

EXPLANATORY MEMORANDUM TO

THE NATIONAL HEALTH SERVICE (QUALITY ACCOUNTS) REGULATIONS 2010

2010 No. 279

1. This explanatory memorandum has been prepared by the Department of Health and is laid before Parliament by Command of Her Majesty.
2. **Purpose of the Instrument**
 - 2.1. These Regulations set out the detail of how providers of National Health Service (NHS) services should publish annual reports - Quality Accounts - on the quality of their services. In particular, they set out the prescribed information for the accounts as well as general content, form and timing of publication, and arrangements for scrutiny and assurance. The Regulations also set out exemptions for small providers and primary care and community services.
3. **Matters of special interest to the Joint Committee on Statutory Instruments**
 - 3.1. None.
4. **Legislative Context**
 - 4.1. The Health Act 2009¹ implemented those parts of the NHS Next Stage Review² (see section 7 of this Memorandum, below) that required primary legislation, including provisions about mandatory annual reporting by NHS healthcare providers on the quality of their services. The Review concluded that from April 2010 all healthcare providers working for or on behalf of the NHS should be placed under a legal requirement to publish an annual Quality Account. Sections 8 and 9 of the Health Act 2009 therefore place that duty on all such providers.
 - 4.2. This duty is to publish information about the quality of services provided or sub-contracted for the period 1 April to 31 March each year as prescribed in Regulations. Sections 8 and 9 of the Health Act 2009 also give the Secretary of State a regulation-making power to determine such matters including the form, further content and timing of publication of a Quality Account.
 - 4.3. Section 8(5) gives the Secretary of State a power to make exemptions from the duty, which enables the quality accounts obligation to be phased in for different sectors and for small providers to be exempted permanently. In their report on the Health Bill³, the Delegated Powers and Regulatory Reform Committee made a recommendation, which the Government accepted and put into effect by way of a subsequent Government amendment, about the type of SI to be used to make these exemptions. The original proposal was to use the affirmative procedure in the first instance and the negative in subsequent years. The Committee's view was that Parliamentary oversight could be sufficiently achieved by adopting the negative procedure from the outset, and the Government brought forward an amendment to put this into effect.
 - 4.4. The programme of work to introduce statutory Quality Accounts envisaged a two stage process: creating a general duty in the primary legislation, and then working collaboratively with stakeholders to develop the detailed Regulations. In debate in both Houses⁴ and in other public statements (see for example the Department's consultation document on the proposed content of Quality Accounts⁵), Ministers have emphasised that the purpose of this stratagem is to allow maximum flexibility to respond to changing circumstances, and to ensure that stakeholders could

¹ Health Act 2009 (c. 21) - http://www.opsi.gov.uk/acts/acts2009/ukpga_20090021_en_1

² Department of Health (2008). High Quality Care for All - NHS Next Stage Review Final Report., CM 7432 - http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_085825

be fully, and continuously, engaged in the design process. This Statutory Instrument is the first set of Regulations made using this power, and reflects the outcome of the recent consultation exercise, about which Ministers made a report to Parliament on 5 February⁶. These Regulations have therefore been co-produced with stakeholders.

- 4.5. Subject to a further round of testing, engagement, and consultation (elements of which are already underway), we hope to make a further set of Regulations next year to remove some of the exemptions so that primary care and community services providers will be required to publish Quality Accounts in 2011.

5. Territorial Extent and Application

- 5.1. This instrument applies to England.

6. European Convention on Human Rights

- 6.1. As the instrument is subject to negative resolution procedure and does not amend primary legislation, no statement is required.

7. Policy background

What is being done and why

- 7.1. The NHS Next Stage Review Final Report, “High Quality Care for All”, was published on 30 June 2008. One of the key components of the quality framework set out in that report was to encourage provider organisation towards more detailed and more transparent reporting on service quality, with a view to improving both the quality of those services⁷ and those organisations’ accountability to the public they serve.
- 7.2. The provisions in the Health Act 2009, which set out the requirement for providers of NHS services to publish Quality Accounts and a power to set out the detail in regulations, contribute towards achieving this objective by creating a statutory requirement to publish such information, which gives it at least the same prominence as financial reporting. This publication will allow easier access to quality information, with the intention of encouraging patients, the public and others to demand higher quality services from the NHS.
- 7.3. The overall objectives of Government policy in relation to Quality Accounts are to allow:
- i. the public to hold providers to account for the quality of NHS healthcare services they provide and to demand action from providers where they believe that providers are falling short on quality;
 - ii. patients, and their carers, to make better informed choices;

³ The Delegated Powers and Regulatory Reform Committee, Third Report, 2008-09, HL29, 5 February 2009 - <http://www.publications.parliament.uk/pa/ld200809/ldselect/lddelreg/29/2902.htm>

⁴ In particular, the debates in the House of Lords, in Grand Committee on 26 February; and in the House of Commons, in the Public Bill Committee debate on 18 June

⁵ Copies of the document and other relevant material can be found at

http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_105304

⁶ The Written Ministerial Statement is available on the Parliament website

⁷ Marshall MN, Shekelle PG, Leatherman S and Brook RH (2000) What do we expect to gain from the public release of performance data? A review of the evidence. *Journal of the American Medical Association*; 83:1866–1874; Shekelle PG, Yee-Wei Lim, Mattke S and Damberg C (2008) Does public release of performance results improve quality of care? A systematic review. The Health Foundation - www.health.org.uk/publications/research_reports/performance_results.html

- iii. commissioners and providers to agree priorities for improvement;
- iv. NHS Trust Boards and their non-NHS equivalents to ensure that they place quality at the heart of their planning and delivery processes; and,
- v. clinical teams to benchmark and compare their performance.

7.4. These functions are, to a limited extent, already fulfilled by information currently available to patients, clinicians and managers, and by performance management mechanisms that already apply to NHS providers. However, there are gaps in ways in which such information is made available, and in the way in which NHS providers are held to account for care quality. The statutory route set out in the Health Act and these Regulations enables the Department to set out a framework that:

- i. ensures that the information that providers publish is accurate, reliable, comparable, and truly and fairly representative of the range and quality of services on offer;
- ii. creates a standardised format that allows comparison between providers by patients commissioners and other stakeholders; yet is also sufficiently flexible (because the details are set out in secondary legislation) to be amended in the light of changing circumstances, policies and priorities, to reflect changes in the way in which other regulators (for example, the Care Quality Commission) play their role within the quality framework, and to accommodate lessons learned from implementation and evaluation; and,
- iii. enables the Department to work with stakeholders in developing policy on Quality Accounts, and reflect that collaboration in both the detailed Regulations and their associated guidance (we are, for example, developing a practitioner toolkit that will draw together lessons learned from testing exercises and from actual reports, and share good practice).

7.5. Regulations 1 and 2 provides an exemption from producing Quality Accounts for community health and primary care providers, as envisaged in the timetable for introduction outlined during the Parliamentary debates and other public forums. This is because these providers typically lack a history of corporate reporting and/or access to expertise in doing so. A programme of engagement, testing and consultation is already underway to develop Quality Accounts for primary care and community services, which aims to bring them within the scheme next year following further consultation and Regulations.

7.6. Regulation 3 also creates an exemption for small providers. This reduces the burden on small organisations and individuals and it is intended that they will remain exempted.

7.7. Regulations 4, 5 and 6, and the Schedule detail the form, prescribed information, and other content of Quality Accounts. Quality Accounts must consist of three parts:

- i. Part 1 contains an overall statement by the provider of the quality of services provided for that year. The purpose of this statement is to ensure that the Quality Account is both accurate (the data are correctly reported) and representative (the conclusions drawn from the data are reasonable and represents the overall status of quality within the organisation). This mirrors the sign-off given to a financial account. A senior employee for the provider, such as the Chief Executive must sign Part 1 to ensure accuracy. The reason for requiring such signature is that it reassures the reader that the Quality Account is the provider's own work and that the provider stands by the contents.

- ii. Part 2 contains the prescribed information which aims to capture the degree of compliance by the provider with national or regulatory priorities – but not to require an exhaustive list of every service provided. The information must be provided in the form of mandatory statements, for example setting out “Whether or not the provider is required to register with the Care Quality Commission (“CQC”) under section 20 of the Health and Social Care Act 2008.”, and any conditions attached to that registration. This shows the reader whether or not the provider meets basic requirements, and provides context for other statements about service quality. The provider must also describe at least 3 priorities for improvement for the following year and how progress on this will be monitored, measured and reported. This is the ‘forward look’ section of the Quality Account. It offers the reader the opportunity to understand what improvements (related to the quality of healthcare services provided) the organisation plans to take over the next year and why those priorities for improvement have been chosen;
- iii. Part 3 is for providers, in consultation with their own stakeholders, to determine. This means that most of the content is for local determination, reflecting the commitments made during the debates on the Health Bill and in other public forums.

