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Accounting for quality to the local community

Findings from focus group research

Key points

- Starting this year, providers of National Health Service (NHS) services are required to publish quality accounts – reports for the public on the quality of the services they provide. One objective of quality accounts is to increase NHS accountability to the public on quality.
- Focus group research was conducted with local community representatives – such as members of local involvement networks (LINks), members of local authority health overview and scrutiny committees (HOSCs), voluntary sector and patient group representatives, and foundation trust members and governors – to explore what they want from quality accounts.
- Research indicated that quality accounts were welcomed. Participants were keen to be involved in the process of selecting quality priorities and quality indicators, and saw the potential of using quality accounts throughout the year to help them hold their local NHS to account on quality improvement. Participants made recommendations about how the content of quality accounts could be assured, data and information could best be presented and the documents could be disseminated.
- However, the policy also presents clear challenges. The burden for local community representatives encouraged to be involved in every local NHS provider's quality account could potentially be considerable. Providers and local community representatives will have to determine desirable levels of involvement and engagement in the quality accounts process. It will also be challenging to ensure the documents are perceived as a fair and representative account of quality, particularly given that quality accounts are necessarily only a partial picture of all the services offered by a provider. Careful attention will need to be paid to presenting the information in a way that is simple and concise but that also provides the necessary explanation and contextual information to make the data meaningful.

Introduction

Starting this year, providers of National Health Service (NHS) services are required to publish quality accounts – reports for the public on the quality of the services they provide (Department of Health 2008). Quality accounts aim to:

- increase NHS accountability to the public about quality by making more information about quality available to the public
- encourage boards (or the equivalent senior management) to focus more on quality improvement to achieve a change within NHS organisations by requiring them to produce and sign up to a report of their performance on quality.

Quality accounts form one part of the government's NHS quality framework – a suite of policies designed to improve the quality of care (Department of Health 2009a). The box below summarises recent guidance on quality accounts.

Recent guidance on quality accounts

(Department of Health 2010a; Department of Health 2010b; Monitor 2009)

Who must produce a quality account

- 2010: acute trusts, foundation trusts, mental health trusts, ambulance trusts, care trusts and their NHS-funded independent and voluntary sector equivalents
- 2011: quality accounts may be extended to remaining groups of providers, such as general practices, dental practices and community services.

Content (for organisations required to produce their first quality account in 2010):

- a statement from the board identifying how the organisation has assured itself about the quality of services
- an outline of the organisation's quality improvement priorities
- information reporting on locally selected indicators of quality
- some nationally determined content, such as participation in national clinical audits and information on data quality
- a description of how decisions were made about what to include in the quality account, who was involved and how the views of patients, the public and regulators were taken into account
- comment from the commissioning primary care trust (PCT) or strategic health authority (SHA)
- comment from the local involvement network (LINk) and/or health overview and scrutiny committee (HOSC) should they choose to provide it.

Assurance process (for organisations required to produce their first quality account in 2010):

- the board is required to satisfy itself that the quality account is accurate, fair and representative prior to signing it off
- quality accounts must be shared with the appropriate LINk, HOSC and commissioning PCT or SHA at least 30 days prior to publication
- providers are encouraged to begin conversations about the quality accounts with the appropriate LINk, HOSC, commissioning PCT or SHA and other stakeholders at an early stage and then maintain a year-round dialogue
- the PCT or SHA is legally obliged to review and comment on the quality account
- the LINk and HOSC are invited to review and comment on the quality account, on a voluntary basis
- Monitor proposes that the quality accounts of foundation trusts are externally audited to ensure the fairness of the account and the accuracy of the data.

The broad policy goals that underpin the introduction of quality accounts are echoed by all the major political parties. For example, in its draft election manifesto for health the Conservative party stressed:

> *...it is essential that doctors and nurses are properly accountable to patients for their performance. We will unleash an information revolution in the NHS by making detailed data about the performance of trusts, hospitals, GPs, doctors and other staff available to the public online so everyone will know who is providing a good service and who is falling behind.* (Conservative Party 2010, p 7)

This paper presents research about meeting the quality account objective to increase NHS accountability to the public on quality. Focus groups were conducted between August and November 2009 with local community representatives, such as members of LINks and HOSCs and members and governors of foundation trusts, to discuss what they want from quality accounts.

