the service. ☐☐☐

6.28 Staff adhere to the facility and/or health authority policy on clothing/uniform. ☐☐◨■

6.29 Staff wear name badges (Patient's Charter). ☐☐■

Human resources

Please also refer to legislation affecting the appointment of employees (Appendix 1)

6.30 There is access to expertise for recruitment, selection and employment procedures when required. ☐☐◨■

6.31 All staff receive a contract of employment on appointment which clearly states the terms and conditions of service. This is issued within 13 weeks. (See Appendix 2 for content of contract.) ☐☐■

6.32 Accurate and complete personnel records are maintained. These are confidential, and available to the employee. They include at least: ☐☐■

6.32.1 application form, offer letter and acceptance ☐☐◨■

6.32.2 copy of contract ☐☐■

6.32.3 job description ☐☐◨■

6.32.4 qualifications/experience ☐☐■

6.32.5 evidence of up-to-date professional/state registration where applicable ☐☐■

6.32.6 valid nursing PIN number ☐☐■

6.32.7 references ☐☐☐

6.32.8 any disciplinary proceedings ☐☐■

6.32.9 any alteration to terms and conditions of employment ☐☐■

6.32.10 training and course attendance records ☐☐◨■

6.32.11 record of recent staff appraisal ☐☐◨■

6.32.12 records of leave ☐☐◨■

6.32.13 records of sickness. ☐☐■

MANAGEMENT ARRANGEMENTS

Weighting ☐

Essential practice ■

Good practice ◧

Desirable practice ☐

please tick

Y	N
☐	☐

Comments

6.33 Written and dated job descriptions are available for all posts. These specify at least the following:

(a) job title, knowledge, skills and experience required for the post
(b) functions, responsibilities and accountability

☐ ☐ ■

6.34 Job descriptions are reviewed annually or on vacation of the post.

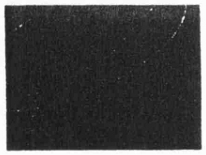
☐ ☐ ◧

6.35 There is a documented appraisal system for all staff.

☐ ☐ ◧

6.36 Appraisal for each staff member is based on the job description and work objectives and identifies strengths in performance, areas requiring further development and educational/training needs.

☐ ☐ ◧



Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

STAFF DEVELOPMENT AND EDUCATION

Standard 7

Continuing education and inservice training programmes are available to all staff to develop their knowledge and skills to meet the needs of the individual and the objectives of the service and the facility.

Comments

Criteria

please tick Y N

Orientation and induction

7.1 There is a planned orientation and induction programme for all categories of newly appointed staff which is tailored to individual need. ☐☐◨■

7.2 Orientation activities include:

7.2.1 introducing new staff to the relevant aspects of the facility and of the service ☐☐◨■

7.2.2 providing information about the facility and the relationship between services ☐☐◨■

7.2.3 preparing the new member for his or her role and responsibilities within the service and facility ☐☐■

7.2.4 explaining the integral role of health promotion and education ☐☐☐

7.2.5 introducing staff to the policies and procedures of the service and the facility ☐☐■

7.2.6 explaining emergency procedures (for example, fire drills and security) ☐☐■

7.2.7 explaining the procedure for summoning help in a case of an emergency (for example, patient collapse) ☐☐■

7.2.8 providing information about health and safety at work ☐☐■

7.2.9 providing information on access to ongoing education and training programmes ☐☐☐

7.2.10 introducing the policy on confidentiality ☐☐■

7.2.11 introducing health records standards ☐☐◨■

7.2.12 explaining the communication systems ☐☐◨■

7.2.13 explaining the method used to evaluate staff performance. ☐☐◨■

7.3 The induction programme is signed, dated and subject to regular review. Each review is dated. ☐☐◨■

Ongoing education

7.4 There is evidence of ongoing education and professional updating (for example, PREPP). ☐☐■

STAFF DEVELOPMENT AND EDUCATION

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

Comments

			please tick Y	N
7.5	The following are available:			
	7.5.1	information on educational opportunities arranged by other institutions	◨	
	7.5.2	support for taking advantage of educational opportunities	◨	
	7.5.3	support for undertaking relevant research		
	7.5.4	orientation in new clinical areas	◨	
	7.5.5	management training		
	7.5.6	information on advances in practice related to primary health care		
	7.5.7	basic life-support skills.	■	
7.6	Multidisciplinary training sessions regularly take place.			
7.7	There is an agreed minimum training for staff.		◨	
7.8	Staff have access to external information and library services and are given allotted time to update their knowledge.			
7.9	Current manuals, pamphlets, journals and relevant text books and information are available for reference and guidance.			
7.10	Cultural awareness training is available for staff if they work with different cultural groups.		■	
7.11	Staff are encouraged to attend relevant conferences, meetings and seminars. Records of activity are kept and reviewed annually.			
7.12	There is a mechanism for staff to share information and experience gained from courses/seminars.			
7.13	Staff have evidence of personal competence (for example, evidence of training, and standards reached).		■	

COMMUNICATION

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

Standard 8

The primary health care team pursues excellence in all aspects of communication with colleagues, patients/clients, carers, health agencies and the local community. Confidentiality is maintained between staff and the patient/client, including information shared with relatives and/or carers.

Comments		*Criteria*	*please tick* Y	N
			☐	☐
	8.1	There is a written communication protocol which details the links with key organisations.	☐	◨
	8.2	The effectiveness of the communication protocol is regularly reviewed.	☐	◨
		Between staff		
	8.3	Staff meet regularly for multidisciplinary discussions to maintain good communication and to review service practices.	☐	■
	8.4	There is evidence of partnership and/or management meetings.	☐	■
	8.5	Staff are aware of the dates of meetings.	☐	■
	8.6	Minutes of meetings are taken and are made available.	☐	☐
	8.7	The minutes identify individuals responsible for specific action.	☐	◨
	8.8	Staff receive feedback from meetings.	☐	◨
	8.9	There is an effective system for the dissemination of written communications.	☐	■
	8.10	Staff have access to relevant written communications.	☐	◨
	8.11	There is a system for passing on urgent/daily messages between all primary health care team members.	☐	■
		With patients/clients		
	8.12	There are systems which facilitate effective communication between the service and the patient/client/carer.	☐	■
	8.13	All staff have an opportunity to train in communication skills and customer care.	☐	☐
	8.14	There is a clear channel of communication for patient's complaints/suggestions/expressions of satisfaction. (See also Audit and Quality in this section.)	☐	■
	8.15	Patients/clients have the opportunity to discuss the diagnosis, treatment, side effects and prognosis with the appropriate professional in as much detail as they need.	☐	■

COMMUNICATION

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

Comments

please tick

	Y	N

8.16 There is evidence that health promotion is covered by members of the primary health care team during patient/client consultations. ☐☐◨

8.17 The communication systems used by patients/clients are regularly assessed for effectiveness and efficiency. ☐☐◨

8.18 The local community health council is consulted about the formulation, monitoring and review of communication systems for patients/clients. ☐☐☐

8.19 The views of patients/clients on the services provided are actively sought (for example, satisfaction surveys, patient participation groups). ☐☐◨

External

8.20 There is evidence of a mechanism for communication and consultation between hospitals and the primary health care team. ☐☐■

8.21 There is evidence of a mechanism for communication and/or consultation with appropriate external organisations, including community health council, FHSA, DHA, RHA, voluntary organisations, local self-help groups and other organisations. (Central Services Agency, and health and social services boards in Northern Ireland and health boards in Scotland.) ☐☐■

8.22 Proposed changes in the patterns of service provision are discussed with the relevant agencies. ☐☐☐

8.23 The 'boundaries' between the primary health care team's responsibilities and those of other complementary agencies are clear to staff. ☐☐■

Community health councils (CHC)

8.24 There is evidence of effective two-way communication with the CHC (for example, recorded outcome of meetings). ☐☐☐

8.25 There is a list of CHC contact names readily available within the facility. ☐☐◨

8.26 The facility provides the CHC with a contact list. ☐☐☐

District health authority (DHA)/Health and social services boards (Northern Ireland), health boards, Scotland and independent health care providers

8.27 There is evidence of effective two-way communication with the DHA and independent health care providers (for example, recorded outcome of meetings). ☐☐◨

8.28 The following are made available:

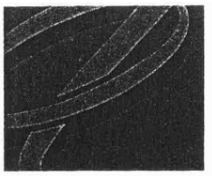
8.28.1 a list of provider units with which contracts have been negotiated ☐☐◨

COMMUNICATION

Weighting ☐
Essential practice ■
Good practice ◧
Desirable practice ☐

Comments

			please tick Y	N
	8.28.2	an accurate list of departments with which the primary health care team may need to communicate		■
	8.28.3	corporate objectives		
	8.28.4	policy statements		
	8.28.5	plans for service provision		■
	8.28.6	service quality specifications		
	8.28.7	plans for monitoring service provision		
	8.28.8	complaints procedure.		■
	Family health services authority (FHSA)			
8.29	There is evidence of effective, two-way communication with the FHSA (for example, recorded outcome of meetings).			■
8.30	The FHSA is informed of a patient's change of address.			■
8.31	The following information is available from the FHSA:			
	8.31.1	the business plan		
	8.31.2	local interpretation of national objectives		■
	8.31.3	FHSA Charter		■
	8.31.4	information on local health needs (see also Mission and Objectives)		■
	8.31.5	guidelines on health promotion		
	8.31.6	improvement grants		
	8.31.7	budgetary control		
	8.31.8	a list of departmental services within the FHSA		■
	8.31.9	key people within the departments		■
	8.31.10	'key dates' for the returns to be made to the FHSA		■
	8.31.11	staffing reimbursements.		■
	Hospitals			
8.32	The facility receives up-to-date information on the services provided by the local hospitals, hospices and secondary care units. This includes at least:			
	8.32.1	consultants and specialty		■
	8.32.2	waiting time for referral to consultants		■
	8.32.3	waiting time for admission		■
	8.32.4	investigations undertaken (for example, microbiological, haematological, and so on)		■
	8.32.5	waiting time for results.		■



COMMUNICATION

Weighting ☐
Essential practice ■
Good practice ◧
Desirable practice ☐

Comments

please tick
Y N

Local medical, dental and pharmaceutical committees

8.33 There is a mechanism to ensure that the views of the primary health care team are presented at meetings of the local medical, dental and pharmaceutical committee when necessary. ☐☐☐

8.34 There is an up-to-date list of representatives on the different working groups of the local medical, dental and pharmaceutical committee. ☐☐☐

8.35 Timely communication is received on the outcome of meetings for those representatives who could not attend. ☐☐☐

Social services

8.36 There is evidence of effective communication with social services (for example, recorded outcome of meetings). ☐☐◧

8.37 There is an up-to-date list of social services contact names available within thefacility. ☐☐◧

8.38 The primary health care team contributes to the development of social services departments' community care plans. ☐☐◧

8.39 There is information available on services provided by social services (for example, priority criteria, waiting lists). ☐☐■

8.40 There is agreement on key operational areas, including client access, assessment procedures, hospital discharge procedures and care management. (See also Community Care Assessments in this section.) ☐☐■

8.41 The facility provides social services with an up-to-date contact list. ☐☐◧

Written communication

8.42 The information contained in referrals enables any therapy/treatment to be conducted safely and effectively. ☐☐■

8.43 Referrals are legible and include: ☐☐■

8.43.1 name ☐☐■

8.43.2 address ☐☐■

8.43.3 postcode ☐☐■

8.43.4 telephone number ☐☐◧

8.43.5 sex ☐☐■

8.43.6 date of birth ☐☐■

8.43.7 state of urgency and reason for urgency ☐☐■

8.43.8 special need ☐☐■

COMMUNICATION

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

Comments

please tick

			Y	N
			☐	☐
	8.43.9	diagnosis	☐	■
	8.43.10	relevant medical history.	☐	■
	Outpatient referrals			
8.44	All referrals contain the details as necessary to provide a background to the patient's condition and include:			
	8.44.1	present condition	☐	■
	8.44.2	past medical history	☐	■
	8.44.3	relevant investigations	☐	■
	8.44.4	social situation, including presence or availability of a carer (if applicable)	☐	■
	8.44.5	psychiatric history (if appropriate)	☐	■
	8.44.6	a comment on urgency.	☐	■
8.45	Copies of referral letters are kept.		☐	◨
	Investigations			
8.46	Requests for investigations			
	8.46.1	are legible	☐	■
	8.46.2	are dated	☐	■
	8.46.3	are on the correct form	☐	■
	8.46.4	contain sufficient details to correctly identify the patient/client	☐	■
	8.46.5	enable the relevant departments to carry out the investigation.	☐	■
8.47	There is a system for receiving and dealing with results.		☐	■
8.48	There is a policy on giving results to patients.		☐	■
	Inpatient/accident and emergency referrals			
8.49	The patient/client and carer are told as clearly as possible the reasons for advising admission to hospital. They are given an opportunity to discuss the reasons for advising admission and allowed, if possible, to choose which hospital.		☐	■
8.50	The patient/client/carer is given sufficient information to enable him or her to make an informed choice.		☐	■
8.51	The admitted patient, whenever possible, has an accompanying letter from the general practitioner which is legible and contains personal details as well as relevant social and medical history.		☐	■
	Discharge from hospital			
8.52	On the day of discharge, where continuing care is needed, a comprehensive summary is made available to the primary health care team indicating the patient's:		☐	■

COMMUNICATION

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

Comments

			please tick Y	N	
			☐	☐	☐
	8.52.1	address and date of birth	☐	☐	■
	8.52.2	diagnosis	☐	☐	■
	8.52.3	prognosis	☐	☐	■
	8.52.4	medication	☐	☐	■
	8.52.5	presence or availability of a carer	☐	☐	■
	8.52.6	support needs and arrangements made	☐	☐	■
	8.52.7	other data relevant to the patient's management.	☐	☐	■
8.53		A full discharge summary is available within a specified period or according to the contract specification.	☐	☐	■
8.54		The content and timeliness of discharge summaries are regularly audited.	☐	☐	☐
8.55		The general practitioner receives information on non-urgent cases, which do not require follow-up by the primary health care team, within three weeks of discharge.	☐	☐	◨

INFORMATION

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

Standard 9

The facility has appropriate and accurate information that is easily accessible to users and enables informed decisions to be made.

