



# The annual health check 2008/09

Assessing and rating the NHS

June 2008

© June 2008 Commission for Healthcare Audit and Inspection

This document may be reproduced in whole or in part in any format or medium for non-commercial purposes, provided that it is reproduced accurately and not used in a derogatory manner or in a misleading context. The source should be acknowledged, by showing the document title and © Commission for Healthcare Audit and Inspection 2008.

ISBN: 978-1-84562-195-7

Concordat gateway number: 128

# The Healthcare Commission

The Healthcare Commission works to promote improvements in the quality of healthcare and public health in England and Wales.

In England, we assess and report on the performance of healthcare organisations in the NHS and independent sector, to ensure that they are providing a high standard of care. We also encourage them to continually improve their services and the way they work.

In Wales, the Healthcare Commission's role is more limited. It relates mainly to national reviews that include Wales and to our yearly report on the state of healthcare. In this work, we collaborate closely with the Healthcare Inspectorate Wales, which is responsible for the NHS and independent healthcare in Wales.

## What we do

**Inspecting:** to inspect the quality and value for money of healthcare and public health.

**Informing:** to equip patients with the best possible information about the provision of healthcare.

**Improving:** to promote improvements in healthcare and public health.

## How we work

- We work closely with patients, carers, and with the public to maintain our focus on improving their experiences of healthcare.
- We promote the rights of everyone to have opportunities to improve their health and to receive good healthcare.
- Our approach to assessing healthcare is based on the best available evidence and aims to encourage improvement.
- We work in partnership to ensure a targeted and proportionate approach to audit and inspection.
- We work locally to build relationships and intelligence about the quality of services throughout England.
- We are independent and fair in our decision-making and report what we find impartially and honestly.
- We are accountable for our actions and for what we achieve in relation to our costs.

# Contents

<b>Foreword</b>	<b>3</b>
<b>Introduction</b>	<b>5</b>
<b>Section 1: What is the annual health check?</b>	<b>7</b>
<b>Section 2: Key influences on the design of the annual health check in 2008/09</b>	<b>11</b>
Key themes from our consultation	15
<b>Section 3: Our proposals for the annual health check in 2008/09</b>	<b>20</b>
<b>Section 4: Our assessments by sector</b>	<b>25</b>
Primary care trusts	25
Our assessment of PCTs as commissioners	26
Our assessment of PCTs as providers	30
Acute trusts	30
Mental health trusts	32
Ambulance trusts	34
Learning disability trusts and services	35
The special organisations	35
<b>Section 5: Key aspects of our assessments</b>	<b>36</b>
Safety	36
Clinical quality	38
Reducing health inequalities and promoting health and wellbeing	41
Children's health and healthcare services	42
Incorporating the views of patients and the public into our assessments	44
<b>Section 6: How the annual health check process works</b>	<b>45</b>
The assessment based on standards	45
Information for trust boards	46
Cross-checking the declarations	46
<b>Appendix 1: Indicators</b>	<b>50</b>
Primary care trusts – commissioning indicators	50
Acute and specialist trusts	52
Ambulance trusts	54
Mental health trusts	55
Learning disability trusts	56
<b>Appendix 2: Our programme of work on services or aspects of care</b>	<b>57</b>
Comparative information	59
<b>Appendix 3: The programme of surveys of NHS staff and patients</b>	<b>60</b>
<b>Appendix 4: Summary of our assessments by sector</b>	<b>61</b>

# Foreword

The Healthcare Commission's 2008/09 assessment cycle will be the fourth year in which we have carried out our annual health check of the NHS. This document sets out the design of our assessment framework for 2008/09 and what the process will involve.

The significance of the annual health check is that it has established general standards across the NHS in areas of real importance to patients and the public. These include safety, cleanliness, the quality of the clinical care that patients receive, and whether they are treated with dignity and respect. When assessing NHS organisations, we systematically seek the views of patients and the public, and use all available information in reaching our judgements. If what patients tell us, or other information, suggests cause for concern, we visit the trusts in question.

The annual health check system of assessment is recognised as having made a real difference for patients. For example, when the Office of Public Management carried out an independent survey of its impact, the key conclusions were:

- Most trusts thought that the components of the annual health check have a positive impact on the care that patients receive: 93% thought this about their self-assessment against core standards; 89% about national targets and 81% about service reviews.
- Sixty-seven per cent of trusts thought that the process had improved patients' safety in their organisations.
- Most trusts welcomed the process of self-assessment that their boards carry out as part of the annual health check process. It helps to reinforce the fact that the board is responsible for the effective delivery of services from the start.

But while most trusts believed that the time and effort involved were reasonable, some were concerned that the process should not be too bureaucratic and that activities should not duplicate those of other regulators.

As usual, we consulted widely on our proposals for assessing NHS trusts in 2008/09 and are grateful to all those who gave us their views. In response, we will:

- Meet trusts' requests for overall stability in the annual health check so that comparisons are valid over time. We will also continue to work on making our processes more efficient, and to work with other regulators to reduce duplication.
- Ensure that what we measure will be tailored more closely to specific types of healthcare, and will focus on the outcomes that the best performing trusts aim to achieve. We have been encouraged by the fact that trusts have asked us to ensure that what we measure is stretching for them and represents good care for patients. So in the area of mental health, for example, we will be measuring outcomes such as support for users after they leave care. For ambulance trusts, we will be measuring the quality of their care – for example,

in handling heart attacks and strokes – as well as their transport activity. In the case of primary care trusts, we will be separating their commissioning (purchasing) activities from their providing activities, to give a clearer focus to each of these widely differing activities.

- Focus on assessing patient pathways and services, through our programme of reviews and benchmark indicators.
- Ensure that our approach is aligned with the Government's priorities, including the NHS Operating Framework and Lord Darzi's review, *Our NHS, Our Future*.

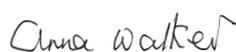
When developing our plans for 2008/09, we have had more discussion with clinical organisations than ever before, and particularly with the royal colleges covering doctors, nurses and other health professionals. We believe strongly that the annual health check must measure what makes sense to them as healthcare professionals.

In October 2008, we will be reporting on the results of the annual health check for 2007/08 on behalf of patients. We expect that more trusts will comply fully with the Government's core standards, that more trusts will be rated "excellent" and "good", and that many fewer will be rated "weak". The public rightly expects trusts to take robust action to help ensure that they meet the standards and perform well for their patients. We will work with strategic health authorities and Monitor to ensure that this happens.

The Care Quality Commission will come into being in April 2009. The new commission will publish the results of the 2008/09 annual health check, and will be required to impose registration requirements on all healthcare providers, including NHS trusts. We strongly believe that the starting point for these registration requirements must be the Government's standards, compliance with which is currently measured in the annual health check. By building on the achievements of the NHS in improving performance to date, such an approach would help to ensure continuous improvement in the quality of care for patients.



Professor Sir Ian Kennedy  
Chairman



Anna Walker CB  
Chief Executive

# Introduction

We introduced the annual health check in 2005. Its key objectives are to:

- Provide assurance that NHS healthcare services in England are meeting essential quality and safety standards for everyone.
- Ensure that healthcare organisations always seek improvement and provide value for money.
- Bring together information on the performance of healthcare services and make it available to patients, the public and NHS staff, including clinicians, so that they can make better informed decisions.

The annual health check also fulfils our statutory duty to provide an annual rating of the performance of all NHS healthcare organisations in England.

As in previous years, the development of the annual health check for 2008/09 has been informed by wide consultation and evaluation. At the end of 2007, we commissioned an external evaluation of the annual health check in 2006/07, which is our latest assessment for which results are available. The evaluation found that an overwhelming majority of trusts consider that the annual health check has a positive impact on patient care and safety, that their staff understood the process and that they considered it to be a good use of their time. There was still room for improvement though, and trusts feel that we can do more to reduce the overlap with other regulators. A significant minority also expressed concern over whether our process allowed for a true reflection of their overall performance. We considered these messages as we developed our plans for 2008/09.

During the 12-week consultation on our plans for 2008/09, we received over 240 written responses from members of the public, voluntary groups, the NHS Confederation, the royal colleges and the Department of Health. We also held nearly 40 consultation events. The great majority of the feedback we received has been very supportive of our approach. In particular, feedback from groups representing clinicians has been very appreciative of the efforts we have made to engage them in developing our plans. We have analysed all the feedback received and have published it in a separate document on our website [www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk). Key aspects are also summarised later in this document.

**About this document**

Section 1 sets out the basic components of the annual health check.

Section 2 describes the key influences on the final design for 2008/09, including feedback from our consultation exercise and the evaluation.

Section 3 contains a table summarising what is staying the same this year and what will change.

The last three sections set out the design of our assessment framework in more detail. Section 4 covers the design by healthcare sector while section 5 sets the important themes underpinning this year’s annual health check. Section 6 describes how the process works.

# Section 1: What is the annual health check?

## **The NHS organisations that we assess**

The annual health check is the system that the Healthcare Commission uses to assess the performance of all NHS trusts and a few other types of organisation in the NHS in England. In 2008/09 we will be assessing:

- Acute trusts (including foundation trusts)
- Ambulance trusts
- Mental health trusts (including foundation trusts)
- Learning disability trusts
- Primary care trusts (both as providers and commissioners of care)
- Care trusts
- The Health Protection Agency
- NHS Direct
- NHS Blood and Transplant.

## **What the rating of an organisation covers**

We have a statutory duty to publish an annual rating of performance for each organisation. We do this in two parts. The first is a score for quality of services. For most organisations, this is in two parts: an assessment of compliance with core standards set by the Department of Health, or whether requirements have been met, and an assessment based on indicators. The core standards<sup>1</sup> set out the basic standards of healthcare that patients can expect to receive. They cover areas of real importance to patients such as the safety and quality of care and the accessibility of services. The indicators are based on a set of 'vital signs' that are published by the Department of Health to provide a national framework of priority issues within which local services are to be planned and provided.

It is important to include both of these aspects in the quality of services score. An assessment against the standards alone does not provide a sufficient measure of performance. Compliance with the standards means that the trust has laid sound foundations for good service delivery and provided a broad-based assurance of performance. Indicator-based assessments are more focused on outcomes in key national priority areas where improvement can be measured over time.

