



The Framework for Quality Accounts

Response to consultation

The Framework for Quality Accounts

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The Framework for Quality Accounts

Response to consultation

Prepared by Quality Accounts Team

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Foreword



High Quality Care for All highlighted the importance of measuring what you do, in order to drive up improvements in quality.

In the introduction to the consultation document I expressed the view that, “the primary purpose of Quality Accounts is to encourage boards to assess quality across the totality of services they offer with an eye to continuous quality improvement. If designed well, the accounts should assure commissioners, patients and the public that trust boards are regularly scrutinising each and every one of their services”

Achieving consensus on the standardised methodology and presentation of financial accounts took many years. The results of this consultation represent the first step in a longer debate on how to measure and present an organisational approach to quality of healthcare.

I think we have made a good start, but this consultation is only the beginning. This response represents the culmination of over a year’s engagement with a wide range of stakeholders. We received responses from numerous NHS providers, Strategic Health Authorities, Primary Care Trusts, Local Involvement Networks, Overview and Scrutiny committees, regulators organisations, along with representation from the private and third sectors. I would like to thank everyone who took the time to respond to this consultation.

The Department of Health, Monitor, the Care Quality Commission and NHS East of England, as well as many other local and national organisations, undertook or participated in the development of this work, and I would like to extend my thanks and appreciation for their efforts and contributions.

Piloting of Quality Accounts for primary and community care providers is about to commence in two Strategic Health Authorities, as we spread and mirror the process of engagement and development of Quality Accounts for other sectors with a diverse range of providers. Also, following discussions at the National Quality Board, Monitor have launched a consultation on the assurance processes for Quality Accounts, which we hope will provide lessons for all providers in ensuring accuracy, validity and representativity of published accounts.

I am delighted by the number of responses to the consultation, and I am confident that the level of enthusiasm for this project shows that Quality Accounts will work by giving organisations the opportunity to demonstrate the quality of service they provide, while also offering assurance to users of services that organisations understand their needs.

A handwritten signature in black ink that reads "Bruce Keogh". The signature is written in a cursive style and is underlined with a single horizontal stroke.

Professor Sir Bruce Keogh
NHS Medical Director, Department of Health

Executive summary

Purpose

1. This document provides the Department of Health's official response to the consultation *The Framework for Quality Accounts – a consultation on the proposals*¹. It informs the regulation and DH toolkit for 2009–2010 Quality Accounts.
2. Respondents were asked to complete a questionnaire in the following areas:
 - Content of quality accounts;
 - Publication of Quality Accounts; and
 - Which organisations will be required to produce a Quality Account.

Introduction

3. *High Quality Care for all*², published in June 2008, was the culmination of the NHS Next Stage review, a year-long process led by the DH and the NHS, involving over 60,000 NHS staff, patients, stakeholders and members of the public.
4. In *High Quality Care for all*: three domains of quality care were identified: safety; effectiveness of care; and patient experience. *High Quality Care for All* committed the DH and the NHS to developing a 'Quality Framework' supporting clinical teams to improve the quality of care locally, a key part of which was the publication of quality information. Quality Accounts are, therefore, one key component of this framework.
5. Quality Accounts are annual reports to the public from providers of NHS healthcare services regarding the quality of services supplied. The public, patients and others with an interest in healthcare, would look to a Quality Account to understand what an organisation is doing well; where improvements in service quality are required; what the priorities for improvement are during the coming year; and how involved users of services, staff, and others with an interest in the organisation, are in determining these priorities for improvement.
6. Quality Accounts aim to enhance public accountability and engage the leaders of an organisation in their quality improvement agenda. Public accountability is gained through the presentation of honest, balanced and meaningful information regarding the quality of services provided within the public domain. The leaders of an organisation will be engaged in the quality improvement agenda, both to achieve public accountability, but also as a consequence of accountability.

¹ *The Framework for Quality Accounts – A consultation on the proposals*, Department of Health, September 2009, available at: www.dh.gov.uk/en/Consultations/Closedconsultations/DH_105304

² *High Quality Care For All*, Department of Health, June 2008

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7. The Health Act 2009³ requires the publication of Quality Accounts from April 2010. The first statutory Quality Accounts will therefore be published in June 2010, and will cover activity in the year 2009–/2010. The primary legislation, as well as placing a duty on providers of NHS services to produce Quality Accounts, also gives the Secretary of State powers to make regulations specifying the information that must be contained in the Accounts; and the content, format and timing of these publications, including provision for locally agreed elements. Regulations may also specify that providers must have regard to guidance issued by the Secretary of State. (The Act means that Regulations may also specify that providers must have regard to guidance issued by the Secretary of State, although that is not the current proposal.)
8. *Framework for Quality Accounts - A consultation on the proposals*, set out the Department of Health's proposals for Quality Accounts and explained which matters would be specified in regulations and what will be left to local determination. These proposals flow from the testing, engagement and other detailed design work undertaken over the last year by the Department of Health, Monitor, the Care Quality Commission (CQC) and NHS East of England, in addition to many other local and national organisations.

Overview of responses

9. The consultation on Quality Accounts was held from 17th September 2009 to 10th December 2009.
10. Over 170 responses were received from a number of organisations including: a range of NHS providers, Strategic Health Authorities (SHAs), Primary Care Trusts (PCTs), Local Involvement Networks (LINKs), Overview and Scrutiny Committees (OSCs), regulators and provider organisations (with representation from the private and third sectors). Chart A (see Page 12) shows the breakdown of the types of provider who responded to the consultation.

Structure and content of Quality Accounts

11. We proposed to require that providers should present the nationally mandated information in the form of statements that will be specified in the regulations.

The statements listed below are cited in more detail in the remainder of the document:

1. **Statement from the provider** – an overall statement of accountability from the provider;
2. **Priorities for improvement** – confirmation that the organisation has identified key improvement priorities and implemented appropriate monitoring and reporting arrangements to track progress;
3. **Review of quality performance** – confirmation that the organisation has set three indicators for each of the domains quality; has reviewed the range of its services with a

³ http://www.opsi.gov.uk/acts/acts2009/ukpga_20090021_en_1

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view to developing a quality improvement plan; and has demonstrated that it monitors quality by participating in clinical audits;

4. **Research and innovation** – confirmation that the organisation participates in clinical research and uses the Commissioning for Quality and Innovation (CQUIN) payment framework;

5. **What others say about the provider** – a statement on the organisation's CQC registration (e.g., whether this is conditional), and of any concerns arising from periodic and/or special reviews; and a statement from LINKs and PCTs; and

6. **Data quality** – a simple data quality score.

12. The consultation responses were generally in favour of mandated elements proposed for Quality Accounts and in the suggested form of statements. All statements will be nationally mandated but some have been revised following consultation. Further details can be found in Chapter 3. Providers will be free to expand on the information covered by the statements as part of the locally determined content where this will help explain their overall quality improvement story. A toolkit will be published shortly after the regulations are made to assist providers with this.

Publication of Quality Accounts

13. The legislation set out in the Health Act 2009 requires providers to supply a copy of their Quality Account to the Secretary of State, in any form specified, by the Secretary of State for the purpose of making the document available to the public. The consultation responses were supportive of the plan to publish Quality Accounts on NHS Choices.
14. Regulations will require providers to publish their Quality Account on a website. In practice, this will be NHS Choices. Providers will be able to do this directly by updating their general description profile. Regulations will require providers to publish their Quality Accounts (and send a copy to the Secretary of State) annually by the end of June. In relation to NHS bodies, this ensures that their Quality Accounts will align with their annual report and accounts.
15. The DH toolkit will draw on findings from work undertaken during 2009 with members of the public, users of services and others with an interest in healthcare, to advise providers on good practice regarding developing and presenting their Quality Account in a meaningful format to the public.

Exemption of small providers

16. It is the Department's view that, following the consideration of the responses received during the consultations, on balance, an exception should be made for small providers within organisations that would struggle with the additional financial and workforce burden in producing an account. Further details are available in Chapter 5.

Primary and community care

17. The current plan is to introduce Quality Accounts for the primary and community care sectors from 2011. An engagement and testing process, similar to that run within NHS foundation trusts and NHS East of England providers, but focused on the particular needs of these two sectors, commenced for providers in NHS North East and NHS East Midlands over the autumn. This will deliver test reports in June 2010 and will help to 'shape' the development of Quality Accounts further, as they become applicable to all providers.
18. The findings from this process, including an evaluation of the project and best practice examples, will be used to update the Regulations and guidance ahead of the introduction of Quality Accounts for primary care and community services providers.
19. For the time being Regulations will include an exemption for primary and community care services.

Assurance

20. Self-certification and stakeholder engagement will form the first steps of an assurance process for Quality Accounts, which can be built on over time.
21. Following discussions at the National Quality Board (NQB), Monitor is holding a consultation on proposals for third-party assurance of Quality Accounts and will be testing this approach in 2010. The Department of Health will work with Monitor and other partners to evaluate the results of these proposals and make recommendations for the future development of the policy to introduce a form of third-party assurance for all Quality Accounts.

Next steps

22. The Regulations for Quality Accounts discussed in this consultation will be made by the Minister and laid in Parliament. The regulations will set out the mandated elements of Quality Accounts and confirm the scope of providers.
23. A toolkit will be published alongside the Regulations that will contain guidance for providers on the production of a Quality Account.

