

# Consultation response

**Ref: 5809**

## Quality Accounts

December 2009

All rights reserved. Third parties may only reproduce this paper or parts of it for academic, educational or research purposes or where the prior consent of Age Concern and Help the Aged has been obtained for influencing or developing policy and practice.

Name: Tom Gentry  
Email: [tom.gentry@ace.org.uk](mailto:tom.gentry@ace.org.uk)

Age Concern and Help the Aged  
Astral House, 1268 London Road  
London SW16 4ER  
T 020 8765 7200 F 020 8765 7211  
E [policy@ace.org.uk](mailto:policy@ace.org.uk)  
[www.ageconcern.org.uk](http://www.ageconcern.org.uk)

Age Concern and Help the Aged  
207–221 Pentonville Road  
London N1 9UZ  
T 020 7278 1114 F 020 7278 1116  
E [info@helptheaged.org.uk](mailto:info@helptheaged.org.uk)  
[www.helptheaged.org.uk](http://www.helptheaged.org.uk)

The Department of Health is consulting on “Quality Accounts”, a mandatory reporting mechanism that will be introduced for NHS and foundation trusts from April 2010. They will require a trust’s board to sign-off, and be accountable to, a set of statements regarding their commitment to delivering high quality services.

This paper represents Age Concern and Help the Aged’s response to the questions asked.

## 1 Summary

- It is vital that the views of service-users and the public are fully integrated into the process of drawing up quality accounts. Quality Accounts should include both an explanation of how patients and the public were involved and a further element that establishes how their views were integrated into the board’s assessment of quality. The public, patients and staff should be involved in the production of quality accounts at the earliest opportunity.
- Quality and adherence to the highest standards of care should be central to the responsibility of a provider’s board, or equivalent. A mandatory statement would be a good way to demonstrate their accountability for a “Quality Account”, but more clarity is needed over the how performance will be monitored and poor practice addressed.
- Identifying priority areas for a Quality Account must reflect patient needs and preferences. Older people are the highest users of most health services and are therefore disproportionately affected by poor standards across the board – they should be centrally involved in identifying priorities.
- Patient experience, particularly for older people, has perhaps the greatest distance to travel in terms of achieving high quality standards and needs to be more closely addressed in a Quality Account.
- A commitment to reviewing services and offering a clear statement of whether the board has or has not developed a plan for improving the quality of their services is welcome. However boards should not be limited to looking at only those areas where data currently exists but should proactively gather and monitor information in all those areas which patients have identified as important.

- The framework for the Quality Accounts does not satisfy the stated rationale that they will act as reports for the public – the provisions for involvement of and dissemination to the public are limited and sometimes optional.
- The proposed publication methods place a heavy emphasis on digital distribution and, in particular, NHS Choices. This is unlikely to serve a very large proportion of older people who do not have access to the internet – only 36% of people over 65 have ever used the internet<sup>1</sup>.
- As many older people access healthcare settings during an emergency or when they are at the end of life, they will not generally be able to exercise choice over where they are treated. This places less of an emphasis on resolving areas relating to these pathways.
- Self-reporting by providers is frequently undermined by patient experience. In this context, Quality Accounts need to contribute to a dynamic process of quality improvement that involves patient and staff and is supported by the board rather than simply originating there.

## 2 Responses to consultation questions

### 2.1. **Do you agree that the inclusion of a mandatory statement from the board is the best way to demonstrate board accountability for the Quality Account?**

Signing a mandatory statement would be a good way to demonstrate board accountability for the Quality Account. What is less clear is how this accountability will be policed and what new mechanisms will exist to start addressing identified shortfalls. The impact assessment published alongside the Health Bill (2009) indicated that misstatements in the Quality Account concerning CQC registration requirements would be acted on, but did not offer any further potential sanctions. While we would not suggest that regulators necessarily take punitive action in such a way that would impact on patient care, it is difficult to judge the effectiveness of such a scheme without having a sense of the consequences of low achievement. The evaluation that has informed this consultation indicated that while the Quality Accounts did raise awareness of quality issues on participating boards, there was little impact on service planning or delivery. This is partly attributed to the time period allowed for the assessment, but clearly, demonstrating accountability is only a one part of the picture – there must be a clear impetus to act on what the Quality Accounts uncover.

