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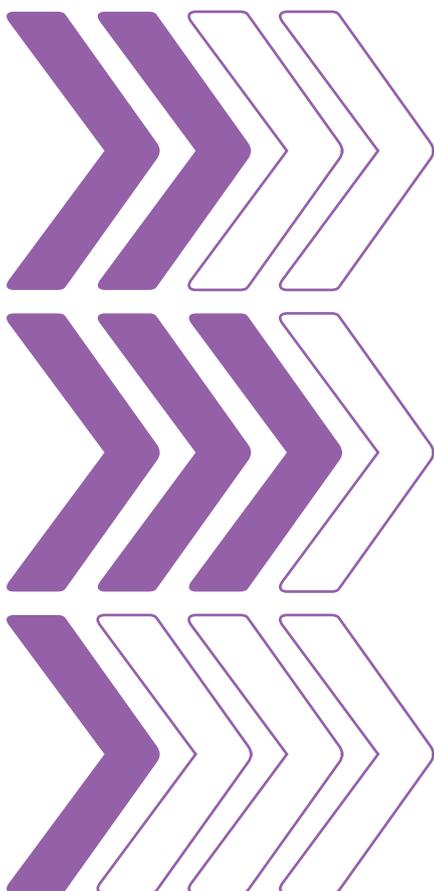
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How do quality accounts measure up?

Findings from the first year



Key points

- In 2010, for the first time, many providers of NHS services have been required to produce quality accounts, which are public reports of the quality of their services and their plans for improvement.
- We have analysed a sample of these, reviewing their compliance with statutory requirements and published guidance and assessing how well they meet principles of good practice in publishing information on quality. We looked in particular at: how they present and use quality measures to report on performance; how they have reported on data quality; their participation in clinical audit and national confidential enquiries; how providers have reported patient and public feedback; how they have involved local stakeholders, and what the external comments have focused on.
- Across all dimensions, there were examples of both good and poor practice, and many very different approaches to style, content and intended audience. Based on these findings, we have made a series of recommendations to providers about how their quality accounts could be improved.
- However, we also raise policy questions about quality accounts, in the context of the new government's policy agenda on information. We conclude that, fundamentally, quality accounts are so varied because they are having to provide commentary on a wide range of services, are serving a broad range of audiences and are also attempting to meet two related, but different, goals of local quality improvement and public accountability. The future for public accountability needs to focus more on the centralised provision of standard, consistent and comparable measures, published in forms that enable interpretation and comparison. Individual quality accounts can then both draw on these measures and select local priorities and measures, as long as those measures can be given with benchmark or trend information to provide some context for interpretation.

Introduction

Following the Health Act 2009, care trusts and providers of acute, mental health, learning disability and ambulance services are required to publish a quality account, a new form of annual report to the public about the quality of services. This applies to all providers over a certain size and includes private and third sector organisations contracted to provide NHS services.

The target audiences for quality accounts are wide-ranging: boards, clinicians and other staff, patients, the public, health overview and scrutiny committees (HOSCs), local involvement networks (LINKs) and commissioners. Quality accounts are intended to be a tool for public accountability and quality improvement. They aim to:

- increase NHS accountability by making more information about quality available to the public
- encourage boards and senior management of health care organisations to focus on quality improvement by ensuring that they assess and report on quality across the entire range of their services and state where they intend to make improvements.

The Department of Health sets out regulations and guidance about what should be included in quality accounts, summarised in the box below (Department of Health 2010c).

Although quality accounts were introduced by the previous government, the current government has re-affirmed its commitment to them as part of an ‘information revolution’ to increase the amount of information about NHS services available to the public (Department of Health 2010b, 2010d). In the White Paper, *Equity and Excellence: Liberating the NHS*, the government stated its intention to ‘revise and extend quality accounts to reinforce local accountability for performance, encourage peer competition, and provide a clear spur for boards of provider organisations to focus on improving outcomes’ (Department of Health 2010a, p 14).

Required content in 2010

Quality accounts should include:

- a statement from the chief executive
- priorities for quality improvement and why they have been chosen
- a review of the quality of services, using selected quality indicators chosen by the provider but aiming to be representative of quality across all the services provided
- a standardised set of statements on data quality, participation in clinical audits and confidential enquiries, participation in research, Commissioning for Quality and Innovation (CQUIN) schemes and Care Quality Commission assessments
- a description of who has been involved and engaged to determine the content and priorities
- external comments provided by the lead commissioning primary care trust (PCT) and the LINK and HOSC, if they choose to provide it, to ensure that there is some external assurance and scrutiny of the content.

The publication of this first year’s set of quality accounts presents an opportunity to review how providers have interpreted the guidance and to examine how well the quality accounts work as effective, transparent and representative public statements of the quality of NHS services.

Aims and methodology

Our aims for this research were to:

- review a sample of quality accounts, analysing their content for how they comply with the statutory requirements and published guidance and how well they meet principles of good practice in publishing quality information derived from previous research, and from that judge how effective they are as a form of public accountability for quality
- make recommendations to policy-makers about issues of principle about quality accounts that need consideration, how the guidance and regulations for quality accounts could be further developed, and how quality accounts can best fit into the new government's policy agenda on information
- make recommendations to providers about how their quality accounts could be improved.

We read and analysed a representative sample of the 2010 quality accounts of the providers of acute and mental health services from both the NHS and independent sector. The quality accounts of ambulance trusts and care trusts were excluded. Given the wide range of content, we focused on three selected aspects of the quality accounts.

- **The quality measures used to review performance** We describe the choice of measures and discuss the reliability and format of presentation.
- **Data quality and participation in national clinical audits and confidential enquiries** We look at whether providers have reported this information as required, what they have said, and we comment on the levels of data quality and participation in national audits and confidential enquiries reported.
- **Patient and public feedback, local involvement and external scrutiny** We describe and discuss how providers have reported patient and public feedback, how they have reported on involving local stakeholders in the quality accounts, and what the external comments have focused on.

We reviewed a total of 64 quality accounts, approximately 25 per cent of the total. This is an approximation because no comprehensive list exists of all the providers who met the criteria for being required to produce a quality account in 2010. In order for this sample to be broadly representative, the providers were selected randomly from the published quality accounts and subsequently checked to ensure geographical spread across the country. We stratified our sample across eight different types of provider, as shown in Table 1. The full list of providers used in the sample is given in the Appendix.

Table 1: Distribution of providers

Provider type	Number of quality accounts in the sample
NHS acute foundation trusts	12
NHS acute non-foundation trusts	22
NHS mental health foundation trusts	9
NHS mental health non-foundation trusts	8
NHS specialist foundation trusts	2
NHS specialist non-foundation trusts	2
Independent providers of acute services	5
Independent providers of mental health services	4

We developed an analysis checklist relevant to each of the three aspects of quality accounts reviewed here, based on the guidance produced by the Department of Health (2010c) and previous research into quality measurement (Raleigh and Foot 2010) and quality accounts (Foot and Ross 2010). We also drew on recent research at The King's Fund into how information can be presented for patients (Boyce *et al* 2010). We piloted this analysis checklist using a sub-sample of 10 quality accounts and made adjustments as a result.

The next section of this paper presents our findings, looking first at the use of quality measures, then at data quality and participation in national clinical audits and confidential enquiries, and finally at patient and public feedback, local involvement and external scrutiny. Each section concludes with recommendations for policy-makers and providers. We end the report with a concluding section that discusses wider issues relating to quality accounts and makes high-level recommendations for policy-makers.

Findings

Use of quality measures

In this section we examine the quality measures and presentation formats used by providers. The Department of Health toolkit asked providers to present information that reflected their type of organisation and the range of services provided. They were asked to include quantitative and qualitative information relevant to specific services and specialties, and to cover the three domains of quality: clinical effectiveness, patient experience and safety (Department of Health 2010c).

The toolkit provided guidance on what sort of material to include and how it should be presented. Organisations were free to select whatever measures they wished to include. A great deal of data is available about the performance of NHS trusts, especially for NHS acute and specialist trusts. Furthermore, large provider organisations, especially NHS acute trusts and to a lesser degree NHS mental health trusts, provide a wide range of clinical services. They therefore had to make choices about the information sources, services or specialties to be included in their quality accounts. It is not a surprise, therefore, that the number and types of measures included varies significantly between providers.

This section looks at the following areas.

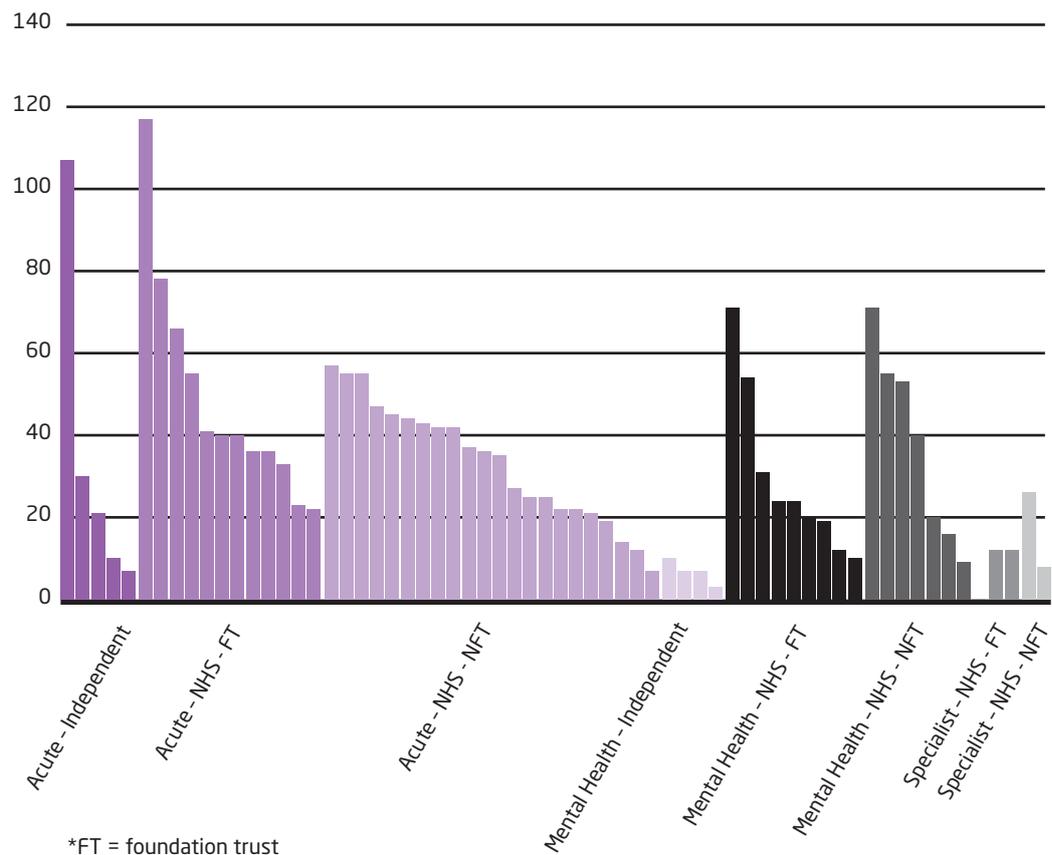
- **Content:** how many measures are used, which aspects of performance are covered and what types of measures are used.
- **Rigour:** whether information about performance over time is given, whether statistical tests are used, whether benchmarking information is given and whether measures are presented in context with appropriate interpretation and explanation.
- **Presentation:** how the data is presented such as how tables and 'traffic-lighting' indicators are used, how graphs are used and how readable the documents are.