Chapter 1: introduction

The Quality Framework

- 1.1 *High Quality Care for All*, published in June 2008, was the final report of the NHS Next Stage Review, a year-long process led by the Department of Health and the NHS which involved over 60,000 NHS staff, patients, stakeholders and members of the public.
- 1.2 In *High Quality Care for All*, we identified three domains of quality care: safety, effectiveness of care and patient experience. *High Quality Care for All* committed the Department of Health and the NHS to developing a Quality Framework to support clinical teams to improve the quality of care locally, a key part of which was publishing quality information. Quality Accounts are therefore one key component of this framework. The purpose and proposed content of a Quality Account, and the processes that should be in place to produce one, have been shaped by a comprehensive stakeholder engagement process and the successful testing process of Quality Reporting in 2008-09 by NHS foundation trusts and NHS trusts in the East of England.
- 1.3 Many countries are realising that public reporting of comparative information about the quality of healthcare is an important way of improving accountability, stimulating quality improvement and empowering members of the public. This process is driven by three main factors:
 - Public reporting can be used to highlight unacceptable variations in the quality of healthcare;
 - Mechanisms for public reporting, such as Quality Accounts, can be used to engage and empower those who have an interest in improving quality, including healthcare users, health professionals, managers, boards and regulators; and
 - Reports, such as Quality Accounts, can be used to stimulate quality improvement and to promote greater accountability.
- 1.4 Quality Accounts are annual reports to the public from providers of NHS healthcare services regarding the quality of services they provide. The public, patients and others with an interest in healthcare, would look to a Quality Account to understand what an organisation is doing well; where improvements in service quality are required; what the priorities for improvement are for the coming year; and how involved users of services, staff, and others with an interest in the organisation, are in determining these priorities for improvement.
- 1.5 Quality Accounts aim to enhance public accountability and engage the leaders of an organisation in their quality improvement agenda. Public accountability is gained through the presentation of honest, balanced and meaningful information regarding the quality of services within the public domain. The leaders of an organisation will be engaged in the quality improvement agenda, both to achieve public accountability, but also as a consequence of accountability.

Framework for Quality Accounts – a consultation on the proposals

- 1.6 The Health Act 2009 requires the publication of Quality Accounts from April 2010. The first statutory Quality Accounts will, therefore, be published in June 2010, and will cover activity in the year 2009–2010. The legislation applies to all providers of NHS healthcare services in England, ranging from large, acute providers to individual general and dental practices. This includes independent healthcare organisations that provide NHS services, which will, therefore, be required to publish Quality Accounts. The primary legislation, as well as placing a duty on providers of NHS services to produce Quality Accounts, also gives the Secretary of State powers to make regulations specifying the information that must be contained in the Quality Accounts; namely the content, format and timing of these publications, including provision for locally agreed elements. Regulations may also specify that providers must have regard to guidance issued by the Secretary of State.
- 1.7 *Framework for Quality Accounts - A consultation on the proposals*, set out the Department of Health's proposals for Quality Accounts and explained which matters would be specified in regulations and what will be left to local determination. These proposals flow from the testing, engagement and other detailed design work undertaken over the last year by the Department of Health, Monitor, CQC and NHS East of England, as well as many other local and national organisations.
- 1.8 For the first year of Quality Accounts all providers or sub-contractors of NHS services will be required to produce a Quality Account but not in relation to the provision of any primary care or community health services.⁴ .Consequently, this consultation related largely to those organisations which will provide a Quality Account in the first year.
- 1.9 The details surrounding requests for those providers that will be brought into the requirement, at a later date, are subject to a testing, engagement and consultation project. However, it is certain that the underlying principles remain relevant to all healthcare providers, as they offer the basis for future years.
- 1.10 Further details of the next steps regarding primary care and community services can be found in Chapter 5.

Testing the vision for Quality Accounts – Quality Reporting for 2008–09

- 1.11 Monitor and the East of England SHA required all NHS foundation trusts in England and all NHS providers in the East of England region to produce Quality Reports in the spring and summer of 2009. This also served as a useful trial for Quality Accounts. The approach to developing Quality Reports was developed following an initial consultation with providers. The response to this consultation is available at: www.monitor-nhsft.gov.uk/home/ourpublications/browse-category/guidance-foundation-trusts/quality-reports

⁴ For the first year of Quality Accounts, only NHS trusts and NHS foundation trusts and their private or voluntary sector equivalents will provide a Quality Account. This includes NHS acute trusts, mental health trusts, learning disability trusts and ambulance trusts. Private or voluntary sector equivalents cover providers of NHS acute, community and mental health services.

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- 1.12 The Quality Reports for 2008–2009 are available for viewing. Quality Reports are included in the 2008–2009 annual reports and accounts of NHS foundation trusts. These are available on the Monitor website at www.monitor-nhsft.gov.uk or the organisations' individual websites, and have been presented to Parliament. Published Quality Reports for the East of England are available directly from the providers' websites.
- 1.13 In summer 2009, the Department of Health commissioned PricewaterhouseCoopers (PwC) to conduct a comprehensive survey of the organisations that participated in the testing exercise. PwC also evaluated the content and presentation of selected quality reports. The full report is published on the Department of Health's website. The conclusions from this study have been used to develop the proposals for Quality Accounts specified in this consultation document.

Chapter 2: overview of responses

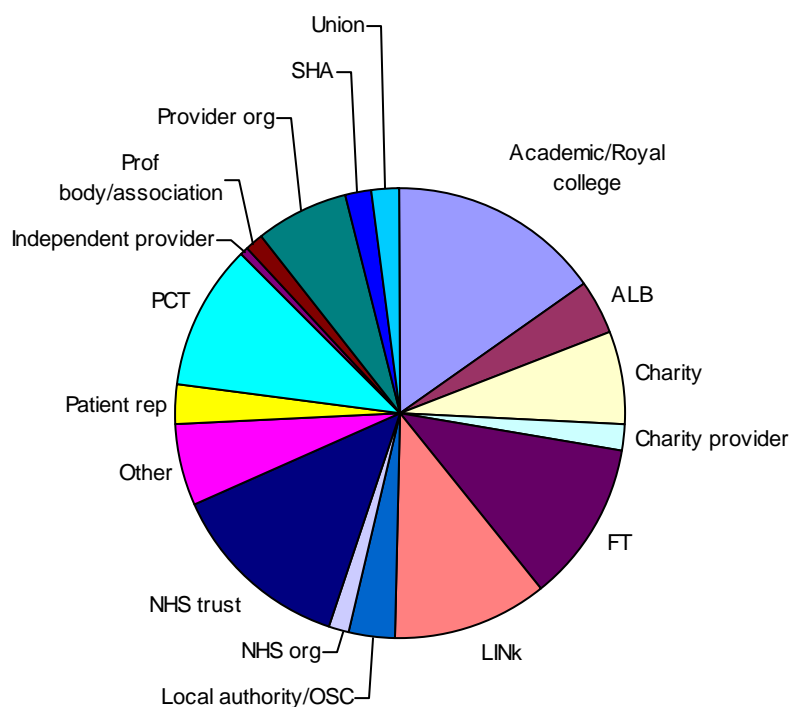
2.1 The consultation on Quality Accounts was held from 17th September 2009 to 10th December 2009.

2.2 Responders were asked to complete a questionnaire in the following areas:

- Content of Quality Accounts;
- Publication of Quality Accounts; and
- Which organisations will be required to produce a Quality Account.

2.3 Over 170 responses were received from a number of organisations including: a range of NHS providers, SHAs, PCTs, LINKs, OSCs, regulators and provider organisations (with representation from the private and third sectors). Chart A shows the percentage breakdown of the types of provider who responded to the consultation.

CHART A



2.4 Almost all responses were in favour of the detailed proposals set out for Quality Accounts and supported the policy objectives of improving accountability, stimulating quality improvement and empowering members of the public.

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- 2.5 A copy of all the responses from organisations can be found on the Department of Health website⁵.
- 2.6 The consultation responses raised a number of important issues and suggested ideas for how Quality Accounts could be improved. Some suggestions we have taken on board now and some we will consider in the future. We will continue to refer to the comments received for this consultation as work on Quality Accounts moves forward.

⁵ <http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm>

Chapter 3: structure and content of Quality Accounts

- 3.1 It is proposed that providers should present the nationally mandated information in the form of statements that will be specified in the regulations. Providers would be free to expand on the information covered by the statements, as part of the locally determined content, where this will help explain their overall quality improvement story. A toolkit will be published shortly after the regulations are made to assist providers with this requirement.

The statements listed below are cited in more detail in the remainder of the document:

1. **Statement from the provider** – an overall statement of accountability from the provider;
2. **Priorities for improvement** – confirmation that the organisation has identified key improvement priorities and implemented appropriate monitoring and reporting arrangements to track progress;
3. **Review of quality performance** – confirmation that the organisation has set three indicators for each of the domains established to assess quality; has reviewed the range of its services with a view to developing a quality improvement plan; and has demonstrated that it monitors quality by participating in clinical audits;
4. **Research and innovation** – confirmation that the organisation participates in clinical research and uses the CQUIN payment framework;
5. **What others say about the provider** – a statement on the organisation's CQC registration (e.g., whether this is conditional), and of any concerns arising from periodic and/or special reviews; and a statement from LINKs and PCTs; and
6. **Data quality** – a simple data quality score.

