USER-SENSITIVE PURCHASING

SAFDER
MOHAMMED

KING'S FUND CENTRE

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Published by the King's Fund Centre
126 Albert Street
London
NW1 7NF

Tel: 071-267 6111

ISBN 1 85717 028 8

A CIP catalogue record for this book is available from the British Library

Distributed by Bournemouth English Book Centre (BEBC)
PO Box 1496
Poole
Dorset
BH12 3YD

The King's Fund Centre is a service development agency which promotes improvements in health and social care. We do this by working with people in health and social services, in voluntary agencies, and with the users of these services. We encourage people to try out new ideas, provide financial or practical support to new developments, and enable experiences to be shared through workshops, conferences, information services and publications. Our aim is to ensure that good developments in health and social care are widely taken up. The King's Fund Centre is part of the King's Fund.

Cartoons by Nicky Hodge
Printed by Eyre and Spottiswoode

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PREFACE

'Championing the people' was one of the catch-phrases of purchasing when the new structures and functions of health authorities emerged following the publication of 'Working for Patients'. Most people agreed that the new functions were sensible, although the connotations of purchaser/provider with the market economy did create tension. While these tensions were being debated elsewhere, most health authorities were getting on with the job in hand. But what was the job in hand and how were health authorities going to achieve a level of measurable success?

The Department of Health had many priorities in the early days of the reforms. Self-governing trusts were hitting the headlines, if not every day, than certainly every week. Despite these distractions, the DoH realised that there was a need to invest in the development of the purchasing function. New skills and techniques needed to be learnt in a short period of time if effective purchasing was to become a reality. Project 26 was set up to share learning from those who were at the leading edge of change in the purchasing arena. The DoH also, at the same time, realised that the focus given to purchasers was an ideal opportunity to investigate how improvements to services for Black people could be achieved through contracts. It funded a project at the King's Fund Centre entitled 'Improving Services to Black People through Contracting', and this report brings together the key messages of that project and examines how contracting and purchasing has, and could, lead to major improvements in service provision for Black people.

The specific issues raised by this report relate mainly to the contracting process and will interest all its stakeholders. The messages are simple but constructive and relate to:

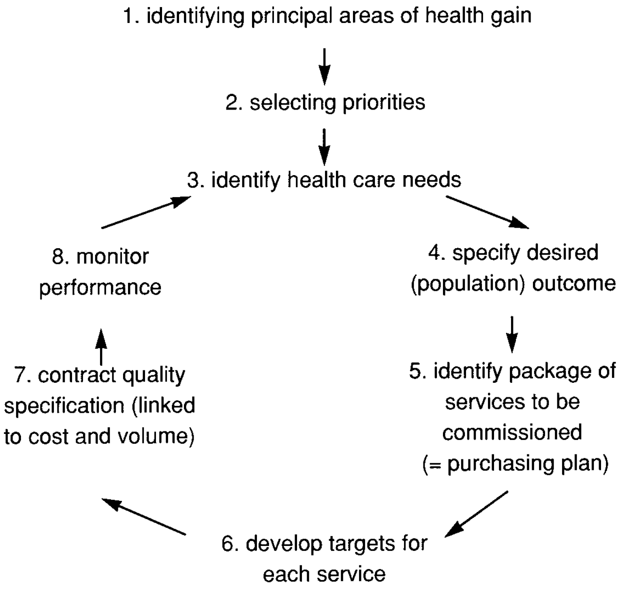
- needs assessment
- user involvement
- development of quality standards
- service improvement through the contracting process.

Perhaps one of the most important issues raised relates to the relationship between needs assessment and user involvement. The report states, quite correctly, that the actual quality of service received by a client is dependent on the correctness of the needs assessment process and the ability of the purchaser to translate those needs into contract specifications.

This reliance on the assessment of need process can prove to be an over-reliance depending on the actual process which takes place. The well-known WHO definition of health refers not solely to a physical but also to a social and mental state (perhaps incorrectly omitting spiritual). In early discussions on assessing needs, the focus was on the physical element. A medically-led model of assessment, where the clients and the general public seemed to have little say in the process, seemed to be favoured, yet there was little evidence of many contract terms reflecting the investment in this assessment of need style. Standards of clinical outcomes continue to seem uncommon, and there are very few that have recognised the need, for example, to carry out a higher proportion of kidney transplants than is currently the case for the Asian population.

Where do the users and potential users fit into the assessment of need system? There are few places within the medical model. The semi-neglected assessment of social, mental and spiritual need would seem to be the answer.

Commissioning and contracting for health gain



If the amount of work to be done in these areas was determined by the number of standards in contracts which touched on these issues, apparently no further work would be required. Standards regarding translation and interpreting are key and are to be found in a large number of contracts, but are they given a focus? The focus of such general terms as 'translation' and 'interpreting' must be clearly determined, for example, in the specific involvement of clients and their relatives in care and discharge planning. As these are not currently part and parcel of the usual medical assessment of need activities this is difficult, as what that focus should be remains a mystery in a number of instances. This report details ways in which the four project sites have gone about the assessment of this non-clinical need, involving users and potential users along the way.

Having these four sites distributed round the country has been extremely beneficial not only to the project as a whole but also to this report. The DoH had funded the King's Fund Centre to have project sites both within and outside London. The disparate nature of the health authorities selected has given the report a wider range of experiences to discuss than others in the same vein. The messages reported here are, while developed in inner-city health authorities, applicable to the majority of DHAs and FHAs.

While the report raises specific messages, some alluded to above the overall focus would seem to be on the function of purchasing departments. These new departments were quite often developed from what used to be known as planning departments. One image of purchasers is of a person burning the candle at both ends, toiling over a computer keyboard. Perhaps what this report suggests is that this is not the sole role of the purchaser; there is a key role as a first among equals. Each authority has staff with a wide range of skills, which need to be utilised effectively. The co-ordination of these skills and associated responsibilities lies with the purchasers – for example, the translation of needs assessment data into sensitive contracts.

Sensitivity to the needs of the Black population, and the necessary improvement in service provision, will only come if there is a real commitment to a comprehensive assessment of need using innovative ways of gaining user views, improving direct service provision and letting contracts to groups from the non-statutory sector. The 'colour blind' approach to tackling the issues must now be seen as discredited. While many groups have to cope with having different needs from those identified through the assessment of need process – translated into contracts – the Black population has the extra burden of coping with the racism that still exists in this country.

Despite these negatives, this report gives hope to all who are interested in the purchase and provision of service for Black people. Purchasing services and the techniques that go along with that are still in their infancy when compared to the direct provision of service. The techniques will improve in quality and range as the system matures. This project will be on-going; the generous support of the Department of Health means that not only the project sites mentioned here, but others, have the opportunity to learn from this project. No doubt there will be other lessons resulting from this work which will enable us all to improve further the services on offer to all, and in particular to Black people.

Huw Jones
Coventry RHA
August 1992

INTRODUCTION

The reform of the health service brought about as a result of the 1990 NHS and Community Care Act has as one of its aims a desire to make services more sensitive and responsive to all users, particularly Black users of the health service. For many, this is a welcome new emphasis on what is after all a 'public service'. Since its inception, the health service has been a major employer of Black people, and so one might assume that the development of services to cater for the multi-racial society that Britain has always been would come about as a matter of course. Unfortunately, this has not been the case, perhaps reflecting the reality of the employment patterns that prevail for Black employees of the NHS.

The poor quality of services offered to Black users has been of concern for a number of years to both the Black population and many who have worked in the health service. Yet the response to this inequality has been lamentable. A series of initiatives have been introduced that have attempted to improve services in particular areas. Yet the approach has not been one that is either consistent or structured: the hallmark of the health service's response to racial inequality can be said to be 'ad hocery and marginalisation'.

