



QUALITY ACCOUNTS

INFORMATION YOU NEED TO KNOW

NHS

The
Information
Centre

for health and social care



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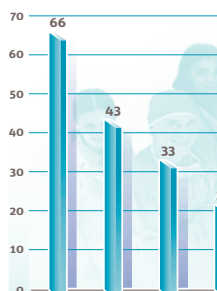
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FOREWORD SIR BRUCE KEOGH

New era of assurance

High Quality Care for All made explicit the need for all clinical teams to measure what they do, in order to continuously improve quality in the services the NHS provides to the public. But the key to this relationship is not in the measurement itself, but how the information is used and what changes are made as a result. This is a long way from where we are and will present a significant challenge.

The primary purpose of Quality Accounts is to change NHS culture by ensuring trust boards work with clinicians to assess quality across all services with an eye to continuous quality improvement. If designed well, the accounts will assure commissioners, patients and the public that trust boards are regularly scrutinising every one of their services in the three domains of quality.

While Quality Accounts require boards to be accountable for their decisions relating to quality improvement, information about quality needs to be discussed honestly with all those with an influence and interest in the organisation and hence the requirement for commissioners and others to be involved in the production of the accounts.

Validity of the published data will be key to the credibility of the accounts so, following discussions at the National Quality Board, Monitor has launched a consultation on the assurance processes for quality accounts, which we hope will provide lessons for all providers in ensuring accuracy of published accounts.

Achieving consensus on the standardised methodology and presentation of financial accounts took many years and was built on iteration and consensus. We will do the same but concertina the timeframe from hundreds of years to a few.

This month sees the laying of the relevant regulations before Parliament and publication of guidance on the first Quality Accounts due in June. Piloting of Quality Accounts for primary and community care providers is about to commence in two strategic health authorities, as we spread and mirror the process of engagement and development of Quality Accounts for other sectors.

I therefore welcome this supplement as a useful resource for organisations, as they seek to identify the information they can potentially use for Quality Accounts. It is a timely contribution to a longer debate on how to measure and present an organisational approach to quality of healthcare.

To maximise the opportunity I urge you to draw on the joint expertise and knowledge of the clinical and managerial professions to develop information relating to quality of services, to look at it with a view to improvement, and then to demonstrate your commitment in your Quality Account.

*Professor Sir Bruce Keogh,
NHS medical director,
Department of Health.*



THE PILOT'S EXPERIENCE



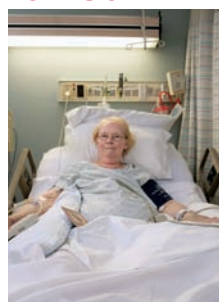
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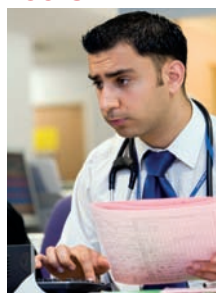
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High quality information for a high level challenge

Quality Accounts present a significant challenge for providers of NHS care. They represent a cultural shift, involving managers and clinicians working together to analyse the quality of care they deliver more rigorously than ever before.

Providers will need to expand and refocus their thinking away from the simple quantitative questions – “how much?” and “what cost?” – to explore the more complex and impressionistic issues of “how good?”, “how worthwhile?” and “how does it feel for patients?”

To support this process, clinical information – both the level of quality it points to and the quality of the information itself – will be placed firmly in the spotlight.

Quality Accounts were introduced in *High Quality Care for All* along with a range of other policies intended to drive care quality. They are also intended to evolve in alignment with each other. Providers, for example, will need to include information about their commissioning for quality and innovation (CQUIN) scheme within their Quality Account.

Quality Observatories too, are expected to support providers in identifying and developing information for quality improvement that can feed into Quality Accounts.

However, the new policies already share a common focus – the need for high quality information as a solid foundation from which to build.

As the central, authoritative source of health and social care information, The NHS Information Centre has the

information that can form the cornerstones of a successful Quality Account, while reducing the burden on providers to seek information from a disparate range of sources.

This supplement examines what information will help providers produce a meaningful quality account, offering advice and examples from those involved with the consultation process and pilot stages: from regulatory bodies and managers to patients, clinicians and providers.

It looks at the type of information commonly used by providers who produced quality reports as part of the pilot stage, and their reasons for doing so.

Information has the potential to not just tick all the boxes in terms of content and structure for initiatives like quality accounts, but to also be used as a blueprint for real change. Regulators like the Care Quality Commission and Monitor, which have been involved in the groundwork for Quality Accounts, may also look to what providers produce in April as a potential marker of commitment to quality improvement.

For a provider to gain a clear insight into the quality of care with offers and how it compares to others, it needs access to high quality information to benchmark and measure against standards. This is integral to accurately identifying quality performance indicators and priorities for improvement that are mandatory for Quality Accounts. In

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The NHS will require more and better information than ever before

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particular the indicators for quality improvement, developed by The NHS Information Centre and the Department of Health, are viewed as a fundamental part of measuring quality for improvement and a vital source of information for Quality Accounts. Clinical audit information and patient survey data are also key to shaping a provider's approach.

The appetite has never been greater within the health service for us to identify and measure productivity and interventions, to maximise our efficiency as organisations while driving improvement in the quality of care.

This is no small challenge. To support this aim, the NHS will require more and better information than ever before.

We hope you find this supplement not only a useful resource to produce meaningful Quality Accounts, but also a spur towards sourcing and using information to meet this wider challenge. ●

Tim Straughan is chief executive and Dr Mark Davies medical director of The NHS Information Centre.





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The NHS Information Centre is England's central,
authoritative source of health and social care information.

We take a close look at what will be required of providers, including the six areas set out in the Department of Health framework and the priorities trusts are selecting

HAVE YOU GOT WHAT IT TAKES?

What are Quality Accounts?

Quality Accounts are short, readable documents in which NHS providers set out how good their services are, where improvement is needed and how they intend to do it. All providers of acute NHS care, including mental health, ambulance and learning disability trusts, must publish one from April 2010. Primary and community providers of NHS care are likely to have to follow suit from April 2011, subject to a testing and evaluation exercise with providers this year.

Why are they being introduced?

Quality Accounts were introduced in *High Quality Care for All* – the final report of the NHS next stage review – alongside several other initiatives all aimed at improving the quality of NHS care.

These include commissioning for quality improvement (CQUIN) schemes, National Institute for Health and Clinical Excellence quality standards and the introduction of Quality Observatories. The initiatives are intended to be closely aligned, meaning there is the potential to use information developed for one to support another.

For example, trusts within NHS Yorkshire and The Humber may use information in the strategic health authority's Quality Account initially developed for the CQUIN scheme (page 14), while NICE quality standards will offer indicators allowing clinical teams to measure their performance and can feed directly into both Quality Accounts and CQUIN schemes.

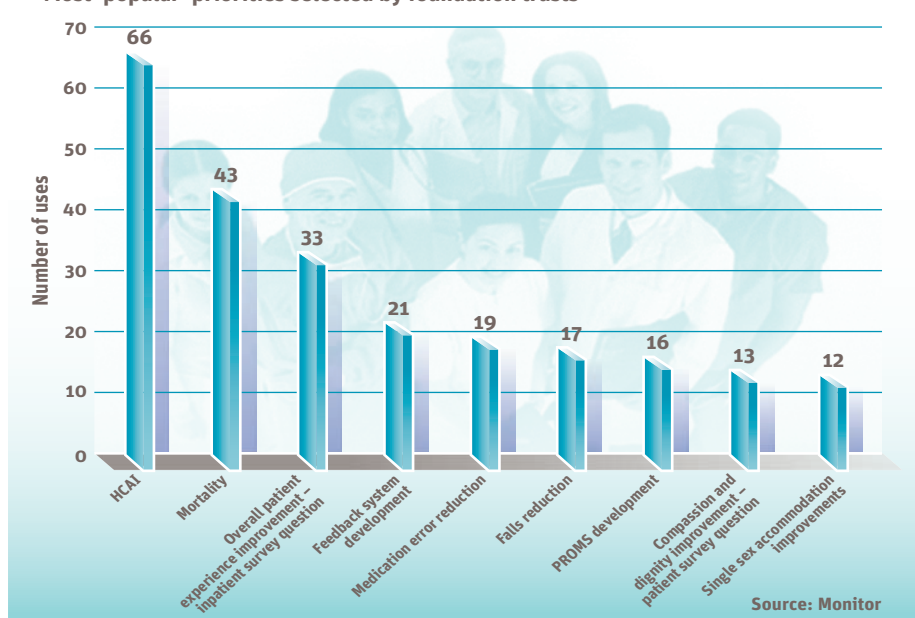
Quality Observatories, required to be established by each SHA, are also expected to help trusts develop local information for use in Quality Accounts and South East Coast Quality Observatory is already helping their trusts with this work (page 13).

