

NHS Policy Salon: Discussion summary

Quality Reporting and Quality Accounts, 9th April 2009

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Background

This discussion is particularly timely, as there is currently an opportunity to refine the design of Quality Accounts (QAs) whilst they are piloted in FTs and in East of England providers. The DH see there being three main objectives for the programme – to enable boards to focus on quality; to enable the public to hold providers to account for quality through published accounts; and enabling patients and carers to know more and to make informed choices about where they seek treatment.

This note outlines some of the key questions that were raised and their implications for the further development of quality accounts. Comments are not attributed as the Salon was held under the Chatham House rule.

For more information about this, or other, NHS Policy Salons please contact Joe Farrington-Douglas, Senior Policy Manager (joe.farrington-douglas@nhsconfed.org) or Rebecca Cotton, Senior Public Affairs Officer (rebecca.cotton@nhsconfed.org).

Key areas of discussion

High Quality Care for All positioned the department as ‘enabling’ rather than ‘doing’ quality itself, and drew substantially on international research into what works in improvement. The ‘seven steps’ for providing the national architecture to enable quality improvement locally include a mixture of existing, enhanced and new levers. There is no single solution but a complex blend. Quality Accounts are an important part of this, though are not the whole answer.

Some decisions have been taken about the QA process, including an annual retrospective reporting requirement; self-certification rather than external audit; gradual roll-out from pilots to all NHS Trusts, community providers and primary care; evaluation to inform details. However there remain a number of questions for discussion and experimentation, including how to ensure the greatest impact; the content including national vs local; assurance of accuracy; application to non-acute providers; and publication timings/ processes.

Participants in the seminar raised a number of points that they felt should be taken into account in policy development and implementation. They included:

Lessons from research

Evidence of effectiveness - There is good evidence that public reporting of quality measures is associated with improvements in care. The evidence for the impact of

reporting on processes that are associated with improved outcomes is strong; the impact of outcome reporting is weaker. The effect size, whilst significant, tends to be small and inconsistent.

Mechanisms of improvement - The mechanism through which publication leads to improvement is not, according to the evidence, through patients choosing different providers nor through commissioners using quality information, but through clinicians and managers using information to benchmark and protect/ enhance reputations.

Embedding quality improvement

Board level focus - Achieving Board level focus on quality would be the main benefit of this policy. It should encourage Boards to build quality improvement capacity within their organisations.

Engaging clinicians and building capacity - The process of quality improvement must be about engaging with clinicians – from both acute and primary care – to take the quality agenda forward locally. It also needs boards to develop the ability to stand back and challenge the data that they are being provided by clinicians. This requires investment in education and learning.

Reporting methods for improvement - It was suggested that quality reports, apart from reporting the chosen indicators, should also set out the organisation's approach to quality improvement and explain how they are embedding it across the whole organisation rather than just in selected areas.

Content of Quality Accounts

Selection of measures - Cancer registries are establishing themselves as the centre for information on quality and processes – they could be an important source of measures. It was also suggested that improvements in Patient Reported Outcome Measures might be a requirement for all Quality Accounts. On the other hand, there was a risk of special interests demanding that their measure be made mandatory, which would undermined the point of the policy. There would be a need to obtain feedback on quality from clinicians in the hospital and local community, rather than allow cherry-picking of evidence.

National vs local determination - There will have to be some national element to QAs in practice, as they will have to show the Trust is meeting CQC minimum standards. Local determination will set the stretching targets. It was argued by some participants that the whole Quality Account should be locally determined, involving commissioners and the public. Some quality initiatives would require more regional collaboration, e.g. on trauma networks where the quality benefits are above the level of the organisation. Patient pathways cross organisational boundaries so there should be some shared measures. It was suggested that where there are locally-determined measures, these could be based on national metrics that have been assured and are high quality.

Comparability - consistent measures allow comparison. However benchmarking should not be the overall purpose as there are other more appropriate routes that allow a finer grained approach.

Assurance and stretch - Incentives are needed to make it in the interests of providers to publish good quality reports and push forward the barriers of quality. There is the danger of a false assurance from using the average of a benchmark peer group.

Learning from financial accounts

Relevance for the public - It was pointed out that financial reporting did not automatically mean good financial management. Financial accounts are technical and non-interactive, and can be difficult to interpret by lay-people. The public can have a very

good understanding of what quality looks like through experience, anecdote and word of mouth. We must ensure QAs engage users and communities.

Supportive architecture - It was also pointed out that financial management is supported by a range of initiatives other than just account publishing (WCC assurance, PbR, Audit, Service Line Management and Patient Level Costings etc), and a similar approach should be taken to quality.

Audit - It was suggested that following the financial accounting model could generate an industry of quality accountants. Even if QAs are not required to be audited, organisations will come forward to provide that service. Audited reports would have greater credibility with the media, so there is a likelihood that a bureaucracy would grow up in this area even if this is not the intention.

Timing – Publishing QAs together with financial reports could ensure alignment. Quality reports need to be both retrospective and prospective.

Quality Accounts and system management

Quality reporting and choice - There is a need for investment in better information for choice, but this should be through NHS Choices rather than quality accounts.

Quality reporting and commissioning - Commissioning has not particularly featured in this policy. It was asked how commissioners should use quality accounts. One example might be for commissioners to set quality challenges for providers in their economy.

Quality reporting in primary care - There was a danger that this would be neglected and primary care providers and commissioners should be looking at this now.

Process and timing of implementation

Top-down pilots - There is concern from some providers about the speed of implementation and top-down design which could crowd out local initiative and hamper effective engagement with staff, stakeholders and the public. However it was also argued that competent boards should have quality priorities and be monitoring them already. Early implementers had an opportunity to shape the roll-out of the scheme.