---

<sup>1</sup> *Internet Access 2009 Households and Individuals*, ONS, August 2009

- 2.2. **Some providers may not have a formal board structure. We would welcome views on how the provisions of the regulations should apply to such bodies.**

Nothing to comment.

- 2.3. **Do you agree that at least three priorities for improvement, agreed by the board, and the rationale for their selection should be included in Quality Accounts? Do you think that providers should report on previously set improvement targets using indicators of quality and including historical data where available?**

There is certainly an argument for identifying key areas of poor quality care which are having a disproportionate impact on service-user outcomes.

Identifying priority areas must be reflective of patient needs and preferences. Older people are the highest users of most health services and are therefore disproportionately affected by poor standards across the board. It is also the case that the issues which matter to older people are rarely reflected in quality measures with the consequence that performance in these areas is not tracked and all too often not delivered.

We agree the rationale for selection of priorities should be included in Quality Accounts however we also want to see a stipulation that boards have engaged with service users, including older service users, when identifying priorities. The proposed framework simply states that the rationale includes “whether or how the views of patients [...] were taken into account”. This needs to be stronger, asking that providers demonstrate robust methods for public engagement rather implying it as optional. Anyone reviewing a quality account after it has been signed-off by a board must have confidence that any priority area reflects local needs and has broad agreement with the people accessing services. It should also include reference to established national priorities for quality improvement such as dignity and end of life care.

Our work on measuring dignity in care commissioned from the Picker Institute shows that it is possible to engage older people in a discussion over quality indicators.

Using historical data would be useful benchmark and boards must be able to justify any failed improvement targets.

**2.4. Do you agree that at least three indicators covering each of the domains of quality should be included in Quality Accounts?**

Patient experience, particularly for older people, has perhaps the greatest distance to travel in terms of achieving high quality standards – this was even demonstrated in PriceWaterhouseCoopers’ evaluation of the test sites in which they found limited evidence of the current status of patient experience and how it was being measured and used. It is also a strong indicator of good outcomes in safety and effectiveness and whether an individual’s needs are being fully met. Older people frequently report poor attention to their dignity and the negative impact this has on the quality of their overall care and outcomes. Creating additional priorities under this patient experience would helpfully draw the attention of a provider’s board to this vital, but often neglected, aspect of care.

**2.5. Do you think that the inclusion of the statement from the board to state that it has reviewed the available data on the quality of care in its services provides an assurance of the quality of services provided?**

This commitment to reviewing services and offering a clear statement of whether the board has or has not developed a plan for improving the quality of their services is welcome. However boards should not be limited to looking at only those areas where data currently exists but should proactively gather and monitor information in all those areas which patients have identified as important. For example we interviewed a number of frail older people to ask them what they valued in the NHS. Whilst waiting times for outpatient appointments and Accident and Emergency admission, an ongoing political priority, were less important in how patients viewed their experience, waiting time for response to the call button were noted as vital in creating a positive patient experience<sup>2</sup>.

It is proposed that the guidance will “encourage” boards to commission third party bodies to scrutinise the quality accounts before they are published, but making this mandatory would offer a stronger assurance of the quality of services provided. It is understandable to want to limit the costs of producing quality accounts, but it is important that this process does not exist in isolation i.e. within the boardroom.

---

<sup>2</sup> IPSOS MORI (2009) Aspirations for healthcare amongst older people: Report prepared for Age Concern

**2.6. Do you think boards should include an explanation of how the review of services was conducted, and how patients and the public were involved?**

It is vital that the views of service-users and the public are fully integrated in the process of drawing up quality accounts. There should be both an explanation of how patients and the public were involved and a further element that establishes how their views were integrated into the board's assessment of quality. This is particularly important when set against quality indicators that may describe best practice in systems but could lose the actual experience and outcomes of service-users. For example, in the final assessment by Healthcare Commission core standards, 99.1% of trusts said they were meeting requirements for nutrition and assistance with eating yet the inpatient survey most recently reported that almost a fifth of inpatients surveyed did not get sufficient assistance to eat. Resolving such disparities is key to improving quality.

Representing the largest proportion of health service users, the views of older people must be specifically sought in any assessment of quality.