Background

What does local public accountability mean?

Accountability in public services has been defined as: 'the obligation of those entrusted with particular responsibilities to present an account of, and answer for, their execution' (Organisation for Economic Cooperation and Development 2005, p 86).

A review of local government modernisation proposed four components to local public accountability:

- *taking into account* the views of citizens when making decisions and setting priorities
- *giving an account* of performance and decisions to citizens
- *holding to account*, where processes exist for citizens to act on the basis of the account they have been given
- *redress*, where citizens have a right of redress when services do not meet an expected standard.

(Ashworth and Skelcher 2005, p 21)

Providing a right of redress against poor service provision is arguably beyond the remit of quality accounts and is covered by such procedures as the complaints process, judicial review and regulatory mechanisms, such as fines and sanctions. However, the first three of these components are certainly relevant to quality accounts. For quality accounts to function optimally as a form of public accountability they should:

- take into account local views about quality
- give a clear, accurate and representative account of the quality of services
- provide mechanisms for the local community to hold providers to account for their performance. Underlying the concept of 'holding to account' is an assumption that those doing the holding have a degree of power over the giver of the account.

We therefore adopted the definition of 'accountability' used in previous research into the accountability of primary care trusts (PCTs) conducted by The King's Fund (Thorlby *et al* 2008), where accountability is defined as taking into account, giving an account, and holding to account.

How locally accountable are NHS providers?

Accountability in the NHS is complex. NHS providers are accountable in a range of ways to different people and organisations: commissioners, strategic health authorities (SHAs), central government, local government, local scrutiny committees, regulators, individual patients, local communities, local involvement networks (LINks) and, in the case of foundation trusts, the members and governors. However, these different groups have varying degrees of power over the activities of providers. For example, the local community that receives outward accountability wields less legal power than commissioners and regulators receiving vertical accountability.

In terms of local public accountability, three groups are perhaps most important:

- LINks, which are independent networks made up of individuals and community groups who work to improve local health and social care services. They have the power to:
  - enter services to review how they are being provided
  - request information from commissioners
  - make reports and recommendations to commissioners, who are expected to respond.
- health overview and scrutiny committees (HOSCs) of local authorities, which have the right to request information from the NHS. They have to be consulted on all substantial changes to local health services and have the power to refer decisions by local health organisations to the Secretary of State.
- foundation trust members, who are drawn from the local public and staff. They elect a board of governors to represent their views to the trust's board of directors. The trust has a duty to consult the governors about strategic planning and the governors appoint the chair of the board of directors and governors.

LINks were announced in 2007 and were formally up and running from April 2008, but there has been little comprehensive analysis of their impact to date. A survey of all acute trusts, conducted late in 2008, showed that trusts were all aware of LINks, although they had not been set up in some areas and trusts were experiencing difficulty in engaging various stakeholders in other areas (NHS Centre for Involvement 2008). More recently, the Department of Health launched an awareness campaign about LINks (Department of Health 2009b).

Local governments have been scrutinising health since 2003. A survey conducted in 2005 found that just under 40 per cent of NHS organisations had acted on recommendations by HOSCs (Centre for Public Scrutiny 2005), and case study research conducted between 2004 and 2007 found evidence of the scrutiny process leading to small but valued changes and improvements (Centre for Public Scrutiny 2007).

One 2008 study that looked at the role of foundation trust members and governors concluded that the roles of members and governors were ill-defined and weak (Lewis and Hinton 2008). Interview research carried out in 2008 found no significant evidence of the impact of governors (Healthcare Commission and the Audit Commission 2008), although a report conducted for the Department of Health concluded that the foundation trust arrangements had made trusts more aware of patient and public views (Mutuo and University of Birmingham 2008).

While each can play a useful role in local public accountability, the evidence suggests that LINks, HOSCs and foundation trust members and governors have had limited impact. By providing new or greater access to information on quality and requiring trusts to consult on their content, quality accounts could, in theory, be a useful route for LINks, HOSCs and foundation trust members and governors to further strengthen their roles.

Public accountability as a driver for quality improvement

Greater public accountability on quality in the NHS can be seen as a valuable end in itself, delivering greater visibility to tax payers about the performance of a publicly funded service (Dixon and Alvarez-Rosete 2008). However, policy-makers hope that greater public reporting of quality information will also stimulate improvements in quality (Department of Health 2008).