Content

Numbers of measures used

The number of measures used in each quality account varies significantly: while approximately two-thirds of the providers use between 11 and 50 measures, 5 providers use more than 70 measures, and 11 providers use 10 or fewer measures (See Figure 1 opposite).

Figure 1: Numbers of quality measures used by providers



The type of organisation is an important determinant of the number of quality measures that are used (See Figure 1 above). Typically, NHS acute trusts use the most measures, and NHS providers in general present more quantitative information than independent providers. Only one independent provider (Shepton Mallet NHS Treatment Centre) provides a similar number of quality measures as the typical NHS acute trust.

Mental health providers vary greatly in the numbers of indicators used, with independent providers offering very little by way of quantifiable evidence to assess quality (Figure 1). Many NHS mental health providers also do not make best use of the data available to measure effectively the quality of care provided. A good example of measuring quality in mental health is provided by Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust which uses a wide variety of indicators and data sources, including measures reflecting patient outcomes such as the ‘number of patients in paid employment’.

Coverage of different aspects of performance

The Department of Health toolkit made broad recommendations about the aspects of performance that should be covered and evidenced in quality accounts. These are covered to varying degrees in our sample of published accounts summarised in Table 2 below.

Table 2: Aspects of performance included in quality accounts

Generally weak	Generally strong
Service-level coverage	Effectiveness, patient experience, safety
Staff feedback	Outcomes
Equality dimensions	Balance between positive and negative

Service-level coverage

Very few trusts map quality to individual services provided and where they do, usually the quality of only one service or specialty is reviewed. This is not surprising, given the wide range of services provided by many organisations, and the need to keep quality accounts to a readable length and format for a lay audience. However, this does highlight a key tension in quality accounts, between comprehensiveness of comment on the range of services provided on the one hand, and the length and complexity of the documents on the other.

Staff feedback

Overall, about one-third of NHS providers in our sample include information from staff surveys; NHS acute trusts are more likely to include staff survey data than NHS specialist and mental health trusts. Only one of the nine independent providers reports any staff feedback. The views of staff are an important marker of an organisation's managerial competence, workforce well-being and hence its ability to deliver high-quality care. Staff views should be shown in the quality accounts. The annual national surveys of NHS staff provide a readily available source of data on the views of NHS staff.

Equality dimensions

The Department of Health toolkit advised, where possible and appropriate, the disaggregation of data by equality target groups, but the assessment of equality issues is almost entirely ignored in our sample of quality accounts. A handful of trusts provide information on the completeness of ethnicity coding in their data, as part of their reporting on performance against Care Quality Commission assessments, but very few report on equality issues in service provision. A rare exception is Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust, which provides extensive information on the use of services and outcomes by ethnic group and age of service users. University Hospitals of Leicester NHS Trust describes how its services aim to cater to the needs of ethnic, faith and other minority and socially excluded groups, such as people with learning disabilities. Although all organisations are expected to comply with equality legislation and to reduce inequalities in access to and outcomes of care, it is striking that so few organisations make any reference to equality issues in their quality account.

Domains of quality

Most of the providers cover the three domains of quality – clinical effectiveness, patient experience and safety – to some degree. Generally, only independent providers fail to cover all of these areas. NHS acute providers and mental health trusts use a greater breadth of indicators and data sources than specialist and independent providers.

Outcomes

Most providers include information on patient outcomes but this is variable across sectors, with more than 90 per cent of NHS acute trusts and about half of independent and specialist providers including outcomes. Mental health trusts are less likely to include outcomes, perhaps because outcomes of mental health care are less readily measurable than outcomes of acute care, although some did report, for example, on employment outcomes for users of mental health services.

Balance between positive and negative

The guidance encourages providers to present a balanced and representative picture of the quality of services, highlighting both positive data and negative data. Although independent providers tend not to present negative data, NHS trusts generally include

both positive and negative data. An example, shown in Example 1 below, is Bedford Hospital NHS Trust which recognises the need to respond to falling patient satisfaction.

Example 1: Responding to negative patient feedback

2.3.2. To improve the patient rating of overall care and experience in the National Patient's Survey

Description of issue and rationale for prioritising

The National Inpatient Survey is the main source for reporting the perception of our patients and is used in the comparative performance tables and quality indicators- CQUINs. The most recent survey (2009) shows a general fall in the patient satisfaction levels but when compared to other trusts, the scores for the responses generally were the same. Also, in the past year, monthly in-house surveys results have dipped to 75% on two occasions, the remainder of the year has been above the 82% benchmark and range up to 98%.

Aim / Goal

To increase the number of favourable responses from patients in response to the CQUINs questions:

Performance to be measured

National Survey questions	2008	2009
Were you involved as much as you wanted to be in decisions about your care and treatment?	52%	42%
Did you find someone on the hospital staff to talk to about your worries and fears?	38%	35%
Were you given enough privacy when discussing your condition and treatment?	70%	66%
Did a member of hospital staff tell you about medication side effects to watch for when you went home?	35%	28%
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	67%	64%

Source: Bedford Hospital NHS Trust

Types of measures used

Overall, the most commonly presented measures, in terms of both the numbers of providers using them and the numbers of measures presented, relate to waiting times, health care associated infections (HAIs) and patient experience surveys. The fact that waiting times are the most commonly used measures possibly reflects their high priority as national targets enforced by the previous government. Likewise, stringent targets were applied to HAIs under the previous government and this data is readily available. It is well known that this aspect of quality is important to patients. The experience of patients is a well-accepted marker of quality and the national NHS patient experience surveys provide a readily available source of data for NHS providers. It is therefore not unexpected that these three sources of data feature prominently among the indicators used.

Measures used by providers of acute services

We examined the types of indicators used separately for providers of acute and mental health services. From our sample of thirty-nine acute providers, including five independent providers, the top three measures used by more than eighty per cent of providers were for HAIs, patient survey data and waiting times (See Table 3 below). However, no single type of indicator is used by all acute providers, and only five measures are used by more than half of them. This finding has serious implications for the comparability of the content of quality accounts.

Table 3: Ten most frequently used measures by NHS and independent providers of acute services

Top 10 measures	% of acute providers using measure
Health care associated infections	92
Patient experience survey	90
Waiting times	82
Hospital standardised mortality ratio - overall and condition/procedure specific	67
Cancelled operations	54
Stroke sentinel clinical audit	49
Re-admission rates	46
Delayed transfers of care	44
Patient safety incidents/never events/prescribing errors	44
Complaints	41

Providers are more likely to include generic measures reflecting the performance of the whole organisation, such as the hospital standardised mortality ratio (HSMR), cancelled operations, re-admission rates, complaints and safety events, than measures of quality in specific services. However, providers of acute services do present measures for a wide range of areas, including: falls, Patient Environment Action Team (PEAT) scores, returns to theatre, HAI screening, prevention of venous thromboembolism, proportion of patients with fracture neck of femur operated on within 48 hours of admission, length of stay and pressure sores.

There are examples of organisations reporting on locally implemented initiatives for improving quality. For example, just under half of all NHS acute and specialist trusts report using the global trigger tool, a tool developed by the Institute for Health Improvement in the United States for monitoring and reducing adverse events.

Measures used by providers of mental health services

The quality accounts of mental health providers are even more varied, with only four types of indicators (patient survey, HAI, delayed transfers of care and falls/incidents) used by more than half of the providers (See Table 4 opposite). Mental health providers are at lower risk of HAIs than acute services, so it is surprising that so many should present measures on HAIs. However, the quality accounts include measures for a wide range of areas, including: compliance with Care Quality Commission core standards, crisis resolution and drug users in effective treatment.

Table 4: Ten most frequently used measures by NHS and independent providers of mental health services

Top 10 measures	% of mental health providers using measure
Patient experience survey	89
Health care acquired infections	63
Delayed transfers of care	58
Falls/incidents	53
Complaints	47
PEAT scores	42
Care programme approach (CPA) 7-day follow-up	42
Gatekeeping	37
Waiting times	32
Re-admission rates	32

Rigour

In addition to examining the content of the material that providers have chosen to include in their quality accounts, we also reviewed the rigour with which their quantitative findings are presented. We looked for trends in performance over time, use of statistical tests, benchmarking against peers or national averages, and clear definition and interpretation of indicators.

Performance over time

Performance over time is an important dimension to understanding an organisation's quality, and we were surprised that around half the reported measures only show a single year's result. Where trend data is presented, it tends to be in four areas: HAIs, patient surveys, safety incidents and HSMRs.

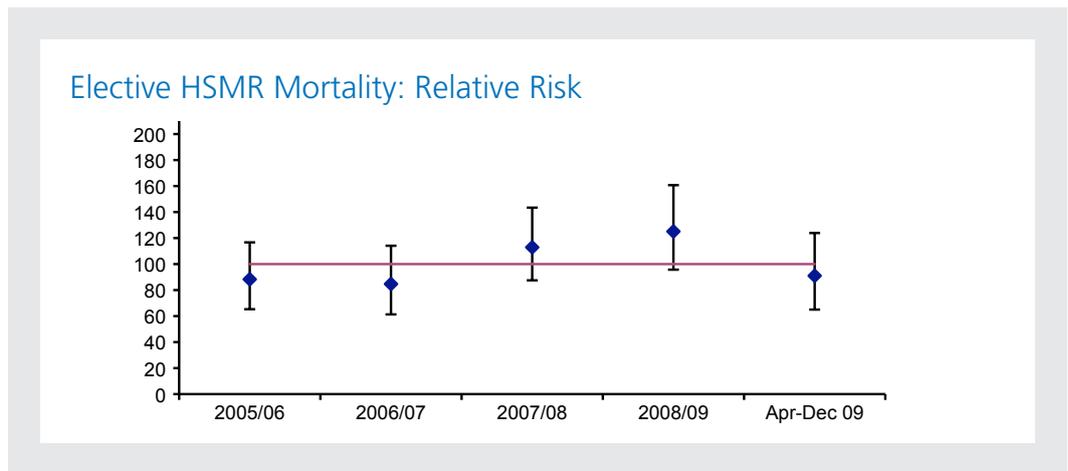
NHS acute trusts overall are twice as likely as independent providers to include more than one year of data when reporting quality information. One reason for this could be that standardised information (such as patient surveys and re-admission rates) are more readily available for NHS than for independent providers, hence they may be more accustomed to reporting performance over time.

