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Patient's Charter: implementation guidance

Three new Rights from 1 April 1992

HSG(92)4
Annex

Patient's Charter: implementation guidance - Three new rights from 1 April 1992

17 January 1992

To be given detailed information on local health services, including quality standards and maximum waiting times.

This right places a dual responsibility on district health authorities. They need to:

- *ensure that service providers make available from 1 April 1992 detailed information about their services and about National and Local Charter Standards, including maximum waiting times.* DHAs and GPFHs will need to build this requirement into their contracts with providers and satisfy themselves, through their monitoring arrangements, that the necessary information is being made available and easily accessible to patients (e.g. Is information routinely given to all patients? Is it prominently displayed at hospitals, clinics and waiting areas?);

- *make information directly available themselves.* Options for doing this include:

  -provision of *information leaflets* about local hospitals and community health services which specifies what is available and where, giving details of National and Local Charter Standards;

  - provision of a well-publicised *DHA contact point* so that people know who to talk to about local service;

  - making greater use of the *media* to raise awareness about local services;

  - provision of information and materials for *CHC and other representative local groups* to disseminate;

  - provision of information through neighbourhood forums, public meetings, exhibitions etc.

Although the above applies specifically to DHAs, FHSAs may wish to consider these options themselves. They will also need to work with contractors to ensure that the various contractual obligations to provide patient leaflets and other such information are met. More generally, they might also satisfy themselves that care is taken to ensure information is easily accessible to patients.

To be guaranteed admission for treatment by a specific date not later than two years from the date when the consultant places the patient on a waiting list.

DHAs and GPFHs will need to introduce Waiting Time Guarantees locally to give effect to this new Right from 1 April 1992. The maximum waiting time for treatment - agreed through contracts - must be within two years.

HAs and GPFHs should set a guaranteed maximum wait in their contracts for each specialty. Wherever possible Districts should be more specific, and set guarantees for particular treatments - eg cataracts, hip replacements, etc. The guarantee would cover all the DHA's residents or GPFH's patients.

There may be some very exceptional circumstances where the guaranteed waiting time may have to be exceeded. Particular exclusions would be:

- where, in the judgement of the GP and patient, it would be best to wait rather longer than the guarantee period to secure the specialised services of a particular doctor;
- highly specialised treatments - for example, organ transplants - where the availability of treatment does not simply rest upon the efficient planning of resources.

Exclusions from the guaranteed treatment time will be exceptional and RHAs are asked to monitor any instances so as to ensure that they are only made in the best interests of the individual and/or the NHS.

New Patients

All patients put on an in-patient or day case waiting list on or after *1 April 1992* must get a letter from the hospital (usually in the consultant's name) informing them of the guaranteed date by which they will be admitted for their particular treatment.

Patients already on a waiting list

Existing contracts which purchasers put in place for 1991/92 will reflect their current agreements on waiting times and may not explicitly and effectively guarantee a maximum waiting time for all patients which is consistent with the Patient's Charter. Thus every patient on a waiting list on *1 April 1992* must be sent a letter, similar to that for new patients, telling them by which date they will be treated.

For most cases treatment should be provided within the guarantee time relevant to that particular specialty. No patient should have been waiting for in-patient treatment for more than 2 years by 1 April 1992. So treatment should be provided within two years of the date the patient was placed on the waiting list. DHAs and GPFHs should therefore agree priorities with local clinicians for particular specialties and conditions and discuss the way in which patients will be scheduled under NHS service agreements.

Action if treatment cannot be given within the guaranteed time by the contracted provider

Units must alert the DHA or GPFH *in good time* if it looks as though the waiting time guarantee cannot be met in a particular case. They should give the DHA or GPFH four months notice so they can make alternative arrangements for treatment, with the patient's and, in the case of a DHA, the GP's agreement. Where a unit is unable to provide treatment within the guaranteed time,the DHA

or GPFH should withdraw funding at the published extra-contractual rate or cost per case rate where the treatment was to have been provided under a contract, using the funds to secure treatment with another provider.

Personalised Plans

Where the patient asks for the operation to be deferred and it is not possible to offer another date within the guarantee period, providers should offer personalised arrangements for treatment as soon as possible thereafter. The guarantee should not be set aside or the two year period restarted from the date of self-deferral. DHAs and GPFHs will need to ensure that this issue is addressed when negotiating contracts with provider units. Similarly, where patients are medically unfit at the time the treatment is scheduled, every effort should be made to secure treatment as soon as the patient is fit.