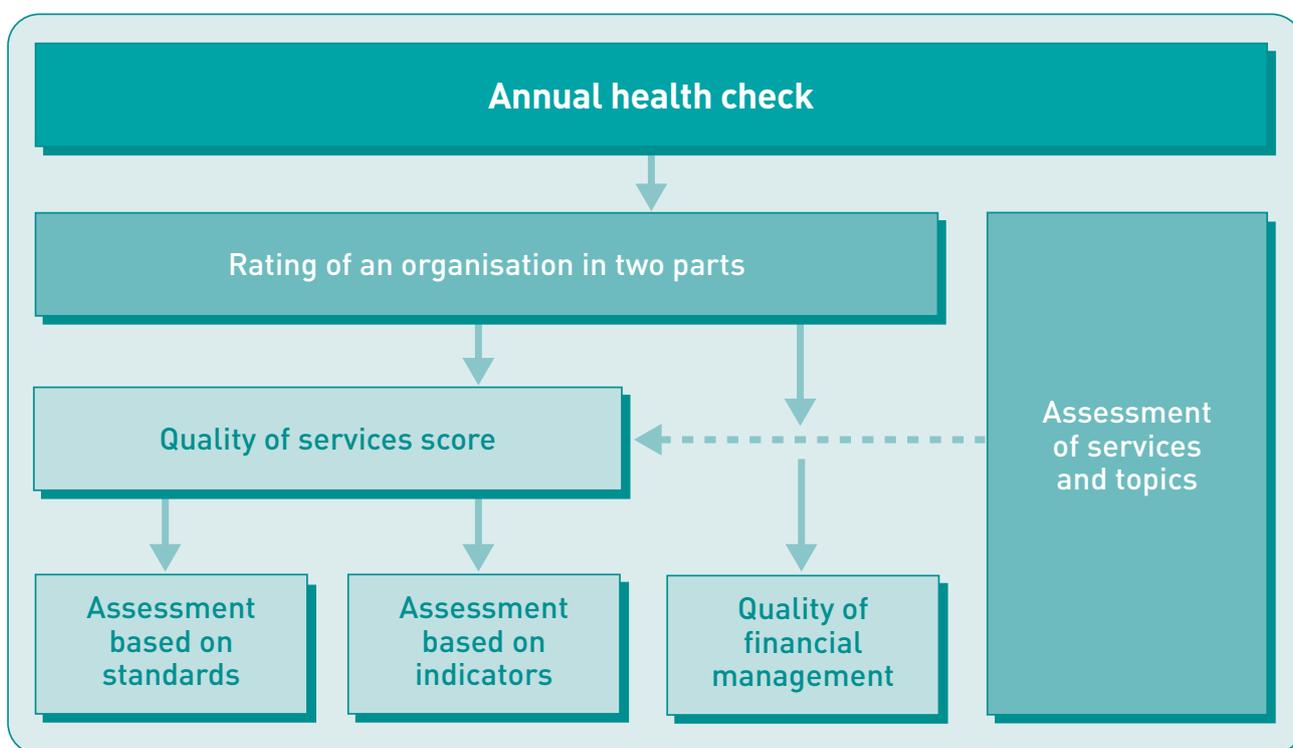
In 2008/09, a score on the quality of financial management, derived from work done by the Audit Commission for non-foundation trusts and Monitor for foundation trusts, will form the second part of the rating. This replaces the "use of resources" score in previous years. It is designed to assess whether services commissioned and provided by trusts have sound financial management in place, and is explained in more detail on page 28.

1. *Standards for Better Health*, Department of Health (2004)

## Section 1: What is the annual health check? (Continued)

Figure 1 below sets out the basic structure of the annual health check, showing how it is wider than just the rating of an organisation, since it includes an assessment of services and topics. These assessments, however, may also raise issues about the performance of individual trusts themselves, which, while not directly feeding into their rating, are taken into account in their assessments of standards.

**Figure 1: Basic structure of the annual health check**



### Assessing services and topics

Both the quality of services score and the quality of financial management score are for organisations as a whole – such as hospital trusts. Patients, however, are particularly concerned about specific services, such as those for maternity, or services for people with cancer. Some services are delivered across the boundaries of different trusts, for example services for people who have had a stroke. Where this is the case, it is important to assess the whole experience of the care that the patient receives, rather than to focus on a single organisation. This will start with their first contact with their GP through to completion of their treatment, including hospital and after care and may include both health and social care.

By contrast, sometimes a risk or concern over one aspect of care is identified, such as the handling of confidential patient information, which warrants a specific investigation.

It is therefore important that our annual health check should provide a picture of performance not only for organisations, but also for services and topics. This is helpful for patients and also enables healthcare organisations to identify the potential for improvement in the services they provide or commission.

Services or topics are selected because:

- They are important areas that affect a large group of patients
- They affect a vulnerable group
- A specific risk or concern has been identified
- The review may stimulate the potential for improvement.

The approach we use varies according to the nature of the service or topics and includes:

- Using data that is already available about the performance of different trusts in a specific service area to identify a sample of trusts where we believe there may be cause for concern and follow up with an assessment visit.
- Providing a structured set of benchmark indicators in a particular service area. These indicators will have been selected, in consultation with clinicians and service providers, as those that are important to focus on key areas of performance.
- Using carefully researched performance frameworks that may require special data collection. This type of assessment results in a specific score for each relevant trust that we publish on our website.
- Carrying out a more general assessment of a service area to identify actions needed for improvement at a national level. This will result in a published national report.

Our assessments or reviews do not directly feed into the ratings for organisations but do so indirectly. If we find evidence of performance in a trust that casts doubt on its declaration of compliance with the standards, we may use this to qualify a trust's overall assessment.

A brief description of the scope of our work on services and topics is included at appendix 2.

## Section 1: What is the annual health check? (Continued)

### **Publishing our information**

Publishing the information that we collect is an important part of the annual health check. It ensures public accountability of NHS organisations. It is expected that the Care Quality Commission (the new regulator from April 2009) will take on the responsibility for publishing the results of the 2008/09 annual health check in the autumn of 2009.

We aim to make all the information that we publish easily accessible on our website, [www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk). We have already made considerable progress in providing people with the information that we hold on their local healthcare organisations.

We are also making progress in presenting all the information that we have about service areas or aspects of care together, so that it is easy for the public to find. We have recently done this for maternity services.

## Section 2: Key influences on the design of the annual health check in 2008/09

We have, wherever possible, tried to maintain stability within our assessments and the structure of the annual health check has stayed broadly the same since its first year. This enables us to track progress over time and minimises the impact that changes to our system have on the service. As in previous years however, we have responded to developments in the context in which healthcare services operate and to the comments and feedback we received during our consultation programme. The major influences on our design are set out below.

### **Assessing progress against the priorities for improvements in the NHS**

Each year, the Department of Health publishes an operating framework for the NHS that sets out the parameters within which local NHS organisations are to deliver better services to patients. The 2008/09 operating framework for the NHS, published in December 2007, focuses on the year ahead within the context of the three year comprehensive spending review settlement and the interim report from Lord Darzi. Our annual health check in 2008/09 encourages improvement in the performance of trusts in line with this. The key themes are reflected both in the operating framework and the annual health check and include:

- Improving cleanliness and reducing healthcare associated infections.
- Improving access through achieving 18-week referral to treatment, and better access to GP and primary care services.
- Keeping people well, improving overall health and reducing health inequalities.
- Ensuring we encourage improvement in the experience of patients, staff satisfaction and engagement.
- Preparing to respond in a state of emergency.

As part of the operating framework, the Department of Health has published a list of indicators or 'vital signs'. These enable local primary care trusts (PCTs), working with local partners, to plan healthcare around the key priority areas, while allowing them greater freedom to exercise local judgement. Consistent with this, the annual health check will also use indicators from the vital signs to rate PCTs. We have reflected the move to more locally set priorities by using local plans to decide on the level of performance where appropriate. We have also selected the indicator sets for trusts that provide services so that they are compatible with the vital signs. These are set out (in appendix 1) under four headings: health and wellbeing, safety, clinical effectiveness and patient focus. This will help patients, clinicians and trusts to understand how the assessments cover these key aspects of healthcare.

### **Ensuring that care is fair, personalised, effective, safe and locally accountable**

In 2007 the Government asked Professor Lord Darzi, a leading clinician and a Government minister, to carry out a review of the NHS. His interim report, *Our NHS, Our Future* was

## Section 2: Key influences on the design of the annual health check in 2008/09 (Continued)

published in October 2007 and outlined a vision for a NHS that is fair, personalised, effective, safe and locally accountable. Many aspects of the annual health check already reflect this vision. Lord Darzi, though, also envisaged a more active role for clinicians and patients in designing the way care is delivered, recognising how important this is in driving improvement. We have always sought to ensure that our annual health check must measure what matters to patients. We have fed their views into our assessments, through surveys and comments received from representative groups, and we intend to increase the impact of the views of patients still further in 2008/09.

We have also had an extensive programme of consultation with clinicians in designing our plans for this year's annual health check. As a result, we are increasing the number of indicators of clinical quality in the rated part of our assessments. We are also working with clinicians to develop other indicators for benchmarking to feed into our assessments of risk to the delivery of good outcomes for patients.

### **A new regulatory framework for health and adult social care**

At the same time as the Government has been publishing new plans for the NHS, it has also been developing plans to reform the regulation of health and adult social care. Following a period of consultation, it published its conclusions in October 2007. A new regulator, the Care Quality Commission, will replace the Commission for Social Care Inspection (CSCI), the Mental Health Act Commission (MHAC) and the Healthcare Commission in April 2009<sup>2</sup>.

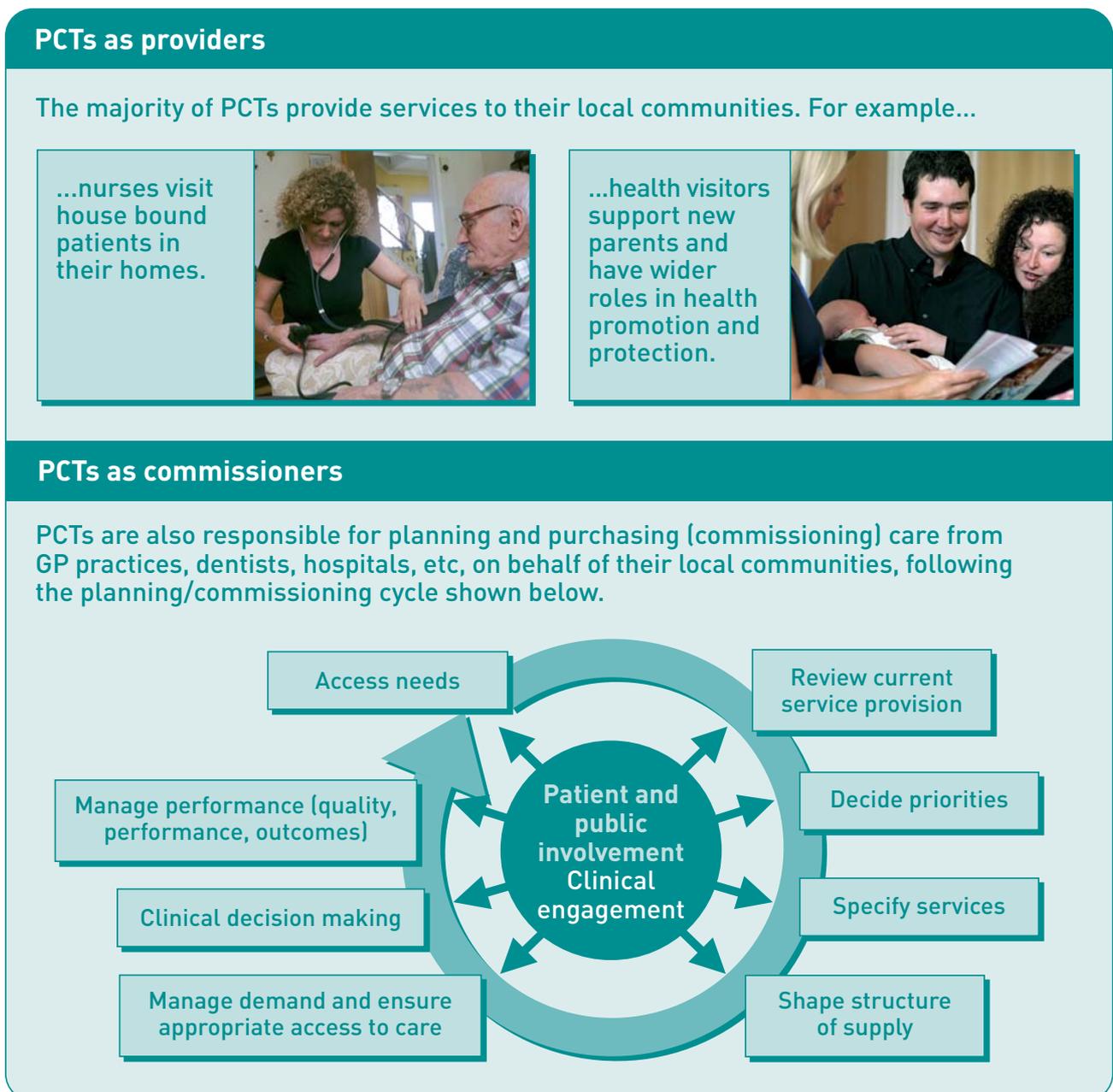
In 2009/10, the Care Quality Commission will continue to register adult social care and independent healthcare services in the same way as currently happens. However, the Government plans a new registration system, which will also require NHS providers to register in respect of the healthcare services they provide. This new registration system will be phased in over the period April 2009 to April 2010. It will build on current registration and inspection systems that apply to social care and independent healthcare sectors and the core standard component of the annual health check in the NHS. We expect that assessments of providers under both these current systems in 2008/09 will be taken into account when they transfer into the new system of regulation.