Mental health providers generally use less trend data; this could be a further reflection of the generally lower use of quantitative data by these providers compared with the NHS acute sector. The mental health measure for which trend data is most likely to be presented is 'delayed transfers of care'.

Use of statistical tests

Despite the guidance provided in the Department of Health toolkit about the use of statistical tests for distinguishing genuine statistical differences from random variations, very few providers from our sample – just nine – include statistical tests for the measures used in the reports. The main approach used is 'confidence intervals for rates' (See Example 2 overleaf). Although statistical notations can make documents less accessible to some readers, for a large range of audiences including clinicians, commissioners and policy-makers, they are essential for judging the significance and reliability of evidence.

Example 2: Use of confidence intervals

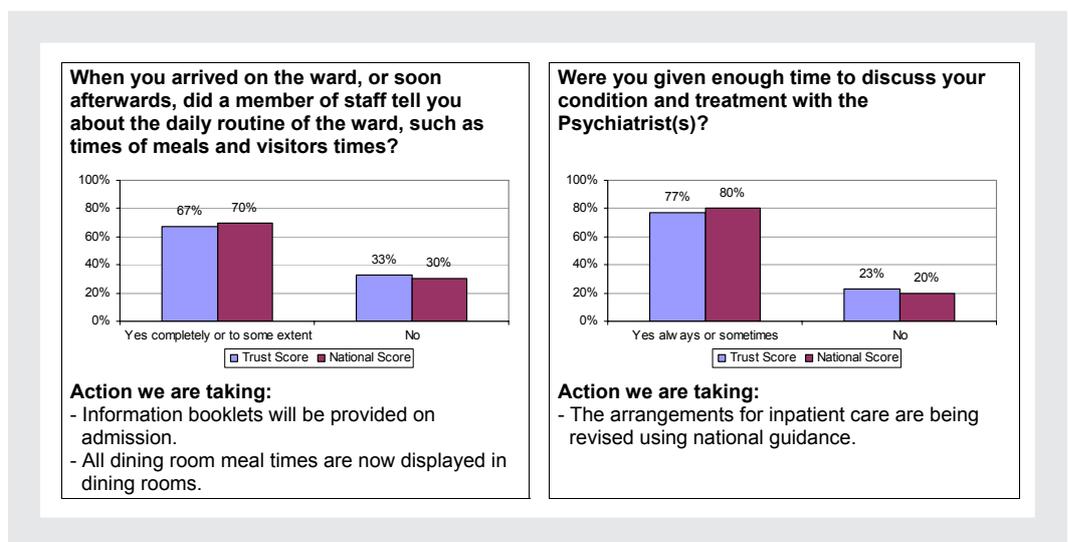


Source: Royal Liverpool and Broadgreen University Hospitals NHS Trust

Benchmarking

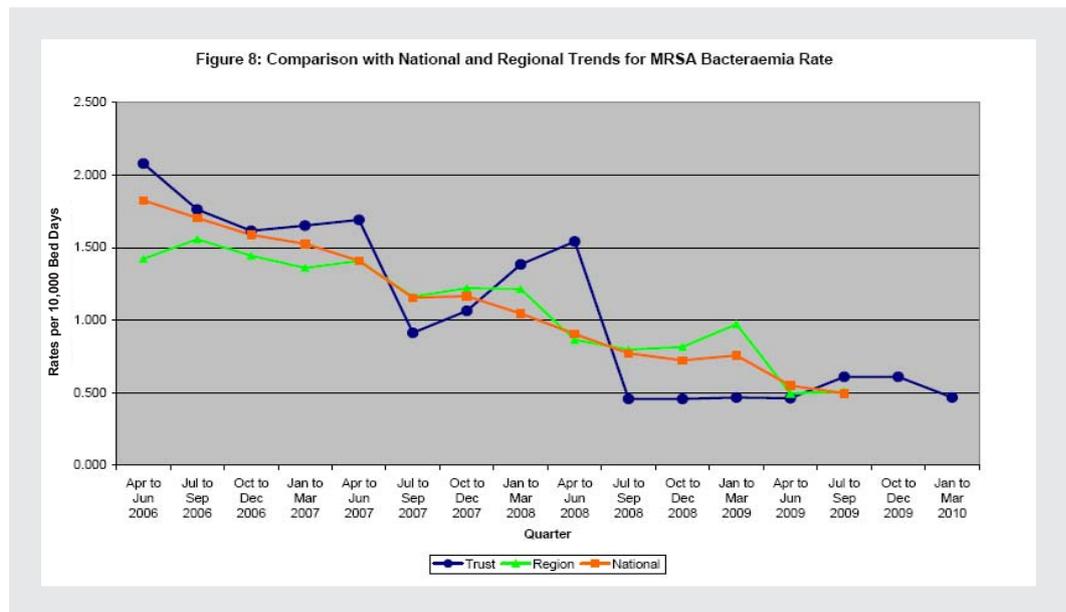
We consider that one of the most important elements for the audience of quality accounts is comparative performance against peers or the national average or a target or a standard, because it is generally not possible to interpret information on quality without benchmarking against a comparator. Comparative data is available through initiatives such as the Information Centre’s Indicators for Quality Improvement, the Better Care Better Value Indicators and analyses provided by the Public Health and Quality Observatories. We were therefore surprised to see that the quality accounts include such little comparative information on performance. Fewer than one in five of the measures presented in the quality accounts are benchmarked. We show some examples of benchmarking that enable interpretation of performance in Examples 3 below and Example 4 overleaf.

Example 3: Benchmarking against the national average



Source: Coventry and Warwickshire Partnership NHS Trust

Example 4: Benchmarking against national and regional averages



Source: Northern Lincolnshire and Goole Hospitals NHS Foundation Trust

Context and interpretation

The reporting of data in a quality account needs to be accompanied by its definition, some description of the context and an interpretation of what it shows. We found that often measures are presented in quality accounts without definition, context or discussion. In some cases, the very design of some of the data presentation sections avoids or discourages this, with many providers choosing to devote parts of their quality accounts to long tables listing quality measures (such as Queen Victoria Hospital NHS Foundation Trust and the Heart of England NHS Foundation Trust). Similarly, not enough attention has generally been paid to introducing and defining the measures used. However, there are examples where this has been addressed (Examples 5 below and Example 6 overleaf).

Example 5: Describing and contextualising an indicator

Patients operations may be cancelled for both clinical and non-clinical reasons. Patients may be cancelled for clinical reasons because they are not well enough to undergo surgery. This may be due to, for example, a bad cold or a heart or lung condition that needs to be stabilised prior to surgery taking place. Cancellations for clinical reasons are generally not considered to be a problem. However, when operations are cancelled for non-clinical reasons, such as staff or bed shortages, theatre scheduling or equipment failure, then this is unacceptable for patients, causing anxiety, distress and inconvenience for them.

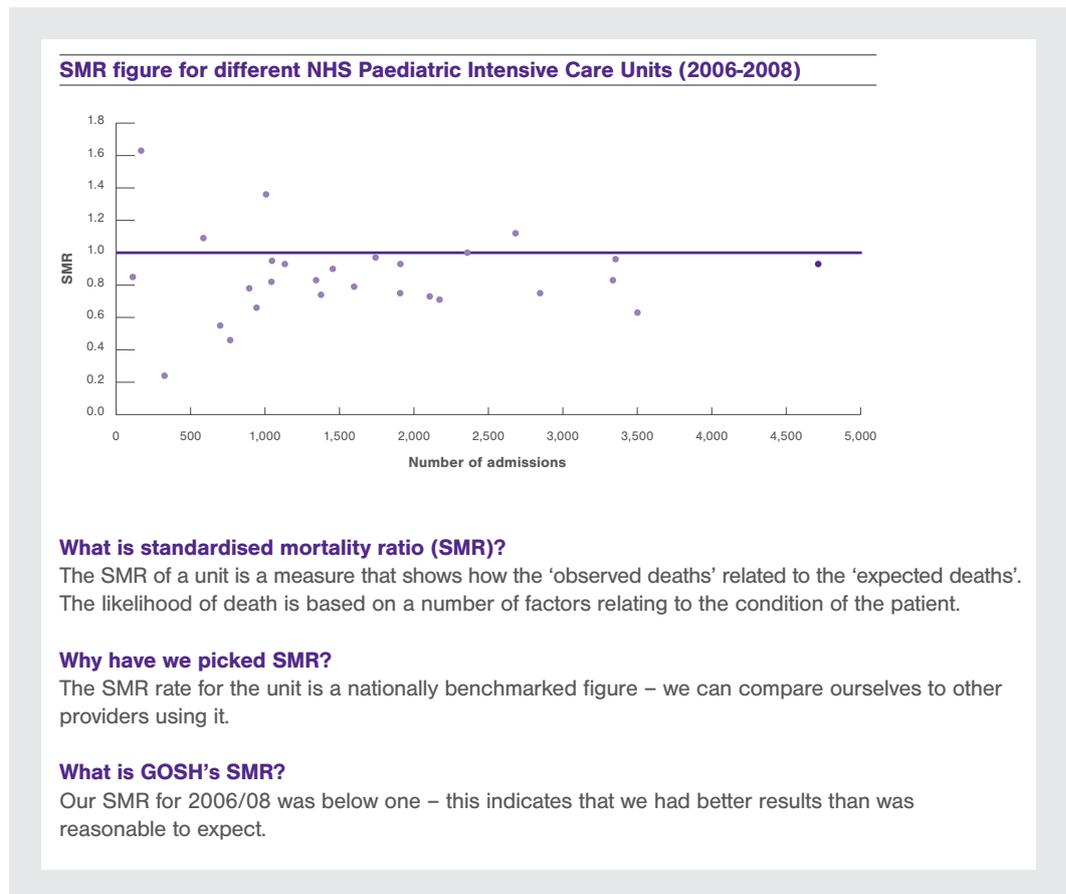
The table below demonstrates our performance in terms of the number of operations cancelled for non-clinical reasons:

Cancelled Operations – non clinical reasons	2008/09 Number (rate)	2009/10 Number (rate)	2010/11 Target
	302 (0.60%)	307 (0.58%)	250

In 2008/09 we cancelled 302 operations for non-clinical reasons. This represented less than 0.60% of total operations.