- 7.8. The Department also examined the issue of assurance, as feedback from potential users of Quality Accounts suggested that they would lack credibility without some added check of the accuracy of their data, the fairness of their interpretation of that data, and the representativeness of the information that they published. This issue was highlighted in the Department’s response to the independent reviews following the Healthcare Commission’s investigation into failings at Mid Staffordshire NHS Foundation Trust⁸. The assurance mechanism for 2009-10, reflected in Regulations 7, 8 and 9, is to require providers to put in place a mechanism of pre-publication clearance by the lead commissioner (a Primary Care Trust or SHA), Local Involvement Network (LINK), and Local Authority Oversight and Scrutiny Committee (OSC). Comments provided on the Quality Accounts by these bodies then have to be included in the published Quality Account.
- 7.9. Regulation 10 sets a deadline of 30 June for publishing the document. The document must be published on a website, and in practice this will be the NHS Choices website. The document must also be sent to the Secretary of State and in practice this means by e-mail. These measures are designed to minimise the cost and burden of publication for the provider, whilst at the same time making the Quality Account widely accessible to the public.

8. Consultation outcome

- 8.1. The underlying policy details for the Regulations were developed from a collaborative consultation involving many hundreds of stakeholders, including the Royal Colleges and other staff groups, patients and their representatives, managers, clinicians and across primary and secondary care, and including the public, private and voluntary sectors. To achieve this, the Department has been working closely with the Care Quality Commission (CQC), Monitor (the independent regulator of NHS Foundation Trusts) and the East of England Strategic Health Authority on a programme to develop this framework in collaboration with staff, public and patients, academic interests and a wide range of other stakeholders. The aim was to achieve the policy objectives by working with providers, their regulators, their staff, and their target audiences to design what Quality Accounts should look like.
- 8.2. Detailed proposals stemming from this process were set out in a consultation document that the Department of Health published on 17 September. The consultation ended on 10 December 2009,

⁸ DH, April 2009. A copy can be found at - http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098660

and a report of the outcome was laid before Parliament on 5 February by way of a Written Ministerial Statement.⁹

- 8.3. Around 170 individuals and organisations responded to the consultation, most of whom were supportive of the proposals. There were, however, some suggestions about the detail of implementation, and these were accommodated, as far as possible, in these Regulations, including:
- i. greater flexibility about the number of priorities for quality improvement that a provider should set. A minimum has been set but no maximum requirement;
 - ii. simplification of the statement on participation in clinical audit;
 - iii. allowing both Local Involvement Networks (LINKs) and Overview and Scrutiny Committees (OSCs) the opportunity to comment on a provider's Quality Account;
 - iv. using the Standard NHS Contract definition of a small provider.

9. Guidance

- 9.1. As a consequence of the ongoing design work, interest and awareness amongst stakeholders has been stimulated and continues to grow. The DH website is one of a number of sources of guidance for practitioners and readers alike. Drawing this together into a comprehensive toolkit was one of the objectives that stakeholders set for the Department. The toolkit was published alongside the Regulations¹⁰.
- 9.2. The Department also alerted NHS providers to the likely new arrangements in July 2009¹¹, which enabled them to make preparations in key areas such as improving data quality, engaging with patients and identifying relevant indicators. This then enables them to have made significant preparation in advance of drawing up their 2009-10 Quality Account for publication in summer 2010.
- 9.3. As mentioned in para. 8.10, the Department are also working on proposals for next year's Regulations in the area of external assurance. The current consultation will help ensure that those affected by any new requirements will be aware of possible forthcoming changes. These will also be reflected in the toolkit, which we intend to update periodically.

10. Impact

- 10.1. An Impact Assessment is attached to this memorandum. In brief, it shows that:
- i. there are clear benefits to the public in increased patient choice and provider accountability;
 - ii. Quality Accounts will improve the quality of patient care;
 - iii. these benefits (which cannot yet be quantified) outweigh the costs (estimated to be £5.1-17.3 million each year).

⁹ The text of the Written Ministerial Statement is available at - <http://www.publications.parliament.uk/pa/cm200910/cmhansrd/cm100205/wmstext/100205m0001.htm#10020536000008> (included in the WMS is a link to the Consultation Response)

¹⁰ The toolkit is available on the Department's website

¹¹ The "Dear Colleague" letter is available at - http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_102794

10.2. The impact on the public sector is an improvement in the quality of NHS healthcare, and of provider boards' accountability to the public whom they serve. There is some additional cost from reporting and publication, but no new data collection, nor diversion from existing work.

11. Regulating small businesses

11.1. These Regulations will not apply to small businesses whose annual contract value is less than £130,000 and who employ 50 or fewer full time employees.

12. Monitoring and review

12.1. The Next Stage Review has an evaluation planned for later this year. The policy on Quality Accounts will also be evaluated again once the first ones are published this summer. These evaluations will be used to inform revised Regulations (if they are needed) next year. This process worked successfully for the current proposals – which form these Regulations – and we are confident that it will be so again. To help ensure that this is the case, we will continue to design our policies with stakeholders (we have a national stakeholder group that represents all relevant interests), and test them against the experiences of frontline practitioners and patients and the public.

13. Contact

13.1. Neil Townley at the Department of Health (tel: 0207 972 5209 or email: neil.townley@dh.gsi.gov.uk) can answer any queries regarding the instrument.

Summary: Intervention & Options

Department /Agency: Health	Title: Impact Assessment of NHS (Quality Accounts) Regulations 2010	
Stage: Implementation	Version: 2.3	Date: 27 January 2010
Related Publications: "High Quality Care for All" http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_0858		

Available to view or download at:

<http://www.>

Contact for enquiries: Karen Noakes

Telephone: 0207 972 1160

What is the problem under consideration? Why is government intervention necessary?

Without robust comparative information on quality it is plausible that both the level and consistency of NHS service quality would fall short of the optimal. Providers publish a range of information about their services but it is difficult for patients, the public and managers to find and use this information. Government intervention is necessary to solve this problem - recent experience has shown that some providers will not take action to resolve the issue if left to themselves.

What are the policy objectives and the intended effects?

Policy objective - to ensure that providers of NHS healthcare publish robust data about the quality of their services to allow patients and the public to hold providers to account for the quality.

Intended effects - Boards of provider organisations will focus on quality improvement as a core function, the public will hold providers to account for the quality of NHS healthcare services they provide, and patients and their carers will make better informed choices - and thereby to raise the quality and consistency of services delivered to NHS patients.

What policy options have been considered? Please justify any preferred option.

Option 1 – do nothing

Option 2 – require providers to publish a limited version of a Quality Account using existing legislation

Option 3 – enact tailored legislative provisions which will require providers of NHS healthcare to publish data annually on quality in a readily accessible standardised format (A 'Quality Account')

Option 3 has been taken and legislation for Quality Accounts is in the Health Act 2009.

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects? After three years the Department will undertake an evaluation of the impact of Quality Accounts.

Ministerial Sign-off For final proposal/implementation stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.

Signed by the responsible Minister:

Mike O'Brien**Date: 5th February 2010**

Summary: Analysis & Evidence

Policy Option: 3	Description: Legislative provision as set out in Health Act 2009
-------------------------	---

COSTS	ANNUAL COSTS	Description and scale of key monetised costs by 'main affected groups' The key costs for the main affected organisations - NHS healthcare providers - are in the production, assurance and publication of the annual Quality Account (see section 7 for details).			
	One-off (Transition) Yrs				
	£				
	Average Annual Cost (excluding one-off)			Total Cost (PV)	£ 5.1-17.3 million
Other key non-monetised costs by 'main affected groups'					

BENEFITS	ANNUAL BENEFITS	Description and scale of key monetised benefits by 'main affected groups' This information is not available currently, but a priority area for the evaluation in Summer 2010 will be to look further at this.			
	One-off Yrs				
	£				
	Average Annual Benefit (excluding one-off)			Total Benefit (PV)	£ n/a
Other key non-monetised benefits by 'main affected groups' Quality Accounts will lead to improvements in healthcare quality for patients, in NHS healthcare providers' accountability for the wider public, in patient choice, and enable better informed decision making by commissioners (see Annex A for details).					

Key Assumptions/Sensitivities/Risks

Key Sensitivity and assumption - The costs are estimated from a small sample size of providers who piloted 'Quality Reports' in 2009 and estimated made based on large providers publishing Quality Accounts only. Key Risk - Producing Quality Accounts places additional burdens on NHS providers.