Our assessment of PCTs in 2008/09 will take these plans into account. PCTs currently have two functions: as commissioners (purchasers) of care and as providers (see figure 2). Under the new legislative framework, they are expected to be treated differently – the provider services will be subject to registration and assessment; the commissioning activities will only be assessed. The annual health check will reflect this by providing separate assessments on the provider and commissioning functions of PCTs.

2. Subject to parliamentary approval.

As we expect that the current assessment of standards will be taken into account during the transfer of existing healthcare providers to the new system of regulation, it is important for patients that trusts meet the standards in full during 2008/09. We intend therefore to follow up with trusts that declare that they do not meet standards or that we assess as “weak” in 2007/08. We will also focus our inspections on themes and standards that we believe to be at greatest risk of non-compliance.

**Figure 2: PCTs as providers and commissioners**



## Section 2: Key influences on the design of the annual health check in 2008/09 (Continued)

Clearly, throughout 2008/09, we will continue to work closely with CSCI and MHAC as the role of the new regulator becomes clearer. We have already been working on some joint ventures. In 2008/09 this will result in the joint development of an assessment of the commissioning of services for people with learning disabilities. We are also developing a joint assessment for the small number of care trusts that provide or commission both health and social care services. While both these initiatives have largely involved the Healthcare Commission and CSCI, MHAC will also be involved in mental health services, including consideration of services for people detained under the Mental Health Act.

### **Improving the commissioning of healthcare to meet local needs**

Another key contextual factor for the annual health check in 2008/09 aimed at driving improvement in the commissioning and planning of healthcare is the World Class Commissioning programme. This initiative by the Department of Health identifies the key competences needed and best practice in planning and purchasing care on behalf of patients, and sets out a compliance framework against which PCTs will be assessed by strategic health authorities as performance managers.

The Healthcare Commission has a statutory responsibility to assess PCTs both in their role as providers of services and as commissioners of services. This is important in providing independent public accountability. In designing our assessment, we have aimed to ensure that:

- We do not extend the scope of our current assessment.
- There is compatibility and consistency between our assessment and the performance management framework used by strategic health authorities, so that the processes complement rather than duplicate each other.
- Where there is overlap, there is consistency, so that evidence from one assessment can be used for the other.

### **Comprehensive area assessments**

As well as bringing together the regulators for health and social care into one organisation, the Government also has ambitious plans to bring together the assessments from a number of regulatory bodies to deliver comprehensive area assessments (CAAs). The CAAs will cover a broad range of activities provided at a local level, such as education and housing provision as well as health. They are designed to look at how well local organisations (including PCTs and NHS trusts) are working together in partnership to deliver the local outcomes people want. Seven regulatory bodies will be involved and will put forward their joint proposals for how this will work later in the summer. The first round of reports from these assessments is due in the autumn of 2009. The information from the 2008/09 annual health check for PCTs will make an important contribution to the CAA judgement process.

## Key themes from our consultation

The key message from our consultation in 2008/09 was of support – both in maintaining the stability of our assessments and, where we have had to make changes, in the direction of travel. However, we have responded where we can to the other main comments made.

**Patients want us to focus more on outcomes and to take their views more into account in our assessments**

There is strong support from groups representing patients and the public for the emphasis on safety and clinical effectiveness in our assessments. They also support our drive to encourage trusts to achieve full compliance with the Government's standards. However, they are keen, that our assessments put more emphasis on the measurement of outcomes. We agree that this is important and will provide more information to allow patients and the public to compare performance between trusts. Our visits to trusts will increasingly look at both the processes underpinning care delivery and its outcomes. We also agree that the views of patients must have an increasing impact in our assessments. During 2008/09, we will continue to engage directly with groups representing patients to obtain feedback on the performance of local trusts. Where there is cause for concern, we will follow this up.

**Tailoring our assessments for different types of healthcare**

In developing our plans for 2008/09 we have made considerable effort to engage with patient groups, trusts and clinicians. We have done this to ensure that the indicators we are using to rate the different trust types are tailored to each sector and ensure that our assessment is focused on safety and clinical effectiveness. This approach has been strongly welcomed.

We will continue to work with the Academy of Medical Royal Colleges, individual colleges, nursing and other clinical bodies to make better use of their information. For example, in relation to service accreditation we will use it within our systems of ongoing assurance on standards throughout the year and in our risk assessments at the end of the year. We are already planning to use this approach with information from the cancer peer review.

People also strongly supported the proposed split in the assessment of PCTs to provide a separate assessment of their commissioning and providing functions. They said that this provides a better 'fit' between our assessment system and the way healthcare is organised.

Section 2: Key influences on the design of the annual health check in 2008/09 (Continued)

**Ensuring that the assessment of PCTs as commissioners and the World Class Commissioning framework are complementary**

In our consultation document we set out our proposal to report separately on the performance of PCTs as providers of services and their performance as commissioners (purchasers). There was overwhelming support for this proposal. However, some people responding were concerned that in providing a separate assessment of commissioning, we should take account of the considerable range of other work being carried out in this area, and in particular the World Class Commissioning compliance framework.

The Healthcare Commission has a statutory obligation to undertake a performance assessment of PCTs, taking into account the Government's standards. These apply equally to the providing and commissioning functions of PCTs and have therefore always been part of our assessment. Our assessment this year will not be extended, but will simply clarify the focus of the assessment of the two different functions. In developing the criteria for our assessment of PCTs, however, we will work closely with colleagues in the Department of Health and the Audit Commission to ensure that our processes complement rather than duplicate each other. We will aim to use World Class Commissioning performance management information in our assessment where we can.

**There was a great deal of support for the topics and services chosen for review, but others were suggested**

Patient groups and trusts were very supportive of our in-depth work on services and topics since it provides a powerful incentive for improvement. They were also supportive of the topics chosen, but other topics were also suggested. Specialised commissioning is an important area and will be picked up in our assessment of commissioning. This year's revision of the criteria for PCTs will include a specific reference to this important role. We will also consider it as a topic for more in-depth review in our future plans.

Other topics suggested were:

- the hygiene code (possibly drawing upon our programme of visits to trusts)
- dentistry
- dementia
- cancer (drawing upon the cancer reform strategy).

We appreciate this feedback and will also consider these topics in our future plans.

**Trusts want earlier guidance on the detail of our plans**

Trusts tell us that they want the detail of our plans earlier in the year. In 2007/08 we published the detailed constructions of the indicators used for the existing and new national targets before the beginning of the assessment year. This year, many of the targets no longer apply or have evolved to form new commitments, so we have developed new sets of indicators, based on the vital signs published by the Department of Health. These have already been published on our website, together with the sources of the data and, where possible, the constructions. Not all the detailed constructions are available at the moment. For some we will need to work with other bodies to ensure consistency. We aim to publish full constructions of all the indicators in the autumn.

We will, however, publish our revised criteria underpinning our assessment on the standards earlier. For 2007/08, the criteria were revised to make them simpler and more outcome focused. They were also tailored to the different types of service. We are not expecting further major changes for acute, mental health or ambulance trusts. There will be some changes for PCTs, reflecting the separation of the provider and commissioner functions, but we are expecting to be able to publish all the criteria later in the summer.

**Making better use of the findings of others to streamline regulation**

Trusts want us to work closely with other regulators to minimise the overlap in our assessments and so avoid any unnecessary duplication. We have been working with the NHS Litigation Authority (NHSLA), and in 2007/08 were able to use the results of their assessments as evidence of compliance with several elements of the standards for acute trusts.

In 2008/09, as the NHSLA extends its risk assessments for mental health and ambulance trusts, we will ensure that our criteria for these trusts are also amended. This will enable us to use the results of assessments by the NHSLA as evidence of assurance of compliance with the relevant elements of the standards.

We are also working closely with the Audit Commission to make better use of each other's information. The Audit Commission has changed its "use of resources" assessment for PCTs in line with the other audited bodies within the comprehensive area assessment. This has given us the opportunity to review how we use their assessment within our own standards-based assessment.

## Section 2: Key influences on the design of the annual health check in 2008/09 (Continued)

### **Making better use of the findings of others to streamline regulation** (continued)

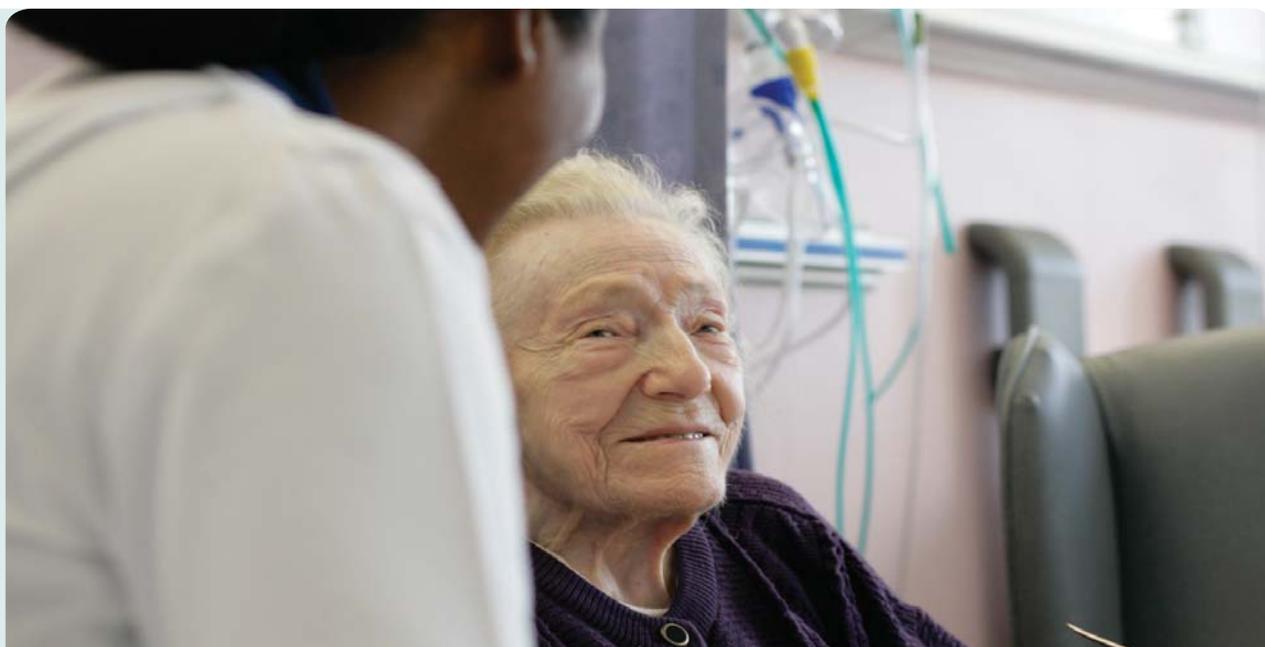
The new assessment will have three themes. We will use only the first, “managing finance”, to provide the quality of financial management score for PCTs. The other two themes will both be used to assess risk for other elements within the standards. They include areas such as corporate governance, use of data, data quality and asset management, which relate to auditors’ statutory duties to satisfy themselves that PCTs have proper arrangements for securing economy, effectiveness and efficiency.

The Audit Commission has separately consulted on the new use of resources framework for PCTs and other bodies. The 2008/09 key lines of enquiry have been finalised following consultation and issued.

Our final plans have taken into account both the changing context in which we operate and feedback from our evaluation and consultation.