Comments

Criteria

please tick

		Y	N
	Information for the primary health care team		
9.1	There are efficient systems for recording, reporting and monitoring information.		■
9.2	Information is collected by the primary health care team to achieve objectives or comply with statutory requirements. This includes at least:		■
9.2.1	age/sex of practice population		■
9.2.2	disease		■
9.2.3	immunisation status		◨
9.2.4	child development data		◨
9.2.5	cervical cytology		◨
9.2.6	risk factors		■
9.2.7	death		■
9.2.8	availability of aids, appliances and facilities which could assist patients/ clients living in the community		◨
9.2.9	referral data.		☐
9.3	The following information is kept:		
9.3.1	patient/client contacts		■
9.3.2	activities performed		■
9.3.3	individual care plans		■
9.3.4	discharge summaries		■
9.3.5	case load profile		☐
9.3.6	referrals to other agencies		■
9.3.7	reasons for referral to other agencies		◨
9.3.8	waiting times for assessment and intervention		◨
9.3.9	parent/guardian-held records		☐
9.3.10	patient satisfaction surveys		☐
9.3.11	comments, complaints and follow-up action.		■
9.4	Prescriptions are legible and provide relevant information to enable safe dispensing and state the full name of the patient.		■
9.5	The practice has referral systems.		■

INFORMATION

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

please tick
Y N

Comments

9.6 There are mechanisms for sharing information within the primary health care team which includes access to general practitioners' computers by other health professionals, circulation of relevant reports, circulars and guidelines. ☐☐■

9.7 The effectiveness of these mechanisms is regularly audited to ensure consistent, accurate data recording. ☐☐◨

9.8 Information systems prevent unauthorised access. ☐☐■

9.9 The turnaround time of information enables staff to make day-to-day decisions. ☐☐■

9.10 The relevant returns and information are submitted to the FHSA. ☐☐■

9.11 The primary health care team has access to the child health system of the DHA. ☐☐◨

9.12 Staff maintain confidentiality in accordance with the Data Protection Act 1984. ☐☐■

9.13 Contingency plans are in place to allow continued operation of procedures in the event of computer failure. ☐☐◨

Information for patients/clients

9.14 There is an up-to-date practice leaflet which as a minimum satisfies the GP in his or her terms of service, paragraph 38(b) (see Patient Access to Services in this section). ☐☐■

9.15 The leaflet is made widely available to the public. ☐☐■

9.16 The leaflet includes:

9.16.1 details of service ☐☐■

9.16.2 the policy on accepting patients to and removing patients from the practice list ☐☐◨

9.16.3 the procedure for contacting doctors and other staff out-of-hours. (See out-of-hours visits under Patient Access to Services in this section.) ☐☐◨

9.16.4 bank/public holiday arrangements. ☐☐■

9.17 The members of the primary health care team are readily identified/named. ☐☐◨

9.18 Patients/carers have details of access to staff responsible for the patient's/client's care. ☐☐■

9.19 Primary health care team members carry official, up-to-date identification when visiting patients/clients in the community. ☐☐■

INFORMATION

Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

Comments

please tick

	Y	N

9.20 Staff are trained to provide appropriate information to enquiries. ◨

9.21 Patients/clients and carers are consulted about their information needs. ◨

9.22 Information leaflets on a wide range of clinical and non-clinical subjects (for example, support groups, self-help groups, patient participation groups, respite care services, residential homes, community health council, patient's access to health records) are readily available and in various languages where appropriate. (See also Patient's Rights and Special Needs.) ◨

9.23 Health promotion literature is available to people in their homes, when access to the health facility is a problem (for example, when a person is housebound).

9.24 All written information is assessed by the staff according to an agreed policy on quality which includes at least the following:

- 9.24.1 content
- 9.24.2 philosophy
- 9.24.3 graphics and style
- 9.24.4 readability
- 9.24.5 suitability for target audience
- 9.24.6 the absence of racist or sexist stereotypes
- 9.24.7 cultural appropriateness.

9.25 There is a policy on the use of commercially sponsored materials.

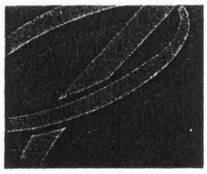
9.26 Health education literature is used in accordance with agreed guidelines.

9.27 There are designated bulletin boards with information about the availability of clinics, screening and services. ◨

9.28 There is a designated member(s) of staff responsible for regularly updating the patient information. ◨

9.29 The material used on notice boards is in accordance with agreed criteria (see 9.24).

9.30 The disease prevention and health promotion programmes and facilities that are offered are advertised. ◨



Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

POLICIES, PROCEDURES AND PROTOCOLS

Standard 10

There are written policies, procedures and protocols which reflect current knowledge and practice and are used to guide staff in their activities. They are the principles of good practice and are consistent with the objectives of the service and relevant regulations.

Comments

Criteria

please tick

		Y	N
10.1	Policies, procedures and protocols are developed by and shared with the primary health care team and relevant patient/support groups.		■
10.2	Staff follow them in all their activities.		■
10.3	There is evidence that in determining policies, procedures and protocols, the relevant influences are considered, both internal and external to the primary health care team (for example current statutory regulations and guidelines and current codes of ethics).		■
	Policies and procedures		
10.4	Policies and procedures are:		
10.4.1	written in a clear and intelligible style		■
10.4.2	determined on the basis of sound information and consultation		■
10.4.3	able to guide those making decisions		■
10.4.4	capable of implementation		■
10.4.5	compiled into a manual		◨
10.4.6	accessible to all staff		■
10.4.7	regularly reviewed; each review is signed and dated.		■
10.5	Policies and procedures are developed for at least the following:		
10.5.1	control of substances hazardous to health (COSHH) regulations		■
10.5.2	health and safety		■
10.5.3	handling suspicious requests for drugs with reference to Misuse of Drugs Act 1971 (Notification of Supply to Addicts)		■
10.5.4	maintaining the cold chain for the immunisation programme		■
10.5.5	emergency care		■
10.5.6	non-accidental injury		■
10.5.7	confidentiality of information in accordance with the Data Protection Act 1984		■
10.5.8	accepting and removing patients from the practice list		◨

POLICIES, PROCEDURES AND PROTOCOLS

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

please tick

	Y	N

Comments

			Y	N
	10.5.9	ongoing care (for example, referral systems within and outside the facility)		■
	10.5.10	civil disturbance		■
	10.5.11	press and television enquiries		■
	10.5.12	support for carers		
10.6	There is a policy for dealing with:			
	10.6.1	accidents/errors/incidents		■
	10.6.2	patient's/client's and/or carer's complaints (in accordance with HC(88)37, facility complaints procedures).		■
10.7	Records are kept which indicate to whom items listed above have been referred and the action which has been taken.			■
10.8	Staff are informed of any policy and procedure changes.			■
	Protocols			
10.9	Written protocols for the management of care are developed by and shared with the primary health care team.			■
10.10	There are agreed protocols which cover the management of at least the following:			
	10.10.1	coronary heart disease screening		■
	10.10.2	blood pressure		■
	10.10.3	well person screening		■
	10.10.4	antenatal/postnatal care		■
	10.10.5	child health and developmental screening		■
	10.10.6	chronic disease		■
	10.10.7	immunisation and vaccination programme		■
	10.10.8	family planning.		■
10.11	Each protocol contains at least the following elements:			
	10.11.1	definition of target/disease group		■
	10.11.2	objective of activity		■
	10.11.3	definition of professional responsibilities, standards and accountability		■
	10.11.4	resource implications and training need		■
	10.11.5	method of contact of target group		■

POLICIES, PROCEDURES AND PROTOCOLS

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

please tick

	Y	N
	☐	☐

Comments

10.11.6	outline of action	☐☐◨■
10.11.7	statement/definition of action criteria	☐☐◨■
10.11.8	agreed method of record keeping and annotation	☐☐◨■
10.11.9	continuing care arrangements	☐☐◨■
10.11.10	system of audit.	☐☐◨■

10.12 Protocols are developed and agreed with local hospitals where appropriate (for example, management of diabetes). ☐☐☐

10.13 Protocols developed:

10.13.1	take into account current clinical opinion	☐☐■
10.13.2	are reviewed at defined periods	☐☐◨■
10.13.3	do not conflict with professional ethics or statutory regulations	☐☐■
10.13.4	are signed and dated	☐☐◨■
10.13.5	are available in each consulting and treatment room.	☐☐☐

10.14 There is a mechanism to ensure that staff involved in the implementation of protocols understand and follow them. ☐☐■

Infection control

10.15 There is a mechanism for addressing and agreeing policies, procedures and protocols relating to infection control (for example, separate waiting area for possibly infectious people, the handling of specimens, the cleaning and sterilising of equipment). ☐☐■

10.16 There is a policy for dealing with injuries resulting from needles or 'sharps' contaminated with blood or body fluids. ☐☐■

10.17 All members of staff, including clerical staff, are offered immunisation against:

10.17.1	hepatitis B	☐☐■
10.17.2	polio	☐☐■
10.17.3	tuberculosis (BCG)	☐☐■
10.17.4	tetanus.	☐☐■

10.18 Notifiable diseases are reported to the consultant responsible for communicable disease control and the public laboratory system. ☐☐■

HEALTH AND SAFETY

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

Standard 11

The facility provides a safe and healthy environment for patients/clients, staff and visitors.

Comments	*Criteria*	*please tick* Y	N
	11.1 Information, training and supervision is available to ensure compliance with Health and Safety at Work Act 1974 and the Management of Health and Safety Information at Work Regulations 1992.		■
	11.2 A poster which outlines the employers' and employees' obligations under the Health and Safety Act 1974 is displayed to comply with the Health and Safety Information for Employees Regulations.		■
	11.3 The risks to the health and safety of the primary health care team and patients are assessed and the necessary preventive and protective measures identified.		■
	11.4 Risks to health from hazardous substances are assessed and control measures employed. Exposure of employees to hazardous substances is monitored, in accordance with the Control of Substances Hazardous to Health (COSHH) Regulations 1988.		■
	11.5 Records are kept of the assessment findings.		■
	11.6 A competent person is appointed to help devise and apply the measures needed to comply with health and safety law.		■
	11.7 Primary health care team members are given explicit information on health and safety matters.		■
	11.8 There is a training programme for health and safety at work (for example handling techniques).		■
	11.9 Where there are five or more employees a written policy on health and safety is developed and reviewed regularly.		■
	11.10 An employer's liability insurance certificate is displayed in a public place.		■
	11.11 All equipment and facilities conform to existing health and safety requirements (CHC(87)3, Health and Safety at Work (in Wales WHC(87)8) and the Workplace (Health, Safety and Welfare) Regulations 1992.		■
	11.12 There are display notices which warn of any hazards.		■
	11.13 There is suitable and sufficient internal and external lighting.		■

HEALTH AND SAFETY

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

please tick

	Y	N

Comments

11.14	The facility is maintained at a suitable temperature (above 16°C).			■
11.15	There is adequate ventilation.			■
11.16	There is a first aid box, including eye-wash equipment, which is readily accessible within the facility.			■
11.17	Waste is disposed of safely, particularly clinical waste and 'sharps'.			■
11.18	There is a separate system for safe disposal of high risk contaminated material in accordance with the special regulations and duty of care under The Environmental Protection Act 1990 (for example, soiled dressings, napkins, blood contaminated materials, spatulas and so on).			■
11.19	There is a system for safe disposal of human tissue.			■
11.20	Provision is made for the safe storage of drugs and chemicals in accordance with the Medicines Act 1968 and for needles and syringes.			■
11.21	Provision is made for the safe storage of employees' personal effects.			◨
11.22	Crisis alarms are available for personnel where appropriate.			◨
11.23	Records are held of any accidents/dangerous occurrences (for example, HMSO Book F2059 and accident report forms 2508).			■
11.24	Workstations are analysed to assess the risk to the health and safety of the user. A record is kept of this assessment.			■
11.25	Workstations that are put into service on or after 1 January 1993 and new components and changes to existing stations comply with Health and Safety Regulations 1992.			■
11.26	Workstations are ergonomically suitable for the worker. A suitable chair is provided.			■
11.27	Display screen equipment users have adequate rest breaks from the screen.			■
11.28	Eye sight tests are offered to staff before they become users of display screen equipment, at regular intervals thereafter, and when a user has visual difficulties related to display screen equipment use.			■
11.29	All display screen equipment users are given training on its use before starting.			■
11.30	Health and safety training is given whenever the organisation of the workstation is modified.			■

HEALTH AND SAFETY

Weighting ☐

Essential practice ■

Good practice ◧

Desirable practice ☐

please tick

	Y	N

Comments

Fire safety

11.31 The premises have a fire certificate or have written evidence indicating the approval of the local authority fire officer. ☐ ☐ ■

11.32 There is a nominated fire officer for the facility. ☐ ☐ ■

11.33 Staff receive regular (at least two yearly) fire training which includes facility evacuation. Records of attendance are kept. ☐ ☐ ■

11.34 Fire exits are displayed and are kept free of obstruction. ☐ ☐ ■

11.35 There is a fire alarm system which is tested and serviced regularly. ☐ ☐ ■

11.36 Fire extinguishers and smoke detectors are placed throughout the facility as recommended by the local authority fire officer and these are on a maintenance contract. ☐ ☐ ■

CLINIC ORGANISATION

Weighting ☐
Essential practice ■
Good practice ◧
Desirable practice ☐

Standard 12

Clinics are organised to provide specialised advice, support and services to a target population for specific, identified health needs.