Quality Accounts will also help inform and draw from the work of regulators like the Care Quality Commission and Monitor. Details of CQC ratings and registration, for example, are part of the proposed mandatory information for Quality Accounts.

How will they improve care quality?

Because they are a public statement about the quality of care a provider gives, Quality

Most 'popular' priorities selected by foundation trusts



Accounts will encourage providers to focus more sharply on care quality. Finance and performance data, the staple concern of managers, will become more closely mirrored in importance by care quality data. The proposed nationally mandated content within Quality Accounts places a clear onus on the use of information from other initiatives, such as CQUIN, which will mean an alignment in the priorities of managers, commissioners and boards.

Who is responsible for them?

The board of relevant provider organisations will be responsible for the accuracy and completeness of their Quality Accounts.

The primary care trust (co-ordinating commissioners) will have an assurance role, offering a statement that the Quality Account is, in its view, based on a reasonable interpretation of available data and that there are no glaring omissions or errors.

The CQC and commissioners, through the SHA, can ask for errors to be corrected.

Patient organisations such as local involvement networks and overview and scrutiny committees will also be offered the opportunity to provide a statement on the Quality Account.

What format will the accounts follow?

According to the framework developed by the Department of Health, Quality Accounts should include six areas, some to include some prescribed content. The six are:

- an overall statement of accountability from the board
- three to five priorities for improvement, including a rationale for their selection
- a review of quality performance, including at least three indicators for each of the three domains of quality – safety, effectiveness and patient experience, referring to historical and benchmarked data where available. Providers need to supply information on their participation in clinical audits and related clinical quality data collection programmes. A statement briefly reviewing all services a trust provides is also required to ensure trusts have considered the quality of care for all services
- research and innovation, including confirmation of participation in clinical research, such as research received favourably by a research ethics committee within the National Research Ethics service. The provider should supply information on the use of the CQUIN payment framework, in terms of agreed quality improvement and



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innovation goals for the last and next year. They may also choose to expand on the rationale behind the goals and the level of associated payments

- what others say about the provider. Provision of CQC status and of any concerns arising from periodic and/or special review; and a statement from local involvement networks and the lead PCT (coordinating commissioner)

- data quality, covering four key indicators selected by the DH: percentage of records submitted to the Secondary Uses Service with a valid patient NHS number; the error rate for clinical coding (for diagnosis and treatment coding) as reported by the Audit Commission in the latest payment by results clinical coding audit; percentage of records submitted to Secondary Uses Service that included a valid patient GP registration code; and the trust's score for information quality and records management, assessed using the Connecting for Health Information governance toolkit.

What content will be included?

Providers themselves will decide what information to include in each statement in addition to the nationally mandated content.

This will be based on local priorities and include consultation with patients, the wider public, clinicians and commissioners. Examples in this supplement show content may be influenced by national priorities included in the NHS Operating Framework and adopted in SHA, PCT and trust visions.

For example, in NHS East of England, where all trusts produced quality reports as part of the Quality Accounts pilot, most trusts included reducing healthcare associated infections as one of their

HOW CAN THE NHS INFORMATION CENTRE HELP?

The NHS Information Centre provides national and local information that can feed into Quality Accounts. Its website not only holds NHS Information Centre data and information resources, but information from other organisations, bringing health and social care information together in one place.

The NHS Information Centre has worked with the Department of Health and NHS staff to develop a menu of indicators for quality improvement for use by local clinical teams and NHS providers. These are intended to be used for Quality Accounts and in particular to help populate the mandatory priorities and indicators sections. The three most popular priorities selected by foundation trusts in the quality report pilot are all included in the indicators menu.

The NHS Information Centre also manages the largest number of national clinical audits in England, which can help populate the review of services statement within Quality Accounts. Covering areas like cancer, diabetes and heart disease, audits help trusts to gain a clear picture of the level of clinical care they provide and to compare this with others.

It is also involved with patient-recorded outcome measures information, which reflects patients' views on the quality and outcome of their care. Providers can use the data to evaluate and benchmark the quality of elective clinical procedures. Quality Accounts require mandatory information about patient experience and more than one in 10 providers in the quality reports pilot selected patient reports as a priority.

'Over 200 priorities were selected but there was common ground between trusts. More than half selected healthcare associated infections'

priorities; which is also a priority within the 2009-10 operating framework (page 6).

Was there a pilot project?

Monitor required all foundation trusts in England to produce a quality report for 2008-09 as a prelude to Quality Accounts. NHS East of England also asked all

providers within its area to produce a quality report for the same period.

What did the pilot show?

- Monitor analysed the priorities that the 112 foundation trusts that took part selected for quality improvements in 2009-10, and the quality indicators against which they assessed themselves for 2008-09.

- On average, foundation trusts identified five priorities to focus on. Although more than 200 priorities were selected (over 100 unique to one foundation trust) there was some common ground between trusts. More than half (66) selected a priority related to reducing healthcare associated infections. Mortality reduction was a common priority for acute trusts. Other common priorities included improving overall patient experience and improving quality measurement systems. Some boards made significant commitments. Examples included reducing healthcare associated infection by 25 per cent, avoidable harm by 30 per cent and hospital standardised mortality ratios to 65.

- More than 250 indicators were chosen, again about 100 of which were unique to one foundation trust. There was no overwhelming consensus on indicators chosen, perhaps with the exception of reducing healthcare associated infections. A wide range of indicators relating to patient survey questions were selected.

- Indicators relating to improving the infection and mortality rates, and patient experience, were also selected by multiple providers in NHS East of England. ●

FIND OUT MORE

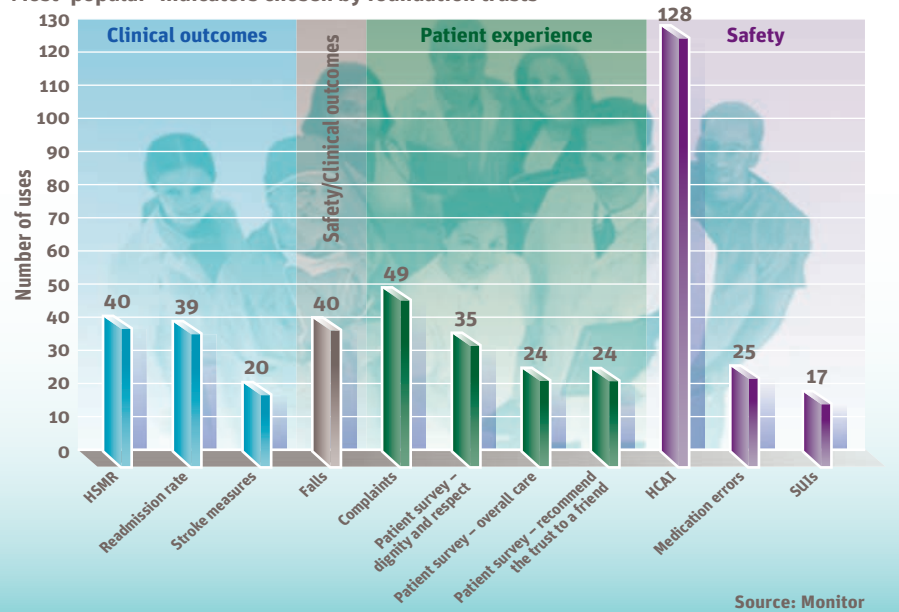
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Most 'popular' indicators chosen by foundation trusts



THE PILOT'S EXPERIENCE

Providers in NHS East of England produced quality reports for the pilot stage of Quality Accounts. Adrian Pennington, project director of the quality framework for the strategic health authority, led the pilot and offers his advice to trusts

HOW IT WAS FOR US

Every organisation, including the strategic health authority, produced a quality report as part of the pilot. Even our community service providers produced one, although they are not included in the first year of official submissions. The pilot has given our trusts experience, having already gone through the process, and as a consequence they are more focused on what they need to do and have an understanding of the purpose of a Quality Account. More importantly, they also have an understanding of how to develop a quality improvement framework.

