Quality Accounts toolkit

Advisory guidance for providers of
NHS services producing Quality Accounts
for the year 2009/10

DH INFORMATION READER BOX

Policy HR/Workforce Management Planning Clinical	Estates Commissioning IM&T Finance Social Care/Partnership Working
Document purpose	Best Practice Guidance
Gateway reference	13463
Title	Quality Accounts toolkit
Author	Department of Health, Quality Framework Programme
Publication date	02 Feb 2010
Target audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, PCT Chairs, NHS Trust Board Chairs
Circulation list	Foundation Trust CEs , Voluntary Organisations/NDPBs
Description	The Quality Accounts toolkit is best practice advisory guidance for providers of NHS services to make use of during the production and publication of Quality Accounts in 2010.
Cross reference	N/A
Superseded documents	N/A
Action required	N/A
Timing	N/A
Contact details	Neil Townley Quality Accounts, Department of Health Skipton House 80 London Road SE1 6LH 0207 972 5209 www.dh.gov.uk/qualityaccounts
For recipient use	

First published February 2010

Produced by COI for the Department of Health

www.dh.gov.uk/publications

Contents

Introduction

Foreword

High Quality Care for All highlighted the importance of measuring what we do in order to drive improvements in quality of care. Of course, it is how we use this information and the changes we make as a result which are the key to successful improvement.

Publishing information on provider performance has been advocated as a mechanism for driving improvement through a variety of means, including public and professional accountability, patient-informed choice and the commissioning process.

However, the evidence suggests that public disclosure does not generally drive improvement through the resulting actions of patients. Rather, it is the organisational response that providers put in place in order to improve their record on quality that drives improvement.

So, the primary purpose of Quality Accounts is to encourage boards to assess quality across the totality of services they offer, with an eye on 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.

The production of Quality Accounts offers the opportunity for organisations to aggregate, review and analyse information relating to quality, so that they can decide where improvement is needed in such a way that it becomes part of the core business of the organisation. To achieve their potential, Quality Accounts should represent a summary of quality across the totality of the services of an organisation, and should be driven by the leaders of the clinical teams delivering those services to ensure that they are both accurate and representative. But the data and information should also be constructively challenged by anyone with an interest in the relevant service. Finally, they must be challenged and agreed by the trust board.

This toolkit offers you good, practical advice to help you maximise the opportunities offered by Quality Accounts. It draws on lessons learned during the past year in discussions with a wide range of stakeholders, testing through pilot quality reports provided by NHS foundation trusts and NHS trusts in the East of England, and the public consultation on the framework for Quality Accounts.

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 this work, and I would like to extend my thanks and appreciation for their efforts and contributions.

As we move into challenging economic times, by placing accountability for how we handle quality of care on an equal footing to how we handle finances, we are demonstrating that quality of care is our core business in the NHS – it is at the heart of everything we do.

Professor Sir Bruce Keogh
NHS Medical Director
Department of Health

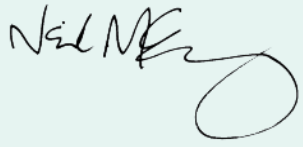
Message from Sir Neil McKay

NHS East of England is extremely pleased to have participated in the first national pilot of producing Quality Reports. The experience has enabled all of our provider organisations to better understand the process and to become ready for the challenges of the next few years.

The pilot has shaped the Quality Accounts regulation framework and has flushed out the need to develop local quality improvement programmes, based on a wide range of indicators. The introduction of quality observatories, providing up to 80% of this data, will prove invaluable and will ensure continuity across commissioner/provider contractual agreements. The use of the Commissioning for Quality and Innovation framework to underpin local quality improvement programmes will also be evidenced in Quality Accounts.

Some organisations will require support. It was clear that the starting point for many organisations across the East of England differed in terms of ability to deliver quality improvement activity. The development of the requisite skills will take time. Some organisations will require intensive support – this will be offered by the strategic health authority, making use of an extensive array of clinical leaders across the East of England. This will be undertaken in agreement with Monitor and the Care Quality Commission.

The introduction of Quality Accounts in 2010 will require all boards to demonstrate the process by which they have developed quality improvement programmes; what they have done to make the organisation ready for this challenge; what they have done to embed the quality agenda alongside financial activity and waiting list frameworks; and their capability to deliver improvement activity. These statements will determine the long-term sustainability of each organisation to continually deliver quality improvements which will ultimately feed the Quality Accounts.



Sir Neil McKay
Chief Executive, NHS East of England
Chair, Quality Accounts Stakeholder Group

Quality Accounts film

In June 2009, Norfolk and Waveney Mental Health NHS Foundation Trust was among the first to produce a quality report, as part of the testing process for Quality Accounts led by Monitor and NHS East of England. A film is available, charting their approach to the development of their report, and offering thoughts on the benefits, challenges and outcomes of undertaking the process, as they work to improve the quality of services. You can view the film by visiting www.dh.gov.uk/qualityaccounts.

1 Purpose of the toolkit

1.1 This toolkit is aimed at providers of NHS services, in order to offer advice as they set out to produce the first set of Quality Accounts for June 2010. It seeks to consolidate the understanding of the purpose of Quality Accounts and to guide their production based on what the public, NHS staff and other interested parties have said during the national engagement and testing processes.

1.2 Other stakeholders who have a role in contributing to, and commenting on, Quality Accounts will also find this useful.

1.3 A Quality Account consists of three separate parts. Parts 1 and 2 are set out in regulations, and this document refers to these requirements. Part 3 is where you (the NHS provider) have the opportunity to make the Quality Accounts most meaningful to your reader, with information relevant to your particular services, based on discussions with service users, staff and others with an interest. This toolkit explores some of the information you may wish to consider including in part 3.

1.4 Quality improvement is an ongoing cycle and organisations are continually updating and adapting their plans and priorities to reflect their particular needs and experiences. So too will the nature of Quality Accounts evolve, and we envisage that, over time, this toolkit will become a mechanism for sharing best practice between organisations, and will be driven by local experiences, both of those producing and of those using the Accounts.

2 Executive summary

Quality Accounts – what are they and what are they for?

2.1 Quality Accounts are annual reports to the public from providers of NHS healthcare services about the quality of services they provide. The public, patients and others with an interest will use a Quality Account to understand:

- what your organisation is doing well;
- where improvements in service quality are required;
- what your priorities for improvement are for the coming year; and
- how you have involved service users, staff and others with an interest in your organisation in determining those priorities for improvement.

2.2 Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda.

2.3 Public accountability is gained through the publication of honest, balanced (i.e. showing not just what you are doing well but also where improvement is required) and meaningful information regarding quality of services into the public domain. It is also dependent on your involvement of the public, service users, the wider community, and others with an interest, professional or personal, in your organisation, in the review of information relating to quality and decisions about priorities for improvement. True public accountability will only be achieved if you listen, utilise and, most importantly, act on the feedback given to you, both during the process and following publication of the Quality Account.

2.4 The leaders of an organisation will be engaged in the quality improvement agenda both in order to achieve public accountability but also as a result of it. By putting information about the quality of services in your organisation into the public domain you are offering your approach to quality up for scrutiny, debate and reflection.[1] Therefore, it is important that you are fully engaged in the review of your services, and listen to the advice of clinicians,

1 Marshall MN, Shekelle PG, Leatherman S and Brook RH (2000) What do we expect to gain from the public release of performance data? A review of the evidence. *Journal of the American Medical Association*; 83:1866–1874.

other members of staff, service users and others in order to determine priorities for improvement. These priorities need to be deliverable and measurable, and should stretch your organisation towards achieving the vision set out for the NHS as a whole of providing high quality care for all.

2.5 All providers of NHS services, no matter how small or large, or what services they provide, should be striving to achieve high quality care for all and, therefore, all are required to produce a Quality Account as set out in the Health Act 2009 and supporting regulations. However, a phased introduction to the requirement will be adopted, with those providers of solely primary care and/or community services deferred until 2011, subject to the results of further testing and evaluation with these providers.

What might a Quality Account look like?

2.6 Some parts of a Quality Account are mandatory and set out in regulations. We expect most of the content to be determined locally.

2.7 In order to engage leaders of your organisation fully in your particular quality improvement agenda, and to reflect the views and needs of your local population and service users, the approach to improvement needs to be owned and individual to your organisation. You should, therefore, determine locally the majority of your Quality Account, which should present an honest picture of what you deliver and what your improvement plans are. However, in order to provide some consistency between provider reports, and to provide assurance that your organisation is meeting essential standards and is involved in cross-cutting initiatives that aim to drive up quality improvement, a series of statements from the board are required as part of the regulations.

2.8 A Quality Account must include:

- a statement from the board (or equivalent) of your organisation summarising the quality of NHS services provided;
- your organisation's priorities for quality improvement for the coming financial year;
- a series of statements from the board for which the format and information required is set out in regulations; and
- a review of the quality of services in your organisation. You might like to think about expressing this in terms of the three domains of quality: patient safety, clinical effectiveness and patient experience.

Who should decide what goes into a Quality Account? Identifying your local improvement priorities

2.9 The board (or equivalent) of your organisation is ultimately responsible for the delivery of services and the quality of the information presented in your Quality Account (meeting both the regulatory requirements and the expectations of stakeholders). However, the process involved in designing your quality improvement plans, and the content of the Quality Account as a bi-product of this, should be produced by true involvement and engagement of all with an interest in your organisation, including users of your services (and organisations in the community who advocate for them).

Making sense of information – reviewing and presenting data

2.10 Quality Accounts are public documents, and while their audience is wide ranging (clinicians, staff, commissioners, patients and their carers, academics, regulators etc.), your Quality Account should aim to present information in a way that is accessible for all. Data presentation should be simple and in a consistent format. Information should provide a balance between positive information and acknowledgement of areas that need improvement. Use of both qualitative and quantitative data will help to present a rounded picture and the use of data, information or case studies relevant to your local community will help make your Quality Account meaningful to its reader.

Quality management systems – embedding quality in your organisation and showing this in your Quality Account

2.11 Quality Accounts offer a commitment to improve quality of services, but in order to make this commitment, you need to know not only what needs improving but also how this can be achieved. Ensure that you are clear about the quality of care you are delivering, how you are delivering this, what needs to improve and how this needs to be done.

How should Quality Accounts be published?

2.12 Quality Accounts will be published electronically on the NHS Choices website and you must make hard copies of the previous two years' Quality Accounts available on request. You should also consider making them available in other formats or different community languages where there is an expressed need to do so. In addition to the publication on NHS Choices, you may also choose to publish this via your own communications channels, such as your organisation's website.

Trust and assurance – who is responsible for assuring the Quality Account?

2.13 Quality Accounts are not marketing documents, but a chance to enter into a real, open and honest dialogue with the public regarding the quality of care in your organisation.

2.14 Assurance is therefore required to ensure trust in the Quality Account, that the information presented is accurate and fairly interpreted, and that the range of services described and priorities for improvement are representative of the services you deliver.

2.15 The board (or equivalent) is accountable for your Quality Account and, therefore, they must assure themselves and then state publicly within the document that the information presented is accurate.

2.16 To provide further assurance, your lead primary care trust (PCT), Local Involvement Network (LINk) and overview and scrutiny committee (OSC) must all be offered the opportunity to comment on your report ahead of publication, and a statement, if offered, must be presented in the Quality Account.

2.17 For providers whose services cover a region, or with significant activity in more than one PCT (e.g. ambulance trusts), an option to consider is to seek the views of all PCTs, LINks and OSCs involved – not just the lead one. Although the lead PCT might well take on the role of coordinating a joint response, that might not apply to LINks and OSCs.

2.18 The National Quality Board has commissioned a piece of work involving the Department of Health and Monitor to consult upon and develop a form of third-party assurance of Quality Accounts, which, subject to consultation, will be introduced in 2011. This toolkit, as well as any amendments to regulations will be updated to reflect any new requirements in advance of their introduction.

What next? Evaluating and moving forward

2.19 An evaluation of Quality Accounts published nationally in 2010 will review nationally the requirements and advice set out in the current guidance.

2.20 NHS North East and NHS East Midlands are leading a pilot of Quality Accounts with a sample of providers across primary care and community services. This pilot, and its subsequent evaluation supports a national project to develop Quality Accounts for all providers of primary care and community NHS services with the view of introducing them into the requirement in 2011.

2.21 Any change to existing or addition of new regulatory requirements will be subject to public consultation. Advice in this toolkit may be amended to reflect changes in approach or examples of good practice.

3 Quality Accounts – what are they and what are they for?

Quality Accounts:

- demonstrate accountability to the public for the quality of services you deliver;
- enable you, the provider, to review your services, decide and show where you are doing well, but also where improvement is required;
- enable you to demonstrate what improvements you plan to make;
- provide information on the quality of your services to patients and the public; and
- demonstrate how you involve and respond to feedback from patients and the public, as well as other stakeholders.

3.1 Quality Accounts are annual reports to the public from providers of NHS healthcare about the quality of services they deliver. The public, patients and others with an interest will use a Quality Account to gain a high level understanding of the quality of your organisation as a whole, to see what you do well, where you need to improve, and to understand what you are doing to achieve improvement in quality.

3.2 Quality Accounts are both retrospective and forward looking. They look back on the previous year's information regarding quality of services, explaining both what you are doing well and where improvement is needed. But, crucially, they also look forward, explaining what you have identified as your priorities for improvement over the coming financial year, and how you will achieve and measure these.

3.3 **Quality Accounts aim to improve organisational accountability to the public and engage boards (or their equivalents) in the quality improvement agenda for your organisation.**

3.4 Work to develop Quality Accounts to date showing the relationship between these elements is illustrated in the diagram below.

3.5 The content of a Quality Account cannot be decided by the board (or equivalent), and therefore the information presented and the decisions taken on improvement as a result, needs to be decided by involving all interested parties; for example, patients and their carers, including those from equality target groups; staff and clinical teams; commissioners and regulators.

3.6 Equally, the document itself simply reports on your work, so should not be seen as a 'stand alone' project for your organisation to work towards. It is the process of reviewing and discussing quality with those who use your services or have an interest in your organisation, and subsequently putting improvement plans in place, which will deliver high quality care. Quality Accounts are a record of this work, and a commitment to achieve the improvements required.

Timescales for introduction of Quality Accounts

3.7 The Health Act 2009 requires all providers of healthcare services in England given under the auspices of the NHS to provide a Quality Account from April 2010. This includes private and third sector organisations contracted to provide NHS services. This will therefore give complete coverage of

the requirement to produce Quality Accounts for NHS healthcare. The regulations provide more detail of the legal requirements including any exemptions to this requirement.

3.8 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 primary care or community health services. Small providers will also be exempted.[2] Consequently, this guidance relates largely to those organisations that will provide a Quality Account in the first year.

3.9 The duty to provide a Quality Account also extends to non-NHS organisations that provide NHS care (for example, private hospitals), and this will ensure that patient accountability extends across care pathways. As the timescale for introduction is based on services provided, these organisations will mirror those of NHS organisations. For instance, an independent sector organisation providing acute, mental health, ambulance or learning disability services will be expected to produce an account in the first year. Those providers solely delivering primary care services or community services will be brought in at a later date.

3.10 The requirement to publish a Quality Account only covers NHS healthcare services – that is those services that have been commissioned by an SHA or PCT. A third sector organisation does not need to include healthcare services that are funded through, for example, charitable contributions or a Section 64 grant.

3.11 The duty to publish a Quality Account falls on a body or person providing the NHS services. Therefore, multi-site organisations need only produce one Quality Account covering the quality of healthcare provided across your organisation. In order to make Quality Accounts more meaningful, it is suggested that large multi-site organisations provide site-specific data on the quality of healthcare services provided and ensure that your report covers the quality of healthcare across all of your sites.

3.12 The Department of Health is running a process of engagement, testing and consultation with primary care and community services providers in

2 Details regarding the nature of the exemptions to the requirement including can be found in regulations 2 and 3 of the National Health Service (Quality Accounts) Regulations 2010. www.opsi.gov.uk. Further information to support and explain these regulations can be found at Annex A to this toolkit.

2009/2010 and information in this toolkit will be updated to reflect their introduction when this occurs.

3.13 In order to develop Quality Accounts for NHS providers in primary care and community services, NHS North East and NHS East Midlands have agreed to pilot Quality Accounts with a sample of providers across general practice, dentistry, community pharmacy, out of hours and urgent care provision, and community services provision. The reports produced in June 2010 by these providers will follow a framework designed with the participating sites, and will lead to an evaluation of the results, which will feed into a further public consultation on the proposals in Autumn 2010. Any regulations and additional guidance required to introduce these providers into the legal duty will be developed at this point.