### Our overall aims for our health check in 2008/09 have been to:

- Remain focused on the issues that matter most to patients and the public, especially safety and the quality and clinical effectiveness of services.
- Take the experience of patients more into account in our assessments, both in the annual health check and when following up throughout the year.
- Engage clinicians more and more in the design of assessments.
- Increase our efforts in investigating and following up reasons for non-compliance with the Government's standards.
- Tailor our assessment further to each of the different healthcare sectors and types of service.
- Remain cost-effective and risk-based in our approach and to rely where we can on the assessments of other regulators.



Key themes from our consultation: Patients want us to focus more on outcomes and to take their views more into account in our assessments.

## Section 3: Our proposals for the annual health check in 2008/09

### At a glance – what will stay the same and what will change

#### Standards-based assessment

What will stay the same	What will change
<p>The boards of all trusts will be required to make a declaration of compliance of their trusts with the core standards.</p>	<p>There will be limited further change to the criteria for acute, ambulance and mental health trusts.</p>
<p>We will issue a small set of benchmark indicators for provider trusts in January 2009, covering safety and clinical effectiveness. We expect that trust boards will use this data together with local information when considering their compliance with the standards.</p>	<p>We will ask the boards of primary care trusts to make a separate declaration on their compliance with the standards for their commissioning function and their function as a provider of services (within a single declaration form). We expect to make some changes to the criteria, reflecting this separation and to publish these later in the summer.</p>
	<p>We will visit <b>all</b> acute trusts to review the effectiveness of their arrangements to reduce the incidence of healthcare associated infections.</p>
	<p>We will also visit some non-acute trusts to check on compliance with the hygiene code.</p>

## Monitoring performance through the year

What will stay the same	What will change
<p>We will continue to use available national information and the views of patients and the public throughout the year to identify and, if appropriate, pursue areas of potential concern.</p> <p>Our work on services and topics will focus on areas where compliance on standards is at risk.</p>	<p>We will follow up trusts that do not meet the standards. Where trusts score “weak” on their quality of services score and where trusts declare that they do not meet a standard, we will work with the Department of Health, strategic health authorities and Monitor to encourage the development of action plans and discuss progress on a regular basis.</p> <p>We will follow up our reviews of children’s hospital services, the management of medicines and community mental health services.</p>

## Assessments based on indicators

What will stay the same	What will change
<p>Some of the existing and new national targets will remain – but will be used differently.</p>	<p>We have developed more tailored sets of indicators that will incorporate any targets that remain applicable and other national priorities. The indicators for primary care trusts (PCTs) are taken from the vital signs framework (except for the data quality on ethnic group). The indicators for provider trusts reflect the vital signs and the four themes: health and wellbeing, clinical quality, safety, and patient focus and access.</p>

Section 3: Our proposals for the annual health check in 2008/09 (Continued)

**Assessments based on indicators** (continued)

What will stay the same	What will change
	<p>For the first time, we will also introduce rated indicators for trusts that provide services to patients with learning disabilities.</p> <p>We are also changing our approach to the way we 'round' up the performance data supplied by trusts. This will have the impact of making the thresholds for some indicators more difficult to reach. More information on this is included in appendix 1.</p> <p>All the indicators are also listed in appendix 1.</p>

**Quality of financial management assessment**

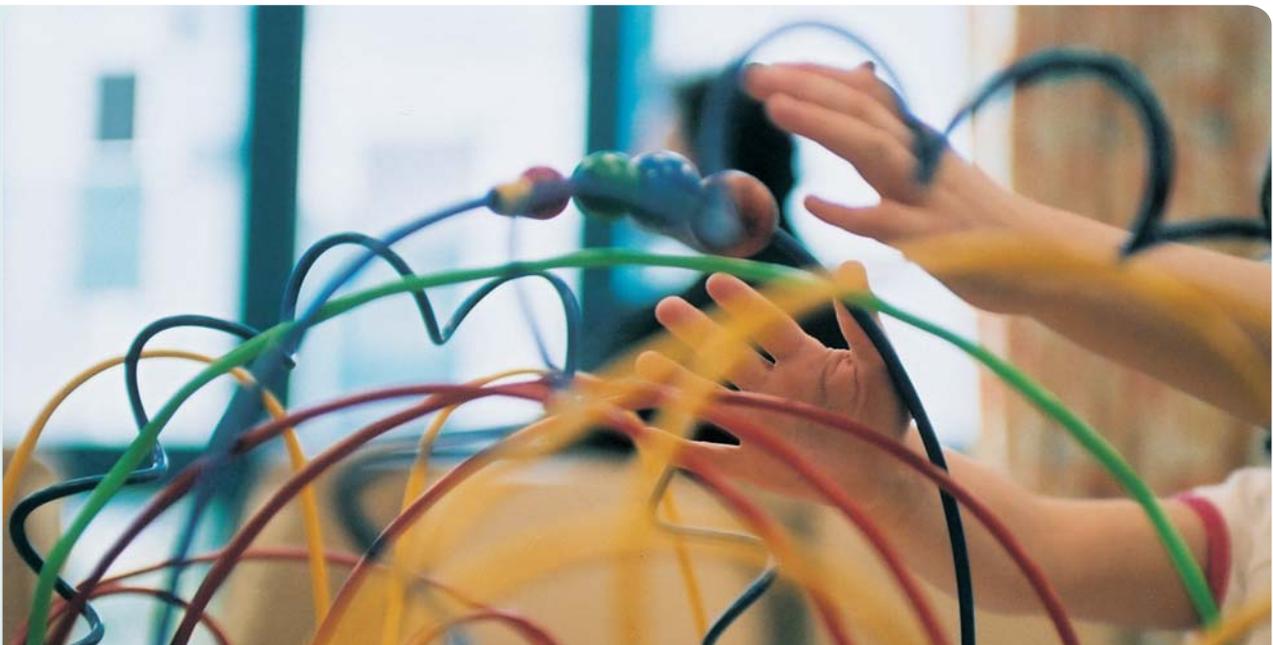
What will stay the same	What will change
<p>As in previous years, we will use the Audit Commission's "use of resources" assessment for non-foundation trusts and the financial risk ratings from Monitor for foundation trusts. This year however, it will be known as the quality of financial management score.</p>	<p>We will continue to use Audit Commission findings in our assessment of financial management for PCTs – but what we use will change. This is because the Audit Commission is changing its assessment of PCTs in line with other audited bodies within the comprehensive area assessment. Their new assessment will have only three themes. We have reviewed the content and have decided only to use the first – "Managing finance" as a directly scored assessment. We have therefore changed the name of this assessment for all trusts to the quality of financial management.</p>

## Quality of financial management assessment (continued)

### What will stay the same

### What will change

We value the work of the Audit Commission, and information from the remaining themes of their assessment will be used both in our assessment of risk and to reduce the questions we ask trusts for other elements within the standards. We believe that this will reduce overlap and the risk of penalising a PCT twice for the same issue in our assessments.



Monitoring performance through the year: We will follow up our reviews of children's hospital services, the management of medicines and community mental health services.

### **Assessments giving a broader picture of performance**

Our annual ratings are of organisations. Patients however, are particularly interested in how individual services perform. We therefore have a rolling programme of work designed to put a spotlight on important areas of concern for patients and the public. The assessments do not feed directly into the calculation of an organisation's rating but may raise concerns that standards are not being met. We will use this information when considering trusts' performance on the standards.

We are planning two in-depth reviews on:

- Commissioning services for people with learning difficulties (jointly with the Commission for Social Care Inspection).
- Medicines management in primary care.

Reports from these reviews are likely to be published in 2009.

We will also follow up three previous service reviews to check on progress. In 2008/09 this will apply to the reviews of children's hospital services; medicines management (acute sector); and community mental health service reviews. We are also working with the National Audit Office on its review of end-of-life care.

National studies are more general assessments of commissioning and service provision and are designed to promote improvement. We are planning four national studies:

- Access to psychological therapies
- Health inequalities
- Patient and public involvement
- Equality of access to services for disabled people.

We will also develop sets of structured benchmarking indicators in two areas:

- Children's health and healthcare services
- Stroke care and prevention.

These will not be scored but will enable clinicians, trusts and the public to compare performance and identify areas for improvement.

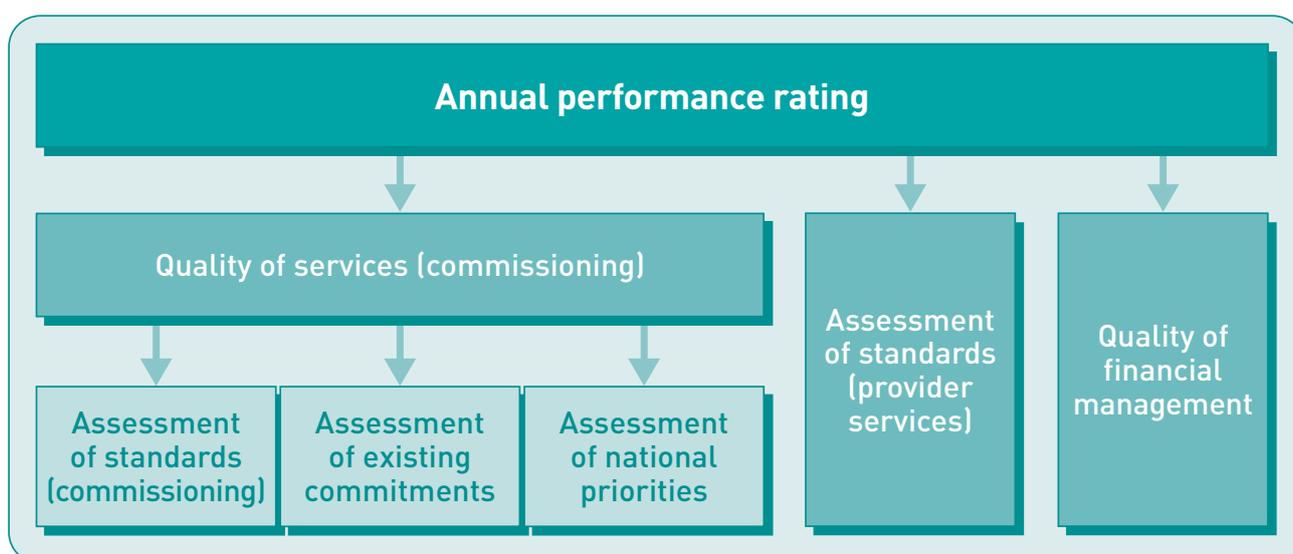
Appendix 2 sets out our reasons for choosing these topics. All have been chosen in line with the principles set out on page 9.

## Section 4: Our assessments by sector

### Primary care trusts

Our assessment of primary care trusts (PCTs) for the performance rating in 2008/09 will have a different structure from previous years. This will allow us to report separately on the performance of services that a PCT provides itself (such as community health services), and its role as a commissioner of health and healthcare services for its local community. The assessment of the PCT as a commissioner will have a strong focus on progress against the national priorities set out in the Department of Health's vital signs indicators.

**Figure 3: Structure for the annual performance rating of PCTs**



Note: PCTs that provide mental health or learning disability services will also have a score for the indicators that apply to these services, but this will not be aggregated with their score on the standards for their provider services.

There are three important reasons for the change:

- Commissioning (and contracting) and the direct provision of services are intrinsically different functions. Separate assessments will give local communities a much clearer picture of how their PCT is performing.
- It reflects the operating framework for 2008/09 that requires PCTs to have a separate internal structure for their commissioning and contracting function to their functions as a provider of services.

## Section 4: Our assessments by sector (Continued)

- It is expected that, under the new regulator, providers of healthcare services will be subject to registration and assessment. They will have to meet essential safety and quality requirements to remain registered and then will be assessed on how well they are performing above this level. PCTs that currently provide services are likely to be required to register these services. It is also expected that the standards-based assessment, carried out by the Healthcare Commission in 2008/09, will be taken into account when providers transfer into the new regulatory system. The structure that we are proposing (see figure 3 on previous page) will facilitate this transfer of the provider functions of PCTs, while at the same time providing an assessment of PCTs as commissioners.