Comments	*Criteria*	please tick Y	N
	12.1 There are written, agreed criteria for the introduction of a new clinic.		■
	12.2 These criteria are developed by appropriate members of the primary health care team.		■
	12.3 The criteria include at least the following:		
	12.3.1 identification of the health needs of the population served		■
	12.3.2 identification of the target population		■
	12.3.3 determination that the clinic is the most effective method of meeting the health need.		■
	12.4 The views of patients/clients are actively sought.		■
	12.5 There is a mechanism to encourage members of the primary health care team to propose suggestions for new clinics.		■
	12.6 When setting up a clinic, there is evidence that at least the following have been considered:		■
	12.6.1 location		■
	12.6.2 staffing		■
	12.6.3 protected staff time		■
	12.6.4 staff training if required		■
	12.6.5 equipment		■
	12.6.6 timing and frequency appropriate to the client group		■
	12.6.7 advertising		■
	12.6.8 implications for other members of the primary health care team.		■
	12.7 Health promotion activities are based on up to date and validated research.		■
	12.8 Clear objectives and agreed impact/outcome measures are developed for each health activity.		■
	12.9 There are policies, procedures and protocols for the clinic.		■
	12.10 There is a mechanism to ensure that all staff are aware of the clinics.		■
	12.11 There is a mechanism to ensure that patients/clients are aware of the clinics.		■

CLINIC ORGANISATION

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

please tick
Y N

Comments

Management and staffing

12.12 There is a named person with responsibility for coordinating/managing the clinics (this need not necessarily be the clinic practitioner). ☐☐■

12.13 The clinic practitioner is responsible for at least the following:

12.13.1 maintaining attendance records ☐☐■

12.13.2 staffing arrangements ☐☐■

12.13.3 maintaining stock levels ☐☐■

12.13.4 ensuring that the equipment is appropriate to the clinic requirements ☐☐■

12.13.5 maintaining equipment. ☐☐■

12.14 The management arrangements for each clinic are clearly defined and communicated to the members of the primary health care team. ☐☐◨

12.15 There is a designated individual(s) to act in the absence of the person managing the clinic. ☐☐■

12.16 Staff are educated, trained/qualified to run their clinic. ☐☐■

12.17 There are written contracts for all health professionals using the clinic facilities (for example, hospital consultants, complementary therapists). ☐☐■

12.18 There are written agreements covering clinics that are organised between two agencies (for example, general practitioners and health authority) which clearly specify the roles and responsibilities of each party. ☐☐■

12.19 The staffing is organised so that health promotion advice and clinics are able to run uninterrupted. ☐☐◨

Referral and appointment systems

12.20 There are agreed, written referral criteria for each clinic. ☐☐◨

12.21 There is a mechanism to ensure that relevant members of the primary health care team are aware of the referral criteria. ☐☐◨

12.22 There is a mechanism to ensure that the patient/client is aware of and understands the referral criteria to enable them to make informed choices. ☐☐◨

12.23 The timing and the frequency of the clinic takes into account the needs of the particular patient/client group. ☐☐◨

12.24 There is a system for the booking of all clinics which is known to all staff. ☐☐◨

CLINIC ORGANISATION

Weighting

Essential practice

Good practice

Desirable practice

Comments

please tick

	Y	N
12.25 There is allocated time for staff running clinics.		
12.26 There is an up-to-date list of all clinics scheduled which includes the date, the name of the person holding the clinic and the nature of the clinic.		
12.27 The patient receives written details about the clinic in advance of the attendance. This includes:		
12.27.1 appointment times and dates		
12.27.2 information about the nature of the clinic		
12.27.3 details about how to cancel the appointment		
12.27.4 responsibility prior to attendance (for examples, samples, fasting)		
12.27.5 what to expect (for example, whether a blood test will be performed).		
12.28 There are clear instructions, prominently displayed which advise the patient what to do on arrival.		
12.29 There is an attendance list with appointment times for each clinic.		
12.30 There is a mechanism to ensure that the patient/client is informed of increased waiting time.		
12.31 Individual clinic waiting times are monitored and results communicated to the practitioner.		
12.32 There is a mechanism to ensure that persistent overrunning of appointment times is addressed.		
12.33 The effectiveness of clinics is evaluated. (See Audit and Quality within this section).		
12.34 Regular minuted meetings are held to keep all staff informed of clinic activity.		

NEAR PATIENT TESTING

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

Standard 13

Near patient testing conforms to protocols developed with an accredited pathology department. The monitoring of near patient testing is the responsibility of a designated senior medical laboratory scientific officer.

Comments

Criteria

please tick

		Y	N
13.1	An accredited pathology laboratory is involved in the setting up and monitoring of any near patient testing regime (for example, operator training, quality control and machine calibration).		■
13.2	Laboratory-based quality control schemes are used.		■
13.3	Diagnostic results obtained are made available to the patient according to an agreed policy (to ensure appropriate interpretation and decisions taken about treatment).		■
13.4	All results are recorded and kept in the health record in a form that identifies the source.		■

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

PATIENT ACCESS TO SERVICES

Standard 14

There are systems enabling patients/clients to gain access to services offered by the facility.

(See also Patient's/Client's Rights and Special Needs, Mission and Objectives in this section, and the sub-section for Receptionists/Administrative Staff in Primary Health Care Team Members section.)

Comments	*Criteria*	please tick Y N
	Appointments	
	14.1 Where there is an appointment system it is individualised and not block booked.	☐☐◨■
	14.2 Appointment systems/surgery hours have a degree of flexibility to ensure access to the facility for patients/clients.	☐☐■
	14.3 There are clear guidelines on the maximum length of time a patient/client should wait for a routine appointment.	☐☐◨■
	14.4 There is a system for informing and reminding the patient/client of appointments.	☐☐☐
	14.5 There is a written procedure for dealing with urgent appointments which is understood and followed by staff and patients/clients.	☐☐◨■
	14.6 There is a system for responding to telephone enquiries promptly.	☐☐■
	14.7 There is a written policy for home visits which is understood by staff and patients/clients.	☐☐◨■
	14.8 The roles of each member of the team are identified and understood by patients/clients/carers.	☐☐◨■
	14.9 There is a practice leaflet available to the patient/client which as a minimum includes the information listed in Schedule 1D of the Regulations in England and Wales and Schedule 1, Part C in Scotland (see Appendix 3).	☐☐■
	14.10 The patient/client is given the opportunity to see the health care professional of their choice at a mutually convenient time, within the times specified in the facility leaflet.	☐☐■
	14.11 There is a list of patients/clients attending surgery/clinic available to the practitioner, including appointment times.	☐☐◨■
	14.12 There is a procedure to ensure that the records of patients attending appointments are made available (see also the Health Records).	☐☐■
	14.13 The patients/clients are aware of the procedure if they arrive late for an appointment	☐☐☐

PATIENT ACCESS TO SERVICES

Weighting

Essential practice ■

Good practice ◧

Desirable practice

Comments

		please tick Y	N
14.14	The patient/client awaiting consultation or treatment is made aware of any delays and given the opportunity to make other arrangements.		■
14.15	The patient/client/carer is given clear instructions on the collection and handling of specimens.		◧
	Out-of-hours visits		
14.16	There is a procedure for contacting staff making out-of-hours visits (for example, a bleep or mobile telephone).		■
14.17	There is a mechanism to ensure that the whereabouts of staff making out-of-hours visits is known (for example, location of visit, purpose and an estimate of the time involved).		■
14.18	Where a deputising or cooperative arrangement exists for out-of-hours visits, there is a procedure for accessing patient records. (See Access to Records in the Health Records section).		◧

Weighting ☐
Essential practice ■
Good practice ◧
Desirable practice ☐

PATIENT/CLIENT CARE

Standard 15

There is a systematic and individualised approach to patient/client care. Patients/clients receive treatment from appropriately trained staff.

Comments	*Criteria*	please tick Y	N
		☐	☐
	15.1 Appropriately trained staff are responsible for the assessment, planning and evaluation of patient/client care.	☐	■
	15.2 The delivery of care is in accordance with agreed standards for clinical practice.	☐	■
	15.3 Staff work in partnership with carers of sick, handicapped and elderly people and provide them with practical and emotional support and education.	☐	◧
	15.4 Maximum use is made of opportunistic health education which is recorded in the patient's/client's record.	☐	◧
	15.5 Staff work with other health professionals and statutory and voluntary agencies to provide a comprehensive, integrated network of care.	☐	◧
	15.6 The health care provided reflects rehabilitation principles which aim to maintain or improve the level of independence of the patient living at home.	☐	◧
	15.7 Palliative care is provided for those with terminal illness which incorporates the skills of the primary health care teams, as well as the support of specialised nursing services, for example, Macmillan or Marie Curie nurses.	☐	◧
	15.8 The general practitioner who has seen the patient is professionally accountable for the clinical care of the patient.	☐	■
	15.9 A named, registered member of staff is responsible for each patient/client referred to his or her care.	☐	■
	15.10 A treatment/care plan is developed in collaboration with relevant primary health care professionals in partnership with the patient/client and carer/advocate which takes into account the patient's/client's beliefs and ability to comply with the regime.	☐	■
	15.11 The treatment/care plan is written in the patient's/client's health record.	☐	■
	15.12 This includes:		
	15.12.1 consultation with the patient/carer	☐	■
	15.12.2 family/carers involved	☐	◧

PATIENT/CLIENT CARE

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

Comments

		please tick Y	N
15.12.3	coordination with health care professionals, social services and other organisations	☐	☐
15.12.4	a statement of the patient's/client's needs	☐	■
15.12.5	expected outcomes	◨	☐
15.12.6	details of specific care given	☐	■
15.12.7	health education including self-care and health promotion	◨	☐
15.12.8	preparation for discharge or ongoing contact	◨	☐
15.12.9	continuing assessment and evaluation of needs	◨	☐
15.12.10	name, signature and designation of the professional responsible.	■	☐
15.13	Relatives are informed of progress and treatment, with the patient's/client's agreement.	◨	☐
15.14	Members of the primary health care team share information which is relevant to the management of the patient/client and involve other organisations as appropriate.	◨	☐
15.15	Relevant information on the process and outcome of intervention is sent to the GP or other source of referral.	■	☐
15.16	Members of the primary health care team participate in reviews of patients/clients in their care.	■	☐
15.17	Staff are involved in research/audit and use the results to effect change/improve practice.	☐	☐
15.18	Clinical advice is only given by suitably trained staff according to the policy of the facility.	■	☐

Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

COMMUNITY CARE ASSESSMENTS

Standard 16

The needs of patients/clients in the community are identified and the service required is delivered by the appropriate organisation.

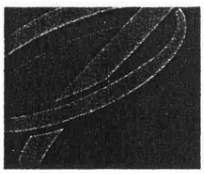
(See also the sub-section for Social Services in Primary Health Care Team Members section.)

Comments

Criteria

please tick

		Y	N
16.1	The facility, DHA, FHSA and social services department take part in joint planning, commissioning and joint activity in assessments, individual care planning, service delivery and review.	☐	■
16.2	When a referral for an assessment is made, the resulting assessment documentation is clearly written, agreed and shared between clients, carers, social services, the primary health care team and the hospital if they are the referrer.	☐	■
16.3	There are written guidelines to assist staff undertaking assessments.	☐	■
16.4	These include:		
16.4.1	a clear specification of the roles of the different staff groups/agencies	☐	◨
16.4.2	the process for referral to the local authority if an assessment of need is requested	☐	■
16.4.3	the process for reporting back to the referrer	☐	■
16.4.4	financial responsibility	☐	◨
16.4.5	information for patients/clients and carers and users about their entitlement to services and benefits and choices available.	☐	◨
16.4.6	arrangements in place for those: (a) leaving long-term care (b) leaving hospital (c) admitted to homes, convalescence and respite care.	☐	■
16.5	There is a mechanism for monitoring the level of referrals.	☐	◨
16.6	A system of recording unmet need is in place which is used to inform the purchasing and planning of services.	☐	◨



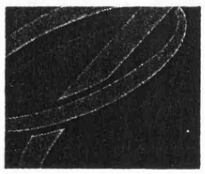
Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

BUILDINGS, FACILITIES AND EQUIPMENT

Standard 17

The environment, facilities and equipment are maintained to a standard which ensures the primary health care team achieves safe, efficient and effective care for all patients/clients.

Comments	*Criteria*	please tick Y N
	Buildings and facilities	
	17.1 The space available is consistent with the relevant professional accommodation guidelines (General Medical Practice Premises, Health Building Note 46, London, HMSO, 1991; and Design Guide, Health Centres in Scotland, Edinburgh, HMSO, 1973).	■
	17.2 The premises meet the standards outlined in the NHS Statement of Fees and Allowances (paragraph 51.10).	■
	17.3 The location and purpose of the facility is clearly indicated.	◨
	17.4 There are signs to facilitate the patient's/client's movement around the building.	◨
	17.5 External and internal walkways are well-lit and even.	■
	17.6 Parking is available for staff and the patient/client close to the facility.	◨
	17.7 There is covered storage space for prams.	☐
	17.8 There is safe access for the delivery of goods.	◨
	17.9 The building is fitted with secure locks and an intruder alarm system.	◨
	17.10 There is a key-holder available for the police to contact should the alarm go off.	◨
	17.11 The building is covered by appropriate insurance policies.	◨
	17.12 There is a regular maintenance programme for redecoration and repairs.	◨
	17.13 There is a housekeeping system to ensure regular removal of waste, dirt and refuse.	◨
	17.14 Glass swing doors are made of safety glass.	■
	17.15 There is storage space available.	☐
	17.16 There is office space available for staff.	◨
	17.17 Workstations are arranged to provide adequate space for movement.	■
	17.18 Wires or leads are secured.	■
	17.19 Each health care professional has access to a private room for confidential consultations.	■
	17.20 There are designated treatment areas.	■



BUILDINGS, FACILITIES AND EQUIPMENT

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

please tick

	Y	N

Comments

17.21 There is a staff rest room/cloakroom with adequate storage facilities. ◨

17.22 Clean toilet/washroom facilities are available, and a separate staff toilet. ◨

17.23 Toilet facilities are accessible to those with physical disabilities. ◨

17.24 Kitchen facilities are available for staff to make drinks and prepare snacks. ◨

17.25 Drinking water is available and labelled accordingly. ■

17.26 There is a facility for secure storage of:

17.26.1 controlled drugs as stated in the Misuse of Drugs Act 1971 ■

17.26.2 drugs and vaccines ■

17.26.3 needles and syringes ■

17.26.4 patient records ■

17.26.5 prescription forms ■

17.26.6 petty cash ◨

17.26.7 cleaning materials. ■

(See sub-section for Pharmacists in Primary Health Care Team Members section.)