3.14 The timetable described above applies to the legal obligation to produce Quality Accounts. However, should you wish to produce accounts ahead of this as a testing or best practice exercise, you are welcome and encouraged to do so. It is certainly the case that the underlying processes of stakeholder engagement and quality measurement ought to be part of any NHS provider's work plan.

Background

3.15 *High Quality Care for All*, published in June 2008, set the vision for quality to be the guiding principle for the NHS. The document was the culmination of a year-long process involving around 2000 clinicians and 60,000 patients, interested parties and members of the public.

3.16 *High Quality Care for All* set out the vision for a National Quality Framework to enable local improvement in quality. This set out seven elements, which all work together to drive up quality of care. These seven elements are:

- Bring clarity to quality – define what quality of care means;
- Measure quality – understand where improvement is happening or is needed;
- Publish quality performance – tell others what you are doing and going to do as a result;
- Leadership for quality – recognise the role of clinicians as leaders and give them the freedom to drive improvements in quality of care;
- Recognise and reward quality;

- Safeguard quality – ensure that essential standards are met; and
- Stay ahead – make best use of innovation and push forward not back.

3.17 Quality Accounts sit within the 'publish quality performance' element but will also rely on and contribute to the effective use of each of the other elements. For instance, it would be difficult to publish the information if the data was not easily available or measured, therefore the Indicators for Quality Improvement (a menu bringing together assured nationally collected indicators of quality) are a resource to draw from in Quality Accounts. Similarly, in order to stay ahead, it is important to review where you are and plan for the future, therefore the information used and published in Quality Accounts will contribute to this knowledge. This, in turn, can help inform priorities for service and operational planning.

3.18 The Department of Health, along with partners in Monitor, the Care Quality Commission (CQC) and NHS East of England, engaged widely to examine the purpose, content and assurance of Quality Accounts. This fed into a consultation on the proposed framework for Quality Accounts which ran between 17 September and 10 December 2009. The findings from these processes and the results of the consultation have shaped this toolkit. Further background and publications produced during the development of Quality Accounts can be found at: www.dh.gov.uk/qualityaccounts.

4 What might a Quality Account look like?

Quality Accounts must cover the following:

Part 1

- **a statement on quality from the Chief Executive** (or equivalent) of the organisation and a statement from the senior employee outlining that to the best of that person's knowledge the information in the document is accurate (in regulations);

Part 2

- **priorities for improvement** (in regulations) – the forward looking section of the report is your opportunity to show clearly your plans for quality improvement within your organisation and why you have chosen those priorities for improvement. You should also demonstrate how the organisation is developing quality improvement capacity and capability to deliver these priorities;
- **statements relating to quality of NHS services provided** (in regulations) – content common to all providers which makes the accounts comparable between organisations and provides assurance that the board has reviewed and engaged in cross-cutting initiatives which link strongly to quality improvement;

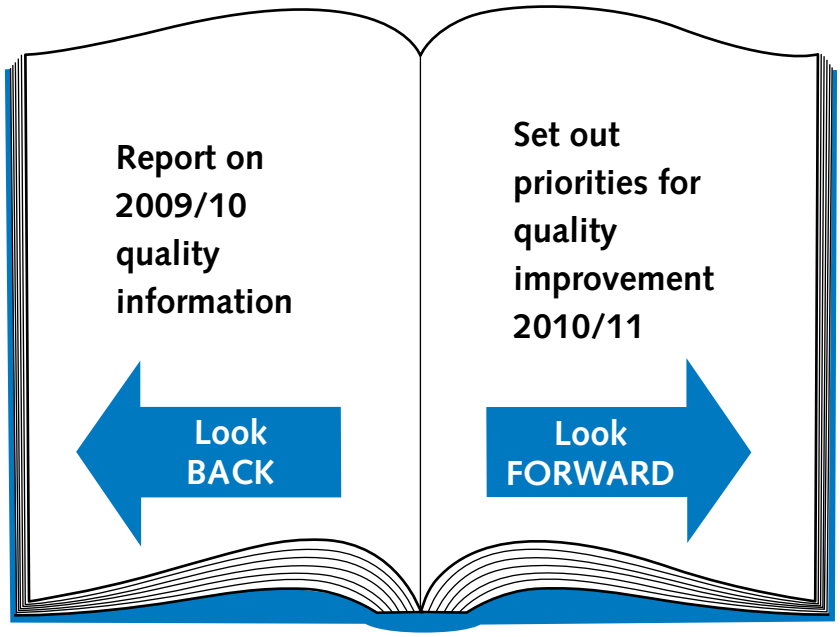
Part 3

- **review of quality performance** (for provider determination) – report on the previous year's quality performance offering the reader the opportunity to understand the quality of services in areas specific to your organisation;
- **an explanation of who you have involved** (for provider determination) and engaged with to determine the content and priorities contained in your Quality Account (in line with current equality legislation and the Health Act 2009); and
- **any statements provided from your commissioning PCT, LINks or OSCs** (in regulations) including an explanation of any changes you made to the final version of your Quality Account after receiving these statements.

4.1 The information contained in this chapter is advisory guidance intended to explain the purpose of the content and how you may make the most of the opportunities afforded by it. It is not, however, a substitute for the regulations, supporting explanatory note and the further guidance to the regulations (Annex A), which you should read and familiarise yourself with before you read this chapter.

4.2 The National Health Service (Quality Accounts) Regulations 2010 can be found on the Office of Public Sector Information website: www.opsi.gov.uk and the further guidance to the regulations is contained at Annex A to this toolkit.

4.3 Quality Accounts need to reflect the quality improvement priorities of your organisation and your local community and therefore it is for you to decide, along with your stakeholders and service users, what goes into the account and how it is presented. However, it is important to bear in mind the purpose of Quality Accounts when deciding what to include: the dual function of both telling where you are but also where you are going.



4.4 Further information is provided below to explain each of the sections outlined at the beginning of the chapter.

Part 1: Statement on quality from the Chief Executive (or equivalent) of the organisation (in regulations)

4.5 It is stated in the regulations that your Quality Account should include:

> Part 1, containing a statement summarising the provider's view of the quality of NHS services provided or sub-contracted by the provider during the reporting period
>
> *and*
>
> The relevant document must include a written statement, at the end of Part 1, signed by the responsible person for the provider that to the best of that person's knowledge the information in the document is accurate.

4.6 This statement will show that your organisation has a clear commitment to improving the quality of care.

4.7 The purpose of this statement is to ensure board approval that the Quality Account is accurate. This mirrors the sign-off given to a financial account, and represents your board's (or equivalent's) own confirmation that they stand by the content of your report.

4.8 This also serves as an introduction to your account and to your organisation. It offers the opportunity for your organisation to set out a summary of its values, achievements and goals, which can then be explored further in the body of the account.

4.9 Given that this is a summary of the quality of the organisation, it would be useful to include information about who has been involved in developing the Quality Account so that the reader knows from the outset how their views may be reflected within your Quality Account.

4.10 It is important that board commitment to quality improvement is not just reserved to this statement alone, but is echoed throughout the Quality Account. The whole of the Quality Account should tell your organisation's story, therefore this statement cannot be seen as a stand alone element. The vision you describe for your organisation in the foreword should be evident in the methods and outcomes you describe in the rest of the Quality Account.

Part 2: Priorities for improvement and statements of assurance from the board (in regulations)

Priorities for improvement

It is stated in the regulations that:

> The relevant document must include, in Part 2, a description of the areas for improvement in the quality of NHS services that the provider intends to provide or sub-contract for the 12 months following the end of the reporting period.
>
> The description must include:
>
> - at least three priorities for improvement;
> - how progress to achieve the priorities identified in paragraph (a) will be monitored and measured by the provider; and
> - how progress to achieve the priorities identified in paragraph (a) will be reported by the provider.

4.11 This is the 'forward looking' section of the Quality Account. It offers the reader the opportunity to understand what improvements (related to the quality of healthcare services provided) the organisation plans to take over the next year and why those priorities for improvement have been chosen.

4.12 As Quality Accounts are annual reports, you would expect to see continuity between accounts as time progresses. Organisations should be prepared to report back on progress against priorities in their next year's accounts. Some priorities may be achieved and a new area could become the focus for improvement, yet the reader first needs to be assured that the quality achieved in the previous year for a given area will not reduce if it is no longer a priority for the coming year. An explanation of how the quality will continue to be measured, maintained and developed should be included when 'retiring' priorities from your future Quality Accounts.

4.13 A review of the Quality Reports published in 2008/09 showed that a manageable number of priorities to set out within the document is between three and five.

4.14 The priorities chosen may align with, or complement, the Commissioning for Quality and Innovation (CQUIN) scheme agreed with commissioners.

4.15 You should indicate how the priorities were decided and who was involved in the decision making process.

4.16 You should consider linking the three domains of quality set out in *High Quality Care for All:* patient safety, clinical effectiveness and patient experience to your priorities, allocating at least one improvement priority to each. This will ensure consistency and give breadth to your quality improvement plans, and prevent your strategy being too focused on one area, to the detriment of the other areas.

4.17 Again, it is important to involve key interested parties in developing these priorities, and the chapter on 'who should be involved in the design of Quality Accounts' offers suggestions. For instance, you may wish to focus on effecting equality improvements for those equality target groups and communities who experience difficulties in accessing and using the NHS.

4.18 Any improvement priorities will need a plan as to how you are to achieve this improvement, the chapter 'Quality management systems, embedding quality in your organisation' suggests some of the factors that you should consider when developing your improvement priorities. It also suggests areas that you may wish to reference in your Quality Account in order to present to the reader 'how' you intend to deliver against these priorities as well as 'what' you intend to do.

Statements of assurance from the board

4.19 In this section we have noted the form of the statement as per the schedule to the regulations, explained the background to the statement and at times suggested how you may wish to expand further on this statement in your Quality Account. If you intend to expand on any of these statements it is imperative that you first meet the requirements by including the completed statements in the format specified in the schedule to the regulations, before adding any additional information.

The regulations state that the Quality Account should also include the following:

> (d) Part 2, containing the information relevant to the quality of NHS services provided or sub-contracted by the provider during the reporting period which is prescribed for the purposes of section 8(1) or (3) of the 2009 Act by paragraph (2)

4.20 The aim of the nationally requested content is to give information to the public, which will be common across all Quality Accounts. This section is deliberately intended to be smaller in comparison to the locally decided and relevant sections, and is expressed as a series of statements from your board, which relate strongly to the drive for quality improvement.

4.21 These statements serve to offer assurance to the public that your organisation as a whole is:

- performing to essential standards (such as meeting CQC Registration), as well as going above and beyond this to provide high quality care;
- measuring your clinical processes and performance (for instance, through participation in National Clinical Audits);
- involved in national cross-cutting projects and initiatives aimed at improving quality, for instance, through recruitment to clinical trials or through establishing quality improvement and innovation goals with the commissioner using the CQUIN payment framework.

4.22 The content of these statements is set out in the schedule to the regulations for Quality Accounts for which you can access an explanatory note at Annex A. They are also summarised in this chapter.

4.23 These statements derive from the type of cross-cutting themes seen in, for example, quality reports, and we would encourage you to expand on any issues highlighted in this nationally mandated section within the locally determined content of your Quality Account.

Review of services

4.24 Providers should complete the following statement:

"During [*reporting period*] the [*name of provider*] provided and/or sub-contracted [*number*] NHS services.

e.g. 2009/10

e.g. Royal Free Hospital NHS Trust

"The [*name of provider*] has reviewed all the data available to them on the quality of care in [*number*] of these NHS services.

The income generated by the NHS services reviewed in [*reporting period*] represents [*number*] per cent of the total income generated from the provision of NHS services by the [*name of provider*] for [*reporting period*]."

4.25 The purpose of this statement is to ensure that you have considered quality of care across all the services you deliver, rather than focusing on one or two areas for inclusion in Quality Accounts. You should develop a plan, signed off by the board (or equivalent) and agreed with stakeholders, for tackling the problems identified by reviewing data on the quality of services offered. This should be a rolling plan.

4.26 The data reviewed should aim to cover the three dimensions of quality: safety, effectiveness and patient experience and indicate where the amount of data available for review has impeded this objective. We expect that your board, in carrying out this review, will commission and consider expert analysis of its own data; involve clinicians and other stakeholders in their deliberations; and build in some element of challenge or peer review to their findings and conclusions. Where possible and appropriate, the data should be disaggregated by equality target groups.

4.27 You should consider building quality improvement processes into your organisational structure, such as the use of clinical dashboards, scorecards, real time feedback mechanisms (including conducting local patient surveys) or other analytical tools. Further information is given in Chapter 8, 'Quality management systems – embedding quality in your organisation and showing this in your Quality Account'.

King's College Hospital NHS Foundation Trust – board 'Go & See' initiative

In addition to the review of data around the board table, at King's College Hospital NHS Foundation Trust each board member sponsors three wards, which they are tasked to go out and see as part of the board 'Go & See' initiative. The focus of this is to offer the board the opportunity to talk to frontline staff, patients and relatives of the wards, giving them first hand knowledge of improvements being made and where further improvements are needed. The checklist focused on hygiene and environment initially. This is also replicated at senior nurse and divisional level, to ensure that the leadership of the organisation, both the board and the senior clinicians, are aware, assured and taking actions to improve hygiene levels and reduce infection rates.

Geraldine Walters, Director of Nursing

"The board 'Go & See' programme has been very helpful in enhancing board to ward communication and understanding. Ward staff have been very pleased to introduce members of the board to their areas and have found their interest and input both supportive and encouraging. This initiative is something we want to build on and expand in the future, widening the focus to incorporate safety and operational efficiency in addition to hygiene and cleanliness."

Rachael Wood, Matron in Gynaecology

"The 'Go & See' visits have been a powerful tool in making the Trust's quality agenda tangible to ward staff, prompting us to take ownership of our areas in a new way. This initiative has been of great value in assisting clinical staff in achieving the highest quality environment possible in a very visible way."

Participation in clinical audits

4.28 The schedule to the regulations requires providers to complete the following statements:

> "During [*reporting period*], [*number*] national clinical audits and [*number*] national confidential enquiries covered NHS services that [*name of provider*] provides."
>
> "During that period [*name of provider*] participated in [*number as a percentage*] national clinical audits and [*number as a percentage*] national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in."
>
> "The national clinical audits and national confidential enquiries that [*name of provider*] was eligible to participate in during [*reporting period*] are as follows: [*insert list*]."

National clinical audits are either funded by the Healthcare Quality Improvement Partnership (HQIP) through the National Clinical Audit and Patients Outcome Programme (NCAPOP), or funded through other means. Priorities for the NCAPOP are set by the Department of Health with advice from the National Clinical Audit Advisory Group (NCAAG).

> "The national clinical audits and national confidential enquiries that [*name of provider*] participated in during [*reporting period*] are as follows: [*insert list*]."

This list could be presented as a table below the statements.

> "The national clinical audits and national confidential enquiries that [*name of provider*] participated in, and for which data collection was completed during [*reporting period*], are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. [*Insert list and percentages*]."

"The reports of [*number*] national clinical audits were reviewed by the provider in [*reporting period*] and [*name of provider*] intends to take the following actions to improve the quality of healthcare provided [*description of actions*]."

These are reports published in 2009/10 which may relate to data collected in 2009/10 but may also relate to an earlier collection of data i.e. the audit and report of the audit fall in different financial years.

"The reports of [*number*] local clinical audits were reviewed by the provider in [*reporting period*] and [*name of provider*] intends to take the following actions to improve the quality of healthcare provided [*description of actions*]."

Local clinical audits are carried out by individual healthcare professionals evaluating aspects of care that they themselves have selected as being important to them and/or their team.

4.29 The purpose of including these statements is that presenting data on your level of participation in clinical audits enables you to communicate to your key stakeholders that you monitor quality in an ongoing, systematic manner to board level. A high level of participation provides a level of assurance that quality is taken seriously by your organisation and that participation is a requirement for clinical teams and individual clinicians as a means of monitoring and improving their practice.

4.30 The importance of clinical audits in stimulating quality improvement stems in your willingness to use the information obtained to take action to make improvements. The statement itself offers the reader of your Quality Account the assurance that you take part in these programmes and use these to inform actions for improvement, as the value gained is in your use of the data and relevant local and national learning to drive improvement. Therefore, patients, the public and your wider stakeholders would benefit from seeing the link between your audit programme and the quality improvement narrative within your Quality Account.

Measuring participation

4.31 The Department's website contains a list of national clinical audits (www.dh.gov.uk/qualityaccounts) drawn up by the National Clinical Audit Advisory Group. This is not a comprehensive list of national audits, but those which collected audit data during 2009/10. You should refer to this list when

reporting on the number of national clinical audits you participated in during 2009/10. Also provided is a list of national clinical audits which propose to collect audit data in 2010/11. This list will help you to prepare for the publication of a Quality Account in June 2011.