### Our assessment of PCTs as commissioners

#### Standards-based assessment

The trust boards of PCTs will, for the first time, make a declaration on their compliance with the Department of Health's core standards for their commissioning and contracting functions, which is separate from their function as providers of services. This will include their responsibility for specialised commissioning groups. Some of the core standards are particularly relevant to their commissioning function (see table 1).

**Table 1: Eight core standards that are particularly relevant to PCTs as commissioners**

C5	Take national guidance into account when planning and delivering care
C6	Work with partners in planning and delivering the care of individuals
C7	Have effective processes for governance, risk management, etc and promote equality, uphold human resources, etc
C17	Take views of patients and carers into account in planning and delivering care (and demonstrate how you are doing this)
C18	Ensure equitable access and offer choice
C22	Work with partners to improve the health of the community and narrow health inequalities
C23	Ensure that disease prevention/health promotion programmes are in place
C24	Protect the public by having a planned, prepared and, where possible, practiced response to incidents

The trust boards of PCTs will, however, have to declare on their assurance of compliance with all the standards. In doing so, as in previous years, they will have to assess whether, as commissioners, they have taken reasonable steps (with regard to their independent contractors), and have appropriate mechanisms (with regard to their commissioned services) to ensure that the services supplied are compliant with the standards.

We will provide separate criteria for the assessment of the commissioning function. We do not expect this to increase the scope of the assessment of PCTs overall, since our assessments have always covered the commissioning function. Rather, we expect the revised criteria (which we aim to publish later in the summer) to clarify how the assessment of standards applies to commissioning.

### **World Class Commissioning**

Some feedback to our consultation asked us to ensure that our assessment complements the assurance framework being used for the World Class Commissioning (WCC) initiative. We continue to have a statutory duty to assess PCTs with regard to their commissioning function in 2008/09 and so we have been working with the Department of Health to ensure that the two systems complement each other and add value without duplication for PCTs. We will highlight areas where there is overlap so that processes for collecting evidence can be streamlined.

We will also aim to use the assurance framework from WCC as part of our assessments of risk for 2008/09. This will help to ensure that our inspections are appropriately targeted and do not duplicate WCC.

### **Assessment based on indicators**

We have developed a range of indicators designed to give a rounded measure of performance focusing on outcomes as well as standards (set out in appendix 1). These indicators will replace the existing and new national targets (although they include any targets that still apply). They are drawn from the vital signs indicators published by the Department of Health. The current proposed set is smaller than that used for the 2007/08 assessment of targets and requires no special data collections.

The indicators will be divided into two sets:

**Existing commitments:** these are areas – such as waiting times in A&E, delayed transfers of care, crisis resolution services – which have been long-standing targets. The public expectation is that good levels of performance will at least be maintained. Similar to the current existing national targets, we envisage that primary care trusts that are classed as “not met” against these commitments will automatically be scored “weak” in their quality of services score. An indicator on data quality in ethnic group recording (not one of the vital signs) will also be included in this set.

## Section 4: Our assessments by sector (Continued)

**National priorities:** the second set of indicators, however, has been called an assessment of national priorities. They are mostly drawn from the second tier of the framework for the vital signs indicators which, while they remain national priorities, are designed not to be prescriptive but to allow flexibility in the level of improvement to be made according to local need. To allow for this, we will use local plans where appropriate to measure performance.

All the indicators are set out in appendix 1.

### **Benchmarking indicators**

In the operating framework for the NHS, the Department of Health set out its intention to ensure that performance against the vital signs is published on an annual basis. We outlined in our consultation document our proposal to publish all the indicators from the vital signs framework for the purpose of benchmarking. We are in discussions with the Department of Health on this approach and we will publish further information on our plans shortly. We believe that trust boards of PCTs would find this useful when considering their performance on the standards and when identifying local priorities.

The information in the wider set of vital signs covers a range of important areas including patient choice of provider. Providing patients with choice is a priority area for the Government and it is important both to publish information about this and to follow up poor performers.

### **Quality of financial management**

All PCTs will be assessed on quality of financial management (replacing the “use of resources” assessment from previous years). This will be based on the Audit Commission’s judgements as before. There will, however, be an important change to this assessment. This will enable the Audit Commission to use the same framework for its assessments of all the other bodies included within the comprehensive area assessment.

The new assessment will have only three themes. We have reviewed the content of the themes and have decided only to use the first, “Managing finance”, for our quality of financial management assessment. We continue to value all of the Audit Commission’s assessment however, and wherever possible will use evidence from the remaining two themes (Governing the business and Managing resources which relate to auditors’ statutory responsibilities) for other aspects of our standards-based assessment. We believe this will reduce the risk of trusts being penalised twice for the same issue in the ratings.

### **Work based on services and aspects of care<sup>3</sup>**

We will carry out two in-depth reviews relevant to PCTs' work:

- The development of an assessment framework for the commissioning of learning disability services based on our recent audit on the provision of such services in conjunction with the Commission for Social Care Inspection.
- A review of the safety of medicines being managed in primary care trusts, focusing on the interface between hospital and primary care following discharge. This will focus on the role of PCTs in assuring safety.

Reports on these reviews will be published in 2009.

As part of our work on health inequalities, we will also carry out a smaller national study on coronary heart disease (CHD) and the performance of primary care through the prescribing of statins and the provision of stop smoking services in relation to prevalence of CHD and life expectancy.

### **GP practice level information**

The Government is consulting on how registration can be introduced for providers of primary care under the new regulator. Currently, PCTs are held to account for the standards of the services they commission from primary care providers. We have carried out some exploratory work on producing practice level comparative information using available information. It shows considerable variation between practices and that poor performance is associated with high levels of deprivation. In 2008/09, we will continue with some exploratory work on the value of this information to identify where good commissioning performance by PCTs can improve the performance of GPs.

### **Comprehensive area assessments**

As set out on page 14, health and healthcare services provided by NHS organisations in partnership with councils are within the scope of the comprehensive area assessments (CAA), as well as within the scope of the annual health check for 2008/09. The assessment of PCTs as commissioners of services is the main aspect of the annual health check that is relevant to the CAA, though aspects of services provided by other NHS trusts may also be relevant. The benchmarking information on performance against all the vital signs will also provide an important input into looking at the risk to delivery of good outcomes for local communities. The first round of reports from the CAAs is planned for the autumn of 2009.

3. Fuller descriptions for all these pieces of work are included in appendix 2.

## Section 4: Our assessments by sector (Continued)

Proposals by the seven inspectorates developing the CAA for how the assessments will work in 2009 will be made in a second joint consultation this summer. Underlying the proposals are requirements that the frameworks for assessing healthcare and the CAA must be aligned; and that the healthcare regulator's contribution to the CAA must be contained within its existing budgets.

The CAA is designed to identify issues at an area level. When the information collected about all sectors has been considered at area level, it is likely that issues involving healthcare will be identified in some areas that will need further enquiry by the inspectorates (including the possibility of inspection), and action to improve performance or future prospects for services by local strategic partnerships and their constituent members.

### Our assessment of PCTs as providers

#### Standards-based assessment

The trust boards of PCTs will also be required to make a declaration on the compliance with the standards of their provider services on the same form as their declaration of their compliance on the commissioning function. We do not expect the criteria for this assessment to be substantially different from the assessment in 2007/08.

PCTs will also be asked to make a declaration on their standards of compliance with the hygiene code (with regard to their provider services).

#### Indicators for services provided by primary care trusts

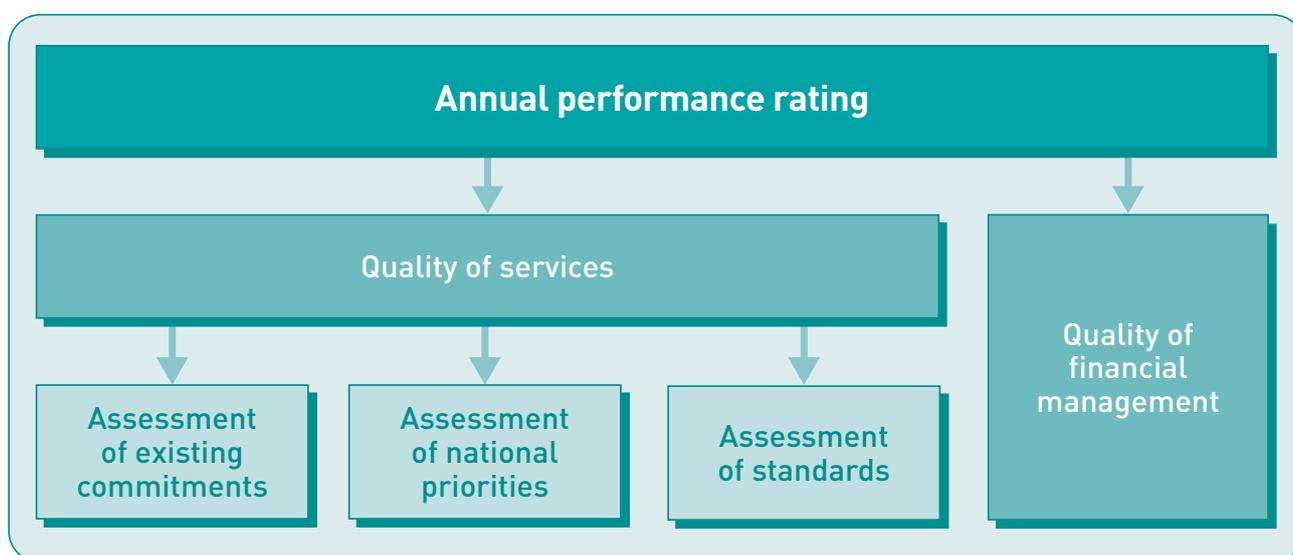
For most PCTs there will be no rated indicators for their directly provided services. This is because there is little robust comparative data, and considerable variation in the services provided. However, PCTs that provide either mental health or learning disability services, or both, will have an assessment based on these indicators, but it will not be aggregated into a single score with the assessment based on standards. This will allow greater comparability across all PCTs on the standards for their directly provided services (although, of course, their standards-based assessment should take into account all their provided services).

### Acute trusts

The structure of our assessment for acute trusts is broadly comparable to previous years (see figure 4). As a result of consultation and feedback however, we believe that the assessment will have a better sector fit and will be more outcome-focused. In particular, we have developed more clinical indicators to be used in the rated part of the assessment. On standards, we build on the changes made for 2007/08 to ensure that: our focus is on the main issues, trusts are meeting the objectives of the standards, and inspections within trusts focus more on outcomes and not just on processes. We have been engaging

extensively with clinicians in developing the assessment. We will continue to work with them to ensure that accreditation data, produced by the royal colleges, can be used to feed into our risk assessment both at the end of the year and during the year.

**Figure 4: Structure of the rating for acute trusts**



### **Assessment of standards**

There will be minimal change to the criteria used in 2007/08.

We will, once more, provide trusts with small sets of benchmark indicators, covering safety and clinical effectiveness, which we expect boards to consider, alongside local information when making their declaration on compliance with the standards.

Trusts will be asked to make a declaration on their compliance with the hygiene code. We have also been asked by the Secretary of State to visit all acute trusts to assess directly their compliance with aspects of the hygiene code. This will impact on their rating in 2008/09.

### **Assessment based on indicators**

We have developed, in consultation with trusts, a set of indicators that we believe constitute a more rounded assessment of performance. They have been selected to be compatible with the vital signs indicators for PCTs. They cover four themes:

- health and wellbeing
- clinical effectiveness
- safety
- patient focus and access.

