

Consultation response

Response to the framework for quality accounts

10 December 2009

The King's Fund is a charity that seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

We are currently undertaking a research project looking at the public accountability function of quality accounts, involving focus groups with members of Local Involvement Networks (LINKs), Overview and Scrutiny Committee (OSC) members, patient group and voluntary sector representatives, and foundation trust members and governors. This project will be reporting in early 2010, but initial findings from this research have informed this consultation response. More detailed results can be made available on request.

Summary of our response

While we support the policy objectives behind the introduction of quality accounts – to drive quality improvement and increase public accountability– we have a number of reservations about whether they can achieve these objectives. We also have comments about the detail of the proposals.

- We do not believe the proposed assurance process provides meaningful independent assurance of the accounts. While on balance we accept that costly new mechanisms for external assurance should not be introduced, at least in the first year, we believe that public trust and confidence in quality accounts could be improved through:
 - the use of nationally assured indicators such as the Indicators for Quality Improvement
 - mandating the inclusion of a set of national indicators to increase the comprehensiveness and consistency of the quality accounts
 - requiring the inclusion of comparative/benchmarked data wherever possible
 - supporting and encouraging trusts to give due attention to involving and engaging staff and the local community in the selection of both indicators and priorities.
- We believe the proposed timetable will be extremely challenging for primary and community care in general, and general practices in particular. We recommend that further piloting is done for types of organisation that face particular legal and practical challenges in fulfilling these proposals, such as voluntary hospices.
- While we welcome the inclusion of statements on data quality, they will need further work to define for non-acute trusts, and we have some recommendations for alternatives.
- While quality accounts will necessarily focus on organisations' own performance, we recommend that the Department explicitly encourages organisations not to let the quality accounts process stop them from also focusing on the quality of care across and between organisations, along care pathways.

Structure and content

Statement from the board

1. 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?

Yes; however, it is unclear what 'representativeness' means in this context. In the proposals, the board statement would confirm that the quality account is 'representative', meaning that it represents the 'overall status of quality' within the organisation. Quality accounts can only provide a partial picture if they are to be readable. Boards should describe how they went about selecting the priorities and indicators they are reporting on and confirm that the figures are accurate.

Further, for quality to become embedded at all levels of the organisation, there needs to be a continuous focus on it by the board with a system of accountabilities and processes below board level where quality is systematically and regularly monitored. Boards should receive regular reports on quality and track progress and performance. If preparing a quality account is seen as only an annual exercise, the focus on quality will fail to take hold.

Non-executive directors may need additional support in interpreting and challenging reports on quality. The King's Fund runs a number of programmes with boards, including the London Board Leadership Programme, which seeks to maximise the contribution of chairs and non-executive directors to the effective leadership of the NHS, and a programme to strengthen the board-level leadership around quality and the patient experience.

The issues around board ownership will be magnified to some extent for foundation trust governors, who on the whole have even less time than board members to spend on trust business, with the exception of the most committed. Foundation trust governors will need specific support to interpret quality information. We recommend that foundation trusts build this support into any development programmes they have for their governors, or ensure that it is provided via third parties such as the Foundation Trust Governors' Association.

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

The most senior individual in the organisation with a role equivalent to a Chair or a Chief Executive should be required to write the statement.

Priorities for improvement

3. 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?

Yes to both. It is important to show not only progress over time but also progress as compared to other similar organisations where possible. See our comments on benchmarking data in answer to question 4 below.

Review of quality performance

Indicators of quality

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

Yes, as a minimum, but the guidance should explicitly encourage more than this, particularly for complex organisations.

Nationally assured menu of indicators

We support the proposal to advise organisations to make use of nationally assured, standardised indicators where possible, such as the Information Centre's Indicators for Quality Improvement. Nationally produced indicators will help to avoid wasteful duplication, ensure consistency of data definitions and standards, and maximise analytical rigour and cost-effectiveness by minimising the demands on limited local analytical capabilities. They would also make comparisons between quality accounts more accurate, strengthening public accountability and increasing public trust and confidence in the documents.