4.32 In addition there are three national confidential enquiries which should also be reported on for 2009/10:

- National Confidential Enquiry into Patient Outcome and Death (NCEPOD);
- Centre for Maternal and Child Enquiries (CMACE); and
- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH).

4.33 Some national clinical audits are mandatory and the Care Quality Commission (CQC) monitors participation in these and others. For the remainder, it is essentially for you to decide which pertain to you as a provider. If you participate in other national audits that do not appear on the list you may want to specify what these are.

4.34 For the statements on participation you are likely to want to involve your medical director and your clinical audit leads in agreeing a sub-set of national audits and national enquiries that cover the clinical services and interventions you provide. This will form your denominator.

4.35 From the list, you should select those national audits and national enquiries to which you participated by submitting data according to the specified requirements of the audit concerned. This will give you a numerator used to calculate the percentage of national audits and enquiries you participate in. Participation in this sense means that you are contributing data. Therefore, if three out of four consultants are providing data on a specific intervention you are participating in the audit. Coverage is dealt with in a later statement.

4.36 You will need to list those national audits and enquiries that you could have participated in, by virtue of the services and interventions you provide, but have chosen not to do so, showing those you participate in and those you have not joined. For each national audit or confidential enquiry that you are not currently participating in, you are encouraged to explain your reasons for not doing so; or if you intend joining in the future, you may wish to set a projected date for commencement of participation.

Measuring coverage

4.37 It is important that conclusions from national audits and national confidential enquiries are based on comprehensive data collection. The range of coverage can be measured in various ways, but for your Quality Account statement, this is broadly the number of patients for whom data are submitted as a proportion of the number for whom data should have been submitted.

4.38 In this section you need to report on those national audits and national enquiries where the data collection was completed during the reporting year. Any national audit or national enquiry that carried out data collection during the reporting period should be included, but an audit collecting data from, say, 1 September 2009 until 31 August 2010 would be covered in your 2010/11 Quality Account (published in June 2011).

4.39 The precise method of calculating coverage is determined by each national audit or national enquiry. Some use the Hospital Episode Statistics (HES) to establish a denominator, but others use different measures for example, the National Lung Cancer Audit compares the number of new cases submitted against the expected number derived from historical cancer registry incidence data.

4.40 You should use the best evidence you have available, including HES, to estimate the baseline number of cases and compare that with the number of cases you submitted to the national audit or national enquiry. Where a national audit uses sampling and you provided the requisite sample of cases, your response should be 100%. Occasionally a national audit or national enquiry will have published its data during the reporting year and coverage data can be extracted from that source. The list of national audits available on the Department of Health website provides links to their national reports. Links to the reports of national confidential enquiries are available through the National Patient Safety Agency website (www.npsa.nhs.uk).

4.41 Where national audits collect and present data for a network of providers, for example the UK carotid interventions audit, it is legitimate to use network data in your Quality Account.

Reviewing reports of national clinical audits

4.42 It is essential that providers, clinicians and managers reflect on the findings of national clinical audits and national confidential enquiries. Where necessary, they should take the lead on instigating changes to improve processes and/or change practice, and review the impact of these changes through participating in subsequent re-audit or other review.

4.43 In your statement, you should state the number of national clinical audit reports (published in 2009/10) that were reviewed by your board and, for each of those audits, the actions taken to improve the quality of services and the outcomes of care.

Reviewing reports of local clinical audits

4.44 Local clinical audit can also be important in measuring and benchmarking clinical practice against agreed markers of good professional practice, stimulating changes to improve practice and re-measuring to determine any service improvements.

4.45 In your statement, you should state the number of local clinical audit reports reviewed by your board and, for each of those audits, the actions taken to improve the quality of services and the outcomes of care.

Further reading

4.46 The Healthcare Quality Improvement Partnership has published a clinical audit guide for NHS boards, *Clinical Audit: A simple guide for NHS Boards and partners* (available at www.hqip.org.uk/).

Adrian Pennington, Director of Quality Improvement at NHS East of England says:

"Clinical audit programmes tend to be linked to the enthusiasm of junior doctors and the interests of consultant clinicians. To ensure clinical audit programmes are explicitly linked to the quality improvement framework the advice that has been given in NHS East of England is as follows:

- Quality improvement programmes will be determined by the evaluation of a broad set of quality indicators relating to clinical information that individual trusts provide to the outside world. Benchmarking this data will determine where to focus improvement programmes.
- The improvement programmes and individual projects within them will undertake process mapping exercises that will deliver new clinical protocols, as well as driving out duplication, waste and improving productivity.
- Clinical audit programmes should be linked to the newly established clinical protocols to ensure effectiveness of delivery and that clinical outcomes are as expected or to determine what possible changes their maybe.
- It may be possible to directly link the clinical audit programme to research that is being undertaken in the particular field. Juniors could screen for the latest papers to make potential changes and developments to the audited clinical protocol."

Research

Participation in clinical research

4.47 It is stated in the regulations that providers should complete the following statement:

> "The number of patients receiving NHS services provided or sub-contracted by [*name of provider*] in [*reporting period*] that were recruited during that period to participate in research approved by a research ethics committee was [*insert number*]."

This means agreed to participate in the research but did not necessarily complete the study.

e.g. our trust

This means a committee within the National Research Ethics Service (NRES).

e.g. 2009/10

4.48 Reporting bodies must keep a local record of research projects, in accordance with section 3.10 of the *Research Governance Framework for Health and Social Care* – this information is therefore readily available from providers.

4.49 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 NRES. Information about clinical research involving patients is kept routinely as part of a patient's records.

4.50 In order to best benefit your reader, you should report this indicator in a context that makes it meaningful. For example, where relevant, and where data is available, it may also be expressed as a percentage of patients in the eligible disease groups, and/or compared with the figures for previous reporting years.

4.51 You are encouraged also to report on other areas, which demonstrate commitment to research as a driver for improving the quality of care and to the patient experience in relation to research. Information on research studies that have received a favourable opinion from a research ethics committee is published by the NRES.

4.52 The model statement in the box below covers relevant measures of success or potential areas for improvement. The National Institute for Health

Research (NIHR) will publish details of data items and sources for this and other suggested statements at: www.nihr.ac.uk/Pages/QualityAccounts.aspx

4.53 For future years, the NIHR will publish comparative information on your performance, which you could consider using in the Quality Account statement on your contribution to health research.

Illustrative model statement:

Commitment to research as a driver for improving the quality of care and patient experience

[*Regulation*]
The number of patients receiving NHS services provided or sub-contracted by [*name of provider*] in [*reporting period*] that were recruited during that period to participate in research approved by a research ethics committee was [*insert number*].

[*Advisory*]
[*Insert sample explanation, e.g. …*] This increasing level of participation in clinical research demonstrates [*provider's*] commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

[*Name of provider*] was involved in conducting [*insert number*] clinical research studies. [*Name of provider*] completed [*insert percentage*] of these studies as designed within the agreed time and to the agreed recruitment target. [*Name of provider*] used national systems to manage the studies in proportion to risk. Of the [*insert number*] studies given permission to start, [*insert percentage*] were given permission by an authorised person less than 30 days from receipt of a valid complete application. [*Insert percentage*] of the studies were established and managed under national model agreements and [*insert percentage*] of the [*insert number*] eligible research involved used a Research Passport. In [*reporting period*] the National Institute for Health Research (NIHR) supported [*insert number*] of these studies through its research networks.

In the last three years, [*insert number*] publications have resulted from our involvement in NIHR research, helping to improve patient outcomes and experience across the NHS."

4.54 The inclusion of this statement demonstrates the link between your participation in research and your drive to continuously improve the quality of services. The Department of Health publication: *NHS 2010–2015: from good to great. Preventative, people centred, productive* (December 2009) states: "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 that are essential if we are to continue to increase both the quality and productivity of services into the future" (paragraph 1.34).

Goals agreed with commissioners

Use of the CQUIN payment framework

4.55 The regulations require one of the following statements to be completed (as applicable):

Either:

"(a) A proportion of [*name of provider*] income in [*reporting period*] was conditional on achieving quality improvement and innovation goals agreed between [*name of provider*] and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework."

e.g. a commissioning PCT

"Further details of the agreed goals for [*reporting period*] and for the following 12 month period are available on request from [*where further information can be obtained*]."

Provide a link to a page on your organisation's website or details of how to obtain this information, e.g. an address to write to.

Or:

"(b) [*name of provider*] income in [*reporting period*] was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because [*insert reason*]."

e.g. provider does not use any of the NHS National Standard Contracts, therefore not eligible to negotiate a CQUIN Scheme.

4.56 The CQUIN payment framework aims to support the cultural shift towards making quality the organising principle of NHS services, by embedding quality at the heart of commissioner–provider discussions. It is an important lever, supplementing Quality Accounts, to ensure that local quality improvement priorities are discussed and agreed at board level within – and between – organisations. It makes a provider's income dependent on locally agreed quality and innovation goals (0.5% on top of actual outturn value in 2009/10, 1.5% in 2010/11).

4.57 The inclusion of the CQUIN framework as a nationally mandated element in Quality Accounts will ensure that:

- The relationship between Quality Accounts and commissioning for quality and innovation schemes is clear to local organisations and the public, helping system alignment.
- You are required to be transparent about whether you are agreeing quality improvement and innovation goals with your commissioners, and earning part of your income by making improvements.
- You are required to make full details of the quality improvement goals agreed with your commissioners available on request to ensure transparency and help schemes improve over time.

4.58 If the CQUIN framework is not being applied to your income, then the Quality Account could expand on this statement to describe how quality improvement and innovation features within negotiation and management of the contract.

4.59 Use of the CQUIN framework indicates that you are actively engaged in quality improvements with your commissioners, some of which may impact beyond the boundaries of the organisation and improve patient pathways across the local health economy. Whether agreement has been reached with commissioners about quality improvement goals is therefore an indicator of your contribution to quality improvement in local health services more broadly. Both you and your commissioner need to be aware of the wider determinants of health inequalities and associated risk factors, and how they, through commissioning for quality improvements, can be addressed.

4.60 In order to expand on this statement you may choose to outline the agreed CQUIN goals, the rationale behind them (e.g. how they fit with local/ regional strategies) and associated payments.

What others say about the provider

Statements from the CQC

4.61 You should complete the following statements:

Either:

"[*name of provider*] is required to register with the Care Quality Commission and its current registration status is [*insert description*]. [*name of provider*] has the following conditions on registration [*insert conditions where applicable*]"

"The Care Quality Commission (has/has not) taken enforcement action against [*name of provider*] during [*reporting period*]"

as of 31 March 2010

Or:

"[*name of provider*] is not required to register with the Care Quality Commission"

4.62 You should state your CQC registration status, any conditions placed on your organisation, any other enforcement action by the CQC and any action required by you. This statement should refer to your status at the end of the reporting period (financial year) for the Quality Account, that is, on 31 March. You should state any conditions or action required since the start of the reporting year.

Either:

"[*name of provider*] is subject to periodic reviews by the Care Quality Commission and the last review was on [*date*]. The CQC's assessment of the [*name of provider*] following that review was [*insert assessment*]."

"[*name of provider*] intends to take the following action to address the points made in the CQC's assessment [*insert details of action*]."

"[*name of provider*] has made the following progress by 31st March [*insert year*] in taking such action [*insert description of progress*]"

i.e. 2010

Or:

"[*name of provider*] is not subject to periodic reviews by the CQC."

4.63 NHS provider periodic review is an assessment of performance against national priority indicators. You should report on the latest available periodic review, published by CQC.

Either:

"[*name of provider*] has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during [*reporting period*] [*insert details of special reviews and/or investigations*]."

"[*name of provider*] intends to take the following action to address the conclusions or requirements reported by the CQC [*insert details of action*].

"[*name of provider*] has made the following progress by 31st March [*insert year*] in taking such action [*insert description of progress*]"

Or:

> "[*name of provider*] has not participated in any special reviews or investigations by the CQC during the reporting period."

4.64 CQC's investigations and national programme of special reviews are developed in response to identified risks in the system. They might include provider-specific conclusions.

4.65 You should also consider including details of how you responded to the findings of these investigations and reviews, and any action you have taken in response. Where investigations are ongoing, you should indicate that information is still being gathered and recommendations have not yet been made.

4.66 You can refer to CQC for further information in relation to registration or other assessments.

Data quality

4.67 Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made ("We can only be sure to improve what we can actually measure", Lord Darzi, *High Quality Care for All*, June 2008). Improving data quality, which includes the quality of ethnicity and other equality data, will thus improve patient care and improve value for money.

4.68 You should complete the following statements within your Quality Account:

NHS Number and General Medical Practice Code Validity

Either:

> "[*name of provider*] submitted records during [*reporting period*] to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:"

In this section you are confirming that you submit returns to the Secondary Uses System (SUS) and then you go on to show the quality of their data as described below.

"– which included the patient's valid NHS number was:
[*percentage*] for admitted patient care;
[*percentage*] for out patient care; and
[*percentage*] for accident and emergency care."

"– which included the patient's valid General Medical Practice Code was:
[*percentage*] for admitted patient care;
[*percentage*] for out patient care; and
[*percentage*] for accident and emergency care."

Only include figures for the data sets which you submit, for example, if you do not provide accident and emergency care, you will not submit accident and emergency care data.

Or:

"[*name of provider*] did not submit records during [*reporting period*] to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data."

4.69 The patient NHS number is the key identifier for patient records. The National Patient Safety Agency (NPSA) is concerned about the number of patient misidentification incidents reported nationally. Between June 2006 and the end of August 2008, the NPSA received over 1,300 reports of incidents resulting from confusion and errors about patients' identifying numbers. Improving the quality of NHS number data has a direct impact on improving clinical safety. Guidance on the NHS number is available at: www.connectingforhealth.nhs.uk/systemsandservices/nhsnumber.

4.70 Accurate recording of the patient's General Medical Practice Code (Patient Registration) is essential to enable the transfer of clinical information about the patient from a trust to the patient's GP. Information on the validation of the *General Medical Practice Code* is available at www.datadictionary.nhs.uk/data_dictionary/data_field_notes/g/general_medical_practice_code_(patient_registration)_de.asp.

4.71 The source for the NHS Number and General Medical Practice Code (Patient Registration) validity percentages is the most recent provider view of the SUS Data Quality Dashboard. The dashboard presents the cumulative percentages of valid NHS numbers and GP Practice Codes in admitted patient care (APC), outpatient care (OP) and accident and emergency care (A&E) records for

each acute trust. You can register to receive SUS Data Quality Dashboards at www.ic.nhs.uk/services/secondary-uses-service-sus/using-this-service/data-quality-dashboards.

Information Governance Toolkit attainment levels

The following statement is also required under the data quality section:

"[*name of provider*] score for [*reporting period*] for Information Quality and Records Management, assessed using the Information Governance Toolkit was [*percentage*]"

The Information Governance Toolkit is available on the Connecting for Health website (www.igt.connectingforhealth.nhs.uk).

4.72 The Information Quality and Records Management attainment levels assessed within the Information Governance Toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation.

4.73 The Information Quality and Records Management percentage score is calculated from the sum of the attainment level scores (0, 1, 2, or 3) for relevant Information Governance Toolkit requirements divided by the sum of the maximum possible attainment level scores (3 throughout). The following table identifies the questions that are relevant to different types of provider:

Provider type	*Requirements*	*Maximum attainment score*
Acute trust	401 to 408, 501 to 511, 601, 602	63
Ambulance trust	401, 403, 405, 408, 601, 602	18
Mental health trust	401 to 408, 501 to 511, 601, 602	63

Clinical coding error rate

The following statement must also be included in the data quality section:

Either:

"[*name of provider*] was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were [*percentages*]."

These should be stated in the same format published by the Audit Commission which is:

- Primary Diagnoses Incorrect [n%]
- Secondary Diagnoses Incorrect [n%]
- Primary Procedures Incorrect [n%]
- Secondary Procedures Incorrect [n%].

Or:

"[*name of provider*] was not subject to the Payment by Results clinical coding audit during [*reporting period*] by the Audit Commission."

4.74 Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard, recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of the patient records. Information about the Payment by Results Data Assurance Framework clinical coding audit is available from the *Audit Commission*.

Additional resources for measuring and improving data quality

4.75 The NHS Information Centre's *Data Quality Programme* provides a range of resources to measure and improve the quality of data. The programme's Data Quality Guild is an e-community with over 1000 members from health and social care organisations who share data quality problems and solutions. You can join the *Data Quality Guild* here.

4.76 The programme's *Data Quality Index* provides a searchable catalogue of health and social care data quality resources.