The history of race initiatives in the health services, like the experience of Black people themselves, suffers from a lack of information. However, it is clear from the documentation that does exist on the range of initiatives and projects that have been undertaken, that the needs of users have rarely been a motivating factor. From the 'Stop Rickets Campaign' of the early 1980s to a whole host of projects the emphasis has been to identify a particular issue and to concentrate effort on that issue at the cost of all other health needs. The effects of this approach have been to marginalise Black people's health needs to a limited number of conditions and issues, as well as to remove any need to develop new approaches that will bring about structural and organisational change across to totality of the health service or indeed across any particular health authority. As a result the health status of the Black population has been left to the vagaries of individual interest or concern.

The White papers 'Working for People' and 'Working for Patients' offer the opportunity for a radical shift in the approaches adopted by health authorities in respect of the health of their local populations. The move away from the complexities and anomalies of the RAWP system of funding to a system of weighted capitation encourages health authorities to examine the health needs of the population in more detail than ever before. Added to these changes, the publication of a national health strategy in the Green paper, 'The Health of the Nation', there is an onus upon health authorities as purchasers of health care to be proactive in their development of service for the whole population. This is, in effect, a shift from a supply-led service to one that is determined by needs and demand.

The King's Fund has for a number of years promoted the need for change in the provision of health and social care services to Black populations, and saw within the reform package a number of opportunities to develop this work further. Not least of these opportunities was the chance to influence new organisations and their new structures from the outset, rather than have race tagged on as a marginal and late addition to the concerns of the organisation, be it a purchaser or provider of services. Grant monies of £100,000 were set aside to promote the development of services to Black populations. These funds were to be allocated through competition open to all health authorities with a Black population of 10 per cent or more (1981 census data was the basis for consideration). Of the 34 applications received, eight were shortlisted and interviewed and four authorities were awarded grants in the Autumn of 1990. The following report describes the progress made in developing structures that allowed Black users and the authorities concerned the opportunity to improve services through the contracting process.

BACKGROUND

During the summer of 1990 the King's Fund Centre planned to award four grants to health authorities to assist in the process of developing services responsive to the needs of Black users. The opportunity to influence the newly adopted contracting process, and to build in a race dimension to the new planning mechanism within the health service was too important to miss. In awarding the four grants, the King's Fund Centre was aware that much was already known about the health needs of Britain's Black population and that there have been many attempts to improve service delivery. It recognised that many of these initiatives were short-term projects that had little or no real impact on the health service in the long-term. Thus this was an opportunity to impact on the new contract mechanisms and all its components – assessment of need, the setting and monitoring of quality standards and the development and improvement of services – with a new emphasis on the need not only to make services more responsive to local users, but also to involve users in the development of services. The ambition was to build into these new mechanisms and structures a race dimension that would be long-term and have a fundamental influence on services, not just for the duration of the projects.

A number of clear objectives were set by the four projects, which were in Central Manchester, Coventry, Ealing, and Parkside health authorities.

It was important that each of the health authorities involved recognised that the success of the projects was to a large extent dependent on their willingness to experiment with the new structures coming into place. They would seek to integrate their work on race issues into the mainstream of their contracting activity, and, perhaps most importantly, to establish within these new structures and mechanisms a role for users and user groups, at least in the assessment of need. On this last issue it was recognised that the health service has a history of 'consulting' local people. It was our intention that this be developed much further so that the process was one of long-term, active participation rather than the short-term, one-off passive consultations of the past.

In each of the project districts there had been a history of activity on race issues and each of the authorities had an equal opportunity in employment policy and were committed to improving their services through a process of change. While there were clear common objectives for each of the projects each was at liberty to set up their project as they felt most appropriate to their management structures.

The following report is thematic, picking out the key issues and themes rather than reporting on the activities of the four project districts. There are areas of overlap across issues and themes, as well as across the project authorities. The general messages are about the development of the purchasing role and the need for purchasers to become more sophisticated, and some of these need to be seen in the wider context of 'The Health of the Nation'. The development of alliances with other organisations, local authorities, FHSAs and voluntary organisations is important. Other issues, like that of user involvement/community participation, are again developing more general themes linked to community care planning and the Patient's Charter. There are, though, more specific messages about the processes that can and have been adopted around the country. Where possible a specific reference will be made either to purchasers or providers that can offer their experience, or to another resource such as a publication or an organisation outside of the health service.

The main themes presented in this report are:

- community participation
- setting standards and developing the contracting process
- developing mechanisms for monitoring outcomes.

THE FOUR PROJECTS

Central Manchester

During the course of the project Central Manchester Health Authority's bid for trust status for its provider units, both acute and community, was approved in April 1991. The original proposal was from the health authority as a purchaser of services. After the trust approval the project moved into the provider units. A freelance consultant was appointed as the project worker for twelve months in the departments of Public Health and Contracting/Planning, working closely with the chief executive.

Three major areas of activity were identified:

- to develop liaison with local Black community groups thus developing the authority's mechanism for the assessment of need
- to work with provider units, 'educating' managers regarding the provision of services that are accessible and appropriate to the needs of the local population
- to assist and advise on the detail of specifications to be included in contracts and service agreements.

It was also part of the authority's ambition to develop a district-wide strategy for race issues. It was envisaged that the project would have a wider impact, with the two other district health authorities in Manchester that form a joint purchasing consortium.

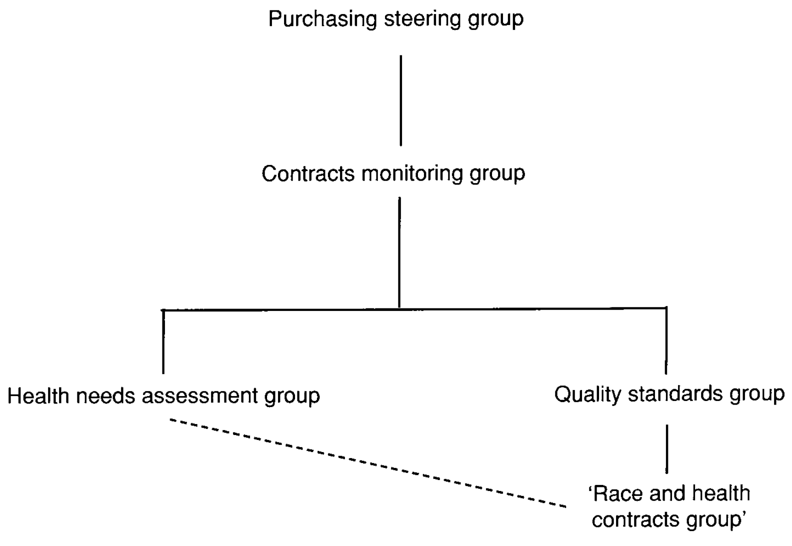
Coventry

The proposal for this project originated with the district community care unit, and anticipated that a newly introduced neighbourhood/patch structure would form the planning base for the development of a needs assessment process that would inform the contracting process. The project worker was initially based in the Holbrooks patch of the health authority's community care unit, and was responsible to the unit chief executive. Appointed for eighteen months, it was envisaged that the new community structure would become established to such a degree that it would be the most appropriate planning medium, allowing for greater local sensitivity and responsiveness in the provision of services. During the course of the project it was realised that the patch structure was not sufficiently well-established as a planning base, the project was moved into the mainstream of contracting activity, and the project worker became accountable to the director of purchasing and contracting.

Ealing

A two-year project was proposed, based in the purchasing directorate responsible to the purchasing manager (quality). The emphasis was to develop a process of ongoing consultation with Black groups to determine quality standards to be included in service specifications, as well as to monitor the impact of service changes brought about as a result of the work of the project. It was also thought that the district would explore how local Black community groups could become direct service providers through the liberalisation of the contracting process. The development of a 'consultative' mechanism was one of the key tasks identified in the project proposal, and had with two aims, firstly to create a process to assess local health needs that involved local Black people, and secondly, to develop this machinery to become part of a process to monitor the outcomes of the contracts placed with a large number of providers.