Nationally mandated indicators

Separate to providing a nationally assured menu of indicators from which organisations could select, the earlier proposals for quality accounts also mandated the inclusion of particular indicators, related to major national priorities such as infection control. We are disappointed to see that this earlier proposal for a section devoted to a set of nationally mandated quality metrics has been dropped. While we support the idea that quality accounts should have some locally determined content, and understand the concern that inclusion of specific national data would make these metrics appear to be major national priorities with a status higher than other issues, we believe the indicators of quality should also include some nationally mandated indicators for the reports to be sufficiently comprehensive and comparable.

We also believe that nationally mandated indicators would have the further benefit of enabling public accountability on the progress of particular national strategic priorities, which could change from year to year, such as the end-of-life care strategy and the dementia strategy.

Our focus group participants particularly liked the combination of information they saw in some of the pilot quality reports where a small number of local priorities were set out but a table of standard quality information was also provided to give a more general overall picture.

Benchmarking data

Crucially, benchmarking data must be included for each metric if the data is to be meaningfully interpreted. We recommend that the guidance requires the inclusion of benchmarking data (such as a national average or a peer group average) alongside every metric where it is available. We recognise that this may be particularly challenging for some metrics and some organisations, such as independent sector providers, and so we recommend that the guidance encourages organisations to seek advice – for example, from Quality Observatories and the NHS Information Centre Indicators for Quality Improvement programme – for sources of benchmarking and comparative data.

Definition of quality

Our focus group participants defined quality more broadly than effectiveness, safety and experience, although these were very important to them. Participants were also keen to see information about:

- access to services
- cost-effectiveness
- health promotion activity
- equity and inequalities
- co-ordination of care between organisations.

Quality accounts inevitably have an organisational focus. This risk is that this will deter organisations from considering quality across organisational boundaries, and across health and social care, which is increasingly important for people with long-term conditions or, for example, those with complex needs such as people with mental health or substance misuse problems. Our focus group participants highlighted co-ordination of care between organisations as a top priority for them. We recommend that the Department of Health guidance explicitly encourages organisations not to let the quality accounts process stop

them from also focusing on the quality of care across and between organisations, along care pathways.

Review of services

5. 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?

No, not fully. We understand that this section is proposed to demonstrate that although the quality account can necessarily report on only a limited number of priorities and indicators, the board is concerned with quality across all its activities. However, a simple percentage of services covered in a one-off review exercise provides little indication of this. Rather, we would recommend a description of the processes that the board uses throughout the year to monitor quality and of how this is cascaded down the organisations to drive quality improvement. See our related comments in answer to question 1.

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

Yes; without that the statement is too simplistic to be useful.

Participations in clinical audits

7. 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.

A simple statement demonstrating participation has some value but gives little insight into how engaged organisations truly are in clinical audits and how they respond to and use the information audits provide to improve care. It is also doubtful that the percentages can be completed in a meaningful way or if they will be comparable across organisations due to definitional differences such as the definition of 'incomplete data'. It would be more useful if the lead organisations on each audit (eg, the Royal Colleges) specified a methodology for measuring data coverage and quality for their respective audits, which is then applied locally and could then be reported through quality accounts.

Further, while it is possible to monitor national audits, the definition of what an audit is locally, what the audit covers and how good it is, can vary significantly. This would not be clear from a quality account.

We welcome the intention to include how organisations have performed against the standards in national audits, although this could be lengthy and complex if it is to be meaningful. One option would be for particular indicators from clinical audit data to be used as one of the sources of data for the indicators section of the quality account.

If quality accounts are to be public documents, designed to be read by the public, or at least by organisations and individuals advocating on behalf of the local community such as LINKs, then it is essential that they are readable, understandable and meaningful to a non-specialist, non-technical audience. Clinical audits may require some introductory explanation and description if this section is to be useful for that audience.