Source: The Royal Wolverhampton Hospitals NHS Trust

Example 6: Describing and explaining an indicator



Source: Great Ormond Street Hospital for Children NHS Trust

Presentation

While many providers have taken considerable care over how their quality account is presented, we found examples in our sample of documents with some basic and avoidable faults in presentation, such as tables and charts that are blurred or too small to be easily readable, axes which don't have labels, acronyms that are not explained and a lack of logical sequencing of the material.

Use of tables and 'traffic-lighting'

The most commonly used method for reporting quality indicators is a table containing a list of diverse, often unrelated, measures. Sometimes, the indicator values are presented alongside either a previous year or a national average or target, and occasionally both. While this is an efficient way of reporting many indicators, it is difficult to accompany data in this configuration with an adequate interpretation or evaluation by the provider. Only very rarely is an indication provided of whether performance is good or not, such as through a separate column or a 'traffic-light', where performance is rated red (poor), amber (adequate or not particularly good) or green (good). An example of synthesising a considerable amount of information with a clear indication of the level of performance and trends over time is shown in Example 7 opposite.

Example 7: Summarising information

Table 7: Our performance against national and core quality standards

Existing commitments		National standard	2009/10	2008/09	2007/08
A&E access	% patients discharged within 4 hours in A&E and MIU	>98%	97.6% ●	98.2% ●	98.3%
Inpatient and outpatient access	Outpatients waiting more than 13 weeks (GP referrals only)	<3 / mth	0.0 ●	0.2 ●	0.1
	Inpatients waiting more than 26 weeks	<2 / mth	1.8 ●	2.3 ●	1.2
Cardiac access	Patients seen within 2 weeks for rapid access chest pain	>99%	100% ●	99.7% ●	100.0%
	Patients waiting more than 3 months for revascularisation	<1%	0% ●	0% ●	0%
Cancelled operations	% elective operations cancelled on day of operation	<0.8%	0.70% ●	1.17% ●	1.58%
	% cancellations not re-admitted within 28 days	<5%	0.9% ●	1.2% ●	0.0%
Transfers of care	Inpatients with delayed transfer of care (monthly average)	<5	2.8 ●	1.2 ●	1.8
Health and well-being	Patients seen within 48 hours of referral to GUM clinic	>99%	100% ●	99.8% ●	99.5%
	Ethnic coding levels of inpatients	>90%	91.9% ●	91.2% ●	88.5%
Clinical quality	Call to balloon time for primary angioplasty – % under 150 minutes	tba*	58.1%	n/a	n/a

Source: Guy’s and St Thomas’ NHS Foundation Trust

The presentation of ‘clinical dashboards’ for monitoring priority areas also provides a useful illustration of how trusts use information in traffic-light form internally for quality improvement (See Example 8 below).

Example 8: Clinical dashboards for internal monitoring

TRUST DATA	Standard Source	Goal	Alert	Action	Oct	Nov	Dec	Jan	Feb	Mar
C Diff cases (attributable to trust)	CQC	<7	7-10	>10	2	3	11	7	15	2
Patient Experience Survey Satisfaction	Local	≥90	70-89	<70	90%	86%	88%	90%	89%	
Pressure Ulcers Developed in hospital	Local	<10	10-20	>20	21	17	8	20	27	12
Patient Falls	Local	<50	50-70	>70	60	67	67	63	65	63
Caesarean Section Rate	CQUIN	<23	23-25	>25	24.2	24.5	27.1	25.0	27.9	26.6
Stroke Patients spending 90% time on TSU	CQUIN	>80%	60-80%	<60%			83%			82%
Compliance with 2 week wait for cancer referrals	National	>93%	90-93%	<90%	90.9	91.7	95.4	94.3	96.7	95.8

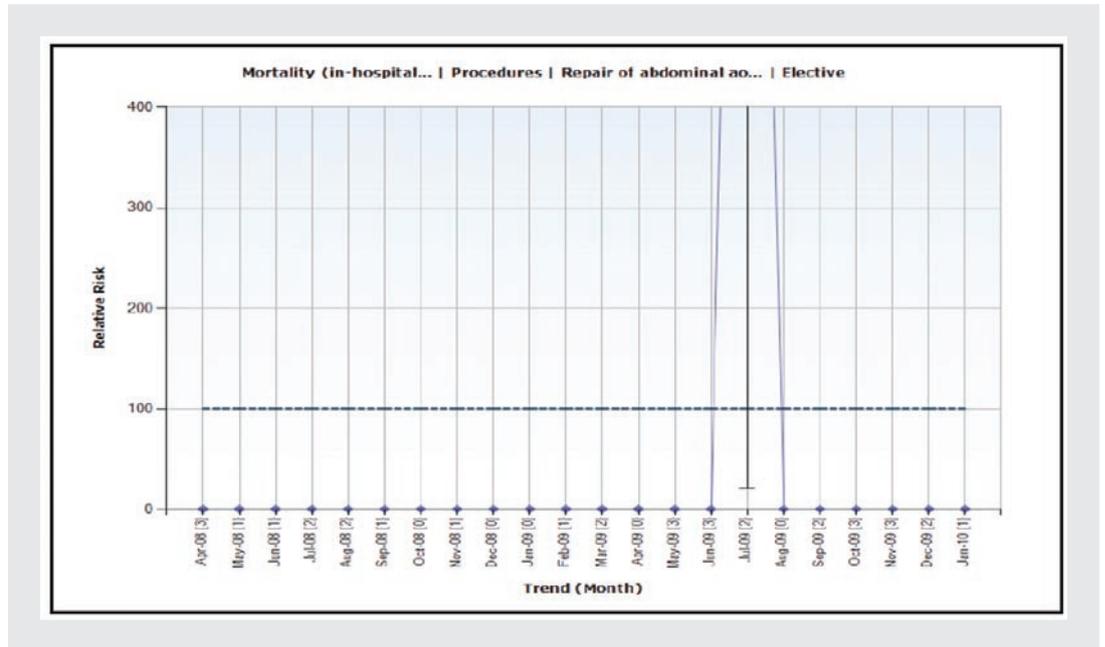
Source: The Hillingdon Hospital NHS Trust

Use of graphs

Around one in five quality measures are presented graphically. Proper use of graphs can allow information to be understood quickly and can be a suitable format for many readers of quality accounts. We therefore felt that graphical data presentation techniques are under-utilised. Three-quarters of graphs use trend data, which is a useful summary format for communicating progress in improving quality. However, sometimes the graphs presented are both difficult to understand and unexplained in the text (See Example 9 overleaf). And sometimes a graph can be misleading, as for example in Example 10

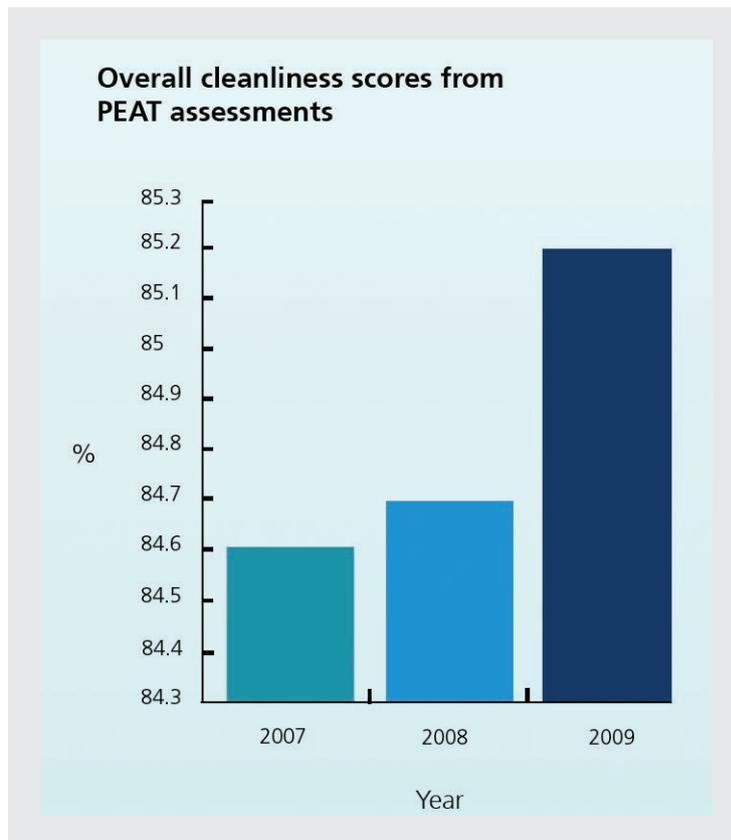
below, where an increase of just 0.6 per cent in the PEAT cleanliness scores appears to be a tripling of achievement, and is the result of using a greatly expanded y axis scale.

Example 9: A graph needing clarification and explanation



Source: Buckinghamshire Hospitals NHS Trust

Example 10: Using an expanded y scale



Source: Ramsay Health Care UK

Clarity

Typically, the quantitative sections of the quality accounts of independent providers are clearer to read and understand, especially for the acute providers, with the information simply and accessibly presented and the messages clearly conveyed. However, these quality accounts tend to have far less quantitative content than the quality accounts of NHS trusts. Some of the quality accounts that are the most challenging to read for a lay audience because of the volume of quantitative information included are those of some NHS acute trusts, such as University Hospitals Bristol NHS Foundation Trust, The Hillingdon Hospital NHS Trust, and Queen Victoria Hospital NHS Foundation Trust. The challenge therefore is to present a rigorous account in an accessible and clear way. Few providers achieve this difficult balance. One example, Example 11 below, shows all the necessary information about a particular quality indicator in a clear and simple format.

Example 11: Providing a clear summary of an indicator

A	Area of Performance:	Environments & Cleanliness		
Metric (Method of Calculating Performance):	Trust Metric: GQ.10 Environments / cleanliness as assessed by the Environment Action Teams (PEAT)			
Performance specific to the services covered by this Quality Account:		We are very proud of our record for cleanliness and in 2009/10 we received the following ratings:		
		Site Name	Environment Score	Privacy & Dignity Score
		Learning Disabilities Unit Hilton Road	Good	Excellent
		Harplands Hospital	Excellent	Excellent

Source: North Staffordshire Combined Healthcare NHS Trust

Conclusion and recommendations

The quality indicators sections are extremely varied in the number and choice of measures, statistical rigour, and format and quality of presentation. This diversity of quantitative content, coupled with lack of benchmarking information, means it is not practically possible to differentiate quality of care between providers on the basis of their quality accounts.

Some of this variation arises simply from relatively good or poor practice by providers in complying with the guidance. The variation in the style and skill with which quantitative information on quality is presented for a lay audience is particularly understandable given how specialist and challenging this task can be and how little experience providers have of this new form of public reporting. Building on the examples of good practice that we found, and learning from the examples of poor practice, a number of specific recommendations are possible for providers wishing to improve their quality accounts in future years. These are given in the box overleaf.