17.27 Precautions are taken to ensure the personal safety of staff at all times. ◨

17.28 There are written procedures for dealing with emergency situations including:

17.28.1 interruption to power and water supplies ■

17.28.2 breakdown in heating systems ◨

17.28.3 interruption to telephone facilities. ■

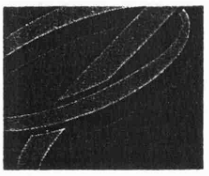
17.29 A no-smoking policy is in operation throughout the building. ◨

Waiting areas

17.30 The waiting areas are welcoming and have facilities which are suitable for the population served. ◨

17.31 There are enough seats to accommodate the maximum number of waiting patients/clients in accordance with the Statement of Fees and Allowances. ◨

17.32 There are facilities for disabled persons (for example, car park space, wheelchair access, high chairs in the waiting room). ◨



BUILDINGS, FACILITIES AND EQUIPMENT

Weighting ☐
Essential practice ■
Good practice ◧
Desirable practice ☐

please tick
Y N

Comments

17.33 Consideration is given to special safety precautions to safeguard children (for example, covers on plugs, lockable gates at the top of staircases). ☐☐■

17.34 There are areas for confidential consultation outside appointments (for example, for distressed patient/carers) including areas for reception staff to obtain and give confidential information. ☐☐■

17.35 The waiting area has:

17.35.1 clean toilet facilities ☐☐■

17.35.2 customer information leaflets (see Information for Patients/Clients) ☐☐◧

17.35.3 information on staff, services, appointment systems, dispensing, and so on ☐☐◧

17.35.4 health promotion material ☐☐◧

17.35.5 a notice board which is regularly updated ☐☐◧

17.35.6 safe play facilities/area suitable for children (conforming to British Safety Standards) ☐☐◧

17.35.7 access to facilities for nursing mothers ☐☐◧

17.35.8 public transport details, including telephone numbers of local taxi services ☐☐◧

17.35.9 a variety of suitable, up-to-date reading material for adults and children. ☐☐☐

17.36 There is a named person responsible for checking each area (for example, health promotion materials, reading material, children's toys, maintenance of equipment). ☐☐◧

Consulting rooms

17.37 The location of the consulting rooms/clinics is clearly and appropriately signposted. ☐☐◧

17.38 There is disabled access to consulting rooms. ☐☐◧

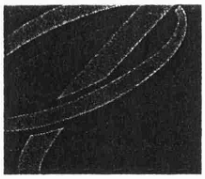
17.39 There is a name on every consulting room within the facility. ☐☐◧

17.40 Each consulting room provides complete visual and audible privacy. ☐☐■

17.41 The consulting rooms are warm, lit, ventilated and clean. ☐☐■

17.42 The consulting rooms contain at least the following:

17.42.1 screens or curtains to ensure additional privacy ☐☐◧



BUILDINGS, FACILITIES AND EQUIPMENT

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

Comments

		please tick Y	N
17.42.2	chairs for the patient/client and relatives		■
17.42.3	toys/books to amuse children during consultations		◨
17.42.4	hand washing facilities which comply with health and safety/infection control policies		■
17.42.5	equipment which is appropriate to the consultation.		■

Equipment

17.43	The equipment available is appropriate for the care/services provided.		■
17.44	Supplies are received from a recognised supplier.		◨
17.45	The equipment available includes at least the following:		
17.45.1	weighing scales		■
17.45.2	ECG machine		☐
17.45.3	autoclave		■
17.45.4	refrigerator (with separate compartment for the storage of vaccines) which is locked when not in use		■
17.45.5	cool boxes		■
17.45.6	height measures		■
17.45.7	emergency resuscitation equipment		■
17.45.8	telephones		■
17.45.9	computer technology		◨
17.45.10	personal attack alarms		☐
17.45.11	page system for staff.		☐
17.46	There is a telephone system which meets the demands of staff and patients.		■
17.47	The telephone system allows direct access to key areas (for example, reception, dispensary, health visitors' office).		☐
17.48	There is a stock control system and designated persons in charge who have responsibility for ordering and controlling stock. This includes:		◨
17.48.1	equipment		◨
17.48.2	forms		◨
17.48.3	stationery		◨
17.48.4	drugs		■
17.48.5	vaccines.		■

BUILDINGS, FACILITIES AND EQUIPMENT

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

please tick

	Y	N
	☐	☐

Comments

17.49 Vaccines are stored at the correct temperature 2-4°C (or 2-8°C if oral polio vaccine is used within one month) and steps taken to ensure that they are only removed from the refrigerator when needed. ☐ ☐ ■

17.50 There is a designated person to take a daily recording (maximum/minimum) of the drug refrigerator temperature. ☐ ☐ ■

17.51 There are written records of:

17.51.1 defrosting ☐ ☐ ☐

17.51.2 maintenance to include seals and hinges. ☐ ☐ ■

17.52 A drug refrigerator is not used for the storage of milk and food. ☐ ☐ ■

17.53 Emergency resuscitation equipment is checked regularly. This is recorded. ☐ ☐ ■

17.54 All equipment is operated by staff appropriately trained. ☐ ☐ ■

17.55 There are training sessions for updating staff on use of equipment. ☐ ☐ ■

17.56 All equipment is checked regularly according to manufacturer's instructions to ensure that it is in accurate working order. Records of these checks are kept. ☐ ☐ ■

17.57 Essential equipment is covered by a 24-hour service contract. ☐ ☐ ■

17.58 All equipment and facilities conform to existing health and safety regulations. ☐ ☐ ■

17.59 There is a planned programme of upgrading and replacement of equipment. ☐ ☐ ◨

AUDIT AND QUALITY

Weighting
Essential practice ■
Good practice ◨
Desirable practice

Standard 18

The primary health care team ensures the provision of high quality care by its involvement in evaluation activities in line with the quality management plan and mission statement for the facility.

Comments

Criteria

please tick
Y N

18.1 The audit/evaluation and quality management plan is developed and agreed by the primary health care team. ◨

18.2 There is a strategy/structure to support the implementation of the audit/evaluation and quality management plan. ◨

18.3 The quality management plan reflects current guidelines and practices. ◨

18.4 The quality management plan includes the development of locally-based standards which build in the users' perspective. ◨

18.5 Locally-based standards are specific, measurable, agreed, realistic, timely and published. ◨

18.6 The primary health care team is the forum for the promotion and discussion of multidisciplinary audit and evaluation. ◨

18.7 The evaluation activities include the following elements: ■

Monitoring (the routine collection of information and statistics about health activities, uptake, compliance and practice population details)

Assessment (the periodic assessment of the information to identify health needs and improve the service)

Action (is taken on identified improvements and documented)

Evaluation (the effectiveness of action taken is evaluated to ensure long-term improvements)

Feedback (the results of these activities are written and circulated to all members of the primary health care team and to patients/clients).

18.8 The audit/evaluation and quality management plan includes at least the following:

18.8.1 collection of statistics to effect change (health profiles and health needs) including data on: ■

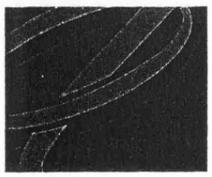
(a) age
(b) disability
(c) ethnicity
(d) gender

AUDIT AND QUALITY

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

Comments

		please tick Y	N
18.8.2	review of services in comparison with the written primary health care team objectives		
18.8.3	service user satisfaction with the process and outcome of intervention		
18.8.4	service uptake by members of the population		■
18.8.5	assessing the degree to which contractual targets have been met		■
18.8.6	monitoring of the secondary care service which includes the views of the patient/client		
18.8.7	accurate health care recording		■
18.8.9	identification of problem areas/risk factors		■
18.8.10	identification of unmet need		■
18.8.11	acute and chronic disease management		■
18.8.12	staff training and development		■
18.8.13	evaluation of professional practice		■
18.8.14	evaluation of clinical performance where appropriate through multidisciplinary audit		■
18.8.15	evaluation of prescribing and PACT data		■
18.8.16	evaluation of joint care provision with external agencies		
18.8.17	evaluation of use of resources (for example, type of stock, amount and so on).		
18.9	There is evidence of ongoing review of the audit cycle by the primary health care team.		■
18.10	Confidentiality is maintained throughout evaluation proceedings.		■
18.11	Staff participate in the formulation of plans for improvement.		■
18.12	Minutes of evaluation meetings are kept which detail conclusions, recommendations, action taken and results of action. These are available to all staff.		
18.13	The deficiencies identified by audit and resulting recommendations are incorporated into the business/action plan for the service.		■
18.14	The service publishes an annual report which satisfies 1E of the New Regulations in England and Wales and Schedule 1, part 1E in Scotland and details performance, activities and future plans (see Appendix 4).		■
18.15	The annual report is available to other agencies and clients.		■



Weighting ☐

Essential practice ■

Good practice ◧

Desirable practice ☐

COMPLEMENTARY THERAPISTS

A government statement on 3 December 1991 established that a general practitioner can employ a complementary therapist within his/her practice to offer NHS treatment, provided that the general practitioner remains clinically accountable for the patient

The following criteria are specific to all complementary therapists and are supplementary to those relating to the core organisational standards and criteria.

Comments

please tick

	Y	N
3 OBJECTIVES		
3.1 The objectives include at least the following:		
3.1.1 ensuring that the complementary therapy is understood by members of the primary health care team and patients/clients	◧	
3.1.2 providing and maintaining high standards of care through analysis, review and evaluation of the service.	◧	
6 MANAGEMENT AND STAFFING		
6.1 The complementary therapist holds a recognised qualification and has experience appropriate to his or her therapy.	■	
6.2 The complementary therapist is a member of professional bodies such as the Council for Complementary and Alternative Medicine (CCAM), the General Council and Register of Osteopaths (GCRO) and the British Chiropractic Association (BCA) or the British Complementary Medicine Association, and abides by their code of conduct and guidance to practitioners.	◧	
6.3 The complementary therapist uses titles or descriptions according to their qualifications.	■	
6.4 All complementary therapists are insured to practice. The insurance policy must state provision for public and employed (if personnel are employed) liability and indemnity as well as the provision for professional treatments.	■	
8 COMMUNICATION		
Internal		
8.1 All members of the primary health care team are informed of the role of complementary therapists and their way of working.		
8.2 Complementary therapists receive sufficient medical details of the patients referred to them by medical practitioners.	◧	
External		
8.3 Advertising is confined to drawing attention to the therapy available, the qualification of the practitioner and details of access to treatment/therapy.	■	

Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

COMPLEMENTARY THERAPISTS

Comments

please tick

	Y	N
10 POLICIES, PROCEDURES AND PROTOCOLS	☐	☐
10.1 Complementary therapists act in accordance with legislation affecting complementary medicine and current professional guidelines.	☐	■
10.2 The scope and limitation of the responsibilities and activities of complementary therapists are clearly defined.	☐	◨
10.3 There are written protocols which detail the procedures involved in treatments, the likely content and length of consultation and the number of consultations. This information is shared with patients/clients.	☐	☐
10.4 If a notifiable disease is clinically identified, the general practitioner is informed.	☐	■
15 PATIENT/CLIENT CARE		
15.1 The delivery of care is in accordance with agreed professional standards for the therapy practice, where in place.	☐	◨
15.2 There are clear and comprehensive records of treatments. (See Health Records section.)	☐	◨
15.3 There are agreed lines of referral to the complementary therapist.	☐	◨
15.4 New patients/clients are asked what medical advice they have received.	☐	◨
15.5 When a complementary therapist discovers a clinical disorder, the patient/client is advised to see the general practitioner.	☐	◨
15.6 When advised to see a general practitioner, the advice is recorded.	☐	◨
15.7 A patient's/client's expressed consent is sought prior to a third party being present during the course of a consultation.	☐	■
15.8 Unless they have the appropriate qualification, complementary therapists do not:		
15.8.1 attend women in childbirth or treat them for ten days thereafter	☐	■
15.8.2 practice dentistry	☐	■
15.8.3 treat venereal disease as defined in the 1917 Act	☐	■
15.8.4 use manipulation or vigorous massage	☐	■
15.8.5 prescribe remedies classified as prescription only in the Medicines Act or described under other legislation.	☐	■
15.9 The complementary therapist advises the parent/guardian to seek 'medical aid' for a child under the age of 16 years.	☐	◨

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

please tick

	Y	N
	☐	☐

Comments

15.10 The complementary therapist secures a signed statement from a parent or guardian who refuses to seek medical aid as defined under the law. ☐ ☐ ■

17 FACILITIES AND EQUIPMENT

17.1 The working conditions are suitable for the practice of the therapy, meeting all national or European legislation covering working practices. They meet the minimum standards set by the statutory-based professional organisation. ☐ ☐ ■

Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

DENTAL PRACTITIONERS

The following criteria are specific to dental practitioners and are supplementary to those relating to the core organisational standards and criteria.

Dental services within the facility can be provided by a general dental practitioner (salaried or independent contractor) or community dental officer.

The community dental service provides comprehensive dental care to patients of all ages who are unable to obtain their routine care from the general service; - it is a complementary service. This includes children and adults with special needs, that is, requiring particular time, facilities and expertise to enable them to receive dental care.

Comments

please tick

	Y	N

3 OBJECTIVES

3.1 The objectives include at least the following:

3.1.1 providing a regular and emergency service for the local population ◨

3.1.2 providing effective, accessible, acceptable and appropriate treatment/service for those identified as having special needs or who are unable to obtain treatment elsewhere. ☐

6 MANAGEMENT AND STAFFING

6.1 Where there is a clinical service head (that is, within the community dental service) or a general dental practitioner, his or her responsibilities include but are not limited to:

6.1.1 administrative arrangements within the service ◨

6.1.2 ensuring that the quality and appropriateness of dental care provided are monitored and evaluated and that all staff participate in audit (medical and clinical) ◨

6.1.3 fulfilling the role of a salaried practitioner within the general dental service ■

6.1.4 responding to the FHSA where appropriate. ◨

6.2 The dental department staff are represented on interdepartmental committees and are involved in decision making on issues related to the provision of dental services. ◨

6.3 The department ensures the following:

6.3.1 the availability and maintenance of equipment, drugs and agents required for safe dental care and the related techniques essential to the proper care of the patient and safety of the staff ■

Comments

			please tick Y	N
	6.3.2	the preparation of records documenting the conduct of care, in a form which enables the evaluation of the quality of care.		
	6.3.3	arrangements and staff availability for emergency cover		
	6.3.4	the meeting of contractual commitments by all dental staff in their work programmes.		
		10 POLICIES, PROCEDURES AND PROTOCOLS		
10.1		Policies and procedures refer to at least the following:		
	10.1.1	initial approach and contacts		
	10.1.2	dental records		
	10.1.3	referrals and transfer		
	10.1.4	consent		
	10.1.5	capitation, continuing care, episodes of care		
	10.1.6	screening and assessment programmes		
	10.1.7	general anaesthesia		
	10.1.8	adverse drug reaction reporting		
	10.1.9	drug defect reporting		
	10.1.10	handling medical product recalls		
	10.1.11	sedation techniques		
	10.1.12	cross-infection		
	10.1.13	high risk patients		
	10.1.14	emergency care		
	10.1.15	domiciliary care		
	10.1.16	recall and review		
	10.1.17	dental health promotion		
	10.1.18	opportunistic screening programmes.		
10.2		If anaesthesia or sedation services are provided within the dental department, policies and procedures include as a minimum that:		
	10.2.1	the pre-anaesthetic assessment of each patient is performed by the anaesthetist who is administering the anaesthetic. Where this is not possible it is done by another anaesthetist who documents the findings and communicates them to the administering anaesthetist		