Part 3: Review of quality performance (provider determination)

4.77 This section is where you will find information relating to the quality of services that your organisation provides. It should therefore should reflect the type of organisation you are (for instance, acute or specialist services, mental health, ambulance etc.), and show data relevant to specific services and specialities as well as what patients and the public say matters most to them.

4.78 If any other organisations (for instance your strategic health authority (SHA), PCT or regulator) have asked for additional information to be included in your Quality Accounts and you choose to do so, this is the section where it should be included.

4.79 Because this section should, in part, refer to specific specialities and services, it is important that clinical teams play a part in choosing the content and developing the story. The chapter on 'who should be involved in the design of Quality Accounts' describes some examples of how this can be achieved.

4.80 Equally, you should aim to present information in both quantitative and qualitative formats so that it is meaningful for the wider public. Chapter 6 on 'Making sense of information – reviewing and presenting data' provides some ideas, based on what members of the public have told us.

4.81 The Indicators for Quality Improvement are one resource from which you could choose your indicators to include in this section. This is a national resource held by the NHS Information Centre, which draws together existing national and assured indicators of quality. Further information can be found in the 'Making use of information' section and the link to the NHS Information Centre webpage is: https://mqi.ic.nhs.uk/

4.82 You may also decide to use real time feedback mechanisms, including conducting local patient surveys, to monitor the quality of services from the patients' point of view on a more frequent/ongoing basis.

4.83 Standard contract quality areas or national clinical audits may also be used as sources of information for inclusion in your Quality Account to represent indicators of quality in chosen services.

4.84 You may want to consider the following areas within your review of quality performance:

First:

- Choose a selection of indicators that covers both organisational (for instance healthcare acquired infection rates) and service specific indicators of quality.
- Decide if you will use real time feedback mechanisms to get more frequent feedback on specific aspects of patient experience. For further information, see Chapter 7 on 'Quality management systems'.
- For each service line you describe, choose indicators that cover the three domains of quality highlighted in *High Quality Care for All:* patient safety, clinical effectiveness and patient experience.

Then:

- Explain why and how you have chosen certain indicators, particular services and specialities.
- Explain why and how you have chosen to conduct a local patient survey (if applicable).
- If the area shows a need for improvement, yet it is not included in your wider local improvement plan (for instance, because it is particular to a specific service) offer a brief explanation of the plan to improve on it.
- While Quality Accounts should demonstrate outcomes it is also important that you offer information on how you are improving services and show evidence for this.

4.85 Our focus groups with members of the public and patient organisations showed us that the choice of content in a Quality Account plays a key role in the public trusting the information. While Quality Accounts are an opportunity for you to show what you are doing well, those Quality Reports that the public saw as 'marketing documents' were distrusted. Use of patient feedback, anecdotes and stories can strengthen your Quality Account, as well as show how patients and the public have influenced your quality improvement agenda. Further information about assurance of the information in your Quality Account can be found in Chapter 9: 'Trust and Assurance – who is responsible for assuring the Quality Account?'

4.86 You should use Quality Accounts as an opportunity to show what you are doing well, but also to be open about areas you need to improve on. The key is to ensure that you commit to improving them, and state how. Further information on giving a rounded account is included in Chapter 6 of this toolkit called: 'Making sense of information – reviewing and presenting data' and expanded upon in Chapter 7, 'Quality management systems – embedding quality in your organisation and showing this in your Quality Account'.

Statements from Local Involvement Networks, Overview and Scrutiny Committees and primary care trusts

4.87 The regulations require you to send copies of your Quality Account to your relevant Local Involvement Network (LINk), Overview and Scrutiny Committee (OSC) and lead commissioning primary care trust (PCT) for comment prior to publication, and you should include these comments in the published Quality Account. This forms part of the assurance process for Quality Accounts and further information can be found in the section: 'Trust and assurance – who is responsible for assuring the Quality Account?'

4.88 It is crucial, however, that discussions with your LINk and OSC organisation(s) and commissioners should be ongoing during the cycle of development of a Quality Account. Further information on early engagement is given in Chapter 5: 'Who should decide what goes into a Quality Account?'

How to provide feedback on the account

4.89 Providers should give information to readers on how they can provide feedback on the report and make suggestions for content for future reports. Focus groups held with members of the public showed that many people did not see themselves getting very involved in the production of Quality Accounts. However, they did want the option to feed into the process, predominantly through feedback. There was, however, strong support for evidence in the report that patients and the public had been involved in the production of the Quality Accounts, and most thought that voluntary patient organisations would be best placed to do so. Further information on involving patient organisations is offered in Chapter 5: 'Who should decide what goes into a Quality Account?'

5 Who should decide what goes into a Quality Account? – Identifying your local improvement priorities

- Quality Accounts are your organisation's report and should be developed with and for those with an interest in and influence on your organisation's approach to the quality of its services.
- Decide early on who you are going to talk to and how.
- Ensure the discussion forms part of an ongoing dialogue about the quality of your services not just as a one-off discussion about your annual Quality Account.
- Ensure those you talk to know what they are contributing to and how it will be acted upon.
- Your Quality Account should reflect and acknowledge the involvement you have had and the contributions made to the process by others.

5.1 Quality Accounts are reports to the public on the quality of services a healthcare provider delivers. It is therefore important that they reflect your organisation as a whole, and tell a rounded story, including a description of the improvement plans in place.

5.2 In order to provide an accurate picture, all members of your organisation and local stakeholders with an interest in your organisation should have a part to play in developing the content and improvement priorities.

5.3 You should reflect the three domains of quality set out in *High Quality Care for All:* patient safety, clinical effectiveness and patient experience. Clinical teams should be able to see information about their service or specialty presented accurately and any improvement plans should be led within these teams. The wider workforce (staff and volunteers) should also recognise the Quality Account as describing the organisation that they work within. Commissioners should be able to see the organisation presented as they understand it, and the public should be able to access information which is meaningful for them and reflects, in part, the aspects of patient experience that matter most to them.

5.4 It is important that the content of Quality Accounts is developed by talking to groups of interested parties, and for their views to be reflected in the end product. In order to ensure that your local population as a whole is given the opportunity to shape the servicesthey receive, you should ensure that your discussions actively include those from equality target groups and that their views are reflected in the Quality Account.

5.5 Quality Accounts are not to be seen as a project in themselves, but rather offer the reader an annual summary of a wider approach to quality improvement. Similarly, the discussion and engagement around Quality Accounts should also be part of a wider discussion with the groups involved around the direction of the organisation and plans to improve quality.

5.6 PricewaterhouseCoopers (PwC) was commissioned to run an evaluation of the Quality Reporting exercise in 2009. Part of this process involved a survey of those responsible for producing their organisation's Quality Report, with a series of questions about the process and outcomes.

5.7 During this survey, PwC found that 41% of respondents felt they had done 'very well' or 'quite well' in engaging stakeholders, with 36% feeling that it did not go so well. This was mostly attributed to the limited timescales in producing Quality Reports. When asked what things would be done differently next year, the most common answers from respondents were that they would look to 'start earlier' and ensure 'better stakeholder engagement'. Respondents felt that this would ensure the content was relevant to their stakeholders.

5.8 Effective stakeholder mapping and involvement is key. However, our focus groups with LINks organisations indicated a concern that this engagement would not be acted upon. Some felt that when they had been consulted before, their views had been 'ignored'. They wanted assurance that their input would be acted upon.

5.9 Engagement should therefore be an ongoing process, not just a one-off event. You should consider this when planning your engagement strategy and ensure stakeholders know from the outset what their input will influence and how they can expect to see it have an effect.

5.10 You are encouraged to refer to the Department of Health's publication *A Dialogue of Equals* (2008), which sets out a process for how NHS organisations can engage effectively with seldom-heard-of marginalised groups. It contains worked-through examples of good practice.

Walsall Integrated Learning Disability Team – Pacesetters programme

Walsall Integrated Learning Disability Team, in partnership with the Department of Health's Pacesetters programme, has increased the uptake to NHS cancer screening programmes. For example, women with learning disabilities have undertaken breast screening through a collaborative project between learning disability nurses and radiographers from the breast screening unit at Walsall Manor Hospital NHS Trust. The successful strategies used in this project have been extended to increase the uptake to cervical screening by women with learning disabilities and bowel cancer screening for the over-60 learning disabled population. Walsall has instigated robust educational groups such as 'Looking After Our Bits'. These groups are running efficiently and well, with over 150 women having attended these groups since 2007. The women are given information so that they have a clear understanding of what to expect at their screening visit, with the hope that it becomes a positive experience. It is also important for women to understand the consequences of screening or not screening. Through a combination of user engagement and raising staff awareness of the needs of this client group, Walsall has improved screening rates from 62 to 100% to date for those women who were able to be screened for breast cancer.

5.11 A strong element that came out of the engagement work with the public and patient organisations, and through the evaluation exercise, was that acknowledgement should be given within the Quality Account to those who helped influence the content and publication. An earlier section of this toolkit suggested making a statement on this within your chief executive's statement. This can then be expanded upon throughout the document, perhaps with patient anecdotes or quotes from stakeholders.

5.12 LINks members also suggested that they could have a role in checking the language of the Quality Accounts to ensure that they are meaningful to the public. This is also a role which members and governors of foundation trusts, non-executive directors of boards and members of other patient and public groups and forums which you engage with during the process may wish to offer.

5.13 Of course, patients and the public are key stakeholders in producing Quality Accounts, but many felt that the organisation's staff should also have a large voice within the Quality Account. If a Quality Account is to truly reflect your organisation and how you work, it needs to reflect the views of those who make it work including staff, and volunteers that work within the organisation or with it (in the case of NHS providers), through partnerships with independent third sector organisations.

5.14 Individual staff and teams should be given the freedom to check the accuracy of the information presented where it relates to their clinical services, and should play a key role in deciding where improvements can be made and how this can be done.

5.15 Volunteers should also have the opportunity to inform the content of the Quality Account. Where volunteers are valued and supported effectively, people's experience of those services, along with staff's experience and well-being, can be significantly enhanced. Volunteers can add value to the development of the Quality Account, and its presentation, from their experience of working within it as well as through their insight from the community's perspective.

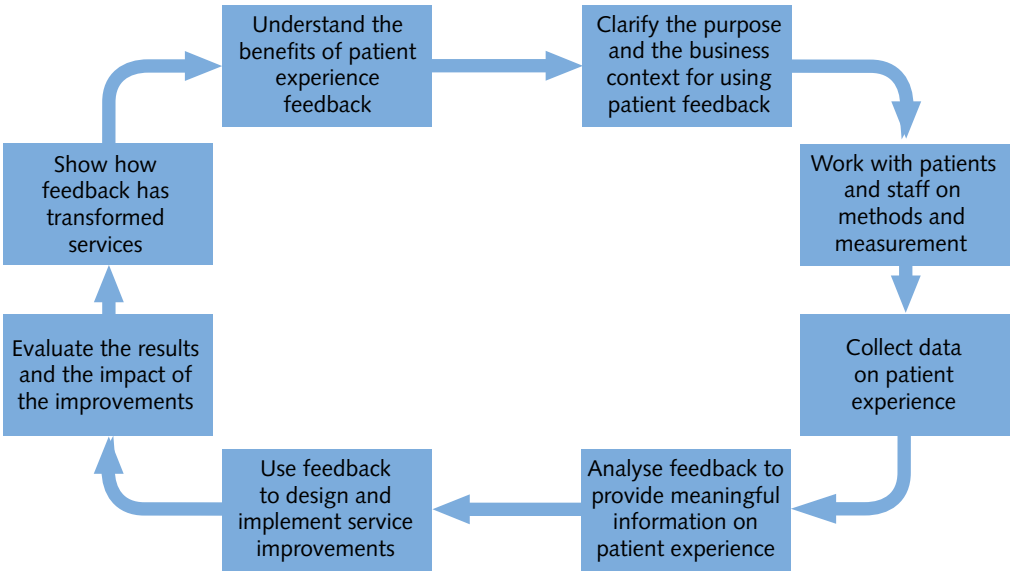
Patient and public engagement and feedback

5.16 There are a range of benefits in collecting and using patient and public feedback. It:

- helps to improve communication between patients and staff;
- helps to build trust and confidence in the NHS locally and nationally;
- informs planning and service improvement;
- helps the organisation to provide accessible and responsive services, based on people's identified needs and wants, and;
- helps patients to shape the services that they use.

5.17 The two main sources of patient experience feedback used in the NHS have traditionally been compliments and complaints, and the National Patient Survey Programme. There is a growing interest from PCTs and NHS providers working in hospital and community settings in collecting information from patients and service users in as near to real time as possible. This is so that results can be assessed quickly. This approach offers a clear opportunity for the NHS to make improvements.

Figure 1: The experience feedback cycle



5.18 In September 2008, the Secretary of State for Health asked the NHS to broaden the use of real-time techniques to collect patient feedback. All hospitals will be expected to start using, or extend the use of, near real-time techniques to collect patient experience feedback, and demonstrate that they are using this feedback to improve services. Providers of NHS services will need to demonstrate that they are delivering this commitment. For more information visit: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_099779.pdf

5.19 Another option available to you is to conduct local patient surveys. A localised support package for the NHS has been developed to monitor the quality of services from the patient's point of view on a more frequent/ongoing basis rather than just relying on the annual snapshot afforded by the CQC nationally coordinated programme.

5.20 An advice centre (contactable by telephone or email) and a 'local survey' page on the NHS patient survey coordination website will contain all survey instruments and guidance on how to conduct a local survey for comparisons with results from nationally coordinated surveys: www.nhssurveys.org

5.21 Local Involvement Networks and Overview and Scrutiny Committees should be involved in your process, and they are offered a formal role under the assurance of Quality Accounts (see Chapter 9). However, you should also consider your existing channels of patient and public engagement and

ensure you involve them: for instance, foundation trusts should involve their members and governors, and all organisations which have patient reference groups or similar should use the opportunity that Quality Accounts present to start, continue or improve their discussions with these groups about quality improvement.

Patient involvement

Royal Surrey County Hospital – haematuria patient pathway redesign project.

At the Royal Surrey County Hospital, the volume of referrals to the haematuria pathway was increasing and the length of time it was taking patients to complete the pathway from GP referral to a decision on treatment was growing. Analysis of the data from January to August 2008 showed that, on average, patients were waiting approximately 60 days.

Following some initial work a multi-disciplinary project team was pulled together as part of the RSCH's major transformation programme, Patients 1st.

The Patients 1st programme was launched in May 2008 to look at three key areas of the patient experience: Compassionate and Respectful Care, Safety and Quality, and Access and Convenience, which is where the Haematuria project sat.

To understand the issues faced by patients, an extensive series of interviews was held with patients using the service. Each patient rated different elements of the service (for example, level of clinical care, compassionate treatment, quality of environment) in terms of their importance and current effectiveness. Patients were happy with the level of clinical care received but they were visiting the hospital up to five times during that period, causing significant inconvenience and expense in car park charges. This was leading to patient dissatisfaction and these findings gave a clear remit for the project to simplify the pathway and enhance the patient experience.

The Haematuria project focused on issues that really matter to patients – safety, quality, easy access and convenience. Patients were heavily involved in defining the project aims and one joined the project team.

The re-designed pathway has reduced the patient's pathway from 63 to 16 days. Patients no longer have five visits to hospital, instead undergoing all diagnostic tests and receiving their results at a one-stop clinic. Patients with malignancy are diagnosed earlier, with only two diagnostic tests, and are placed on the appropriate pathway as soon as possible. The redesigned pathway has improved the quality of care for patients and the diagnostic pathway has been enhanced with no additional cost to the PCT. Overall, the biggest difference has been to improve the patient experience. One patient representative commented: "the focus on both the patient and the process were complementary".

An additional highlight of the project from the trust's perspective was that new ways of approaching projects and of problem solving were introduced to the project team. These are skills which the team members can use to solve other problems which they may encounter in the future.

5.22 Patient involvement, which can go further than just feedback, engages patients much more closely in service change and improvement so that they are contributing more innovatively and productively. There is evidence that where patients are involved in a more interactive way – in an ongoing dialogue with staff to develop solutions or improvements – there can be considerable benefits in terms of impact on quality; better, more efficient use of resources; and a much better experience for patients.

5.23 In general, it is important to establish a mechanism for prioritising suggested areas for improvement, so that your priorities are realistic and manageable. Chapter 7 describes some areas for consideration when developing priorities, but it is important to establish a mechanism not only for discussion but also for feedback with those groups you have talked to about why certain areas were chosen over others.

