17 September 2009

To: Overview and Scrutiny Committee Members

Dear Sir / Madam,

The framework for Quality Accounts – a consultation on the proposals

I am writing to inform you that the Department of Health has launched a public consultation on the proposals for the framework for Quality Accounts, and would encourage you to read these and respond to the questions.

Quality Accounts aim to improve public accountability and to encourage boards to drive improvements in the quality of care their organisations provide. They will be annual reports to the public, from NHS providers of healthcare, reporting on the quality of healthcare services they provide.

The consultation can be found at: http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_105304 and will run until Thursday 10th December. Details of how to respond to the consultation are included in the consultation document.

The proposals stated within the consultation document, are drawn from a series of engagement, testing and other design processes, which have taken place since the vision for Quality Accounts was set out in *High Quality Care for All* (June 2008). Further background on these is included within the body of the consultation document. Events with OSCs members have played a key role in shaping these proposals, especially with regards to how members could be involved in Quality Accounts, and you will find reference to this proposed role in the document.

The results of this public consultation will be summarised into a report from the Department of Health, which will in turn inform the regulations and guidance for Quality Accounts, ready for their statutory introduction from April 2010.

I would value your participation in this consultation exercise, and encourage you to share this with others who you feel may also have an interest in responding.

Yours sincerely,

Professor Sir Bruce Keogh
NHS Medical Director, Department of Health

Department of Health

The Framework for Quality Accounts

A consultation on the proposals

DH INFORMATION READER BOX

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Department of Health

The Framework for Quality Accounts

A consultation on the proposals

Contents

Foreword

High Quality Care for All was explicit that Quality Accounts would be a key vehicle for making information on quality available to the public. But how will they contribute to improving quality in our NHS?

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

The published evidence suggests that public disclosure does not generally drive improvement through the resulting actions of patients or commissioners. 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 to continuous quality improvement. If designed well, the accounts should assure commissioners, patients and the public that trust boards are regularly scrutinising each and every one of their services.

These purposes might seem at odds with reports that are intended for public consumption. Through this consultation we should aim to refine the process to ensure public involvement at every stage.

The proposals outlined in this document are a result of engagement, testing and detailed design work undertaken over the last year since the publication of *High Quality Care for All*. 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 their efforts and contributions are very much appreciated.

I believe this is a unique opportunity for the NHS. Quality Accounts will both act as a catalyst to improve quality and provide an opportunity for organisations to demonstrate measurable improvements in quality of care over the coming years.

The challenge we seek to address through this consultation is how to refine a format and methodology for the accounts that is concise yet provides assurance that quality issues are being analysed and addressed across the full spectrum of that organisation's activity. We should also take the opportunity to consider how

the preparation and presentation of Quality Accounts could be used to reduce the duplication of data flow between NHS organisations.

So please review, analyse and constructively criticise the proposals outlined in this consultation and send us your feedback by 10 December 2009.

Professor Sir Bruce Keogh
NHS Medical Director
Department of Health

Executive summary

Purpose

This document serves two main purposes:

- First, it sets out our detailed proposals on the purpose, content and format of Quality Accounts, and the underlying processes and infrastructure. The Department of Health will also publish separate guidance to assist providers in maximising the opportunities presented by Quality Accounts.
- Second, it launches a consultation on the proposed content of the regulations which will set out what a Quality Account should look like and which we plan to have in force next year. The consultation also seeks views on other policy areas that are being developed for Quality Accounts.

Audience

This consultation will be of relevance to all providers of NHS healthcare services, third sector organisations with an interest in healthcare, patient groups, healthcare service users and members of the public.

Timing

The consultation will run from 17 September to 10 December 2009. We will then produce a report setting out the views expressed and how we intend to respond to or act on them; and then we intend to make regulations early in 2010.

Legislation

The publication of Quality Accounts will be a legal requirement from April 2010, subject to the successful passage of the Health Bill 2009. This legislation will apply to all providers of NHS healthcare services, from large acute providers to individual GP and dental practices. Independent healthcare organisations that provide NHS services will also be required to publish Quality Accounts.

Scope

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

ambulance trusts. Private or voluntary sector equivalents would cover providers of NHS acute, community and mental health services (subject to an exemption relating to small providers). All other healthcare providers (in particular providers of primary care and organisations that provide only community health services) will be exempt in the first year.

Consequently, this consultation relates largely to those organisations which will provide a Quality Account in the first year, although the underlying principles remain relevant to all healthcare providers, as they provide the basis for future years.

Background

In *High Quality Care for All*, published in 2008, the Government proposed that all providers of NHS healthcare should produce annual 'Quality Accounts' just as they publish financial accounts. These will be reports to the public on the quality of the services they provide looking at the three domains of quality:

- safety;
- effectiveness;
- patient experience.

The primary aim of Quality Accounts is to support the NHS in improving the quality of healthcare services. Quality Accounts will achieve this by improving accountability to the public by engaging boards or their equivalents in understanding and improving the quality of care offered by their organisations.

There is evidence to show that publishing information about the quality of healthcare within an organisation drives improvement.[1] Once information about the quality of healthcare is put in the public domain, providers pay greater attention to quality and make changes to improve their record.

Each Quality Account should address the quality of the services offered by the organisation as a whole and should be presented as a short, readable document that is accessible to all members of the local community.

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*; 283:1866–1874; Shekelle PG, Yee-Wei Lim, Mattke S and Damberg C (2008) *Does public release of performance results improve quality of care? A systematic review*. The Health Foundation (www.health.org.uk/publications/research_reports/performance_results.html)

The proposals outlined in this document are a result of testing, engagement and other detailed design work undertaken by the Department of Health, Monitor, the Care Quality Commission (CQC) and NHS East of England, as well as many other local and national organisations in the last year.

We expect that while some content will be set nationally, a large amount of the content of a Quality Account should be determined locally (through engagement with local stakeholders) and should report on local priorities. Quality Accounts will:

- make healthcare providers more accountable to patients, carers and the wider community;
- allow clinical teams to review and drive up their performance (with the option for benchmarking);
- provide a framework for commissioners' and providers' discussions about their local priorities for service improvement.

Boards will be responsible for the accuracy and completeness of their Quality Account, and for compliance with the regulations and guidance that we are developing. As set out in the primary legislation, the CQC and commissioners – through the strategic health authority (SHA) – can also ask for errors to be corrected.

Working with our stakeholders in the design of Quality Accounts

A comprehensive stakeholder engagement process has been informing, and will continue to inform, the shape of Quality Accounts. The advice from all our stakeholder and engagement activities over the last year, which included over 1,000 stakeholders, has fed directly into our detailed proposals for Quality Accounts.

Monitor and the East of England SHA required all NHS foundation trusts in England and all NHS providers in the East of England region to produce Quality Reports in the spring and summer of 2009. This also served as a useful trial for Quality Accounts and, following its success, formed the basis for the proposals set out in this document. The Department of Health commissioned a survey of the organisations that produced Quality Reports in 2008/09 and evaluated the content and presentation of a selection of them. Key findings from this study are listed in Annex A and the full report is published on the Department of Health's website.

Proposed structure and content of a Quality Account

As a result of this work, we propose that the nationally mandated content of a Quality Account, which will be set out in regulations, should comprise a select number of statements from the board containing prescribed information, which relate strongly to the drive for quality improvement.