Ealing: overall purchasing structure



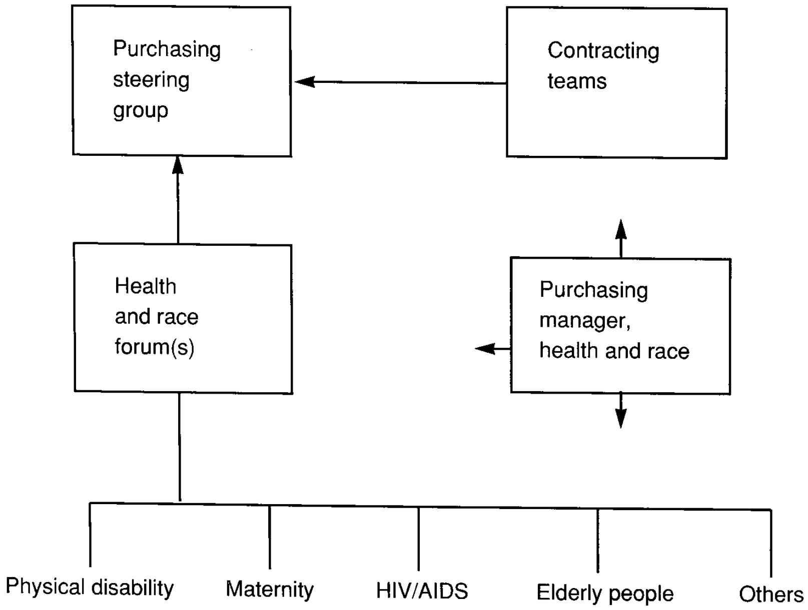
Parkside

The district had already appointed a health and race manager to work across its provider unit and wished to develop its work further with a post in the purchasing directorate/authority. Using a King's Fund grant for the first two years a permanent post was created which is based in the purchasing directorate accountable to the assistant director of purchasing. The emphasis of the project is on acute services, and a number of specialties were identified:

- maternity services
- HIV/AIDS services
- care of elderly people
- and disability.

The need for a more participative approach to the assessment of need was identified as a priority for action. The approach adopted by Parkside suggested that the race dimension to contracting would be integral to the purchasing function. Moreover, the evaluation of the work of the project would be seen as part of the overall monitoring of contracts and that this evaluation process would provide a framework both for the assessment of quality in all contracts and the response of providers to specifications.

Parkside: health and race purchasing structure



COMMUNITY PARTICIPATION

NEEDS ASSESSMENT

Much is said about the new role of purchasing authorities as the new advocates of the health of their local population. The 'Health of the Nation', as well as setting explicit targets for the first time, sets out the lead role purchasers have in assessing the health needs of their local population. The concept of health gain is central to the ambitions of the White paper. Purchasers are having to plan for health gain rather than the maintenance of health. In all of the pronouncements it is clear that health services have to become not only more aware of but also more responsive to, the needs of their populations. There are clearly many ways of getting to know what actual and potential users want from the health service. It is equally clear that no one of these methods in isolation is correct or will produce a total picture.

The range of methods currently used to determine health need is enormous, moreover the variety of methods reflects the changing nature of the health service. Health needs cannot be measured and determined through purely quantative methods; greater credence is being given to qualitative information. Within this change of emphasis, the user (actual and potential) has been given a new position of responsibility. The rush to involve the user to define needs, quality, and in some cases even priorities, has to be welcomed, but cautiously.

For a number of years there has been growing interest in the role of users in the development of services and recently this has been manifest in a number of Government and Department of Health initiatives. Not least of these is the

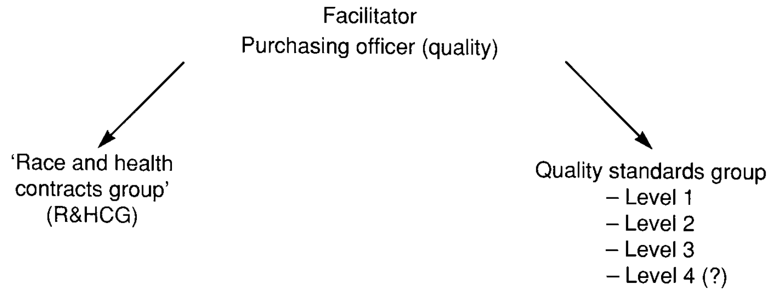
Citizen's Charter and its health counterpart the Patient's Charter. Both set out a new part for the 'citizen' to play. Despite the limits of these initiatives there is clearly a new mood within the health service promoting the value of the user and the community in general. *Local Voices*, a recent publication by the NHSME, details the efforts of a number of health authorities around the country to involve the local population in service planning and development. All of this is a far cry from the secrecy and limited consultations which the health service was noted for.

If the experiences of the four project districts are of any value, they show that there are no easy methods and that sustained effort, energy and investment are needed to establish and consolidate relationships with users, user groups and the community in general.

THE EALING HEALTH AUTHORITY CONSULTATIVE MECHANISM

Ealing Health Authority set up a consultative mechanism with a variety of stages and a range of different techniques to develop a better picture of the health needs of their local Black populations. The concentration is on integrating information sources. A major strand in this work has been the creation of a series of consultative levels. Each of these levels feeds into the others and helps to develop a broader picture based on the direct expression of need by users and user groups.

Ealing's consultation process
Seeking participation – modes of participation



The first stage of the process was to trawl all the Black organisations in the district and to identify those who had a genuine interest in health-related issues. This process in itself has been informative for the health authority. Not only have they made contact with a large number of organisations, they have also a better idea of the activities of these organisations and the people they serve. It has also given the health authority a clearer idea of the constraints under which many of these organisations operate often very high commitment to their users and the issues that they are tackling.

WORKING WITH COMMUNITY ORGANISATIONS

Many of these organisations have to devote almost all of their meagre resources to fulfil their original remit, that is to say, to provide a service to the population that they serve and often represent. One of the negative impacts of this is that they have little time or money for organisational development, or, perhaps more importantly in this case, they have little time to take on new issues. It can also mean that such organisations are unable to represent either themselves or their constituents effectively at meetings with statutory bodies. These organisations can become parochial in their concerns, which can often mean concentrating simply on survival and the ability to provide a basic level of service to their own users.

The experiences of many health authorities reflect this pattern. Parkside, for example, had set up a number of public meetings as part of a strategy to develop a local consultation framework to inform local communities of the new approach it was adopting and the role that those groups could develop within this example. Unfortunately the response from community groups was poor. Health authorities have to be aware of the reality of the situation faced by the community groups with which they want to engage – it will not be easy.

Some of the issues listed above are practical; there are a range of issues that are more political in nature. The National Health Service has not been the best of acquaintances to Black people either as an employer or a provider of services. There will be natural apprehension of and at times cynicism about the approaches made by health authorities. Ealing, aware of much of this, has managed to begin a dialogue with many of its local community organisations, some of whom it has had little contact with previously. This has been achieved as a result of an investment on the authority's behalf in terms of both time and commitment.

The time has been that of the project worker who has, over a relatively short time-span developed good links with the many Black, health-related organisations. This approach has not been limited solely to the more traditional types of community organisations such as temples and other religious places. Contact has been made with a wide range of groups, from cultural and religious groups to the campaigning organisations that have at times been critical of the health authority and its performance. Time has also been a consideration in the process of 'consultation' with these groups, with both the people who run them and those who use them. A planned and staged series of contacts with groups has been a cornerstone of the approach adopted in Ealing. Initial contacts had been made with 'community leaders', as an act of at least gaining permission to develop the process of consultation. Through this process the health authority has been able to reach the users of the community-based organisations. Commitment is manifest in the readiness of the authority to accept the role of the race and health contracts group within the purchasing structure.

Ealing: levels of consultation
Consultation – levels 1,2 and 3

1. Level 1 – To make initial contact with Black and ethnic minority community/voluntary groups.
2. Level 2 – To consult with **users** of Black and ethnic minority organisations.
3. Level 3 – Consensus groups.