6 Making sense of information – reviewing and presenting data

Reports should be written in a way that makes them accessible for all:

- Data presentation should be simple and in a consistent format.
- Information should provide a balance between positive information and acknowledgement of areas that need improvement.
- Consider using qualitative anecdotes from patients, staff or other stakeholders to add contrast to the data.
- Consider giving data, information or anecdotes that relate to the concerns of local groups or communities including equality target groups.

6.1 Quality Accounts are public documents; they will be read by patients, their carers and the general public, and will be published on the NHS Choices website. Yet their audience also includes clinicians, NHS staff, commissioners, academics and other experts in healthcare. It is important that the information given is detailed enough to give an accurate and evidence-based account of your story, while remaining a short, readable document whose information is meaningful to the public.

6.2 In this chapter you will find information on how to write documents and examples of good practice based on the independently run evaluation of the test Quality Reports in 2009; discussions with patients and the public; and existing literature on this subject. This chapter also gives advice on how to collect or identify good quality clinical data and correctly interpret it, and how to clearly present the results to tell the story of your organisation's efforts to improve quality in the year to date and your priorities for the year ahead.

Quality Observatories were set out in *High Quality Care for All* as a key piece of regional infrastructure for driving up quality through the use of information and data. Each of the ten regions in England has its own Quality Observatory, which is a valuable resource for use by clinical teams, providers and PCTS. Their role includes:

- providing a local service to commissioners and clinical teams, including the provision of analytical advice to enable quality improvement on the ground;
- promoting and supporting the development of regional quality indicators as tools for quality improvement – spanning safety, effectiveness and patient experience;
- supporting the identification and development of quality indicators at provider level to feed Quality Accounts; and
- signposting to information which will help to drive quality improvement within the region.

Quality Observatories will therefore be a valuable analytical resource for you to draw upon while developing your Quality Accounts.

Visit www.qualityobservatory.nhs.uk to contact your particular regional Quality Observatory and find out what support they can offer you.

Writing in a way that is accessible for all

6.3 Quality Accounts will be read by a variety of people, from members of the public to medical directors, prospective employees to commissioners. These audiences require different kinds of information and it can be challenging to meet all their requirements. Effective engagement is, of course, a key way of ensuring relevance, but giving thought to the way your information is presented can also ensure that these documents are accessible for all readers.

6.4 The information given in the rest of this chapter starts with the basics of selecting information and interpreting it, then looks at how to present it. A key message from our discussions with the public and NHS staff was that there should not be a need to produce more than one version of the document for different audiences; this would not be cost-effective and may undermine trust in the Quality Accounts if they were seen as edited. However, some innovative ideas were suggested which you should consider.

6.5 Members of the public said that technical jargon and medical terms may be needed at times, but felt that simply and consistently providing a short explanation after a term is used would help readers to understand the story being told. It does no harm for an 'expert' to read over a quick explanation of the term, but it can alienate the non 'expert' if an explanation is not given. One possibility would be to ask your non-executive directors, patients, or volunteers and non-medical staff to help you to spot areas where an explanation is needed.

6.6 The members of the public that we spoke to also said that they distrusted reports that didn't offer any analysis or explanation of statistics. Without this information it is difficult for someone to understand whether the results presented show good quality or a need for improvement, and what the implications are for them as a potential user of your services. You may want to include some discussion of:

- how the indicator that you are presenting is defined;
- how and by whom it is collected;
- why you are interested in this indicator, and why the reader should be interested;
- what the results mean for your organisation; and
- what the results mean for them as a patient.

6.7 An idea that gained a lot of support from most stakeholders we talked to was having a 'summary' at the front of the report which highlights the key points plainly and clearly, with a more data-rich and detailed report for those who want to read on. If you choose to do this, it is important to remember that the remainder of the report should still be written to be read by all, using some of the techniques explained in this chapter.

6.8 You may also consider including a glossary at the end of the document, or you could simply include a 'plain English' explanation of each specialist term in brackets throughout the document.

6.9 You should also be prepared to provide your Quality Accounts upon request in different community languages and in different formats where there is an express need to do so.

Selecting good indicators

What makes a good indicator of quality?

6.10 Some indicators, such as those in Indicators for Quality Improvement (IQI), are quality assured at a national level and you can be confident that they are good indicators of the quality of care your organisation provides. However, you may decide that your organisation would benefit from measuring something that is not well covered by a nationally assured indicator. In this case it is important to choose a locally determined measure that is a good indicator of quality and reflects the issues that the public and patients have indicated matter most to them.

The good indicators guide

The Association of Public Health Observatories (APHO) has produced a short, practical resource for anyone in any health system who is responsible for using indicators to monitor and improve performance, systems or outcomes. The guide gives information that will help you to choose the right indicators and includes the questions that you should ask when selecting which indicators to use in your Quality Account:

- Do the indicators address the **important** issues?
- Are they scientifically **valid**? (Do they actually measure what they are claiming to measure?)
- Is it actually **possible** to populate the indicator with meaningful data?
- What is the **meaning**? What is the indicator telling you and how much precision is there in that?
- What are the **implications**? What are you going to do about it?

The Good Indicators Guide is available at: www.apho.org.uk.

What is good data?

6.11 A quality indicator can only produce useful results if the data that it is based on is sufficiently relevant, complete and reliable. It is therefore important if you collect any data locally that you are able both to ensure that it is good data and to recognise when it is not.

6.12 The more **complete** the data you collect, the more accurately your indicator will represent the quality of care in your organisation. If the data is relevant to the people collecting it, or they have volunteered it themselves, they will be more enthusiastic and engaged with its collection and your data is likely to be more complete. You should monitor your systems and look out for missing data. If you find that large amounts of data are missing you should revisit your procedures and talk to those collecting the data to identify why.

6.13 It will not always be possible to collect data on every relevant incident or procedure. In such cases you need to decide whether the data that you have collected correctly represents the whole picture, or whether there is a systematic difference between the incidents for which you were able to get data and those for which you weren't. If you are looking at a sample of incidents, is the measurement process itself introducing any bias? You may not be able to completely remove biases such as these, but you should bear them in mind when interpreting your data.

6.14 There will always be an element of human error in collecting data. You should take steps to make your data more **reliable** by making sure that those responsible for data collection fully understand what they are expected to collect and why.

6.15 If you want data that is **comparable** between different clinical teams or time periods, it is important that you are aware of – and where possible avoid – systematic differences. You can do this by ensuring that the procedures for collecting data are consistent across the board and remain the same over time.

Developing a local indicator

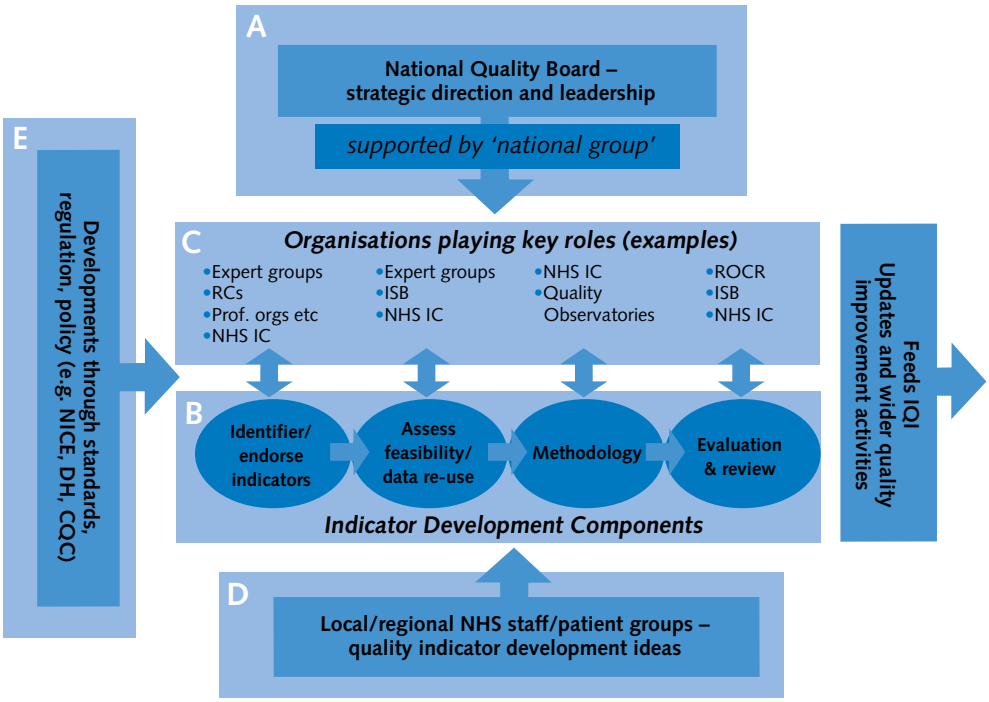
6.16 A governance model for quality indicator development has been designed to formally establish a more strategic approach to the development of quality indicators going forward, including the further expansion of the IQI menu. It has been developed through extensive stakeholder engagement and aims to clarify roles and responsibilities to support both 'top-down' strategic leadership and 'bottom-up' indicator development and innovation.

6.17 Figure 2 below illustrates how the various parts of indicator development fit together in the model to improve the coverage and utility of quality indicators across NHS services. It will be embedded from January 2010.

6.18 In summary, the cornerstones of the governance model include:

- **Assuring national quality indicators** – developing an 'IQI-ready' indicator will require assurance from various organisations, including relevant professional bodies.
- **Getting indicators into IQI** – the NHS Information Centre will be responsible for the addition of indicators that are deemed ready into the IQI menu.
- **Managing long-term IQI development** – the National Quality Board will provide the strategic direction for quality indicator development work, with a National Quality Indicator Development Group established to 'gatekeep' IQI development and drive forward indicator work.
- **Supporting local quality indicator development** – the Governance Model will also support 'bottom-up' local indicator development.

Figure 2: The governance model for quality indicator development



6.19 You can read more about the IQI on the NHS IC website: www.ic.nhs.uk/services/mqi. To make a suggestion for a new indicator to be considered for inclusion in IQI, email the NHS IC via the 'make a suggestion' link on their site.

How to interpret data

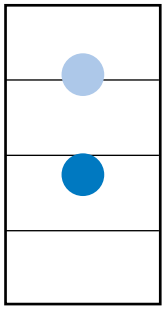
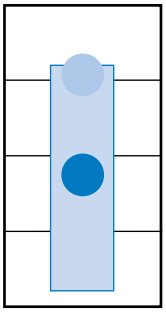
Think about the questions that you are trying to answer

6.20 Before starting, it is important to be clear what questions you are trying to answer. You may want to know whether a particular aspect of the quality of care in your trust has improved since last year, or you may want to know whether your performance is better than, worse than or about the same as the national average. Think about the questions that your audience is likely to ask when they read your Quality Accounts and try to ensure that you provide the answers.

6.21 Each question will provide two or more alternative hypotheses, and it is your job to see which is supported by the data. The second example given above presents three hypotheses: the quality of care in your trust is better than the national average; it is worse than the national average; or it is about the same as the national average. You need to decide which of these is consistent with the data and rule out those that are not.

Consider the effects of chance and bias

6.22 If, for example, the data shows that your organisation is getting a lower score on a particular indicator than the national average it does not necessarily mean that the quality of care is lower than the national average. There is an element of chance involved in the outcomes that you are measuring, so you cannot automatically rule out the hypothesis that the quality of care in your trust is as good as, or even better than, the national average.

Worse, or about the same?	
Chart 1 	Chart 1 shows the value of an indicator for your organisation (dark blue) compared with the national average (light blue). Your score is lower, so you might conclude that your performance is worse than a typical organisation. In this case that would be wrong. This value is the best estimate of your performance, but there is some uncertainty around it. Chart 2 shows the confidence interval associated with the value. As the national average is within this range, you should conclude that your performance is *not significantly different* from the national average.
Chart 2 	

6.23 To account for this uncertainty, statisticians use **confidence intervals**. A confidence interval is the range of values within which, given the data, you can have a stated level of confidence the underlying quality of care lies. Statisticians commonly use a 95% confidence interval, meaning that there is only a one in 20 chance that the quality of care is outside the range. This may sound like a strict requirement, but one in 20 is about the same as the likelihood of rolling 11 with two dice – it could happen. Information on how to calculate and use confidence intervals is available from a wide range of sources, including APHO's *Technical Briefing 3* (see www.apho.org.uk).

6.24 The smaller the **sample size** (the number of events the results are based on), the greater the effect of chance and so the wider the confidence interval. If you were to toss a coin five times you might get five heads, so you might (incorrectly) conclude that the coin lands on heads every time. However, if you were to toss a coin 100 times it is very unlikely that you would make the same mistake. Similarly, an indicator based on a procedure that you only perform five times in a year will be less accurate than one based on a procedure that you perform 100 times. As a rule of thumb you should try to use a sample size of at least 30.

6.25 As well as chance, you should also consider whether there is any **bias** in your data. One reason for bias is case-mix: the age of the population, social deprivation, incidence of smoking and many other factors could affect the outcomes that you are likely to achieve. Before coming to conclusions about the quality of care that you provide you should try to think of all such factors. In some cases you may be able to adjust for these factors.

Take an objective view of the data

6.26 In order to interpret your data correctly you should approach it without any preconceived ideas about what conclusions you might reach. There are numerous examples seen in everyday life of how parties with vested interests can reach convenient conclusions from data. Approach your data with an open mind and be willing to come to unpopular conclusions if that is what the data is telling you. Our engagement events with the public and service users have shown us that many people feel that presenting areas where development and improvement are needed gives the Quality Account honesty and integrity. Therefore, you should consider reporting on such conclusions within the Quality Account and use it as an opportunity to state what you are going to do to make improvements.

How to present data

Telling a story about your data

6.27 Whenever you are writing about data it is important that you tailor your style and approach to your audience. The audience for Quality Accounts is primarily the public, but also includes clinicians, NHS staff, commissioners, academics and other experts in healthcare.

6.28 When writing your Quality Accounts, focus on the key messages that matter and are of interest to your audience. It is important to do more than just recite the data in words. You need to explain to the reader what key messages the data contains about the quality of care provided by your organisation and what this means for them.

6.29 Our engagement with patients and the public has shown us that it is critical that Quality Accounts use language that your audience will understand. If you need to use technical language, explain its meaning. Avoid overly long sentences, try to be as concise as possible and stick to simple words and everyday English. However, break any of these rules if by doing so you can make your writing clearer and easier to understand.

Using tables and graphs

6.30 Tables and graphs provide a visual representation of your data that can be more effective than text in getting your message across. They can also break up text and make your Quality Account much more visually appealing and engaging for the reader. This section contains tips on how to use tables and graphs effectively.

Creating clear and concise tables

Presenting numerical data in a table can help you to use fewer numbers in the text of your Quality Accounts and allow you to concentrate on the key messages in your story.

The title should contain all the information needed to understand the table. Avoid acronyms and abbreviations where possible.

Table 1 – Percentage of patients readmitted to hospital within 28 days of discharge following stroke treatment

	2008-09	2009-10
Organisation A	9.9	9.5
Organisation B	11.2	11.0
Organisation C	10.3	10.4
All of England	**10.6**	**10.3**

Present data in a logical order to make it easier to digest.

Right justify numbers so that their relative sizes are visually obvious.

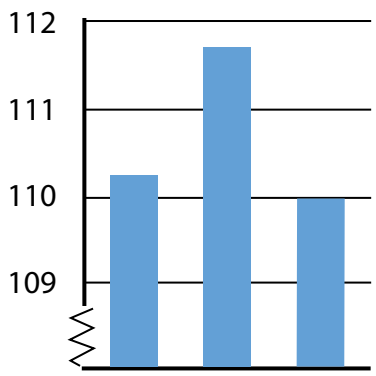
Smaller tables make it easier for the reader to find and understand the numbers.

Use bold text to highlight totals.

Quote numbers only to the accuracy required to illustrate the key message.

Axes that don't start at zero

You should usually start your vertical axis at zero so that the relative sizes of the values in your graph are visually apparent. However, you may occasionally need to start the axis at another value (for example, if you are trying to represent a small range of variation in large values which will not be noticeable on an axis starting at zero). In such cases you should make this obvious by inserting a zigzag at the bottom of the axis.



General rules for using graphs

6.31 A good graph can be an extremely effective way of presenting the key results from your data, but a poor graph can be confusing or misleading. The following tips should help you to create graphs that are both engaging and revealing to the reader.

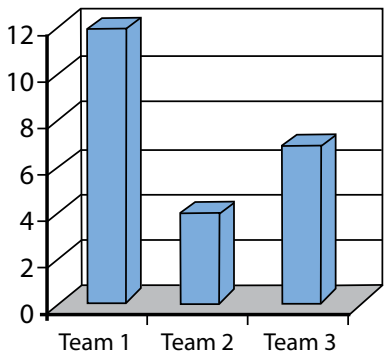
6.32 A graph should have **one clear visual message**. Resist the temptation to attempt to convey more than one idea in a graph, as this is more likely to confuse than illuminate the situation.