These statements derive from the type of cross-cutting themes seen in the Quality Reports published in 2008/09 which were discussed at our stakeholder engagement events:

1. statement from the board – an overall statement of accountability from the board;
2. priorities for improvement – confirmation that the organisation has identified key improvement priorities and the monitoring and reporting arrangements to track progress;
3. review of quality performance – confirmation that the organisation has set three indicators for each of the domains of quality; has reviewed the range of its services with a view to developing a quality improvement plan; and has demonstrated that it monitors quality by participating in clinical audits;
4. research and innovation – confirmation that the organisation participates in clinical research and uses the Commissioning for Quality and Innovation (CQUIN) payment framework;
5. what others say about the provider – a statement on the organisation's CQC registration (e.g. whether conditional) and of any concerns arising from periodic and/or special reviews; and a statement from Local Involvement Networks (LINks) and primary care trusts (PCTs);
6. data quality – a simple data quality score.

In subsequent years, when the requirement to publish Quality Accounts is extended to all providers of NHS healthcare, the regulations and guidance will be extended to cover those organisations as well.

The nationally mandated component of Quality Accounts will also evolve as other related policies develop – the CQUIN payment framework, CQC registration, Monitor's compliance regimes and National Institute for Health and Clinical Excellence (NICE) quality standards – and we expect to see annual revisions, refinements and amendments for at least the first few years.

The nationally mandated sections proposed in Quality Accounts serve to offer the public assurance that the organisation as a whole is performing to required

standards (such as meeting CQC registration) and measuring its clinical processes and performance (for instance through participation in national clinical audits); and also that it is involved in national cross-cutting projects and initiatives aimed at improving quality, for instance through recruitment to clinical trials, or through establishing improvement and innovation goals with the commissioner using the payment framework for CQUIN.

Boards will then be free (subject to stakeholder feedback and the requirements of any assurance mechanisms that become part of the production process) to determine the rest of the content, drawing on nationally and locally validated indicators to underpin their narrative and giving a fair and rounded picture on quality. The existing Quality Reports illustrate both the variety of indicators used and the common underlying theme of quality improvement. They also show that left to themselves, but within a framework developed by Monitor, trusts succeeded in:

- using the right data (from the menu available) to illustrate their story;
- reporting the areas of most relevance (usually in terms of activity level) to their business;
- making a clear case for quality improvement.

Proposed processes for Quality Accounts

Assurance

One key message from our engagement activity is that confidence in the assurance process is key to maximising confidence in the Quality Accounts themselves.

We propose to develop a spectrum of assurance mechanisms which will support the assurance process but will not replace the accountability of the board for the accuracy of its own Quality Account.

As a first step, we are requiring lead (the co-ordinating commissioner) PCTs to endorse providers' Quality Accounts – i.e. to confirm their belief that the Account is based on a reasonable interpretation of the available data; and that there are no glaring errors or omissions. To make this process run more smoothly, our Quality Accounts guidance will suggest that providers share their planned content at an early stage with commissioners, and also with their other stakeholders – including their own staff, and patient groups (for example LINks). This will help ensure that the proposed content is a comprehensive representation of the quality of health services provided, and that it covers topics that are of particular interest to the local community.

We propose to build on this basic process and step up the level of assurance by introducing further levels incrementally. For example, we will consider introducing 'trust to trust', stakeholder and/or independent peer reviews, which will test both accuracy and comprehensiveness. These exercises may be undertaken as part of the board's own assurance process, or as part of an external audit.

Although we intend to explore further the external audit option, we do not believe that it is necessarily the best option for every Quality Account at this stage. However, providers can consider commissioning an independent review of a specific risk area as part of their own internal assurance processes, or seek assurance through a third party. That might also be an option for stakeholders to explore as part of their sign-off.

We consider that these options are interlinked and complement one another, and that none on its own can provide exactly the level of required assurance.

Publication

It is proposed that all providers should publish their Quality Account on the NHS Choices website. Providers will be able to do this themselves by updating their general description profile. The Department of Health is considering whether a tool that assists readers in comparing information between providers should be adapted to allow comparison between the nationally mandated statements in Quality Accounts.

The Department of Health will require providers to publish their Quality Accounts by the end of June each year to align with their annual report and accounts.

In addition, foundation trusts will be required by Monitor to present their Quality Accounts as part of their annual report and accounts.

Which organisations will be required to produce a Quality Account?

For the first year of Quality Accounts, only NHS trusts (and their private or voluntary sector equivalents), including foundation trusts, NHS acute trusts, mental health trusts, learning disability trusts and ambulance trusts, will be required to provide a Quality Account. All other healthcare providers will be exempt in the first year.

The duty to provide a Quality Account will also extend to non-NHS organisations that provide NHS healthcare (for example private hospitals).

The current plan is to introduce Quality Accounts for primary and community care sectors from 2011. An engagement and testing process, similar to that run within foundation trusts and NHS East of England providers but focused on the particular needs of these two sectors, is due to commence in autumn 2009 and will deliver test reports in June 2010. This will help shape the development of Quality Accounts further as they begin to apply to all providers.

Exemption of small providers

We intend to exempt providers that do not have a significant NHS workload. In the absence of any other definition of what constitutes a small-scale provider, we propose that providers which treat fewer than 100 NHS patients each year or with a yearly NHS contract worth less than £100,000 should not be subject to the duty to publish a Quality Account.

This consultation will run from 17 September to 10 December 2009.

You can respond to this consultation by completing the accompanying questionnaire and emailing it and any other comments to QualityAccounts@dh.gsi.gov.uk

We will respond to this consultation prior to making the regulations for Quality Accounts early in 2010.

This consultation follows the Government's Code of Practice on Consultation.

1. Putting quality at the heart of the NHS

The Quality Framework

1.1 *High Quality Care for All*, published in June 2008, was the final report of the NHS Next Stage Review, a year-long process led by the Department of Health and the NHS which involved over 60,000 NHS staff, patients, stakeholders and members of the public.

1.2 In *High Quality Care for All*, we identified three domains of quality care: **safety**, **effectiveness** of care and **patient experience**. *High Quality Care for All* committed the Department of Health and the NHS to developing a Quality Framework to support local clinical teams to improve the quality of care locally, a key part of which was publishing quality information. Quality Accounts are therefore one key component of this framework. The purpose and proposed content of a Quality Account, and the processes that should be in place to produce one, have been shaped by a comprehensive stakeholder engagement process and the successful introduction of Quality Reporting for 2008/09 by foundation trusts and NHS trusts in the East of England.

1.3 Many countries are beginning to see that public reporting of comparative information about the quality of healthcare is an important way of improving accountability, stimulating quality improvement and empowering members of the public. This process is driven by three main factors:

- Public reporting can be used to highlight the unacceptable variation in the quality of healthcare.
- Mechanisms for public reporting, such as Quality Accounts, can be used to engage and empower those who have an interest in improving quality, including healthcare users, health professionals, managers, boards and regulators.
- Reports, such as Quality Accounts, can be used to drive quality improvement and promote greater accountability.

Consultation on the proposed details of Quality Accounts

1.4 The publication of Quality Accounts will be a legal requirement from April 2010, subject to the successful passage of the Health Bill 2009. The first statutory Quality Accounts will therefore be published next summer, and will cover activity in the year 2009/10. The legislation will apply to all providers of NHS healthcare services in England, from large acute providers to individual GP and dental practices (see paragraph 1.6). This includes independent healthcare organisations that provide NHS services, which will therefore be required to publish Quality Accounts. The primary legislation, as well as placing a duty on providers of NHS services to produce Quality Accounts, also gives the Secretary of State powers to make regulations specifying the information that must be contained in the Accounts; and the content, format and timing of these publications, including provision for locally agreed elements. Regulations may also specify that providers must have regard to guidance issued by the Secretary of State.