There is a small amount of direct evidence available, mostly from the USA, which shows mixed results about the impact of reporting data to the public (the 'giving an account' aspect of accountability) (Fung *et al* 2008; Shekelle *et al* 2008). Public reporting seems to have only a very limited impact on patients making choices, purchasers (commissioners) and clinicians. However, studies show public reporting has an effect on hospitals, which respond by introducing or focusing more on quality improvement initiatives (Marshall *et al* 2000). This research has demonstrated how putting performance information in the public domain appears to be able to drive change at the hospital level by motivating hospitals to protect or improve their reputation relative to others (Hibbard *et al* 2003; Hibbard 2008). This evidence suggests that publishing data can motivate hospitals to improve, quite apart from any other accountability mechanisms or external pressures they may face.

However, this effect is not universal. An evaluation of the impact of publishing the Scottish Clinical Resource and Audit Group data found that it did not contribute to quality improvement because the data was not seen as credible and lacked timeliness, incentives and external scrutiny (Mannion and Goddard 2003). Public reporting has also been shown to exert a negative effect; for example, intentional misrepresentation, bullying and staff anxiety (Mannion *et al* 2005; Marshall *et al* 2004).

How can public reporting on quality be made most effective?

There is a considerable body of research, which makes the following recommendations for maximising the impact of public reporting on quality improvement:

- ensure good data quality (Audit Commission 2009)
- use standardised measures covering outcomes, the experience of patients and processes of care
- ensure measures are easily understandable and presented in a visually interesting way with clear explanations
- use independent benchmarks (Berwick 2002; Dranove *et al* 2003; Marshall *et al* 2004).

More recent research that looks specifically at quality accounts through an evaluation of a pilot exercise (PricewaterhouseCoopers 2009) and other research into how quality accounts could be used by patients and the public (Ipsos MORI 2009; National Voices 2009) has stressed the need for clear, simple information that patients, the public and LINks can trust and have confidence in. As this paper will show, the focus group participants raised similar issues.

Methodology

In this research, we explore what local community representatives involved in health scrutiny think about quality accounts and what they want from them. This paper aims to provide useful advice to:

- NHS organisations developing quality accounts
- local community representatives seeking to be involved in and influence quality accounts

- policy-makers developing future policy on quality accounts and public accountability for quality.

We conducted five two-hour focus groups between August and November 2009 in Norwich, Cambridge, Bedford, Stevenage and London. These locations were chosen because the NHS trusts in these areas had taken part in the pilot 'quality reporting' exercise earlier in the year (PricewaterhouseCoopers 2009) so locally relevant quality reports were available to use as prompts for discussion. All sessions were audio-recorded and transcribed, and the transcripts were analysed iteratively.

Attempts were made to include:

- people involved in formal local accountability structures for health
- members of local involvement networks (LINks)
- local voluntary sector representatives
- health overview and scrutiny committee (HOSC) members
- foundation trust governors and members.

However, many participants had more than one relevant role, including:

- local authority staff responsible for scrutiny
- member of a patient and user group organised by a local NHS organisation
- service user
- carer.

In total, 35 people took part. Table 1 below demonstrates the split between all the different participant roles.

Role	No of participants in that role
LINk member or co-ordinator	15
Local voluntary sector representative	12
NHS-organised patient or user group	8
Foundation trust governor	6
HOSC member	4
Local authority scrutiny staff	4
Service user	2
Foundation trust member	1
Carer	1
Other	1

Findings

Taking into account

Who to involve

Participants unanimously felt that trusts should take their views into consideration when developing their quality accounts and all agreed that the trust should be legally required to engage the local involvement network (LINk) or health overview and scrutiny committee (HOSC) in the quality accounts process. There was a strong feeling that trusts should engage with and be accountable to the public and that working via the LINk could be an important way of doing this, since part of the remit of LINks is to gather the views of the public.

To have any meaningful involvement in quality accounts, I certainly think we should… provide our own evidence from the public.
(Stevenage participant)

Involving other stakeholders in the process – such as service users, carers, staff and (where applicable) the members and governors of foundation trusts – was also identified as being important.