Recommendations for providers when developing and writing a quality account: use of quality measures

Content

- Include both positive and negative aspects of performance
- Include the equality dimensions of performance
- Include staff feedback
- Aim to ensure an overall balance in terms of the number and spread of indicators
- Make greater use of available nationally benchmarked indicator sets, such as the Indicators for Quality Improvement
- Mental health providers should make greater use of quantitative data sources such as the Mental Health Minimum Data Set (MHMDS)
- Independent sector providers should, where possible, use data comparable to the NHS

Rigour

- Ensure statistical rigour and use statistical tests where appropriate
- Benchmark performance against the national, peers, a standard or target, as appropriate
- Present trend data i.e. performance over time
- Ensure all indicators are explained – why they are chosen, what they mean and what they are saying, especially for clinical and/or complex measures of quality

Presentation

- Present the quality measures in context
- Tell a story and avoid presenting a random assortment of indicators
- Accompany all information with an explanation of whether it represents good or poor performance
- Ensure tables and graphs are constructed reliably and have clear titles and legends

However, the variation and lack of comparability we found is not solely, or in fact mainly, the result of the varying success of providers in complying with the guidance; it is rather an inevitable result of the way quality accounts are designed. Fundamentally, the sections on quality indicators vary and lack comparability because providers have free choice over which indicators to select. NHS acute providers, in particular, have an extensive range of potential data sources.

This has implications for future guidance on quality accounts, given the new government's clear focus on publishing more quality information to the public in a comparable form. This wider question about the future of quality accounts is discussed further in our overall conclusion to this paper.

The quality indicators sections of the quality accounts also suffer from two particularly difficult inherent tensions in the guidance:

- the need for both comprehensiveness and readability
- the need for both simplicity and statistical rigour.

The first tension is the choice between having quality measures that cover all or most services comprehensively versus producing a document of a readable length and format. While some quality accounts include relatively few and simple presentations of measures, others include a much wider range of measures covering more varied dimensions of quality, and this inevitably makes them more lengthy and complex to read. Few provide feedback on the quality of specific services, which patients wanting to use those services may be interested in. This is not surprising, given the range of services provided by most acute hospitals and providers of mental health services, and the multidimensional nature and complexity of measuring quality. But it does raise a question about what the review of performance in quality accounts should cover and in how much detail.

The second tension lies between simplicity and statistical rigour. The Department of Health toolkit rightly advised that measures should, where appropriate, be accompanied by tests of statistical significance. Many indicators of clinical quality are estimates and should be presented in a format that enables distinction between differences from a norm that are statistically significant and those that are not. In fact, very few of the providers in our sample include statistical tests such as 'confidence intervals', and few explain what these are. Likewise, a small number of organisations attempt to explain technical concepts in interpretation, such as risk-adjustment. While measures of quality should be presented in a statistically appropriate and reliable manner, we recognise that this information is often technically complex and requires skilled presentation to a lay audience.

Recommendations for policy-makers

- We recommend that providers see the primary audience of quality accounts as the general public and write their quality account with this audience in mind. This means aiming to be summative and representative of quality across the organisation and balanced across the different dimensions of quality. The measures should be presented with sufficient context and description to be meaningful.
- We recommend that guidance is given about the use of statistical tests, standardised descriptions of common statistical terms and their meanings, and tools are made available to support organisations in ensuring clarity and consistency in the presentation of quality indicators.

Data quality, participation in clinical audit and confidential enquiries

In this section we analyse the responses of providers to the requirements relating to data quality and participation in national audits and confidential enquiries mandated in the Department of Health toolkit. We also comment on the performance of providers in these areas.

Data quality

High-quality data is vital for a number of reasons, including to ensure that information about the quality of care is accurate and forms the basis for meaningful planning. It also supports decision-making processes, the reimbursement process for services provided, patient choice and public accountability. A number of quality indicators are derived from Hospital Episode Statistics (HES), which are compiled from the Secondary Uses Service (SUS) and contain details of the records of inpatients, outpatients and patients attending accident and emergency (A&E) departments.

The Department of Health toolkit included a mandatory requirement for providers to confirm whether or not they submit returns to SUS for inclusion in HES and, if they do, then to show the quality of their data for specified data fields. For the NHS number and General Medical Practitioner (GMP) fields, they were asked to provide this information separately for inpatients, outpatients and A&E department attendees. The NHS number is important because it is the key patient identifier, and the GMP code is important for transferring patient information between providers and GPs. Diagnostic and procedure coding is important for assessing the quality of care and for payment purposes. Information on the coding quality of NHS number and GMP codes is available from the SUS Data Quality Dashboard, which organisations can access from the Information Centre. Information on the coding quality of diagnoses and procedures is available from the Audit Commission, which assesses NHS trusts' data quality in the context of Payment by Results.

Table 5, opposite, shows the number of organisations in our sample that provide information about the coding of NHS numbers and GMP codes. Many organisations, such as specialist and mental health trusts and independent providers, do not provide A&E services and were therefore not required to complete this section. But it appears from the table that, while all acute foundation trusts and specialist trusts provide the required information, a few acute non-foundation trusts and mental health trusts do not or provide incomplete data.

Of the five independent providers of acute services, only one provides this information. It is unclear why other independent organisations providing, for example, elective surgical or other care for NHS-funded patients do not comment on the data quality section in relation to their NHS-funded patients. Independent mental health service providers are not required to submit data to SUS for their NHS patients.

Table 5: Organisations submitting SUS data

Data field/provider type	Total number of organisations in the sample	Organisations submitting SUS data for:		
		Inpatients	Outpatients	A&E
NHS number				
NHS acute - foundation trust	12	12	12	11
NHS acute - non-foundation trust	22	21	21	20
NHS specialist acute	4	4	4	-
Independent acute	5	1	1	-
NHS mental health foundation trust	9	9	6	-
NHS mental health - non-foundation trust	8	7	6	-
Independent mental health	4	0	0	-
GMP code				
NHS acute - foundation trust	12	12	12	11
NHS acute - non-foundation trust	22	18	18	18
NHS specialist acute	4	4	4	-
Independent acute	5	1	1	-
NHS mental health foundation trust	9	8	5	-
NHS mental health - non-foundation trust	8	7	6	-
Independent mental health	4	0	0	-

For NHS trusts that provide this information, valid coding of NHS number and GMP codes ranges from about 90 per cent to 100 per cent between providers (with the exception of Buckinghamshire Hospitals NHS Trust, where coding is considerably poorer). Although the quality of coding on these key fields is quite good, it should, in fact, be 100 per cent accurate.

Payment by Results tariffs do not yet apply to mental health services, and the Audit Commission's current audits of Payment by Results clinical coding include only NHS organisations (although some independent providers are providing services subject to Payment by Results tariffs). Hence only NHS acute and specialist trusts were expected to provide the information on quality of diagnostic and procedure coding.

While all 4 specialist and all 12 acute foundation trusts in our sample provide this information, 4 of the 22 acute non-foundation trusts do not. The coding quality of diagnoses and procedures differs significantly between providers from good to poor, with one-quarter to over one-third of codes being incorrect for some providers. Overall, across the 33 acute and specialist trusts in our sample, the proportion of incorrect codes ranges from:

- 1.3 to 49.5 per cent for primary diagnosis
- 1.5 to 35.8 per cent for secondary diagnosis
- 0 to 29.8 per cent for primary procedure
- 0 to 27.8 per cent for secondary procedure.

Hospital Episode Statistics include a large number of other data fields about the care patients receive, and the outcomes, but the toolkit did not ask for the quality of other fields to be reported. Nor did the toolkit ask for mental health trusts to report on their data quality in the Mental Health Minimum Data Set (MHMDS), which is a national data set of records for users of NHS specialist mental health services (community and inpatient). However, some mental health trusts do provide this information as part of

their reporting on performance against Care Quality Commission assessments, which includes assessment of data quality on the MHMDS.

Participation in national clinical audits

Clinical audits are intended to be used by clinicians as a tool for improving the quality of care in specialist clinical areas. A high level of participation in clinical audits provides assurance that quality is taken seriously by the organisation and the results are used for monitoring and improving practice. The Department of Health toolkit asked providers to specify which national clinical audits covered the services they provide, the proportion they participated in, and the completeness of participation. A small number of NHS trusts and about half of the nine independent sector organisations (acute and mental health combined) do not provide this information (See Table 6 below).

Table 6: Providers submitting information about participation in national clinical audits

Provider type	Required information provided on clinical audit	Partial information provided on clinical audit	Did not attempt clinical audit section
NHS acute	29	3	2
NHS specialist	2	1	1
Independent acute	2	0	3
NHS mental health	15	1	1
Independent mental health	2	1	1

Furthermore, participation in clinical audit is far from complete (See Table 7 below). However, the number of audits that individual NHS organisations say they are eligible to participate in ranges widely from 5 to 54 in the acute sector and from 2 to 10 in the mental health sector. The few independent sector organisations that provide this information report eligibility for only one or two audits. Of the nine independent providers, two providers of acute services (Clinicenta and Shepton Mallet NHS Treatment Centre) and two providers of mental health services (Priory Healthcare and St Andrew's Healthcare) say they are eligible for and participate in national clinical audits.

Table 7: Rates of participation in national clinical audits

Organisation type		Number of clinical audits eligible for	Number of clinical audits participated in	Average stated percent participation
NHS acute trusts	Max	54	43.0	100.0
	Mean	30.4	24.0	85.9
	Min	5.0	5.0	51.3
NHS mental health trusts	Max	10.0	8.0	100.0
	Mean	5.3	3.8	67.5
	Min	2.0	0.0	0.0
NHS specialist trusts	Max	22.0	20.0	90.9
	Mean	19.0	13.0	76.3
	Min	16.0	6.0	38.0

Participation in clinical audit is of little practical use unless the information is collected for all patients covered by the audit. Coverage in audits is far from complete across all sectors, varying significantly both in terms of individual organisations' coverage across

the different audits they participate in, and between organisations. A small number of providers report good coverage across all clinical audits they participate in (these include Airedale NHS Foundation Trust, Guy's and St Thomas' NHS Foundation Trust, Mid Essex Hospital Services NHS Trust, Royal Brompton and Harefield NHS Foundation Trust, Surrey and Sussex Healthcare NHS Trust, and Walsall Hospitals NHS Trust).

Participation in national confidential enquiries

National confidential enquiries are designed to improve the learning from failures of care as a mechanism for driving quality improvement. The Department of Health toolkit asked providers to specify their eligibility for and participation in the three national confidential enquiries: National Confidential Enquiry into Patient Outcome and Death (NCEPOD); Centre for Maternal and Child Enquiries (CMACE); and the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI/NCISH).