DENTAL PRACTITIONERS

please tick

	Y	N

Comments

	10.2.2	there is a timely assessment, enabling satisfactory measures to be taken to prepare the patient for anaesthesia and to perform any additional investigations which may be warranted by the patient's condition		■
	10.2.3	there is evidence that the patient has been provided with information to give informed consent to the procedure		■
	10.2.4	the special requirements of children are addressed		■
	10.2.5	the dentist performing the procedure is available before the anaesthetist commences		■
	10.2.6	anaesthesia is commenced and terminated only in the presence of a member of the staff whose sole duty is to assist the anaesthetist until such time as the latter indicates that assistance is no longer required		■
	10.2.7	appropriate recovery staff are available until the patient has recovered from the anaesthetic		■
	10.2.8	an anaesthetist is present until the patient has recovered from the anaesthetic		■
	10.2.9	there are pre-use safety checks for all anaesthetic machines and monitoring equipment.		■
10.3	There are written health and safety guidelines which include:			
	10.3.1	anaesthetic equipment hazards		■
	10.3.2	controlled drug handling		■
	10.3.3	drug errors		■
	10.3.4	electrical hazards		■
	10.3.5	evaluation and testing of equipment		■
	10.3.6	fire and explosion		■
	10.3.7	instructions on use and maintenance of instruments		■
	10.3.8	notification of biohazards		■
	10.3.9	patient positioning		■
	10.3.10	patient transport		■
	10.3.11	radiation hazards		■
	10.3.12	'sharps' handling and disposal		■

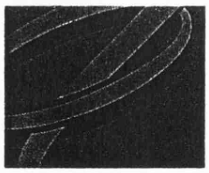
DENTAL PRACTITIONERS

Comments

		please tick Y	N
10.3.13	use of scavenging equipment for removal of various vapours and waste anaesthetic gases.		■

17 FACILITIES AND EQUIPMENT

17.1	Where radiographic equipment is used, this conforms with the regulations on ionising radiations.		■
17.2	Appropriate shielding and protective clothing is worn in the presence of biohazards or radiographic equipment which conforms with the regulations on ionising radiations.		■
17.3	Where general anaesthetic or sedation is given, the Poswillo recommendations are followed and include that:		
17.3.1	the design of the anaesthetic service provides space for the reception, anaesthesia, surgery, recovery and observation of patients		■
17.3.2	suitably equipped accommodation is provided for the patient awaiting surgery, separate from the operating room and access corridors		■
17.3.3	the facilities used for induction of anaesthesia are designed and equipped for safe practice following the guidelines set by the Association of Anaesthetists and/or the Royal College of Anaesthetists		■
17.3.4	scavenging of waste anaesthetic gases and vapours is in accordance with HC(76)38		■
17.3.5	the storage of all portable gas cylinders meets the health and safety regulations		■
17.3.6	areas in which anaesthetics are administered comply with information contained in appropriate circulars		■
17.3.7	there is an equipped and staffed area for recovery from anaesthesia which in general complies with guidelines issued by the Association of Anaesthetists and/or Royal College of Anaesthetists		■
17.3.8	emergency resuscitation equipment is easily accessible from every section of the facility and the procedure for summoning assistance is known by all staff		■
17.3.9	emergency resuscitation equipment is checked regularly. This is recorded.		■
17.4	All documents referred to in these criteria are available in the surgery.		◨



Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

GENERAL PRACTITIONERS

The following criteria are specific to general practitioners and are supplementary to those relating to the core organisational standards and criteria.

Comments

		please tick Y	N
	3 OBJECTIVES		
3.1	The objectives include at least the following:		
3.1.1	developing a multidisciplinary team approach to meet the health care needs of the local population		■
3.1.2	providing and maintaining high standards of care by participating in multidisciplinary analysis, review and audit of service		■
3.1.3	agreeing prescribing intentions.		◨
	6 MANAGEMENT		
6.1	The roles and responsibilities of the general practitioners regarding the management of the practice are clearly identified.		◨
6.2	There is a duty rota.		◨
	7 STAFF DEVELOPMENT AND EDUCATION		
7.1	Continuing medical education is undertaken annually.		■
	8 COMMUNICATION		
8.1	There are written agreements developed by the partners which ensure that care for patients is covered at all times.		■
8.2	The partners hold regular meetings to discuss business planning and to review their service.		◨
8.3	Minutes of these meetings are taken.		◨
	10 POLICIES, PROCEDURES AND PROTOCOLS		
10.1	General practitioners are actively involved in the formulation of medical policies, procedures and protocols.		◨
10.2	Policies and procedures are developed for at least the following:		
10.2.1	maximum distance for home visits		■
10.2.2	communicable diseases		■
10.2.3	repeat prescriptions (including review times)		◨
10.2.4	notifiable drug addiction		■

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

Comments

			please tick Y	N
			☐	☐
	10.2.5	adverse drug reaction reporting	☐	◨
	10.2.6	drug defect reporting	☐	◨
	10.2.7	medical product recalls	☐	■
	10.2.8	practice prescribing.	☐	◨
10.3	There is an internally agreed drug formulary.		☐	☐
10.4	The patient is advised when medication can be obtained more cheaply directly from the chemist rather than prescription.		☐	◨

17 FACILITIES AND EQUIPMENT

17.1	There is a policy covering the equipment required for the general practitioner's emergency bag.		☐	■

Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

NURSES

The following criteria are specific to all nurses; that is, practice nurses, health visitors, district nurses, midwives, community psychiatric nurses, Macmillan, Marie Curie and other specialist nurses. These criteria are supplementary to those relating to the core organisational standards and criteria.

please tick

	Y	N
6 MANAGEMENT AND STAFFING	☐	☐
6.1 Nurses act in accordance with legislation affecting nursing practice and current professional guidelines (UKCC).	☐	■
7 STAFF DEVELOPMENT AND EDUCATION		
7.1 Nurses identify their training/educational needs and update their professional practice in accordance with the UKCC standards and principles for practice.	☐	■
10 POLICIES, PROCEDURES AND PROTOCOLS		
10.1 There is a policy for the administration of drugs (including telephone instructions).	☐	◨
15 PATIENT/CLIENT CARE		
15.1 There are records of nursing care which are signed and dated by the nurse responsible.		
15.2 The nursing record conforms to UKCC guidelines.	☐	■

Comments

Weighting ☐

Essential practice ■

Good practice ◧

Desirable practice ☐

PHARMACISTS/DISPENSING STAFF

The following criteria are specific to pharmacists and other staff based in health centres or surgeries involved in the provision of a pharmaceutical service. The criteria marked with an asterix (*) apply to pharmacists only. These criteria are supplementary to those relating to the core organisational standards and criteria.

Comments

please tick

	Y	N

5 SERVICE AGREEMENTS/CONTRACTS

5.1 The service agreements/contracts comply with NHS (Pharmaceutical Services) Regulation 1992 and are in accordance with the Drug Tariff. ☐ ☐ ■

5.2 The service agreement/contract specify at least the following:

5.2.1 quality of service ☐ ☐ ■

5.2.2 expected delivery times ☐ ☐ ◧

5.2.3 agreed levels of discount ☐ ☐ ◧

5.2.4 agreed costings ☐ ☐ ◧

5.2.5 agreed standards for the quality of goods supplied. ☐ ☐ ■

6 MANAGEMENT AND STAFFING

6.1 There is a certified identification of the on-duty pharmacists.* ☐ ☐ ■

6.2 The opening hours of the pharmaceutical service are clearly displayed. ☐ ☐ ■

6.3 The pharmacist/dispensary staff act in accordance with legislation affecting pharmacy practice and current professional guidelines. ☐ ☐ ■

6.4 The pharmacist/dispenser has access to a general practitioner throughout the working day. ☐ ☐ ◧

6.5 There is an education and counselling service for patients/clients and their relatives. ☐ ☐ ◧

7 STAFF DEVELOPMENT AND EDUCATION

7.1 The pre-registration training for pharmacists is in accordance with the Royal Pharmaceutical Society of Great Britain (RPSGB) guidelines and takes place under supervision of a recognised tutor.* ☐ ☐ ■

7.3 Dispensary staff have a recognised dispensing qualification. ☐ ☐ ◧

7.3 There is provision for continuing education for pharmacists in accordance with RPSGB guidelines and for dispensary staff. ☐ ☐ ◧

9 INFORMATION

9.1 Prescriptions conform to legal requirements as directed by the Medicines Act 1968. ☐ ☐ ■

The patient/client is given clear instructions concerning his or her medication. ☐ ☐ ■

Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

PHARMACISTS/DISPENSING STAFF

Comments

		please tick Y	N
9.2	There are information leaflets available for 'off-the-shelf medication'.		■
9.3	There is information available concerning criteria for payment or non-payment of prescriptions.		◨
9.4	Items are prescribed and dispensed in an original pack so that they remain accurately labelled.		■
9.5	Supplementary labels/information leaflets from the manufacturer of supplies are included.		◨
9.6	Prescriptions are properly endorsed.*		■
9.7	There are pharmaceutical records kept which are in accordance with the RPSGB guidelines.		■
9.8	There is up-to-date information concerning drugs, chemicals and new products available from drug companies.		■
9.9	There is a mechanism for sharing new product information with the primary health care team.		◨
9.10	There is a list of nurse prescribers.		

10 POLICIES AND PROCEDURES

10.1	The Medicines Act 1968, the Misuse of Drugs Act 1971 and the Poisons Act 1972 are complied with.		■
10.2	The policies and procedures cover at least the following:		
10.2.1	dispensing outside contracted hours (for example, on-call rota, urgent dispensing)		■
10.2.2	disposal of out-of-date, returned, or inappropriately labelled drugs		■
10.2.3	checking of expiry dates		■
10.2.4	information and advice provided to the primary health care team		■
10.2.5	information shared with the primary health care team (for example, registering abuses of medication)		■
10.2.6	information leaflets issued to the patient/client		■
10.2.7	labelling of drugs		■
10.2.8	non-prescription dispensing		■
10.2.9	repeat prescriptions		■
10.2.10	prepackaging of drugs		■
10.2.11	use of cold boxes and 'ice packs'		■
10.2.12	drug recall procedure		■
10.2.13	use of cytotoxic drugs		■

Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

PHARMACISTS/DISPENSING STAFF

Comments

		please tick Y	N
10.2.14	use of materials in accordance with COSHH regulations		■
10.2.15	spillage and contamination		■
10.2.16	handling controlled drugs *		■
10.2.17	a syringe and needle exchange scheme		■
10.2.18	use of patient/client medication records		■
10.2.19	reporting adverse drug reactions		■
10.2.20	referral to prescribers		■
10.2.21	emergency supplies		■
10.2.22	security of service		■
10.2.23	stock control and ordering		■
10.2.24	storage of prescriptions		■
10.2.25	reception of goods		■
10.2.26	dispensing errors		■
10.2.27	drug storage		■
10.2.28	basic accounting		■
10.2.29	cleaning		■
10.2.30	use of original packs		■
10.2.31	dispensing medicines liable to abuse		■
10.2.32	extended services (for example, residential and nursing homes collection and delivery services, diagnostic testing) *		
10.2.33	supervision of dispensing staff.		■

15 PATIENT/CLIENT CARE

15.1 The delivery of pharmaceutical care is in accordance with agreed professional standards for pharmacy practice.* ■

15.2 All pharmacists maintain medication records where they believe it will benefit the patient/client.* ■

17 FACILITIES AND EQUIPMENT

17.1 Secure storage areas are available which conform to statutory and manufacturers' requirements. ■

17.2 There are secure areas for the safe delivery of pharmaceutical products. ■

17.3 There are security systems (for example, alarms, controlled access) to protect staff working in the pharmacy/dispensary. ■

17.4 Reference books are available. ■

17.5 There are refrigerators/freezers dedicated for the safe storage of certain medicines. ■

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

PHARMACISTS/DISPENSING STAFF

Comments

please tick

	Y	N
	☐	☐

17.6 Equipment includes:

17.6.1	a smooth, impervious dispensing surface	■
17.6.2	a sink with water supply	■
17.6.3	weighing equipment	■
17.6.4	counting equipment	■
17.6.5	computer technology	■
17.6.6	packaging for dispensed items	■
17.6.7	dosage dispensers	■
17.6.8	glass measures.	■

18 AUDIT AND QUALITY

18.1 There is a system to evaluate the pharmaceutical service. This includes collection of key information such as:

18.1.1	prescriptions processed	■
18.1.2	number of items issued	■
18.1.3	number of prescriptions returned by the Prescription Pricing Authority	■
18.1.4	reason for return by Prescription Pricing Authority	■
18.1.5	out of stock items	■
18.1.6	expired items	■
18.1.7	patient consultation (for example, reason, outcome).	■

Weighting

Essential practice ■

Good practice ◨

Desirable practice

PRACTICE/BUSINESS MANAGERS AND ADMINISTRATORS

The following criteria are specific to practice/business managers and administrators and are supplementary to those relating to the core organisational standards and criteria.

Comments

please tick

	Y	N
3 OBJECTIVES		
3.1 The objectives include at least the following:		
3.1.1 the efficient and effective management of staff employed by the practice		
3.1.2 the efficient and effective management of the resources of the practice.		
6 MANAGEMENT AND STAFFING		
6.1 The manager/administrator ensures that there are appropriately trained practice staff available to meet practice requirements and support high quality patient care.		
6.2 There are rotas for doctors, receptionists and administrative staff which cover holidays, sick leave and locums.		
6.3 The manager is involved in the preparation of the business/service plans for the practice.		
6.4 The manager is responsible for overseeing the effective management of the facility and its resources, including:		
6.4.1 claims for items of service, target payments and clinic payments		
6.4.2 salaries and reimbursement within FHSA guidelines		
6.4.3 income and expenses		
6.4.4 petty cash.		
6.5 The manager/administrator liaises with the accountant, bank manager and the inland revenue.		
10 POLICIES, PROCEDURES AND PROTOCOLS		
10.1 There are policies and procedures for at least the following:		
10.1.1 allocation and review of resources		
10.1.2 operating the switchboard and telephone answering equipment.		
17 FACILITIES AND EQUIPMENT		
17.1 The manager/administrator has overall responsibility for security, repairs, maintenance of premises, services and equipment.		

Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

PROFESSIONS ALLIED TO MEDICINE

The following criteria are specific to the professions allied to medicine and are supplementary to those relating to the core organisational standards and criteria. Professions allied to medicine include the following services, which may be provided outside the facility:

		please tick Y	N
chiropody	☐		
clinical psychology	☐		
nutrition and dietetics	☐		
occupational therapy	☐		
physiotherapy	☐		
speech and language therapy	☐		
other (specify)	☐		

Please tick a box to indicate which service applies.