When to involve

Participants felt it was essential for local involvement to take place early on in the production of quality accounts and that it should be part of an ongoing process of involvement throughout the year. Without early engagement, some participants were wary of being included in a very tokenistic manner towards the end of the exercise when they felt there would be limited time to provide any meaningful input.

Well, what doesn't make practical sense is if it's going to be published on the 1 April say and you get it on the 25 March… because… you've got no chance of altering anything in it, and it's just a matter of rubber stamping.
(Bedford participant)

Involvement in selecting priorities

Some participants stressed that various stakeholder groups, particularly service users and LINks, should suggest which quality improvement priorities the quality accounts should focus on, so that the quality account was meaningful to the local population. It was thought that public involvement would also ensure the information could be trusted to provide a fair account. A small number of participants even suggested that the local community should have control over the selection of a specific proportion of the priorities and indicators.

It has to be something that is determined as objectively as possible by people within the system – that is, the providers, the users, the carers – rather than for point scoring.
(Cambridge participant)

Giving an account

Defining quality

Expectations about the content of quality accounts were very much based on what the term 'quality' meant to the participants. When asked to define 'quality of care', the participants provided a wide range of answers (answers are presented in order from most frequently mentioned):

- patients' points of view on the care they received from the trust
- aspects of the patient experience; such as, satisfaction with care received, being treated with dignity and respect, the way in which trust staff communicate with patients
- accessibility and waiting times
- clinical effectiveness and outcomes (clinician- and patient-reported)
- cleanliness and infection rates.

I think probably the single most important one [definition] *is what the users think.*
(Cambridge participant)

Other information about the trust that some participants wanted included in the quality accounts were:

- the names of trust staff and their responsibilities
- the skills and experience of the clinicians
- the trust's finances
- how the trust provided treatment along the care pathway
- how well treatment was co-ordinated with other services
- whether treatment benefited and was accessible to all groups of patients equally.

Audience

Participants had varied views about who the audience of the quality accounts would or should be. Some suggested individual patients could use them to make choices about where to go for treatment, although others pointed out that the documents would not necessarily cover information about a specific service a patient wanted to know about. Some saw a need for quality accounts to be accessible to the general public for accountability and others saw their primary audience as scrutinisers and representatives of the public who had some knowledge of health issues and were involved in some direct way in holding their local NHS to account.

Benchmarking and comparisons

There was a consensus among participants that the public would not be able to understand data presented by the trust without some contextual information, such as the local population profile, national averages or comparisons with other trusts.

I would still want to know, as a member of the public, what the mortality rate is between hospitals, because that is an indicator to me potentially about the level of care.
(Bedford participant)

It was also felt that comparing performances might motivate clinicians and managers to improve performance and quality where this was needed.

I see it as a mechanism for driving up standards and driving up quality… managers do pay an awful lot of attention to how they are doing relative to where they should be because they are always, always comparing their performance to trusts across the rest of the country and there is no doubt that they want to be the very best trust in the country and so it [quality accounts] will be a mechanism for driving things up, I'm sure.
(Cambridge participant)

Local versus national priorities

There was some debate among the participants about whether quality accounts should be entirely locally determined or have some national mandated indicators. Some participants thought it was important for the content of a trust's quality account to reflect relevant local issues. Issues can vary by area, and a quality account using a 'one size fits all' approach could result in local priorities being overlooked. These participants were aware that the characteristics of local populations differed across the country and that this could have an impact on the outcome data. It would not necessarily be a case of comparing 'like for like':

The quality accounts should be different for every single trust depending on what the issues are in that trust.
(Norwich participant)

However, other participants felt that the content of quality accounts should reflect issues that apply to all trusts so that:

- comparisons could be made
- data would be measured and presented in the same way
- trusts were reporting not only on those priorities against which they had performed well.

For example, commenting on one sample report that had included a table giving performance information against a set of major national priorities, one participant said:

…talking about consistency and measuring and independent verification of facts, we've got the review of quality on the back page here which actually gives all the targets… I think for a little table like that, that's where you'll get consistency… I know the validation procedure for those measurements is very stringent.
(London participant)

Trusting the information

A strong theme to emerge from the analysis of transcripts was the importance of trusting the quality account. Participants generally tended to lack trust in quality accounts and questioned:

- whether the public (or LINks) were involved in deciding the priorities
- where and how the data was produced
- whether the data gives a full and accurate picture of performance (including context)
- whether the data is misleading (for example, through the omission of areas of under achievement).