Price Base Year	Time Period Years	Net Benefit Range (NPV) £	NET BENEFIT (NPV Best estimate) £
--------------------	----------------------	-------------------------------------	---

What is the geographic coverage of the policy/option?	England			
On what date will the policy be implemented?	01/04/2010			
Which organisation(s) will enforce the policy?	SHAs/PCTs			
What is the total annual cost of enforcement for these organisations?	£ 0			
Does enforcement comply with Hampton principles?	Yes			
Will implementation go beyond minimum EU requirements?	N/A			
What is the value of the proposed offsetting measure per year?	£ 0			
What is the value of changes in greenhouse gas emissions?	£ 0			
Will the proposal have a significant impact on competition?	No			
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium £14,078	Large £14,078
Are any of these organisations exempt?	Yes	Yes	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices)			(Increase - Decrease)
Increase of	£ 0	Decrease of	£ 0
Net Impact			£ 0

Key: Annual costs and benefits: Constant Prices (Net) Present Value

QUALITY ACCOUNTS: IMPLEMENTATION STAGE IMPACT ASSESSMENT - EVIDENCE

1. INTRODUCTION

1.1 Primary legislation for Quality Accounts is set out in the Health Bill 2009. This requires all providers of NHS services to produce annual reports on the quality of services they provide. The detailed content for the accounts will be set out in the NHS (Quality Account) Regulations (“the Regulations”). Under the Regulations the obligation will not apply to community health services or primary care services. It is intended that this exemption will be removed in 2011. Small providers with a low income and few staff will also be exempt from the obligation to produce a quality account and it is intended that this exemption will remain in place. Quality Accounts will allow:

- i. the public to hold providers to account for the quality of NHS healthcare services they provide and to demand action from providers where they believe that providers are falling short on quality;
- ii. patients, and their carers, to make better informed choices;
- iii. commissioners and providers to agree priorities for improvement;
- iv. NHS Trust Boards and their non-NHS equivalents to ensure that they place quality at the heart of their planning and delivery processes; and,
- v. clinical teams to benchmark and compare their performance.

1.2 This impact assessment provides an update on costs for statutory Quality Accounts (Option 3 of the original IA, which is available at

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_093305),

as implemented through the NHS (Quality Account) Regulations, which means that it looks only at the first year of Quality Accounts (ie. publication in Summer 2010 ,covering activity in 2009-10). These costs are based on a sample of Trusts that participated in an evaluation of the quality reporting test in Summer 2009.

2. BACKGROUND

2.1 High Quality Care for All

(http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_085825),

published 30 June 2008, set out a vision of improving quality in NHS healthcare, and detailed how that vision would be achieved. Chapter 4 in particular set out a new quality framework, which is designed to build on previous quality work undertaken by the NHS and on changes to the regulation of health and social care set out in the Health and Social Care Act 2008.

- 2.2 The quality framework policy aims to ensure that all NHS healthcare services are of a high quality, and that unacceptable local or regional variations are removed. The quality framework will do this by bringing clarity to the definition and measurement of quality in NHS healthcare, by ensuring that priorities are identified correctly, that appropriate standards are set, that the correct tools for measuring quality are available, that information on quality performance is published, and that improvements in quality are recognised and rewarded.
- 2.3 The Health Act 2009 implemented those parts of the NHS Next Stage Review that required primary legislation, including provisions about mandatory annual reporting by NHS healthcare providers on the quality of their services. The Review concluded that from April 2010 all healthcare providers working for or on behalf of the NHS should be placed under a legal requirement to publish an annual Quality Account. Sections 8 and 9 of the Health Act 2009 therefore place that duty on all such providers with a power to make regulations to set out the detail.
- 2.4 The details of how to implement this policy were developed over the course of 2009 in collaboration with the NHS, the professions, the regulators and with patients and the wider public. This IA looks at the set of Regulations that came out of that process.

3. POLICY OBJECTIVE

- 3.1 The ultimate objective of the overall quality framework is to raise the level and consistency of the quality of NHS services. The obligations in the Health Act and Regulations setting out the detail on Quality Accounts contribute towards achieving this ultimate objective through requiring the publication of information on quality. This publication will allow easy access to quality information, with the intention of encouraging patients, the public and others to demand higher quality services from the NHS. In particular, the objectives of Quality Accounts are to:
- make healthcare providers more accountable to patients, carers and the wider community;
 - allow clinical teams to review and drive up their performance (with the option for benchmarking);
 - provide a framework for commissioners' and providers' discussions about their local priorities for service improvement
- 3.2 We set out options to achieve these objectives in a consultation document, the content of which came from the engagement and testing process mentioned in para. 2.4. The Regulations achieve this by:
- exempting small providers from the obligation to produce a Quality Account;
 - exempting community health and primary care providers from the obligation to produce a Quality Account (this is intended to be a temporary exemption for one year only – subject to further policy development and consultation);

- setting out prescribed content;
- setting out the mechanism for assurance;
- prescribing the manner and timing of publication.

3.3 Each of the objectives of Quality Accounts set out in para. 3.1 is, to some extent, already fulfilled by information which is currently available to patients, clinicians and managers, and by performance management mechanisms which already apply to NHS providers. However, there are some key gaps in ways in which information is provided, and in the way NHS providers are held to account for their delivery of NHS healthcare. We considered a range of options for filling these gaps, as detailed in the original impact assessment that accompanied publication of the Health Bill in January 2009. Placing a legislative requirement on providers to publish Quality Accounts was the option Parliament implemented through primary legislation in the Health Act 2009.

3.3 In addition, a further important intermediate objective of Quality Accounts is to allow researchers to compare the effectiveness of different interventions, care processes, management structures and other determinants of care quality.

4. CONTENT, FORM AND PUBLICATION OF A QUALITY ACCOUNT

4.1 In order to ensure local ownership of Quality Account, the majority of the report for 2009/10 will be locally determined and owned by boards, clinicians and staff. A smaller, nationally mandated component of Quality Accounts that is common to all Quality Account will allow some direct comparison. The nationally mandated information is to be provided in the form of statements which will be set out in the Regulations. These statements include:

- a statement from the board – an overall statement of accountability from the board;
- priorities for improvement – confirmation that the organisation has identified key improvement priorities and the monitoring and reporting arrangements to track progress;
- review of quality performance – confirmation that the organisation has set three indicators for each of the domains of quality set out in High Quality Care for All; has reviewed the range of its services with a view to developing a quality improvement plan; and has demonstrated that it monitors quality by participating in clinical audits;
- research and innovation – confirmation that the organisation participates in clinical research and uses the CQUIN payment framework;
- what others say about the provider – a statement on the organisation's CQC registration (e.g. whether conditional), and of any concerns arising from periodic

and/or special reviews; and a statement from Local Involvement Networks (LINKs) and primary care trusts (PCTs);

- data quality – a simple data quality score.

- 4.2 Quality Accounts will be prepared covering a standard reporting period April – March, and will be published by 30 June each year. Providers will have to upload an electronic copy of their Account to NHS Choices by the deadline for publication. Providers will also have to supply a hard copy of their Quality Account from 30 June onwards to anyone who requests a copy.
- 4.3 Providers will be encouraged – but not required – to provide either electronic or hard copies of their Quality Accounts in a range of formats, eg community languages, large print, Braille. Some providers may choose to do this, either individually or by working together with other local providers to share printing /Braille / translation costs. Alternatively, depending on demand, PCTs may wish to ensure that accessible versions providers' Accounts are available to people in their area.

5. ASSURANCE

- 5.1 In our initial consideration of the costs associated with Quality Accounts, we considered a range of audit costs that spanned extensive external audit of Quality Accounts to limited validation of Quality Accounts. At the time we concluded that the additional burdens that an audit requirement could place on providers were not proportionate to the additional assurances that audit may bring. Extensive stakeholder engagement since the publication of the first impact assessment for Quality Account has led us to the view that some form of assurance over the accuracy, interpretation and representativeness of Quality Accounts is crucial to ensuring that the public have confidence in the Quality Accounts themselves.
- 5.2 The development of an assurance package for Quality Accounts is being led by the National Quality Board (NQB) and, subject to further policy development work and consultation, will be introduced by way of further Regulations in future years. As a first step, in the first year of Quality Accounts, we will be requiring providers to share their Quality Accounts prior to publication each June with:
- their commissioning PCT or SHA
 - the appropriate Local Involvement Network (LINK)
 - the appropriate local authority Overview and Scrutiny Committee (OSC)
- 5.3 The Regulations will require commissioning PCTs/SHAs to corroborate a provider's Quality Account by confirming in a statement, to be included in a provider's Quality Account, that in their view the account contains accurate information about the services provided to it.
- 5.4 PCTs will not be expected to check data that a provider has included in their Quality Account that are not part of existing contract/performance monitoring discussions. The opinion that the PCT offers will cover issues that the PCT is in a position to comment on. It is not therefore a signing off of the Quality Account - that remains the responsibility of the provider.

5.5 The Regulations also give both the appropriate LINK and OSC (defined in the Regulations) the opportunity, on a voluntary basis, to review and supply a statement, for inclusion in a provider's Quality Account. This could for example indicate whether they believe, based on the knowledge they have of the provider that the report is a fair reflection of the healthcare services provided.