## Section 4: Our assessments by sector (Continued)

They will be divided into two sets:

**Existing commitments:** the first set will be an assessment of existing commitments and, as with existing national targets in previous years, we envisage that trusts that classed as “not met” against these commitments will automatically be rated as “weak” for their quality of services score.

**National priorities:** the indicators have been set to measure performance in key national priority areas. Some of these indicators are new for this year and have an improved focus on safety and clinical effectiveness.

All the indicators are listed in appendix 1. Some of the indicators were included in the assessment of targets previously and have been marked with an asterisk in the lists.

### Quality of financial management

All trusts will be assessed on their quality of financial management. This replaces the use of resources assessment used in previous years. As before, for foundation trusts, this will be based on the work of Monitor and for non-foundation trusts, the Audit Commission. There are not expected to be significant changes.

### Work based on services and aspects of care<sup>4</sup>

We will follow up the improvement review of children’s services to check on progress.

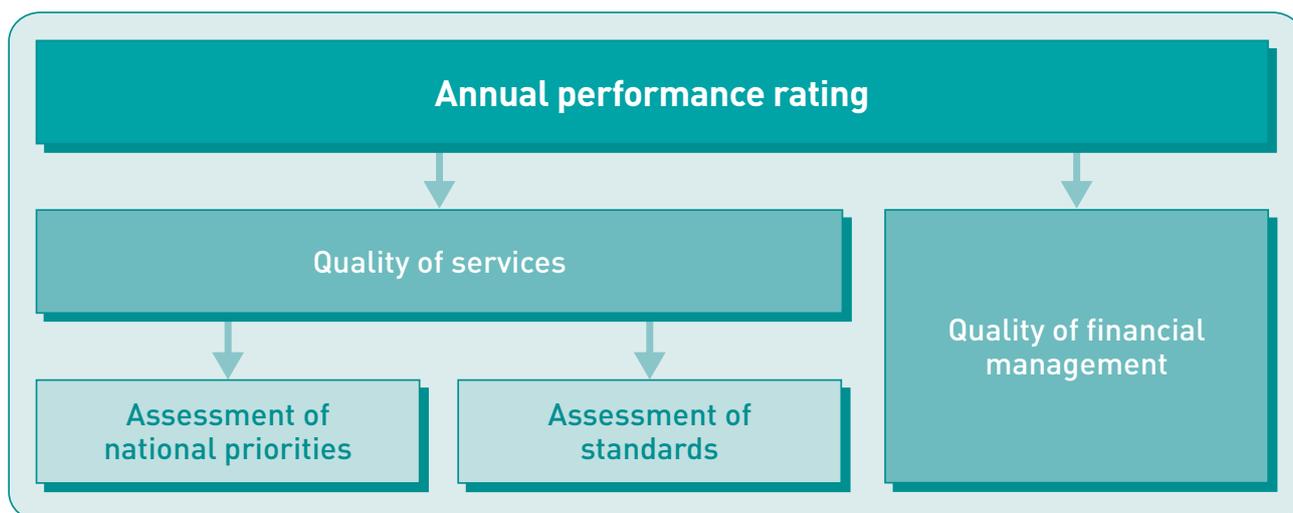
### Mental health trusts

In previous years, the Government’s set of targets for the mental health sector was relatively limited. Consequently service users and carers, and NHS staff considered that the health check assessment, which reflected these targets, was rather narrow. This year we have consulted widely on the indicators that we are using for rating trusts in 2008/09 and believe that they better reflect the issues service users and carers have told us are important and provide a more rounded assessment. We also believe they achieve a better balance between measuring processes and measuring outcomes for patients.

Our intention to have a specific measure on social inclusion received a significant amount of support during the consultation period. We have, however, decided to defer the inclusion of this indicator because of the related work currently being undertaken by the Sainsbury Centre for Mental Health due to report later this year. We expect that this will yield some robust social inclusion measures that can be used in future assessments.

4. Fuller descriptions for all these pieces of work are included in appendix 5.

**Figure 5: Structure of the rating for mental health trusts**



### **Assessment of standards**

There will be minimal change to the criteria used in 2007/08.

We will, as for the 2007/2008 annual health check, provide trusts with small sets of benchmark indicators, covering safety and clinical effectiveness. We expect boards to consider these, alongside local information, when making their declaration on compliance with the standards.

Trusts will be asked to make a declaration on their compliance with the hygiene code. We also intend to extend the scope of our hygiene code inspection beyond the acute sector. This will be based on risk and may include the mental health sector.

### **Assessment based on indicators**

We have developed, in consultation with trusts, a set of indicators that will constitute a more rounded assessment. They have been selected to be compatible with the vital signs indicators set for PCTs. They will cover four themes:

- health and wellbeing
- clinical effectiveness
- safety
- patient focus.

## Section 4: Our assessments by sector (Continued)

The indicators will be used as a single assessment of national priorities, and are included in appendix 1. Some of the indicators were included in the assessment of targets previously and have been marked with an asterisk in the lists.

### **Quality of financial management**

All trusts will be assessed on their quality of financial management. This replaces the use of resources assessment used in previous years. As before however, for foundation trusts, this will be based on the work of Monitor, and for non-foundation trusts, the Audit Commission.

### **Work based on services and aspects of care**

We will follow up our review of community mental health services to check on progress. There will also be a small national study on access to psychological therapies.

## **Ambulance trusts**

We have been working to ensure that the indicators in the annual health check provide a more rounded assessment for the ambulance service. This is to reflect the full role of the ambulance service (as set out by the Government in its 2005 report *Taking healthcare to the Patient* in the provision of an increasing range of services and the wider role it plays in the provision of healthcare, in addition to its more traditional transport service. This also reflects patients' and the ambulance sector's wish to have a more rounded assessment including clinical quality. Therefore, as with previous years, the indicators include some clinical measures, a number of which are new for 2008/09. We have consulted extensively in their development.

Our assessment for ambulance trusts has the same structure as that for mental health trusts. Existing and new national targets have been replaced by a single assessment of national priorities.

### **Assessment of standards**

There will be minimal change to the criteria used in 2007/08.

### **Assessment based on indicators**

Although the set of indicators that will be used to rate ambulance trusts is still quite small (11), there are several that are being used for the first time to provide a more rounded assessment. This is the result of wide consultation with the patient groups, trusts and the Department of Health. They have been selected to be compatible with the recently published vital signs indicators set for PCTs. They will cover three themes:

- clinical effectiveness
- safety
- patient focus and access.

As for mental health trusts, the indicators will be used as a single assessment of national priorities, and are listed in appendix 1. Those that were previously included in the assessment of targets are marked with an asterisk. Given the importance of meeting the targets on response times, we envisage that an ambulance trust will not receive a score of “excellent” if it is not meeting these targets.

### **Quality of financial management**

All trusts will be assessed on their quality of financial management. This replaces the use of resources assessment but, as before, will be based on the Audit Commission’s judgements and the financial risk ratings from Monitor for foundation trusts.

### **Learning disability trusts and services**

In the light of concerns about the quality of learning disability services in our 2007 national audit, we gave a commitment to introduce, for the first time, a set of performance indicators as part of the 2008/09 annual health check. This was welcomed in our consultation, although respondents also recognised the limitations of existing national data. We are therefore only introducing a small number for 2008/09.

### **Assessment of standards**

There will be minimal change to the criteria used in 2007/08.

### **Assessment based on indicators**

We will use a small set of indicators to rate trusts that provide learning disability services – two of which are specific to these service providers: the number of people with care plans and a measure on continued use of campus provision. The other two indicators, on data quality on ethnic group and delayed transfers of care to other sectors are also included in the assessments for other organisation types.

### **Quality of financial management**

All trusts will be assessed on quality of financial management. This replaces the use of resources assessment but, as before, will be based on the Audit Commission’s judgements.

### **The special organisations**

The special organisations (the Health Protection Agency, NHS Direct and NHS Blood and Transplant) will be assessed against standards in 2008/09, as in 2007/08.

We are not expecting to make significant changes to the criteria for these organisations.

## Section 5: Key aspects of our assessments

This section summarises how our assessments in 2008/09 will focus on several important aspects of healthcare. These are:

- safety
- clinical quality
- the experience of patients and the public – including dignity and access to care
- health and wellbeing – including reducing health inequalities.

We also have a duty to be concerned with the need to safeguard and promote the rights and welfare of children and have summarised our work for this group of patients.

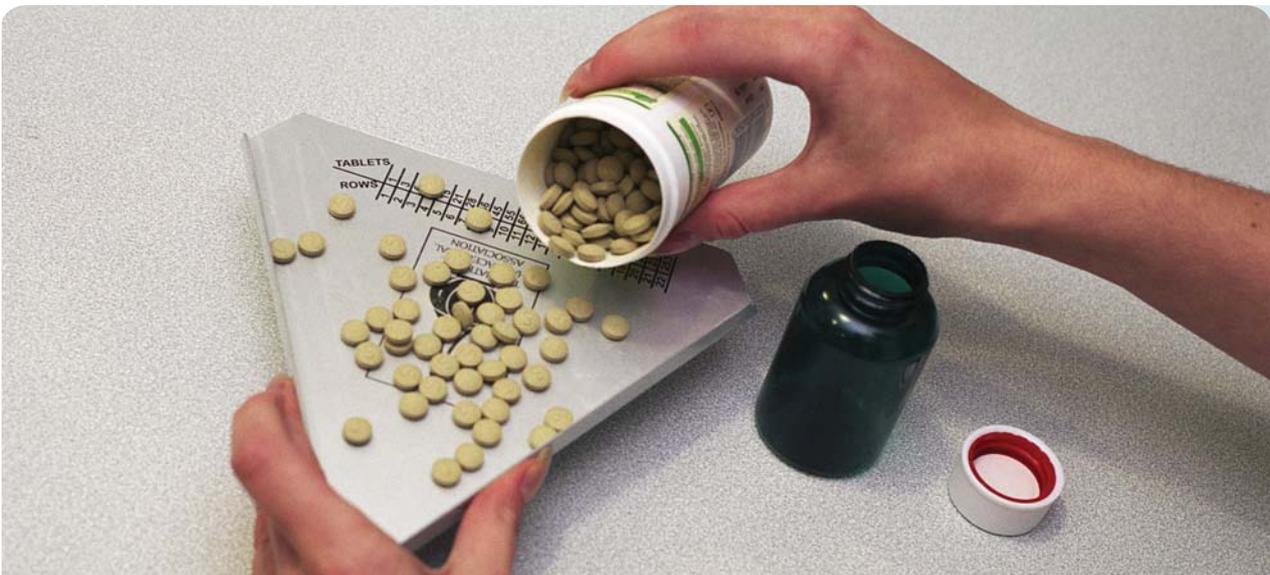
### Safety

The public expect safety to be at the heart of our assessments. Since 2005, our standards-based assessments have encouraged trusts to develop a strong corporate approach to the management of safety. Our approach in 2008/09 will have a new focus on outcomes and how organisations address major risks to safety. We intend to improve our assessments in areas where data reported to the National Patient Safety Agency, such as falls and the management of medication, and information collected by the Health Protection Agency, suggests the greatest level of risk. In our visits to trusts, we intend not just to focus on corporate approach to these areas but also on the actions taken and outcomes.

In 2008/09 we will also:

- Include indicators on safety within our indicator-based assessment of acute, ambulance and mental health trusts. The proposed list of indicators is included in appendix 1.
- Develop a small set of benchmarks on safety. We will build on the set of benchmarks for the 2007/08 annual health check covering issues such as mortality rates and the percentage of staff that experienced violence or harassment. The benchmark indicators are provided to supplement local information for trust boards to consider when making decisions on declaration on relevant standards.
- Continue with our assessments on the management of controlled drugs and ionising radiation. Controlled drugs are monitored through compliance with core standard C4d and National Minimum Standard C24 for the independent sector. We also have a programme of both risk-based and responsive inspections with regard to the Ionising Radiation (Medical Exposure) Regulations.
- Carry out an in-depth review of the management of medication in primary care. It will look at what primary care trusts do, as commissioners, to ensure safe practice. As part of the review, we will look at what action primary care professionals take to ensure safety of medicine use after a patient is discharged from acute or mental health facilities.