Statement from the board

Q1: Do you agree that the inclusion of a mandatory statement from the board is the best way to demonstrate board accountability for the Quality Account?

Q2: Some providers may not have a formal board structure. We would welcome views on how the provisions of the regulations should apply to such bodies.

What we proposed:

- 3.2 Boards (or their equivalent) should declare their accountability for the content of their Quality Accounts by signing up to a statement from the chief executive of the body, summarising the trust's view of the overall quality of the services that it provides. This

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statement will show that the board has a clear commitment to improving the quality of care.

What we heard:

- 3.3 The vast majority of responses were in favour of including a statement from the Chief Executive or equivalent (eg senior partner) declaring their accountability for the content of their Quality Accounts and summarising the trust's view of the overall quality of the services that it provides.
- 3.4 Out of the total 170 responses, 115 were in favour of the statement, compared to 6 that were opposed to the statement.

Most definitely, as this will demonstrate, a positive commitment to improving the quality of care.
NHS Lincolnshire

- 3.5 Respondents felt that a statement from the Chief Executive would establish the context and was suitable coming from those ultimately accountable for the organisations quality. The statement of accountability would send an important message to the public.
- 3.6 However, some respondents also queried whether this could simply become a 'box-ticking' exercise.
- 3.7 Respondents felt that there should be a consistent approach across all organisations and that there should be someone who was ultimately accountable for the quality of care. Suggestions included:
- Whoever approves the financial accounts;
 - Senior manager (clinical and non-clinical);
 - Contractual arrangements could name who approves a quality account;
 - An individual registered with the CQC or responsible office;
 - Whoever is the legal sponsor for the care;
 - The authorised signatory;
 - Provider committees;
 - Trustees; and
 - Directors.

Our response:

- 3.8 The mandatory inclusion of a statement of overall accountability from a senior employee, e.g., the Chief Executive, will be legislated. This statement will ensure approval that the Quality Account is accurate (i.e., that the data are reported correctly) and that the report on the quality of healthcare provided is balanced and unbiased.

Priorities for improvement

Q3: Do you agree that at least three priorities for improvement, agreed by the board, and the rationale for their selection should be included in Quality Accounts? Do you think that providers should report on previously set improvement targets using indicators of quality and including historical data where available?

What we proposed:

3.9 It was proposed that a Quality Account should include a description of areas for improvement including:

- Three to five priorities for quality improvement – agreed by the board. This should include a rationale for how these priorities were selected and whether or how the views of patients, the wider public and staff were considered;
- The key improvement initiatives for each priority. This should include a description of how progress towards improvement targets will be monitored and measured; and
- Reporting of improvement targets against defined measures. In subsequent years, providers should report on progress made on the priorities, including the use of historical data, where available.

3.10 It is proposed that the regulations would specify that the Quality Account must include a description of areas for improvement. In particular, the regulations would require that the description included the three points outlined above. In addition, Department of Health guidance and Monitor's *NHS Foundation Trust Financial Reporting Manual* would provide advice on the format and content of this description.

What we heard:

3.11 The majority of responses were in favour of describing areas for improvement. Out of the total 170 responses, 101 were in favour of priorities for improvement, compared to 17 that were opposed to the priorities for improvement.

The three target priorities should be included in the Quality Account to ensure focussed action, however these could change over time if data suggests there are problems in some areas and success in others. Although three target areas are good for a large organisation such as an NHS Trust, this should not preclude more if the organisation feels this is relevant.

Portsmouth Hospitals NHS Trust

3.12 Respondents considered that historical data and a discussion of future improvements would add accountability to quality improvements. Quality Accounts should indicate whether previous improvement objectives were achieved. Information on the implementation of improvements would give an indication of progress.

3.13 Respondents felt that allowing boards the 'freedom' to select priorities, in conjunction with the openness of Quality Accounts, would facilitate both local and national improvement objectives. Respondents wanted Quality Accounts to include the rationale behind the establishment of objectives and public involvement in this process.

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3.14 A number of respondents felt that mandating three to five priorities for quality improvement was too prescriptive. Conversely, having a limit may restrict providers, for instance in large organisations where more than five priorities may be implemented to encompass the services provided. Equally, setting a minimum, which forces providers to select three priorities, restricts those organisations where two ambitious priorities for improvement may be targeted.

Our response:

3.15 Priorities for improvement offer the public the assurance that boards are thinking about quality enhancement. It was suggested that boards should describe three to five areas of improvement; however, the number of priorities should be proportionate to the size of the organisation. We will write in legislation that providers should describe a minimum of three priorities for improvement. to set a steer nationally of our expectation as this is the first year that organisation will have written a Quality Account .However, the priorities themselves will be determined locally through engagement with local stakeholders.

Review of quality performance

i. Indicators of quality

Q4: Do you agree that at least three indicators covering each of the domains of quality should be included in Quality Accounts?

What we proposed:

3.16 It was proposed that a Quality Account should include a description of at least three indicators for each of the domains of quality, chosen by the board in consultation with stakeholders, and with an explanation of the underlying reasoning for the selection – under the separate headings of:

- Safety;
- Effectiveness; and
- Patient experience.

3.17 For each of the measures described, the Quality Account should refer to historical data and benchmarked data where available. This proposal will be set out in our guidance (and in Monitor's *NHS Foundation Trust Financial Reporting Manual*) – rather than set out in regulations, as the exact content will be left to local determination.

What we heard:

3.18 The majority of responses were in favour of including a description of at least three indicators for each of the quality domains, selected by the board in consultation with stakeholders, and with an explanation of the selection rationale. Out of the total 170 responses, 98 were in favour of priorities for improvement, compared to 17 that were opposed to the priorities.

It is important that quality is as far as possible demonstrated across the whole service. Requiring reporting on at least three indicators for each of the three domains goes some way

to achieving this.

Allied Health Professions Federation

3.19 Respondents felt inclusion of at least three indications of quality was a sensible approach and would help to focus indicators. Respondents were in favour of organisations demonstrating continuing quality improvement, using meaningful indicators. Respondents felt that focusing on the three domains of quality was helpful, as it would assess quality across the organisation.

3.20 A number of respondents felt that setting a minimum of three indicators was too prescriptive and that the number of indicators should be representative of the organisation's size.

Our response:

3.21 Three indicators have been proposed to provide boards with at least one indicator for each quality domain and, therefore, show a balanced indication of quality across the organisation. Boards are free to describe as many indicators of quality, as appropriate.

3.22 It will be proposed in guidance that the number of indicators should be proportionate to the organisation's size.

ii. Review of services

Q5: Do you think that the inclusion of the statement from the board to state that it has reviewed the available data on the quality of care in its services provides an assurance of the quality of services provided?

Q6: Do you think boards should include an explanation of how the review of services was conducted, and how patients and the public were involved?

What we proposed:

3.23 It was proposed that providers should supply information on the review of services, in the following statement:

"The trust provides services in [n] specialties/areas. The board (or equivalent) has reviewed the available data on the quality of care in [n] of these specialties/areas. This represents [n%] of the trust's activity [measured by income generated]. The board [has/has not] used the results of this review to develop a plan for improving the quality of the trust's services."

3.24 The purpose of this statement is to ensure that a provider has considered quality of care across all the services it delivers, rather than focusing on one or two areas for inclusion in the Quality Account. Organisations should develop a plan, which should be signed off by the board and agreed with stakeholders, for tackling the problems identified by reviewing available data in the quality of services that it offers. This should be a rolling plan. Based on experience to date, boards will want to expand on this statement further in their Quality Account.

What we heard:

3.25 Out of the total 170 responses, 62 were in favour of the statement on the review of services, compared to 49 that were opposed to the statement.

3.26 Respondents felt that although the statement would go some way in demonstrating that providers had considered services across the organisation, it did not necessarily offer assurance of the quality of the services provided.

It provides an assurance of Board support and engagement for quality improvement but not necessarily on the quality.

Department Of Wound Healing in Cardiff

3.27 Comments in favour of the statement included:

- Boards are responsible for the accuracy and completeness of their Quality Account and should look at their range of services, when considering quality improvement;
- Should be based on the Board being satisfied that they are assured of robust internal systems; and
- The statement is important so that the provider can give an account of the evolution of the improvement programme over time.

3.28 The majority of respondents, who disagreed with the inclusion of the statement of review of services, felt it would not provide the necessary quality assurance. Respondents considered that the statement was useful to illustrate the proportion of a provider's activity that is reviewed and offers an indication of the broad quality improvement plans established. However, a simple statement from boards that they have reviewed the data does not alone offer an assurance of the quality of services provided, or demonstrate factually the specific improvements that have occurred.

3.29 The majority of respondents wanted boards to include an explanation of how the review of services was conducted and patients and public involvement in this process. Out of the total 170 responses, 100 were in favour of an explanation of how the review of services was conducted compared to 10 that were opposed to inclusion of an explanation.

Boards will need to evidence how stakeholder discussions have supported priorities for Quality Accounts by describing the process by which the Quality Accounts were produced, including how the Board, Members, patients and public were engaged, should be central to the report. Achieving high quality engagement will be difficult in the first year, but should develop in subsequent years

South Tees Hospitals FT

Our response:

3.30 We will legislate for the inclusion of a statement on the review of services.

3.31 Guidance will state that the plan for addressing the problems identified from available data review in the quality of services offered should be approved by stakeholders,

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including patients and the public. Moreover, patients and the public should be involved throughout the publication of the Quality Account in its entirety.