6. IMPACT OF QUALITY ACCOUNTS

Benefits

- 6.1 The standardised content of part of the Quality Account will enable patients to compare providers, and will supplement the information which is available on NHS Choices.
- 6.2 The local part of the Quality Account will allow providers to work with local groups to determine what is important locally and to provide a report on these issues. This type of information is not likely to appear in other sources, eg NHS Choices.
- 6.3 The requirement to produce a Quality Account will allow NHS Trust Boards and their non-NHS equivalents to focus attention on quality issues.
- 6.4 Commissioners and clinicians will have easy access to information which is focused on quality, which will enable them to do better at planning and delivering NHS healthcare.
- 6.5 Information is provided to the patients, the public and other local commentators at a time and in a way which will allow them to hold local providers to account for the quality of services they provide. There is considerable literature addressing the impact of publishing various information in the form of reports, report cards and other performance management tools.
- 6.6 In general, the evidence suggests that publishing information of this nature is positive in terms of informing the public about the performance of organisations, understanding the outcomes of care and informing decisions on system improvements, to varying degrees (i.e. going beyond simply being of benefit to the public). However, there are risks associated with the publication of information about healthcare provider performance (see below). Annex A gives further details of the benefits – and risks – based on a review of the available literature, as well as describing how Quality Accounts should be developed to ensure that there is the best chance of the benefits being realised.
- 6.7 However, another common theme was a lack of quantifiable evidence on the effects of publishing such information. Therefore, the benefits are presented as qualified, non-monetised benefits, which add context to the costs and rationale for our proposals.

Risks

- 6.8 Producing Quality Accounts places additional burdens on NHS providers. Any additional burden consumes resources that would otherwise have been available for direct patient

care. There is also a risk that patients and the public may be confused about the relationship between Quality Accounts and other published information relating to quality, eg information available on NHS Choices and information available from Care Quality Commission performance assessment of providers. However, the benefits in terms of increased accountability were welcomed across the board in the consultation.

- 6.9 In some specific cases, perverse incentives have been reported – for example, selecting patients whose treatment is likely to result in a favourable outcome, which in turn will feed through to an ability to report “better” results. However, these are generally associated with individual clinicians rather than at organisational level and are largely isolated effects that are likely to be outweighed by the benefits and can be mitigated against with careful planning and definition of indicators reported on.
- 6.10 There is a risk that the data available to NHS providers may not be sufficiently robust to produce a Quality Account which providers feel able to sign off as true and fair. But it is also the case that the Department of Health and the NHS – at all levels – are working to ensure that new metrics are available and that data quality is improved. The risk of poor data quality is therefore one which should decrease over time. In the meantime, we would expect providers to draw attention to any element of their Account – whether in the prescribed or locally determined part – where the provider feels that there the data needs to be read with a suitable caveat.
- 6.11 There is a risk that the absence of any requirement to have Quality Accounts independently audited or validated may lead providers to publish information which they know is false – or to publish information without undertaking sufficient checks to ensure its accuracy. We believe that the risk of this is small, given that other assurances in the system will act as a brake on providers. Firstly, the prescribed content of the Quality Account will be validated by virtue of being drawn from information sources which are themselves validated. This applies principally to those elements of information which providers have already supplied to the Care Quality Commission, Monitor and PCTs. Nevertheless, we recognise that independent assurance is valued by the public, and these Regulations make provision for that.
- 6.12 In addition, we encourage providers to seek external audit or third party validation. We would expect that some providers would welcome the opportunity to have their Quality Accounts audited or validated, either to give them a competitive “edge” over their local competitors or to demonstrate to patients, the public and commissioners that they provide high quality services. Other providers may not rush to embrace audit or validation, but may be encouraged to do so by patients and other bodies.
- 6.13 There may be a lack of resource within organisations to prepare Quality Accounts – recruitment on either a temporary or permanent basis may be required to supplement existing information management capacity. Nevertheless, given the importance placed by the patients and the public on the value of transparency and reporting, as well pressure from regulators, commissioners and the media, providers are keen (responses to the consultation confirm this) to make a good job of this.
- 6.14 We assume that the report will not be a purely technical data report and therefore some senior time for overseeing the report is factored in. This was one of the outcomes from the

evaluation of last summer's Quality Reports, and providers care for their reputation, as well as the requirements of the Regulations, incentivises senior ownership.

6.15 Publication costs can be highly variable depending on the quality and quantity of reports produced in hard copy. We have allowed for this variation and have further assumed virtual zero cost for internet publication, providing existing communication channels eg NHS Choices are used. Many providers will use their annual report as a vehicle for transmitting the content of their Quality Account and the cost can be reasonably assumed to be as minimal as the provider wishes it to be.

6.16 We assume that no costs are incurred for data collection as any indicators reported on will either exist already or be derived as part of a separate project to develop Clinical Quality Metrics (which would have its own Impact Assessment).

6.17 One mitigation of some of the uncertainty around production and publication costs, is that Regulations' making only minimum requirements for reporting, such as making an electronic copy available for web publishing at virtual zero cost.

Evaluation

6.18 There is a lack of quantifiable evidence about the impact of publishing health care data. We are committed to undertaking a rigorous evaluation of the impact of Quality Accounts, in the context of other policies to improve measurement of quality and outcomes, on the quality and consistency of care delivered to NHS patients.

Variants

6.19 We have examined the following component parts of Quality Accounts:-

- Content of a Quality Account
- Method of publication
- Frequency of publication
- Audit of Quality Accounts

Content – central and local requirements

6.20 Section 4 above describes a Quality Account which is composed partly of centrally-set information, which would be set out in regulations made by the Department of Health, and partly of local information, chosen by providers themselves. The table below documents the key advantages and drawbacks of three variants – a Quality Account which is wholly set by the centre, one which contains both centrally-set and locally derived information and one which is entirely locally determined.

QA centrally mandated	QA centrally mandated and locally determined	QA locally determined
Standardised accounts will be easier to scrutinise and compare	Some element of central mandate will improve the standardisation and comparability of reports but also provide a relevant local context	More relevant to patients and the public as it focuses on local issues

Brings together information from a smaller number of reliable sources	Brings together information from a range of disparate sources	Brings together information from a range of disparate sources
Will improve public accountability in a standardised format at national level	Will improve public accountability at both national and local level for the public and other users	Will improve public accountability on locally relevant issues
BUT: An Account which has only centrally set information will not allow for consideration of local priorities and issues		BUT: An Account which is wholly determined locally will not allow users to compare providers on a like-for-like basis

Method of publication

6.21 Quality Accounts have a potentially wide range of users – patients, the public, local commentators, the NHS, local bodies such as Local Authorities, regulatory bodies such as the Care Quality Commission and the Department of Health. Quality Accounts should be easily accessible to each of these users in a form which is of most use to them. But at the same time, we are keen to ensure that providers do not face undue burdens when producing these reports.

6.22 We have therefore examined whether reports should be published by each provider, or whether it would be more cost-effective if providers were to “club together” and to contract the production out en bloc. The table below sets out the key advantages of both methods. However, we feel that it is for providers themselves to decide on the most cost effective of these methods, so long as the reports are prepared according to the Department’s requirements.

Multi-report production	Individual contracting
Will provide economies of scale and costs in producing reports for the full range of NHS providers	Will allow a greater degree of tailoring the report to suit the local audience
Will enable a greater degree of consistency of reporting to be achieved	

6.23 We also examined whether publication of a Quality Account should be entirely electronic, entirely hard copy, or a mixture of both. The table below notes our work on this issue, and demonstrates why we feel that a largely electronic publication, with a limited run of hard copies, will keep costs down for providers while ensuring that users can access reports in a way which works best for them.

Electronic publication	Electronic plus limited hard copy publication	Extensive hard copy publication
Up-to-date method of transmitting information to broad audience	Up-to-date method of transmitting information to a broad audience but also reaching users without access to the internet	Familiar method for publishing reports, which the public are used to.

Relatively low costs to distribute reports to a broad audience	Relatively low costs to distribute reports to a broad audience while maintaining some flexibility to service other users	
BUT: will not work for users who do not have access to the internet or who are not familiar with using it.		BUT: this would be costly for providers and would be a waste of resources if not all the hard copies were read/used

Frequency of publication

6.24 High Quality Care for All proposed that Quality Accounts should be published annually, to ensure that the published content is up to date. As part of our work we examined whether it would be possible to produce Quality Accounts more frequently – say quarterly – to ensure that providers show the most up-to-date quality position with regard to the quality of their services, and can be held to account for this. The table below shows the key issues with annual and quarterly publication.

Annual publication	Quarterly/frequent publication
Enables regular reporting to maintain public accountability at reasonable intervals, while keeping costs manageable	Enables reporting of indicators in a more timely fashion
Likely to ensure that all information will have been updated at successive reports	Enables quicker response to concerns to be undertaken

6.25 We believe that requiring providers to publish Quality Accounts once per year will be adequate to ensure that their content is up to date and the burdens placed on providers are kept to a minimum. However we know from the Quality Reports testing process that providers like to opt to include “signposts” to any data which may be more up to date than that in the Quality Account, to ensure that patients have the most up to date information on which to base their care choices.