1.5 This consultation document sets out the Department of Health's proposals for Quality Accounts and explains which matters will be specified in regulations and what will be left to local determination. These proposals flow from the testing, engagement and other detailed design work undertaken over the last year by the Department, Monitor, the Care Quality Commission (CQC) and NHS East of England, as well as many other local and national organisations.

1.6 For the first year of Quality Accounts, only NHS trusts and NHS foundation trusts and their private or voluntary sector equivalents will provide a Quality Account. This includes NHS acute trusts, mental health trusts, learning disability trusts and ambulance trusts. Private or voluntary sector equivalents cover providers of NHS acute, community and mental health services (subject to an exemption relating to small providers). All other healthcare providers (in particular providers of primary care and organisations that provide only community health services) will be exempt in the first year. **Consequently, this consultation relates largely to those organisations which will provide a Quality Account in the first year, although the underlying principles remain relevant to all healthcare providers, as they provide the basis for future years.** Please refer to paragraph 3.6 for more information about the timetable for the introduction of varying types of provider into the requirements.

Rationale for Quality Accounts

1.7 In *High Quality Care for All*, the Government proposed that all providers of NHS healthcare should produce annual 'Quality Accounts' just as they publish financial accounts. These will be reports to the public on the quality of the services they provide looking at the three domains of quality:

- safety;
- effectiveness;
- patient experience.

1.8 The primary aim of Quality Accounts is to support the NHS in improving the quality of healthcare services. The increased public accountability stemming from Quality Accounts will drive boards (and their equivalents) to engage in understanding and improving the quality of care offered by their organisations. There is evidence to show that publishing information about the quality of healthcare within an organisation drives improvement. Once information about the quality of healthcare is put in the public domain, providers pay greater attention to quality and make changes to improve their record.[2]

1.9 Each Quality Account should address the quality of the services offered by the organisation as a whole and should be presented as a short, readable document that is accessible to members of the local community. A Quality Account should be developed with stakeholders – commissioners, staff, patients and the wider community[3] – and not just presented to them.

1.10 Real quality improvement will only be delivered if it is driven locally by the boards, clinicians and managers in NHS organisations, and therefore we envisage that while some content will be set nationally, a locally owned Quality Account should have a large amount of its content determined locally (through engagement with local stakeholders) and should report on local priorities. Quality Accounts will then be able to:

2 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*; 283:1866–1874; Shekelle PG, Yee-Wei Lim, Mattke S and Damberg C (2008) *Does public release of performance results improve quality of care? A systematic review*. The Health Foundation (www.health.org.uk/publications/research_reports/performance_results.html)

3 The wider community includes equality target groups; that is people and groups who may experience discrimination and disadvantage because of their ethnicity, age, religion and belief, sexual orientation, disability, sex or gender identity

- make healthcare providers more accountable to patients, carers and the wider community;
- all our clinical teams to review and drive up their performance (with the option for benchmarking);
- provide a framework for commissioners' and providers' discussions about their local priorities for service improvement.

1.11 Boards will be responsible for the accuracy and completeness of their Quality Account, and for compliance with the regulations and guidance that we are developing. As set out in the primary legislation, the CQC and commissioners – through the strategic health authority (SHA) – can also ask for errors to be corrected.

1.12 A comprehensive stakeholder engagement process has been informing, and will continue to inform, the shape of Quality Accounts (see Annex B for further information). The advice from all our stakeholder and engagement activities over the last year, which included over 1,000 stakeholders, has fed directly into our detailed proposals for Quality Accounts.

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

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

1.14 The Quality Reports for 2008/09 are now available. Quality Reports are included in the 2008/09 annual reports and accounts of NHS foundation trusts. These are available on the Monitor website at www.monitor-nhsft.gov.uk or the organisations' own websites, and have been laid before Parliament. Quality Reports published by providers in the East of England are available directly from the providers' own websites.

1.15 Providers were asked to write a Quality Report which was to include:

- a statement on the quality of care offered by the organisation, signed by the chief executive;

- a description of the priorities for quality improvement, the action the organisation plans to take in response, and the rationale for the prioritisation;
- a response to issues raised by the regulators or public representatives in the last year;
- a quantitative description of the quality of care, including indicators selected by the organisation covering safety, effectiveness and patient experience (supplemented by indicators covering the Department of Health's national priorities and compliance with core standards, as declared to the CQC).

1.16 In summer 2009, the Department of Health commissioned PricewaterhouseCoopers (PwC) to conduct a comprehensive survey of the organisations that participated in the testing exercise. PwC also evaluated the content and presentation of a selection of Quality Reports. Key findings from this study are listed in Annex A and the full report is published on the Department of Health's website. The conclusions from this study have been used to develop our proposals for Quality Accounts in this consultation document.

2. Proposal for the introduction of Quality Accounts

The proposal

2.1 Our stakeholders were clear that, in order to ensure local ownership of Quality Accounts, the majority of the report should be locally determined and owned by boards, clinicians and staff. A smaller, nationally mandated component of Quality Accounts was also supported to give the public information that will be common across all Quality Accounts and to allow some direct comparison.

2.2 The strong consensus that emerged from our engagement process is that the nationally mandated component of Quality Accounts should not set new priorities or be used as a tool for performance management. Quality improvement is about harnessing ambition – it is not another type of system regulation. It was thought that the nationally mandated component of Quality Accounts should not merely duplicate what is already published in Vital Signs.[4] We wanted to avoid including all Vital Signs and similar indicators in Quality Accounts because this would produce a lengthy document, but we also wanted to avoid including only a select few because this might create the impression that the Department of Health was creating alternative or 'super' priorities over and above existing ones.

2.3 In view of this, our proposal for this first set of regulations is that the nationally mandated content of a Quality Account should comprise a selected set of information, presented in the form of a number of statements from, or approved by, the board of the provider body, which relate strongly to the drive for quality improvement. The required information and the form of the statements would be specified in the regulations. The nationally mandated content is not intended to be wholly distinct from the rest of the Quality Account. These statements derive from the type of cross-cutting themes seen in, for example, Quality Reports, and we expect that providers will expand on any issues highlighted in this nationally mandated section. In addition to the regulations, the Department of Health proposes to issue guidance on both the nationally mandated content (which will be required through regulations) and on the locally determined content.

4 The Operating Framework, published in 2007, introduced a new approach to planning and managing our priorities both nationally and locally – the Vital Signs (www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082542)

Structure and content

2.4 We propose to require providers to present the nationally mandated information in the form of statements which will be specified in the regulations. Providers would be free to expand on the information covered by the statements as part of the locally determined content where this will help explain their overall quality improvement story.

2.5 The proposed form of these statements is set out below. The precise wording of the statements prescribed to be in the regulations is subject to final decision by the Department of Health following this consultation. We are seeking your views about whether the statements cover the right issues and whether they are worded correctly. The proposed scope of the regulations for Quality Accounts is detailed in Annex C and supporting information on how to develop the local content of a Quality Account is provided in Annex D.

2.6 In subsequent years, when the requirement to publish Quality Accounts is extended to all providers of NHS healthcare, the regulations and guidance will also be extended similarly. The nationally mandated component of Quality Accounts will also evolve as other related policies develop – the Commissioning for Quality and Innovation (CQUIN) payment framework, CQC registration, Monitor's compliance regimes, and the National Institute for Health and Clinical Excellence (NICE) quality standards – and we expect to see annual revisions, refinements and amendments for at least the first few years.