PUBLIC PERCEPTIONS

Within this process it has been clear that there is little clarity of the role of the health service in general, the health authority, in its new role as a purchaser, in particular, and other statutory organisations. A broad range of issues have been raised in meetings with community groups and their users. Some of the issues are of a general nature, others are patently the responsibility of other organisations such as the FHSA, social service departments or environmental health department of the local authority. There has also been a great deal of hostility towards the health authority because of frustration at its previous record. This frustration cannot be ignored, it is part of a process of building trust and showing the commitment of the health authority in its new role as a purchaser of services. Indeed, while some of the frustration being expressed can be regarded as negative comment, much of it reflects on the poor quality of the service as seen by the recipients – this is the first real opportunity they have had to vent their frustration directly at the 'health authority'.

STANDARDS AND CONTRACT SPECIFICATIONS

While the process of developing a closer relationship with the community is clearly not only possible but also has real benefits, there are a number of obstacles to be overcome if the process is to become long-term and fruitful for all involved. One difficulty is that in making a transition from the 'traditional' methods of assessing health needs to the creation of new processes that give at least equal weight to the voice of the user. There is a general feeling that while this aim is entirely laudable, the inherent difficulties are enormous. The need for purchasers to be able to translate the involvement of the community into real change through contracts is new only in the sense that the object of change is now detailed in a contract specification. Within purchasing authorities the changes have brought about the impetus for the sort of long-term planning that aims not only to improve services but also has 'health gain' as an imperative.

The contract culture has brought with it a number of new structures within purchaser and provider units and with those structures are numerous new processes. The assessment of need, one of these new processes, plays a large part in determining what the user will receive as quality services. While valuable, consumer satisfaction surveys are of limited use in isolation from other sources of information, particularly as a means of establishing and developing standards of care. In the course of their work each of the project authorities set out to develop new sets of standards for their services. Clearly drawing a link between the results of the involvement of the community and the standard setting process is a key task.

STANDARD SETTING

The need to set standards is crucial to the development of a viable contractual process. Without standards and targets it would be impossible for providers to perform except in the sort of system that is totally supply led, the sort of system that we are trying to get away from. Building needs assessment processes that reflect the expectations of the local community is as important as the twin needs of creating a means of appraising options and monitoring the provision of care. The emphasis of the projects has been to develop such systems with the direct involvement of their local populations. While these processes are still in their infancy, there are already clear messages as to how purchasers can work with their residents and their providers to create service specifications that are more responsive to need.

Setting standards is a complex business. The purchasing intentions of health authorities are driven by a range of factors, not least the availability of the services required. Standards are part of the process which enable service developments to occur. It is important that purchasers are clear as to the services they want to procure and how they want them to be delivered. The quality issues that surround the provision of services can be broken down into a number of areas, such as those that pertain to hotel services and those that relate to clinical care. Both are issues that purchasers will be assessing when they review their providers' performance. The establishment of these review mechanisms, then, is clearly as important as the contract-setting process. Indeed it can be argued that both are part of the same process, with review and assessment criteria being built into contracts and service specifications from the outset.

The early emphasis of the reforms was on the role of providers. There is now a realisation, with the publication of the Green paper 'Health of the Nation', that purchasers are key actors in the equation if 'health gain' is to become a real objective for the health service. Particularly if purchasers are to become, in the words of the Secretary of State, 'champions of the people':

> '...*health authorities need to adopt a radically new approach to seeking people's views. The new approach should focus on greater involvement of local people and better communication with them.*'

This must surely mean that local people are involved both in the assessment of needs and, as importantly, in monitoring the quality of the services they are using not just through satisfaction surveys but through radical new approaches which can and should include talking directly with users and their advocates, thus giving voice to the rhetoric of the Patient's Charter. This means that mechanisms to give Black users a voice that will be heard are important, as is the need to get away from the sort of *ad hoc* approach to Black people's health concerns that has characterised the response of the health service for many years.

> *'There is an urgent need to move away from "meaningful references" about health and race and to setting concrete objectives that influence our purchasing strategy ...'.*
>
> ***Parkside purchasing plan, 1991.***

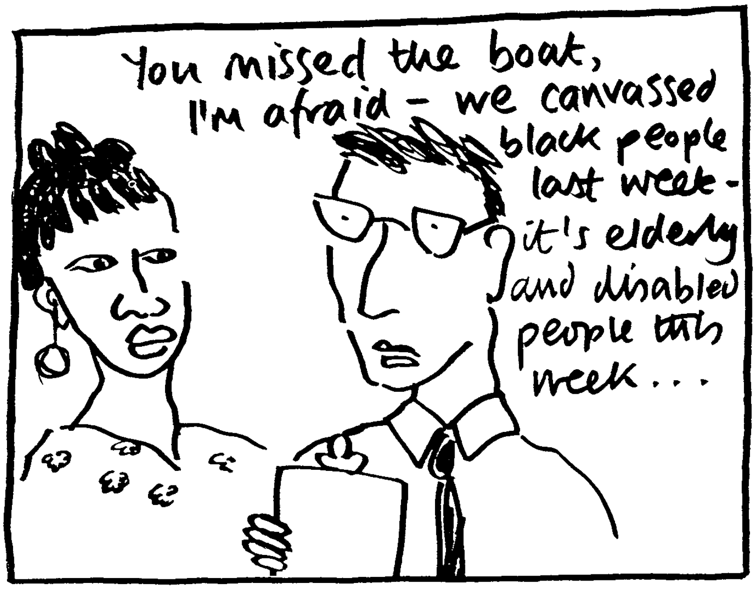
NEGOTIATION

The process of setting clear and achievable standards is one of negotiation – negotiation between purchasers and the local population as well as between purchasers and providers. There is some difficulty in being able to translate the wishes of users into contract specifications, as often the needs expressed by users are diffuse and ill-defined and may not be in line with stated priorities. It is clear, however, that contracts and specifications are part of a development tool that will help reshape services to become more responsive to need. It is this that should form part of the negotiation between purchaser and provider in relation to the needs of Black users. For purchasers that are dealing with a large number of providers, and especially if the provider is having to respond to a large number of purchasers, there can be difficulties. It is, though, likely that purchasers will be basing their purchasing strategies on sets of principles that are similar, particularly so if the purchasers and providers are within the same region, as a result of the corporate contracts between the region and districts.

PRINCIPLES FOR PURCHASING

Parkside Health Authority has identified the following criteria as the basic principles on which its purchasing plan and intentions are based:

- access
- equity
- acceptability
- efficiency
- appropriateness
- effectiveness.



Within each of these principles there is a range of practical issues to be addressed. In some cases there are issues that are, in effect, common knowledge, and that can be progressed without having to resort to the old standby for inactivity – the need for more research. Issues such as: the dietary requirements for interpreters or user advocates; the need for hospital menus to reflect the needs of a diverse population; for facilities for religious observance; and the need to respect the modesty of female users of the health service, particularly those from religious groups which particularly emphasise modesty; the need for more female doctors in maternity or screening services, are all well known. Or, in relation to clinical care, the need for provision of services for sufferers of sickle-cell anaemia and thalassemia, diabetes, hypertension and other conditions that disproportionately affect Black populations, are also known. The knowledge available allows purchasers to translate statements that reflect their concerns on these issues into contracts and service specifications and thus into measurable activity for providers. It is not enough simply to state that providers must ensure that services are responsive to the needs of Black people. While this may be well-intentioned it achieves little in practice. It reflects the discredited 'colour-blind' approach that characterised the response of many in the health service until relatively recently.

THE CONTRACTING PROCESS

Contracting allows purchasers to specify in some detail not only the services they wish to procure for their population but also the quality of those services. This gives purchasers the opportunity to write into contract specifications a wider range of quality measures than has been the case previously. In some cases this has led to a re-design of services, making them more responsive to local user demands. Moreover, many health authorities as purchasers are looking to develop outcome measures beyond cost and volume, for both clinical and non-clinical issues. For purchasers and providers these outcome measures are important insofar as they are benchmarks against which services can be assessed. The process by which attainable and measurable standards are reached is precisely that part of the contracting process around which there is a veil of vagueness that is difficult to penetrate. In most instances, health authorities are unwilling to disclose the detail of the processes they have set up to negotiate agreements with providers. In the four projects it has been apparent that this is the stage of the contracting process where development is the key issue. The commitment to be much more open about the planning and development of purchasing plans and the detail of contracts is important, not least if local users are to become involved.