7. Costs - Summary of costs and cost profile for 2009/10

Production and publication costs

Previous estimates

- 7.1 In the previous version of this Impact Assessment (IA), published on the 2nd of December 2008, the costs of producing and publishing a Quality Account were estimated from theoretical calculations. Costs were broken down into production costs and publication costs.
- 7.2 It was assumed that the majority of the production costs would be due to extra staffing requirements, which would consist of some senior analyst time and some senior management time. An estimated range for the production costs incurred by a typical organisation was produced by multiplying a range of salaries for each of the two staff types (the Agenda for Change pay scales were used) by a range of time requirements.
- 7.3 The publication costs were based on an estimate of the number of copies that would be produced and a typical cost per copy from a survey of three commercial printing companies. The estimated typical production and publication costs are given in figure 1.

Figure 1: estimated production and publication costs for a typical trust, as used in the previous Impact Assessment

	Estimated cost (£)
Production	3,375 (1,535 – 7,698)
Publication	216 (9 – 739)
Total	3,591 (1,544 – 8,437)

Source: calculation spreadsheet for *Quality Accounts Impact Assessment, December 2008*

- 7.4 Costs were then scaled up to the number of trusts that will be producing Quality Accounts each year. The resulting cost profile for production and publication provided in the previous IA is reproduced in figure 2. For more details of the calculation, please see the previous IA, which can be found on the Department of Health website.

Figure 2: production and publication cost estimates from the previous IA

£000s	2009/10	2010/11	2011/12	2012/13	2013/14
Production	1,370 (625 – 3,125)	1,370 (625 – 3,125)	6,600 (1,350 – 12,860)	6,600 (1,350 – 12,860)	6,600 (1,350 – 12,860)
Publication	90 (5 – 300)	90 (5 – 300)	1,500 (25 – 3,105)	1,500 (25 – 3,105)	1,500 (25 – 3,105)
Total	1,460 (630 – 3,425)	1,460 (630 – 3,425)	8,100 (1,370 – 15,965)	8,100 (1,370 – 15,965)	8,100 (1,370 – 15,965)

Source: *Quality Accounts Impact Assessment, December 2008*

Results of the Quality Reports pilot

- 7.5 In order to better understand the costs of producing Quality Accounts, as well as other issues, a pilot group of Foundation Trusts (FTs) and trusts from NHS East of England were asked in to produce “Quality Reports” in 2009 to a similar specification. Following production, an evaluation was undertaken by PricewaterhouseCoopers (PwC) which looked at, among other things, the costs incurred by trusts in the production of Quality Reports. The costs estimates used in this IA are taken from this evaluation, which is published on the Department of Health website (1). These are therefore a sample of Trusts, and whilst the

final cost to the NHS is not yet known, it is not expected to be significantly higher than the estimates.

7.6 Trusts participating in the pilot were asked to estimate the costs that they incurred for various parts of the production and publication process. The results presented in the report of the evaluation (page 23) are reproduced in figure 3.

Figure 3: costs incurred by trusts in the Quality Reports pilot

Contribution to cost of:	Average approximate cost	Range	Base	No. who said didn't know
Agreeing priorities and measures	£3,452	£0 - £20,000	9	62
Stakeholder engagement	£1,367	£0 - £10,000	12	59
Collecting and analysing the data	£5,027	£0 - £30,000	11	60
Preparing the report	£2,921	£0 - £14,000	14	57
Publishing the report	£1,311	£0 - £8,000	14	57
Total	£14,078	£0 - £30,000		

Source: *Quality Reports Testing Exercise: Evaluation, August 2009*

7.7 It is clear that both the production costs (equivalent to the total of the first four rows) and the publication costs were significantly underestimated by the method employed in the previous IA. Specifically, the resource required to agree and measure priorities and for stakeholder engagement was not factored into the time estimates, while the time required for the other tasks was underestimated.

7.8 It should be noted that, while based on real data and so superior to the previous estimates, these results still have significant limitations. As can be seen from the last two columns, only a small proportion of the trusts involved in the pilot were able to provide information on costs; this could lead to sampling error, or may introduce a bias, as the trust that reported these figures may not be representative of the group. The ranges given also show that there was great variation in the costs incurred, so the average (mean) may be skewed by outliers. Furthermore, the trusts selected for this pilot are not representative of all trusts in England: many are Foundation Trusts and the rest are confined to a geographical region. It is also possible that involvement in the pilot, or simply the fact that this is the first time that these organisations have produced a Quality Report or Quality Account, had a behavioural effect on the organisations in the sample.

Production costs for the first year

7.9 In order to produce an updated estimate of the cost profile for Quality Accounts across England, the cost estimate from the Quality Reports pilot is scaled up to the total number of trusts producing a Quality Account in each year.

7.10 The first year of Quality Accounts, to be published in June 2010, will apply to acute services only. Applying the costs calculated above to a 250 acute trusts and 120 Foundation Trusts (the assumption used in the work commissioned by the Department to look as assurance costs for Quality Accounts), to overall production costs for the first year of Quality Accounts are given in figure 4.

Figure 4: total production costs for the first year of Quality Accounts

Average approximate cost	Range
£5.2m	£0 – £11.1m

Assurance costs

Previous estimates

7.11 In the previous version of this IA, the costs of assuring Quality Accounts were based on the costs of the Healthcare Commission (now the Care Quality Commission) Annual Health Check (AHC). The precise nature of the assurance process was not agreed at that point, so two estimates were provided: one for full audit and one for voluntary external validation.

7.12 Based on similar audit functions carried out as part of the AHC, the cost of full audit was estimated as £8-12k for a large organisation, and around 10% of that for much smaller providers. An assumption was made that assurance by voluntary external validation would incur 10-30% of the costs of full audit.

7.13 Costs were then scaled up to the number of trusts that it was expected would be producing Quality Accounts in each year, giving the cost profile shown in figure 5. For more details of the calculation and assumptions, see the previous IA.

Figure 5: assurance cost estimates from the previous IA

£000s	2009/10	2010/11	2011/12	2012/13	2013/14
<i>Auditing</i>	3,980 (3,180 – 4,775)	3,980 (3,180 – 4,775)	17,305 (9,845 – 24,765)	17,305 (9,845 – 24,765)	17,305 (9,845 – 24,765)
<i>Voluntary external validation</i>	795 (635 – 995)	795 (635 – 995)	3,710 (1,230 – 6,190)	3,710 (1,230 – 6,190)	3,710 (1,230 – 6,190)

Source: Quality Accounts Impact Assessment, December 2008

Assurance costs for the first year

7.14 While the assurance processes for 2010/11 onwards are yet to be agreed, the first year's Quality Accounts will be assured by a process corresponding to the combination of self-certification and stakeholder review. The estimated costs for these options are given in figure 6. These are based on standard costs for staff time, and estimates from PWC's survey of staff time likely to be taken up with fulfilling this assurance role.

Figure 6: estimated costs of assurance, based on 370 trusts

£000s	Self-certification	Stakeholder review	Both options
<i>Incremental setup costs (Monitor and DH)</i>	270 – 350	270 – 350	270 – 350*
<i>Training costs</i>	6 – 13	6 – 13	6 – 13*
<i>Expenses for stakeholders conducting the reviews</i>	N/A	300 – 500	300 – 500
<i>Trust staff time</i>	2,500 – 3,000	2,000 – 2,300	4,500 – 5,300
Total	2,800 – 3,400	2,600 – 3,200	5,100 – 6,200

Source: Department of Health, September 2009

* The assumption has been made in combining the estimates for the two options that the incremental setup costs (for DH and Monitor to employ staff to oversee the project) and training costs will only need to be met once for the two options.

Total costs for the first year

Estimated total costs

7.15 Combining the total production and assurance costs calculated above (ie. the range of total production costs (£0 - £11.1m) in figure 4, and the range of assurance costs (£5.1m - £6.2m) in figure 6), the total costs incurred in the first year of Quality Accounts are estimated to be **between £5.1 million and £17.3 million**.

7.16 The nearest equivalent estimate from the previous IA (the total with voluntary external validation) was a range of £1.0 million to £4.6 million.

Limitations

7.17 As well as the inherent limitations of the contracted work on which this estimate is based, a further key limitation is that the assumption that Quality Accounts will apply to 370 acute trusts and Foundation Trusts in the first year is not wholly accurate.

7.18 In fact, all organisations providing acute services will be required to produce Quality Accounts for these services. This will include all acute trusts and Foundation Trusts, but also a number of smaller independent providers. Due to their smaller size, these providers are likely to incur lower costs than those estimated here for trusts. However, this does mean that the above figures are likely to be an underestimate of the total cost of Quality Accounts.

8. SPECIFIC IMPACT TESTS

Competition Assessment

Will the proposal have a significant impact on competition?

8.1 Minimal. Any centrally imposed requirement creates a barrier to entering the market, although we do not believe that the requirement to produce a Quality Account will discourage any potential provider, and the production of a Quality Account, which will contain some standardised information, will make it easier for a new entrant to overcome reputational barriers. All providers of NHS healthcare (apart from small providers) will, in time, need to prepare Quality Accounts. There will be no competitive advantage to small providers as the compliance cost for non-exempt providers is not significant. There will therefore be no competitive advantage – or disadvantage – to existing providers.