Comments

6 MANAGEMENT AND STAFFING

6.1 Professions allied to medicine act in accordance with legislation affecting professional practice and current professional guidelines. ■

6.2 Each profession allied to medicine is managed by a member of that profession who is qualified by education or training. ◨

15 PATIENT/CLIENT CARE

15.1 Clear, accurate and up-to-date patient/client records are maintained which describe all elements of the treatment/care provided. ■

15.2 Records are maintained in accordance with accepted procedures and current legislation. ■

15.3 The practitioner maintains written evidence of problem-oriented goals and treatment plans. ◨

15.4 A primary assessment of need is carried out for each patient/client. ◨

15.5 Relevant information on the process and outcome of intervention is sent to the general practitioner or other source of referral. ◨

17 BUILDINGS, FACILITIES AND EQUIPMENT

17.1 If clinical drills are used, these are dust extracting with autoclavable handpieces. ■

17.2 Chiropody clinics have non-carpeted floors, preferably with splash back skirtings and welded seams. ■

17.2 Medical gases are stored securely with suitable warning notices displayed. When in use, adequate ventilation is available. ■

Weighting ☐

Essential practice ■

Good practice ◧

Desirable practice ☐

PROFESSIONS ALLIED TO MEDICINE

please tick

Y	N

Comments

17.4 Professions allied to medicine using equipment emitting ionising radiation ensure that they are certified under the 1985 and 1988 Ionising Radiation Regulations and the equipment and premises comply with current regulations. ☐ ☐ ■

17.5 Professions allied to medicine using equipment which emits ionising radiation ensure the primary health care team are fully conversant with safety procedures while the equipment is in use. ☐ ☐ ■

17.6 There are warnings which advise on the wearing of eye protection wherever grinding, sanding or cutting machinery is used by professions allied to medicine. ☐ ☐ ■

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

RECEPTIONISTS/ADMINISTRATIVE STAFF

The following criteria are specific to receptionists and administrative staff and are supplementary to the core organisational standards and criteria.

Comments

			please tick Y	N
		7 STAFF DEVELOPMENT AND EDUCATION		
7.1		Inservice training is available to all members of staff. The programme includes, for example:		
	7.1.1	updating on all policies and procedures		◨ ■
	7.1.2	confidentiality issues		■
	7.1.3	The FHSA and the Statement of Fees and Allowances		◨ ■
	7.1.4	awareness of special needs of patient/client groups		◨ ■
	7.1.5	communication with other agencies		◨ ■
	7.1.6	customer care		■
	7.1.7	telephone techniques		■
	7.1.8	the complaints procedure		■
	7.1.9	emergency procedures		■
	7.1.10	first aid and basic life support skills		◨ ■
	7.1.11	self-defence.		
		10 POLICIES, PROCEDURES AND PROTOCOLS		
10.1		There are policies and procedures in relation to:		
	10.1.1	staff advice to patients/clients and access to health professionals		◨ ■
	10.1.2	appointment systems, including emergency and follow-up appointments		■
	10.1.3	waiting times for booking appointments and delays in surgery		◨ ■
	10.1.4	flexibility of appointment times		◨ ■
	10.1.5	patient/client privacy, including confidential conversations with reception staff		■
	10.1.6	informing patients of diagnostic results		■
	10.1.7	prescriptions and repeat prescriptions.		■

Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

Comments

please tick

	Y	N
	☐	☐

18 AUDIT AND QUALITY

18.1 There is a system to evaluate the reception/administration service. This includes: ◨

18.1.1 receiving and dealing with complaints/suggestions from staff and users of the facility ■

18.1.2 compiling, recording and investigating incident reports/complaints/suggestions and discussing these at an appropriate level within the facility ■

18.1.3 collection of key information such as

(a) length of time patients/clients wait for next available appointment with any health professional

(b) length of time patients/clients wait for next available appointment with health professional of choice

(c) non-attendance for appointments. ☐

Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

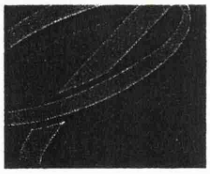
SOCIAL WORKERS

The following criteria are specific to social workers and are supplementary to the core organisational standards and criteria.

Comments

please tick

		Y	N
	7 STAFF DEVELOPMENT AND EDUCATION	☐	☐
7.1	Social workers are included in any relevant educational programmes organised by the primary health care team.	◨	
7.2	There is evidence that social workers have access to professional updating courses.	◨	
	9 INFORMATION		
9.1	There is a local information directory, such as a local organisational directory, which contains at least the following:	◨	
9.1.1	district health and social services team	◨	
9.1.2	local policies of the primary health care team and the social services community team	◨	
9.1.3	statutory and legislative framework within which social work departments operate	◨	
9.1.4	resources available in and outside the local area	◨	
9.1.5	guidance on the patient's/client's entitlement to services	◨	
9.1.6	information leaflet on social work in community health care	◨	
9.1.7	office opening times.	◨	
9.2	The information directory is reviewed annually and, when information changes, it is updated and dated.	◨	
9.3	An up-to-date list of services received by individuals is shared with the primary health care team.	◨	
9.4	Carers are informed about services by the social services department (Policy Guidance, para 2.25).	■	
	10 POLICIES, PROCEDURES AND PROTOCOLS		
10.1	Policies and procedures are developed for at least the following:		
10.1.1	referral system	■	
10.1.2	assessment	■	



Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

Comments

		please tick Y	N
10.1.3	care planning and management		■
10.1.4	delivery of service		■
10.1.5	recording/open access to records (to include computer records)		■
10.1.6	closure of files		◨
10.1.7	destruction of files		◨
10.1.8	out-of-hours visits		■
10.1.9	administration of medication if given by social service employee.		■

18 AUDIT AND QUALITY

18.1 There is a system to evaluate the service. This includes:

18.1.1	recording the receipt of services by individual clients and carers		◨
18.1.2	monitoring service allocations to clients/carers.		◨

Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

HEALTH RECORDS (CONTENT)

These criteria relate to 'hard copy' and computer health records.

Standard 19

A health record is maintained for all patients registered with the facility. The health record is accurate, complete, usable for retrieving information and allows for effective continuing patient care

Comments	*Criteria*	*please tick* Y	N
	Content		
	19.1 Entries into the records, including alterations, are made only by authorised staff and are legible, dated, attributable and in ink		■
	19.2 There is an up-to-date list of staff who have authorised access to health records.		◨
	19.3 A clear and logical format is used. Where blank spaces appear, they are scored through.		◨
	19.4 The abbreviations and symbols used are agreed by the relevant members of the primary health care team.		◨
	19.5 The notes provide a relevant, chronological account of the patient's care, and support clinical decisions.		◨
	19.6 Where possible, originals of all reports by medical, nursing and allied health professionals are filed in the records.		■
	19.7 Each record contains at least the following identification data:		
	19.7.1 a unique medical record number (for example, NHS number)		■
	19.7.2 a reference number for operational/administrative purposes (for example, community health index number)		☐
	19.7.3 name in full on every page		◨
	19.7.4 address and postcode		■
	19.7.5 telephone number		■
	19.7.6 date of birth		■
	19.7.7 sex		■
	19.7.8 person to notify in an emergency (next of kin)		■
	19.7.9 main carer's name and address		■
	19.7.10 general practitioner		■
	19.7.11 significant conditions which cause loss of function		■
	19.7.12 language/cultural considerations and contact point for translator if required		■

Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

HEALTH RECORDS (CONTENT)

Comments

please tick

			Y	N
	19.7.13	risk factors - genetic, environmental, hypersensitivities		■
	19.7.14	socioeconomic group		◨
	19.7.15	status (for example, married, unemployed, retired).		◨
19.8		'Alert' notations for conditions such as allergic responses and drug reactions are prominently displayed.		■
19.9		The record contains chronologically the following:		■
	19.9.1	present and past medical history		
	19.9.2	an up-to-date summary sheet/problem list which contains significant diagnoses and procedures. These are coded and computerised as appropriate to include: (a) significant family history (b) social considerations - including details of alcohol and tobacco consumption (c) employment status/occupation (d) environmental situation where appropriate (for example, housing)		◨
	19.9.3	repeat/ongoing medication		■
	19.9.4	progress notes/clinical consultations		■
	19.9.5	laboratory and x-ray results.		■
19.10		The health record includes details of attendances at the facility, home visits and relevant telephone contacts.		■
19.11		There is a mechanism for dealing with incoming letters and laboratory reports which indicates that these have been seen and dealt with.		■
19.12		There is evidence of informed patient consent where appropriate.		■
19.13		All prescriptions are signed by qualified staff.		■
19.14		Details of drug therapy are recorded which include at least the following:		
	19.14.1	any modification in drug therapy is authorised by a qualified practitioner		■
	19.14.2	when starting new medication, instructions given to the patient/client and/or carer are recorded.		◨
19.15		Orders for special diagnostic tests are noted in the records.		■
19.16		Information given to the patient/client and/or carer is recorded.		◨
19.17		Information on patients given by carers is recorded separately from the patient's health record if this is the carer's wish.		■

Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

HEALTH RECORDS (SYSTEMS)

Standard 20

Health records are securely stored and are readily accessible to authorised staff only. Legislation is complied with and information in the health record is safeguarded from use by unauthorised persons.

Comments	*Criteria*	*please tick* Y	N
	Data protection and ethical principles		
	20.1 The facility is registered under the Data Protection Act 1984.		■
	20.2 Personal data held is used only for a specified and lawful purpose. (Data users can comply with this principle by registering all their purposes and by establishing procedures to ensure that new purposes are added to the register as and when they arise.)		■
	20.3 Personal data is not used or disclosed in any manner incompatible with the purposes registered.		■
	20.4 The data collected is compatible with the stated purpose.		■
	20.5 Data is accurate and kept up to date.		■
	20.6 There is a written policy on the length of time that personal data is held.		◨
	20.7 Staff are aware of and follow the Access to Medical Records Act 1990.		■
	20.8 An individual is entitled within a reasonable time and without undue delay or expense:		■
	20.8.1 to be informed by any data user whether personal data is held about that individual		■
	20.8.2 to access any such data held by a data user		■
	20.8.3 to have such data corrected or erased if necessary		■
	20.9 There are security measures to prevent unauthorised access to or alteration, disclosure or destruction of personal data and protect against accidental loss or destruction of personal data.		■
	20.10 There is a system for acquiring and transferring health records which allows for rapid availability of new patient records.		■
	20.11 The facility has agreed policies and procedures specific to the management of health records. Where several practices share a building, a health records management committee may be appropriate.		◨

Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

HEALTH RECORDS (SYSTEMS)

Comments

please tick

	Y	N
	☐	☐

20.12 There is a mechanism to encourage the patient to update their personal details (for example, by use of the practice leaflet). ◨

Confidentiality

20.13 The information in the health record is safeguarded from use by unauthorised persons. ■

20.14 The information in the health record is used by all staff in accordance with their professional code of confidentiality and contract of employment. ■

20.15 Where computerised health records are maintained, specific measures are taken to ensure confidentiality in accordance with the Data Protection Act 1984. ■

Access

20.16 The primary health care team agrees a policy regarding access to health records and transfer of information between professionals. ◨

20.17 Information on patient/client access to health records is available to patients/clients. ◨

Filing systems

20.18 There is a filing system which enables the rapid retrieval of health records. ◨

20.19 There is an effective monitoring system so that records can be traced at all times (for example, tracer cards). ◨

20.20 The primary health care team develops a written policy for completion of records and filing. ■

Storage

20.21 The health records are stored securely to protect records against loss, damage or use by unauthorised persons. ■

20.22 When records are computerised, back-up copies of the system and/or data files are taken and are securely kept at another site or in a fire-proof safe/cabinet. ■

Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

MINOR SURGERY

Standard 21

Minor surgery procedures are undertaken by trained and qualified staff using equipment and facilities which allow for the provision of safe, efficient and effective treatment. Staff ensure the provision of high quality minor surgery through evaluation activities.

Comments

Criteria

please tick Y N

21.1 The practitioner undertaking minor surgery is suitably trained and competent to carry out the specified procedure and has written accreditation from the local family health services authority. ☐☐■

21.2 All staff involved in minor surgery:

21.2.1 have up-to-date legal indemnity for minor surgery ☐☐■

21.2.2 are aware of the need for confidentiality. ☐☐■

Patients

21.3 The patient is fully informed of the procedures, possible outcomes and risks involved. ☐☐■

21.4 The patient is provided with information about other choices. ☐☐■

21.5 Written consent is obtained and recorded in the patient's health records, together with any warning to the patient. ☐☐◨

21.6 The patient is fully informed of follow-up arrangements and any likely restriction of lifestyle which may result from the procedure. ☐☐◨

21.7 Staff ensure that the patient has the necessary social support following minor surgery. ☐☐◨

21.8 There is a policy for dealing with children which includes written consent from parents or guardians. ☐☐◨

21.9 There is a designated area for patients to recover following minor surgery. ☐☐◨

21.10 There is evidence that the patient has given informed consent when a student is present or is undertaking the procedure. ☐☐■

Training

21.11 There is written evidence of individual competence for the procedures undertaken. ☐☐■

21.12 Staff involved in minor surgery are trained in resuscitation techniques. ☐☐■

21.13 Those undertaking minor surgery are involved in a training programme which includes refresher courses and opportunities to develop new techniques. ☐☐◨

21.14 Records of training are maintained. ☐☐☐

Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

MINOR SURGERY

Comments

please tick

	Y	N
	☐	☐

21.15 Students and trainee general practitioners performing minor surgery are supervised by a suitably qualified practitioner. ■

Records

21.16 The patient's health record is available when the procedure is conducted. ◨

21.17 The details of the procedure are written into the patient's health record in a clear, concise manner. This includes reasons for performing the procedure and the full record of treatment. ■

21.18 There is a record of the batch number, expiry date and dosage of any local anaesthetic used. ■

21.19 The relevant claim forms from the FHSA are available and completed for each procedure undertaken in accordance with practice policy. ◨

(See also Health Records, Section 3)

Policies and procedures

21.20 There are written, dated policies and procedures which are developed by the relevant members of the primary health care team. ■

21.21 Staff are aware of, and follow, the policies and procedures relating to minor surgery. ■

21.22 Policies and procedures are reviewed regularly, revised as necessary and dated. ◨

21.23 These policies and procedures address at least the following (see also Health and Safety and Infection Control in Section 1):