Virtually all NHS providers provide information on participation in national confidential enquiries. Of the 34 NHS providers of acute services, almost all provide this information, and most say they were participating in both NCEPOD and CMACE. All 17 mental health trusts in our sample say they participate in the NCI/NCISH.

None of the five independent providers of acute services report on this section, although it is likely that at least some of their services fall under the remit of the national confidential enquiries. Of the four independent providers of mental health services, two say they participate in the NCI/NCISH (Priory Healthcare and The Huntercombe Group).

Conclusion and recommendations

Data quality

The very purpose of quality accounts is undermined if the information on which they are constructed is flawed. Although arguably inclusion of data quality in quality accounts may be of little interest to a lay audience, it puts a public focus on an important aspect of providers' performance. As the Bristol Inquiry (Kennedy 2001) showed, organisations cannot assure the quality of their care without robust information systems and failures of care can go undetected if such systems and monitoring processes are not in place. A report by the Audit Commission notes that, although the NHS has made progress in improving the accuracy of its clinical coding, significant variations between trusts persist (Audit Commission 2010). The Commission estimates that, of the £21 billion spent on the four specialties they audited for three years, £1 billion (5 per cent) was incorrectly paid. Reports produced by the Information Centre show significant deficiencies in the quality of data submitted by independent sector providers of NHS-funded care, which are required contractually to submit similar datasets as the NHS (Information Centre 2009). If measurement is to be a driver for improvement and for public assurance about the quality of care, it is critically important that the data about patients collected by all organisations is complete, accurate, and complies with nationally defined specifications and standards.

Our analysis shows that there is significant room for improvement in the coding of even basic fields such as the patient's NHS number and GMP code. Diagnostic and procedure coding has improved over the years, but it shows variation across trusts and needs to get much better. We also found that most independent providers of NHS-funded care do not provide this information. This could be because their data quality is not audited by the Audit Commission and it is not clear whether or not the Information Centre's Data Quality Dashboard includes NHS-funded independent providers.

We also think that public accountability for data quality must extend well beyond just the few core data fields that the Department of Health toolkit asked organisations to comment on. It should be more comprehensively assessed and publicly reported on. Mental health trusts are required to complete the MHMDS and it is equally imperative that their data quality is fit for purpose. From April 2010, independent and third sector mental health providers are required to collect the MHMDS, and it would therefore be appropriate for them to report on their data quality in the 2011 quality accounts.

It should be noted that these data quality assessments relate to the validity of the codes used, they do not provide a guarantee that the appropriate valid codes are used for every patient in each instance.

Recommendations for providers on data quality

- All providers of NHS-funded services should use tools such as the SUS Data Quality and Data Coverage Dashboards from the Information Centre to monitor their data quality on a regular basis and to ensure continuous improvement where indicated.
- Mental health service providers should use the Information Centre reports on the quality of the MHMDS to monitor and improve data quality.

Recommendations for policy-makers on data quality

- Quality accounts need to provide more demanding information about data quality and should include a summary but comprehensive measure of HES data quality.
- All providers of NHS-funded care, whether NHS or independent, should be required to submit information on data quality in their quality accounts.
- For mental health trusts, and independent sector providers of mental health services, this requirement should extend to reporting on the quality of their MHMDS data.
- The information about HES data quality held by the Information Centre should be published for all providers of NHS-funded care.
- The Audit Commission has had an important role in data quality and it will be important for these functions to be retained elsewhere if the Audit Commission is dissolved.

Clinical audit and confidential enquiries

As with data quality, participation in clinical audit and confidential enquiries may be of limited interest to much of the audience for quality accounts. However, again, it does shine a spotlight on an important aspect of provider performance. While participation rates in the three national confidential enquiries are almost complete, our analysis shows highly variable participation rates in clinical audits. There also appears to be some lack of clarity about the requirements for reporting on this by independent providers of NHS-funded care.

Monitoring and acting on clinical audit data is critical for improving the quality of care and for public assurance, hence we strongly support its mandatory inclusion in quality accounts. However, the mandatory sections on clinical audits and confidential enquiries are lengthy and often comprise several pages in a quality account, as they

require providers to submit lists of all the audits they are eligible for, participate in, and completion rates. It is questionable whether this level of detail is of interest or relevance to a public audience and consideration should be given to the optimal way of presenting this information.

Recommendations for policy-makers on clinical audits and confidential enquiries

- Feedback on participation in clinical audits and confidential enquiries should continue to form a mandatory component of quality accounts, and the reporting requirements for independent providers should be made clear. However, the format of this section needs to be reconsidered, or be moved to an annex or a central website, given the length and detail of the content required and its questionable relevance for patients and a lay audience.

Patient and public feedback, local involvement and external scrutiny

As well as presenting information about quality and performance, quality accounts must demonstrate local accountability. Quality accounts should show what feedback patients and the public have given about the quality of services and whether any action has been taken by the trust to address any issues. Local community stakeholders should be given the opportunity by providers to ‘shape’ the content of the quality account, as well as to review and comment on it.

Providers are encouraged to begin conversations with stakeholders at an early stage in the production of quality accounts and then to maintain an ongoing dialogue. These were key findings of our previous research with stakeholder groups on accounting for quality (Foot and Ross 2010).

There are a number of ways in which providers can involve others in producing the quality account, including:

- capturing opinions about content and priorities for quality improvement
- inviting the lead commissioning primary care trust (PCT) to review and comment on the quality account (mandatory)
- inviting health overview and scrutiny committees (HOSCs) and local involvement networks (LINKs) to review and comment on the quality account (optional)
- inviting feedback from the general public on the published quality account and suggestions for content in next year’s quality account.

In this section we review how the feedback and views of patients, the public and other external stakeholders have been reflected in the quality accounts. We look at:

- feedback from patients and the public, including national and local surveys, ‘real-time’ feedback and qualitative feedback such as patient quotes
- involvement in service design and delivery
- involvement in the quality accounts process
- whether feedback is sought on the quality account
- the external statements from PCTs, LINKs and HOSCs.

Feedback from patients and the public

Feedback can enable a provider to monitor the quality of its services from the point of view of patients and others. The quality accounts were analysed to explore whether providers make any reference to gathering feedback from patients during the previous year and plans to do so in the year ahead. The methods used to gather patient feedback were of particular interest.

Analysis shows nearly all providers refer to patient feedback from the previous year with only a very small number of exceptions (which are all acute service providers). The methods used by more than half of providers to capture feedback during the previous year can be grouped into two broad categories:

- national inpatient and outpatient surveys co-ordinated by the Care Quality Commission
- local inpatient and outpatient surveys carried out or commissioned by individual trusts.

In terms of the local surveys, around one-third of providers refer to obtaining feedback in 'real time', particularly regarding patient experience. This means providers surveyed patients' opinions periodically during the past 12 months. The purpose of real-time feedback is to collect and assess data more quickly and use the opportunity to make timely service improvements (Department of Health 2009). Within the sample, popular methods of carrying out real-time surveys are using electronic, hand-held 'Patient Experience Trackers' (PETs) which enable providers to download data and change the questions being asked in local surveys if desired.

Reviewing complaints or compliments received from patients and the public about the quality of services is another common method cited by around one-third of providers. Other methods to gather feedback are also given, including reviewing contacts made via patient advice and liaison services (PALS), feedback received from patient forums and comments left on the NHS Choices website.

We identified a small number of providers using methods of gathering patient feedback that we consider to be particularly innovative. For example, in their quality account, Walsall Hospitals NHS Trust states it has established focus groups in clinical areas so that patients can share their views directly with the staff involved in their treatment, although it is disappointing that no further details are given about the process or outcomes.

It should be noted that a few quality accounts only make vague references to patient feedback and do not provide much or clear information about the methods used. Here is an example of ambiguous text about how real-time feedback is being collected (verbatim): 'Patient Opinion supporting real-time feedback from patients has been introduced'. No further details are provided about the tools that were used or an explanation that 'Patient Opinion' refers to an organisation.

We also looked for statements about providers' plans to collect patient feedback in the future. Overall, around three-quarters of providers state they have plans to capture patient feedback in the coming year or years. Mental health providers do this more than acute providers and NHS trusts do this more than independent providers. A number of providers state they will introduce new surveys or tools that will enable real-time feedback and PETs appear to be particularly popular in this regard, with one provider exploring the option to incorporate the PET into the bedside entertainment system. A small number of providers state they will recruit and train volunteers to carry out local, real-time patient surveys.

According to the Department of Health toolkit, qualitative patient feedback in the form of anecdotes or stories can 'strengthen' quality accounts and demonstrate how patients and

the public have influenced the quality improvement programme (Department of Health 2010c, p 42). Quotes and stories can provide an indication of how patients perceive the quality of care. They can also add a very human and personal dimension to a document that contains a considerable amount of depersonalised data.

Less than half of the quality accounts include qualitative patient feedback. Typically this is in the form of patient stories (which could span a page or more of the document in some instances) or direct patient quotes. In our analysis we found that independent providers tend to include more examples of qualitative patient feedback than NHS trusts, and that non-foundation trusts tend to include more examples of qualitative patient feedback than foundation trusts.

Where included, a modest number of providers have used both supportive and challenging feedback in their quality accounts. For example, Clinicenta summarise some of the positive comments patients made in a patient satisfaction survey about staff being 'respectful' or 'informative' (Clinicenta 2010, p 13) and on the next page they list a number of issues that patients feel need to be improved, such as nurses not offering the 'personal touch the consultants offered' and 'Seeing surgeon too soon post-operatively when [the respondent was] still tired and sleepy' (Clinicenta 2010, p 14). In contrast, the Royal United Hospital Bath NHS Trust includes more than 10 patient quotes throughout its quality account which praises the hospital's staff, levels of cleanliness and the mixed-sex accommodation in the Medical Assessment Unit. This can leave the reader with an unrealistic impression that the provider needs to do very little to improve the quality of its services.

A small number of providers present patient quotes without the date or source. Consequently the reader cannot be certain what time period the quote is being used to illustrate or where the quote has come from. Patient stories can be emotive and attention-grabbing so it is necessary to have some context and transparency attached to them.

Feedback from the general public on quality accounts

We were interested to determine whether providers use the quality accounts to make it clear that feedback would be welcome about the content of the quality accounts and ideas for next year's content. Analysis showed this is stated explicitly in less than one-third of the quality accounts and NHS providers did this much more than independent providers.

A good example of seeking public feedback is provided in the quality account for Shrewsbury and Telford Hospital NHS Trust. After the quality improvement priorities for 2010/11 have been outlined, the trust asks readers for their views on quality priorities. Specifically readers are asked in what areas the trust could make the biggest improvements and how, in what way patients and communities can be involved in improving quality and suggestions for priorities in 2011/12. Later in the document, readers are also asked for their views on the presentation of the quality account and instructions are given about how to give feedback to the trust.