- We will work with the National Patient Safety Agency, strategic health authorities and others to identify ways of using information on serious patient safety to highlight areas of risk and target interventions better.



Key aspects of our assessments: In 2008/09 we will carry out an in-depth review of the management of medication in primary care.

### **Healthcare associated infections and the hygiene code**

Patients and the public are, rightly, particularly concerned about hygiene within hospitals, and whether trusts are taking adequate steps to prevent the spread of healthcare associated infections. In addition to the two high profile investigations that we have carried out recently, we have also been conducting risk-based unannounced inspections in local trusts to check compliance with aspects of the hygiene code, where information suggests there may be cause for concern. We have also carried out inspections in trusts where concerns about other standards have triggered a visit.

In 2008/09 we will extend the scope for this programme to non-acute settings.

We have also been asked by the Government to expand our programme of visits with regard to healthcare associated infections to cover all acute trusts in 2008/09. We will use an assessment of risk to prioritise the order of trusts visited and to determine what is inspected during our visits.

## Section 5: Key aspects of our assessments (Continued)

We will continue to assess progress on meeting the national priorities for MRSA and *Clostridium difficile* infections in our indicator-based assessments of trusts.

### Clinical quality

Patients expect that their clinical care will be high quality, based on evidence of effective best practice and delivered by competent clinicians. Assessing the quality of clinical care provided by trusts is an important role of the Healthcare Commission, focusing both on indicators and outcomes. In 2008/09 we will do this in several ways.

As in previous years, we will ask trust boards to declare that they are compliant with standard C5 and aspects of other core standards that feature clinical quality issues. For core standard C5, this means that they have key processes in place and:

- They conform to National Institute for Health and Clinical Excellence (NICE) technology appraisals, and where it is available, take into account nationally agreed guidance when planning and delivering care and treatment.
- Clinical care and treatment are carried out under supervision and leadership.
- Clinicians continuously update skills and techniques relevant to their clinical work.
- Clinicians participate in regular clinical audit and reviews of clinical services.

However, compliance with this standard is not enough to assess that the care delivered to patients is of high clinical quality. The core standards relate mostly to the processes and systems that underpin the delivery of quality care. At best it can provide a good foundation but attention to outcomes is also needed. We will therefore, for the first time in 2008/09, introduce an element of follow through in our targeted assessment visits to trusts. We will select a 'tracer' aspect of clinical care and request specific evidence of good practice to back up general evidence of assurance compliance with the standard.

Our engagement with clinical staff has underlined the need for robust, valid and reliable outcome measures to assess clinical quality. Lord Darzi, in his recent interim review commissioned by the Department of Health, said that clinicians want to compare their performance with others. There is however, "a lack of directly comparable data" and "it is not benchmarked in a systematic way". He proposed that a clear framework be established with standard ways to measure results which will allow clinicians "to demonstrate the high quality of what they do" and "identify what is needed to sustain and improve that high quality". The report of the high level group chaired by Sir John Tooke has also advocated a more integrated structure for "diagnosing and treating problems of clinical effectiveness"<sup>5</sup>.

5. *Report of the High Level Group on Clinical Effectiveness* (chaired by Sir John Tooke): a report to the Chief Medical Officer, Department of Health, (October 2007).

In our consultation document, we sought views on including an indicator on venous thrombo-embolism prophylaxis (VTE) for the acute trust rating. The consultation responses recognised that this was an important area, but generally considered that there is currently not an adequate, consistent data source available for rating. However, when trust boards complete their declaration on standards, it is important that they consider the implications of nationally agreed best practice for the services they provide and whether and how such guidance should be implemented. This includes the relevant guidance on VTE.

In 2008/09 we will:

- Build systematically on our earlier work by including a number of indicators of clinical quality in the set used for rating trusts (see appendix 1). These have been developed in consultation with trusts and clinicians. They will be small in number as we are limited to using information that does not require special data collection.
- Develop a set of benchmarking indicators of clinical quality. These will build on the set of benchmark indicators for the 2007/08 annual health check. Wherever possible these will be focused on outcomes. We expect that they will be taken into account by trust boards alongside local data when considering their compliance with the standards for their declarations. Comparison with the performance with other trusts will help to drive improvement.
- Develop a structured set of benchmark indicators on stroke care and prevention. The indicators will be chosen, after consultation with clinicians and stakeholders, to be comprehensive. In the first instance, not all the information needed will be available and we will publish the information that is available, and work with the service to develop data sources for the remainder. One of the key aims of this work will be to provide clinicians with useful information to drive improvement in services.
- Include elements of the assessment of clinical quality in the work being planned on end-of-life care and on safe prescribing of medication for patients after they have been discharged from hospital. We also plan to follow up previous service reviews on children's services, medicines management and community mental health, and indicators of clinical quality will be used, wherever possible, as part of this process.

We have been working with the Academy of Medical Royal Colleges, Royal College of Nursing, NICE and other clinical organisations to develop a more strategic approach to our assessments of clinical quality. We will build on this through the year. In particular, we will work with the royal colleges and other key clinical organisations in the development of their accreditation schemes. We acknowledge the potential that these have to be valuable parts of our assessment processes in the future. Where we can, we will feed in any information already available from these schemes, for example from the cancer peer review scheme, into the information that we use to risk assess trusts on their compliance with clinical standards.

## Section 5: Key aspects of our assessments (Continued)

Another way that trusts ensure the delivery of high quality clinical care is by supporting the education and training of their clinicians as advocated by Sir John Tooke's report. Some of the Government's standards also highlight this (core standards C5c and C11). In 2008/09 we will use both survey data and qualitative information produced by the Postgraduate Medical Education and Training Board in our risk assessments for trusts. We will also consider using information from the staff survey on training as part of the benchmarking set we will give to trusts.

### **Patient-centred care**

Healthcare must, of course, be safe and evidence-based – but it must also be focused on patients and be humane. Healthcare organisations face many competing pressures every day – but it is important that they do not lose sight of the basics. Many patients need help with personal hygiene, nutrition and continence. When they are ill and unable to move, they are also at risk of developing pressure ulcers, usually preventable with good nursing care. Whatever their diagnosis or care needs though, patients should always be treated with dignity and respect, including being kept informed about all aspects of their care. The 2007 patient survey data highlighted wide variation in the performance of trusts in many vital areas of patient-centred care. We expect lower performing trusts to be taking action to improve the experience of patients and we will make extensive use of the patient survey in targeting follow-up inspections.

An important role for the Healthcare Commission to encourage trusts to see getting these basics right as a priority. We already do this through our assessment of the core standards in *Standards for Better Health*. For example core standard C13a requires that:

- “Healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect.”

Core standard 15b requires that:

- “Healthcare organisations have systems in place to ensure that patients' individual nutritional, personal and clinical dietary requirements are met, including where necessary help with feeding and access to food 24 hours a day.”

Core standard 16 requires that:

- “Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after care.”

‘Essence of care’ is a toolkit published by the Department of Health that was designed to help health (and social) care organisations focus on these essentials. Trusts have found it helpful when reviewing their own practice. We already consider that audits done as part of these reviews are useful and may help trusts when considering how to demonstrate

compliance with relevant standards. As we develop our inspection guides for 2008/09, we will review whether we can build further on this.

We will also work closely with clinicians to develop, where possible, outcome indicators for these important basic aspects of care.

### **Reducing health inequalities and promoting health and wellbeing**

All trusts have a responsibility to ensure that the services they commission or provide actively reduce health inequalities for the people they serve and that they promote wellbeing. As in previous years, we will ask all trusts to declare that they are compliant with public health core standards C22, C23 and C24 in *Standards for Better Health*. This means that trusts ensure that they cooperate with each other and with local authorities and other organisations, making appropriate and effective contributions to local partnership arrangements to improve the health of the community and narrow health inequalities.

We will continue to develop our focus on measuring how commissioning drives health improvement and reduces inequalities in health outcomes and access to healthcare. The focus for provider trusts will be on their role in promoting good health for their patients, staff and visitors to include:

- Providing services to help people stop smoking and have a smoke-free environment
- Providing opportunities for healthy eating
- Providing opportunities for physical activity
- Encouraging sensible drinking of alcohol
- Improving mental health and wellbeing
- Promoting sexual health.

In 2008/09 we propose to carry out a national study of the performance of primary care trusts (PCTs) in the reduction of health inequalities, using coronary heart disease as an example. The study will look at the prescribing of statins and achievement of smoking quit rates at PCT level in relation to the prevalence of coronary heart disease and life expectancy for each PCT. This study will use newly available estimates of prevalence, calculated by the Eastern Health Observatory.

We will also publish information on comparative performance for each PCT. This will include all relevant indicators in the vital signs framework, many of which are closely linked to initiatives to reduce inequalities in health and to improve the health of the population. We will work jointly with the Department of Health and others to ensure robust comparisons of performance are presented including, where appropriate,

## Section 5: Key aspects of our assessments (Continued)

international best practice. Our thoughts on this are at an early stage and we would like to explore our thinking through consultation.

### Children's health and healthcare services

We have a statutory duty to be concerned with the need to safeguard and promote the rights and welfare of children and we take this responsibility seriously. Children's health services are increasingly commissioned as part of children's trust arrangements, in partnership with local authorities, with outcomes measured across the health community. We need to ensure that our assessments reflect this joined-up working while enabling us to focus on the contribution played by health organisations, either acute trusts or PCTs.

In 2008/09 we will report on a small set of indicators following up from our previous review of children's hospital services. The review identified some significant deficiencies in care (for example insufficient staff training and facilities to cater specifically for children's needs). Eleven indicators were identified to follow up and track progress in these areas, which are being collected for us by Durham University in its child health, child and adolescent mental health services and maternity services mapping<sup>6</sup>.

We are also developing a set of structured benchmarks on children's health and healthcare services, supplementing those already collected under public health and mental health criteria, and using existing datasets and collections where these are available. These indicators will focus primarily on services provided or commissioned by PCTs, and will link into the core standards. They are grouped into three main themes, aligning with the Department of Health/Department for Children, Schools and Families Child health Strategy (expected to be published in September 2008). These themes are:

- Universal children's services, promoting health and wellbeing. These will explore the use of indicators on services such as immunisation and screening provided to all children in order to promote health.
- Services for vulnerable children, where extra health service support is necessary, usually for a relatively short term. These will include indicators in such areas as mental health and teenage pregnancy.
- Services for children with disabilities and long-term complex needs.

We expect these indicators to:

- Provide an overview of the risk profile of the PCT with respect to improving children's health and healthcare services.

6. Durham University was asked by the Department of Health in 2002 to collect information from trusts related to child and adolescent mental health services. Trusts found this helpful and so this has been expanded to cover other aspects of child health.

- Trigger discussions about children's services at board level to foster improvement across the service.

We are also intending to examine and improve the impact that joint area reviews (JARs) and youth offending team (YOT) inspections have on our assessments of NHS organisations. For example, where there are concerns, we may carry out follow up visits, taking escalated action as appropriate and we will continue to feed the results into standards-based assessments across the range of relevant standards.

### **Towards a future inspection programme on children's health services**

The JAR programme and the current YOT inspection cycle will both be completed by December 2008, but the learning and benefits from this joint inspectorate programme are already shaping our design of future assessment work. This needs to reflect the increasingly joined-up nature of community-based care provision across an authority area. We will be working with other regulatory partners to consider how children's health will be included in future assessment processes, for example as part of comprehensive area assessments (CAAs), and as a themed strand in Her Majesty's Inspectorate of Probation's proposed modified YOT inspection programme. We would aim increasingly to focus our expertise, for example by advising and supporting inspectors from other organisations where children's health is a consideration, such as for youth justice, safeguarding children and education and social care establishment inspections. We will seek to ensure that health service contributions to YOTs and health outcomes for children being assisted by YOTs will continue to be considered, and that the new CAA and other parallel programmes include robust assessment of health provision of this particularly vulnerable group of young people.