21.23.1 booking minor surgery appointments ◨

21.23.2 obtaining consent ◨

21.23.3 patients recovery following minor surgery ◨

21.23.4 handling laundry. ■

General Anaesthesia

21.24 General anaesthesia or sedation is only given by an individual with suitable training and ability of a consultant in accordance with standards set by the Royal College of Anaesthetists. ■

21.25 A qualified first-level registered general nurse or operating department assistant is available for support when anaesthesia or sedation is used. ■

Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

MINOR SURGERY

please tick

	Y	N

Comments

21.26 Where anaesthesia or sedation is given, policies and procedures are developed which cover at least the following ◨

21.26.1 the pre-anaesthetic assessment of each patient is performed by the anaesthetist who is administering the anaesthetic. Where this is not possible, it is done by another anaesthetist who documents the findings and communicates them to the administering anaesthetist ■

21.26.2 the assessment is timely, enabling satisfactory measures to be taken to prepare the patient for anaesthesia and to perform any additional investigations which may be warranted by the patient's condition ■

21.26.3 special requirements of children ■

21.26.4 the practitioner performing the procedure must be available before the anaesthetist commences ■

21.26.5 anaesthesia is commenced and terminated only in the presence of a member of the staff whose sole duty is to assist the anaesthetist until such time as the latter indicates that assistance is no longer required ■

21.26.6 appropriate recovery staff are available until the patient has recovered from the anaesthetic ■

21.26.7 an anaesthetist is present until the patient has recovered from the anaesthetic ■

21.26.8 there are pre-use safety checks for all anaesthetic machines and monitoring equipment. ■

21.27 There is evidence that the following have been considered:

21.27.1 the design of the anaesthetic service provides space for the reception, anaesthesia, surgery, recovery and observation of patients ◨

21.27.2 suitably equipped accommodation, separate from the operating room and access corridors, is provided for the patient awaiting surgery ◨

21.27.3 the facilities used for induction of anaesthesia are designed and equipped for safe practice following the guidelines set by the Association of Anaesthetists and/or the Royal College of Anaesthetists ■

Weighting ☐
Essential practice ■
Good practice ◨
Desirable practice ☐

Comments

		please tick Y	N
21.27.4	scavenging of waste anaesthetic gases and vapours in accordance with HC(76)38		■
21.27.5	the storage of all portable gas cylinders meets the health and safety regulations		■
21.27.6	areas in which anaesthetics are administered comply with appropriate guidance circulars		■
21.27.7	there is an equipped and staffed area for recovery from anaesthesia which complies with guidelines issued by the Association of Anaesthetists and/or Royal College of Anaesthetists		■
21.27.8	all documents referred to in this standard are available in the facility.		◨

Health and safety guidelines

21.28	There are written health and safety guidelines which include:		
21.28.1	anaesthetic equipment hazards		■
21.28.2	controlled drug handling		■
21.28.3	drug errors		■
21.28.4	electrical hazards		■
21.28.5	evaluation and testing of equipment		■
21.28.6	fire and explosion		■
21.28.7	instructions on use and maintenance of instruments		☐
21.28.8	notification of biohazards		■
21.28.9	patient positioning during procedure		◨
21.28.10	patient transport		◨
21.28.11	radiation hazards		■
21.28.12	'sharps' handling and disposal		■
21.28.13	use of scavenging equipment for removal of various vapours and waste anaesthetic gases.		■

Histology

21.29	There is a written policy which identifies tissue removed during minor surgery which requires histological examination.		■
21.30	There is a procedure for handling tissue removed during minor surgery which requires histological examination.		◨
21.31	The patient is informed of the waiting time for histology results.		◨

Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

MINOR SURGERY

Comments

please tick

Y N

21.32 The histology report is seen either by the practitioner performing minor surgery or by the patient's own general practitioner if different. ☐☐■

21.33 Any follow-up action is written into the patient's health record. ☐☐◨

Sterilisation of equipment

21.34 There are written policies and procedures for sterilisation. ☐☐■

21.35 Special advice is sought in formulating sterilisation policies and procedures (from, for example, a microbiologist or infection control nurse). ☐☐◨

21.36 The policies and procedures address at least the following:

21.36.1 obtaining sterile supplies ☐☐◨

21.36.2 sterilisation carried out on the premises. ☐☐■

Facilities and equipment

21.37 There is a designated area for minor surgery which is appropriate for the intended procedure. ☐☐■

21.38 The designated minor surgery area:

21.38.1 ensures patient privacy ☐☐■

21.38.2 is ventilated, well-lit and clean ☐☐■

21.38.3 is maintained at a suitable temperature ☐☐■

21.38.4 is separate from the main thoroughfare of activity ☐☐◨

21.38.5 is not used for other purposes while minor surgery is in progress. ☐☐■

21.39 The couch is positioned to enable access to the patient and is appropriate to the procedure being undertaken. ☐☐◨

21.40 The couch is covered with a suitable material to maintain cleanliness. ☐☐■

21.41 There is an area in or adjacent to the designated minor surgery area for the patient to prepare privately. ☐☐■

21.42 There is protective covering for the patient. ☐☐■

21.43 There is protective clothing for the staff undertaking the procedure. ☐☐■

21.44 There are hand-washing facilities. ☐☐■

21.45 The instruments and equipment are appropriate for the procedure being undertaken. ☐☐■

21.46 A record of the name of stock items, the batch number and the doctor's supplier is maintained and the record annotated to show the dates between which each batch is used. ☐☐◨

Weighting ☐

Essential practice ■

Good practice ◨

Desirable practice ☐

MINOR SURGERY

Comments

please tick

	Y	N
	☐	☐

21.47 There is a procedure for checking that all instruments and equipment are safe and in good working order. ☐ ☐ ■

21.48 All instruments and equipment in contact with an open wound are sterile. ☐ ☐ ■

21.49 Emergency resuscitation equipment is easily accessible and the procedure for summoning assistance is known by all staff. ☐ ☐ ■

21.50 Emergency resuscitation equipment is checked regularly. This is recorded. ☐ ☐ ■

21.51 All equipment is regularly maintained according to the manufacturer's instructions and in accordance with health and safety guidelines. ☐ ☐ ■

Audit

21.52 The evaluation activities include a review of at least the following:

21.52.1 indications for surgery ☐ ☐ ☐

21.52.2 complications arising from procedure, including infection rates ☐ ☐ ◨

21.52.3 histological diagnosis ☐ ☐ ◨

21.52.4 patient satisfaction ☐ ☐ ☐

21.52.5 workloads ☐ ☐ ☐

21.52.6 records ☐ ☐ ☐

21.52.7 staff skills and training. ☐ ☐ ☐

21.53 A cost/benefit analysis is undertaken to ensure efficient and effective use of resources. ☐ ☐ ☐

APPENDIX 1

RELEVANT LEGISLATION AND REGULATIONS

1 The NHS and Community Care Act 1990

This made the legislative changes necessary for the implementation of the white papers Working for Patients, Promoting Better Health and Caring for People. The key point is the distinction drawn between purchasers and providers.

2 The Family Health Services Authorities (Membership and Procedure) Regulations 1990

Make provisions about the membership and procedure of family health service authorities and remove the previous regulations relating to family practitioner committees.

3 The National Health Service (General Medical Services) Regulations 1992; The National Health Service (Pharmaceutical Services) Regulations 1992

Consolidate, with amendments, the provisions of the National Health Service (General Medical and Pharmaceutical Services) Regulations 1974 which relate to general medical and pharmaceutical services. These regulations therefore regulate the terms on which general medical and pharmaceutical services are provided under the National Health Service Act 1977.

4 The National Health Service (General Dental Services) Regulations 1992

Concern the arrangements under which general dental services are provided under part II of the National Health Service Act 1977. They supersede the National Health Service (General Dental Services) Regulations 1973 ('the 1973 regulations').

5 Statement of Fees and Allowances Payable to General Medical Practitioners in England and Wales (The 'Red Book')

6 The NHS (Fund-holding Practices) Regulations 1993

Relate to applications by medical practitioners providing general medical services for recognition as fund-holding practices and the grant of recognition by regional health authorities or, on appeal, the Secretary of State.

7 Nurses, Midwives and Health Visitors Act 1992

States that the UKCC changes from a body where the majority of members are appointed by the Secretary of State to a body where two-thirds of the members are elected.

The Act centralises all professional conduct investigations. It also changes the constitution of the four national boards from elected to appointed bodies and takes away their role in managing and financing the provision of education and training for the professions.

8 Health Service and Public Health Act 1968

Lays down the regulations for informing about communicable diseases.

9 Children Act 1989

Provides the foundations for law on children in Britain. The philosophy running through the Act is that the best place for a child to be brought up is usually with his or her own family. Under the Act, great collaboration is needed in the provision of services for children deemed to be in need and in their protection. Health care professionals will need to liaise with social services departments to a greater extent than previously. The Act emphasises a child's right to make informed decisions in relation to his or her medical care.

APPENDIX 1

10 Data Protection Act 1984

The Act was passed to bring Britain into line with other western democracies, 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.

11 Access to Health Records Act 1990

Allows individuals right of access to information about themselves recorded from 1 November 1992 in manually held records (subject to certain exemptions).

12 Health and Safety at Work etc, Act 1974

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

13 Health and Safety (Display Screen Equipment) Regulations 1992

States the requirements for workstations with display screen equipment.

14 Work Place (Health, Safety and Welfare) Regulations 1992

Distinguishes between new and existing workplaces and states the minimum health and safety requirements for the workplace.

15 Control of Substances Hazardous to Health Regulations 1989 (COSHH)

States that all employers are required to:
(a) identify hazardous substances at work
(b) assess the risks
(c) minimise the risks
(d) inform all employees
(e) train employees on risks and precautions.

16 Environmental Protection Act 1990

Details the code of practice on the disposal of clinical waste.

17 Medicines Act 1968

Makes provisions about medicinal products for human use and related matters.

18 Misuse of Drugs Act 1971

Makes provisions about dangerous or otherwise harmful drugs and related matters.

19 Poisons Act 1972

Makes provisions about non-medical poisons. Poisons included in the Poisons List are subject to detailed controls covering sale, labelling, transport, storage and the containers in which they must be sold.

20 Medicinal Products: Prescription by Nurses, etc, Act 1992

Permits nurses with a district nursing or health visiting qualification to prescribe certain products from a nurse prescribers' formulary. The statutory rules will specify the categories of nurses who can prescribe under this legislation.

APPENDIX 1

21 NHS Notification of Births and Deaths Regulations 1974

States that a doctor or midwife present at a birth must inform the DHA of that birth (or stillbirth) within 36 hours. A medical practitioner treating a patient in a terminal illness must provide the registrar of deaths with the certificate of death stating inter alia the cause of death.

22 Abortion Act 1967

States that a practitioner terminating a pregnancy must notify this to the Chief Medical Officer (CMO) of the Department of Health or the CMO of the Scottish Home and Health Department.

Legislation Affecting the Appointment of Employees (Source: 'We need a Practice Manager' MSD/RCGP)

23 Disabled Person (Employment) Act 1944 and 1958

Under these Acts, disabled persons are registered by the Secretary of State for Employment and certain employers are obliged to have a quota of disabled persons in their employment. Certain work is designated as being especially suitable for disabled persons and only registered disabled persons may be engaged in these employments. District advisory committees were established throughout Britain to advise the Secretary of State on matters relating to the employment of disabled persons.

24 Rehabilitation of Offenders Act 1974

States that an ex-offender, after a 'period of rehabilitation' of up to ten years, has no need to disclose a previous conviction unless his or her sentence exceeded two and a half years' imprisonment.

Once a conviction becomes 'spent', an employer cannot refuse to employ, dismiss or otherwise discriminate against an ex-offender on the grounds of a previous conviction.

NB: Medical practitioners (doctors, nurses, midwives, opticians, pharmacists) are exempt from this Act.

25 Sex Discrimination Act 1975

Makes it illegal for employers, professional bodies and trade unions to discriminate either directly or indirectly on the grounds of sex or marital status except where a particular sex or marital status could be shown to be a bona fide requirement. Similarly it became illegal to place an advertisement indicating an intention to discriminate either directly or by implication (indirectly).

26 Race Relations Act 1976

The objectives were to eliminate patterns of racial discrimination and to remedy individual grievances. To this end the complaints machinery was strengthened and the new Commission for Racial Equality was given considerable powers of investigation in addition to increased enforcement powers.

Direct or indirect discrimination on the grounds of race, ethnic or national origins, in the fields of employment, education facilities and services, housing, and in clubs with more than 25 members, and which is to the detriment of the person discriminated against, is unlawful.

APPENDIX 2

CONTENT OF CONTRACT OF EMPLOYMENT

Terms and conditions of employment to include:

Job title

Date employment commenced *
Date continuous period of employment commenced *
Salary *
Increment hours of work *
Annual holiday, including bank and public holidays *

Provision

Fitness for work *
Notification of absence *
Special leave sick pay - statutory sick pay and local sick pay policy *
Maternity arrangements *

Pension scheme

Retirement information *
Notice of termination *
Disciplinary and grievance procedure *
A scheme is in operation if more than 20 employees are employed (although it is strongly recommended that such a procedure is drawn up to prevent potential problems and misunderstandings) *

Practice protocols/guidelines

To include at least:

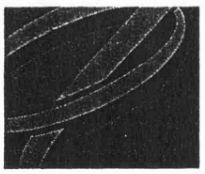
Health and safety at work policy
Fire instructions
Equal opportunities policy
Fair employment (Northern Ireland)
Confidentiality
Staff appraisal and training
Responsibility for personal property
Responsibility for practice/surgery property

Other items which should be considered:

Smoking policy
Press, television and media enquiries
Uniform

* Required to be included by law.

(Reference: AHCPA Personnel Management Handbook)



APPENDIX 3

SCHEDULE 1D OF THE REGULATIONS IN ENGLAND AND WALES AND SCHEDULE 1, PART C IN SCOTLAND, INFORMATION TO BE INCLUDED IN PRACTICE LEAFLETS

Personal and professional details of the doctor

1 Full name.

2 Sex.

3 Medical qualification registered by the General Medical Council.

4 Date and place of first registration as medical practitioner.

Practice information

5 The times approved by the FHSA during which the doctor is personally available for consultation by patients at his or her practice premises.

6 Whether an appointment system is operated by the doctor for consultations at his or her practice premises.

7 If there is an appointment system, the method of obtaining a non-urgent appointment and the method of obtaining an urgent appointment.