**2.7. For the statements on participation in clinical audits, please provide your view on their suitability for inclusion as nationally mandated content in Quality Accounts. In addition, please identify whether the description of the statement is well defined or open to interpretation and provide any other comments on the proposed statement.**

A statement of participation in clinical audits is welcome, but there should be further provision for requiring evidence on how the board have responded to a clinical audit, whether positive or negative. Performing well in a clinical audit should not be a disincentive to invest in a particular area, assuming the job is done and the positive response recorded. Equally, failure to address a negative audit would indicate that the board are not taking recommendations seriously. There should be further clear criteria to show how a trust is judged eligible for clinical audits to avoid misrepresentation of the overall percentage.

**2.8. For the statement on participation in clinical research, please provide your view on its suitability for inclusion as nationally mandated content in Quality Accounts. In addition, please identify whether the description of the statement is well defined or open to interpretation.**

Age Concern and Help the Aged welcomes an emphasis on research and believe this would contribute some impression of the board's commitment to quality. However, the statement as it currently stands is limited in its scope and open to interpretation. Older people are often neglected in clinical research despite being the largest group of potential

beneficiaries. It is not sufficient to state that the trust has taken part in any research; there should be provision to ensure that the research represents the needs and demography of the local population and service users. While we appreciate that this could be resource heavy on an annual basis, a further element of the statement should be included that shows that research is scheduled in the following year to address any neglected groups.

- 2.9. **For the statement on the use of the Commissioning for Quality and Innovation (CQUIn) payment framework, please provide your view on its suitability for inclusion as nationally mandated content in Quality Accounts. In addition, please identify whether the description of the statement is well defined or open to interpretation and provide any other comments on the proposed statement.**

Though we are not yet able to judge how effective CQUIn is at driving up quality, addressing this in the quality account statements as a further indicator would be instructive. We would raise some concerns over how well this indicates a commitment to quality before it has been evaluated as an effective mechanism for quality improvement.

- 2.10 **For the statements from the Care Quality Commission (CQC), please provide your view on their suitability for inclusion as nationally mandated content in Quality Accounts. In addition, please identify whether the description of the statements are well defined or open to interpretation and provide any other comments on the proposed statement.**

This is a basic indicator that should be included in the assessment of a provider's services as a matter of course and would be usefully codified within the Quality Account.

- 2.11 **Do you agree that Local Involvement networks and primary care trusts should be given the opportunity to comment on a provider's Quality Account and that providers should include this response in their account? Should this include local authority overview and scrutiny committees?**

The public and patients should be involved in the production of quality accounts at the earliest opportunity. LINKs should not be seen as the only route to achieving this. Where a representative group of service-users, supported to interpret and understand a quality account, do not agree with the contents, this should be included in the quality account or addressed before publication. Point 2.60 in the consultation document says that guidance will "suggest" involvement at an early stage, but this should be stronger. In itself, failure to involve service-users and the

public should be an indication that the board are not furthering their commitment to quality.

Primary care trusts have a key role in ensuring quality standards are being met by the services they are commissioning and should also be involved at an early stage.

**2.12 How much time should Local Involvement networks and primary care trusts be given to provide a response on a provider's Quality Account?**

This will always vary given the individual nature of local services and the availability and skill set of involved and expert users. Involving patients and the public throughout the process will mitigate this and enable boards to respond to feedback as it occurs rather than addressing it all at once. Age Concern and Help the Aged is commissioned by CQC to run a programme called Experts by Experience that supports older people to take part in the assessment of care homes. Widening the provision of such programmes in healthcare is one way of assisting in meaningful service-user engagement.

**2.13 For the statements on data quality, please provide your view on their suitability for inclusion as nationally mandated content in Quality Accounts. In addition, please identify whether the description of the statement is well defined or open to interpretation and provide any other comments on the proposed statement.**

Good quality data is vital to making the quality accounts meaningful and we welcome a statement referencing this specifically. We would welcome a further statement about steps to be taken where data quality is poor.