In East of England we saw the chief executive's statement as the most important section of the Quality Account at this stage, because it sets out what a trust plans to do in terms of quality improvement and it readies the workforce.

In terms of priorities and indicators, the ones that the trusts included were on the whole very good. However, the focus tended to be on politically current areas like MRSA, stroke and *C difficile*, so the reports were not fully reflective of all the services the trusts offer. I think moving forward it will be important to extend the scope of priorities and indicators so more services are included. Clinical engagement will be fundamental to this.

Every provider included something about patient experience in its Quality Account but this is an area that the NHS has historically been weak in with regard to information. We used the National Patient Survey, but we have also been working to ensure that every

trust now has a patient experience tool in place to ensure we can access information that is more up to date. The tool asks simple questions that can be answered even at bedside or in the corridor, such as: "Would you recommend this hospital to anyone else?" and it would be possible to get the results of these questions within weeks.

There is an obvious imbalance in what information is available for different types of trusts. For the acute trusts, they potentially have 30-60 data sources to determine priorities as they tend to have access to much more nationally collected information.

I also think clinical audit programmes linked to newly developed clinical protocols, born out of quality improvement programmes, will have an increasingly important role in documents like Quality Accounts. How much a trust has participated in local and national audit is already part of the proposed mandatory information. This also enables sustainability dimensions to be understood.

Mental health trusts had to use more local information and even this was limited. As a result of the pilot, all the mental health trusts within the SHA are planning to come together to determine how we can improve and expand local information.

The pilot also highlighted Quality Observatories as having a massive role to play in helping provide information for documents like Quality Accounts. They should be helping trusts by providing independent information to close gaps where there is a lack of data about services,



and they should provide trusts and commissioners with exactly the same format of information reports.

Quality Observatories should also capitalise on access to national datasets by feeding these back into local reporting systems, as around 80 per cent of information that organisations use comes from national data.

This will be a vital function moving forward our own observatory, Quality Intelligence East.

Quality reports in NHS East of England Common priorities: acute/foundation trusts

- Reduce healthcare associated infection rates
- Improve patient experience
- Improve hospital standard mortality rates.

Common priorities: mental health trusts

- Improve service user involvement in care planning process
- Deliver single sex accommodation
- Undertake clinical audit
- Implement PROMS.

Common priorities: primary care trusts

- Improve infection control
- Reduce smoking
- Improve sexual health.



‘We have been working to ensure that every trust has a quality experience tool in place’

Adrian Pennington



NHS EAST OF ENGLAND’S TOP TIPS FOR QUALITY ACCOUNTS

Know your information

Chief executives need to be aware of all the information provided by trusts about their services to external organisations, what the purpose of the information is and what information is comparative and can be used for benchmarking. A surgeon within our SHA is the clinical lead for the National Mastectomy and Breast Reconstruction Audit, so we are contributing to a national picture of care. However, it is important to be able to use that audit to look at the local picture and compare our own performance with others.

Get ready to engage

There absolutely needs to be a credible culture of engagement, in particular clinical and patient engagement, in determining the content of Quality Improvement Programmes that will be reported in Quality Accounts. It is also very important to assess the readiness of staff within the organisation to be able to engage with the process.

Be realistic with goals

Trusts need to be realistic about what they can achieve when setting their priorities. A trust may have identified 16 areas it needs to potentially address in a Quality Account, but it

may only have the resources to look at 10 of them, for example. It is important to assess the impact on staff and, in particular, determine the available skill base and the capacity for clinical involvement.

Assess demand

Different providers are coming from different baselines for Quality Accounts, particularly with mental health and community organisations. Trusts need to recognise the value of projects in order to prioritise. For example, an acute trust may have 10 MRSA cases and nine of those may be on admission, so even though this is a national priority there may not be the same value for it remaining a local priority. It is important to recognise the impact of not setting a priority and of understanding the possible consequences.

Report as standard

A standard format for reporting information means Quality Accounts are a much more meaningful resource. Nationally, resources like the indicators for quality improvement will be helpful to this process. It is also important to share Quality Accounts with commissioners and other providers regionally and nationally.

WHAT THE REGULATORS SAY

The Care Quality Commission and Monitor will be looking to Quality Accounts as a potential marker of a provider's commitment to service improvement. Here they set out their expectations

RATED BY THE

THE CARE REGULATOR JAMIE RENTOUL

The Care Quality Commission will look to Quality Accounts to demonstrate that providers are committed to improving quality from the board to the front line. If they encourage boards to take responsibility for quality and monitoring its improvement, Quality Accounts will be an important step towards better public accountability.

To improve accountability, Quality Accounts must draw on information that is accessible and meaningful to patients and the wider public. They must be the enemies of jargon and corporate-speak. As far as possible, they must enable people to compare the quality of different services.

Although there will be mandatory elements, much of the content will be decided and owned locally. In our contribution to the development of Quality Accounts, we have emphasised they need to reflect the views of the community.

The account of quality should not just be about the clinical effectiveness of care but the actions being taken to make sure people are genuinely at the centre of care and that care meets people's needs in a joined-up way. They should be produced with the involvement of patients, staff, representative groups such as local involvement networks, and the wider public.

Engagement with stakeholders is vital, and in accord with the CQC's philosophy of putting outcomes and experience for people who use services at the centre of our regulatory work.

It is important that providers involve clinicians and other frontline care staff, because they

are responsible for delivering improved services for people.

Although of course we welcome something that puts quality on the agenda, we would not want to see a new "industry" created that takes up undue amounts of resources. For instance, we are keeping an eye on how the assurance framework for Quality Accounts develops; this needs to be meaningful but we think it should also be kept in proportion.

It is mandatory for each Quality Account to include a statement on the organisation's registration status with CQC and how it has responded to any assessments or requirements we have made of it. We would encourage providers to be open in recognising priorities for improvement; how a provider addresses these issues can be a marker of an organisation that takes quality seriously.

Beyond this formal requirement, we would like a provider's Quality Account to show:

- how the board is focusing on the quality of care and public accountability
- how it is identifying and addressing local priorities
- how it involves and responds to the views of patients and the wider public
- an assessment of its strengths and weaknesses.

Quality Accounts will be a source of information for the CQC that may be of use operationally. As well as using them to inform our local dialogues with providers and commissioners, they may also help us to identify common threads that suggest issues in the broader system that should be addressed. ●

Jamie Rentoul is director of regulation and strategy at the CQC.



'Quality Accounts must be the enemy of jargon and corporate-speak'

TOP TIPS

- Provide an honest account which celebrates progress but is also challenging in setting priorities for improvement
- Strike a balance between data and narrative about the quality of care, broadly defined
- To demonstrate local accountability, it must be relevant to communities and reflect what local people are saying is important to them

REGULATORS



THE FOUNDATION TRUST INDEPENDENT REGULATOR ADRIAN MASTERS

Monitor introduced quality reporting for foundation trusts in 2008-09, after working with NHS East of England, the Care Quality Commission and the Department of Health. We are already seeing a changing approach to quality as a result.

Quality reports help develop board ownership of the quality agenda and give boards a greater ability to drive improvements. They give trusts an opportunity to describe their performance and identify where they feel progress is needed, developing the “improvement mindset” within the organisation.

In the pilot work we completed early last year, board ownership led to ambitious board driven improvement priorities, measures and programmes of work.

Equally important was engagement with clinicians and patients to ensure the quality report is relevant and credible.

Quality reports/Quality Accounts are just one element of the system of quality improvement at the trust. We would expect quality to be embedded in a trust’s overall strategy and for boards to be regularly tracking performance against their quality goals. We would also expect boards to regularly assess and understand current and future risks to quality and be taking steps to address these.

In their 2008-09 quality reports last summer, foundation trusts submitted a range of indicators that went beyond reporting against national targets, and boards made specific promises about how

they planned to improve quality in 2009-10.

Foundation trust boards will be held to account for whether they have delivered on these promises, by their governors and members, when they present their annual reports in 2010.

Monitor has worked with the DH to help inform the development of Quality Accounts, and we are consulting on including the full DH requirements within our annual reporting guidance for 2009-10, as well as additional reporting

‘Quality Accounts give trusts an opportunity to identify where progress is needed’

requirements for foundation trusts.