3.32 Self-certification will form the first steps to an assurance process for Quality Accounts, which can be built on over time. Details on further assurance methods are discussed in Chapter 6.

iii. Participation in clinical audits

Q7: For the statements on participation in clinical audits, please provide your view on their suitability for inclusion as nationally mandated content in Quality Accounts. In addition, please identify whether the description of the statement is well defined or open to interpretation and provide any other comments on the proposed statement.

What we proposed:

3.33 It was proposed that providers should supply information on clinical audit participation, in the following statements:

“The trust was eligible to participate in [n] national clinical audits and related clinical, quality data collection programmes, such as national confidential enquiries, covering services provided. It elected to participate in [n] of these. The full list of potential audits and those the trust participated in are listed in Appendix [n].

In relation to the trust’s participation:

- The trust participated in [n%] of the clinical audits for which it was eligible;
- Of the clinical audits in which the trust participated, the care of [n%] of eligible patients was measured during the reporting period;
- [n%] of patients are not covered by available audits during this period; and
- The proportion of incomplete data within the year reported on in the clinical audits undertaken was [n%].”

“The trust [undertakes/does not undertake] a programme of local audit on clinical performance which is reported to the trust board.”

3.34 This statement covers local and local-network clinical audits and specifies how a trust must report on its participation. Clinical audit is a professional quality improvement activity led by clinicians enabling managers, patients, commissioners and clinicians to understand and demonstrate the process by which an organisation delivers high-quality patient care in accordance with recommended standards and provides data to enable quality improvement to occur.

3.35 The purpose of including this statement is that presentation of data about the level of participation in clinical audits enables a provider to communicate to its key stakeholders that it monitors quality in an ongoing, systematic manner to board level. A high degree of participation provides a level of assurance that quality is taken seriously by the organisation and that participation is a requirement for clinical teams and individual clinicians, as a means of monitoring and improving their practice.

What we heard:

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3.36 This section of a Quality Account elicited mixed support. Out of the total 170 responses, 78 were in favour of the statement on clinical audit, compared to 30 that were opposed to the statement.

Yes, although participation in clinical audit is not an end in itself. The Quality Accounts should demonstrate what improvements in practice have resulted from participation in audit
NHS Eastern and Coastal Kent

3.37 Respondents commented that the role of clinical audit is important in terms of the quality of services, as it explains clearly the standards expected based on 'best evidence'. It helps clinical teams judge whether standards are being met locally and enables benchmarking nationally. Many responses that were in favour of having the statement wanted alterations to the statement itself, to make it more meaningful.

3.38 Respondents were unsure as to the relevance that the level of participation in clinical audits provided in terms of the quality of the organisation. Respondents felt that this measured the 'process' rather than the 'outcome' and that providers sometimes had a good rationale for not participating in a clinical audit.

3.39 Respondents commented that some national audits were merely data collection exercises and that organisations first need to be better informed about the available, national clinical audits. They also commented that information on audit findings was not readily accessible.

3.40 Respondents questioned whether measures of patient coverage were a meaningful reflection of a number of patients whose care was measured. Some national audits collect samples, e.g., the National Sentinel Stroke Audit collects data on the first 60 admissions over fixed 3-month period.

Our response:

3.41 We agree with those respondents who suggested that Quality Accounts should include a description of local actions taken to improve quality, with consideration of findings from national clinical audits and confidential enquiries. A statement in regulations will be mandated that providers will document details of national clinical audits and confidential enquiries that were reviewed annually, together with information about the actions that these reviews stimulated locally to improve quality.

3.42 Quality improvement is influenced by various factors. National clinical audits and confidential enquiries contribute to quality by giving providers and clinical teams robust information to stimulate and support quality improvement. We recognise that the term 'clinical audit' embraces the assessment of review using evidence-based criteria and/or the outcome of care by comparison with other providers.

3.43 The notion that national clinical audits are merely data collection exercises is refuted. Clinical audits provide data on the quality of services that can facilitate providers to initiate an open dialogue about local care, benchmarked against professional standards and values and measured against other providers. If providers do not act on the results of national clinical audits or national enquiries, that is not a direct failing of the audit. For the

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future, we will look at the completeness of information about clinical audit as one of the standard measures for assuring Quality Accounts.

3.44 The Chief Medical Officer's report *Good Doctors, Safer Patients*⁶, called for the reinvigoration of clinical audit to enable it to reach its potential as a rich information source to support service improvement. This analysis is reinforced in the *White Paper Trust, Assurance and Safety*⁷. The National Clinical Audit Advisory Group (NCAAG) will advise the Department of Health on a menu of national clinical audits that providers are encouraged to join. The number of relevant audits for any given provider will depend on the range of services delivered. The menu will be revised annually and appear on the Department of Health's website and contain links to the audit reports.

3.45 We agree with those respondents who commented that the proposed measure of eligible patients covered by national audits was unsuitable. It is important however, that providers report their response rates. We will mandate that for each national audit providers will report on the completeness of their submission by measuring the number of cases submitted, as a percentage of the number required by the terms of the audit.

Research and innovation

i. Participation in clinical research

Q8: For the statement on participation in clinical research, please provide your view on its suitability for inclusion as nationally mandated content in Quality Accounts. In addition, please identify whether the description of the statement is well defined or open to interpretation.

What we proposed:

3.46 It was proposed that providers should report on the following statement:

"The number of patients recruited in the previous year to clinical research (that is, research approved by a research ethics committee) was [n]."

What we heard:

3.47 There were mixed responses for the inclusion of a statement on the level of provider participation in clinical research. Out of the total 170 responses, 59 were in favour of the statement on clinical research, compared to 46 that were opposed to the statement.

View is that research is an essential component of a high quality healthcare system. If we accept that the statement about participation in clinical research is a measure that is already collected, then we agree this could be mandated for Quality Accounts.

The NHS Confederation

⁶ *Good doctors, safer patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients*, Department of Health, July 2006

⁷ *The White Paper Trust, assurance and safety: The regulation of health professionals*, Department of Health, February 2007

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- 3.48 Some respondents agreed that research was an essential component of the NHS and that it was important that trusts engage in a number of good quality research projects. It was felt that good quality research would help to produce strategies for quality improvement.
- 3.49 Respondents also had the view that the number of patients involved in clinical research should be proportionate to the organisation's size.
- 3.50 Other respondent felt that the level of research undertaken did not necessary relate to the quality of patient care provided. It would be the outcome of the research that would illustrate improvements in quality. Other respondents felt that the volume of research did nothing to show the value of the research being undertaken by the organisation.

Our response:

- 3.51 The statement on research and innovation will be mandated in regulations. Department of Health guidance will encourage providers to report on how the outcomes of research have improved quality locally.
- 3.52 Research is a core part of the NHS, enabling the NHS to improve the current and future health of the people it serves. 'Clinical research' means research that has received a favourable opinion from a research ethics committee within the National Research Ethics Service (NRES). Information about clinical research involving patients is part of the records that NHS reporting bodies routinely keep in accordance with Section 3.10 of the *Research Governance Framework for Health and Social Care*. This information is therefore readily available from providers.
- 3.53 As stated in *NHS 2010–2015: from good to great. Preventative, people-centred, productive*⁸, as we move into a more challenging financial climate, research and innovation will become even more important in identifying the new ways of preventing, diagnosing and treating disease. This will be essential if the quality and productivity of services will continue to increase into the future.

ii. Use of the CQUIN and innovation payment framework

Q9: For the statement on the use of the Commissioning for Quality and Innovation (CQUIN) payment framework, please provide your view on its suitability for inclusion as nationally mandated content in Quality Accounts. In addition, please identify whether the description of the statement is well defined or open to interpretation and provide any other comments on the proposed statement.

What we proposed:

- 3.54 It was proposed that the provider should supply information on the use of the CQUIN payment framework, in that the following statement:

⁸ *NHS 2010 -2015: from good to great. Preventative, people centred, productive*, Department of Health, December 2009

“A proportion of the [name of organisation]’s contracted income in [last year] was conditional on achieving quality improvement and innovation goals agreed between the provider and its commissioners through the CQUIN payment framework. Further detail of the [last year] agreed goals and new goals agreed for [next year] is available on request from [state where further information on agreed goals can be obtained].”

What we heard:

3.55 The majority of responses were in favour of a statement on the use of the CQUIN payment framework. Out of the total 170 responses, 73 were in favour of the statement on the use of the CQUIN payment framework, compared to 30 that were opposed to the statement.

Believes that the CQUIN payment framework will become an increasingly significant lever for demonstrating improvements in the quality of provider services. As such we believe the proposed statement is suitable for inclusion as nationally mandated content. The statement is well defined.

The Royal College of Midwives

3.56 Favourable respondents considered that the statement was suitable as quality improvement is linked to quality innovation. Other respondents commented that it would enhance the role of CQUIN, increase transparency and provide an incentive for providers and commissioners to agree on opportunities for quality improvement.

3.57 Some respondents had concerns that the value of CQUIN payments was too small a proportion of the total contract and that involvement in CQUIN may be misleading in terms of quality. Other respondents felt that it would be more useful to publish the value of the income received. They also commented that the payments may not be the best indicator of quality innovation, as they may be dependent on the targets set by the commissioner.