PRIORITISING THE WORK

In consulting with the local population, purchasers are developing a sense of priority and gaining an understanding about the issues around the priorities that are being set. In their negotiations with providers, purchasers are beginning to set an agenda for the development of services. Within this phase of the process it is realised that some purchaser demands have to be set as developmental standards in the first instance and that others are set as immediate issues. Some of the examples given above regarding religious, cultural and linguistic issues are more easily and immediately dealt with, they are not new issues, nor are they particularly difficult issues to deal with. That they have not been dealt with previously is an indictment of the health service in general. In their report, *Action not Words*, NAHAT gave examples of the way health authorities around the country were dealing with such issues, as well as giving advice and contacts in the health service, to assist those that had not yet taken the issues on.

In their negotiations with providers, Parkside Purchasing Authority has set out a number of minimum requirements on which it will be monitoring the effectiveness of the services it purchases. These are included in Appendix 1. In the main these are practical issues relating to the non-clinical component of the care received by users.

OUTCOMES

The outcomes of the projects need to be seen at four levels: first, in terms of the original brief set by each of the project authorities and the changes that have come about in the organisational cultures of the four authorities concerned; secondly, at the level of measurable change in the services offered to Black users; thirdly, in terms of the development of mechanisms allowing users, particularly Black users, an input into the commissioning of services; and fourth, and perhaps most importantly, the value of these processes to the user. This final point has to be seen in the context of the relatively different approaches adopted by the project authorities as well as in terms of the newness of the approach. This also applies to the extent to which services and the way they are organised and delivered has changed. Contracting as an activity has only been in place for two years, this period having been marked by the Department of Health's desire to maintain a 'steady state'. The effect of this has been to limit the role and 'power' of purchasers.

THE IMPACT ON THE ORGANISATIONS

To examine the impact on the organisations and their development first, it is difficult to say with any certainty whether or not the funding and the subsequent projects were the motivators of the sorts of structural developments that have taken place. It is even more difficult to determine whether or not the greater value that is seemingly being put on the voice of the user has come about due to the projects or to the wider influences of the White papers, the Patient's Charter and the importance attached to consumerism that is reflected in some of the work of the NHSME. That said, it is clear that in each of the project authorities there are new relationships between users and user groups and that the new structures and processes that have come about as a result of the reform of the NHS reflect this.

Certainly the four authorities have benefited from the approaches adopted by each of the project workers. They have brought inventiveness to the work and that is reflected in the quality of the commitments that are growing within both purchasers and providers to develop services that are more responsive to the needs of local Black users. How well-established these new mechanisms will become is difficult to determine, but certainly one of the impacts of the work has been to give new confidence to Black users and user groups. The growth of the Manchester Action Committee for the Health of Ethnic Minorities (MACHEM), for example, is a success that, while not attributable directly to the project, is reflective of the new confidence that prevails. Moreover, the relationships that MACHEM has developed and nurtured with each of the health authorities in Manchester is a tribute to the membership of MACHEM and to the health authorities, which have clearly invested a great deal of time and energy to achieve positive outcomes – not only on issues such as the development of policies relating to equality of opportunity in employment, but also in the development of service specifications and services themselves.

SERVICE DEVELOPMENT AND CHANGE

The second level of outcome, that of service development and change is somewhat less clear. Contracting as an activity within the health service is still relatively in its infancy, moreover, political expediency has distorted the evolution of the process. The initial emphasis on the role of providers has had the effect of undermining the development of purchasers. So much for the Government's proclaimed championing of the consumer! In each of the project districts the early thrust has been on the development of a new set of relationships with the local community – the revision of contracts and service specifications has followed.

Only one of the four projects, Central Manchester, has completed its planned course. As a provider-led project it is the only one to have produced service protocols that have been jointly agreed with purchasers. Given that these protocols are in the earliest stages of use it is difficult to assess their efficacy. Yet it is fair to say that in each of the projects there have been levels of success that were not expected at the outset.

INCREASED INFORMATION

The quality of the information that has become available to health planners, as well as the detail which users and user groups have been able to add to existing planning tools, has been invaluable. When this information-base is augmented by data on the racial and ethnic origins of service users (this will be a requirement of all in-patient facilities as of 1 April 1993) its value will increase markedly, as will its utility. That this information has been translated into tangible tasks that can be written into a service specification is one of the positive outcomes of the work undertaken by each of the project authorities. How these are built into everyday activity by providers and the impact they have on users is difficult to determine.

It must be recognised that outcome measures are notoriously difficult to determine, so it is important that they are applied and developed in those areas where there are definite measures. In the main these will be in non-clinical areas of care, the emphasis being on the involvement of users in much the same way as in the assessment of health need. The structures set up to allow users a greater say in the planning and development of services are extended to give them input to in the satisfaction element of any review of service contracts, and to give them opportunity to voice opinions on the service as it is provided.

STRUCTURAL CHANGE

It is important that much of what is being suggested is likely to be contentious within the organisation. Few, if any of the institutions that make up the NHS are free from pervasive deeply-ingrained, endemic, institutional racism. Thus it is possible that some within the organisation will see any activity aimed at the Black population as special treatment, or giving in 'to those with chips on their shoulders'. This said, it is important that these issues are discussed at the highest levels within the organisation, and that the organisation makes its commitment explicit. To leave it as a tacit commitment is no real commitment. In such

situations the lack of any real leadership and ownership allows, at the very least, others within the organisation to avoid their responsibility, and at worst it is an ambiguous message to people inside and outside the authority. It is within these circumstances that the less overt, more subtle forms of individual racism are 'allowed' to operate. In addition, in these circumstances there is no commitment to the sort of structural and organisational change that is necessary to achieve changes in the way institutions respond to racial inequality.

The need for structural change is not simply to make services and institutions more responsive to Black people, but is necessary if services are to become more user friendly in general. It is not enough to translate questionnaires and leaflets into Urdu or Turkish if they are seeking views on services that are inaccessible and unresponsive, particularly if they are surveys that are aimed at finding levels of satisfaction. It is often difficult to express dissatisfaction with any feeling through such surveys. Further, the type of questions posed in such surveys may miss the concerns of Black users. Concerns such as the the impact of racism on Black people's lives and their health status are often difficult to express, as are views about the clinical care received. In some instances the concerns raised by users are nothing to do with the health service, or are related to other care providers within the service and so are not recorded. Users are not necessarily aware of the divisions and distinctions between health and social care or between the various statutory bodies and their various responsibilities. Gaps in information cause difficulties for users as well as planners and providers, hence the need for other means of gaining user views, particularly if they are expected to be a form of audit on services delivered.

Ealing Health Authority is attempting to extend the process of community participation from an involvement in the assessment of need through to an assessment of the quality and efficacy of the service itself. As with the processes being adopted to assess need it is envisaged that the purchasers will use the information gleaned from this exercise to redefine their specifications with providers. The creation of a 'feedback loop' gives users and user groups ownership of the process and indeed of the service. In theory such processes are based on the mutual benefits that accrue to both the community and the health service, be that as purchaser or provider.

APPENDIX 1

PARKSIDE HEALTH AUTHORITY: QUALITY STANDARDS – HEALTH AND RACE

This document supports the *General Quality Standards – Schedule Two* for provider contracts. It is intended to give specific guidance to providers on key quality concerns regarding black and minority clinic service users.

Our overall aim is to establish realistic standards of service which meet the requirements of the purchaser and to which the provider is committed. Initially, our objective is therefore to establish a modest baseline of mutually agreed expectations and to target a few key areas for improvements in 1992/3.

The service specification outlined comprises of three sections:

- Overall aims and objectives: This section describes Parkside Health Authority's quality objectives for black and minority ethnic residents. It gives providers scope to interpret a range of practical measures for securing improvements in patient care have been agreed with purchasers and which can be monitored.
- Basic standards: This section describes the basic systems which every provider unit is expected to have in order to maintain a culturally appropriate, acceptable and accessible service for black and minority ethnic patients and staff. The Purchasing Authority wishes to reserve the right to audit these procedures as appropriate.
- Key performance criteria: This section identifies four key performance targets where Parkside expects provider units to achieve measurable/quantifiable improvements during 1992/93.