We will continue to work closely with the DH to ensure that foundation trusts are able to produce one integrated annual report that will comply with both the DH regulations for Quality Accounts and Monitor’s reporting requirements (which cover financial and non-financial matters, including quality).

We are consulting on proposals to begin to require external assurance on elements of Quality Accounts, in order to increase the level of trust and confidence which the public can place in the Quality Accounts of foundation trusts and to continue with their development. ●

Adrian Masters is director of strategy at Monitor.

TOP TIPS

- Recognise the critical importance of board ownership and commitment to quality improvement
- Understand that quality reports/Quality Accounts are one mechanism to help hold boards accountable for that commitment
- The quality report/Quality Account needs to be relevant and credible to staff, patients and public – both in general and in the form of governors as their representatives
- The quality report/Quality Account needs to become as important to understanding trust performance as the financial accounts, and we will need to develop similar standards and assurance mechanisms over time

Quality Accounts require managers, clinicians and patients to agree priorities. So how do

GRILLING THE STAKEHOLDERS

THE CHIEF EXECUTIVE MIKE FARRAR

Chief executives and boards have to try to plan Quality Accounts with strategic objectives in mind, to say how far they have got in terms of achieving those objectives.

My view is that boards and chief executives have to be prepared to put information out there even if it is not always favourable to the trust.

A Quality Account is not going to be useful if we are selective with the information we include just so we can say how wonderful we are.

Even if the relevant information says we are not making as much progress as we would like, we should take a warts and all approach, not a cherry picking one.

Foundation trust boards should be asking governors what sort of information should be included in Quality Accounts to illustrate their objectives,

while all boards should take responsibility for ensuring that the information is comparable, because there is an obvious limit to the use of information if you cannot compare it.

It is anticipated that our Quality Observatory – AQA (Advising Quality Alliance) – will provide relevant information to support organisations in the North West in compiling Quality Accounts. National metrics we select will most likely be the ones that relate to national targets, and guidance from organisations



like the Care Quality Commission will be important. Making sure that information in Quality Accounts is meaningful to the public is important because at the end of the day they are our stakeholders.

There needs to be breadth when it comes to what information demonstrates “quality” – as quality means different things to different people, especially patients and the public.

Patient-reported outcome measures should be more advanced by the time Quality Accounts are published, so they will obviously play a part in the information we select.

Patients want to feel that their money is being well spent and that the trust looks after their health, and that is what the board needs to keep in focus.

NHS North West has developed an Advancing Quality programme to support medical teams in improving quality of care, information from which is

likely to feed into Quality Accounts.

The programme, which aligns incentives for commissioners, hospitals and patients, has metrics covering the areas of pneumonia, heart attack, heart failure, heart bypass operations and hip and knee replacement surgery.

Hospitals use the metrics developed by an American firm which developed the same system in more than 200 not-for-profit hospitals in the US. The reliability and quality of the data means trusts can benchmark against hospital groups in the States. ● *Mike Farrar is chief executive of NHS North West.*

TOP TIPS

- Keep strategic objectives in mind
- Make sure information is comparable
- Ensure choice of information has a broad focus

THE CLINICIAN MARK DAVIES

By aligning information for clinicians to improve services and managers to determine priorities around the quality agenda for initiatives like Quality Accounts, these two worlds start to overlap much more significantly.

I am convinced the future of the NHS will be written by managers who are clinically orientated and clinicians who are managerially orientated. It is that common ground that will drive improvements in the health service.

The data we decide to measure, not just for Quality

Accounts but for all information initiatives, should be grass-roots up, based on the priorities of local teams.

Clinical teams need to sit down and reflect on the quality of their own service and start having conversations, internally at first, about the sort of things they want to measure and what sort of measures will be useful for driving quality.

This should lead to conversations with people who commission those services. Although these are early steps they are in many ways the most important to ensure Quality Accounts are relevant locally and a useful catalyst for change.

We need to use both standards and benchmarking, both of which are valid forms of measurement. Standards include National Institute for Health and Clinical Excellence quality standards, measuring what we do against a gold standard, and clinical audits.

Benchmarking is more about looking for differences, and although it often doesn't show good or bad, it does show areas you might want to look into. Although benchmarking means you are usually not measuring against a particular standard, the potential from innovative use of this information is just as high.

In terms of the indicators

providers will need to include in Quality Accounts, patient surveys will play an important part in measuring patient



various stakeholders view the challenge ahead?



Hospitals will benefit from benchmarking against US counterparts

experience – and patient-reported outcomes measures will be a fundamental source. Adverse event reporting on subjects like healthcare associated infections is an important marker of safety and there will be an emphasis too on clinical outcome measures. Although local systems are important, there is a stock of established, national information that we can make use of locally. Hospital episode statistics, for example, are an information rich resource that we don't make as much use of as we could do. In the quality reports pilot, many providers picked length of stay data, which is within

HES, as one of their indicators for clinical outcomes. In turn, sources like HES feed into resources like NHS Comparators and more recently the indicators for quality improvement, where information is already available across over 200 indicators. ● Dr Mark Davies is medical director of The NHS Information Centre.

TOP TIPS

- Decide priorities from grass-roots up
- Use both standards and benchmarking
- Make use of existing national information systems

THE PATIENT
MARY LEDGARD

Quality Accounts are potentially very valuable, if they are looking at the right sort of information. What concerns me is there are so many performance measures produced by so many organisations that the additional information in Quality Accounts may simply confuse people. Trusts need to clearly explain the measures they are using and why they have selected them. Quality Accounts need to include information about things that worry patients. These are issues like cleanliness and infections and big subjects like dementia. When I visit patients and families around the county the information they want is: is the patient being helped to eat and drink, are they being kept clean and warm and are they being cared for appropriately? An idea that formed in my mind from the working group is that there should be a multidisciplinary team, involving patients, clinicians and managers, who are involved in assuring information included in Quality Accounts. That is really important in some shape or form because otherwise the public won't have any trust in the document.

For a Quality Account to be useful there has to be clear accountability and people have to be able to ask questions of the data. What a patient wants to see is information that relates to their local area, not just the strategic health authority's strategic plan. For example, some of the hospitals in my area serve very rural places, so discharging a person from hospital becomes a bigger issue in terms of aftercare

than it perhaps would be in an urban area. We also want to see information that we can compare consistently – rather than objectives changing every year so we cannot tell whether something has improved from the previous year or not. The way that the information is presented should be easy to understand and I think there needs to be a visual mix. I have some people in my organisation that do not like or understand charts, for example, whereas I think actual images of things spell out a message more clearly. Language is obviously crucial and I would urge trusts to avoid the use of acronyms and jargon – just because a manager or clinician is familiar with a term, it doesn't mean patients are – so please keep it simple. ● Mary Ledgard is vice chair of Norfolk local involvement network and was a patient representative at Quality Accounts assurance workshops run by the DH and PricewaterhouseCoopers.



TOP TIPS

- Make sure the information is meaningful to patients
- Be honest with patients about services
- If you have got something wrong, say you got it wrong

Representatives from Luton and Dunstable Hospital Foundation Trust and Norfolk and Waveney Mental Health Foundation Trust give their verdicts on the pilot

THE PILOT HAS LANDED



Using strategic objectives in Luton

It was fairly easy to select our priorities for the quality report as they mirror those in our trust strategy. Patient safety is our highest priority and in particular reducing our hospital standardised mortality ratio. Related priorities are around further reducing *C difficile*, MRSA and other hospital acquired infections.

The data for the selected indicators was already being collected and reported to support existing local and national initiatives. Data sources included the trust's patient safety reports for cardiac arrest rate information and the trust's patient information system for the average inpatient length of stay for elective and emergency procedures. Other data used for the Quality Account is already routinely collected for national collections, for example complaints data.