6.33 Give your graph a **clear heading** that contains all the information that the reader needs to understand its content. Avoid acronyms and abbreviations and use proper grammar.

6.34 Avoid unnecessary **visual effects**, as these can make the graph much harder to understand. Many common software packages can draw three-dimensional graphs – steer clear of these as they make it more difficult to see, for example, the height of a bar.

6.35 Try not to use **legends or keys** unless you are presenting regional data in the form of a map. It is usually better to add labels directly to the graph.

3D graphs are more difficult to read, so avoid them.



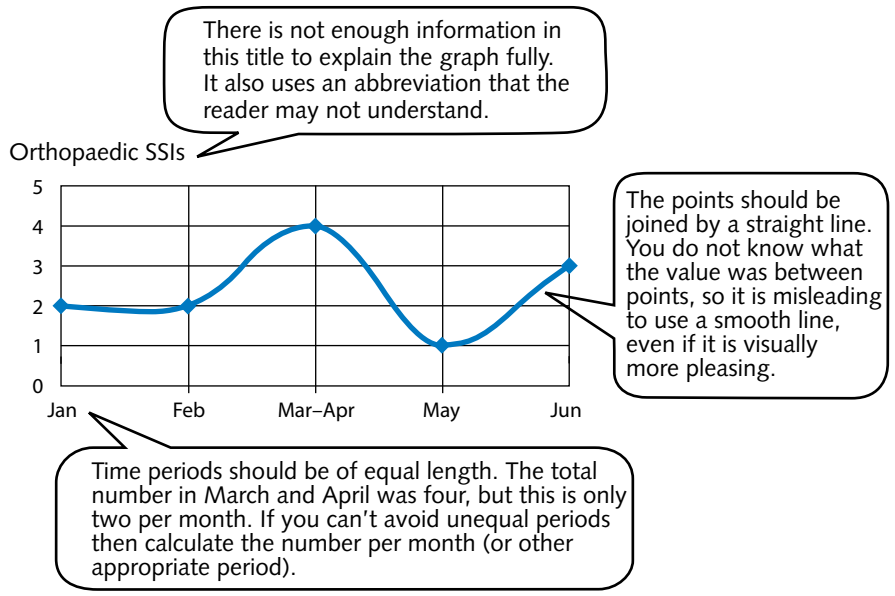
6.36 Label all of your **axes** clearly and state the units that you are using; give all values in the same units.

Choosing the right type of graph

6.37 You should try to choose the most appropriate type of graph for the data that you want to present. For example, if you are looking at how something changes over time a line graph will usually be the best choice, while if you are comparing results from different teams or areas you will probably want to use a bar chart.

Common pitfalls for graphs that show something changing over time

The graph below shows how a quality indicator has changed over time for your organisation. There are a few things wrong with it that will mean that it is less informative than it could be and in some cases misleading.



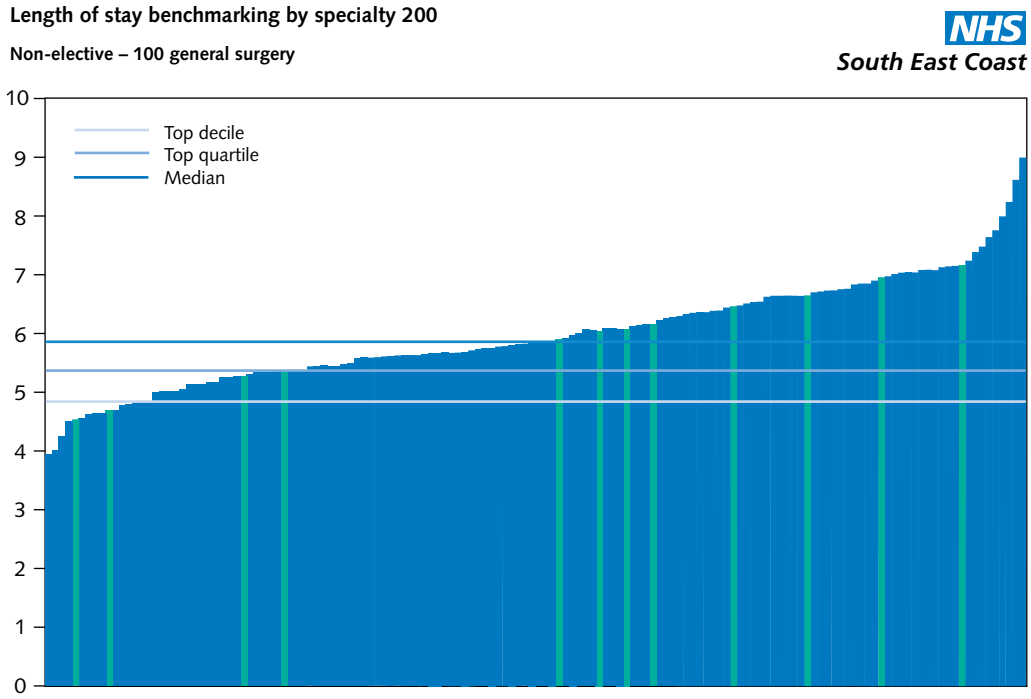
Benchmarking your results

6.38 Samantha Riley, head of the Quality Observatory at NHS South East Coast, has provided some useful tips in the paragraphs below for you to consider when approaching benchmarking of results.

6.39 Benchmarking can be a really useful tool to encourage improvement and can be undertaken at a range of levels – individual, team or organisational. By looking at comparative information, it is possible to understand how teams/organisations are performing compared with their colleagues, neighbouring trusts and best performers in the country.

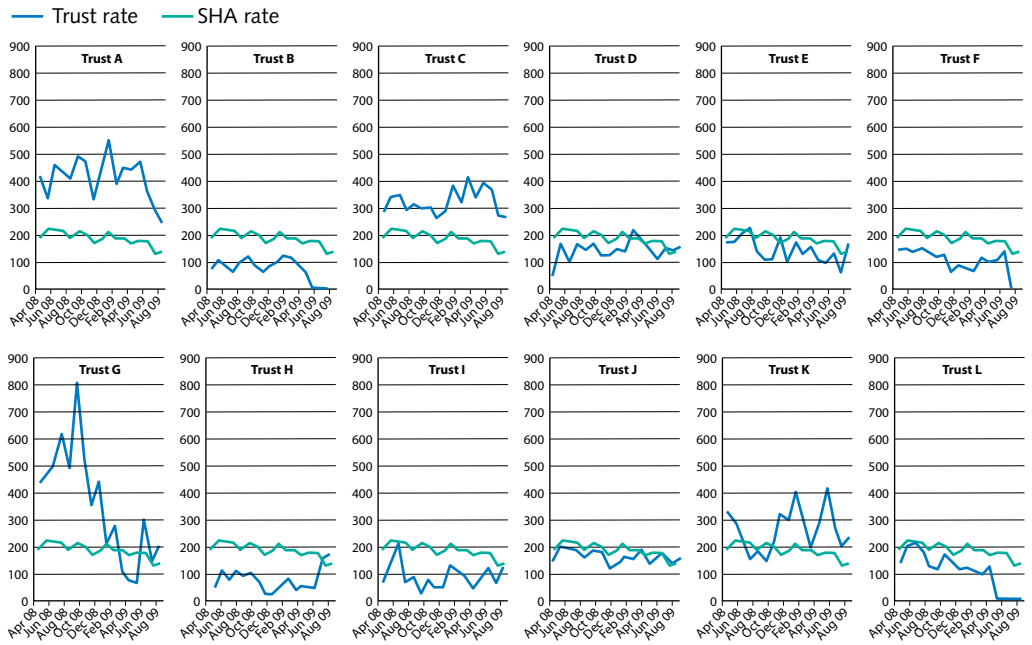
6.40 The way in which information is presented is very important – it needs to be visually appealing and at the same time enable the user to quickly and easily understand what the data is saying. In the example below, we can see

the average length of stay for patients undergoing a non-elective procedure within the specialty of general surgery. The green bars (anonymised) indicate individual trusts within South East Coast and the blue bars indicate trusts in the rest of England. This representation provides only a snapshot in time, however; it is also really important to understand what is happening over time.



6.41 Here is another example, looking at an indicator within our Safer, Smarter Nursing Metrics programme – falls per 10,000 admissions. Each graph shows the monthly rate over time (in blue) for the acute trusts within our region. The green line indicates the SHA average. A rate is a much better indicator to use than the actual number of falls if information from different organisations is to be compared, as organisations can vary significantly in size and a rate provides a level of standardisation.

Safer, Smarter Nursing Metrics – acute trust benchmarking
Falls (per 10,000 admissions)



6.42 All comparative analysis has to be viewed with caution as it is easy to jump to the wrong conclusion. For example, it would be easy to conclude that Trust C is performing poorly as it has a relatively high level of falls. The reality may be that the threshold for reporting falls is lower in Trust C and a higher number of falls is therefore reported. This highlights a really important point to consider when benchmarking – you must be comparing like with like. There must be clearly defined data sets and definitions associated with the indicators you are comparing, otherwise benchmarking is at worst useless and at best misleading.

6.43 It is often difficult for individual organisations to access benchmarking information as they do not have access to regional and national data sets. This is where regional Quality Observatories can help out as they can provide a range of benchmarks. You can find links to each Quality Observatory at www.qualityobservatory.nhs.uk. Follow the link to South East Coast, which has developed a large number of benchmarking tools and products, if you would like to see further examples.

Guidance for boards

6.44 In providing steers for the content of Quality Accounts, and in using the information contained within them, boards may want to refer for guidance to *The Intelligent Board*, a publication produced by an independent steering group of experts from the NHS to help boards to be effective, particularly in the use of information. The report is available from the Appointments Commission website: www.appointments.org.uk/publications.aspx

7 Quality management systems – embedding quality in your organisation and showing this in your Quality Account

Ensure that you are clear about:

- the quality of care you are delivering;
- how you are delivering this;
- what needs to improve, how this needs to be done, and what new systems, or changes to existing systems, are needed to deliver the change effectively and with the support of those involved (staff, users of the service and others with an interest); and
- showing the 'how' as well as the 'what' in your Quality Account so that your Quality Account will be more meaningful to the reader and invite accountability for the delivery of quality improvement.

7.1 The quality reporting exercise in 2009 was successful in highlighting how Quality Accounts could be further developed before their introduction in 2010. PricewaterhouseCoopers was commissioned to lead an evaluation of this exercise, to review both the process involved and the results, and to make recommendations.

7.2 The vision set out in *High Quality Care for All* was for Quality Accounts to show outcomes, what organisations do, and the quality of the services they provide. Outcomes are often the basis of many indicators and are a crucial means of assessing the quality of patient care received.

7.3 However, PwC's report made the key recommendation that Quality Accounts should also show how organisations strive to maintain and improve the quality of the services they offer. This recommendation supported the views of many stakeholders consulted during the development of Quality Accounts, who also thought it crucial to show how you were working to embed and improve quality within your organisation, based on what your stakeholders have told you is important to them.

7.4 PwC termed these elements 'quality management systems' and demonstrated how they work hand in hand with the three domains of quality highlighted in *High Quality Care for All* through the following diagram:[3]

7.5 Quality Accounts are tools to be used for reviewing your services, highlighting where improvements are needed, and committing to and making the changes as a result. For Quality Accounts to be of most use to your organisation, and more meaningful to the reader, we would strongly suggest that you consider your approach to quality and quality improvement and explain this in your Quality Account. Further information about some areas to consider within your Quality Account are described further in this section.

7.6 If you choose to present this information in your Quality Account, it should appear in Part 3 of the document.

Workforce factors

7.7 The Next Stage Review process and the development of the NHS Constitution demonstrated the explicit link between high-quality working practices and high-quality care. If we are really serious about quality

3 PricewaterhouseCoopers, Quality reports testing exercise evaluation, August 2009

becoming the organising principle of the NHS, improvements to patient and staff experience must be made in parallel. To achieve high-quality care, you need to ensure you have a high-quality workforce where staff and volunteers are committed, engaged, trained and supported. One of the main ways of measuring this is through the staff survey.

7.8 Our discussions with stakeholders during 2008 and 2009 showed wide support for the inclusion of workforce issues in Quality Accounts. This was both in terms of their input in developing the content, as described in Chapter 5, but also in terms of showing information relating to the workforce within this content.

7.9 It is important, when considering what information to include, to ensure that it supports your quality improvement narrative. A link should be made between information about workforce factors and the quality of patient care, focusing on the three domains of quality: patient safety, clinical effectiveness and patient experience.

7.10 The Health Act 2009, which received Royal Assent on 13 November, creates a statutory duty on all NHS bodies, primary care services, and third sector and independent providers of NHS services in England to "have regard to" the Constitution when performing their functions. This duty will also cover Monitor and the new Care Quality Commission. The NHS Constitution sets out four pledges to staff:

- The NHS commits to provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.
- The NHS commits to provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed.
- The NHS commits to provide support and opportunities for staff to maintain their health, well-being and safety.
- The NHS commits to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

7.11 These pledges underpin the suggested areas for inclusion in Quality Accounts. Quality Accounts offer you the opportunity to raise questions

about how well you are meeting these commitments to staff in the NHS Constitution, put in place plans to support improvements and measure the impact.

Planning and developing the workforce

7.12 Members of the public told us that they see the experience and training of the staff they meet in the NHS as crucial to the quality of care they will receive. They want to know that those caring for them have received the best training, are up to date in their practice and are the most appropriate people to be overseeing their care. The staff pledges in the NHS Constitution set a clear expectation that all NHS providers provide staff with personal development and, where appropriate, professional development. Every organisation should have a strategy in place to ensure the training, development and learning required to deliver service and care improvements is identified and delivered. Quality Accounts can show this by including data from the NHS staff survey about the number of effective appraisals that take place and the number of staff who have personal development plans and fair access to learning opportunities.

7.13 Having a workforce that is up to date and fit to practise is key to the delivery of safe, effective and respectful care. Work is being undertaken by the professional regulators and other professional and management bodies to develop plans for the revalidation of registered professionals. This work is most advanced in the medical profession with initial pilots in place and more comprehensive pilots planned to begin in 2010 across the NHS. A self-assessment tool called AQMAR – Assessing the Quality of Medical Appraisal for Revalidation has been developed and used by the vast majority of NHS bodies in preparation for medical revalidation. You could include in the Quality Account information that AQMAR has been undertaken on a regular basis, and that the board has agreed and monitored a development plan, building on the findings.

7.14 When setting out your quality improvement priorities, consider whether you have robust systems in place to identify the workforce you need, both now and in the future, to meet service plans and what is affordable. Workforce plans should be developed with clinicians and should identify any initiatives that need to be put in place to manage gaps between the demand for and supply of workforce, including reviewing how services could be delivered differently. These plans should be prepared in partnership with other organisations so that the workforce needs across care pathways can be planned. With robust plans and strategies in place, you might expect to

see an improvement in vacancies, staff turnover and the use of temporary staffing, all of which can be reflected in the Quality Accounts. You could also measure progress against plans for changes in skill mix and unit labour cost.

7.15 Of course, when planning any workforce it is important to think about the future. The quality of student placements should be high so that you can be confident that students are able to deliver high-quality care during their placement and that they have a good experience of working in the NHS. We know bad student placements can lead to students dropping out of their courses and Quality Accounts could include data about the rates of attrition from the placements in your organisation. You could also work with higher education institutes to consider how improvements to the quality of placements could be measured.

Staff experience

7.16 The NHS will demonstrate its commitment to improving the health of the nation through its commitment to improving the health of its staff. This will also enable organisations to demonstrate their commitment to the NHS Constitution and the pledge to provide support and opportunities for staff to maintain their health, well-being and safety. The physical and mental health and well-being of staff is closely linked with positive patient outcomes and is essential for a productive, self-reliant workforce. You can include in your Quality Accounts data from the NHS staff survey which demonstrates improvements in this area, which in turn will deliver better services to patients/service users.

7.17 Staff health and well-being are important factors in providing safe and effective care for patients. But every year, staff who could be providing care are off work due to ill health. Developing a strategy for staff health and well-being, including providing proactive occupational health services (such as physiotherapy and mental health care) and training for managers in dealing with staff health and well-being, can help reduce the number of days that staff are absent through ill health. Quality Accounts are a useful vehicle for providing information about sickness absence rates and the impact on quality of care provided.

Leadership

7.18 Evidence shows that good leadership, which looks out to patients and communities, is more likely to drive and deliver service improvement. Real and sustained change flows from having leaders, including clinical leaders,

who articulate the common goal of improving quality and who connect everyone to the wider purpose of the organisation.