Agreeing waiting time guarantees in contracts

Guarantees should be agreed in accordance with the principles set out in EL(91)84 issued on 11 June 1991. Provider units should not offer contracts to one purchaser which would disadvantage the patients of other purchasers. Equally, a purchaser creating additional capacity through his contractual arrangements with the provider unit will be entitled to the consequential level of patient service specified in the relevant contract. Such additional capacity should however also offer advantages for other purchasers' patients and the potential for this should be fully explored before contracts are agreed.

To have any complaint about NHS services - whoever provides them - investigated and to receive a full and prompt written reply from the chief executive or general manager.

All NHS authorities and where appropriate provider units and NHS Trusts have in place systems whereby complaints are investigated. This right seeks to ensure that *any* complaint about NHS services - *whoever provides them* - is investigated and a prompt reply received from the chief executive or general manager.

In this context when DHAs as purchasing authorities or GPFHs purchase hospital services from providers in the independent sector they must stipulate in their contracts that any complaints about those services by or on behalf of patients will be dealt with in accordance with procedures similar to those prescribed in directions made in reference to the Hospital Complaints Procedures Act 1985 (see Circular HC(88)37). Contracts with NHS DMUs and Trust Units and with independent provider units should secure the following principles:

Complaints of a non-clinical nature

- Each provider may designate an officer to act on behalf of the chief executive or general manager to receive and investigate complaints. However the formal response to the complaint should come from the chief executive or general manager;

- The complaints should be dealt with in accordance with written procedures, reflecting the principles of the NHS Complaints Procedures, and agreed with the purchasing authority;

- The procedures, including how to complain and to whom to complain, must be made known within the provider unit through the media of advice to patients and displayed notices;

- The provider unit's management board should monitor the arrangements and should keep the relevant purchasing authorities informed about progress in dealing with complaints;

- When the service has been purchased by a DHA the provider unit should ensure that complainants know to which purchasing authority to turn if they are dissatisfied with the outcome of a complaint and the DHA should be notified in respect of any such event.

Clinical Complaints

- The Director of Public Health for the purchasing authority must be notified of any formal complaint concerning the application of clinical judgement in the provision of the contracted service regardless of whether the provider unit is a DMU, NHS Trust or independent provider;

- Provider units, and the clinicians working within them, should follow the principles of the NHS Clinical Complaints Procedure. Where the complainant is dissatisfied with the result of local investigations, any subsequent enquiries (i.e. stages 2 and 3 of the Clinical Complaints Procedure) will be carried out by the regional director of public health of the region in which the provider unit is situated.

Health authorities will be required to publish annually details of complaints (both non-clinical and clinical). Further guidance on the content and format of these reports will follow in the near future.

Family Health Service Authorities

This duty also applies to FHSAs. When a complaint is received by an FHSA, arrangements should be made for it to be screened to check whether the complaint alleges breach of the Terms of Service of a GP, dentist, pharmacist or optician. If it is a matter included within the Terms of Service, the complainant can be offered the opportunity of informal conciliation or of following the formal regulated procedures in the normal way. Any complaint which falls outside the Terms of Service comes within the new Right in the Charter and, after obtaining the comments of the practitioner concerned if necessary, a prompt reply should go to the complainant from the general manager.

National Charter Standards

The following sets out guidance on certain National Charter Standards:

Respect for privacy, dignity and religious and cultural beliefs

This Standard seeks to ensure that local action is taken to ensure that the privacy, dignity and religious and cultural beliefs of each patient are respected. In particular Health Service Guidelines on meeting the spiritual needs of patients and staff were issued early in 1992 (HSG(92)2).

Waiting time for an ambulance

When an emergency ambulance is called, it should arrive within fourteen minutes in an urban area or nineteen minutes in a rural area. (This is not dependant on where the patient lives but rather where the patient is at the time.) HSG(91)29 which will be distributed in late January 1992 should be followed.

In summary, this states that purchasing authorities are required to secure the provision of emergency and urgent ambulance services for the District(s) they cover. In doing so they should ensure that contracts are in line with the National Standard set out in the Patient's Charter and as a minimum the following targets should be set and monitored:

- in response to 50% of all emergency calls, an ambulance will reach the patient within 8 minutes;
- in response to 95% of all emergency calls, an ambulance will reach the patient within 14 or 19 minutes in urban and rural areas respectively; and,
- in response to 95% of all urgent calls from clinicians, the patient reaches the treatment centre within 15 minutes of the agreed time.

Waiting time for initial assessment in accident and emergency departments

The intention of this Standard is to ensure that patients receive a clinical assessment on arrival at the accident and emergency department. Triage offers one widely used and acceptable method for achieving this but other organisational models can be used.