8 The method of obtaining a non-urgent domiciliary visit and the method of obtaining an urgent domiciliary visit.

9 The doctor's arrangements for providing personal medical services when he or she is not personally available.

10 The method by which patients are to obtain repeat prescriptions from the doctor.

11 If the doctor's practice is a dispensing practice, the arrangements for dispensing prescriptions.

12 If the doctor provides clinics for patients, their frequency, duration and purpose.

13 The numbers of staff, other than doctors, assisting the doctor in his or her practice and a description of their roles.

14 Whether the doctor provides (1) maternity services (2) contraception services (3) child health surveillance (4) minor surgery services.

15 Whether the doctor works single-handed, in partnership, part-time or on a job-share basis, or within a group practice.

16 The nature of any agreements whereby the doctor or the doctor's staff receive patients' comments on his or her provision of general medical services.

17 The geographical boundary of the doctor's practice area by reference to a map of a scale approved by the FHSA.

18 Whether the doctor's practice premises have suitable access for all disabled patients and, if not, the reasons why they are unsuitable for particular types of disability.

19 If an assistant is employed, details of him or her as specified in paragraphs 1-4 of this schedule.

20 If the practice is either a general practitioner training practice for the purposes of the National Health Service (Vocation Training Regulations 1979) or undertakes the teaching of undergraduate medical students, the nature of arrangements for drawing this to the attention of patients.

APPENDIX 4

SCHEDULE 1E OF THE NEW REGULATIONS IN ENGLAND AND WALES AND SCHEDULE 1, PART 1E IN SCOTLAND, INFORMATION TO BE PROVIDED IN ANNUAL REPORTS

1 The number of staff, other than doctors, assisting the doctor in his or her practice by reference to:

(a) the total number (but not by using their names)
(b) the principal duties of each employee and the hours each week the employees assist the doctor
(c) The qualifications of each employee
(d) the relevant training undertaken by each employee during the preceding five years.

2 The following information on the practice premises:

(a) any variations in relation to floor space, design or quality in the preceding five years
(b) any such variations anticipated in the course of the forthcoming 12 months.

3 The following information on the referral of patients to other services under the National Health Service Act 1977 during the period of the report:

(a) the total number of patients referred to a specialist as inpatients and the total number of patients referred to a specialist as outpatients,

In each case the clinical specialty and the name of the hospital concerned should be given. Specialities include:

general surgical
general medical
orthopaedic
rheumatology (physical medicine)
ear, nose and throat
gynaecology
obstetrics
ophthalmology
paediatrics
psychiatry
geriatrics
dermatology
neurology
genito-urinary
x-ray
pathology
others (including plastic surgery, accident and emergency, endocrinology)

(b) the total number of cases (of which the doctor is aware) in which a patient referred himself or herself from one of the categories of specialties listed in 3 (a) above under the National Health Service Act 1977.

4 The doctor's other commitments as a medical practitioner with reference to:

(a) a description of any posts held
(b) a description of all work undertaken, including in each case the annual hourly commitment.

5 The nature of any arrangements whereby the doctor or his staff receive patients' comments on the doctor's provision of general medical services.

6 The following information on orders for drugs and appliances:

(a) whether the doctor's practice has its own formulary
(b) whether the doctor uses a separate formulary
(c) the doctor's arrangements for the issue of repeat prescriptions to patients.

APPENDIX 5

THE PATIENT'S CHARTER

The Patient's Charter is a mixture of: established rights available to all citizens; national service guarantees and targets; local service guarantees and targets.

Patients' rights in the general medical services

Patients have the right to:

1 Be registered with a general practitioner.

2 Change doctor easily and quickly.

3 Be offered a health check on joining a doctor's list for the first time.

4 Receive emergency care at any time through a family practitioner.

5 Have appropriate drugs and medicines prescribed.

6 Be referred to a consultant acceptable to them when their general practitioner thinks it necessary, and to be referred for a second opinion if they and the GP agree this is desirable.

7 Have access to their health records, subject to any limitations in the law, and to know that those working for the NHS are under a legal duty to keep their contents confidential.

8 Choose whether or not to take part in medical research or medical student training.

9 If they are between 16 and 74, and have not seen their doctor in the previous three years, to have the health check to which they are entitled under the existing health promotion arrangements; and to be offered a yearly home visit and health check if 75 years old or over.

10 Be given detailed information about local family doctor services through their family health services authority's local director.

11 Receive a copy of their doctor's practice leaflet, setting out the services he or she provides.

12 Receive a full and prompt reply to any complaints they make about NHS services.

The Patient's Charter also sets nine standards which health authorities and trusts are expected to deliver.

1 *Respect for privacy, dignity and religious and cultural beliefs* The charter standard is that all health services should make provision so that proper personal consideration is shown. A detailed definition of the standards has to be produced locally.

2 *Arrangements to ensure everyone, including people with special needs, can use services* The charter standard is that all health authorities should ensure that the services they arrange can be used by everyone including children and people with special needs, such as those with physical and mental disabilities.

3 *Information to relatives and friends* The charter standard is that health authorities should ensure that there are arrangements to inform relatives and friends about the progress of a patient's treatment, subject of course to their wishes.

4 *Waiting time for ambulances* The charter standard is that when an emergency ambulance is called it should arrive within 14 minutes in an urban area or 19 minutes in a rural area.

APPENDIX 5

5 *Waiting time for initial assessment in accident and emergency departments*
The charter standard is that patients will be seen immediately and their need for treatment assessed by a trained health care professional. This can be delivered by means of triage, although a simple test of the effectiveness of the initial assessment is whether the first question patients are asked on arrival is 'What is your name, address and GP?' or 'What is wrong; how can I help?'.

6 *Waiting time in outpatient clinics*
The charter standard is that patients will be given a specific appointment time and be seen within 30 minutes of that time.

7 *Cancellation of operations* The charter standard is that operations should not be cancelled on the day patients are due to arrive in hospital. However, this can happen because of emergencies or staff sickness. If, exceptionally, an operation has to be postponed twice the patient will be admitted to hospital within one month of the date of the second cancelled operation. Many hospitals have improved this standard to one cancellation.

8 *Named, qualified nurse, midwife or health visitor* The charter standard is that each patient should have a named, qualified nurse, midwife or health visitor who will be responsible for their nursing and midwifery care.

9 *Discharge of patients from hospital*
The charter standard is that before discharge from hospital a decision should be made about any continuing health or social care needs the patient may have.

GPs and primary health care teams have been asked to consider setting quality standards for their practices (for example, for the way in which they pass on the results of tests, for their health promotion activities, for their facilities for disabled people and for parents with children, and the services they provide for cultural minorities).

FHSAs have also been asked to work with local medical committees, individual GPs and primary care teams to set local voluntary standards (for example, how long it takes people to get an appointment with their doctor or repeat prescription; how long it takes to see a doctor or nurse; and how quickly they can reach a doctor or nurse in an emergency).

DEFINITION OF TERMS

ACCOUNTABILITY The state of being answerable for one's decisions and actions. Accountability cannot be delegated.

ACTIVITIES The functions undertaken by staff in the normal course of their work which make possible the provision of a primary health care service.

APPRAISAL SYSTEM The evaluation by colleagues of the performance of individuals or groups using established criteria.

ASSESSMENT The collection and interpretation of data and the identification of patient/client problems.

BUSINESS PLAN A plan of how to achieve the mission of the facility. The plan includes financial, personnel and other sub-plans, as well as service development and a quality strategy.

CARER Anyone who regularly and, in an unpaid capacity, helps a relative or friend with domestic, physical or personal care needed because of illness or disability.

CLINIC A defined health care session.

CLINIC PRACTITIONER Health practitioner running the clinic.

COMPLEMENTARY THERAPIST Any practitioner who offers an alternative therapy to orthodox medical treatment. Complementary medicine does not replace conventional medicine.

CONTINUING EDUCATION Activities designed to extend knowledge to prepare for specialisation and career advancement and to facilitate personal development.

CRITERION A descriptive statement which is measurable and which reflects the intent of a standard in terms of performance, behaviour, circumstances or clinical states. A number of criteria may be developed for each standard.

EVALUATION The process of determining the extent to which goals and objectives have been achieved. Actual performance or quality is compared with standards in order to provide a feedback mechanism which will facilitate continuing improvement.

FACILITY The health centre, the general practice or any other site providing a primary health care service.

HEALTH EDUCATION Seeks to enhance positive health, and to prevent or diminish ill health by influencing beliefs, attitudes and behaviour.

HEALTH PROMOTION is the name given to the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health (WHO/Nutbeam 1986).

HEALTH PROTECTION Comprises legal controls, other regulations and policies and voluntary codes of practice which aim to enhance positive health and prevent ill health.

HEALTH PROFESSIONAL A person qualified in a health discipline who is currently working in, or from, the facility (for example, a registered nurse or physiotherapist).

HEALTH RECORD Information, including opinion, about the physical or mental health of an identifiable individual which has been made by or on behalf of a health professional in connection with the care of that individual. The entire health record is contained in one file with a unique identification number for each patient.

IMPLEMENTATION The delivery of planned health care.

INDUCTION PROGRAMME Learning activities designed to enable newly-appointed staff to function effectively in a new position.

DEFINITION OF TERMS

JOB DESCRIPTION Details of accountability, responsibility, formal lines of communication, principal duties, entitlements and performance appraisal. It is a guide for an individual in a specific position within an organisation.

JOB SPECIFICATION Details of the attributes and qualifications required for a specific position within an organisation.

MISSION STATEMENT A statement of values and beliefs which underpin the activities of the primary health care team.

MULTIDISCIPLINARY The combination of several disciplines working towards a common goal.

NEAR PATIENT TESTING Pathology tests undertaken outside a laboratory and performed by non-laboratory personnel.

OBJECTIVES Hoped-for results, goals or targets

ORGANISATIONAL CHART A graphic representation of the responsibility, relationships and formal lines of communication within the facility.

PLANNING The determination of priorities, expected outcomes and health care interventions.

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

PREVENTION The term used to describe activities which reduce the occurrence of a disease process, illness, injury, disability, handicap or some other unwanted phenomenon or state.

It comprises four stages:

* prevention of the onset or first manifestation of a disease process, or some other first occurrence, through risk reduction;
* prevention of the progression of a disease process or other unwanted state by early detection when this favourably affects outcome;
* prevention of avoidable complications of an irreversible, manifest disease or some other unwanted state;
* prevention of the recurrence of an illness or other unwanted phenomenon.

PROCEDURE A mode of action.

PROTOCOL Guidelines or flow chart to guide staff.

PRACTICE The partners, employed staff and their patients/clients.

DEFINITION OF TERMS

PRIMARY HEALTH CARE TEAM General practitioners, all staff employed by the practice and all other multidisciplinary professionals attached to the practice, for example, community nurses, dietitians, physiotherapists, counsellors, social workers, chiropodists, occupational therapists, speech and language therapists.

QUALITY Defining and making explicit the service to be provided and ensuring that it is delivered in a consistent and continuous way.

QUALITY MANAGEMENT PLAN A planned, systematic plan for the use of selected evaluation tools designed to measure and assess the structure, process and/or outcomes of practice against established standards, and to institute appropriate action to achieve and maintain quality.

RESPONSIBILITY The obligation that an individual assumes when undertaking delegated functions. The individual who authorises the delegated function retains accountability.

STAFF All individuals working from or within the facility - full time, part time, casual or contract.

STAFF DEVELOPMENT The formal and informal learning activities which contribute to personal and professional growth. It encompasses induction, inservice and continuing education programmes.

STANDARD The desired and achievable level of performance corresponding with a criterion, or criteria, against which actual performance is measured.

STRUCTURE The organisational characteristics of the setting in which care is delivered.

USER Someone who uses or could use the services offered by the facility.

APPENDIX 6

MEMBERSHIP OF THE CENTRAL WORKING GROUP

Ballyowen Health Centre, Belfast

Ms B Connolly, *Community Health Manager*

Bedgrove Health Centre, Aylesbury

Mrs W Palastanga, *Practice Nurse*
Dr A Walters, *General Practitioner*

Bennetts End Surgery, Hemel Hempstead

Mrs S Gower, *Practice Manager*
Mrs A Smedley, *Practice Nurse*

Bridgegate Surgery, Retford

Mrs J Bakewell, *District Nurse*
Mrs J Beattie, *Practice Manager*
Mrs W Moody, *Coordinator*

Dunluce Health Centre, Belfast

Miss A Canavan, *Social Worker*

Grove Medical Centre, Deptford, London

Dr A Mohamedali, *General Practitioner*
Miss F Wells, *Coordinator*

Lawson Street Health Centre, Stockton-on-Tees

Dr J Harley, *General Practitioner*
Mrs A P Preece, *Senior Nurse, District Nursing*

Mount Surgery, Pontypool

Dr D Jones, *General Practitioner*
Mrs G Jones, *Dental Practitioner*

White Rose Surgery, South Elmsall

Dr R Aggarwal, *General Practitioner*
Mrs L Taylor, *Assistant Practice Manager*

APPENDIX 7

MEMBERSHIP OF THE NATIONAL ADVISORY GROUP

REPRESENTATIVE

Mr R Hudson, *Community Unit Manager, Gwent Health Authority*

Mr J Newton, *Joint Chief Executive, Doncaster HA/Doncaster FHSA*

Mr S Langford, *Lambeth, Southwark and Lewisham FHSA*

Dr G Rivett and Dr R Field, *Department of Health*

Mr B Hassell, Chief Executive, *Independent Healthcare Association*

Dr J Huntington, *Fellow in Primary Health Care Management/Independent Consultant*

Dr D Plamping, *Primary Health Care Group, King's Fund Centre*

Mrs J Robinson, *Carers' Programme, King's Fund Centre*

Dr Y Doyle, *Consultant in Public Health Medicine, SELCA*

Mrs T Morley, *Chairman and Secretaries of the Professional Bodies of Professions Allied to Medicine*

Mrs D Hagel, *Honorary Secretary, Health Visitors' Association*

Mr D Day, *Deputy Director, NAHAT*

Dr D Irvine, Dr M Pringle and Dr G Roberts, *Royal College of General Practitioners*

Ms B Stilwell, *Principle Lecturer in Health and Community, Royal College of Nursing Studies*

Mr P Illsley, *Senior Manager, Health Studies Department, Audit Commission*

Mrs A Bibbings, *Assistant Director for Development, Carers' National Association*

Ms J Whelan, *Information and Policy Officer, Health and Social Services Department, Age Concern England*

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