Small Firms Impact Test

8.2 Small healthcare providers, defined as a provider with fifty or fewer full time employees whose income during the reporting period is £130,000 or less will be exempt from the requirement to produce Quality Accounts.

8.3 All other providers of NHS healthcare over that threshold should, in time, be required to produce a Quality Account. This will include both providers in the public and independent sectors offering healthcare services from a range of organisations, eg GP and dental practices, pharmacies as well as hospital trusts.

Legal Aid Impact Test

Will the proposal introduce new criminal sanctions or civil penalties?

8.4 No.

Other Economic issues

Will the proposal bring receipts or savings to Government?

8.5 No.

Will it impact on costs, quality or availability goods and services?

8.6 Yes. This proposal is designed to improve the quality of NHS healthcare.

Will it impact on the public sector, the third sector, consumers?

8.7 Yes. It will cover all types of provider of NHS healthcare services, including public and third sector providers. It will also impact on patients / consumers, by giving them additional information on which to base choices about the quality of their care. It will also help them to hold providers of NHS services to account, which should help to drive up the quality of these services.

Will the proposal result in new technologies?

8.8 No.

Will the proposal result in a change in the investment behaviour both into the UK and UK firms overseas and into particular industries?

8.9 No.

Carbon and Greenhouse Gas Assessment

Will the proposal lead to change in the emission of Greenhouse Gases?

8.10 No.

Other Environmental issues

Will the proposal be vulnerable to the predicted effects of climate change?

8.11 No.

Will it lead to a change in the financial costs, environmental and health impacts of waste management?

8.12 No.

Will it impact significantly on air quality?

8.13 No.

Will it involve any material change to the appearance of the landscape or townscape?

8.14 No.

Will it change the degree of water pollution; levels of abstraction of water; exposure to flood risk?

8.15 No.

Will it disturb or enhance habitat or wildlife?

8.16 No.

Will it affect the number of people exposed to noise or the levels of exposure?

8.17 No.

Health Impact Assessment

Will the proposal have an impact on health, wellbeing or health inequalities?

8.18 The proposal is designed to improve the quality of healthcare offered by the NHS, as part of the overall Quality Framework set out in High Quality Care for All, published on 30 June 2008.

Equality Assessment

Will the proposal have an impact on:-

Race equality

Gender equality

Disability Equality

Human Rights

Quality Accounts are designed to fulfil a number of purposes and therefore to yield a number of benefits. The chief benefits to patients and the public are designed to be:-

Better information on quality which will allow local individuals and groups to hold their local NHS services to account for the quality of the healthcare they provide.

Better information on quality to support patients, their carers and families to make more robust choices about their care.

It is not expected that Quality Accounts will systematically impact upon groups according to their background, nor is the policy expected to widen inequalities.

Equality Assessment

Will the proposal have an impact on:-

Race equality
Gender equality
Disability Equality
Human Rights

Summary

8.19 Quality Accounts are designed to fulfil a number of purposes and therefore to yield a number of benefits. The policy is designed to ensure that providers of NHS healthcare publish information on the quality of the services they provide so as to allow:-

- local individuals and groups to hold their local NHS services to account for the quality of the healthcare they provide.
- patients, their carers and families to make more robust choices about their care.

8.20 It is not expected that the preferred option will systematically impact upon groups according to their background, nor is the policy expected to widen inequalities. We formally consulted over 12 weeks on the details of Quality Accounts and will ensure that the future evaluation of the policy fully addresses equalities issues.

Positive Impact

8.21 The evidence (see annex A) is generally positive about publishing information, and demonstrates that patients are keen to have more information (refs 5,10,14 - Annex A). While the evidence is less clear about the use that patients have made of this data in exercising choice, the existence of Quality Accounts could provide a valuable platform for patients to begin to involve themselves in the choice agenda. However, it should be recognised that there are concerns about the impact of such reporting on 'vulnerable' population groups eg those on low incomes, less educated, chronically sick or people from black and minority ethnic groups (ref 4 - Annex A). There is a lack of empirical evidence concerning the impacts on these groups, positive or negative, of publishing information. The lack of evidence is a result of more attention being paid to other aspects of quality improvement. It does not indicate that the concerns are baseless, but neither does it confirm any specific adverse effects.

8.22 It confirms the more general point that there has been a lack of systematic evaluation

of the effects of publishing healthcare quality information. However, it is also true that the potential negative impacts are not only recognised but that there are recommendations in the literature about how to protect against negative impacts. These can be summarised as:

- documenting and evaluating any differential effects of publicly reporting healthcare quality information
- making specific efforts to address the information needs of 'vulnerable' groups - for instance providing information that recognises social and cultural information needs and not just information on diseases and clinical procedures
- oversampling minority groups and stratifying data
- using appropriate risk-adjusted methodologies when reporting information

- 8.23 Therefore, while mitigating action can and should be taken to minimise potential adverse impacts on different population groups, more critically, the effects need to be properly evaluated.
- 8.24 Providers will be obliged to publish Quality Accounts which contain accurate information and provide a balanced view of the healthcare services they provide. Local involvement network groups (LINKs) and Overview and scrutiny committee's will have the opportunity to comment on a providers Quality Account, this should provide assurance that accounts are representative to the local populations needs. This will be tested when we evaluate the policy.
- 8.25 Quality Accounts have the potential to enable local individuals and groups in the six equality groups to play a greater role in holding local providers to account for the services they receive. It is important that patients and the public are engaged during the process of producing a Quality Account. This was reflected in responses to the consultation on Quality Accounts. DH guidance therefore states that in order to ensure that the local population as a whole is given the opportunity to shape the services they receive, providers should ensure that discussions actively include those from equality target groups and that their views are reflected in the Quality Account. This will be tested when we evaluate the first set of Quality Accounts later this year.
- 8.26 Providers will also be encouraged to report how they work with Local Government and other local partners. Certain groups – older people in particular but also those with physical and learning disabilities – may have the quality of their experience, or the safety of transition affected by the interaction with other partners including adult social care. Quality Accounts could show how the Trust engages other partners to share its vision for quality improvement as part of its wider business strategy
- 8.27 Quality Accounts will provide commissioners with a lever to promote a focus on equality issues among providers, in conjunction with the contracting process and CQUIN, and in conjunction with Joint Strategic Needs Assessments and work around achieving World Class Commissioning competencies. This will be tested when we evaluate the policy.
- 8.28 Within the following equality strands we note areas that Quality Accounts could help to address - alongside other national and local initiatives like CQUIN - and could help to promote increased local action on raising awareness and development of local solutions to equalities issues. Examples of such equalities issues are given below, but these are by no means the only equalities issues that we hope Quality Accounts will be able to address:

Age: Young black men tend not to engage with mental health services to the same degree as other groups, which can lead to worse health outcomes (2).

Race: Although the incidence of cancer is lower among BME groups than amongst white British people, awareness of cancer is generally also lower (3).

Gender: Women with CHD are less likely than men to be referred to specialists, have their cholesterol recorded, and are less likely to be prescribed some medications, when compared to men (4).

Disability: Among British Sign Language users, 70% of those admitted to A&E were not provided with a BSL/English interpreter to enable them to communicate (5).

Sexual orientation: Whilst divulging sexual orientation is not mandatory, the lack of openness between clinician and their patient might result in compromising their care. For example, a survey of lesbian health care needs found that only 64% of respondents had had a cervical smear in the last three years, compared to 80% nationally (6).

Religion: We do not expect any significant impact on different religious groups, but our evaluation will test whether this is the case.

- 8.29 Local flexibility deciding on part of the content of a Quality Account will, we hope, give providers, with additional encouragement from local commissioners, an incentive to improve equality for under-served and discriminated groups in local populations and to report on their initiatives. This will also be tested when we evaluate the policy.
- 8.30 DH Guidance for Quality Accounts suggests that Quality Accounts can be used to provide a clear statement about what organisations are doing to ensure that leaders become more representative of the communities they serve and should link in to the organisation's Talent and Leadership Plan where appropriate.
- 8.31 Quality Accounts should be accessible by all. Quality Accounts will be read by a variety of people, from members of the public to Medical Directors, prospective employees to commissioners. The NHS Single Equality Scheme obliges all providers to ensure that Quality Accounts are suitable to be read by all. Guidance will ask that providers consider the communication needs of their local community and whether it is appropriate to communicate all, or part, of a Quality Account in different languages or formats (e.g. Braille). They should also consider distribution methods for those members of the community who may not have access to the internet, having regard to their duties under equality legislation when preparing their Quality Accounts.
- 8.32 The Quality Accounts policy therefore has the potential to have a powerful positive impact on equalities issues, and our evaluation of the policy will focused on whether these hoped-for benefits have been realised.

Negative Impact

- 8.33 Commissioners and providers, or providers acting alone, may choose to include indicators in their Quality Accounts that are easier to meet by excluding particular groups, whether they are aware of this or not. Some groups who are not currently excluded from health care provision may therefore be excluded due to these local decisions about what to include in the Quality Account. This risk will be mitigated by highlighting the issue in the guidance that the Department will produce for providers on how to prepare Quality

Accounts.