Research and innovation

Participation in clinical research

8. 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.

This statement is very limited. It takes no account of the size of the organisation, the types and range of services it provides, or the quality of the research it is signed up to. A more general statement about the active research projects approved by an ethics committee within NRES as stated in para 2.28 would be more appropriate, although this doesn't allow for statistical comparability.

Use of the Commissioning for Quality and Innovation payment framework

9. 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.

We would expect the improvement priorities to reflect agreements with commissioners through CQUIN and other routes. Therefore, we do not think this additional section is needed.

What others say about the provider

Statements from the Care Quality Commission

10. 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.

This seems reasonable.

Statement from Local Involvement Networks and primary care trusts (PCTs)

11. Do you agree that Local Involvement Networks and PCTs 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?

The main findings of our focus groups with regard to the involvement of LINKs and scrutiny committees were as follows.

- Participants agreed strongly that quality accounts should be developed in partnership and consultation with the local community and its representatives, of which LINKs are an important part.
- The priorities, concerns and interests of the local community ought to feature heavily in the trusts' decision-making about what they include in their quality account.
- It was thought that foundation trusts would want to involve their members and governors, and trusts would also want to involve other patient and user groups such as those connected to particular services within the trust.
- This involvement should happen early and then throughout the process.
- LINKs would not want to be sent drafts in an almost finished form; they want to be involved in selecting the priorities and which measures are included.

- LINKs should be encouraged to provide their own evidence from the local community about what issues are important to people and what the priorities should be.
- Participants felt that there would be considerable variation around the country in which and how many LINKs a trust was involved with, and how many trusts a LINK was involved with. Trusts would need to involve potentially more than one LINK, although 'lead LINKs' are often in existence, at least informally, for many trusts.
- Once all NHS organisations are producing quality accounts, this involvement could be an enormous potential burden on organisations such as LINKs, detracting from their ability to engage with the community and drive their own issues, and this is a concern.
- There was disagreement about whether LINKs ought to provide a commentary for inclusion in the report. Some felt this would detract from the independence of LINKs, and others added that it could foster 'tick box' involvement with LINKs. On the other hand, some thought it was a useful opportunity to raise the profile of LINKs.
- Among those who thought that providing commentary was a good idea, there were also mixed views about whether this should be in answer to particular questions or free text, with some suggesting both would be best. Most preferred free text.
- Participants supported the idea that LINKs could potentially advise or inform the lead commissioning PCT's comments and assurance of quality accounts. Generally, it was felt that different arrangements would be needed for different local relationships. Sometimes the LINK might want to relate particularly to the PCT, sometimes to the individual trusts.
- Several participants thought that PCTs should provide training and capacity-building for the LINKs to be able to fulfil the role of engaging with quality accounts in areas such as understanding data. If a LINK decides this training is needed, we recommend that they commission this from a suitable training provider with the advice of the PCT.
- With regard to OSCs, it was noted by one participant that quality accounts could be seen as a technical administrative matter and therefore outside of the remit of an OSC. We expect that OSCs may well choose to use the quality accounts as part of their information-gathering to fulfil their role, but do not expect that they will want a formal relationship with the quality accounts process.

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

When asked how much time a quality account would involve, some of our focus group participants said they would need to see a draft 2–3 months prior to publication since they will want to meet, discuss and possibly consult others, including other LINKs, and may want to influence the content of the account not just provide additional commentary. Most were uncomfortable with the premise of the question, stressing that LINKs should be involved throughout, not just in seeing and commenting on a draft. For LINKs' commentary role to be practical, it will be important for them to have been involved at as early a stage as possible through their ongoing discussions with the trusts, so that the specific content of the quality account is not a surprise.

Data quality

13. 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.

We strongly commend the principle of including an assessment of data quality in the quality accounts. However, the text in the box is formulated almost entirely in the context of an acute trust, and does not include national data sets other than Hospital Episode Statistics (HES), such as Mental Health Minimum Dataset (MHMDS) for mental health trusts. It is largely not relevant for other provider categories in the first year (ambulance trusts, mental health trusts, learning disability trusts and care trusts), and will of course need amending further when other organisations start doing quality accounts.