Be honest; whatever you put in there, it has to be the truth, it's not washed out figures or anything, it has to be God's honest truth.
(Stevenage participant)

I actually doubt their ability to be self-critical… they'll sing their praises and obscure their faults.
(Norwich participant)

The participants came up with the following suggestions for how these questions about reliability and validity could be addressed:

- focusing on patients and patients' concerns will show the trust takes the quality accounts process seriously
- data should be provided with some context and explanation
- data should be made available at regular intervals to external organisations, such as LINks, for scrutiny. This would enable them to build up a picture of quality over a given period so they could verify whether the data included in the quality account reflected what they knew.

Length and level of detail

Although participants wanted to see a variety of information included in quality accounts, some participants did suggest that too much information could be overwhelming. There was a variety of views about what should be included or excluded:

…and surely there's so much information you could do information overload, couldn't you; there could be so many layers of information and then you could have too much.
(Bedford participant)

Participants emphasised the importance of ensuring the report was clear and concise to engage the public. This presents a particular challenge for trusts, who were asked at another point in the focus group to provide a range of additional contextual information which would help explain the data. Generally, a small and manageable number of priorities and indicators were favoured.

If this came through my door I don't think I'd have gotten beyond page four.
(Cambridge participant)

I also like that they've only got four priorities. Sometimes it's too easy to have a shopping list and you just end up not achieving anything.
(Stevenage participant)

Some participants suggested there could be different versions of quality accounts produced that could be delivered in different modes (perhaps online); for example, a brief summary for a lay audience and a more detailed report for those able to scrutinise the information more thoroughly.

Language and presentation

Participants were in particularly strong agreement that the content should be accessible to the public, written in 'plain English' and avoid the use of medical or managerial jargon and acronyms:

I'm reading things here and thinking, 'what does that mean, "in quarter and accumulative trajectories"?'. I know what they mean roughly, but I wouldn't… you know, who's going to look at it?
(Stevenage participant)

We need to go back to plain English, get rid of the stupid terminology, make it readable.
(Norwich participant)

My advice would be 'KiSS': Keep it Simple Stupid.
(Cambridge participant)

Statistical and technical information seen in sample quality accounts was perceived to be unsuitable for a lay audience. Simplification was considered vital in order to retain people's interest in the document. Participants also wanted quality accounts to be visually appealing; for example, pictures could be used to complement the text.

Dissemination

Participants felt the quickest, easiest and least expensive way to disseminate quality accounts was via the internet. However, there was recognition that not all members of the public have access to the internet, therefore there was a need for clear signposting to quality accounts via community routes, such as patient groups and LINks, or hard copies available in general practitioner surgeries, hospital waiting areas, libraries and supermarkets.

Some focus group participants suggested there should also be more active dissemination of quality accounts; for example, through presentations to various community groups:

…do presentations to the Women's Institute, do presentations to the patient participation groups, take it to the local pub etcetera, but it needs to be in the local communities.
(Norwich participant)

There was some concern about how accessible quality accounts would be to individuals with visual impairment or for whom English is not a first language. Participants were keen to encourage trusts to consider the usual ways of ensuring publications are accessible, such as producing audio versions and versions in different languages.

Cost

Although participants' suggestions focused on the additional activity they would want to see trusts engage in to make the most of quality accounts, some participants did question the cost and effort involved in producing them at all. Some participants wondered whether it was a worthwhile use of financial resources to produce quality accounts at a time when budgets were severely constrained. Similarly, some participants were sceptical about diverting time and human resources away from the delivery of high-quality care to produce quality accounts.

I worry about all of these documents, that actually… we're just ticking the box when actually the time should be spent – and the money – on looking after the patients.
(London participant)

Holding to account

Ongoing dialogue

Participants felt strongly that engagement with external organisations should involve a meaningful two-way dialogue. They wanted to feel satisfied that they had been listened to throughout the course of the year and when providing feedback on a draft quality account, and that the trust has taken some action on what they had suggested, where possible.

Focus group participants identified that quality accounts could function as a means to check the progress a trust had made on its quality priorities from year to year. It was suggested that regular updates from the trust would help interested parties keep track of progress. Early and continuous involvement in the process would help participants assess the representativeness of the data presented in the final quality account.