The proposed statements listed below are set out in more detail in the following pages:

1. statement from the board – an overall statement of accountability from the board;
2. priorities for improvement – confirmation that the organisation has identified key improvement priorities and the monitoring and reporting arrangements to track progress;
3. review of quality performance – confirmation that the organisation has set three indicators for each of the domains of quality; has reviewed the range of its services with a view to developing a quality improvement plan; and has demonstrated that it monitors quality by participating in clinical audits;
4. research and innovation – confirmation that the organisation participates in clinical research and uses the CQUIN payment framework;

5. what others say about the provider – a statement on the organisation's CQC registration (e.g. whether conditional), and of any concerns arising from periodic and/or special reviews; and a statement from Local Involvement Networks (LINks) and primary care trusts (PCTs);

6. data quality – a simple data quality score.

1 – Statement from the board

2.7 Boards (or their equivalent) should declare their accountability for the content of their Quality Accounts by signing up to a statement from the chief executive of the body, summarising the trust's view of the overall quality of the services that it provides. This statement will show that the board has a clear commitment to improving the quality of care.

2.8 The purpose of this statement is to ensure board approval that the Quality Account is both accurate (the data are correctly reported) and representative (the conclusions drawn from the data are reasonable and represent the overall status of quality within the organisation). This mirrors the sign-off given to a financial account, and represents the board's own confirmation that it stands by the content of its report. Some providers may be individuals, partnerships or bodies which are not incorporated and do not have a formal board structure. How these organisations respond to this statement will have to be considered.

2.9 It is proposed that this statement should be mandated in the regulations for Quality Accounts.

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

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

2 – Priorities for improvement

2.10 It is proposed that a Quality Account should include a description of areas for improvement including:

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

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

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

3 – Review of quality performance

i. Indicators of quality

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

- safety;
- effectiveness;
- patient experience.

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

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

ii. Review of services

2.14 We propose that providers should supply information on the review of services, in a statement to the effect of:

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

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

2.16 Providers will want to consider building quality improvement processes into their organisational structure including, for example, through clinical dashboards, scorecards and other analytical tools, and explain in their Quality Account how they have conducted their review of services.

2.17 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 in carrying out this review boards will want to consider commissioning an expert analysis of their 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.

2.18 It is proposed that this statement should be mandated in the regulations for Quality Accounts.

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

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

iii. Participation in clinical audits

2.19 We propose that providers should supply information on participation in clinical audits, in a statement to the effect that:

> "The trust was eligible to participate in [n] national clinical audits and related clinical quality data collection programmes, such as national confidential enquiries, covering services it provides. It elected to participate in [n] of these. The full list of potential audits and those the trust participated in are listed in appendix [n].
>
> In relation to the trust's participation:
>
> - The trust participated in [n%] of the clinical audits for which it was eligible.
> - Of the clinical audits in which the trust participated, the care of [n%] of eligible patients was measured during the reporting period.
> - [n%] of patients are not covered by available audits during this period.
> - The proportion of incomplete data within the year reported on in the clinical audits undertaken was [n%]."

Data on performance against the standards contained within the audit are available via the Healthcare Quality Improvement Partnership's (HQIP's) website (www.hqip.org.uk), which contains links to the audit reports. Department of Health guidance will advise on how providers can present data in relation to performance as shown in clinical audit data from both national and local audits.

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

2.20 This statement covers local and local-network clinical audits and specifies how a trust must report on its participation. Clinical audit is a professional quality improvement activity led by clinicians that enables managers, patients, commissioners and clinicians to understand and demonstrate how an organisation is delivering high-quality patient care in line with recommended standards, and provides data to enable quality improvement to take place.

2.21 The purpose of including this statement is that presenting data on its level of participation in clinical audit enables a provider to communicate to its key stakeholders that it monitors 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 the organisation and that participation is a requirement for clinical teams and individual clinicians as a means of monitoring and improving their practice.

2.22 It is proposed that statements in this form should be mandated in the regulations for Quality Accounts.

2.23 In the accompanying Department of Health guidance, providers will be encouraged to describe how, in addition to participation in clinical audits, they have performed against the standards given. While participation in both national and self-directed local clinical audits sets out a minimum assurance about attention to clinical quality within the trust, presentation of data about levels of performance gives more detail to key stakeholders about the levels of quality achieved.

2.24 The guidance will provide advice on how data from clinical audit can be set out and reported in the locally determined sections of a provider's Quality Account. Further guidance available from the HQIP covers how a provider can improve its audit work and how audit data can be used by consumers, including patient groups, to inform choice and improve confidence in clinical quality.

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

4 – Research and innovation

i. Participation in clinical research

2.25 We propose that providers should report on the following statement:

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

2.26 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 which has received a favourable opinion from a research ethics committee within the National Research Ethics Service (NRES). Information about clinical research involving patients is part of the records that NHS reporting bodies routinely have to keep in accordance with section 3.10 of the Research Governance Framework for Health and Social Care. This information is therefore readily available from providers.

2.27 It is proposed that a statement in this form should be mandated in the regulations for Quality Accounts.

2.28 Department of Health guidance will suggest that providers report this indicator in a context that makes it meaningful. For example, where relevant and where data are locally available, it may be expressed as a percentage of patients in the eligible disease groups and/or compared with the figures for previous reporting years. We will also encourage the NHS to report on other areas that demonstrate its commitment to research as a driver for improving the quality of care and to the patient experience in relation to research. Information on research projects which have received a favourable opinion from a research ethics committee is published by NRES.

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

ii. Use of the Commissioning for Quality and Innovation payment framework[5]

2.29 We propose that the provider should supply information on the use of the CQUIN payment framework, in a statement to the effect that:

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

2.30 The CQUIN payment framework aims to support the cultural shift towards making quality the organising principle of NHS services. In particular, it aims to ensure that local quality improvement priorities are discussed and agreed at board level within (and between) organisations.

2.31 The CQUIN payment framework is intended to embed quality at the heart of commissioner-provider discussions by making a small proportion of provider payment conditional on locally agreed goals around quality improvement and innovation (0.5% contract value in 2009/10). It is an important lever to help make quality the organising NHS principle, supplementing Quality Accounts.

2.32 It is proposed that a statement in this form should be mandated in the regulations for Quality Accounts.

2.33 The inclusion of the CQUIN payment framework as a nationally mandated statement in Quality Accounts would ensure that:

- the relationship between Quality Accounts and CQUIN schemes is clear to local organisations and the public, helping **system alignment**;
- **providers are required to be transparent** about whether they are agreeing quality improvement and innovation goals with their commissioners, and earning part of their income by making improvements;

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

- providers are required to make the full detail of the quality improvement goals agreed with their commissioners available on request, which is a crucial **driver for improvement**.

2.34 If the CQUIN payment framework is not being applied to provider income, then this information could prompt questions about the extent to which quality improvement and innovation feature within contract negotiations and management. Use of the CQUIN payment framework, on the other hand, indicates that the provider is actively engaged in quality improvements with its 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 the provider's contribution to quality improvement in local health services more broadly.

2.35 Providers may choose to expand further on their agreed goals, the rationale behind them (e.g. how they fit with local or regional strategies) and the level of associated payments in their Quality Account.