7.19 Successful leaders engage with their colleagues, and with patients and communities, to develop a clear vision of what quality means and a clear understanding of everyone's role in delivering it. Quality Accounts can provide information about how leadership at team, service or organisational level is making a difference to the patient experience, for example through improved services or increased patient satisfaction.

7.20 In order to deliver quality improvements, organisations need to look at the capability and capacity of their current and future leaders. As we move forward, leadership must be for everyone in the NHS and, in particular, we need to enable more clinicians, and people from black and minority ethnic backgrounds, to take up key leadership positions. With that in mind, organisations may want to consider the leadership development opportunities they are providing. Is access to these opportunities transparent and open to all? What does the staff survey show: do all staff have personal development plans; have their appraisals been completed? Quality Accounts can be used to provide a clear statement about what organisations are doing to ensure that leaders become more representative of the communities they serve. They should link in to the organisation's Talent and Leadership Plan where appropriate.

Staff engagement

7.21 Organisations that deliver NHS services rely on good partnership working with trade unions. They also rely on partnership working with professional organisations and stakeholders. The benefits of such working are best realised when staff representatives bring an authentic voice to the partnership in the spirit of flexibility and constructive joint problem solving, with the aim of service improvement as a general statement of principle.

7.22 Those delivering care are often those who can best understand the reality of the quality of care being given and can suggest ways of improving their services locally. As discussed in Chapter 5, your workforce, both clinical and non-clinical, should be involved not only in designing the content of your Quality Accounts but also in the wider quality improvement plans which you present.

7.23 You should not consider Quality Accounts as 'an item' to engage you staff on, but rather as part of a wider ongoing conversation with staff about improving quality of care in your organisation directly and/or via representative groups or bodies. Quality Accounts should be able to show elements of this conversation, helping to demonstrate your quality narrative. This can be done by showing how staff are helping to shape your quality improvement agenda, perhaps giving examples of where this has helped to improve quality in particular areas or services. Examples could include improvements made through engagement with staff directly or through partnership with representative bodies.

7.24 The NHS staff survey provides one measure of how well the pledges are being delivered, including the staff engagement pledge. The NHS staff survey is a useful source of nationally agreed indicators of staff satisfaction, staff engagement and other behaviours, which you could consider drawing from for your Quality Accounts to show how quality of care within your organisation is viewed by its workforce. Indicators which show insight for the public into the views of your workforce on this subject will be reported in the 2009 NHS staff survey. Important indicators are given by the scores recorded in the following key findings:

"% staff feeling satisfied with the quality of work and patient care they are able to deliver"

"Staff job satisfaction"

"Staff advocacy"

"Staff able to contribute to improvements at work"

Links between quality and resources

7.25 When describing how you are achieving and will achieve quality, you will raise questions about the use of your resources, in terms of the need for additional resources or prioritisation and improvement of existing resources.

7.26 The previous section described how your largest resource, your workforce, could best be engaged and reflected in your Quality Account; this section discusses further areas that contribute to the wider improvement of quality, and which you could consider including information on in the body of your Quality Account.

Information resources – quality in measurement

7.27 Trust in the content of your Quality Accounts relies on the story told being honest, open and rounded, and on the data within the Quality Account being robust. Without productive and effective measurement and collation of data, the analyses made and actions for improvement identified will not be valid.

7.28 Due to this critical link between data quality and Quality Accounts, the regulations include a requirement for information relating to data quality to be published in Quality Accounts. Further information on this is found in Chapter 5.

7.29 In addition to these organisational-level statements, it is also important to recognise that service-line measurement, reporting and improvement relies on data collected at team level. Those involved in delivering a service should play a key role in not only verifying the data relating to that particular service before it is used in a Quality Account, but also in reviewing and deciding how to prioritise and deliver improvements.

7.30 Questions to consider regarding the effectiveness of your measurement systems and processes include:

- How is information being collated and examined by those responsible at all levels of the organisation? Do you have systems in place for information to transfer between clinical teams and the board and back again?
- Do your clinical teams make use of helpful tools such as scorecards, dashboards or other locally designed systems to continuously review their performance locally?
- What do clinical teams do with national indicators relevant to their specialty? Do they utilise the data collected and if so, how? Are they developing new indicators to use locally?

7.31 These are all questions which you should be able to answer as part of your quality improvement strategy. Therefore you should also consider describing some of these, for instance what you are doing well, or what you need to improve on, with regards to measurement within your quality narrative. This may be well placed in the data quality section of your account, or aligned to your priorities for quality improvement in terms of describing how you intend to improve and how you intend to measure this improvement.

King's College Hospital NHS foundation trust – development of clinical scorecards

King's College Hospital has taken a structured approach to demonstrating clear leadership from the board in terms of reviewing the services provided by the organisation. It has incorporated quality measures into scorecards at trust, divisional and team level, and is in the process of finalising ward-level scorecards. At trust level, the scorecard pulls together a balanced list of national indicators of quality, which are reviewed monthly by the board. Clinical divisions, focusing on specific areas, also review performance on quality indicators monthly to ensure regular scrutiny of quality. A simple traffic light system helps identify areas that are weaker in performance and if an indicator is red for two months running, an action plan must be brought to the monthly performance meetings, chaired by the Director of Operations and regularly attended by the Medical Director and the Director of Nursing.

The divisional scorecards include trust-wide indicators, plus others chosen which relate specifically to quality of the services offered in that division. Team-level scorecards go into more detail on top of this. By reviewing data at all levels, the scheme allows individual teams and divisions to take action to improve quality in their areas. The standardised approach also allows comparison across divisions, so that where a low performance score occurs across all divisions on a particular area, it can be escalated through the scorecard system and a trust-wide approach can be taken.

Tim Smart, Chief Executive of King's College Hospital

"There is no doubt in my mind that as a result of the board focusing far more on quality, King's College Hospital delivers better care and is a better place to work."

Roland Sinker, Director of Operations

"By providing the right information to the right people at the right time, the performance and quality scorecards have enabled staff at all levels to focus on improving quality and efficiency at the same time."

7.32 NHS Connecting for Health is embarking on a pilot phase to develop Clinical Dashboards with providers of NHS services. Clinical Dashboards act as enablers to improve clinical quality and productivity. They provide a visual display of information, typically taken from a range of existing systems

(sometimes even crossing organisational boundaries), to show and track local performance. In addition they can enable clinicians to 'drill down' and generate customised reports on underlying data. This allows clinical teams to lead local clinical governance cycles more effectively and provides practical opportunities to identify and then maintain effective change. Further information about clinical dashboards can be found at: www.connectingforhealth.nhs.uk/clindash

Quality of the environment in which care is delivered

7.33 Many of the patients and members of the public interviewed during the focus groups on Quality Accounts identified cleanliness and condition of the facilities/premises their main priorities for inclusion within a Quality Account. This not only links to the experience a patient has of their care but also has links to safety, particularly in relation to healthcare acquired infections.

7.34 *High Quality Care for All* and its vision to place quality at the heart of everything the NHS does was a catalyst for change and improvement in many areas. Nationally, mechanisms were put in place to help support local organisations and clinical teams in their delivery of this. One such tool is the Premises Assurance Model (PAM) developed by the NHS in partnership with the Department of Health. The PAM is intended to support NHS organisations to demonstrate how they are delivering the environmental components of the NHS Constitution. It will provide a comprehensive reference point for organisations to compare the quality and efficiency of their premises with their peers. It is being rolled out firstly to the NHS Acute Hospital Sector in April 2010 and further information will be published in a separate guidance document, which will identify how the model functions.

7.35 The model is structured around five domains, with three – safety, effectiveness and patient experience – directly focusing on the quality agenda (the remaining domains are finance and value for money (VFM), and Board Governance). As a self-assessment tool, it comes pre-loaded with Hospital Episode Statistics (HES) activity, and nationally collected environment performance data. It is designed to identify how well premises support the delivery of effective patient care, allowing NHS Acute Sector Providers

and PCTs, at board level, to take steps to improve the quality of patient environments to support the delivery of high-quality care.

7.36 The PAM is a resource which can be drawn on to show how the quality of premises is affecting the quality of patient care delivered. The PAM contains a range of indicators and metrics, which focus on patient experience drawn from nationally reported information. This information is also balanced against patient experience self-assessment questions drawn from areas such as national patient surveys, complaints, real-time feedback and/or locally conducted patient surveys. The PAM is intended to make a major contribution in the provision of information upon which to base environment quality achievement and strategies, and you can use this information in your Quality Account.

Aligning quality and your wider business strategy

7.37 *High Quality Care for All* set the vision for quality to be put at the heart of the NHS, and it is important that as we prepare for a tighter financial climate, we do not lose sight of this vision, nor of the positive changes already achieved.

7.38 In order for the system to focus on improving both quality and productivity simultaneously, work is needed by all levels of the system. Nationally, the Department of Health has established a programme of work to support the NHS and its partners to focus on Quality, Innovation, Productivity and Prevention (QIPP). Organisations across the system will need to work to identify and prioritise those activities which improve both quality and value for money.

7.39 Quality and productivity are not mutually exclusive and can go hand in hand. Improving processes and procedures, and prioritising the most effective treatments reduce errors and waste, improve the quality of care, and make the health service more efficient and productive, as does keeping people healthy and independent for as long as possible.

7.40 Innovation plays a key role in the link between quality and productivity, as new practices and technologies can help to improve standards and give rise to cash-releasing savings at the same time. Chapter 5 showed that innovation and research should feature in your Quality Account, with a statement in the regulations with regards to research. You should also use this section to explain any other innovative work you are undertaking, and how it is improving quality in your services. This should include an

explanation of how you are adopting and diffusing innovative techniques to drive the improvements you have identified as priorities.

7.41 Quality and productivity are the central resources to provide evidence on how to improve quality and productivity in the NHS. The NHS Evidence Collection, organised around care pathway groups, was launched in December 2009, and will evolve and expand over time to build a comprehensive library of quality and productivity evidence. To visit the evidence, go to: www.evidence.nhs.uk/qualityandproductivity

7.42 Ensuring that strategic and business objectives are aligned with the focus on quality will help you to ensure that quality is embedded throughout the organisation. Your Quality Account should demonstrate that delivering high-quality care for all is part of your core business, and is taken seriously by your organisation.

7.43 Local government and other local partners can support the organisation's focus on quality and directly contribute towards specific quality objectives. Certain groups – older people in particular but also those with physical and learning disabilities – may have the quality of their experience, or the safety of transition, affected by interaction with other partners, including adult social care. The input of other service providers working in partnership may also contribute towards quality improvement objectives around acute admissions and discharge practice, among other areas. Your Quality Account could show how your trust engages other partners to share its vision for quality improvement as part of its wider business strategy.

8 How should Quality Accounts be published?

- NHS Choices will host every Quality Account in an electronic format for use and review by the public.
- You are also required to make hard copies available on request.
- You may choose to publish or distribute this elsewhere in addition to meeting legal requirements, for instance on your organisation's website.

8.1 The regulations state that Quality Accounts must be published by 30 June following the end of the reporting period. They should be published electronically on NHS Choices, or another website if NHS Choices is not available at the time of publication, and a copy sent to the Secretary of State.

8.2 Organisations required to produce a Quality Account by June 2010 will be able to publish documents on their NHS Choices profile pages. Most organisations already use a system to publish and maintain their profile pages on the nhs.uk site. From spring 2010, new functionality will be added which will allow users of the system to upload their Quality Accounts.

8.3 Information on how to upload your Quality Account will be published in March 2010. For queries relating to the NHS Choices profile pages and content management system please contact thechoicesteam@nhschoices.nhs.uk

8.4 You should also email qualityaccounts@dh.gsi.gov.uk by 30 June with a copy of your Quality Account or a link to the website where it is published.

8.5 For those of you unable to upload your Quality Account on to your organisation's pages on NHS Choices, the copy sent to the Secretary of State will enable the Department of Health to publish the document on NHS Choices (the obligation will still fall on your organisation to ensure it is made available on a website by 30 June).

8.6 Following the publication of a Quality Account, there is a legal requirement under the Health Act 2009 for you to place a notice at the premises where your patients are receiving their healthcare services, stating where your

Quality Account can be obtained. You do not need to place a notice in buildings where you do not have control of the premises.

8.7 During the quality reporting pilot in 2009, many foundation trusts chose to present their Quality Account as part of their annual report and accounts. This is one method of ensuring consistency across the reporting and publication period. However, all Quality Accounts will be published on NHS Choices, the audience for which is the general public; therefore you must ensure that you can easily separate the Quality Accounts chapter from the annual report in order to send it as a separate document to this particular portal.

8.8 Equally, the Health Act 2009 states that each provider must make available on request, to any person who 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.

8.9 Feedback from patients and the public showed that the vast majority did not feel that providers should distribute these door to door, due to the cost and environmental implications. However, online publication, with the option of providing the Quality Accounts in different formats on request to those who require them, was supported.

9 Trust and assurance – who is responsible for assuring the Quality Account?

Quality Accounts are not marketing documents, but a chance to enter into a real, open and honest dialogue with the public regarding the quality of care in your organisation. Quality Accounts will achieve their full potential only if they are credible, and the content is subject to independent scrutiny and challenge.

9.1 Powers have been granted in the Quality Accounts section of the Health Act 2009 that:

- give the CQC and SHAs a role in asking for errors and omissions identified in published Quality Accounts to be corrected;
- require providers to send a copy to the Secretary of State; and
- enable the Department of Health to make regulations about:
  - the form and content, in addition to the nationally mandated content;
  - imposing duties to ensure the accuracy of information;
  - how and when a Quality Account must be published; and
  - the provider having regard to guidance issued by the Secretary of State. Although the wording of the Act means that regulations may also specify that providers must have regard to guidance issued by the Secretary of State, that is not the current proposal.

9.2 The assurance mechanisms for this first year of Quality Accounts require you to:

- include a set of mandatory data quality statements within your Quality Account, covering:
  - the use of the NHS number (which measures the completeness of the data held on patients);
  - the clinical coding error rate (which measures the accuracy of data recording);
  - the use of GP medical practice code (which again measures patient data completeness); and

  - the Information Quality and Records Management score (covering the quality of data systems and process within an organisation);
- provide a self-certification of the accuracy of the information in the Quality Account; and
- set up a mechanism of pre-publication clearance by the coordinating commissioning PCTs, LINks and OSCs.

9.3 Further information regarding the role of PCTs, LINks and OSCs in the assurance mechanism for Quality Accounts can be accessed in Professor Sir Bruce Keogh's letter of 14 January 2010 which can be found at: www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_111113

9.4 You will also find more explanation of the regulations at Annex A to this toolkit.

9.5 As long as the legal requirements concerning assurance are met, you are able to then go further, should you wish, and invite other stakeholders to comment. For example, some of you may have other patient reference groups or similar forums, which you engage with on a frequent basis. You may therefore wish to ask them for a statement, similar to that requested from your LINk or OSC, to include in your Quality Account in order to enhance your narrative and demonstrate the involvement of service users.

9.6 Assurance is required to ensure that the information in Quality Accounts is accurate and fairly interpreted, and that the range of services described and priorities for improvement are representative (i.e. they reflect the services you deliver – both in terms of highest volume and value, as well as those that are important to your patients; the information should present both positive areas and also be open about areas which need improvement).

9.7 The National Quality Board has commissioned work involving the Department of Health and Monitor to build on this system of assurance. This will involve a form of third party assurance of Quality Accounts, which, subject to consultation, will be introduced in 2011. This toolkit, as well as any amendments to regulations, will be updated to reflect any new requirements in advance of their introduction.

10 What next? Evaluating and moving forward

National evaluation of 2009/10 Quality Accounts

10.1 The Department of Health intends to evaluate the first year's publication of Quality Accounts in order to draw lessons from that experience to inform the next set of regulations. One area of interest, highlighted in the responses to the consultation, is to look at identifying what core data the majority of providers are including in their Quality Account. This would then provide a starting point for increasing the content set by the Department of Health in the regulations.

Exploring further options for the assurance of Quality Accounts

10.2 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 from 2011.

National Institute for Health and Clinical Excellence (NICE) quality standards

10.3 As a result of the *High Quality Care for All* report (June 2008), NICE has started to develop independent standards clarifying what high quality care looks like for specific services across the three dimensions of quality: clinical effectiveness, patient safety and patient experience. NICE quality standards will act as a final distillation of clinical best practice, derived from the best available evidence from NICE guidance or other sources accredited by NHS Evidence to provide a set of specific concise quality statements and associated measures that:

- act as markers of high quality, cost-effective patient care across a pathway or clinical area;
- are derived from the best available evidence from NICE guidance and other sources accredited by NHS Evidence; and
- are produced collaboratively with the NHS and social care professionals, along with their partners and service users.