3.58 Other respondents felt that patients and the public would not have an understanding of the CQUIN payment system and it would be simpler to present the actual achievements. A couple of respondents suggested that the statement could be included in guidance, rather than regulations.

Our response:

3.59 The statement on the CQUIN payment framework will be mandated in Regulations.

3.60 The CQUIN payment framework aims to support the cultural shift towards making quality the organising principle of NHS services, by embedding it at the heart of commissioner–provider discussions. The CQUIN payment framework is an important tool, supplementing Quality Accounts, to ensure that local quality improvement priorities are discussed and agreed, at board level, within (and between) organisations.

3.61 The purpose of this statement is to demonstrate that the organisation successfully co-operated with its commissioners to agree joint priorities for quality improvement to be linked to income and, also, to ensure that CQUIN schemes are made available to interested parties. We decided against a statement on the proportion of CQUIN income earned because CQUIN goals are agreed locally, varying between providers; unhelpful

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comparisons on the amount earned could undermine local ambition. We want and expect CQUIN goals to be more ambitious in 2010–/2011 and over time.

3.62 The key comparable accountability issues in relation to the CQUIN framework are that providers are working with their commissioners to reach agreement on a CQUIN scheme, as required, and that they are making their CQUIN schemes available publicly on request, to ensure transparency and support learning. We would expect providers to give more detailed information separately on their actual achievements, how their CQUIN goals fit with other organisational priorities and wider local/regional strategies and the amounts of money involved."

What others say about the provider

i. Statements from the Care Quality Commission

Q10: For the statements from the Care Quality Commission (CQC), please provide your view on their suitability for inclusion as nationally mandated content in Quality Accounts. In addition, please identify whether the description of the statements are well defined or open to interpretation and provide any other comments on the proposed statement.

What we proposed:

3.63 It was proposed that the provider should supply information relating to registration with the CQC and periodic or special reviews, in the following statements:

[for all providers]

"Our current CQC registration status is [insert text] and we have [no/n] conditions on our registration. The CQC [has/has not] taken enforcement action against us since the start of the reporting year [in relation to]."

[for NHS bodies]

"The most recent periodic review carried out by the CQC made the following conclusions [insert text]. In view of this, we have decided to [insert text describing actions being taken to address any problems identified, and progress in carrying them out]."

"We have taken part in the [insert text] special review by the CQC. We have considered the findings from that review, and have decided to [insert text describing actions taken to address any problems identified in the special review]."

What we heard:

3.64 The overwhelming majority of responses were in favour of the provider supplying information relating to registration with the CQC and periodic or special reviews.

3.65 Out of the total 170 responses, 102 were in favour of providers supplying information relating to registration with the CQC and periodic or special reviews, compared to 10 respondents opposed to supplying information.

The Commission particularly welcomes the inclusion of a specific statement about a provider's registration and any other reviews that we have undertaken in relation to their services. This core regulatory element will demonstrate to the public that a provider takes responsibility for ensuring the essential standards of quality and safety are maintained. In order to demonstrate accountability and ownership of quality improvement, it is crucial that providers are required to identify and respond to any concerns raised by CQC, including clear actions and progress made to date.

Care Quality Commission

Our response:

3.66 The statements from CQC will be mandated in regulations.

3.67 The CQC have indicated that they believe Quality Accounts will be a useful source of local information to inform their assessments of and discussions with providers about the quality of services, their approach to quality improvement and how they engage and respond to feedback from people who use services.

ii. Statement from LINKs and PCTs

Q11: Do you agree that Local Involvement Networks and primary care trusts should be given the opportunity to comment on a provider's Quality Account and that providers should include this response in their account? Should this include local authority overview and scrutiny committees?

Q12: How much time should Local Involvement networks and primary care trusts be given to provide a response on a provider's Quality Account?

What we proposed:

3.68 It was proposed that the regulations would require providers to send copies of their Quality Account to their relevant LINKs and to their lead PCT prior to publication for comment, and require the provider to include those comments in the published Quality Account.

What we heard:

3.69 The majority of respondents were in favour of PCTs and LINKs providing a statement in Quality Accounts. Out of the total 170 responses, 109 were in favour of PCTs and LINKs providing a statement in Quality Accounts, compared to 15 that were opposed to the statement.

This is a vital part of the external assurance process for Quality Accounts particularly in respect of their fairness or representativeness LINKs will also have an important role to play in ensuring that Quality Accounts will be easily understood by the general public. PCTs should be involved as early as possible in the process of producing the Quality Account, to avoid late challenges to its representativeness OSC should also be allowed an external scrutiny roll where this is practical given increasing pressures on their workloads and budgets.

Audit Commission

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3.70 Respondents were keen for local stakeholders to be involved during the entire process of publication of the Quality Account. Many respondents felt that Overview and Scrutiny Committees (OSCs) should also have the opportunity to comment but that this could be left to local decisions. Other responses suggested that Foundation Trust Governors and local Patient Advice and Liaison Service (PALS) could also be asked for statements.

3.71 Some NHS providers said they would prefer for PCTs and LINKs to make statements in their own materials, rather than have a statement in Quality Accounts. Some respondents also felt this could become quite a burdensome process for PCTs and LINKs.

3.72 The majority of responses felt that PCTs and LINKs should be given one month or six weeks to provide a response to on a providers Quality Account.

Our response:

3.73 Confidence in the assurance process is key to maximising confidence in the Quality Accounts themselves. Year-round stakeholder engagement during the process of producing a Quality Account was also seen as an important feature to ensure that Quality Accounts are locally meaningful and reflect local priorities.

3.74 As a first step, we will be requiring providers to share their Quality Accounts prior to publication each June with:

- Their commissioning PCT (or SHA)⁹;
- The appropriate LINK¹⁰; and
- The appropriate local authority OSC¹¹.

3.75 It is intended that the commissioning PCT or SHA will have a legal obligation to review and comment on a provider's Quality Account, while LINKs and OSCs will be offered the opportunity to comment on a voluntary basis.

3.76 It is intended that the commissioning PCT (or SHA) for a provider will be required to corroborate a provider's Quality Account by confirming in a statement, to be included in a provider's Quality Account, regardless of whether they consider the document contains accurate information in relation to the services supplied by the provider. In addition, the commissioning PCT (or SHA) would have to include any other information they consider relevant on the quality of NHS services given by the provider for the year reported in the statement.

3.77 Co-ordinating commissioning PCTs will be advised to check the accuracy of data provided in the Quality Account against any data they have been supplied with during the

⁹The detail which PCT (or SHA, for providers solely commissioned by an SHA) a provider should send their to will be in the Regulations. For instance where all the NHS services that an organisation provides are provided under arrangements with one Primary Care Trust, they will send their Quality Account to that PCT. Or for example if an organisation provides NHS services to a number of PCTs which are all co-ordinated by one co-ordinating PCT, then they will send their Quality Account to that co-ordinating PCT.

This includes collaborative commissioning organisations where the PCT has delegated commissioning responsibility to them.

¹⁰This will be the LINK or LINKs in the local authority area in which the provider's principal office is located.

¹¹This will be the OSC in the local authority area in which the provider's principal office is located.

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year and this will be reviewed as part of a provider's contractual obligations. PCTs will not be expected to check data, which a provider has included in their quality account, that are not part of existing contract/performance monitoring discussions. The corroborative opinion that the PCT offers will be published in the Quality Account, and will cover issues that the PCT may be in a position to comment upon. It is not, therefore, an approval of the Quality Account – that remains the responsibility of the provider.

- 3.78 It is intended that providers will have to give both the appropriate LINK and OSC the opportunity, on a voluntary basis, to review and supply a statement, for inclusion in a provider's Quality Account. We would expect this statement to indicate whether they believe, based on the knowledge they have of the provider, that the report is a fair reflection of the healthcare services provided and will be issuing guidance accordingly. Depending on local arrangements, an OSC may wish to leave this role entirely to the LINK (or vice versa) and this should be agreed between the two organisations.
- 3.79 Providers should give PCTs, LINKs and OSCs **30 working days** to prepare comments on the Quality Account prior to publication.
- 3.80 Further advice will be provided to PCTs, LINKs and OSCs in guidance. We appreciate that for the first year of Quality Accounts those providing assurance over Quality Account will not have had the full financial year to work with providers in the Quality Accounts development process. We will be encouraging providers to engage with public and patients throughout the process of producing a Quality Account.
- 3.81 These requirements will form the first steps to an assurance process for Quality Accounts, which can be built on over time. Details on further assurance methods are discussed in Chapter 6.

Data quality

Q13: For the statements on data quality, please provide your view on their suitability for inclusion as nationally mandated content in Quality Accounts. In addition, please identify whether the description of the statement is well defined or open to interpretation and provide any other comments on the proposed statement.

What we proposed:

- 3.82 It was proposed that providers should supply information on the quality of data, in that the following statements:

"In records submitted to the Secondary Uses System (SUS) for inclusion in Hospital Episode Statistics (HES), the percentage of records including the valid patient's NHS Number was [n%]."

"The trust's error rate for clinical coding (for diagnosis and treatment coding), as reported by the Audit Commission in the latest Payment by Results (PbR) clinical coding audit, is [n%]."

"In records submitted to the Secondary Uses System (SUS) for inclusion in Hospital Episode Statistics (HES), the percentage of records including the valid patient's General Practitioner Registration Code was [n%]."