Valid NHS number and GP code are of course important, and we support their inclusion, but they are also reasonably completely and accurately coded in HES. We support the suggestion for reporting on clinical coding as assessed by the Audit Commission. But we also suggest that, for acute trusts and independent providers of acute services, a more generic indicator of data quality such as the HES Data Quality Index is used, which covers a wider range of fields.

Rationale for the proposed nationally mandated statements

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

The objectives set out in the proposal for the nationally mandated content are that it should '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'.

While the proposals do broadly meet these objectives, for quality accounts to achieve their overarching purpose (to increase public accountability on quality) we believe that organisations will need significant encouragement and scrutiny to ensure that the process of producing a quality account is not a tick-box paper exercise or an opportunity to promote only what's good about an organisation, but a genuine attempt to review and report on quality, good and bad. To do this, greater consideration needs to be given particularly to:

- processes for validation, scrutiny and assurance
- involvement and engagement of both staff and local community
- comparative/benchmarked data
- supporting the use of nationally assured indicators such as the Indicators for Quality Improvement
- the inclusion of a set of nationally mandated indicators.

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

We acknowledge and welcome the statement in the proposal that requirements for the nationally mandated content for quality accounts will develop over time and may be extended to include information about related policies such as NICE Quality Standards.

We would also recommend the inclusion of a set of nationally mandated indicators. Please see our comments regarding this in answer to question 4.

Assurance processes for Quality Accounts

While no consultation questions are asked on this section, we are keen to comment.

Our focus group participants felt that some form of external independent assurance of the content of quality accounts was absolutely essential, with many participants seeing the documents as 'PR brochures' and unlikely to be 'honest' or 'warts and all' as they felt they should be. There was a general lack of trust in the documents, with people tending to feel that boards would naturally 'sing their praises and obscure their faults' making the documents fail as an honest and representative account of quality and leading some participants to have 'serious reservations' about their usefulness. Participants did not on the whole feel that lead PCTs would have the capacity and skills to perform the assurance role adequately, and many hoped that LINKs could provide further external assurance through their involvement.

We agree that it will be a considerable task for lead commissioning PCTs to assure each quality account, particularly when attempting to assure the non-quantitative, narrative content. PCTs will need to ensure that contracts are designed so that they have routine access to quality data. We are not convinced that PCTs have the financial and analytical resource to do this well.

On balance, however, we accept that it would be inappropriate to require costly new systems to be introduced to provide external assurance of quality accounts, at least in their first year, since the information they will include is generally already in the public domain. However, to maximise public trust and confidence in quality accounts we urge the Department of Health to take the following measures.

- Assess after the first year the degree to which local stakeholders feel the documents are sufficiently assured, and build in further additional assurance mechanisms if necessary.
- Support and encourage trusts to give due attention to involving and engaging both staff and the local community in the selection of indicators and priorities.
- Require the inclusion of comparative/benchmarked data wherever possible.
- Support the use of nationally assured indicators such as the Indicators for Quality Improvement.
- Mandate the inclusion of a set of national indicators to increase the comprehensiveness and consistency of the quality accounts.

Paragraph 1.11 of the proposal states that the primary legislation enables CQC and commissioners, through SHAs, to ask for errors in quality accounts to be corrected. Does this mean that CQC will also perform some monitoring role in relation to quality accounts? It is unclear from the proposals if CQC plan to do this, and, if so, how this would relate to PCTs' assurance role.