Clinical engagement was important in identifying priorities, much of which took place ahead of quality reports while we were updating our trust strategies. Possible priorities were discussed and agreed at management executive meetings attended by clinical directors, general managers and executives. Our director of infection prevention and control, a consultant microbiologist, was very involved in shaping the priority around HCAs. ● *Elaine Hide is director of quality at Luton and Dunstable Hospital Foundation Trust.*

LUTON AND DUNSTABLE'S REPORT

Priorities

- Reduce mortality ratio
- Further reduce HCAs
- Achieve year on year improvement in scores from National Patient Survey

SELECTED INDICATORS

Patient safety

- Mortality ratios
- Cardiac arrest rate
- Central line infections: adults

Clinical effectiveness

- MRSA
- *C difficile*
- Average inpatient length of stay.
- Readmission rate; knee replacements and trauma and orthopaedics

Patient experience

- Patient experience tracker; trust average satisfaction score
- Number of identified hospital acquired Grade 3 and 4 pressure ulcers
- Number of complaints
- Percentage of patients who would recommend the trust to a friend (for maternity)



Patient consultation in Norfolk

We have had a very good relationship with the trust and were told what Quality Accounts are all about and what was going to happen. However, there was a very short timeframe for it all to come together, which is not the way that local involvement networks work, as we need time to canvas members.

We had a round table discussion with policy leads from the trust as part of our usual meeting with them every two months. Although time was short we felt our suggestions were recognised; dementia is a key issue for us and this was included in the quality report.

Moving forward for the next round of Quality Accounts, trusts need to allow time to consult with patients and the public so more people have the chance to express their views. ● *Esther Harris from Norfolk local involvement network was involved with Norfolk and Waveney Mental Health Foundation Trust's pilot quality report.*

NORFOLK AND WAVENEY'S REPORT

Priorities

- Increase provision of cognitive behaviour therapy for people with a recent diagnosis of schizophrenia
- Increase number of service users who say a member of their care team has fully discussed their medication with them in the last three months
- Achieve increased rates of diagnosis of dementia at an early stage of illness
- Increase number of assessments and referrals for inpatients wishing to quit smoking

SELECTED INDICATORS

Service user safety

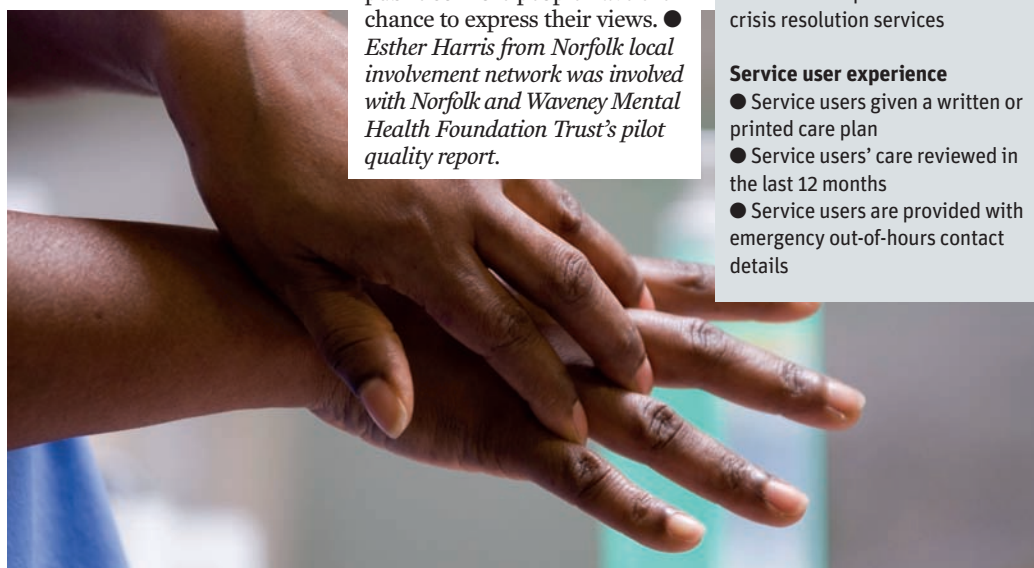
- Seven-day follow-up of service users on enhanced care programme approach to post-hospital discharge
- Incident reporting
- "Never events" as defined for mental health by the National Patient Safety Agency

Clinical effectiveness

- Physical health checks
- Percentage of NICE guidelines implemented
- Access to inpatient services via crisis resolution services

Service user experience

- Service users given a written or printed care plan
- Service users' care reviewed in the last 12 months
- Service users are provided with emergency out-of-hours contact details





Samantha Riley (centre) with the South East Coast Quality Observatory team

WATCHING BRIEF

Quality Observatories emerged from *High Quality Care for All* and can support trusts in identifying and developing information to feed into Quality Accounts. Samantha Riley explains how NHS staff can engage with information for Quality Accounts and wider quality improvement

Trusts need good quality, meaningful information to support both national and local initiatives that aim to improve the quality of care. As a Quality Observatory, we have access to a wide range of regional and national data sources that can help NHS staff achieve both local and national visions.

We provide analysis and support around the use of data to help trusts fulfil the regional vision – *Healthier People, Excellent Care* – to improve the quality of care provided to patients, while at the same time providing services which are cost effective and provide good value to the taxpayer.

Clinical involvement with the specification and analysis of clinical information is critical, as it not only develops awareness among clinicians with regards to the datasets available, but makes sure the analysis is closely aligned to the care process and meaningful to staff who are driving improvements in quality and productivity.

I have ensured that each clinical pathway lead for *Healthier People, Excellent Care* is linked to an identified specialist information analyst. Each analyst supports their lead in the development of quality and productivity metrics to describe the vision for this pathway and then provides a range of analysis to describe

'We hope to see an improvement against the agreed indicators'

current baselines and progress over time.

We are hoping to agree a set of core metrics to be incorporated into Quality Accounts. By agreeing a common set of metrics with clearly defined definitions, it will be possible for the Quality Observatory to provide regular monthly or quarterly comparative analysis to NHS organisations in Kent, Surrey and Sussex.

By identifying the variation between different organisations and feeding back regular analysis, we hope to see an improvement against the agreed indicators and a reduction in variation.

When thinking about which indicators to include in a Quality Account it is important for a trust to:

- be clear about the area it is trying to improve and ensure the indicator chosen is fit for purpose
- think about the balance of measures it is using to ensure that a comprehensive view of quality is provided, covering each domain of quality

SELECTED INFORMATION SOURCES USED BY SOUTH EAST COAST QUALITY OBSERVATORY

"The dataset most extensively used by the observatory is the HES Online database www.hesonline.nhs.uk, as it provides national benchmarks on any indicator that can be derived from the nationally collected commissioning datasets," says Samantha Riley.

Other data sources used extensively by the team include:

- Secondary Uses Service, providing anonymised patient-level data for each trust and primary care trust in the region
- The Health Protection Agency's data collection system for healthcare associated infection
- Central returns information submitted by organisations to the Department of Health via UNIFY 2
- The Quality Outcomes Framework annual results and monthly data from the Quality Management and Analysis system
- The NHS Information Centre's Omnibus collection for mental health work and smoking at time of delivery
- The national cancer waiting times database, figures available via the National Clinical Health Outcomes Database (particularly relating to standardised mortality rates and disease prevalence).
- National audit data from the National Audit Office, The NHS Information Centre and the Royal College of Physicians among others.
- Financial and workforce data sets including programme budget data and the electronic staff record data warehouse

- ensure that clear definitions are associated with each metric and efficient data collection processes are in place.

Information used for quality accounts will not provide a cast iron answer to the challenge of improving care, but will point to where questions need to be asked. Clinical engagement is vital to this process. ● Samantha Riley is head of the South East Coast Quality Observatory.



With the Commissioning for Quality and Innovation schemes set to play a key role in Quality Accounts, we look at how one SHA has developed core quality assurance indicators for its providers

GROWING INTO A

New initiatives born out of *High Quality Care for All* are expected to evolve in alignment with each other to drive care quality. This common ground includes reporting on Commissioning for Quality and Innovation schemes within Quality Accounts.

The introduction of the CQUIN framework saw primary care trusts within NHS Yorkshire and the Humber agree a set of core quality assurance indicators for providers to use as part of their new contracts.

NHS Doncaster director of quality and care assurance Julie Bolus led the work on behalf of the PCTs, working closely with Sue Hillyard, associate director of performance and delivery at the strategic health authority, which sponsored the work.

"It is likely some of the assurance indicators will be selected by providers for their Quality Accounts, in addition to the mandatory statement they are required to submit about CQUIN goals," says Ms Bolus.

"The core indicators were developed according to whether the provider offers an acute, mental health or community service and the priorities for each set derive from the SHA's overarching strategic framework *Healthy Ambitions*. The framework came together following a review that included engagement with 150 clinicians through groups covering the eight care pathways."