"The trust's score for Information Quality and Records Management, assessed using the

Information Governance Toolkit, was [n%].”

3.83 Four key indicators were selected that seek to highlight data quality in a Quality Account and its relation to quality healthcare.

What we heard:

3.84 The majority of responses agreed that there should be a statement on the quality of data. Out of the total 170 responses, 69 were in favour of the statement on data quality, compared to 26 responses opposed to the statement.

3.85 Respondents agreed that data quality was an important measure of service quality and that data accuracy and quality were the key areas of quality indicators.

It was agreed by all that data quality is important however the reference to data quality needs to be meaningful to the respective quality account. Some participants were not clear about the value of including the wider issues of data quality within Quality Accounts and how much interest this will be to the general public in the context of Quality Accounts.

NHS Northwest Quality Observatory (AQA)

3.86 Some respondents felt the statement would be too difficult for patients to understand and that a simplified statement should be provided.

Our response:

3.87 The statement on data quality will be mandated in regulations. The statements will be amended in light of comments.

3.88 Department of Health guidance will include information on the use of indicators from the provider's Information Governance Toolkit to describe the quality of information systems and the processes operating in their organisation.

3.89 Some of the figures used in the statements on data quality are calculated from a sample of data. For instance, the statements on clinical coding error rates are derived from a sample of patient notes taken from a select service area - providing an indication of the accuracy of a provider's data. We will encourage providers in guidance to refer to the sample size and services reviewed when publishing clinical coding error rates but we will not stipulate in regulations how this should be done in order to give organisations the freedom to express this in such as way as is understandable to their readers.

Rationale for the proposed nationally mandated statements

Q14: Do you agree that our proposals for the nationally mandated content of Quality Accounts meet the objectives set out in the proposal?

Q15: Are there any other areas that should be included in the nationally required section of Quality Accounts?

What we proposed:

Response to consultation

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3.90 The nationally mandated sections proposed in Quality Accounts would serve to offer the public assurance that the organisation, in general, is performing to required standards (e.g., meeting CQC registration) and measuring its clinical processes and performance (e.g., through participation in national and local clinical audits). In addition, it should be involved in national 'cross-cutting' projects and initiatives aimed at improving quality (e.g., via recruitment to clinical trials or establishing improvement and innovation goals with the commissioner using the payment framework for CQUIN).

What we heard:

3.91 The majority of respondents agreed that the proposals for nationally mandated content of Quality Accounts met the objectives.

3.92 Some respondents felt that the nationally mandated elements were too 'prescriptive' and that the entire content of a Quality Account should be determined locally. Respondents also commented that providers should be free to determine content and that the mandated components of Quality Accounts should be continually reviewed.

3.93 Other areas suggested for inclusion as mandated content were:

- Mandatory indicators covering the three domains of quality;
- Efforts to improve quality across organisational boundaries/care pathways;
- Compliance with National Institute for Health and Clinical Excellence (NICE) guidelines;
- Complaints;
- Incidents;
- Mandatory training compliance;
- National staff and patient surveys;
- Patient views;
- Infection control;
- Staff:patient ratios; and
- Leadership development and quality of leadership.

Our response:

3.94 We will mandate the nationally required sections for Quality Accounts as set out in this chapter (the other material suggested in paragraph 3.93 will not be mandated). We will keep the mandated elements under review and continue to engage with stakeholders on what the mandate elements of Quality Accounts should look like. Much of the material set out in para. 3.95 could be an aid to a provider's contextualising some of the content of their Quality Account, and all those involved in the production process will wish to bear that in mind.

Chapter 4: publication

Publication of Quality Accounts

Q16: Do you agree with the proposed publication methods?

What we proposed:

- 4.1 The legislation set out in the Health Act 2009 requires providers to supply a copy of their Quality Account to the Secretary of State in any form specified by the Secretary of State for the purpose of making the document available to the public. In addition the Regulations can specify how the document should be published.
- 4.2 It was proposed that all providers should publish their Quality Account on the NHS Choices website. Providers would be able to do this themselves by updating their general description profile. The Department of Health is considering whether a tool that assists readers in comparing information between providers should be adapted to allow comparison between the nationally mandated statements.
- 4.3 The Department of Health proposes that the regulations would require providers to publish their Quality Accounts (and send a copy to the Secretary of State) by the end of June each year. In relation to NHS bodies, this ensures that their Quality Accounts will align with their annual report and accounts. It is accepted that some data on the quality of health services for the previous financial year might not be available within that timescale, or if submitted to a national body may not yet be validated. Providers would be asked to use the 'latest available data' and state whether the source of the data is a national body (e.g. the NHS Information Centre) or whether it has been derived from local sources.
- 4.4 During the testing period in 2009, NHS foundation trusts were required to present their Quality Account as part of their annual report and accounts. This is one method of ensuring consistency across the financial reporting and Quality Accounts publication period. A separate 'Quality Accounts' document is required for publication. Providers will be required to submit an electronic version of their Quality Accounts for publication on the NHS Choices website. In addition to this, NHS foundation trusts will continue to be required by Monitor to publish their Quality Accounts in their annual reports and accounts.
- 4.5 Providers should also consider the communication needs of their local community and whether it is appropriate to communicate all, or part, of a Quality Account in different languages or formats (e.g., Braille). Providers should also consider distribution methods for those members of the community who may not have access to the Internet, having regard to their duties under equality legislation when preparing their Quality Accounts.
- 4.6 Providers may also want to consider developing a public-facing summary leaflet of their Quality Account.

What we heard:

- 4.7 Respondents were in favour of publishing Quality Accounts on the NHS Choices website. Out of the total 170 responses, 90 were in favour of the proposed publication methods, compared to 14 that were opposed to the methods.
- 4.8 Respondents also felt that Quality Accounts should also be published by providers and made available to the public.

We agree that Quality Accounts should be published on the NHS Choices website. The consultation states that providers should also consider the communication needs of their local community when disseminating the information and ensure that Quality Accounts are available in different formats and languages and through mediums other than the internet for those who don't have access – all of which we support.

Asthma UK

Our response:

- 4.9 The Department of Health will make regulations that require providers to publish their Quality Accounts on NHS Choices (and send a copy to the Secretary of State) by the end of June each year, as set out above.
- 4.10 The Department of Health guidance will draw on findings from work undertaken during 2009 with members of the public, users of services and others with an interest to advise providers on good practice regarding developing and presenting their Quality Account in a meaningful format to the public.
- 4.11 The Health Act 2009 states that each provider must make available on request, to any person that requests it, hard copies of the previous two years' Quality Accounts. Again, organisations may want to think about how to provide this as a separate document in these instances.

Q17: Do you have any other comments on the proposals?

What we heard:

4.12 Other comments included:

- The purpose of Quality Accounts should be clarified;
- Further work is needed on assurance of Quality Accounts;
- Providers will need approved guidance to support the production of Quality Accounts;
- Quality Accounts will need reviewing after the first tranche;
- Thought should be given to the amount of annual reporting NHS organisations have to complete;
- There is overlap between Quality Accounts and other reporting systems;
- Sources of data should be referenced;
- The target audience is unclear; Quality Accounts cannot be suitable for both providers and the public;
- Highlighting the quality of some areas could mean effort is lost on others; and

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- Quality Accounts could become long and complex.

Our response:

4.13 Respondents raised some interesting points that will continued to be reviewed as the framework for Quality Accounts is evaluated and developed further.

4.14 Additional work on assurance is going ahead and is detailed in Chapter 6.

4.15 A toolkit will be published alongside the Regulations that will contain guidance for providers on the production of a Quality Account.

Chapter 5: which organisations will be required to provide a Quality Account?

- 5.1 The Health Act 2009 states that, all providers of healthcare services in England given under the auspices of the NHS will be required to provide a Quality Account from April 2010. Such services are those provided under section 1(1) of the National Health Service Act 2006. This includes providers of health services provided jointly with another person and services provided under sub-contracting arrangements. It also includes private sector organisations contracted to provide NHS services. This therefore gives, in the first instance, complete coverage of the requirement to produce Quality Accounts for NHS healthcare.
- 5.2 Any exemptions to this requirement will be made through regulations. For the first year of Quality Accounts all providers or sub-contractors of NHS services will be required to produce a Quality Account but not in relation to the provision of any primary care or community health services.¹² Small providers will also be exempted.
- 5.3 Consequently, this consultation related largely to those organisations which will provide a Quality Account in the first year, although the underlying principles remain relevant to all healthcare providers, as they provide the basis for future years.
- 5.4 A process of engagement, testing and consultation was initiated with primary care and community services providers in autumn 2009. Some of the questions in this consultation related to how and when Quality Accounts should be introduced into the primary care and community services sectors.

Individuals, partnerships or bodies that are not incorporated

Q18: Some providers may be individuals, partnerships or bodies that are not incorporated. We would welcome views on how the proposals would operate for such bodies.

What we heard:

- 5.5 Generally respondents felt that a provider who is not incorporated should still have to produce a Quality Account. Respondents commented that the responsibility to produce a Quality Account should be proportionate to the size of the organisation.