**2.14 Do you agree that our proposals for the nationally mandated content of Quality Accounts meet the objectives set out in the proposal?**

No. The rationale is that they will act as reports for the public, but the provisions for involvement of and dissemination to the public are limited and sometimes optional. There is arguably little in the consultation document itself to match the statement in the introductory pages that "the Accounts should be developed with stakeholders [...] not presented to them". In particular, 2.44 outlines how copies should be sent to LINKs and PCTs prior to publication, implying the majority of the work in producing the Account will have already been completed. Further, LINKs should not be considered as the only source for patient engagement and strict requirements for working with other groups and the third sector should be included.

The limited costs involved and the feedback from the Quality Reports evaluation indicate that an active response to the contents of a Quality Accounts is not an inevitable, or perhaps expected, consequence. While we would not encourage the Quality Account to be a burdensome administrative process, they equally should not be a pointless exercise. In consolidating a wide range of quality indicators and regulatory feedback, they are potentially very useful, but they should not exist in a vacuum.

**2.15 Are there any other areas that should be included in the nationally required section of Quality Accounts?**

An additional statement that outlines that a provider has taken full account of National Institute for Health and Clinical Excellence (NICE) guidance would help to address non-implementation of best practice.

**2.16 Do you agree with the proposed publication methods?**

No. The proposed publication methods place a heavy emphasis on digital distribution and, in particular, NHS Choices. Among the very large number of people who do not have access to the internet at home, older people feature heavily. While the consultation makes provision for hard copies on request, it does not make it clear how their availability will be advertised. A public-facing summary is suggested; we would recommend that this is made mandatory and clearly displayed in an accessible place in the healthcare setting. While we appreciate that the Quality Account is not intended as a “score card” for each setting, ensuring there is targeted distribution will contribute to a board’s sense of accountability.

Guidance must also include a commitment to evaluating how successful any method of distribution is, both in terms of not excluding any particular groups and in having an impact on services.

**2.17 Do you have any other comments on the proposals?**

Our main concerns are how the Quality Accounts will improve the quality of care for older people, an issue that should be shared by all NHS providers as older people are the group most likely to access them. In this regards, we would raise the following key issues:

- As outlined above, the dissemination plans have an emphasis on digital distribution, a conduit that older people are least likely to use.
- The circumstances under which many older people access healthcare settings are during an emergency or when they are at the end of life and will not generally be able to exercise choice over where they are treated. This places less of an emphasis on resolving

areas relating to these pathways as older people will not be able to “vote with their feet” and avoid a poor performing provider. Self-reporting by providers is frequently undermined by patient experience, seen in the example earlier regarding poor nutrition. Academic papers cited in the impact assessment draw out the further issue of quality reporting creating perverse incentives that have prevented people with complex health needs being included in assessments. Older people often have complex needs as well as multiple co-morbidities and allowing providers to identify their own priorities may concentrate efforts on simple, achievable measures.

- We welcome the emphasis placed on engaging staff as stakeholders in this process, but as with patient engagement, there needs to be more clarity about what this means in practice. As you will know, the evaluation of the Quality Reports did not find that staff were significantly involved in shaping the quality agenda despite it being a key objective. The framework does not offer any specific reassurance that this is being addressed. Staff and patients must be allowed to play a central role in identifying poor areas of practice and driving up quality.

**2.18 Some providers may be individuals, partnerships or bodies that are not incorporated. We would welcome views on how the proposals would operate for such bodies.**

Nothing to comment.

**2.19 Do you agree that small providers should be exempt from producing Quality Accounts? If so, are the proposed criteria the right ones?**

We do not have specific objections to exempting small providers or the criteria suggested.

**2.20 What are your views on the proposed process for delivering Quality Accounts in the primary and community care setting?**

The detail on this process is limited and difficult to comment on. Reflecting the time limitations in evaluating Quality Reports, which underpin this consultation, and how this prevented an assessment of how boards responded to these provisions, a longer timescale would benefit any evaluation of Quality Accounts in primary care and community settings.

**2.21 Our testing showed that a typical cost for a provider to produce a Quality report was around £14,000–£22,000. Do you think that this is a realistic estimate?**

We do not have any major comments about the costing for Quality Accounts, though the scale presented would not appear to reflect the difference in the size of providers that will be involved – assuming this covers everything from a setting serving 100+ service-users to a large foundation or acute trust. This costing also does not appear to account for any remedial steps needed to resolve issues identified by the Quality Account.