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

5 – What others say about the provider

i. Statements from the Care Quality Commission

2.36 We propose that the provider should supply information relating to registration with the CQC and periodic or special reviews, in statements to the effect that:

[for all providers]

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

[for NHS bodies]

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

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

2.37 Providers should state their CQC registration status, any conditions placed on the provider and any action required. This statement should refer to a provider's current status (at the time of publication), not just status at the end of the financial year. Providers should state any conditions or action required since the start of the reporting year. For the first year of Quality Accounts (2009/10), providers will be asked to report on Healthcare Associated Infection (HCAI) registration, as well as any action required by the CQC in relation to full registration.

2.38 NHS provider periodic review will include an assessment of performance against national priority and existing commitments indicators. NHS bodies should report on the latest available periodic review, published by the CQC.

2.39 The CQC's national programme of special reviews is developed in response to identified risks in the system. They then include all relevant providers, or target providers where there is evidence of poor performance.

2.40 It is proposed that statements in this form should be mandated in the regulations for Quality Accounts.

2.41 In Department of Health guidance, providers will be encouraged to include details of how they responded to other CQC reviews. Providers can refer

to the CQC for further information in relation to registration or other assessments.

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

ii. Statement from Local Involvement Networks and primary care trusts

2.42 Providers will be encouraged to include in their Quality Accounts a response from their LINks and their lead (the co-ordinating commissioner) PCT(s) on their view of their Quality Account (a description of the PCT's additional role in assurance is at paragraph 2.61).

2.43 Department of Health guidance will advise that providers should consider sharing the proposed content of their Quality Account at an early stage with commissioners, their own staff and patient groups such as LINks. This is to ensure that the proposed content is a fair representation of the quality of the health services provided and that it highlights areas that are of particular interest to the local community.

2.44 We propose that the regulations would require providers to send copies of their Quality Account to their relevant LINks and to their lead PCT prior to publication for comment, and require the provider to include those comments in the published Quality Account.

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

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

6 – Data quality

2.45 We propose that providers should supply information on the quality of data, in statements to the effect that:

> "In records submitted to the Secondary Uses System (SUS) for inclusion in Hospital Episode Statistics (HES), the percentage of records including the valid patient's NHS Number was [n%]."
>
> "The trust's error rate for clinical coding (for diagnosis and treatment coding), as reported by the Audit Commission in the latest Payment by Results (PbR) clinical coding audit, is [n%]."
>
> "In records submitted to the Secondary Uses System (SUS) for inclusion in Hospital Episode Statistics (HES), the percentage of records including the valid patient's General Practitioner Registration Code was [n%]."
>
> "The trust's score for Information Quality and Records Management, assessed using the Information Governance Toolkit, was [n%]."

2.46 Good quality information underpins the delivery of effective 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 help improve patient care and improve value for money.

2.47 We have selected four key indicators that seek to highlight data quality in a Quality Account and its relation to quality healthcare.

2.48 The patient NHS Number is the key identifier for patient records. The National Patient Safety Agency has identified that the largest single source of nationally reported patient safety incidents relates to the misidentification of patients. Improving the quality of NHS Number data has a direct impact on improving clinical safety.

2.49 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 patient records. Information about the clinical coding audit is available from the Audit Commission.

2.50 Accurate recording of the patient's GP practice is essential to enable the transfer of clinical information about the patient from a trust to the patient's GP. Information on the capture and validation of registered GP practice on referral or accident and emergency attendance can be sourced from the Spine Personal Demographics Service or Open Exeter.

2.51 The Information Quality and Records Management scores assessed within the Information Governance Toolkit provide an overall measure of the quality of data systems and processes within an organisation. The scores cover requirements for formally checking data processes and the accuracy of patient records. Information about the Information Governance Toolkit is available from Connecting for Health.

2.52 Department of Health guidance will include information on how providers can use indicators from their Information Governance Toolkit to describe the quality of information systems and processes operating in their organisation.

2.53 It is proposed that statements in this form should be mandated in the regulations for Quality Accounts where the statement is relevant to the provider (i.e. those providers not submitting data to the Secondary Uses System will not complete the statements relating to this system).

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

Rationale for the proposed nationally mandated statements

2.54 The nationally mandated sections proposed in Quality Accounts would serve to offer the public assurance that the organisation as a whole is performing to required standards (such as meeting CQC registration) and measuring its clinical processes and performance (for instance through participation in national and local clinical audits); and also that it is involved in national cross-cutting projects and initiatives aimed at improving quality (for instance through recruitment to clinical trials or through establishing improvement and innovation goals with the commissioner using the payment framework for CQUIN).

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

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

2.55 Further information on choosing content for a Quality Account is provided in Annex D.

Assurance processes for Quality Accounts

2.56 There are two discrete elements in a Quality Account that require some level of assurance so that users, whether board members or patients, can have confidence in its contents. The first is whether the data are reported accurately – this is about not only the *quality* of the data but also the *interpretation*. The second is whether the Quality Account is representative in its reporting of the services provided and the issues of concern to stakeholders. While it is primarily the provider's responsibility to ensure that its Quality Account meets these requirements, much of the data used in a Quality Account will come from nationally collected sources, validated by other organisations. This gives some assurance over data accuracy.

2.57 For example, while the CQC will not be either scrutinising or validating Quality Accounts, its work means that it routinely gathers intelligence about and checks data from NHS providers, as part of its role in registering providers and periodically reviewing their performance. The CQC may therefore spot factual inaccuracies and/or significant omissions in those parts of a Quality Account that relate to its responsibilities. The Health Bill 2009 therefore obliges providers to make corrections to their Quality Accounts if notified of an error or omission by the CQC and to republish the account within 21 days, correcting the error or omission and including a statement explaining the correction. The Bill also gives commissioners (through the strategic health authority) a similar role in relation to the data reported to them.

2.58 We are also recommending that a nationally mandated statement is included in Quality Accounts which refers specifically to data quality (see paragraph 2.45), with the aim of improving the accuracy of clinical data recording and reporting. We also will ask boards to self-certify that they are accountable for the content of the Quality Account and to confirm that it is both accurate and representative.

2.59 However, one key message from our engagement activity is that confidence in the assurance process is key to maximising confidence in the Quality Accounts themselves. We therefore carried out a study of the available options on assurance (summarised below), including those used in other countries and in other areas of activity, which we will develop further.

2.60 As a first step, we are requiring lead (co-ordinating commissioner) PCTs to endorse a provider's Quality Account – i.e. to confirm that they believe that it fairly represents and interprets the data, and gives a comprehensive coverage of the providers' key services. To achieve this, the regulations will require providers to send a draft of their Quality Account to the lead (the co-ordinating commissioner) PCT(s) before publication. The Department of Health will direct PCTs (under the National Health Service Act 2006) to validate the data and check their accuracy, and providers will be required to make any necessary amendments. To make this process run more smoothly, we propose that our guidance would suggest that providers share their planned content at an early stage with commissioners, and also with their other stakeholders – including their own staff, and patient groups (for example LINks). This would help ensure that the proposed content is representative (not every service will be reported on, but the report should be unbiased in what it reports on) of the quality of the health services provided, and that it covers topics that are of particular interest to the local community.

2.61 In response to concerns raised by stakeholders, we propose to build on this basic process and step up the level of assurance by introducing further levels incrementally. For example, we will consider introducing 'trust to trust', stakeholder and/or independent peer reviews, which will test both accuracy and representation. These exercises may be undertaken as part of the board's own assurance process, or as part of an external audit.

2.62 Although we intend to explore further the external audit option, we do not believe that it is necessarily the best option for every Quality Account at this stage. However, providers can consider commissioning an independent review of a specific risk area as part of their own internal assurance processes, or seek assurance through a third party. That might also be an option for stakeholders to seek as part of their sign-off.