10.4 Potential audiences for NICE quality standards include: patients and the public; clinicians; public health practitioners; commissioners; and service providers.

10.5 NICE is currently running a pilot development exercise on four topics chosen by the National Quality Board: stroke, dementia, venous thromboembolism prevention and neonatal care. We expect the first NICE quality standards developed from the pilot process to be available in April 2010.

10.6 Once developed, quality standards will become a useful resource for Quality Accounts, and the Department of Health will work with NICE to explore how the relationship between the two could best be developed, with a view to requiring Quality Accounts to cover information relating to the use of these standards. In the meantime, further information regarding NICE Quality Standards can be found at: http://www.nice.org.uk/aboutnice/qualitystandards/qualitystandards.jsp

NHS Constitution

10.7 The NHS Constitution sets out the principles and values that guide how the NHS should act and make decisions. All NHS organisations and other bodies supplying NHS services must have regard to the NHS Constitution, and providers will wish to take account of this when developing the content for their Quality Accounts.

Your next steps

10.8 It is important that both the Quality Accounts and the wider improvement agenda are continually reviewed, built upon and improved for the future. It may be worth inviting back some of those who helped you design your Quality Account to review the finished product and start planning for next year as a result.

10.9 It is, of course, the content of the Quality Accounts which needs to be reviewed to ensure that the improvement plan is progressed. Quality Accounts are annual and the public will want to see consistency between them so that, year-on-year, progress updates are given on the results of last year's planning and

prioritisation, followed by an account of what will happen in the next year. This looking both back and forward in Quality Accounts is crucial to giving the public information about the quality journey your organisation is on.

11 Useful resources

Department of Health webpage on Quality Accounts

This provides an overview of the policy, is a portal for publication of the key documents relating to the development of Quality Accounts and answers some frequently asked questions. Documents referred to in this toolkit which fed into the development of the policy for Quality Accounts during 2009, such as the PricewaterhouseCoopers report on the evaluation of the testing exercise and the Ipsos MORI reports on their engagement both with NHS organisations and patients and the public, can be accessed on this page.

www.dh.gov.uk/qualityaccounts

Primary legislation: Health Act 2009

The Health Act 2009 creates the duty for all providers of NHS services to produce an annual Quality Account.

www.opsi.gov.uk/acts/acts2009/ukpga_20090021_en_1

Secondary legislation: Statutory Instrument

The secondary legislation (in the form of regulations) gives the detailed requirements relating to the form, content, publication and assurance of Quality Accounts. The regulations can be found under the title of: The National Health Service (Quality Accounts) Regulations 2010.

www.opsi.gov.uk/

Response to consultation on the framework for Quality Accounts 2010

A consultation on the proposed framework for Quality Accounts in the first year of production ran between 17 September and 10 December 2009. The Department of Health published a response to this consultation in February 2010 and this can be viewed at:

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

Impact assessment (including equality impact assessment)

The impact assessment, including the equality impact assessment can be found alongside the response to the consultation.

www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Regulatoryimpactassessment/DH_111389

High Quality Care for All

This is the final report of Lord Darzi's NHS Next Stage Review, published in June 2008. It responds to the ten SHA strategic visions and sets out a vision for an NHS with quality at its heart.

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

Strategic health authorities' visions for better healthcare

Each of the nine SHAs involved in Lord Darzi's Review published their visions for better healthcare during May and early June 2008. These documents will form the basis of Lord Darzi's *Our NHS, our future* report, which will enable and support their delivery.

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085400

NHS Constitution

The NHS Constitution was published on 21 January 2009. It was one of a number of recommendations in Lord Darzi's report *High Quality Care for All*, published on the 60th anniversary of the NHS, which set out a ten-year plan to provide the highest quality of care and service for patients in England.

www.dh.gov.uk/en/Healthcare/NHSConstitution/index.htm

Foundation Trust Network *Quality Accounts: Making the most of your Quality Accounts*

Drawing on work in progress within member organisations and working in partnership with Tomorrow's Company to access learning and best practice from the world of business and commerce, the Foundation Trust Network has produced a guide for foundation trusts on developing Quality Accounts:

www.nhsconfed.org/Networks/FoundationTrust/Workstreams/Quality/Pages/Quality-accounts.aspx

Quality reports produced by NHS foundation trusts

A selection of the quality reports produced by NHS foundation trusts can be found on the Monitor website at:

www.monitor-nhsft.gov.uk/home/our-publications/browse-category/guidance-foundation-trusts/quality-reports-and-accounts

Quality reports for other NHS foundation trusts in 2009 and for NHS providers in NHS East of England can be found on the individual organisations' websites.

12 Acknowledgements

Many thanks to all who have contributed to the design of this toolkit, by comment, contribution or case study.

The Department of Health would like to thank colleagues at Monitor, the Care Quality Commission, NHS East of England and the Audit Commission for their work to develop Quality Accounts through the Quality Accounts governance group. Equally, thank you to all organisations and individuals represented on the Quality Accounts stakeholder group whose efforts and contributions over the course of the past year have been much appreciated.

Special thanks are extended to Sir Neil McKay for his role as chair of the Quality Accounts stakeholder group, and Dr William Moyes for his role as Chair of the National Quality Board sub-group for Quality Accounts assurance.

Annex A: Further guidance on the NHS (Quality Accounts) Regulations 2010

Introduction

This guidance has been prepared by the Department of Health as a guide to what the regulations mean for providers required to publish a Quality Account and what they are legally obliged to do. It provides guidance only and it should be read in conjunction with the regulations themselves. It also provides guidance on how to meet the requirements set out in the regulations.

General obligation

There is a legal requirement under the Health Act 2009 for all people or bodies who provide, or arrange for others to provide (sub-contract), NHS services to produce a Quality Account from 1 April 2010. Details of the contents of the Quality Account, exemptions and process are set out in these regulations.

Subcontracted Services

A provider must include information on the quality of healthcare services it provides as well as any services it has subcontracted out to another organisation to provide **unless** the sub-contractor is an NHS body (eg a PCT or NHS Trust) or has been commissioned by a PCT or SHA to provide other NHS healthcare services. If this is the case then it is the sub-contractor who should include a description of the quality of healthcare services that they have been sub-contracted to provide, alongside any other NHS services they provide. If the subcontractor makes further sub-contracting arrangements then the provider should include those sub-contracted services in their Quality Account – the obligation to provide a Quality Account does not extend beyond the subcontractor.

Citation, commencement and interpretation

This section explains that the regulations will come into force on 1 April 2010, along with the provisions relating to Quality Accounts in the Health Act.

Key definitions are also provided:

- The definition of 'provider' is set out in the Health Act 2009 as the organisation or person required to publish a Quality Account. The 'provider' means all providers of NHS services in England including 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.

- The 'relevant document' means a Quality Account containing information in relation to the reporting period set out in the Health Act 2009. The 'reporting period' is defined in the Health Act 2009. The first reporting period for Quality Accounts will be 1 April 2009 to 31 March 2010, and subsequent reporting periods will run from 1 April to 31 March each year.

Regulation 2 – Exemption for community health services and primary care services

This regulation exempts primary care services and/or community healthcare services from the obligation to publish information in a Quality Account. This means that in practice organisations which only provide these services will not have to produce a Quality Account. It will also mean that organisations who provide a mixture of acute care, primary care and community healthcare will not have to publish information relating to the quality of their primary care services and community healthcare services. So, for example, mental health trusts which provide both acute and community healthcare will report only on the quality of acute healthcare services provided.

It is intended that the requirement to publish a Quality Account will be extended to cover primary care and community healthcare from April 2011 onwards and that this requirement will be reflected in later regulations.

Regulation 3 – Exemption for small providers from the duty to publish information

This regulation exempts small providers from the legal requirement to publish a Quality Account. An organisation is defined as a small provider if it has a small number of staff (50 or fewer full-time (or full-time equivalent) employees) and its annual income from the provision of NHS services (not including those services that are exempt from the obligation to publish information in a Quality Account – i.e. primary care and community health) is relatively low (£130,000 or below).

The size of an organisation may fluctuate during the year. The regulation therefore sets out that the size of an organisation should be calculated on 1 April each year (or on the first day that NHS services are provided or sub-contracted for those organisations starting mid-way through the year).

The number of full-time equivalent employees is calculated by dividing the total number of hours worked by all employees on 1 April by the standard contracted hours for the organisation.

Annual income is to be measured by the actual income received during the financial year (i.e. as of 31 March). In order to prepare for the publication of a Quality Account which covers activity for the previous financial year, it is recommended that organisations use their projected contractual income to assess at the start of the year whether they are likely to meet the definition of small provider.

Regulation 4 – Prescribed information, content and form of document

This regulation sets out what information should be provided in a Quality Account and in what format. The Quality Account should be set out in three parts:

- Part 1 containing a written statement summarising the provider's view of the quality of NHS healthcare services they have provided. This statement should be signed by the responsible person for the provider (see Regulation 6 – Signature by senior employee);
- Part 2 containing the nationally mandated information that is set out as a series of statements listed in the schedule attached to the regulations (further guidance on the statements is provided below); and
- Part 3 containing information chosen by the provider to demonstrate the quality of NHS healthcare services provided.

The schedule attached to the regulations for Quality Accounts sets out, in column 1, a description of the data to be included in the statement (prescribed information) and, in column 2, the format in which you should write the statement (form of statement). A provider should complete the statement that is relevant to their organisation (two options are given for each statement). The completed statements should be included in Part 2 of the Quality Account.

Regulation 5 – Written statements by other bodies

This regulation sets out the requirement for a Quality Account to include any written statements sent to the provider from the appropriate commissioning primary care trust (PCT), Local Involvement Network (LINk) and/or Overview and Scrutiny Committee (OSC) in relation to their view of the provider's Quality Account. Each statement should be no longer than 500 words. The Quality Account should also include an explanation of any changes made to the final

version of the Quality Account that were made subsequent to (and possibly as a result of) the statements being provided.

Regulation 6 – Signature by senior employee

This regulation sets out the requirement for a senior employee (for example, the Chief Executive) of an organisation to sign a written statement (Part 1), thus declaring their accountability for the content of the Quality Account.

Regulation 7 – Priorities for improvement

This regulation sets out additional information that should be included in a Quality Account. Providers should include a section which confirms that the organisation has identified key areas for improvement and has in place plans to monitor and report on progress. This section should include:

- at least three priorities for improvement;
- how progress to achieving these priorities will be monitored and measured by the provider; and
- how and when this progress will be reported back to others in the future.

Regulation 8 – Document assurance by commissioning primary care trust

This regulation sets out the legal requirements for both providers of NHS services and their commissioning PCTs or strategic health authority (SHAs). It sets out:

- the requirement for a **provider** to send a copy of their Quality Account to their commissioning PCT or SHA within 30 days beginning with 1 April at the end of the reporting period (i.e. by 30 April each year);
- the requirement for a **commissioning PCT or SHA** to check the accuracy of the information contained in the provider's Quality Account in relation to the services provided to it; and
- the requirement for the **commissioning PCT or SHA** to then provide a written statement (maximum 500 words) for publication in the provider's Quality Account. The statement should confirm whether or not they consider the provider's Quality Account to contain accurate information and include any other comments they consider relevant – for instance, whether or not they believe it is a balanced report of the quality of healthcare services provided. This statement should be returned to the provider within 30 days of receipt.

The provider should send their Quality Account to one commissioning PCT (or SHA if the provider is a PCT or is not commissioned by a PCT). Where a provider has more than one commissioning PCT, they should send their Quality Account to the coordinating commissioning PCT.

Where the provider provides services to more than one coordinating commissioning PCT, they should send their Quality Account to the coordinating commissioning PCT in the SHA area in which the provider is located.

Where the provider provides services to more than one coordinating commissioning PCT in the SHA area in which it is located, they should send their Quality Account to the coordinating commissioning PCT which is responsible for the largest number of patients that the provider has provided NHS services to during the reporting period.

Where there is no coordinating commissioning PCT, they should send their Quality Account to the commissioning PCT which is responsible for the largest number of patients that the provider has provided NHS services to during the reporting period.

Where a provider is commissioned by more than one SHA (and no PCT), they should send their Quality Account to the SHA which is responsible for the largest number of patients that the provider has provided NHS services to during the reporting period.

Regulation 9 – Document assurance by appropriate Local Involvement Network

This regulation sets out the requirement for a **provider** to send a copy of their Quality Account to their appropriate LINk within 30 days beginning with 1 April at the end of the reporting period (i.e. by 30 April each year).

To fulfil this obligation, the provider should send their Quality Account to the LINk or LINks in the local authority area in which the provider's principal office is located. The method of communication (post, email etc) is not specified in the regulation and should be left to local determination.

Regulation 10 – Document assurance by appropriate Overview and Scrutiny Committee

This regulation sets out the requirement for a **provider** to send a copy of their Quality Account to their appropriate OSC within 30 days beginning with 1 April at the end of the reporting period (i.e. by 30 April each year).

To fufil this obligation, the provider should send their Quality Account to the OSC in the local authority area in which the provider's principal office is located. The method of communication (post, email etc) is not specified in the regulation and should be left to local determination.

Regulation 11 – Publication and provision of copies

This regulation sets out the requirement for a provider to publish their Quality Account by making it available on NHS Choices or another website if NHS Choices is not available to the provider (for example, the organisation's own website or another website specified by the Department of Health). The provider is also required to send a copy of the report to the Secretary of State. A report should be sent to the Secretary of State by emailing the document or a link to the document, with details of whether/where the report is published on NHS Choices/the provider's own website, to qualityaccounts@dh.gsi.gov.uk

Both actions should be completed by 30 June each year. Providers will be able to upload their Quality Account to NHS Choices from 1 April each year. For those providers unable to upload their Quality Account on to their organisation's pages on NHS Choices, the copy sent to the Secretary of State will enable the Department of Health to publish the document on NHS Choices (the obligation will still fall on the provider to ensure it is made available on a website by 30 June).

Annex B: Glossary

Acute trust

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.

Association of Public Health Observatories

The Association of Public Health Observatories (APHO) represents a network of 12 public health observatories (PHOs) working across the five nations of England, Scotland, Wales, Northern Ireland and the Republic of Ireland. They produce information, data and intelligence on people's health and health care for practitioners, policy makers and the wider community. http://www.apho.org.uk

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 and strategic health authorities 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, 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 are the key organisations responsible for commissioning healthcare services for their area. They 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 trust

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 on 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 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 12 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 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 2000 frontline staff, which involved 60,000 NHS staff, patients, stakeholders and members of the public.

Hospital Episode Statistics

Hospital Episode Statistics 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 which could be used for local quality improvement and as 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 which 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 in which 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 Institute for Health and Clinical Excellence

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

National Patient Safety Agency

The National Patient Safety Agency 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, coordinated by the Care Quality Commission, 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 is part of the National Patient Safety Agency. It provides a robust ethical review of clinical trials to protect the safety, dignity and well-being of research participants as well as ensure 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 for all NHS organisations across the six counties.

NHS Information Centre

The NHS Information Centre are England's central, authoritative source of health and social care information. Acting as a 'hub' for high quality, national, comparative data for all secondary uses, they deliver information for local decision makers to improve the quality and efficiency of frontline care. www.ic.nhs.uk

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.

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 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.

Pacesetters programme

The Department of Health funded Pacesetters programme is a transformational change programme in which the Department supports strategic health authorities and NHS trusts to work with their local communities, to reduce health inequalities arising out of discrimination and disadvantage for both patients and staff. Pacesetters is the only Department of Health equality programme that works across **all** equality strands, and additionally focuses on innovation in the field of equality and diversity. The programme tests innovations and identifies good practice and learning in order to share, spread and sustain them throughout the NHS – to make a permanent positive difference to people and communities.

Periodic reviews

Periodic reviews are reviews of health services carried out by the Care Quality Commission (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: www.cqc.org.uk/guidanceforprofessionals/healthcare/nhsstaff/periodicreview2009/10.cfm

Primary care trust

A primary care trust 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, for example 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. The term quality report has been used to distinguish it as part of the testing process, in comparison to a Quality Account, for which there is a legal requirement.

Registration

From April 2009, every NHS trust that provides healthcare directly to patients must be registered with the Care Quality Commission (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 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/the-secondary-uses-service-sus/using-this-service/data-quality-dashboards

Special review

A special review is a review carried out by the Care Quality Commission (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 authorities

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 ten in total) are responsible for:

- developing plans for improving health services in their local area;
- making sure 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
- making sure that national priorities – for example, 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.

First published February 2010

Produced by COI for the Department of Health

www.dh.gov.uk/publications