The data collection templates were designed by the SHA following feedback

from providers and commissioners, says Ms Hillyard.

"Providers are required to submit data quarterly to a central point within the SHA, which stores all CQUIN scheme data in a central database and provides feedback and analysis of the data to all organisations. The provider is also required to send a copy of its data to the host commissioner."

Economies of scale

Ms Bolus says: "Core indicators mean trusts of the same type are using the same datasets and this produces comparable information right across the region. By having common threads of information running through every trust, staff are able to benchmark and this gives us economies of scale. Trusts can see how they are performing against each other and this means the data we use has real meaning."

"This information is important for the public, too, because they will be able to compare trusts across the region."

"We use a mix of nationally and locally collected information for indicators and a mix of existing and new data. It is a



Julie Bolus

'Trusts can see how they perform against each other and this means the data has real meaning'

CQUIN IN A NUTSHELL

What is CQUIN?

The CQUIN payment framework was introduced following *High Quality Care for All* and, like Quality Accounts, aims to make care quality the core value of NHS providers. The framework makes a proportion of provider income conditional on locally agreed quality and innovation goals. In 2009-10 this accounts for 0.5 per cent of a provider's contract value, rising to 1.5 per cent in 2010-11.

Local CQUIN schemes contain goals for quality and innovation that have been agreed between the

provider and the commissioner. They specify quality indicators, the improvement or threshold expected, how achievement is measured and how payments are made. The goals to be included in CQUIN schemes are for local agreement; the only national requirement is that there should be at least one goal in each of four areas: safety, effectiveness, patient experience and innovation.

In 2010-11, acute provider CQUIN schemes will also include two nationally defined goals on reducing the impact of venous-

thromboembolism and improving responsiveness to the personal needs of patients.

Why is it important to Quality Accounts?

CQUIN was introduced alongside Quality Accounts by *High Quality Care for All* and it is intended that the two initiatives, alongside others like Quality Observatories and National Institute for Health and Clinical Excellence quality standards, will develop in close alignment. Information about local CQUIN goals is part of the proposed

mandatory information required for Quality Accounts.

The CQUIN framework will support Quality Accounts by ensuring providers agree quality improvement and innovation priorities each year with commissioners. Use of the framework is an indicator of the provider's contribution to quality improvement.

The process of developing Quality Accounts will also support the use of the CQUIN framework, by helping to identify local priorities for quality improvement to inform CQUIN schemes.

NEW WAY OF LIFE



combination of retrospective and real time collection, such as information gathered from the patient's bedside or information recorded as part of admission processes.

"In acute trusts, for example, one of the core indicators is care and compassion, especially for the elderly. Mental health and acute providers now undertake a point prevalence audit for pressure sores, where over a short period of time a small team carries out an audit across all areas. Data collected includes the number of patients by age and number with a Waterlow Score – the

estimated risk of a patient developing a pressure sore – or equivalent. This indicator is very much in its first 'data collection year' and we expect to see improvements in year two.

"However, we have already seen an impact from our nursing and maternity indicators. Nearly all areas of these are reflected in the national High Impact Actions for nursing and midwifery proposals,

resulting from work led by chief nurses from the 10 SHAs in collaboration with the Royal College of Midwives, Royal College of Nursing, the Nursing and Midwifery Council, the NHS Institute for Innovation and Improvement and the Department of Health.

"Much of this information will provide a useful base for Quality Accounts for providers, but one of the major challenges for any type of trust is to ensure public assurance. Between now and publication, providers should be consulting with the public about their views on services and what is important to them." ●

MINI FACT FILE

Core CQUIN indicators by trust in Yorkshire and the Humber

Acute trusts

- Movement towards consultant obstetrician presence on labour ward as recommended in *Safer Childbirth*
- Movement towards midwife:delivery staffing ratios recommended in *Safer Childbirth*.
- Increasing the number of mothers breastfeeding on discharge from midwifery services
- Improving the care of children and young people with diabetes mellitus
- Implementation of NICE clinical guidance 68: stroke and transient ischaemic attack
- Improving end of life care
- Hip and knee replacement best practice bundle
- Acute myocardial infarction best practice bundle
- Care and compassion: malnutrition and pressure sores

Mental health trusts

- Improving access to assessment for people experiencing acute mental health problems
- Improving access to assessment for people experiencing non-acute mental health problems
- Improving health outcomes for black and minority ethnic clients
- Care and compassion: care of elderly clients with mental health problems
- Meeting the needs of children and adults with learning disabilities



Sue Hillyard

DATA

Quality Accounts require a statement on how good a provider's data quality is. Mark Davies and Iain Carpenter discuss why clinicians are central to making it as good as it can be

DOING IT BY MORE THAN THE NUMBERS



Mark Davies A provider clearly has to have a good standard of data for it to be sure of the quality of care it offers patients. For Quality Accounts, it is proposed that providers will have to include a mandatory statement about how well they record their data.

This includes information about the records they submit to the Secondary Uses Service, in terms of how many records have a valid NHS number for a patient, and how many records they submit to SUS for inclusion in hospital episode statistics have a valid patient GP registration code. They will also have to include their error rate for clinical coding for both diagnosis and treatment.

It is very difficult to drive quality improvement without effective measurement of clinical activity, and my view is that clinicians play a vital role in

this process. For Quality Accounts and the quality framework in general to fully achieve their potential, clinicians need to be increasingly involved in the decision-making process around data; both alongside managers and boards locally, and also from a national perspective.

We need to close the gap of credibility that exists between the clinical and managerial communities to improve data quality and the relevance of the data we collect.



Iain Carpenter Clinicians may have previously regarded data as something relevant to managers, not to them, but the dawn is breaking. Good information is invaluable to supporting evidence-based commissioning and making informed decisions.

People will fight tooth and

nail to improve their services and the benefit of good quality information is that you can have a properly informed debate between clinicians, managers and commissioners, which is likely to help reach a happier solution.

I passionately believe that useful, reliable information starts with a universal standard of data entry, which begins with the dialogue between patient and doctor. That is why clinical and managerial engagement – from deciding what to measure to helping others in an organisation interpret data – is important. If all of us – clinicians, managers and other professionals – start to really think about and understand the importance of clinical information and its relevance, in five or 10 years' time maybe it will be possible to have a universal standard of data entry as practice.

MD Standardisation of clinical information has historically been seen as a barrier to recording a complete and rich clinical record, and something that takes clinicians away from what they should be doing – seeing patients. But actually it is a powerful enabler that unlocks the potential of data and it means that the quality of information can be assured closer to the care process. If you

record information well, you are recording it once and in a way that is assured and fit for multiple use, which commissioners and regulators can also use. We need clinicians to take more control of the data that describes their activity and see it as directly relevant to patient care.

IC It seems to take forever to structure an admission record, for example, but research shows that if this does happen, things like post take-over ward rounds take 15 per cent less time. Something clinicians really worry about, relating to the reduced working hours of junior doctor teams, is the increased number of hand-overs. This is a high risk area, but if you have good clinical systems fed with good clinical





GOOD DECISIONS BASED ON GOOD QUALITY DATA

Good quality information resources can only be built from good quality data. The NHS Information Centre's national Data Quality Programme helped to shape the Department of Health's Quality Accounts proposal.

The programme is improving the quality of data throughout health and social care by raising awareness about the impact of data quality and helping data suppliers to improve data quality.

More than 1,000 staff from over 340 health and social care organisations have joined the Data Quality Programme's Data Quality Guild – the e-community for data quality practitioners to share data quality issues, solutions and best practice.

The programme is also developing a range of indicators to help organisations measure their data quality and monitor data quality improvements. It publishes the monthly DQIndex, a searchable catalogue of web available resources for data quality standards and guidance.

Each month the programme focuses on a particular "mission of the month". Previous missions have included the NHS Number, Raising The Profile of Data Quality, Streamlining Data Collection and How Good is your Organisation's Data?

To find out more, and join the Data Quality Guild visit www.ic.nhs.uk/dataqualityprogramme.

The hospital that treats a patient can have more effect on outcome than the person's age

'If you have good clinical systems fed with good clinical information, the hand-over process is so much better'

information, that hand-over process is so much better. The information is there, it is retrievable by the team who are being handed over to, and there is not going to be misinterpretation.