Publication of Quality Accounts

16. Do you agree with the proposed publication methods?

While we support the wide dissemination of quality accounts, including on websites, it is important to recognise that enabling patient choice is not their stated purpose. Quality information needed for choice is quite different; it needs to be specific to the hospital site and specialty, and it needs to be comparable and timely. The King's Fund is currently undertaking a project looking at the presentation of quality information on NHS Choices designed to help patients choose hospitals. This research is ongoing, but interim findings are confirming research that too much information can result in the public feeling 'overloaded', confused and less able to make decisions even though they have more information. The public also remain to be convinced that there are differences in the quality of service between hospitals, so they need to be provided with information that will explain why and how quality differs between hospitals. Quality accounts should not be confused with initiatives to provide the necessary information to support patient choice.

An organisation's quality account should be published on its own website if they have one, through existing networks of patient and user groups, and in formats that make the documents accessible to speakers of different languages and people with sight problems and learning disabilities.

Our focus group participants took a mixed but generally unfavourable view of the readability and presentation of the quality reports produced in the pilot exercise, with most finding that they lacked sufficient context for them to understand the data given, with poor presentation of graphs and data and too much jargon, making them inaccessible by a lay audience. Some participants did compliment the documents, however, saying they were succinct, clear and visually appealing. Many participants proposed that trusts should produce 'lay summaries' or 'leaflet versions' with one suggesting that publication on the web makes it easy to present the information at different levels for different audiences.

17. Do you have any other comments on the proposals?

Evaluation

Evaluation of quality accounts will be critical to feed in to their further development. Therefore, we strongly recommend that independent evaluation of the process, impact and use of quality accounts is built into the process from the beginning, at least for a sample of participating organisations.

Overall, the evaluation should seek to establish to what extent the quality accounts meet their intended objectives. Specifically, it should include at a minimum a study of the:

- experience of data collection and preparation of the quality account, and the burden in terms of staff time and cost
- methods and rationales used for selection of local priorities
- quality of presentation of the information in the reports, in terms of accuracy, relevance, readability and accessibility
- methods used for disseminating and publicising the report among intended users
- views and responses of patients, carers and service users, and whether and how these groups access and use or intend to use the report
- impact on board discussion, in what ways boards responded to and discussed the quality account, and the reflections of board members on the process.
- experience of different audit and assurance options, to inform future policy on the assurance process.

Which organisations will be required to provide a Quality Account?

The consultation questions in this section address non-incorporated providers, small providers, and primary and community care providers. However, we believe there are other specific issues that it is important for the Department of Health to clarify for other types of providers. One particular example would be the charitable hospice sector. Hospices provide specialist palliative care and so we assume will fall within the remit of the first year of the roll out of quality accounts. However, they have their own statutory reporting requirements to the Charity Commission, which follow a different timetable to that proposed for quality accounts. We recommend that the Department of Health seeks specialist advice from the Charity Commission, the Office of the Third Sector and the hospice sector to address how the proposals can accommodate them. One option could be for hospices to be included in the second year of rollout, and the first year could then be spent piloting an appropriate approach for them.

18. 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.

In general, these proposals seem to have been developed with large acute hospitals in mind rather than having been designed from the beginning to be adaptable to the huge range of type and size of provider. We recommend that all provider types are extensively consulted on the feasibility of these proposals for them and pilots and evaluations are built in where necessary.

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

While it might seem logical to exempt small providers from producing quality accounts, the proposed criteria risk allowing significant parts of the health sector to be exempt. For example, many independent sector mental health facilities treat fewer than 100 patients. One option could be for small providers who are part of a consortium, group or wider company to require a single quality account from that parent group.

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

The prospect of every GP practice and every community care provider following the processes and producing a quality account as proposed seems very challenging. We understand some preliminary piloting of this is under way in the North East and East Midlands and hope that this is yielding useful information.

21. 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?

For a quality account that demonstrates best practice in terms of involvement and dissemination, and for organisations with extensive and complex services, we suspect this that range is an underestimate. Our understanding of the quality reporting exercise was that it was necessarily conducted quickly using readily available information, with no comprehensive 'review of services' as is proposed here, limited involvement of external groups such as PCTs and LINKs, and very limited dissemination and promotion. Therefore, we believe that production of a quality account as proposed here would be likely to cost more.