Involvement

Involvement in service development

Patient and public involvement refers to being involved in shaping health care services. Within this study we made a distinction between involvement in service development (or delivery) and involvement in the quality accounts process specifically. Around three-quarters of providers refer to involving patients and the public in service development. NHS trusts mention involvement activity more than independent providers, particularly with patients, and foundation trusts mention involvement activity more than non-foundation trusts. Methods given include:

- seeking feedback through focus groups or surveys
- including individuals in service development, for example, patients/service users being involved in the recruitment of new staff
- including patients in board meetings or committees
- various other activities, for example, campaigns to promote hygiene on wards.

Involvement in the quality accounts process

It is understood to be best practice for quality accounts to describe how decisions on content (including quality improvement priorities) were made, who was involved in the process and how the views of patients, the public, commissioners and stakeholders have been taken into account. Our previous research on quality accounts showed LINKs and HOSC members feel strongly that their involvement in the process must be an 'ongoing' and 'meaningful two-way dialogue' (Foot and Ross 2010, p 7 and p 11 respectively). Thus, we analysed quality accounts to determine whether trusts involved others in the process of producing quality accounts for 2009/10 and if so:

- who has been involved?
- in what way are others involved?
- is involvement part of an ongoing dialogue?

Around two-thirds of quality accounts refer to involving others in the process. Further analysis shows NHS trusts refer to this type of involvement much more than independent providers, and non-foundation trusts refer to this type of involvement more than foundation trusts. Mental health service providers refer to involving patients/service users, the public and staff more than acute service providers do.

Individuals and groups involved in the quality accounts process

The individuals or groups most commonly cited by providers as being involved in the quality accounts process are commissioners followed by staff, patients/service users and LINKs. The full range of people and organisations are listed in the box below. The ways in which stakeholders are involved vary and this is also outlined in the following sub-section.

People and organisations involved in the development process

- PCT(s)
- staff
- patients/service users
- LINK(s)
- HOSC(s)
- governors
- carers
- members
- general public/the local community
- internal groups/committees* (for example, Patient Safety and Quality Committee)
- trust board
- unnamed stakeholders (for example, voluntary organisations)
- various others (for example, GPs or the strategic health authority).

*In some instances internal committees include patient representatives.

Types of involvement in the quality accounts process

Analysis showed the text about involvement in the quality accounts process could be categorised as either providing a reasonably detailed description of methods used to involve others, providing a very limited description or providing no description at all beyond stating who was involved.

Reasonably detailed descriptions of methods include:

- discussions or consultation
- meetings
- specific quality accounts events open to staff, stakeholders and the public
- seeking opinions and input by writing to others and putting an announcement in local media, or on the trust website or intranet
- surveys of opinions.

For example, Somerset Partnership NHS Foundation Trust describes using mixed methods of involvement including meetings with the Users and Carers Group in the summer and winter of 2009 to obtain ideas about content for the quality account, as well as sending letters to all members of the Members Council asking for their views. The trust sent letters inviting comments and suggestions to stakeholder organisations. Meetings took place between the trust, PCT and LINK to plan the consultation process and the trust asked for suggestions about the quality account. A number of suggestions were worked into a draft form and then further meetings and presentations took place with the Users and Carers Working Group and the Patient and Carer Experience Group. The consultation process was also featured on the trust's website. Other good examples of involvement noted in our analysis are Norfolk and Waveney Mental Health NHS Foundation Trust, North Staffordshire Combined Healthcare NHS Trust, Shrewsbury and Telford Hospital NHS Trust and South Tees Hospitals NHS Foundation Trust.

Limited descriptions of involvement have been given in a number of instances. This means providers state they have had 'conversations' or carried out some form of 'consultation' with others but they have not given any specific details about how or when. Without this level of detail, it is not possible to assess the extent to which some trusts involved others in the production of their quality accounts.

Ongoing dialogue between providers and stakeholders

We are aware that this is the first year in which providers have been required to publish quality accounts. They may need some more time to embed the practice of seeking patient, public and stakeholder feedback and input to maintain an ongoing dialogue. In part, this could explain why not all providers make reference to this in their 2009/10 quality accounts, particularly independent service providers. Among those providers that do refer to the involvement of others, there is considerable variation in the level of detail provided. This gives the impression that some providers have made more of an effort than others to involve patients, the public and stakeholders in the production of their quality accounts.

External statements from PCTs, LINKs and HOSCs

Missing comments

While the PCT statement is mandatory, trusts are required only to offer an opportunity to the LINK and the HOSC to comment if they choose to. Despite this, almost as many

quality accounts have LINK comments as have PCT comments. Slightly fewer have HOSC comments.

It is important to note that 10 quality accounts do not include the mandatory PCT comment, and therefore the PCTs have technically failed to meet their statutory obligation. Five of these quality accounts are for independent sector organisations which had multiple sites across the country. The issue of how not only PCTs but also LINKs and HOSCs can reasonably comment on national multi-site providers is a serious difficulty in the current regulations. As Lambeth HOSC comments in Marie Curie Cancer Care's quality account:

We understand that you are required to submit [the quality account] to [us] as your principal offices are based in the borough. However... it is questionable whether it is appropriate for the elected members of [the borough] to comment on behalf of the nation... Nor do we consider it appropriate that you should be required to make your Quality Account reflective of... local priorities or locally meaningful when your work is on a national basis... [Also] in order to undertake such a task in a meaningful way would require significant resourcing ...[which]... is considered impossible within existing funding arrangements.

Multiple comments

While most of quality accounts that include statements only include one of any type of statement, a small number have multiple comments. Six include statements from more than one PCT, eight include statements from more than one LINK, and eight include statements from more than one HOSC.

Content of the statements

Statements from PCTs, LINKs and HOSCs tend to focus on a mixture of:

- the quality accounts as documents
- their experience of the process of commenting on the quality account
- the quality of care provided by the organisation.

The quality account itself

Most of PCT, LINK and HOSC comments give some assessment of the quality accounts themselves. Overall, their verdict of the documents is mixed. Slightly more PCTs offer positive comments than negative ones, whereas LINKs and HOSCs give slightly more negative comments than positive ones. Common issues brought up are the inclusion or not of particular issues or services mentioned which they feel are important, and whether or not the content is clear and accessible.

The quality accounts process

LINKs and HOSCs in particular comment on their experience of the process of commenting on the quality account. In total, 33 of the LINKs and HOSCs make either direct or indirect reference to a short timescale for reviewing the quality account and providing comments, and often urge the trust to engage with them earlier next year, which is particularly important for LINKs who need time to consult their members. Some LINKs say they only received the final draft and were disappointed not to have been included earlier in the process. Among PCTs, only four comment that there appears to have been insufficient engagement of others in developing the quality account, and five specifically congratulate their providers on their engagement activity.

Several LINKs and HOSCs explain how they wrote their comment, which was normally either by consulting internally among a few main members or more widely at meetings, and/or meeting with staff from the provider. One LINK – Staffordshire – posted an item on its website inviting comments, but no responses were received.

The quality of care

Overall the LINK and HOSC statements are more positive about the quality of care being provided than they are about the quality accounts documents and process. When making comments about quality, they most often comment on patient experience and patient safety, perhaps reflecting issues which they had particular expertise or interest in, and least often on measures of the clinical effectiveness of care. Other themes in the comments are: access to services, including whether or not particular services are provided by the trust, and problems with discharge. The PCTs also commented less on clinical effectiveness than on patient safety and patient experience. They too raised many other themes outside of these domains of quality, such as issues around data quality, the use of agency staff, relationships with social care and performance against access targets.

Conclusion and recommendations

To summarise, we can see the extent to which providers have involved others in the production of quality accounts is variable; there are some very good examples of involvement and some poorer ones too. Most providers refer to ‘gathering patient feedback during the past year’. It is important, however, that this momentum is maintained and the collection of patient feedback continues to be a priority. Increasing the use of real-time feedback (ideally within two weeks) was an ambition of the previous government and also reflects the current government’s health policy aims, such as information on outcomes being generated in real time by patients and service users (Department of Health 2010d).

Where examples of patient feedback are used in quality accounts (for example, in patient quotes), these provide a personalised point of view of quality. However, a balance of positive and challenging messages and the context of patients’ stories or quotes are important to show transparency.

A number of providers describe involving patients and the public in the development of services but we find it difficult to assess or measure this. ‘Involvement’ is very much open to interpretation so it is not clear to us whether the extent of involvement in service development described by providers in the sample is sufficient and/or good. A wider discussion is necessary about what good patient and public involvement is.

The weakest area is demonstrating meaningful and ongoing involvement of stakeholders in the quality accounts process. Not all providers refer to seeking the input of stakeholders and, where it is highlighted there is not always sufficient description of exactly how stakeholders have been involved. Some providers do not demonstrate that dialogue with stakeholders was more than a ‘one-off discussion’. And some do not make it clear that they welcome the feedback of general readers on the content of the present quality account and suggestions for next year’s quality account. Thus, the extent to which quality accounts demonstrate local accountability is questionable.

In terms of the external statements, it is notable that a significant proportion comment on the short timescales involved. This is clearly a challenge for these organisations and one which risks getting harder if, and when, more types of health care providers, such as primary and community care, are required to produce quality accounts.

Building on the examples of particularly good practice that we found, and learning from the examples of poor practice, a number of specific recommendations are possible for

providers wishing to improve their quality accounts in future years. These are given in the box below.

Recommendations for providers when developing and writing a quality account: patient and public feedback, local involvement and external scrutiny

Patient and public feedback

- Include both positive and negative feedback about services
- Be clear and specific about how you have sought feedback
- Give quotes and stories in context to explain where they come from
- Invite readers of your quality account to make comments and give feedback

Local involvement and external scrutiny

- Seek guidance on how to involve stakeholders in the quality accounts process from the Department of Health toolkit, previous research and good examples of involvement in other organisations' quality accounts
- Recognise and respond to what PCTs, LINKs and HOSCs have said in their comments on this year's quality account
- Begin speaking about next year's quality account to your LINK and HOSC as early as possible and seek to involve them throughout the process of developing the quality account
- Give LINKs in particular as much notice as possible (over and above the 30 days' notice requirement) in which to comment on the quality account, so that they have time to consult their wider membership and/or discuss the quality account at a meeting
- Offer support to LINKs and HOSCs in analysing and interpreting the quality data, particularly the data on clinical effectiveness

One important policy problem is evident in the external scrutiny requirements for multi-site providers. It is not reasonable to expect one particular PCT, LINK and HOSC to provide external comment for multi-site providers, particularly large national providers. This means that these quality accounts may lack any meaningful external scrutiny.