We've got members of LINk on the hospital committees… when the report comes out, because you've been on that committee for the whole year and you've seen it progressing through, you know whether that figure looks right or wrong.
(Bedford participant)

The quality accounts process was also identified as having the potential to develop relationships between LINks and local trusts. Through working together on the content of quality accounts, LINks and trusts could build a better understanding of each other's work.

Providing a written contribution

The guidance on quality accounts proposes that LINks and HOSCs would have the opportunity to provide a written comment in the quality account. There was debate among participants about whether doing this was the most appropriate way to provide feedback and no overall consensus was reached. Those in favour of providing written comment believed that quality accounts should include an explicit public voice. Those participants not in favour of the inclusion of written comments expressed concern that their input could be misconstrued as an endorsement of the trust. It was considered more important to engage these organisations in the quality account process properly and ask them for feedback than to provide them with a discrete section in the report.

We have to be completely independent and I don't think… we should have anything in the report saying, 'LINk has read this, LINk thinks it's good, so should you,' because it's not our job.
(Bedford participant)

Working with the PCT

Guidance suggests that providers commissioning PCTs will also be involved in the assurance of quality accounts, which prompted particular discussion among the LINks members about whether the LINk would want to work closely with the PCT. Participants debated whether their primary relationship was with their PCT or their providers. Overall, it was felt that different LINks would have different relationships and that the process of being involved in quality accounts would vary; some LINks would work well with individual providers and other LINks would work better with their PCT. Again, the underlying concern was that the LINk should always retain its objectivity.

You would have to be careful here that you've got providers and you've got commissioners and I wouldn't like to think that LINks are going to take one side or the other.
(Stevenage participant)

Capacity

Some participants pointed out that LINks and HOSC members involved with more than one trust may find it challenging to provide feedback on numerous quality accounts. Some expressed concern about the time commitment required to consult on a number of different quality accounts and the availability of support to understand complex data. If participants were invited to be involved in more than one quality account, they said they would need to decide whether or not they had the capacity to comment on more than one quality account.

When you're dealing with consultation, the kind of time required by a voluntary group is so much different to the actual professional situation where people are being paid to do something as opposed to people who might not be meeting for another month. And, of course, in August and December, you don't have any meetings at all. And that's the kind of practical problem that will need to be addressed in some way.
(London participant)

Participants tended to agree that quality accounts had value as a tool for holding NHS organisations to account only if they themselves chose to make use of them.

I would have thought... it's a question of how much we want to hold them to account. If they produce these figures or at least update them on a monthly basis, when we see things slipping, surely it's then up to us.
(Norwich participant)

Others stressed that support would be needed, and perhaps PCTs could provide it.

It's really important for the PCTs to make sure they train and… support the LINks, if they want meaningful engagement… do some capacity building.
(Bedford participant)

Overall value of quality accounts

Towards the end of the focus groups, participants were invited to suggest how much difference they felt quality accounts would make to public accountability for quality. Views varied from 'not very much at all' to 'quietly optimistic'.

I think they'll just be viewed by the trusts as yet another piece of paperwork they've got to complete.
(Norwich participant)

It's the 'oxygen of publicity' as they say. Because I think this work does go on… I'm not cynical enough to think it doesn't – and there are improvements – but the role [of quality accounts] is to make the NHS institution more accountable. And it's a pretty good stab at that.
(London participant)

Discussion

While the participants came from a range of organisations, there was a strikingly high level of agreement on most topics. Three particularly strong themes emerged:

- involvement
- trust
- presentation.

Involvement

Participants unanimously saw the development of quality accounts as a process that would benefit from patient and public engagement and involvement. Quality accounts have the potential to help trusts to involve and be accountable to their local communities. For quality accounts to be a success in this regard all the elements of successful patient and public engagement and involvement are required, in particular:

- the provision of appropriate and accessible opportunities for involvement
- early and frequent dialogue
- an openness to change as a result of involvement.

This means discussing what the content of the quality account should be with organisations like local involvement networks (LINks) and health overview and scrutiny committees (HOSCs).