2.63 We consider that these options are interlinked and complement one another, and that none on its own can provide exactly the level of required assurance. We propose to develop a spectrum of assurance mechanisms to support the assurance process. These will not replace the accountability of the board

for the accuracy of its own Quality Account. Key issues for an assurance mechanism to address include ensuring that providers explain how their locally determined improvement goals (i) came to be chosen; and (ii) differ from the requirements set by the NHS Operating Framework and as such those used by the CQC in its periodic review. We will develop these options with stakeholders over the course of the next 12 months.

Publication of Quality Accounts

2.64 The proposed legislation set out in the Health Bill 2009 requires providers to supply a copy of their Quality Account to the Secretary of State in any form specified by the Secretary of State for the purpose of making the document available to the public.

2.65 It is proposed that all providers should publish their Quality Account on the NHS Choices website. Providers would be able to do this themselves by updating their general description profile. The Department of Health is considering whether a tool that assists readers in comparing information between providers should be adapted to allow comparison between the nationally mandated statements.

2.66 The Department of Health proposes that the regulations would require providers to publish their Quality Accounts (and send a copy to the Secretary of State) by the end of June each year. In relation to NHS bodies, this ensures that their Quality Accounts will align with their annual report and accounts. It is accepted that some data on the quality of health services for the previous financial year might not be available within that timescale, or if submitted to a national body may not yet be validated. Providers would be asked to use the 'latest available data' and state whether the source of the data is a national body (e.g. the NHS Information Centre) or whether it has been derived from local sources.

2.67 During the testing period in 2009, NHS foundation trusts were required to present their Quality Account as part of their annual report and accounts. This is one method of ensuring consistency across the financial reporting and Quality Accounts publication period. A separate 'Quality Accounts' document is required for publication. We will require providers to submit an electronic version of their Quality Accounts for publication on the NHS Choices website. NHS foundation trusts will continue to be required to publish their Quality Accounts in their annual reports and accounts.

2.68 The legislation states that each provider must make available hard copies of the Quality Accounts for the previous two years to any person who requests it.

2.69 Providers should also consider the communication needs of their local community and whether it is appropriate to communicate all, or part, of a Quality Account in different languages or formats (e.g. Braille). They should also consider distribution methods for those members of the community who may not have access to the internet, having regard to their duties under equality legislation when preparing their Quality Accounts.

2.70 Providers may also want to consider developing a public-facing summary leaflet of their Quality Account.

Q16: Do you agree with the proposed publication methods?

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

3. Which organisations will be required to provide a Quality Account?

3.1 The Health Bill 2009 envisages that, all providers of healthcare services in England given under the auspices of the NHS will be required to provide a Quality Account from April 2010. Such services are those provided under section 1(1) of the National Health Service Act 2006. This includes providers of health services provided jointly with another person and services provided under sub-contracting arrangements. It also includes private sector organisations contracted to provide NHS services. This therefore gives, in the first instance, complete coverage of the requirement to produce Quality Accounts for NHS healthcare.

3.2 Any exemptions to this requirement will be made through regulations. For the first year of Quality Accounts, only NHS trusts and NHS foundation trusts and their private or voluntary sector equivalents will provide a Quality Account. This includes NHS acute trusts, mental health trusts, learning disability trusts and ambulance trusts. Private or voluntary sector equivalents would cover providers of NHS acute, community and mental health services (subject to an exemption relating to small providers). All other healthcare providers (in particular providers of primary care and organisations that provide only community health services) will be exempt in the first year.

Consequently, this consultation relates largely to those organisations which will provide a Quality Account in the first year, although the underlying principles remain relevant to all healthcare providers, as they provide the basis for future years.

3.3 We are starting a process of engagement, testing and consultation with primary care and community services providers in autumn 2009. Some of the questions in this consultation relate to how and when Quality Accounts should be introduced into the primary care and community services sectors.

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

3.4 The duty to provide a Quality Account will also extend to non-NHS organisations that provide NHS care (for example private hospitals), and

this will ensure that patient accountability extends across care pathways. Discussions with stakeholders to date indicate that they support this approach.

Exemption of small providers

3.5 We intend to exempt providers that do not have a significant NHS workload. In the absence of any other definition of what constitutes a small-scale provider, we propose that providers which treat fewer than 100 NHS patients each year or with a yearly NHS contract worth less than £100,000 should not be subject to the duty to publish a Quality Account.

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

Timescale for inclusion of primary and community care sector

3.6 The current plan is to introduce Quality Accounts for primary and community care sectors from 2011. An engagement and testing process, similar to that run within NHS foundation trusts and NHS East of England providers but focused on the particular needs of these two sectors, is due to commence in autumn 2009 and will deliver test reports in June 2010. This will help shape the development of Quality Accounts further as they begin to apply to all providers.

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

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

Organisation type*	Common names	Services provided	Date of regulations' coming into force	Reporting year for first Quality Account	Publication date for first Quality Account
NHS trusts and NHS foundation trusts	Acute trust Foundation trust Ambulance trust Learning disability trust Care trusts (other than PCT care trusts) Mental health trust	Acute Ambulance Community services Mental health services	1 April 2010	2009/10	June 2010
Primary care trusts (PCTs)	PCT Primary care provider arm PCT care trusts	Community services Primary care Out-of-hours care NHS walk-in centres	1 April 2011	2010/11	June 2011**
Primary care contractors	GP Dentist Community pharmacist Dispensing appliance contractors Optometrist	Primary care Community services Out-of-hours care	1 April 2011	2010/11	June 2011**

* and private or voluntary sector equivalents.
** subject to testing and evaluation exercise.

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

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

(The report on the Quality Accounts testing exercise is available at: www.dh.gov.uk/qualityaccounts)

4. Overview of the consultation process

4.1 This consultation will run from 17 September to 10 December 2009.

4.2 You can respond to this consultation by completing the accompanying questionnaire and emailing it and any other comments to QualityAccounts@dh.gsi.gov.uk

4.3 We will respond to this consultation prior to laying the regulations for Quality Accounts early in 2010.

4.4 This consultation follows the Government's Code of Practice on Consultation. In particular we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks with consideration given to longer timescales where feasible and sensible;
- be clear about the consultation process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure that the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach. We will make particular efforts to reach equality target groups, including those who are seldom heard by public bodies;
- keep the burden of consultation to a minimum to ensure that consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure that officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the Code of Practice is on the Better Regulation website at: www.berr.gov.uk/whatwedo/bre/consultation-guidance/page44420.html

Comments on the consultation process itself

4.5 If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:

Consultations Co-ordinator
Department of Health
3E48, Quarry House
Leeds LS2 7UE

E-mail: consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

4.6 We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter at: www.dh.gov.uk/en/FreedomOfInformation/DH_088010

4.7 Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

4.8 If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, among other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

4.9 The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

4.10 A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the consultations website at: www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm

Annex A: Evaluation of the Quality Reporting process for 2008/09

In June 2009, in the run-up to the publication of Quality Reports by all NHS foundation trusts and NHS trusts in the East of England for 2008/09, the Department of Health commissioned a comprehensive survey of the organisations that participated in the testing exercise. The research also evaluated the content and presentation of a selection of Quality Reports.

Key findings from this study were that:

- even in the short time available for this test, the Quality Report process helped to reinforce engagement in the quality agenda;
- organisations successfully used existing indicators or indicators that were suggested nationally;
- on average, both the reported financial and non-financial burdens for producing a Quality Report were relatively low – typically organisations spent £14,000–£22,000 and around 30 person-hours producing the report;
- some respondents felt that they would have more involvement from stakeholders when deciding the content of the Quality Reports;
- the majority (72%) of those responsible for the production of the Quality Report were clinically qualified, the majority of whom were nurses.