OVERALL AIMS AND OBJECTIVES

Parkside Health Authority requires the provider to take practical initiatives to address the following quality objectives regarding black and minority ethnic services users.

(i) to ensure there is adequate provision for patients to communicate with health workers in the language in which they feel most comfortable.

(ii) to provide information translated into community languages about local health care services, which is easily accessible.

(iii) to use other forms of non-written communication.

(iv) to ensure that the environment in which black and minority ethnic people work and patients cared for is safe and conducive to well being through:

- providing meals which meet cultural and religious requirements
- making provision for observance of religious practices
- ensuring that cultural beliefs and practices about death and bereavement are observed.

(v) to improve consumer choice of the services available, as might be the case with women requesting to consult and be treated by female doctors.

(vii) to establish mechanisms to consult with black and minority ethnic services users regarding their treatment and use of services.

(vii) to monitor the use of services by ethnic groups to allow effective targeting and planning for different ethnic groups.

BASIC STANDARDS

Parkside Health Authority requires the provider to have effective systems in place capable of producing viable outcomes with regard to the following:

- ethnic monitoring of service users
- compliance with relevant race relations legislation regarding standards to ensure equality of opportunity
- anti-racist and customer care training
- clinical practice which is culturally acceptable
- patient information which is linguistically and culturally appropriate.

KEY PERFORMANCE CRITERIA

Parkside Health Authority requires the provider to meet the standards and monitoring arrangements in the key performance areas laid out in this section regarding black and minority ethnic users.

1. Ethnic monitoring

1.1 The provider will demonstrate that it is developing systems for ethnic monitoring of patients. The authority has produced guidelines highlighting the key areas in implementing systems for ethnic recording. These are:

(i) appropriate publicity information for staff and patients

(ii) training for staff involved

(iii) standardised classification of ethnic group.

2. Health promotion

2.1 The provider will demonstrate that it has identified key areas for health promotion within black and minority ethnic communities. These areas specifically include:

- HIV/AIDS prevention
- coronary heart disease prevention
- hypertension
- diabetes
- mental health
- substance mis-use.

2.2 These areas of activity will be monitored through the Health Promotion Unit.

3. Interpreting and translation services

3.1 The provider will demonstrate that steps are being taken to secure appropriate interpreting and translation facilities. The following standards of service should apply:

(i) Patients should be able to communicate with health workers in the language they feel most comfortable with.

(ii) Information should be provided to patients which is linguistically and culturally appropriate.

(iii) the provider will ensure that appropriate measures are taken to promote awareness of the necessity to use these services amongst their staff.

(iv) The provider should monitor the demand and uptake of these services.

4. Complaints

4.1 the provider will ensure that it has complaints procedures which enable patients to register complaints they regard as being racially motivated. The provider will inform the Authority of such complaints through the established channels and include additional information regarding action taken and responses made to the complainant.

APPENDIX 2

PARKSIDE HEALTH AUTHORITY: AGREEMENT ON HEALTH AND RACE OBJECTIVES BETWEEN PARKSIDE MENTAL HEALTH UNIT AND PARKSIDE PURCHASING AUTHORITY (DRAFT)

The Purchasing Authority has established baseline Quality Standards on Health and Race, targeting key areas for improvement in 1992/93.

PURPOSE

The purpose of the agreement is to outline objectives on health and race standards agreed between Parkside Mental Health Unit and the Purchasing Authority for 1992/93 in the following areas:

- ethnic monitoring
- interpreting and translation
- staff training
- diet
- religion.

The Purchasing Authority's view is to encourage the provider to make progress during the year. The Authority therefore encourages the provider to liaise with the Purchasing Manager for Health and Race within the year. Areas where work can be undertaken which are not part of the agreed objectives will be encouraged and where appropriate undertaken collaboratively.

1. ETHNIC MONITORING

Standardised systems for ethnic monitoring are required for all services by April 1993.

1.1 Objective

To prepare and implement, in planned stages, an ethnic monitoring programme during 1992 in the following areas:

(i) Petterson Wing

(ii) Central Middlesex Hospital

(iii) Wembley Hospital – Outpatients

(iv) Villa Four

1.1.1 In accordance with the Purchasing Authority's guidelines on ethnic monitoring, the following key components should be incorporated:

(i) a planned timetable for implementation

(ii) appropriate publicity information for patients and staff

(iii) training for key staff to be involved

(iv) standardised OPCS classification of ethnic group.

1.1.2 The Purchasing Authority recommends the following data sets for ethnic monitoring:

(i) ethnic group

(ii) religion

(iii) language.

1.2 Monitoring

The provider has agreed to hold six monthly monitoring meetings. These will focus on:

(i) evidence that the components specified in the objective are being addressed

(ii) progress to-date on the above in the specified areas

(iii) problems encountered by the providers in carrying out the objectives.

2. INTERPRETING AND TRANSLATION

Provision of appropriate interpreting services and translation information is required to improve access to services for non-English speaking services users.

2.1 Objectives

2.1.1 To work with the Parkside Interpreting Service (GRIP):

(i) to assess the level of need for interpreting services

(ii) to develop the most appropriate approach to meeting identified needs in the specified areas.

2.1.2 To promote the use of the service among staff and provide information on service standards which should apply.

(i) GRIP have produced guidelines on using the service which should be disseminated to appropriate staff

2.1.3 To secure an appropriate level of services to meet expected uptake.

2.1.4 To assess the resource implications.

2.1.5 To monitor uptake and demand for the service.

2.1.6 To ensure mechanisms are in place for service users feedback regarding the quality and appropriateness of the service.

2.1 Monitoring

The provider has agreed to hold six monthly monitoring meetings. These will focus on:

(i) evidence that an assessment of interpreting need has occurred

(ii) evidence that use of interpreting services has been promoted among staff

(iii) a description of the service and level of provision with supporting data

(iv) cost of providing the service

(v) evidence that service users' views are being sought

(vi) problems encountered in meeting any objectives.

3. STAFF TRAINING

Appropriate training is required which equips staff to respond to the differing needs of a multi-ethnic and multi-cultural community.

3.1 Objectives

To prepare and implement, in planned stages, a staff training programme during 1992. In particular the provider will produce a costed proposal on health and race training for staff which incorporate the following components:

(i) customer care

(ii) anti-racism/health and race awareness.

3.2 Monitoring

The provider has agreed to hold six monthly monitoring meetings. These will focus on:

(i) evidence that a detailed staff training programme has been produced

(ii) timescale for implementation

(iii) evidence that the key components specified have been included

(iv) progress to-date on the above in the three hospitals

(v) problems encountered by the provider in carrying out the objective.

4. DIET

4.1 Objective

The provider will ensure the provision of meals which meet the cultural and religious requirements of service users. The provider will specifically undertake to:

(i) review current provision of meals

(ii) set specific standards relating to the provision of culturally appropriate diets.

4.2 Monitoring

The provider has agreed to hold six monthly monitoring meetings. These will focus on:

- evidence that a review of the provision of culturally appropriate meals has taken place or is underway
- evidence showing the range of meals available
- evidence that standards have been developed and mechanisms in place to monitor them
- problems encountered in carrying out the objectives.

5. RELIGION

5.1 Objectives

5.1.1 The provider will ensure the provision of appropriate facilities for patients' observance of religious practices. the provider will specifically undertake to:

(i) review current provision of facilities in place

(ii) assess the range of religions practised by service users

(iii) take steps to ensure that facilities are in place to enable service users to practise their own religion and to provide information about the service.

5.1.2 The provider will ensure that staff:

(i) receive training on religious and cultural beliefs about death and dying (c/f 3.)

(ii) observe the appropriate practices relating to death and dying

5.2 Monitoring

The provider has agreed to hold six monthly monitoring meetings. These will focus on evidence that the following have been undertaken or are underway:

(i) a review of current provision and assessment of range of provision required

(ii) steps taken to improve the provision of facilities

(iii) information provided to service users

(iv) steps taken to provide training for staff

(v) steps taken to establish a mechanism for service users feedback.