Interestingly, participants took a much broader view of quality than the current favoured definition – safety, effectiveness and experience (Department of Health 2008) – and emphasised that a quality account could cover issues such as inequality, access, efficiency and value for money. Some participants also pointed out that patients often felt quality of care was worst at the interface between organisations. This raised concerns about whether the organisational focus of quality accounts would deter organisations from considering quality across organisational boundaries and across health and social care. This is increasingly important for people with long-term conditions or complex needs, such as people with mental health or substance misuse problems. At the very least, quality accounts are unlikely to be a means to deliver public accountability on this aspect of quality.

Many of the participants raised as an issue the potential practical difficulties of taking part in the quality accounts process, particularly if invited to be involved in more than one. Even in the first year all acute trusts, foundation trusts, mental health trusts, ambulance trusts, care trusts and their independent and voluntary sector equivalents will produce a quality account, and in the second year this may extend to every general practice and primary and community care provider. This could potentially create an enormous burden on LINks and HOSCs, which might have to be selective about if, where and how they engage in the quality accounts process. There is a risk that annual cycles of quality accounts from large numbers of organisations will overwhelm the capacity of those who want to be involved in them.

Early involvement in the quality accounts process will probably be limited this year since quality accounts are a new requirement for trusts and some trusts may have been waiting for the recently published Department of Health guidance before giving the policy their full attention. So, it is likely that the aspirations of participants for close involvement will be met in only a small proportion of cases. However, the introduction of quality accounts could in theory prompt a self-improving cycle: quality accounts may promote greater involvement, which may lead to more successful quality accounts, which may prompt further involvement.

To what extent trusts should invest in and prioritise this activity is another important question. What is the right amount of local involvement? Should the NHS strive to achieve the final rung of citizen control on Shelley Arnstein's famous ladder of citizen participation (Arnstein 1969)? This research has not set out to answer these questions. The published guidance on quality accounts, and indeed the guidance on patient and public engagement and involvement more generally, sets basic statutory requirements and promotes best practice, but stops short of being explicit about what sort of impact this engagement and involvement activity should achieve and leaves the ultimate decision about how far to take involvement in the hands of trusts, their commissioners and their local communities. These groups will have to judge for themselves how much energy and how many resources to devote to involvement in quality accounts and be aware of any opportunity costs this may present for local engagement in other matters, such as commissioning or service redesign.

Trust

One of the most significant risks of quality accounts as a form of public accountability is that local communities do not trust they are honest and representative accounts of the quality of care provided. Issues of trust and confidence came up repeatedly in every focus group. Our participants felt that it was likely that quality accounts would resemble public relations brochures rather than honest 'warts and all' evidence. This led some participants to have serious reservations about the usefulness of quality accounts. Consequently, it was considered essential to have some form of external independent assurance of the content.

One simple way of maximising trust in the data provided would be for the government to require the inclusion of a nationally mandated set of indicators on specific elements of quality. However, after two rounds of consultation, the Department of Health is allowing trusts to choose the indicators they feel are most appropriate for them. This provides trusts with the freedom to make quality accounts more relevant to their local priorities and minimises the risk of distorting local clinical priorities that may result from employing a specific set of national indicators. However, trusts will need to work harder to ensure and demonstrate that their data is robust, fair and representative. Choosing indicators, such as the Indicators for Quality Improvement, will help ensure that the data presented is nationally comparable and consistent, and less open to challenge. Successful involvement of groups such as LINks, HOSCs and foundation trust members and governors in the choice of priorities and indicators will help ensure that the choice of indicators is fair and representative and limit the risk that important areas of local concern are missed.

Trust could also be improved by adding other formal scrutiny and assurance procedures. The Department of Health has concluded that it would be inappropriate to require costly new systems to be introduced to provide external assurance of quality accounts, at least in their first year. Our research indicates that trust is such a fundamental issue to the success of quality accounts, it is likely that further levels of assurance will need to be developed over time. It is interesting to note that the early proposals from Monitor for foundation trust quality accounts include external audit, which is a step further than the Department of Health's guidance for NHS trusts (Monitor 2009; Department of Health 2010b). The Department of Health is committed to consulting with those involved in the first year of the process to learn from the experience – no doubt this will include assessing the degree to which stakeholders feel the documents are sufficiently assured – and is already considering further additional assurance mechanisms (Department of Health 2010b).

It is important to recognise that quality is complex and multidimensional, and that any organisation will necessarily have to select what is covered in their quality account. Although an organisation may have good intentions and may have taken great care to ensure involvement and assurance, quality accounts will always be open to challenge about what is included and what is left out.