The study looked at 16 reports in depth and concluded that:

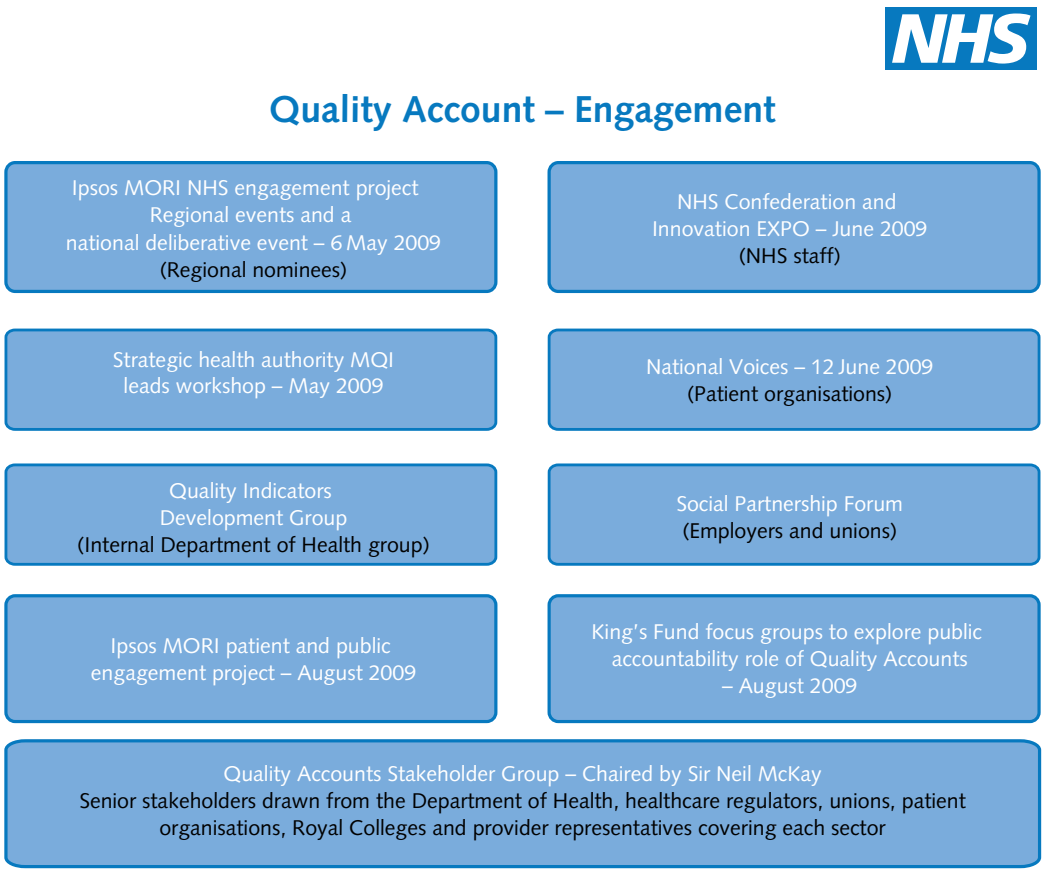
- most Quality Reports made a clear case for improving quality in the organisation but also needed to link their quality agenda with their business and strategic objectives;
- organisations needed to engage more with staff and patients in order to help shape the quality agenda (this was an acknowledged challenge, and was made a priority for the following year);
- most Quality Reports gave a good account of how the status of quality was monitored within the organisation, but more work was needed on demonstrating how continuous improvement would be measured and managed.

The full report of this evaluation, including the results from the telephone survey, evaluation of a selection of Quality Reports and recommendations made, is published in a separate document on the Department of Health website at: www.dh.gov.uk/en/Healthcare/Highqualitycareforall/Qualityaccounts/index.htm

The conclusions from this report have been used to develop our proposals for Quality Accounts.

Annex B: Stakeholder engagement – Who has been involved so far in the design of Quality Accounts?

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



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

Quality Accounts Stakeholder Group

We established a Quality Accounts Stakeholder Group in December 2008 to consider the development and delivery of Quality Accounts. This group has played a key role in the development of Quality Accounts by shaping the policy, giving direction and engaging with different stakeholders. The group is chaired

by Sir Neil McKay, Chief Executive of NHS East of England, and members include senior stakeholders drawn from the Department of Health, healthcare regulators, the Royal Colleges, trades unions and patient organisations. It also has representatives from across different healthcare providers, including the independent healthcare sector.

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

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

Ipsos MORI NHS engagement project

As part of the engagement process, Ipsos MORI was appointed to facilitate a series of regional events to discuss Quality Accounts, culminating in a national deliberative event held on 6 May 2009 in London, which brought together nominated representatives from all of the regions. This work was jointly commissioned with NHS East of England, the Care Quality Commission (CQC) and Monitor.

The national deliberative event discussed the purpose, content, publication and validation of Quality Accounts and the full Ipsos MORI report can be found at: www.dh.gov.uk/en/Healthcare/Highqualitycareforall/Qualityaccounts/index.htm

Patient and public engagement project

Over the summer, we focused our engagement efforts particularly on gaining views from the public, service users and patient organisations. We ran a joint engagement exercise with the CQC and patient organisations to discuss how best to engage patients and the public in Quality Accounts and the role of Local Involvement Networks (LINks). We jointly commissioned Ipsos MORI to run workshops with the public and LINks representatives. The King's Fund also ran two workshops with patient representatives. We also held a joint workshop with National Voices, attended by representatives of around 25 patient organisations, which looked at how Quality Accounts could be most meaningful to patients.

The full Ipsos MORI patient and public engagement report is published separately from this document and will be available on the Department of Health website

from September 2009 at: www.dh.gov.uk/en/Healthcare/Highqualitycareforall/Qualityaccounts/index.htm

The advice from all our stakeholder and engagement activities, which included over 1,000 stakeholders, has fed directly into our detailed proposals for Quality Accounts.

Annex C: Proposed scope of the regulations for 2010

Statement from the board

We propose that the regulations specify that a Quality Account should contain a statement from the board to the effect that:

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

Priorities for improvement

It is proposed that the regulations would specify that the Quality Account must include a description of areas for improvement. In particular, the regulations would require that the description includes the three points outlined below:

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

We propose that the regulations would require that providers include in their Quality Account information on the quality of services in the form of statements on the following lines:

Review of services

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

Participation in clinical audits

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

In relation to the trust's participation:

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

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

Participation in clinical research

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

Use of the Commissioning for Quality and Innovation (CQUIN) payment framework

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

Statements from the Care Quality Commission (CQC)

[for all providers]

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

[for NHS bodies]

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

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

Data quality

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

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

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

"The trust's score for Information Quality and Records Management, assessed using the Information Governance Toolkit, was [n%]."

Validation and assurance processes for Quality Accounts

Regulations would require providers to share their Quality Account with the lead (co-ordinating commissioner) primary care trust (PCT) and with relevant Local Involvement Networks.

Directions under the National Health Service Act 2006 would require the lead PCT to validate a provider's Quality Account.

Annex D: Proposed scope and content of the supporting Department of Health guidance

Our stakeholder engagement work highlighted a number of issues (the details are set out in the section below 'Designing your Quality Account – advice based on discussions with our stakeholders') that we felt would be best covered through guidance rather than regulation. These are the areas that need to be worked through on the ground. This will give Quality Accounts that local flavour that has most meaning for patients and the public.