(Parkside Purchasing Authority, February 1992)

APPENDIX 3

CENTRAL MANCHESTER: MATERNITY SERVICES CONTRACT SPECIFICATION

DESCRIPTION OF SERVICES REQUIRED

Aims and objectives

The Central Manchester Health Authority wishes to secure maternity services which are presented in a manner which is sensitive, appropriate and accessible to all sections of the Black and ethnic minority population and which takes full account of women's racial and cultural origins.

Detailed objectives of maternity services have been outlined in the main contract for maternity services between Central Manchester National Health Service Trust with Central Manchester Health Authority.

Specific objectives to address the needs of Black and ethnic minority women are to:

- increase the uptake of antenatal parentcraft services by black and ethnic minority women
- reduce the perinatal mortality and stillbirth rates
- improve customer satisfaction with the non-technical aspects of care
- improve communication (linguistic, cross-cultural and interpersonal) between service providers and service users.

Within this context, the Purchasers have identified the following priorities for service improvements in 1991/92:

- positive measures to increase the number of female obstetricians, anaesthetists and theatre technicians to ensure the choice of female staff to all women wherever possible
- increase the proportion of care given directly by midwives during antenatal and postnatal care
- the establishment of a linkworker/advocacy service which covers antenatal and postnatal care
- a specialist liaison midwife to work closely with women from the ethnic minority communities (including work with community organisations)
- close liaison with the local authority and the voluntary sector in developing jointly-funded initiatives to improve the access of services to women whose first language is not English (English for pregnancy classes)
- clear guidelines regarding the screening, counselling, treatment and support

services for sickle cell and thalassaemia and other inherited conditions of which Black and ethnic minority people are at risk

- education and training of staff in race awareness and non-racist practice and in an appreciation of beliefs surrounding pregnancy and childbirth
- translation of leaflets and booklets to all pregnant women into the relevant community languages, the content being culturally and racially appropriate
- where English is not the first language, ensuring there is someone who speaks the woman's language to accompany her during labour.

Monitoring

The Provider should undertake to monitor services as set out in accordance with the Central Manchester Health Service Trust contract for Health Services with Central Manchester Health Authority and will be requested to give evidence to the Purchaser of appropriate measures being taken to achieve the above objectives.

APPENDIX 4

CENTRAL MANCHESTER: CONTRACT SPECIFICATION FOR MENTAL HEALTH SERVICES

Location and description of services

The mental health services in Central Manchester have been outlined in the main contract for mental health services between the Central Manchester National Health Service Trust with Central Manchester Health Authority. Services included are:

- Community services
- Inpatient services
- Outpatient services
- Daycare services
- Rehabilitation services

Types of care

Mental health promotion, assessment, treatment, rehabilitation, long-term support and monitoring based in clients' homes, residential homes, hostels and hospitals.

Community-based services such as psychotherapy (individual and family and group therapy), health promotion and education of other health service staff, voluntary sector workers and the general public about mental illness.

Support to staff from any part of the health service who provide counselling.

Description of service required

Aims and objectives

The Central Manchester Health Authority wishes to secure mental health services which are presented in a manner which is sensitive, appropriate and accessible to all sections of the Black and ethnic minority population and which takes full account of the racial and ethnic origins of service users.

Detailed objectives of the mental health services have been outlined in the main contract for mental health services between Manchester Central National Health Service Trust with Central Manchester Health Authority.

Specific objectives to address the needs of Black and ethnic minority service users are:

- to improve preventive services to this sector of the population and avoid labelling
- to reduce the level of mis-diagnosis
- to increase the number of Black and ethnic minority service users to day care services, thus reducing the numbers in hospital residential care
- to improve communication between Black service users and carers.

Within this context, the Purchasers have identified the following priorities for service improvements in 1991/92:

- the production of information about medication and other forms of treatment to service users and their carers translated into relevant community languages
- access to interpreting services to both staff and service users
- appropriate and acceptable advocacy services (including professional and citizens' advocacy)
- the development of a mechanism to effectively consult with local Black and ethnic minority service users about their needs and wants
- close liaison with GPs and FHSAs, social services and housing departments, the voluntary sector and other agencies to ensure that care plans reflect the social, cultural and individual needs of service users from Black and ethnic minority communities
- liaison with the probation, police and prison services to ensure that mentally ill people are not inappropriately managed
- an investigation of the experience of services by Black and ethnic minority people with regard to types of mental health services used
- to increase the number of community psychiatric nurses from Black and ethnic minority communities
- monitor services used by ethnic minority people (use of the psychiatric register as a starting point)
- the development of a range of culturally sensitive and appropriate psychological therapies
- the development of a training strategy to include race and culture issues for all levels of professionals involved in mental health (including doctors, social workers, psychiatric nurses, and psychologists).

APPENDIX 5

THE CENTRE FOR ARMENIAN INFORMATION AND ADVICE

CONSULTATION NOTES – LEVEL 2

Date: 11 October 1991
Time: 1.30–3.30pm
Venue: Sydney Miller House, 26-28 Crown Street, Acton

1. INTRODUCTION

The Centre for Armenian Information and Advice (CAIA) was established in 1986 and has a paid membership of over 250 people. The Centre employs two full-time and two part-time staff, and also relies on sessional and volunteer workers who assist in operating some of the projects.

On this occasion, the Senior Citizens' Club which meets regularly at the Sydney Miller House was consulted. The group had been informed prior to the meeting that I would be attending and a list of the questions which were to be asked were circulated as requested by the general secretary.

Approximately 35 members attended, of whom two-thirds were women. Because of the language barrier it had been agreed previously that Misak Ohanian (general secretary) would interpret the questions put by the purchasing officer (quality) and answers given by the members. Before the questions were asked, a brief introduction to the changes taking place in Ealing Health Authority were given as well as a short explanation of my role.

2. A) WHAT TYPES OF HEALTH SERVICES DO YOU MAKE USE OF?

- Dentists, chiropodists, GPs, opticians
- Hospitals – Ealing (especially orthopaedics), Hammersmith, Charing Cross, Western Ophthalmic Hospital, West Middlesex Hospital, Isleworth and Chiswick Health Clinic.

B) WERE YOU SATISFIED BY THE QUALITY OF SERVICE?

Chiropodists

Members felt that the appointments given were too few and far between. It was also felt that the language barrier meant that clients could not communicate effectively with the chiropodists. Clients complained that chiropodists cut patients' nails every three months whereas previously it used to be every six weeks.

Ealing Hospital – Accident and Emergency Department

One women felt that when she was admitted after a serious car accident, she should have been kept in for at least 24-hours. She claimed that she had been released too early, she felt that it should have been apparent to the staff that she was unable to move without immense pain.

General Practitioners

The time spent waiting to see GPs was felt to be too long. Members felt that when it came to waiting lists and times, elderly people should receive priority attention.

It was also claimed that GPs were not thorough enough when investigating ailments. This made members feel that they were not receiving enough individual attention.

One member complained that he had been registered with a GP for six years and had still not received his NHS card.

C) HOW COULD SERVICES BE IMPROVED?

- Language provision.
- Chiropodists should go back to visiting their clients every six weeks as opposed to every three months.

D) ATTITUDES OF NHS STAFF

Several members complained that nurses were rude to them. This was felt to be attributable to a general communication gap. There was also a perception that if you were a 'foreigner' you were treated differently to 'English' people.

E) OTHER EXPERIENCE WITH THE NHS

Case Study 1

Mr A had been referred to the Western Ophthalmic Hospital continually for two years for an operation to improve his sight. On each occasion a blood and urine sample would be taken and then Mr A would be told to wait for his next appointment. During the two years he was never told what his condition was, neither was he informed of his progress. After the two years he complained and found out that he was not on a waiting list for an operation. Shortly after, Mr A was given a date for his operation. Mr A felt that this reflected the negligence on the side of the health professionals which was further complicated by language barriers.