- 8.34 Evidence shows that certain groups are better able to make use of published information on quality than others (7), and so while exclusion rates may remain constant the gap of relative quality between groups may widen, thus increasing inequalities. This small risk will be mitigated by highlighting this possibility in the guidance that the Department will produce for providers on how to prepare Quality Accounts. In preparing this guidance we will specifically seek the views of those groups who work with or represent the six equality groups to ensure that the information in Quality Accounts is presented in a way which is easy to understand. Further, PCTs and SHA will have an assurance role to pick up such potential unintended consequences.
- 8.35 In general, there is a considerable volume of data available on the six equality strands, though to varying degrees for different strands. For instance, age and gender data are routinely collected and ethnic group data frequently collected in NHS data sets, but data on eg sexual orientation is rarely recorded. Furthermore, there is a lack of systematic analysis of healthcare information by these strands for various reasons relating to availability, completeness and data quality. The Department of Health has taken steps to address these issues through its Equality Monitoring Group and has worked with the Office for National Statistics on "Measuring Equality - A Review of Equality Data" (8) including completing a data audit of equality data across several health datasets. The Department has also stressed to the NHS the importance of collecting eg ethnic monitoring data in relation to its statutory duties, through its "Practical Guide to Ethnic Monitoring in the NHS and Social Care"(9).
- 8.36 Therefore, there is the potential for equality specific analysis to be included in Quality Accounts and as outlined in paragraph 7.22 there are recommendations which can be followed to improve the chances of that information being of benefit to all population groups.
- 8.37 In addition, there is a possibility that local providers will structure the local elements of their Quality Account in a way which prevents all local people, and particularly those in six equality groups, from gaining access to provider Accounts or understanding the information that is contained in them. We have mitigated against problems with access by ensuring that all providers must provide a copy of their Account to anyone who asks,(s. 9(6) of the Health Act 2009) and must display a notice advertising the availability of their Account (s. 9(7) of the Health Act 2009). We will mitigate against the risk that Accounts may not be understood by ensuring that this is covered in the Department's guidance on Quality Accounts, and we will specifically seek the views of those groups who work with or represent the six equality groups when we are drawing up this guidance.

Next Steps

- 8.38 The analysis at Annex A draws together the findings of published research on the effects of publishing information on quality of healthcare, and from this research shows that there is a need to ensure that Quality Accounts use standardised measures which are robust and easily understandable and are used to help to develop a culture of understanding and using the data contained in Accounts.
- 8.39 The Department has and will be undertaking a number of engagement and consultative work as Quality Accounts are further developed over the next year or so. We will ensure that the views of the six equality groups are fully covered in this work, and that their views feed into the detailed development of Quality Accounts. We have also written DH guidance for providers on producing a Quality Account which covers equality issues throughout the guidance.

8.40 We are holding a 'Quality in the NHS' - Listening Event on 17th February 2010. The purpose of this event is for DH to listen to views, comments and opinions on Quality in the NHS from people with a wide and differing experiences and expertise in equality. It will, hopefully, provide the opportunity for people to express their views about the potential impact on equality and human rights as the NHS focuses on delivery of Quality and improved productivity across the NHS.

8.41 There will be a formal academic evaluation of the policy after it has been running for three years. This will assess the full effects of the policy, including the impacts on each of the six equality groups, enabling any negative or unintended consequences to be addressed in the future. If any negative impacts become apparent ahead of the evaluation then the Department will take action immediately to deal with these impacts. This is in addition to the evaluation of Quality Accounts that we will conduct in the Summer.

Rural Proofing

Will the policy have a different impact in rural areas?

8.42 No.

Social

Could the proposal have a differential impact

on:

Children and young people

Older people?

Could the proposal have a differential impact

on:

Income groups

Devolved countries

Particular regions of the UK?

8.43 No. The proposal is designed to improve the quality of healthcare services for all users of NHS healthcare in England, as is not designed to have a greater or lesser impact on any one group of users.

Sustainable Development

Have you considered all of the above issues and does the proposal comply with Sustainable Development Principles?

Living with environmental limits;
Ensuring a strong, healthy and just society;
Achieving a sustainable economy;
Promoting good governance; and
Using sound science responsibly.

8.44 We have considered sustainable development issues. While the proposal is not designed specifically to promote sustainable development issues, there is nothing in the proposal that impedes a move towards a more sustainable health economy, and by ensuring that the publication of Quality Accounts is primarily web-based we have ensured that resources involved in printing and distributing hard copies of Quality Accounts are kept to a minimum.

References

- 1 PricewaterhouseCoopers. Quality Reports Testing Exercise: Evaluation (2009)
<http://www.dh.gov.uk/en/Healthcare/Highqualitycareforall/Qualityaccounts/index.htm>
- 2 SP Singh, N Greenwood, S White & R Churchill (2007), "Ethnicity and the Mental Health Act 1983", British Journal of Psychiatry, 191:2, pp.99-105
- 3 Cancer Reform Strategy Equality Impact Assessment (December 2007)
- 4 Dr David Wilkins, Dr Sarah Payne, Dr Gillian Granville, Dr Peter Branney , "The Gender and Access to Health Services Study", Equality & Human Rights Group, Department of Health
- 5 Disability Rights Committee (2004), "Discriminating treatment? Disabled people and health services"
- 6 Stonewall's Survey of Lesbian Health Care Needs (2005)
- 7 RM Werner & DA Asch (2005) "The Unintended Consequences of Publicly Reporting Quality Information", Journal of the American Medical Association, 293 pp1239 – 1244
- 8 Office for National Statistics (2007) Measuring Equality – A Review of Equality Data
<http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=15048&Pos=&ColRank=2&Rank=272>
- 9 Department of Health (2005) Ethnic Monitoring in the NHS and Social Care
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4116839

Specific Impact Tests: Checklist

Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.

Type of testing undertaken	<i>Results in Evidence Base?</i>	<i>Results annexed?</i>
Competition Assessment	Yes	No
Small Firms Impact Test	Yes	No
Legal Aid	Yes	No
Sustainable Development	No	No
Carbon Assessment	Yes	No
Other Environment	Yes	No
Health Impact Assessment	Yes	No
Race Equality	Yes	No
Disability Equality	Yes	No
Gender Equality	Yes	No
Human Rights	Yes	No
Rural Proofing	Yes	No

Annexes

Annex A : Benefits and risks associated with publicly disclosing health care performance data

A principal element of this project is public accountability for the quality of health care services through publishing a Quality Account. There is considerable literature addressing the impact of publishing various information in the form of reports, report cards and other performance management tools.

It should be recognised that while a primary function of Quality Accounts is public accountability, there are other potential benefits that relate to improving the quality of services. The following section set these out and update the evidence provided in the previous version of the Impact Assessment.

Evidence suggests that over time, and particularly in the last 10-15 years, there has been increasing demand for more health care performance data to be made publicly available^{1,2,3}. Furthermore, in that time, there has also been an increasing level of acceptance of a place for such information in the form of eg 'report cards'⁴. While this is becoming more the case in the UK, it has been particularly true of the US and hence a greater proportion of the literature on publicly disclosing performance data originates from the US.

Nevertheless, the prevalent themes have some relevance to the UK, if not the precise manner in which the information is used.

The impetus for the increasing demand for published performance data is at least partly due to greater transparency being advocated as essential in the delivery of public services^{5,6,7}, through greater public accountability^{2,6,8,9} and stimulating quality improvements^{2,10,11,12,13}.

The evidence is generally positive about publishing information, though this is based more on the theoretical application^{5,10,14} rather than how this has tended to happen in practice. A common theme of the literature, therefore, is the lack of quantifiable evidence on the effects of publishing information and bemoans a lack of rigorous evaluation of such schemes^{2,3,8,11,15,16}.

However, some limited success in disclosing information has been reported, particularly in promoting quality improvement at the hospital level^{8,10,11,12,13,14}. Report cards can induce better processes or outcomes for a variety of reasons. These include improvements made to improve the reputation of the organisation¹² or identifying 'low' performing organisations, which then feel compelled to improve¹³.

Furthermore, it is considered that voluntary reporting alone can be ineffective¹⁷ in promoting transparency and driving change and that there is a role for central regulation in the reporting process¹⁶.

As well as prompting improvements in the organisations, the production of Quality Accounts themselves can have a beneficial effect on how the organisations operate, and the quality of the report that will be produced.

With the demand for better quality healthcare, there has been considerable pressure for organisations to adopt practices which aid continuous improvement. Total Quality Management¹⁸ – TQM - is a widely recognised industry management approach to this task, which is increasingly being applied in healthcare.

TQM relates to all levels of an organisation working in tandem to achieve improvements in quality. The results of pilot work on producing 'Quality Reports' demonstrated that to produce an effective report required commitment from staff in all parts of the organisation, right up to the most senior managers.

Replicating that mode of working in the production of a Quality Account is, therefore, likely to accrue benefits in terms of organisational effectiveness, particularly where it converges with evidence-based medicine¹⁹. The acknowledged risk, however, is that such joined up management approaches are traditionally more difficult to implement in healthcare than in other industries¹⁹, especially if the techniques are not properly applied by senior management²⁰.