¹² For the first year of Quality Accounts, only NHS trusts and NHS foundation trusts and their private or voluntary sector equivalents will provide a Quality Account. This includes NHS acute trusts, mental health trusts, learning disability trusts and ambulance trusts. Private or voluntary sector equivalents cover providers of NHS acute, community and mental health services

Exemption of small providers

Q19: Do you agree that small providers should be exempt from producing Quality Accounts? If so, are the proposed criteria the right ones?

What we proposed:

5.6 It was intended that providers that do not have a significant NHS workload will be exempt from producing a Quality Account. In the absence of any other definition of what constitutes a small-scale provider, it is proposed that providers treating fewer than 100 NHS patients annually or those with an annual NHS contract worth less than £100,000, should not be subject to the duty to publish a Quality Account.

What we heard:

5.7 There was mixed support for excluding small providers. Out of the total 170 responses, 41 were in agreement with the exemption for small providers, compared to 47 respondents opposed to the exemption.

5.8 A number of respondents felt that producing a Quality Account would be too burdensome for small providers. In contrast, other respondents felt that all organisations providing NHS services should be accountable to the public for the quality of their services and, therefore, should have a duty to produce a Quality Account.

It may be appropriate for small providers to be exempt from producing a Quality Account but we should never sacrifice quality, particularly as small providers may actually be providing services to the most vulnerable people in society. So it is important that all providers have a commitment to quality and they are held accountable for their actions/services.

North Yorkshire Scrutiny of Health Committee

Our response:

5.9 It is the Department's view that, on balance, an exception should be made for small providers within organisations that would struggle with the additional financial and workforce burden in producing an account. Regulations will state that providers who employ less than 50 full-time employees and have an annual NHS contract worth less than £130,000 should not be subject to the duty to publish a Quality Account.

5.10 Providers of healthcare are regulated by the Care Quality Commission. Small providers of regulated activities would still need to be registered with the Care Quality Commission¹³ and continue to be compliant with the requirements of registration by ensuring that people experience care that meets the essential standards of quality and safety described in CQC's Guidance about Compliance¹⁴.

Primary and community care

¹³ Response to consultation on the framework for the registration of health and adult social care providers and consultation on draft regulations, Department of Health, March 2009

¹⁴ <http://www.cqcguidanceaboutcompliance.org.uk/>

Q20: What are your views on the proposed process for delivering Quality Accounts in the primary and community care setting?

What we heard:

5.11 The majority of responses were in favour of primary and community care providers producing a Quality Account as this would ensure a level playing field. Out of the total 170 responses, 60 were in favour of the proposals for delivering Quality Accounts in the primary and community care settings, compared to 7 respondents who were opposed to the proposals. Respondents pointed out that the framework for Quality Accounts for primary and community care would have to be revised.

The extension of Quality Accounts to the primary and community care setting is essential to ensure that the whole patient pathway is subject to the same level of evaluation. It will be much more difficult to implement and the proposed process is satisfactory.

Gloucestershire LINK

Our response:

5.12 The current plan is to introduce Quality Accounts for primary and community care sectors from 2011. An engagement and testing process, similar to that run within NHS foundation trusts and NHS East of England providers but focused on the particular needs of these two sectors, commenced for providers in NHS North East and NHS East Midlands over the Autumn and will deliver test reports in June 2010. This will help shape the development of Quality Accounts further as they begin to apply to all providers.

5.13 The Department of Health will utilise the lessons from the previous testing, engagement and this consultation exercise, in order to inform the testing process in primary and community care.

5.14 The findings from this process, including an evaluation of the project and best practice examples, will be used to update the regulations and guidance ahead of the introduction of Quality Accounts for primary care and community services providers.

5.15 For the time being Regulations will include an exemption for primary and community care services.

Organisation type	Common names	Services provided	Date of regulations coming into force	Reporting year for first	Publication date for first
NHS	Acute	Acute Ambulance Community services Mental Health Services Learning disability services	1 April 2010	2009-10	June 2010
	Ambulance trust				
	Foundation Trust				
	Care trusts				
	Ambulance Trust				
Foundation trust					
Learning Disability Trust					
Learning Disability trust					
Care Trusts					

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	Mental Health Trust				
	PCT provider of secondary care services				
Independent providers of NHS services (acute, mental health and ambulance services)	Social Enterprise providers	Acute Ambulance Community services Mental Health Services Learning disability services	1 April 2010	2009-10	June 2010
	Not for profit providers				
	Commercial providers				
PCT provider	PCT	Community services Primary care Out of hours care NHS Walk in centres	1 April 2011	2010-11	June 2011*
	Primary Care Trust provider arm				
Independent providers of NHS services (primary, urgent and community care)	Social Enterprise providers	Primary care Community Services Out of Hours Care Urgent Care	1 April 2011	2010 - 11	June 2011*
	Not for profit providers				
	Commercial providers				
Primary care contractors	General Practitioner	Primary care	1 April 2011	2010-11	June 2011*
	Dentist				
	Community pharmacist				
	Dispensing Appliance Contractors				
	Optometrist				

* - could defer for a further year, subject to the results of the evaluation of the testing exercise

Q21: our testing showed that a typical cost for a provider to produce a Quality report was around £14,000–£22,000. Do you think that this is a realistic estimate?

What we heard:

5.16 Many respondents felt they could not comment on this question. Some felt this was a realistic estimate, while others felt it was an underestimate. Many respondents commented that this would be a large burden for small providers.

Our response:

5.17 The Impact Assessment that will accompany the Regulations has been revised. A copy will be made available on the Department of Health Website¹⁵. It shows that:

- There are clear benefits to the public in increased patient choice and provider accountability;
- Quality Accounts will improve the quality of patient care; and
- These benefits outweigh the costs.

5.18 The requirement will not apply to small businesses.

¹⁵www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm

Chapter 6: assurance and next steps

6.1 We will continue to work with stakeholders as Quality Accounts are developed further

Assurance

6.2 Self-certification and stakeholder engagement will form the first steps to an assurance process for Quality Accounts, which can be built on over time.

6.3 Following discussions at the National Quality Board, Monitor are holding a consultation¹⁶ on proposals for third party assurance of Quality Accounts and will be testing this approach in 2010. The Department of Health will work with Monitor and other partners to evaluate the results of these proposals and make recommendations for the future development of the policy to introduce a form of third party assurance for all Quality Accounts.

Next steps

6.4 The Regulations for Quality Accounts discussed in this consultation will be made by the Minister and laid before Parliament in Spring 2010, and will come into force on 1st April. The regulations will set out the mandated elements of Quality Accounts and confirm the scope of providers.

6.5 A toolkit will be published alongside the Regulations this Spring that will contain guidance for providers on the production of a Quality Account.

National evaluation of 2009–2010 Quality Accounts

6.6 Nationally, the Department of Health carried out an evaluation exercise of the Quality Reports from 2009, aimed at informing the direction of the regulations and guidance. We also intend to run an evaluation of Quality Accounts after the first year of publication, in order to further review and revise where necessary.

Primary care

6.7 As detailed in Chapter 5, we will consult again on the framework for primary care following the results of testing and subsequent evaluation.

¹⁶<http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/consultations/monitors-consultations/consultation-seeking-exte>

Annex A: stakeholder engagement

Alongside the formal consultation a comprehensive stakeholder engagement process has been informing, and will continue to inform, the shape of Quality Accounts. This process is mapped out below.

Quality Account – Engagement

The engagement process focused on the acute sector and those providers producing Quality Accounts in the first year. Key features of this process are summarised below.

Quality Accounts Stakeholder Group

We established a Quality Accounts Stakeholder Group in December 2008 to consider the development and delivery of Quality Accounts. This group has played a key role in the development of Quality Accounts by shaping the policy, giving direction and engaging with different stakeholders. The group is chaired by Sir Neil McKay, Chief Executive of NHS East of England, and members include senior stakeholders drawn from the Department of Health, healthcare regulators, the Royal Colleges, trades unions and patient organisations. It also has representatives from across different healthcare providers, including the independent healthcare sector.

Strategic health authority visits from the NHS medical Director and Sir Ian Carruthers

During 2009 the NHS Medical Director, Professor Sir Bruce Keogh, and Sir Ian Carruthers, Chief Executive of NHS South West, have visited each region of the NHS and met front-line staff and senior leaders across a number of different care settings. They have looked at examples of local quality improvement and the use of the tools set out in the Quality Framework, including Quality Accounts.

Ipsos MORI NHS engagement project

As part of the engagement process, Ipsos MORI was appointed to facilitate a series of regional events to discuss Quality Accounts, culminating in a national deliberative event held on 6 May 2009 in London, which brought together nominated representatives from all of the regions. This work was jointly commissioned with NHS East of England, the Care Quality Commission (CQC) and Monitor. The national deliberative event discussed the purpose, content, publication and validation of Quality Accounts and the full Ipsos MORI report can be found at www.dh.gov.uk/en/Healthcare/Highqualitycareforall/Qualityaccounts/index.htm

Patient and public engagement project

Over the summer, we focused our engagement efforts particularly on gaining views from the public, service users and patient organisations. We ran a joint engagement exercise with the CQC and patient organisations to discuss how best to engage patients and the public in Quality Accounts and the role of Local Involvement Networks (LINKs). We jointly commissioned Ipsos MORI to run workshops with the public and LINKs representatives. The King's Fund also ran two workshops with patient representatives. We also held a joint workshop with National

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Voices, attended by representatives of around 25 patient organisations, which looked at how Quality Accounts could be most meaningful to patients.