Presentation

The final prevalent theme that emerged from our research was the importance of presentation. Quality accounts are intended to be public documents and as such should be very readable, yet the quickly compiled pilot quality reports that were used in the focus groups to prompt discussion received a mixed, but generally poor, assessment from our participants. This echoes the findings of the formal evaluation of the pilot exercise (PricewaterhouseCoopers 2009). Ideas to improve readability originating from the focus groups included:

- provide contextual information, particularly some reference to how the trust compares to national averages or benchmarks, to enable the reader to understand if the data represents good, great, or poor performance
- produce different versions of quality accounts for audiences with varying levels of interest and understanding
- avoid the use of jargon
- explain data clearly.

Conclusion and recommendations

There is no doubt that quality accounts provide an opportunity for greater public accountability on quality across three dimensions: *taking into account*, *giving an account* and *holding to account* (Ashworth and Skelcher 2005, p 21). However, while trusts may find the letter of the policy relatively straightforward to fulfil, our research shows that achieving the spirit of the policy will be more challenging. As stated at the start of this paper, quality accounts have two aims:

- to increase NHS accountability to the public about quality by making more information about quality available to the public
- to encourage boards (or the equivalent senior management) to focus more on quality improvement by requiring them to produce and sign up to a report of their performance on quality.

It may prove that this second aim, where quality accounts motivate change at board level, will be a more powerful driver of quality improvement; we do not know at this stage. However, public accountability as an objective of quality accounts has the potential to drive quality improvement and is also a valuable end in its own right. This research suggests that a commitment to involvement, maximising trust and ensuring good presentation will help this policy achieve its goal of greater public accountability for quality.

Recommendations for national policy-makers

- Continue to support and encourage trusts to give due attention to involving and engaging both staff and the local community in the selection of indicators and priorities. In doing this, consider what it is hoped involvement and engagement will achieve and what level of involvement and engagement is required for this to happen.
- Evaluate the success and impact of the first year of implementation of this policy, paying particular attention to the extent to which stakeholders feel the documents are sufficiently assured and building in further levels of assurance as needed.
- Explicitly encourage organisations not to allow the quality accounts process to stop them from also focusing on the quality of care at the interface between organisations and along care pathways.
- Consider if and how quality accounts could be expanded in future years to provide greater public accountability on efficiency, value for money and equity.

Recommendations for providers and commissioners

- Input from local involvement networks (LINks), health overview and scrutiny committees (HOSCs), members and governors, and other patient and public groups should be sought as early as possible. Trusts should see quality accounts as a year-round process and provide regular data updates throughout the year.
- It will be important to review your services as comprehensively as possible and make judgements about how to select a sample of indicators that will accurately and fairly represent the overall quality of services you provide. The views and input of stakeholders, including commissioners, will also help decide which priorities and indicators to select.
- Providers and commissioners can work together with their local quality observatory to ensure good data quality and the use of robust and comparable indicators. The King's Fund has recently published a discussion paper entitled *Getting the Measure of Quality*, which provides guidance on how to develop and use effective quality measures (Raleigh and Foot 2010).
- Pay due attention to how readable and accessible your quality accounts are. Work in the USA (for example, talkingquality.gov and the wider work of the US Agency for Healthcare Research and Quality) offers advice on how to present quality information for a public audience.

Recommendations for LINks, HOSCs, foundation trust members and governors, and local patient, service user and community organisations

- Prepare for how you will respond to invitations to comment on quality accounts, including how you will come to a view on:
  - which providers it is important for you to work with if you are invited to work with more than one
  - which priorities and indicators of quality should be included
  - whether the data is presented clearly and provides sufficient context to be meaningful

  - whether you think the data presented is a balanced representative picture of the quality of care for that provider
  - who should be involved in deciding and commenting on the content.
- Consider ways in which you could best co-ordinate your activities with others. Individual patient and service user groups and community organisations could consider working with their LINk if they do not already do so. Neighbouring LINks could consider sharing or dividing responsibilities if there are particularly large or specialist trusts serving more than one LINk area. LINks, HOSCs and PCTs could work together to agree how they will comment on the content.
- Discuss with your local provider(s) how you can best work together and be involved in the quality accounts process throughout the year.

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