Screening Services

At this stage of the meeting, women members were taken aside to ask them specific questions around breast and cervical screening. This process was facilitated by Diana Ohanian (projects administrator).

Do you know about the local breast and cervical screening facilities?

Only seven out of approximately 22 women had had any form of tests done. Although some had received letters from GPs, the women felt no adequate explanation had been given to them about the importance of being screened.

It was also discovered that although many had been informed about breast cancer screening, few had much awareness of cervical cytology.

CONCLUSION

Although initially reluctant to share some of their experiences the senior citizens did seem to relax and even 'enjoy' the experience of having a speaker visit them. The main issues raised were around:

- inadequate language provision
- frequency of visits by chiropodists
- staff attitudes.

Also, it has to be borne in mind that in meetings where a common language is not spoken by the group members and the facilitator many areas can remain unexamined. When there is a common language, certain topics can be investigated on a deeper level.

Shabnam Sharma
Purchasing Officer (Quality) March 1992

APPENDIX 6

SOUTHALL WOMEN WORKERS ASSOCIATION

CONSULTATION MEETING – LEVEL 2

Date: 6 November 1991
Time: 12.30 – 2.30pm
Venue: Southall 'Unified Community Action' Area Office

1. INTRODUCTION

1.1 The Southall Women Workers Association (SWW) was set up in 1986 by the then UCA area co-ordinator. Initially, it was supposed to be a group for women living and (or) working in Southall from either the statutory of voluntary sectors, to come together, share ideas and provide each other with support. Over the years, it has become a group dominated mostly by Asian women working in the local voluntary sector, although a few of the original members from the statutory sector still attend. The initial aims of sharing information and giving each other support still exists, but over the last few years the association has 'geared' itself more towards a campaigning/educational role. It is now in the process of producing a booklet documenting the history and struggles of women in Southall.

1.2 Members were aware that I would be attending the meeting, as an agenda had been circulated previously with an item on 'Ealing DHA'. Eight women attended, which was slightly lower than anticipated, but about average. This is due to the fact that all meetings are held during lunch hours, resulting in a different number and group of women meeting on each occasion, dependent on time available to them.

1.3 Local changes in DHAs were first discussed, followed by a brief overview of the role of the purchasing officer (quality) within those changes. With the group's permission, a series of more specific questions was then brought forward.

2. WHICH TYPES OF HEALTH SERVICES DO YOU MAKE USE OF?

2.1 GPs, Haematology at West Middlesex Hospital, Maternity and Diabetic clinic and Ealing Hospital. Accident and Emergency at Ealing Hospital, Queen Charlottes and Chelsea Hospital, dentists.

3. WERE YOU HAPPY WITH THE QUALITY OF THE SERVICES PROVIDED?

3.1 Generally, satisfaction was expressed with the services provided at West Middlesex Hospital, although it was felt that the hospital was generally 'very dirty and messy'.

3.2 A woman who had used the Diabetic Clinic at Ealing Hospital was very pleased with the service provided. She agreed, however, with other members that on the whole medical staff at Ealing Hospital were 'unsympathetic' about people's pain.

3.3 Comments were also made about the quality of the food served on wards at Ealing Hospital. Particular reference was made to the Maternity Unit where women felt it was especially important to administer 'proper' diets to those who had given birth. A reference was also made to the general treatment of women in the Maternity Unit by the medical staff. One woman felt that she had lost her baby due to the negligence of staff in the Unit. She had been taken in to hospital after feeling her contractions begin prematurely. On arrival she was told that the sensations she was feeling were not contractions, but nonetheless she would be admitted. Her 'contractions' began again in the middle of the night, when she called a nurse she was told to 'shut up' and that she was not experiencing contractions. The woman then stayed in her bed until the pains grew so bad that medical staff had to tend to her. The woman felt that she had lost her baby because help did not arrive on time. At the time she did not complain because she was unaware of any agency which could give her advice and stand on her behalf. She also felt that she would not recommend women to have their babies delivered at Ealing Hospital.

4. HOW COULD SERVICES BE IMPROVED?

4.1 Accident and Emergency

Better provision and assistance for mothers with children would enable women to wait for appointments which took a long time. Queen Charlotte's Hospital was given as a model for good practice where general services, but especially maternity, were regarded as 'very good'.

4.2 Well Women's Clinics

The option for women to be examined by female doctors at Well Women's Clinics' should be advertised more extensively.

4.3 Dentists

Women felt that the general 'attitude' of dentists should be raised as there was a feeling that dentists turned away patients whose treatments were not 'profitable'.

5. ATTITUDES OF NHS STAFF

5.1 Receptionists

Generally commented upon as being 'rude' especially at the triage in A&E, Ealing Hospital.

5.2 Nursing staff

In the Maternity Unit at Ealing Hospital nursing staff were thought to be 'unsympathetic'.

6. SCREENING SERVICES

6.1 All the women present had heard about breast and cervical cancer screening. However, not all had been screened. Of those who had been for cervical screening, the majority had not been aware of Well Women's Clinics which could have been used as alternatives to being examined by male doctors. All women had had examinations done due to their own initiatives and commented that their GPs had not asked them why they had not had them done earlier.

6.2 When questioned about how the service could become more responsive to their needs, the women suggested:

- attending appointments with groups at local centres, eg Dominion Centre, Southall
- more 'personalised' letters being sent to them from their GP
- 'friendly' calls from practice nurses reminding them that they were due for an examination.

7. CONCLUSION

Most of the women gathered were professional women who were working in either the statutory or voluntary sector. However, it was evident that many were still largely unaware of the health services which were available to them. For instance, only one woman was aware that cervical screening could also be provided at Well Women's and Family Planning Clinics by female staff. It was highlighted that women had not been for cervical smears because they had not wanted to be examined by male doctors.

Overall, the consultation meeting highlighted that professional working women, who were assumed to have better access to information and services, were also not taking up certain services.

Shabnam Sharma
Purchasing Officer (Quality) January 1992

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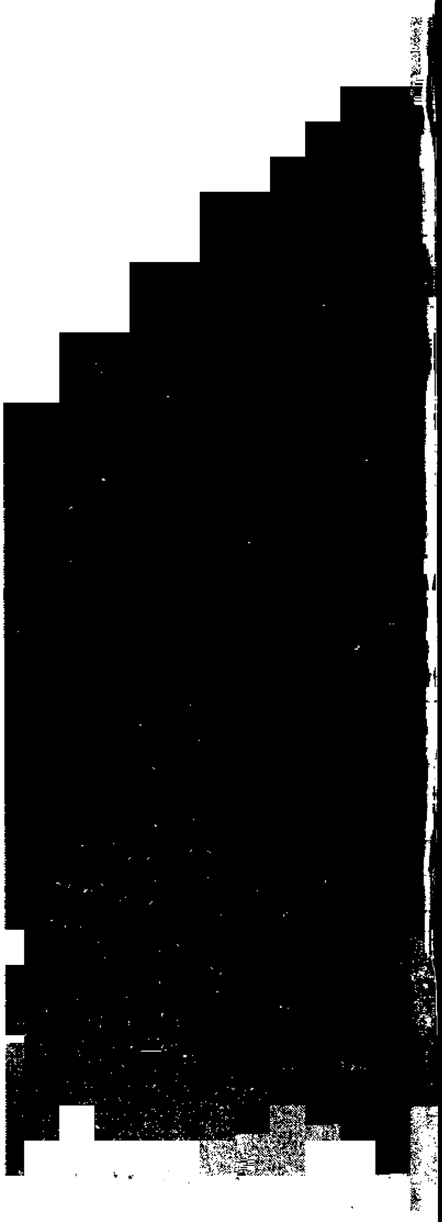
USER-SENSITIVE PURCHASING

SAFDER MOHAMMED



The health service reforms of the 1990s have put special emphasis on making services more sensitive and responsive to users. This report looks at the work of four health authorities which have a history of activity on race issues and where there is a clear commitment to improving their services through the active participation of users in standard setting and monitoring of outcomes.

The report includes examples of the four health authorities' standards and specifications.

ISBN 1-85717-028-8

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