Annex B: glossary

Acute trusts

A trust is an NHS organisation responsible for providing a group of healthcare services. An acute trust provides hospital services (but not mental health hospital services which are provided by a mental health trust).

Ambulance trusts

There are currently 12 ambulance services covering England, providing emergency access to healthcare. The NHS is also responsible for providing transport to get many patients to hospital for treatment. In many areas it is the ambulance trust that provides this service.

Audit Commission

The Audit Commission regulates the proper control of public finances by local authorities and the NHS in England and Wales. The Commission audits NHS trusts, primary care trusts (PCTs) and strategic health authorities (SHAs) to review the quality of their financial systems. It also publishes independent reports which highlight risks and good practice to improve the quality of financial management in the health service and, working with the Care Quality Commission (CQC), undertakes national value for money studies. Visit: www.audit-commission.gov.uk/Pages/default.aspx

Board (of trust)

The role of the trust's board is to take corporate responsibility for the organisation's strategies and actions. The chair and non-executive directors are lay people drawn from the local community and are accountable to the secretary of state. The chief executive is responsible for ensuring that the board is empowered to govern the organisation and to deliver its objectives.

Care Quality Commission

The Care Quality Commission (CQC) replaced the Healthcare Commission, Mental Health Act Commission, and the Commission for Social Care Inspection in April 2009. The CQC is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. Visit: www.cqc.org.uk

Clinical audit

Clinical audit measures the quality of care and services against agreed standards and suggests or makes improvements where necessary.

Commissioners

Commissioners are responsible for ensuring adequate services are available for their local population by assessing needs and purchasing services. Primary care trusts (PCTs) are the key organisations responsible for commissioning healthcare services for their area. They

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commission services (including acute care, primary care and mental healthcare) for the whole of their population, with a view to improving their population's health.

Commissioning for Quality and Innovation

High Quality Care for All included a commitment to make a proportion of providers' income conditional on quality and innovation, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Visit: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443

Community services

Health services provided in the community, for example health visiting, school nursing and podiatry (footcare).

Department of Health

The Department of Health is a department of the UK government but with responsibility for government policy for England alone on health, social care and the NHS.

Foundation trusts

A type of NHS trust in England that has been created to devolve decision-making from central government control to local organisations and communities so they are more responsive to the needs and wishes of their local people. NHS foundation trusts provide and develop healthcare according to core NHS principles – free care, based on need and not ability to pay. NHS foundation trusts have members drawn from patients, the public and staff and are governed by a board of governors comprising people elected from and by the membership base.

Health Bill

A Bill is a proposal for legislation formally presented to Parliament for debate, amendment and approval. The Health Bill was introduced into Parliament on 15 January 2009. It proposes measures to improve the quality of NHS care, the performance of NHS services and public health. One of the policies in the bill is a duty on providers of NHS healthcare to produce new Quality Accounts.

Health Act

An Act of Parliament is a law, enforced in all areas of the UK where it is applicable. The Health Act 2009 received Royal Assent on 12th November 2009.

Healthcare

Healthcare includes all forms of healthcare provided for individuals, whether relating to physical or mental health, and includes procedures that are similar to forms of medical or surgical care but are not provided in connection with a medical condition, for example cosmetic surgery.

Healthcare Quality Improvement Partnership

The Healthcare Quality Improvement Partnership (HQIP) was established in April 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality in England and Wales. It is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices.

High Quality Care for All

High Quality Care for All, published in June 2008, was the final report of the NHS Next Stage Review, a year-long process led by Lord Darzi, a respected and renowned surgeon, and around 2,000 front-line staff, which involved 60,000 NHS staff, patients, stakeholders and members of the public.

Hospital episode Statistics

Hospital Episode Statistics (HES) is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere.

Indicators for Quality Improvement

The Indicators for Quality Improvement (IQI) are a resource for local clinical teams providing a set of robust indicators from which they can select as the basis for local quality improvement and a source of indicators for local benchmarking. The IQI can be found on the NHS Information Centre website at:
www.ic.nhs.uk/services/measuring-for-quality-improvement

Learning disability trusts

Learning disability trusts provide a range of healthcare and social support services for people who have learning disabilities and other long-term complex care needs.

Local Involvement networks

Local Involvement Networks (LINks) are made up of individuals and community groups who work together to improve local services. Their job is to find out what the public like and dislike about local health and social care. They will then work with the people who plan and run these services to improve them. This may involve talking directly to healthcare professionals about a service that is not being offered or suggesting ways that an existing service could be made better. LINks also have powers to help with the tasks and to make sure changes happen.

Mental health trusts

There are currently 60 mental health trusts covering England, which provide health and social care services for people with mental health problems.

Monitor

The independent regulator responsible for authorising, monitoring and regulating NHS foundation trusts.

National Patient Safety Agency

The National Patient Safety Agency (NPSA) is an arm's length body of the Department of Health, responsible for promoting patient safety wherever the NHS provides care. Visit: www.npsa.nhs.uk

National Patient Surveys

The National Patient Survey Programme, co-ordinated by the CQC, gathers feedback from patients on different aspects of their experience of recently received care, across a variety of services/settings. Visit: www.cqc.org.uk/usingcareservices/healthcare/patientsurveys.cfm

National Research Ethics Service

The National Research Ethics Service (NRES) is part of the NPSA. It provides a robust ethical review of clinical trials to protect the safety, dignity and well-being of research participants as well as ensuring through the delivery of a professional service that it is also able to promote and facilitate ethical research within the NHS.

NHS Choices

The first port of call for the public for all information on the NHS.

NHS East of England

NHS East of England is the strategic health authority for the east of England, covering Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk. NHS East of England is the regional headquarters of the NHS, and provides strategic leadership to all NHS organisations across the six counties.

NHS Next Stage review

A review led by Lord Darzi. This was primarily a locally led process, with clinical visions published by each region of the NHS in May 2008 and a national enabling report, *High Quality Care for All*, published in June 2008.

National Institute for Health and Clinical excellence

The National Institute for Health and Clinical Excellence (NICE) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. Visit: www.nice.org.uk

NICE Quality Standards

A NICE quality standard is a set of specific, concise statements acting as markers of high-quality, cost-effective care across a pathway or a clinical area. NICE quality standards are derived from the best available evidence. Visit: www.nice.org.uk/aboutnice/qualitystandards/qualitystandards.jsp

Overview and Scrutiny Committees

Since January 2003, every local authority with responsibilities for social services (150 in all) have had the power to scrutinise local health services. Overview and scrutiny committees (OSCs) take on the role of scrutiny of the NHS – not just major changes but the ongoing operation and planning of services. They bring democratic accountability into healthcare decisions and make the NHS more publicly accountable and responsive to local communities.

Periodic review

Periodic reviews are reviews of health services carried out by the CQC. The term ‘review’ refers to an assessment of the quality of a service or the impact of a range of commissioned services, using the information that the CQC holds about them, including the views of people who use those services. Visit:

<http://www.cqc.org.uk/guidanceforprofessionals/healthcare/nhsstaff/periodicreview2009/10.cfm>

Primary care trusts

A primary care trust (PCT) is an NHS organisation responsible for improving the health of local people, developing services provided by local GPs and their teams (called primary care) and making sure that other appropriate health services are in place to meet local people’s needs.

Providers

Providers are the organisations that provide NHS services, e.g. NHS trusts and their private or voluntary sector equivalents.

Quality Framework

High Quality Care for All, published in 2008, committed the Department of Health and the NHS to developing a Quality Framework which will support local clinical teams to improve the quality of care locally.

Quality Reports

Monitor and NHS East of England required all NHS foundation trusts in England and all NHS providers in the East of England region to produce Quality Reports in spring/summer 2009.

Registration

From April 2009, every NHS trust that provides healthcare directly to patients must be registered with the CQC. In 2009/10, the CQC is registering trusts on the basis of their performance in infection control.

Regulations

Regulations are a type of secondary legislation made by an executive authority under powers given to them by primary legislation in order to implement and administer the requirements of that primary legislation.

Research

Clinical research and clinical trials are an everyday part of the NHS. The people who do research are mostly the same doctors and other health professionals who treat people. A clinical trial is a particular type of research that tests one treatment against another. It may involve either patients or people in good health, or both.

Secondary Uses Service

The Secondary Uses Service (SUS) is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development. Visit: www.ic.nhs.uk/services/secondary-uses-service-sus

Special review

A special review is a review carried out by the CQC. Special reviews and studies are projects that look at themes in health and social care. They focus on services, pathways of care or groups of people. A review will usually result in assessments by the CQC of local health and social care organisations. A study will usually result in national-level findings based on the CQC's research. Visit:

www.cqc.org.uk/guidanceforprofessionals/healthcare/nhsstaff/specialreviews/specialreviewsandstudies2009/10.cfm

Strategic health authority

Strategic health authorities (SHAs) were created by the government in 2002 to manage the local NHS on behalf of the secretary of state.

SHAs (there are 10 in total) are responsible for:

- Developing plans for improving health services in their local area;
- Ensuring that local health services are of a high quality and are performing well;
- Increasing the capacity of local health services – so they can provide more services; and
- Ensuring that national priorities – e.g., programmes for improving cancer services – are integrated into local health service plans.

SHAs manage the NHS locally and are a key link between the Department of Health and the NHS.



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