I was also involved in a project where clinicians used hospital episode statistics data to look at the average length of stay of patients in three hospitals that were part of the same trust. We looked at this alongside information relating to patients in different specialties; and also age groups who did or didn't have a physical disability.

The analysis showed huge variations between the hospitals. The actual hospital a patient was treated in had a greater effect on their length of stay than that of their age and as

great an effect as a physical disability. We could see from time series information that one hospital was doing well and another was improving, whereas the other one was not doing very well at all.

As a consequence of having that information, clinicians started visiting the other hospitals involved in the study and joining colleagues on ward rounds, to see what they could learn and how they could improve. Without that data, we couldn't have started making those improvements. ●

Professor Iain Carpenter is a retired hospital consultant and associate director of the Record Standards Unit at the Royal College of Physicians. Dr Mark Davies is a practising GP and medical director of The NHS Information Centre.

MAKE IT EASY ON

The NHS Information Centre can help with content for Quality Accounts. Check out our guide

INDICATORS FOR QUALITY IMPROVEMENT (IQI)

Developed by The NHS Information Centre and the Department of Health in close conjunction with NHS professionals, IQI brings together information produced by different organisations into one central, free resource. The service was developed to support trusts with quality improvement work, but also supports other quality initiatives such as Quality Accounts and CQUIN schemes.

IQI at present consists of a library of more than 200 nationally assured indicators for clinical teams to use and download for local quality improvement and benchmarking.

Although trusts are free to select different indicators for Quality Accounts, the DH encourages them to pick them from the IQI menu, so trusts can compare themselves with others who use the same ones.

The indicators can be used to help providers define both their overarching priorities for quality improvement required for Quality Accounts and also the areas of clinical effectiveness, patient safety and experience



they need to focus on. The indicators are already split into the three defined areas and cover a range of pathways of care based on those examined during the NHS next stage review, including acute care, planned care, long term conditions, children's health and mental health.

More than half of the providers involved with the quality reports pilot selected

"reducing healthcare associated infection rates" as one of their priorities – and would have been able to use the *C difficile* and MRSA indicators from the Health Protection Agency that are part of the IQI library.

The indicators are refreshed monthly with the most recent data, which can be accessed via a search facility or by using a clickable grid. Each indicator has 21 meta data fields, giving

complete transparency to the detailed methodology and data sources used.

Clinicians and NHS professionals contributed to the selection of indicators through The NHS Information Centre's Clinical Quality Indicators Survey, run in partnership with the DH and supported by five royal colleges and the Cardiovascular Society.

Work to develop indicators to fill gaps in coverage and replace some of the initial indicators is in progress in a range of clinical areas, driven or supported by the relevant royal colleges and specialist societies.

A new governance body, working to the national quality board, is being formed by the DH after wide consultation. Its role will include advising the quality board on strategic priorities for national quality indicator development and acting as a gatekeeper to scheduling the addition or removal of IQI indicators. It will also provide governance for quality indicator development.

FIND OUT MORE

→ www.ic.nhs.uk/iqi

CLINICAL AUDITS

It is proposed that providers should supply mandatory information on how many national clinical audits they take part in – and how much data they provide to them – as part of Quality Accounts.

The NHS Information Centre manages more national clinical audits than any other organisation in England, covering areas such as cancer, diabetes, kidney care and heart disease.

Clinical teams and local level managers at Derby Hospitals Trust are using vascular access

information they are collecting for the National Kidney Care Audit to identify and improve the quality of patient care.

"As a clinician, I believe audit is important as it provides information that can help reduce harm for patients – and as a clinical director, that this information is a major marker of how well my unit looks after its patients," says Richard Fluck, a renal consultant at the trust.

"The challenge is for all units in the country to match those who are the best in offering quality care. Audit information

allows us to benchmark against the rest of country and identify those units with expertise, and also areas where locally we may not be up to scratch.

"Audit is also about demonstrating to people that it's possible to achieve good levels of care. I grew up in a generation who looked very inwardly at what we achieved locally, with the attitude of 'that's the best we can do'. But audit allows us to look across the country and challenge ourselves to say: 'Why can't we perform to the same level?'"

Dr Fluck continues: "Audit is not just about doctors – it's about patients, nurses, radiologists and local level managers. At this level I don't see our use of audit information as split by 'managers' and 'clinicians'; I see it as one team. We may have minor differences of opinion about the direction we are taking at one point, but both groups want the same thing: safe care, efficient care and high quality care."

FIND OUT MORE

→ www.ic.nhs.uk/ncasp

YOURSELF

to the range of offline and online support available



PROMS information can be used to evaluate the relative clinical quality of providers of elective procedures

DISCOVERING THE PATIENT VIEW: PROMS

The views of patients are central to Quality Accounts and engagement with them should be central to deciding content. Additionally, as part of the assurance of Quality Accounts, providers are required to offer their lead local involvement network and overview and scrutiny committee the opportunity to provide a statement within the account.

This statement will focus on whether they believe the quality described in the account to be a fair reflection of the quality of care they receive from the organisation.

Patient-reported outcome measures reflect the views of NHS patients and provide trusts with an indication of the outcomes or quality of care.

More than one in 10 providers involved with the quality reports pilot selected implementing PROMs as a priority. PROMS are typically short, self-completed questionnaires that measure a patient's health status or health related quality of life before and after an intervention. All providers of NHS funded care are required to collect them for four clinical areas; hip replacements, knee replacements, hernia and varicose veins.

PROMs information can be used to evaluate the relative clinical quality of providers of elective procedures; and can be used by clinicians, managers, regulators and PCT commissioners for benchmarking.

PROMs can also be used for:

- evaluating the efficacy and cost-effectiveness of different technical approaches to care, using PROMs in association with other measures
- establishing whether referrals for elective procedures are appropriate, by examining variation in baseline PROMs scores across the country
- clinical audit
- by patients and GPs exercising choice.

PROMs are coordinated by the Department of Health and a number of organisations are involved in the collection, processing, analysis and reporting the data, including providers, primary care trust commissioners, The NHS

Information Centre and contractors. The Information Centre's role includes converting the questionnaire responses into health status measurements and linking the PROMs data to other routinely collected administrative data held about the patient, such as hospital episode statistics, in a secure environment.

The NHS Information Centre is also responsible for removing patient details from the data once it has been linked, to preserve the anonymity of the patient in any subsequent analysis.

FIND OUT MORE

PROMS will be available to trusts in 2010.

➔ www.ic.nhs.uk/proms

USING NHS COMPARATORS TO IDENTIFY PRIORITIES

NHS Comparators is a free online tool that is widely used across the health service, from commissioners and managers to clinicians. It can be used by providers to help them identify priorities.

Users have access to more than 200 comparators, including:

- secondary care activity data
- data derived from GP lists
- quality and outcome framework data
- prescribing data.

NHS Comparators has information that can be used for benchmarking against other organisations locally or across the country.

Data can be sorted by specific clinical conditions and, where appropriate, data is adjusted to reflect age and gender balance. The tool can be used to look at costs – from average cost per admission to how much an organisation spends on prescribing.

Previously available on the NHS N3 network, NHS Comparators has been developed by The NHS Information Centre and has now been rolled out to the worldwide web. New users need to register for a user name and password and the service is completely free for NHS users.

Leigh Garraway, chief officer of Chiltern Vale Commissioning Consortium in Bedfordshire, spotted significant differences in urgent admission rates to hospital by GP practice, using NHS Comparators.

“Comparators made it easy to see these different rates, and which clinical conditions were driving those admissions,” he said.

“We found our rates were similar to the averages for Bedfordshire, the East of England and nationally, but NHS Comparators showed that another primary care trust just down the road had a much lower rate compared with ours.

“This has triggered a great deal of work around our GP out of hours service.

“NHS Comparators is such a simple system to use. It empowers you to question important differences in care and make real time adjustments.”

FIND OUT MORE OR REGISTER FOR NHS COMPARATORS

➔ www.nhscomparators.nhs.uk



INFORMATION FAST: MY IC

My IC is a new feature on The NHS Information Centre's website that allows users to create their own information homepage. My IC gives users free access to a library of more than 250 useful data, statistical resources and analytical tools from The NHS Information Centre and other public sources. It saves them time and effort in accessing the information they need to do their job and allows them to have their most used resources in one place.