Therefore, alongside the regulations and statutory guidance for Quality Accounts, the Department of Health will also publish supporting advisory guidance to support providers as they develop Quality Accounts in 2010. This advisory guidance will be presented in the form of a toolkit and will be finalised and published once the results of the consultation are reported.

The toolkit will consolidate understanding of the purpose of Quality Accounts and will suggest ideas to consider while producing them, based on what the public, NHS staff and other interested parties have said during the national engagement and Quality Reporting processes.

The outline of the chapters which we propose to include in the toolkit is set out below. Each chapter will draw on the findings from the engagement and Quality Reporting exercises during the development of Quality Accounts, present advice to providers as a result and show a range of examples through case studies, quotes and other presentation tools.

The proposed content for the toolkit is:

- Quality Accounts – what are they and what are they for?
- What might a Quality Account look like?
- Who should decide what goes into a Quality Account?
- Making sense of information – telling your story.
- How should Quality Accounts be published?
- Organisational systems and processes – showing how quality is being improved.
- The role of patient organisations (such as Local Involvement Networks) and commissioners in the development of Quality Accounts.

- What next? – evaluating and continuing improvement.
- Useful resources.
- Glossary.

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 it is by producing them and learning from the process that these will grow to reach their full potential. Therefore the toolkit will also need to grow and be updated on a regular basis, so that organisations can share and learn from best practice.

Designing your Quality Account – advice based on discussions with our stakeholders

In advance of the toolkit becoming available, there are some issues that providers can start to work through now.

Quality Accounts should consist of locally meaningful content based on locally determined priorities. The process of deciding the locally determined content of Quality Accounts should involve local stakeholders, including patient and public representatives. The Quality Account should contain information relating to the quality of services that the organisation provides. It therefore should reflect the type of organisation you are (for instance acute trust, mental health, ambulance etc.) and show data relevant to specific services and specialties which cover the three domains of quality highlighted in *High Quality Care for All*: safety, effectiveness and patient experience.

Information should be presented in both quantitative and qualitative formats so that it is meaningful for the wider public, choosing a selection of metrics which offer both organisational (for instance healthcare-acquired infection rates) and service-specific indicators of quality.

The Quality Account should also contain details of a local improvement plan, providing a forward look at priorities. It should offer the reader the opportunity to understand what improvements (specifically related to the quality of healthcare services provided) the organisation plans to make over the next year.

As Quality Accounts are annual reports, we expect to see continuity between them as time progresses. Organisations should report on progress against priorities in their Quality Accounts the following year.

The Quality Reports produced during the testing process showed that setting out between three and five priorities was manageable. Additional advice on how to set out the local section of a Quality Account will be provided in Department of Health guidance as outlined above. For instance, a provider may wish to consider linking the three domains of quality set out in *High Quality Care for All* – safety, effectiveness and patient experience – to their priorities, allocating at least one improvement priority to each.

Support in choosing indicators – Indicators for Quality Improvement

Indicators for Quality Improvement (IQI) have been developed to help local clinical teams measure what they do to improve the quality of care they deliver to patients.

In *High Quality Care for All*, the final report of the NHS Next Stage Review, Lord Darzi set out ambitious commitments for making quality improvement the organising principle of the NHS. His vision was that all NHS staff will measure what they do as a basis for transforming quality. The IQI are a resource for local clinical teams to do this – providing a set of robust indicators which they can select from as the basis for local quality improvement.

This initial menu of over 200 indicators was drawn together following extensive consultation with NHS professionals and professional bodies. This helped to determine which indictors were considered good measures of quality.

These indicators are primarily intended for use by NHS staff. Supported by appropriate statistical techniques to analyse and interpret the data, they will inform quality improvement activities. This includes the ability to use the data to benchmark between providers and against the national average. We anticipate that as Quality Observatories are developed, they will have a role in supporting such analysis. The timeliness of the latest available data provided by the IQI will be dependent on the source of the data collection.

This is an *initial* menu of indicators – currently drawn together from indicators in existing national sets. It will be updated and improved to expand the list and ensure the indicators comprehensively cover the three domains of quality and all care pathways. We are currently defining the process for developing new indicators.

We will engage key stakeholders on proposals to develop further tools to support useful analysis of the IQI to drive quality improvement. We expect indicators from

the IQI to be used to populate provider Quality Accounts – some as core elements of the report and others selected by providers for the locally determined element of their Quality Account. There will be expertise available to consult on this within regional Quality Observatories.

Descriptions of the indicators with accompanying data can be found on the NHS Information Centre website at: www.ic.nhs.uk/services/measuring-for-quality-improvement

Annex E: Where to find examples of Quality Reports

University College London Hospitals NHS Foundation Trust
www.uclh.nhs.uk/Publications

Wrightington, Wigan and Leigh NHS Foundation Trust
www.wiganleigh.nhs.uk/Internet/About_Us/annual_reports.asp

The Queen Elizabeth Hospital King's Lynn NHS Trust
www.dh.gov.uk/Qualityaccounts

Annex F: Glossary

Acute trusts

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

Ambulance trusts

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

Audit Commission

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

Board (of trust)

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

Care Quality Commission

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

Clinical audit

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

Commissioners

Commissioners are responsible for ensuring adequate services are available for their local population by assessing needs and purchasing services. Primary care trusts (PCTs) are the key organisations responsible for commissioning healthcare services for their area. They commission services (including acute care, primary care and mental healthcare) for the whole of their population, with a view to improving their population's health.

Commissioning for Quality and Innovation

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

Community services

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

Department of Health

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

Foundation trusts

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

Health Bill

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

Healthcare

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

Healthcare Quality Improvement Partnership

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

High Quality Care for All

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

Hospital Episode Statistics

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

Indicators for Quality Improvement

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

Learning disability trusts

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

Local Involvement Networks

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

Mental health trusts

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

Monitor

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

National Patient Safety Agency

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

National patient surveys

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

National Research Ethics Service

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

NHS Choices

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

NHS East of England

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

NHS Next Stage Review

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

National Institute for Health and Clinical Excellence

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

NICE quality standards

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

Overview and scrutiny committees

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

Periodic review

Periodic reviews are reviews of health services carried out by the CQC. The term 'review' refers to an assessment of the quality of a service or the impact of a range of commissioned services, using the information that the CQC holds about them, including the views of people who use those services. Visit: www.cqc.org.uk/guidanceforprofessionals/healthcare/nhsstaff/periodicreview2009/10.cfm

Primary care trusts

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

Providers

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

Quality Framework

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

Quality Reports

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

Registration

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

Regulations

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

Research

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

Secondary Uses System

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

Special review

A special review is a review carried out by the CQC. Special reviews and studies are projects that look at themes in health and social care. They focus on services, pathways of care or groups of people. A review will usually result in assessments by the CQC of local health and social care organisations. A study will usually result in national-level findings based on the CQC's research. Visit: www.cqc.org.uk/guidanceforprofessionals/healthcare/nhsstaff/specialreviews/specialreviewsandstudies2009/10.cfm

Strategic health authority

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

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

- developing plans for improving health services in their local area;
- 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;
- 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.

The King's Fund

The King's Fund is an independent charitable organisation that works to improve healthcare in the UK by providing research and health policy analysis.

Vital Signs

The Operating Framework, published in 2007, introduced a new approach to planning and managing our priorities both nationally and locally – the Vital Signs. Visit: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082542

Annex G: Acknowledgements

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