Further evidence suggests benefits for including patients in the process of developing the right information to report on, as patients can see this as worthwhile and enjoy being asked, especially when that leads to tangible service improvements^{21,22}.

As patients are beginning to have a greater say in the information they want to see, Quality Accounts will fulfil some of that appetite, as already demonstrated by the increasing volume of information on healthcare published by NHS Choices, the NHS Information Centre for Health and Social Care, Dr Foster and commercial providers of healthcare information.

However, as mentioned, there is evidence, despite slow uptake, that although consumers do want more information^{1,12} about health care providers there is little concrete evidence of them using it, for instance to exercise a choice in providers²³. This can be down to other barriers to changing behaviour, such as the information not being interpreted correctly if it is poorly presented. Alternatively, many people use their own direct experiences of health services to 'dispute' published information. To maximise the effects or benefits of publishing information, it needs to be disseminated widely and to diverse audiences to ensure the maximum coverage and avoid marginalising vulnerable groups so that they are empowered to use the information⁴. Further work on developing assurance for the production of Quality Accounts is also aiming to ensure that the information presented is as accurate and representative as possible, so as to be as helpful to the user as possible.

At the professional level, some cynicism is reported about published indicators of health care as not truly reflecting the care they provide, though they may be the originators of the data (sometimes without realising it). This can be mitigated by the development of robust and transparent measures¹³.

The greatest perceived risk from publishing information is the potential 'gaming' behaviour that may result^{1,2,9,24,25,28}. A frequently cited example is that of physicians in New York deselecting 'risky' patients for CABG procedures in order to make the outcome measures look more favourable. However, while some draw the conclusion that publishing information was responsible for this, others have concluded that the supposed 'gaming' behaviour was anecdotal or not supported by the evidence⁹.

Either way, this is an area where particular attention would need to be paid in the development of Quality Accounts. Several studies have addressed this issue and the risks can be mitigated

by following the recommendations that arise. These recommendations can be broadly summarised as follows:

- Standardised measures need to be used ^{4,6,9}, particularly where case-mix⁴ adjustment is a critical issue to allow for pre-existing health conditions that patients are suffering from prior to treatment, as well as the likelihood of success for a given severity of condition, addressing the potential for dysfunctional practice ^{25,26}.
- Measures should be designed to be robust and easily understandable ^{27,28} – this links to the previous point as it pertains to data quality but also illustrates that fitness-for-purpose is key. Information will not be used by the public unless it can be easily and unambiguously interpreted ^{1,7}.
- Create a culture of understanding and using the data – there is evidence to suggest that close working with the media can improve the reporting of publicly disclosed information and therefore make it more useful to the general public ^{1,4,7}.
- Consider the audience – three purposes for publicly reporting information are generally cited – public accountability, professionally orientated model, market orientated model ie greater transparency, incentive to improve services and informing choice ^{1,4,9,13}.
- Involve the whole organisation and public/patients in producing Quality Accounts to empower staff and users of services to identify and implement quality improvements to healthcare services ^{19, 21, 22}.
- To guard against deselection of risky patients, evaluation of quality measures should include population level data to complement institutional level outcome data.

A further clear message from the literature is the need for more rigorous research and evaluation into the publication of performance data ^{3,11,15,16}. This is beginning to take place, but most of the evidence reported here dates back to around 2000 – 2005 with some of the more specific well-reported schemes, such as reporting on cardiac surgery in the US dates back as far as the mid-1990s.

The more recent literature has tended to focus on the lessons that can be learned about making the publication of performance data more effective.

To summarise. The evidence is limited, either way, on the benefits of publishing information. It is generally felt that for transparency, publishing the information is both desired and desirable. In some cases there has been limited tangible benefits reported in improving quality at the hospital level, particularly where staff are engaged right across the organisation, but by the same token some specific risks have been flagged up.

References

1. Chassin M.R., Hannan E.L., DeBuono B.A., Benefits and Hazards of Reporting Medical Outcomes Publicly, *New England Journal of Medicine*, Vol 334, pp394-398 (1996)
2. Hamblin R., Publishing 'quality' measures: how it works and when it does not ?, *International Journal for Quality in Health Care*, Vol.19, No.4, pp183-186 (2007)

3. Marshall M.N., Romano P.S., Impact of reporting hospital performance Qual. Saf. Health Care, Vol.14, pp77-78 (2005)
4. Davies H.T.O., Washington A.E., Bindman A.A., Health Care Report Cards: Implications for Vulnerable Patient Groups and the Organisations Providing Them Care, Journal of Health Politics, Policy and Law, Vol. 27, No.3, pp379-399 (2002)
5. Fung C., The public reporting of performance data: an intervention in need of more evaluation National Quality Measures Clearinghouse (2008)
6. Berwick D.M., Public performance and the will for change Journal of the American Medical Association, 288(12), pp1523-1524 (2002)
7. Comptroller and Auditor General, Good practice in performance reporting in executive agencies and non-departmental public bodies Stationery Office (2000)
8. Ito H., Sugawara H., Relationship between accreditation scores and the public disclosure of accreditation reports: a cross sectional study Qual. Saf. Health Care, Vol.14, pp87-92 (2005)
9. Propper C., Wilson D., The use and usefulness of performance measures in the public sector CMPO Working Paper Series no. 03/073 (2003)
10. Schneider E.C., Lieberman T., Public disclosed information about the quality of health care: response of the US public Qual. Health Care, Vol.10, pp96-103 (2001)
11. Fung C., Lim Y-W., Mattke S., Damberg C., Shekelle P.G., Systematic Review: The evidence that publishing patient care performance data improves quality of care Annals of Internal Medicine, Vol.148, Issue 2, pp111-123 (2008)
12. Hibbard J.H., What can we say about the impact of public reporting ? Inconsistent execution yields variable results Annals of Internal Medicine, Vol.148, Issue 2, pp160-161 (2008)
13. Hibbard J.H., Stockard J., Tusler M., Does publicizing hospital performance stimulate quality improvement efforts ? Health Affairs, Vol.22, No.2, pp84-94 (2003)
14. Lansky D., Improving quality through public disclosure of performance information Health Affairs, Vol.21, no.4, pp52-62 (2002)
15. Marshall M.N., Hiscock J., Sibbald B., Attitudes to the public release of comparative information on the quality of general practice care: qualitative study British Medical Journal, Vol.325, p1278-82 (2002)

16. Marshall M., Davies H., Public release of information on quality of care: how are health services and the public expected to respond ? *Journal of Health Services Research Policy*, Vol.6, no.3 (2001)
17. McCormick D., Himmelstein D.U., Woolhandler S., Wolfe S.M., Bor D.H., Relationship between low quality-of-care scores and HMO's subsequent public disclosure of quality-of-care scores *Journal of the American Medical Association*, 288(12), pp1484-90 (2002)
18. Sun H. Total quality management, ISO 9000 certification and performance improvement, *International Journal of Quality and Reliability Management*, vol.17, no.2, pp168 – 179 (2000)
19. Ovretvelt J. Total quality management in European healthcare, *International Journal of Health Care Quality Assurance*, vol. 13, no.2, pp74 – 79 (2000)
20. Jackson S. Successfully implementing total quality management tools within healthcare: what are the key actions ? *International Journal of Health Care Quality Assurance*, vol.14, no.1, pp157 – 163 (2001)
21. Stevenson K., Sinfield P., Ion V., Merry M., Involving patients to improve service quality in primary care
22. Crawford MJ., Rutter D., Manley C., Weaver T., Bhui K., Fulop N., Tyrer P., Systematic review of involving patients in the planning and development of health care, *British Medical Journal*, vol. 325, pp1263 – 1267, (2002)
23. Marshall M.N., Shekelle P.G., Leatherman S., Brook R.H., The public release of performance data: what do we expect to gain ? A review of the evidence *Journal of the American Medical Association*, 283(14), pp1866-74 (2000)
24. Jacobson B., Mindell J., McKee M., Hospital mortality league tables *British Medical Journal*, Vol.326, pp777-778 (2003)
25. Marshall M.N., Romano P.S., Davies H.T.O., How do we maximise the impact of the public reporting of quality of care *International Journal for Quality in Health Care*, Vol.16, Supp.1, ppi57-i63 (2004)
26. Gibberd R., Hancock S., Howley P., Richards K., Using indicators to quantify the potential to improve the quality of health care *International Journal for Quality in Health Care*, Vol.16, Supp.1, ppi37-i43 (2004)
27. Finlayson E.V.A., Birkmeyer J.D., Baker D.W., Cebul R.D., Should consumers trust hospital quality report cards ? *Journal of the American Medical Association*, 287(24): pp3206-08 (2002)
28. Dranove D., Kessler D., McClellan M., Satterthwaite M., Is more information better ? The effects of "Report Cards" on health care providers *Journal of Political Economy*, Vol.111, no.3, pp555-588 (2003)