This new feature has been designed for informatics professionals working across health and social care, who use data and statistical information for planning and management decision making.

To use My IC, users need to register, choose either one of several pre-populated frontline theme profiles (clinical, public health, finance and performance, workforce, social care or commissioning), or create their own page from scratch.

FIND OUT MORE OR TO REGISTER FOR MY IC

➔ www.ic.nhs.uk/my-ic

HOSPITAL EPISODE STATISTICS ONLINE

HES Online is a secure records based system covering all trusts in England, including acute hospitals, primary care trusts and mental health trusts. Controlled by The NHS Information Centre, the system also covers NHS work done by the independent sector, including treatment centres, and care given to private patients in NHS hospitals.

HES Online contains separate records – one for each episode of care – for admitted

patient care, outpatient and accident and emergency attendances, at provider, primary care trust, strategic health authority and national level.

Providers can use HES information to assess their own inpatient, outpatient and A&E activity and compare it against others.

Each admitted patient care record contains a wide range of information, including:

- clinical information about

diagnoses and operations

- information about the patient, such as age group, gender and ethnic category

- administrative information, such as time waited and date of admission

- geographical information on where the patient was treated and the area in which they lived.

More than 16 million new admitted patient care records are added to the system each

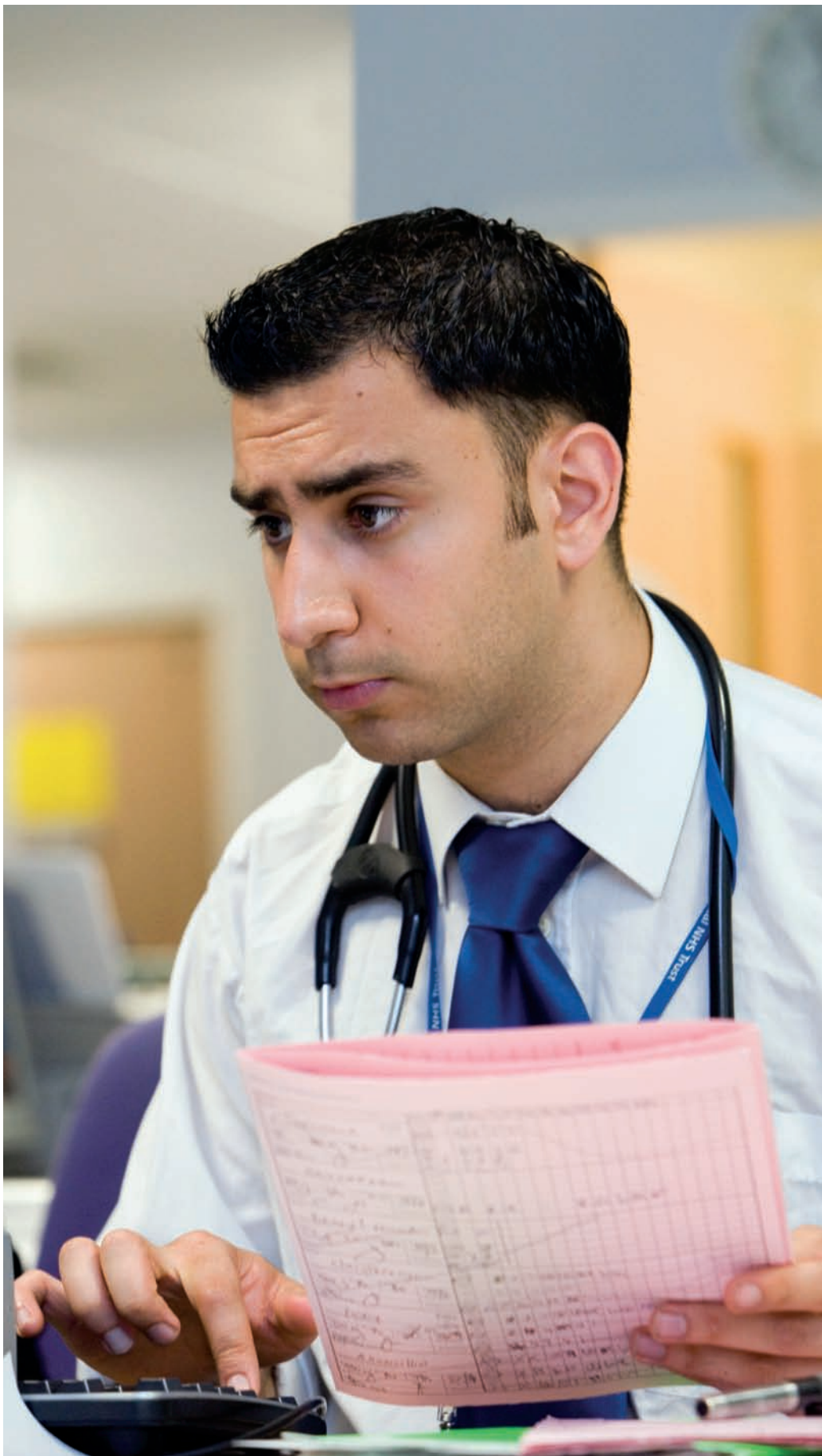
year and information from 1989 onwards is available.

More than 60 million outpatient attendance records are also added every year and dates from 2003 onwards.

A&E attendance records have been available since 2007-08, with around 12 million attendances added each year.

FIND OUT MORE

➔ www.hesonline.nhs.uk



More than 16 million new admitted patient care records are added to HES Online each year

MINI FACT FILE: THE NHS INFORMATION CENTRE

The NHS Information Centre is England's central, authoritative source of health and social care information.

Its primary aim is to provide accessible, high quality, timely information to help providers improve decision making and deliver better care.

Its information and services cover areas including:

- hospital care
- health and lifestyles
- mental health
- audits and performance
- population and geography

For more information contact:
www.ic.nhs.uk
0845 300 6016
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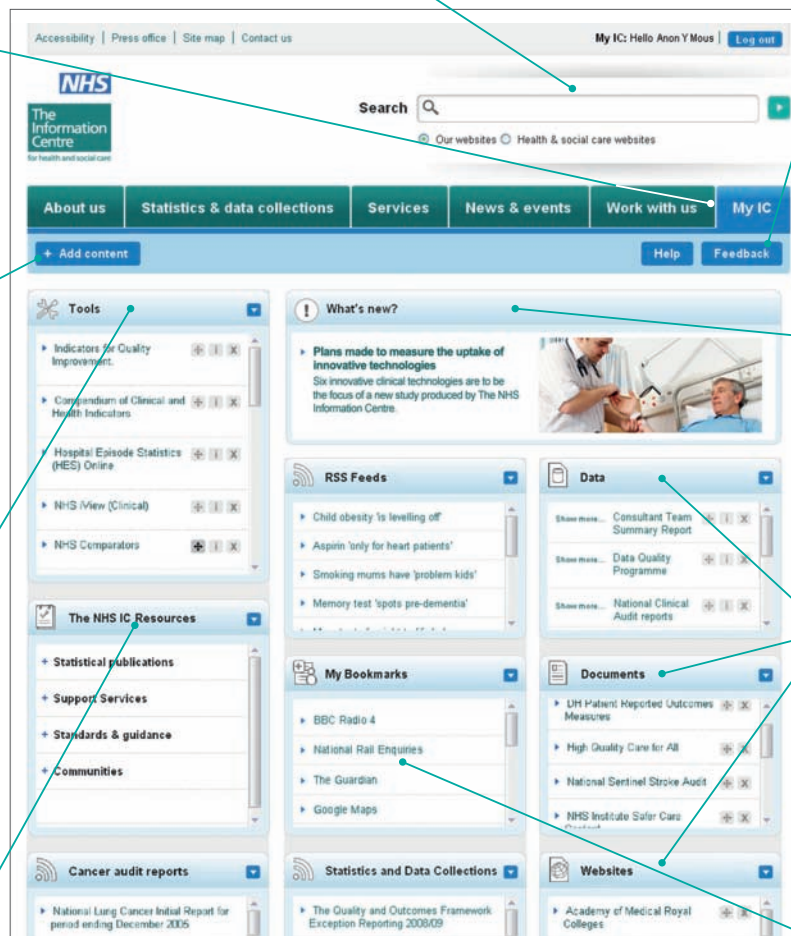
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