Recommendations for policy-makers on external scrutiny

- We recommend that regulations should be amended to ensure that national multi-site provider quality accounts have alternative scrutiny and external comment requirements.

Where next for quality accounts? Overall conclusions and recommendations

The overriding impression that this analysis gives is of variation and a lack of comparability. The quality accounts are extremely varied on almost all dimensions, from the number and choice of measures and how they are presented, to variation in coding quality and participation in national clinical audits and confidential enquiries, and variation in the extent of local involvement and the comments made by PCTs, LINKs and HOSCs.

While some of this variation arises simply from relatively good or poor practice by providers in complying with the guidance, much of it is an inevitable result of the way quality accounts have been designed. The aims and audiences for quality accounts have been set very broad. A previous discussion paper on quality measurement from The King's Fund noted that information about quality should be tailored around the audiences it is targeted at and the objectives it is intended to support (Raleigh and Foot 2010). To have a generic report that aims to meet the needs of boards, clinicians and staff, patients, the public, HOSCs and LINKs, and commissioners is ambitious; inevitably, any given report will meet the requirements of some better than others, and perhaps of none altogether satisfactorily.

The most fundamental tension at the heart of quality accounts is between requiring content that enables comparability and allowing providers local flexibility in the information chosen. Transparency and comparability is an important policy goal, as we have advocated in previous research on quality accounts (Foot and Ross 2010). In *Liberating the NHS: An information revolution* (Department of Health 2010b), the Department of Health is consulting on its proposals for developing information, which include a proposal for greater standardisation of quality accounts by mandating some of the content to make it easier to compare provider outcomes. This would include identifying use of common standards for benchmarking performance against peers. Greater consistency and more central prescription of some of the measures used in quality accounts would certainly make for greater comparability. To help achieve this, it then arguably follows that a central body could take the role of defining, collecting and publishing these measures (for example, on the NHS Choices website). Having a central body doing this work would enable greater quality assurance of the data and ensure consistency in definitions and presentation formats. It would also enable the public to compare multiple providers on particular measures more easily than downloading separate quality accounts, and it would be less costly than all providers having to produce the relevant material. Individual providers could then also publish these measures in their own quality accounts.

This issue of minimising production costs is important in the context of the financial pressures facing the NHS and wider economy. The production costs are felt not just by the providers themselves but by all the stakeholders involved in quality accounts, including LINKs, HOSCs and commissioners.

Alongside this greater role for core measures defined and published centrally, the local dimension of quality accounts is also important and must be retained. Boards will need to retain responsibility for reviewing and assuring the accuracy of data being collected in their organisation. Greater central support in defining, analysing and publishing quality data should not undermine local governance and accountability for that data. Requiring boards to write and sign up to a statement on performance and their plans for improvement is an important and valuable way to provide greater local accountability for quality. And asking providers to engage their local communities in setting and scrutinising locally-relevant quality improvement priorities has important potential to drive improvement.

Recommendations for policy-makers

- Core quantitative measures of the quality of services should be compiled and disseminated from a central source to enable greater comparability and public accountability for quality.
- This core data could then be reproduced locally in individual quality accounts.
- Alongside this, individual quality accounts should then be free to choose other measures relating to local issues and priorities, remembering that this data should still be benchmarked or provided with trend information.
- An evaluation of the usage by and feedback from various audiences and the production costs (to all stakeholders) should be used to help determine the future frequency of quality accounts.

Our review of the first year's quality accounts has undoubtedly shown that many providers across the country have begun to use them to some good effect to report on a wide range of important quality issues and make that information available to the public. As quality accounts progress in future years, however, it will be important to place them clearly and coherently into the government's broader information strategy. Currently, quality accounts are operating both as a form of local quality improvement and as a form of public accountability. This double purpose has inevitably led to documents which are extremely varied and which cannot be meaningfully compared. While local involvement in and local scrutiny of quality improvement remains essential, and the locally-determined elements of quality accounts could and should retain an important role, we conclude that greater public accountability on quality can be better served with more quality assured, comparative information being made available centrally and replicated consistently in providers' quality accounts.

Appendix: List of providers included in the sample

NAME OF PROVIDER	PROVIDER TYPE
NHS	
Barking, Havering and Redbridge University Hospitals NHS Trust	Acute
Bedford Hospital NHS Trust	Acute
Buckinghamshire Hospitals NHS Trust	Acute
Hinchingbrooke Health Care NHS Trust	Acute
Mid Essex Hospital Services NHS Trust	Acute
Portsmouth Hospitals NHS Trust	Acute
Royal Cornwall Hospitals NHS Trust	Acute
Royal Liverpool and Broadgreen University Hospitals NHS Trust	Acute
Royal United Hospital Bath NHS Trust	Acute
Shrewsbury and Telford Hospital NHS Trust	Acute
Southampton University Hospitals NHS Trust	Acute
St Helens and Knowsley Teaching Hospitals NHS Trust	Acute
Surrey and Sussex Healthcare NHS Trust	Acute
The Hillingdon Hospital NHS Trust	Acute
The Royal Wolverhampton Hospitals NHS Trust	Acute
Trafford Healthcare NHS Trust	Acute
University Hospitals of Leicester NHS Trust	Acute
Walsall Hospitals NHS Trust	Acute
West Hertfordshire Hospitals NHS Trust	Acute
Western Sussex Hospitals NHS Trust	Acute
Winchester and Eastleigh Healthcare NHS Trust	Acute
Worcestershire Acute Hospitals NHS Trust	Acute
Airedale NHS Foundation Trust	Acute foundation trust
Calderdale and Huddersfield NHS Foundation Trust	Acute foundation trust
Guy's and St Thomas' NHS Foundation Trust	Acute foundation trust
Heart of England NHS Foundation Trust	Acute foundation trust
Liverpool Women's NHS Foundation Trust	Acute foundation trust
Norfolk and Norwich University Hospitals NHS Foundation Trust	Acute foundation trust
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	Acute foundation trust
Queen Victoria Hospital NHS Foundation Trust	Acute foundation trust
Royal Brompton and Harefield NHS Foundation Trust	Acute foundation trust
South Tees Hospitals NHS Foundation Trust	Acute foundation trust
University Hospitals Bristol NHS Foundation Trust	Acute foundation trust
Wirral University Teaching Hospital NHS Foundation Trust	Acute foundation trust
Berkshire Healthcare NHS Foundation Trust	Mental health
Coventry and Warwickshire Partnership NHS Trust	Mental health
Derbyshire Mental Health Services NHS Trust	Mental health
Leeds Partnerships NHS Foundation Trust	Mental health
North Staffordshire Combined Healthcare NHS Trust	Mental health
South West London and St George's Mental Health NHS Trust	Mental health
Suffolk Mental Health Partnership NHS Trust	Mental health
Worcestershire Mental Health Partnership NHS Trust	Mental health
Central and North West London NHS Foundation Trust	Mental health foundation trust
Cornwall Partnership NHS Foundation Trust	Mental health foundation trust

NAME OF PROVIDER	PROVIDER TYPE
NHS	
Norfolk and Waveney Mental Health NHS Foundation Trust	Mental health foundation trust
North East London NHS Foundation Trust	Mental health foundation trust
Northumberland, Tyne and Wear NHS Foundation Trust	Mental health foundation trust
Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust	Mental health foundation trust
Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust	Mental health foundation trust
Somerset Partnership NHS Foundation Trust	Mental health foundation trust
Sussex Partnership NHS Foundation Trust	Mental health foundation trust
Great Ormond Street Hospital for Children NHS Trust	Specialist
Nuffield Orthopaedic Centre NHS Trust	Specialist
Clatterbridge Centre for Oncology NHS Foundation Trust	Specialist foundation trust
Royal National Hospital for Rheumatic Diseases NHS Foundation Trust	Specialist foundation trust
Independent	
BMI Healthcare	Acute independent
Clinicenta Ltd	Acute independent
Marie Curie Cancer Care	Acute independent
Ramsay Health Care UK	Acute independent
Shepton Mallet NHS Treatment Centre	Acute independent
Priory Healthcare	Mental health independent
The Huntercombe Group	Mental health independent
The Retreat York	Mental health independent
St Andrew's Healthcare	Mental health independent

References

- Audit Commission (2010). *Improving Data Quality in the NHS: Annual report on the PbR assurance programme 2010*. London: Audit Commission. Available at: www.audit-commission.gov.uk/SiteCollectionDocuments/Downloads/26082010pbrnhsdataqualityreport.pdf (accessed on 26 August 2010).
- Boyce T, Dixon A, Fasolo B, Reutskaja E (2010). *Choosing a High-quality Hospital: The role of nudges, scorecard design and information*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/choosing_a.html (accessed on 23 November 2010).
- Clinicenta (2010). *Clinicenta Elective Surgery 2009/10 Quality Account*. Oxford: Clinicenta Ltd. Available at: www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Documents/clinicenta-electives-final.pdf (accessed on 21 July 2010).
- Department of Health (2010a). *Equity and Excellence: Liberating the NHS*. Cm 7881. Norwich: The Stationery Office. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353 (accessed on 12 July 2010).
- Department of Health (2010b). *Liberating the NHS: An information revolution. A consultation on proposals* [online]. Department of Health website. Available at: www.dh.gov.uk/en/Consultations/Liveconsultations/DH_120080 (accessed on 18 October 2010).
- Department of Health (2010c). *Quality Accounts Toolkit: Advisory guidance for providers of NHS services producing quality accounts for the year 2009/10* [online]. Department of Health website. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_112359 (accessed on 2 June 2010).
- Department of Health (2010d). *Quality Accounts: Written answers and statements, 1 July 2010* [online]. They Work For You website. Available at: www.theyworkforyou.com/wms/?id=2010-07-01a.48WS.1 (accessed on 5 July 2010).
- Department of Health (2009). *Understanding What Matters: A guide to using patient feedback to transform care* [online]. Department of Health website. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_099780 (accessed on 3 June 2010).
- Foot C, Ross S (2010). *Accounting for Quality to the Local Community: Findings from the focus group research*. London: The King's Fund.
- Information Centre (2009). *Data Quality Report for Independent Sector NHS Funded Treatment Q4 2008/09* [online]. NHS Information Centre website. Available at: www.ic.nhs.uk/webfiles/Key%20IS%20information/IS%20Data%20Quality%20Report%20Q4%202008_09_V1.0.pdf (accessed on 18 October 2010).
- Kennedy I (2001). *The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol*. Bristol: Bristol Royal Infirmary Inquiry.
- Raleigh VS, Foot C (2010). *Getting the Measure of Quality: Opportunities and challenges*. London: The King's Fund.

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