Waiting time in outpatient clinics

This Standard is intended to put an end to block booking systems and long waits for patients attending outpatient clinics. Each patient must be given a specific appointment and seen within 30 minutes of that appointment time.

However, many patients require X-rays, blood tests and other procedures prior to their appointment. Arrangements will need to be made to ensure that these investigations are carried out in advance of the outpatient consultation.
If such investigations are normally scheduled for just prior to the outpatient appointment arrangements will need to ensure that the patient is called at an appropriate time to enable those investigations to be performed in advance of the time set for the consultation.

Where, for unavoidable reasons it is not possible for the patient to be seen within 30 minutes of their appointment time, for example where the clinician is called away to deal with an emergency, those patients waiting to be seen should be informed of the reasons for the delay and an apology given.

Cancellation of operations

The purpose of this Standard is twofold. It is intended specifically to assist those patients who have been inconvenienced by having their operation cancelled after they have arrived in hospital or on the day they were due to arrive, twice in succession. More generally it is also intended to reduce the number of cancellations for organisational reasons. Where an operation has been cancelled after arrival in hospital or on the day the patient was due to arrive in hospital, twice in succession, patients should be admitted to hospital within one month of the date of the second cancelled operation.

Treatment postponed because the patient is found to be unfit will not count as being "cancelled" for the purpose of the Standard.

This Standard is specifically aimed at reducing distressing circumstances caused by organisational problems/difficulties. Application of the Standard in the many various circumstances which can occur should therefore always favour the patient where they themselves have not contributed to those circumstances. For example, where patients who have already experienced one cancellation move home, this factor should not disadvantage them; mechanisms will need to be put in place which will ensure that the system of redress will still apply.

A named qualified nurse, midwife or health visitor responsible for each patient

On admission to hospital or referral to community health services, every patient should have a named qualified nurse, midwife or health visitor allocated to them. The principle is similar to that of a medical consultant and a variety of organisational models can be used. Primary Nursing is one particular organisational model where the primary nurse carries a caseload of named patients. The nurse is supported by a team of associate nurses and other appropriate assistance. However it is not necessary for other forms of "named nurse" to have this structure and support system.

The aim of the Standard is to encourage a partnership between the nurse, midwife or health visitor and the patient/client which enables the patient/client to be involved in developing a joint care plan. Such a partnership would continue throughout the hospital stay until handover to the community nursing services when a similar arrangement would be made.

DHAs and GPFHs will need to ensure that this Standard is made explicit in contracts and it applies to both hospital and community services. All patients in hospital should be able to have a named nurse; where progress has not been made already in the first instance this could be the ward sister. Over time, however, it is expected that this principle would be developed further. The majority of people being cared for by the community nursing services will already have a named nurse or midwife. Clients receiving health visiting services will have a named health visitor. Provider units need to examine their existing skill-mix and deployment of staff in order to move towards this Standard when negotiating contracts with purchasers.

Discharge of patients from hospital

Before a patient is discharged from hospital, a decision should be made about any continuing health, including rehabilitation, or social care needs they may have. The provider unit should agree arrangements for meeting these needs with agencies before the patient is discharged. The patient should be consulted and informed at all stages. DHAs and GPFHs will need to make this explicit in contracts and in applying this Standard, the guidance set out in HC(89)5 and the accompanying booklet *Discharge of Patients from Hospital* issued in February 1989 should be followed.

Local Charter Standards

From 1 April 1992, DHAs and, as appropriate, GPFHs should set clear Local Charter Standards. DHAs should also publicise these Standards:

- waiting time for first outpatient appointments. (This should be viewed in the context of the right to be guaranteed admission within two years and the total waiting time for the patient);
- waiting times in accident and emergency departments, after the need for treatment has been assessed;
- waiting times for NHS transport to take the patient home where a medical need for such transport exists;
- ways to assist patients and visitors to find their way around hospitals through enquiry points and better signposting;
- name badges for staff that have direct contact with patients and visitors.

DHAs should also publicise the name of a person who can be contacted if more information on Local Charter Standards is needed.

Better Information Services

Regional health authorities need to establish general information services which will provide access to information on:

- local Charter Standards;
- the NHS services that are available;
- waiting times for outpatient, day case and inpatient treatment by hospital, specialty and individual consultant, set out in a standard way;
- common diseases, conditions and treatments;
- how to complain about NHS services;
- how to maintain and improve health.

The NHSME is working with regions to develop and establish standards for a national network of telephone helpline services in each region to provide this information from April 1992. Regional health authorities will need to make appropriate arrangements, in the light of current information services provided within each region, to collect and make available the types of information prescribed. Further guidance will be issued to regions early in 1992.