### **Safeguards**

We remain vigilant in our role of ensuring that children at risk are identified, while recognising the increasing role of local safeguarding children boards (LSCBs) in overseeing effective joint working and training around child protection and safeguarding issues. We invited LSCBs to provide a comment on trusts' core standards declarations in May 2008, and will continue with this engagement, providing input into our assessments wherever possible. We expect to publish in July the third Joint Chief Inspector's review on safeguarding children and young people jointly with OFSTED and other inspectorates and will support implementation of the recommendations arising from that work. We will monitor the declarations of trusts on core standard C2 and follow up as appropriate, should safeguarding concerns be raised, publishing our findings of this and other safeguarding work in our State of Healthcare report.

## **Incorporating the views of patients and the public into our assessments**

Patients and the public want to be involved in decisions about health and healthcare. Core standard C17 requires that trusts take the view of patients, their carers and others into account in designing, planning, delivering and improving healthcare services. We assess compliance with this standard as part of our regular assessment. People also want their views to count in assessments of healthcare organisations. In 2008/09 we will gather the views and experiences of patients and the public through:

- The national programme of surveys of patients. In 2008/09 the programme of surveys will continue to affect how we monitor trusts throughout the year (see appendix 3 for what we will cover).
- The new local involvement networks (LINks) due to have been established in April 2008 to provide a channel for local voices.
- Engagement with national and local voluntary organisations, and community-based and patient-led organisations, making special efforts to reach marginalised groups that are often most vulnerable to ill health and whose voices are seldom heard. We will put particular emphasis on this direct engagement since many of the new LINks have not yet been fully established and will not therefore have been in existence for the full assessment year.
- Commentaries received from overview and scrutiny committees and the boards of governors of foundation trusts.
- Ensuring that we involve patients in the design of our in-depth reviews.
- Using the analysis of the complaints that are referred to us and an indication of how well trusts are handling concerns raised by patients.

These views of patients feed directly into the information that we use to assess the risk that trusts are not compliant with the Government's standards.

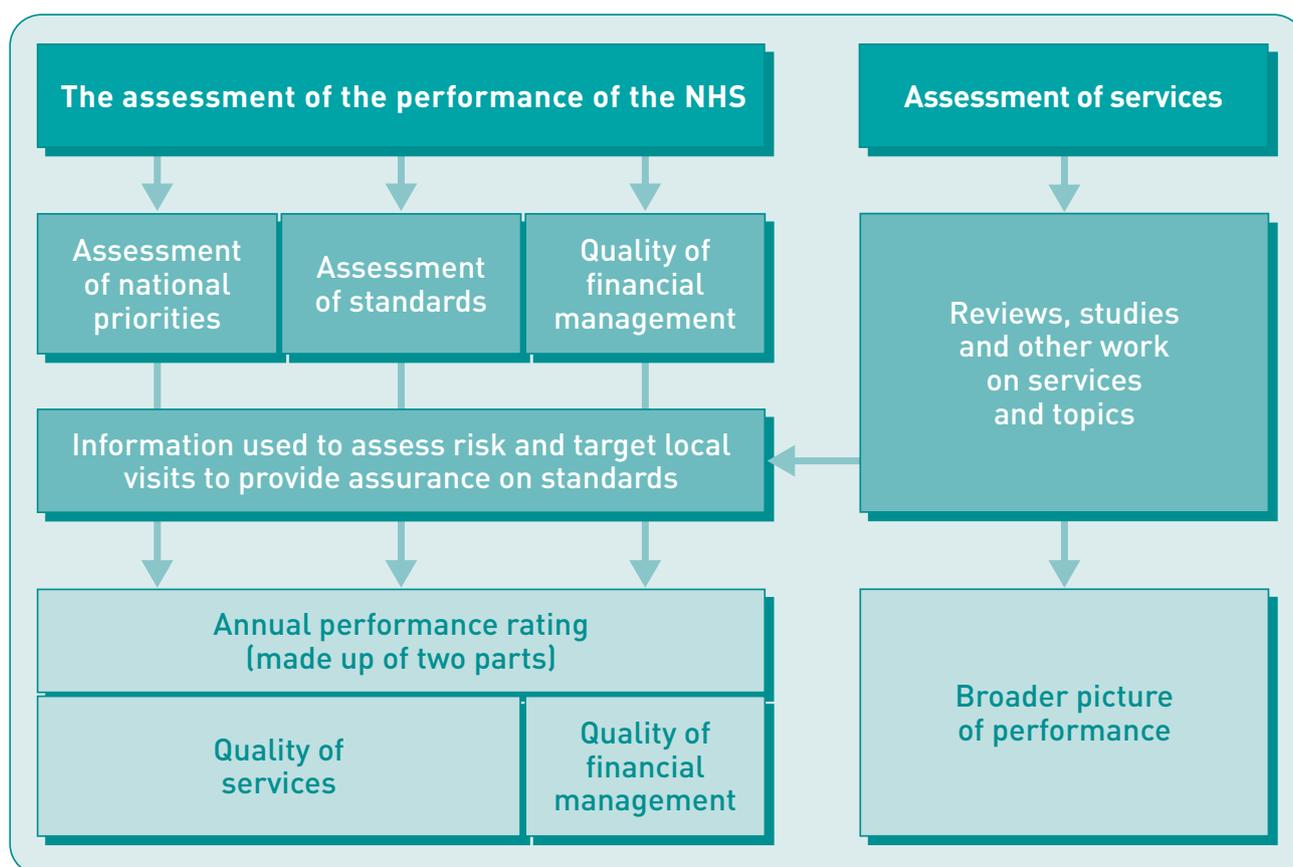
It is also important however, that we are responsive to the views of patients not just at the end of the year, when local organisations are formally invited to comment, but during the year, allowing us to respond quickly to patient concerns. We do this by feeding views passed from local groups and regional staff into our databases when we receive them. We then 'screen' the data through the year allowing new data to influence where we visit trusts.

We will also carry out a national study on patient and public engagement. This will focus on investigating the efforts that trusts and independent healthcare providers are taking to engage patients in the design of services. We will be finding out how effective this engagement is, and identifying the most successful strategies.

## Section 6: How the annual health check process works

The rated part of the annual health check is made up of a score for quality of services and a score for the quality of financial management (see figure 6). The quality of services score is itself made up of a score based on an assessment of the core standards and an assessment based on indicators. The quality of financial management, derived from work done by the Audit Commission for non-foundation trusts and Monitor for foundation trusts, forms the second part of the rating and is presented separately. The structure of the rating is a little different for PCTs this year reflecting the separation in their provider and commissioner functions and this is explained more fully on page 25.

**Figure 6: The annual health check in 2008/09**



### The assessment based on standards

Trust boards are responsible for ensuring that the governance and the services provided by their trust comply with the standards laid down by the Government. In April 2009 they will, as previously, be required to declare to what extent they comply with the standards and we will use this as the basis for our assessment.

## Section 6: How the annual health check process works (Continued)

Each year, we publish the criteria on which they should base that declaration, and for 2008/09 we aim to do this later in the summer – earlier than in previous years. For provider trusts we are not expecting any significant changes from 2007/08. For PCTs the revised criteria will reflect the separation in the assessment of their provider and commissioning functions.

### Information for trust boards

As in 2007/08, we will provide a small set of benchmark indicators to show the performance of the trusts in relation to similar trusts on aspects of safety and quality. We expect this information to be useful to trust boards, along with data that is available locally to them, when reviewing their compliance with the standards. We intend to provide this information for acute and mental health trusts.

### Cross-checking the declarations

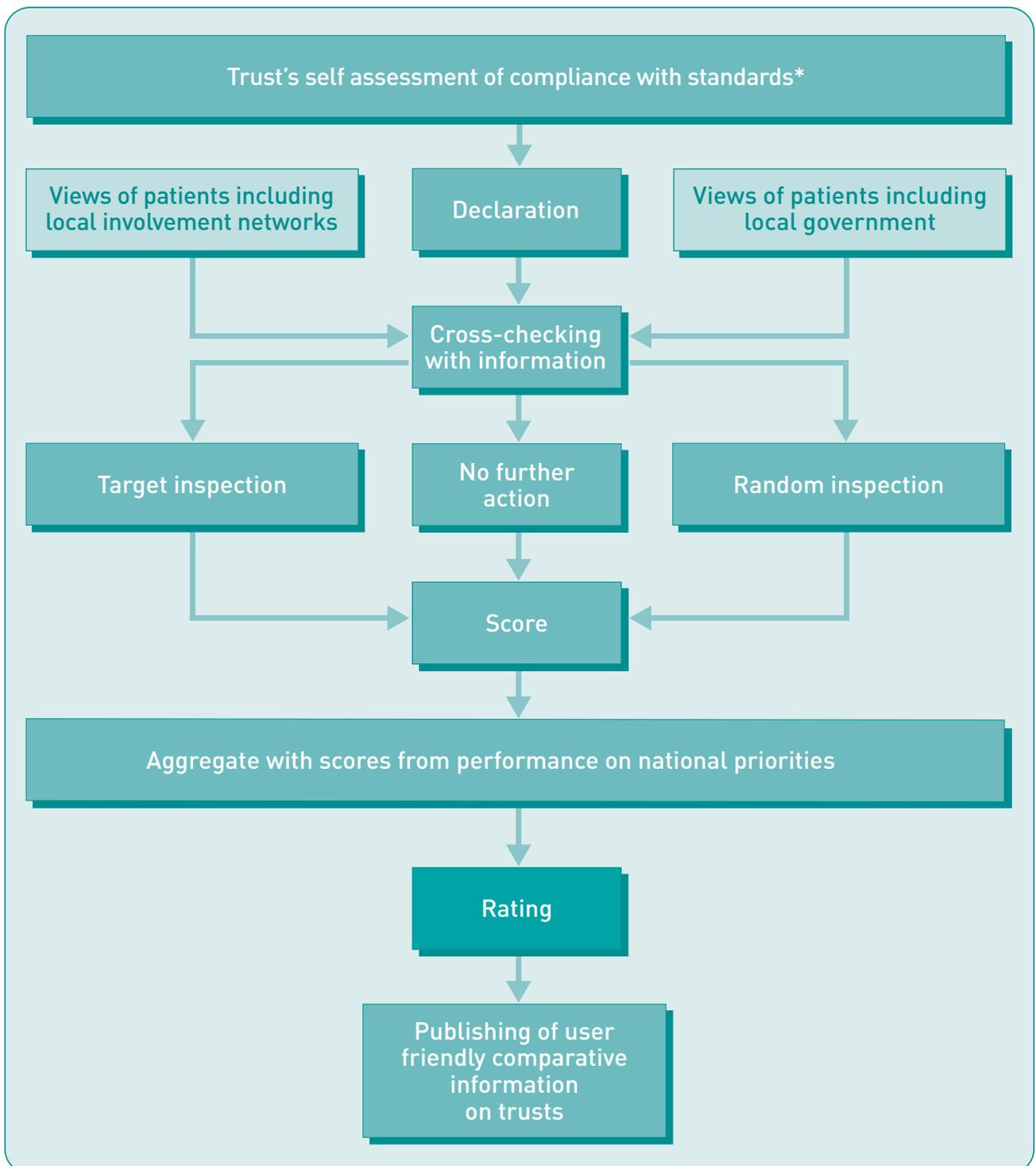
We cross-check declarations made by trust boards against the nationally available data that we hold, including the set of indicators we issue to trust boards (described above). An important part of this information comes from the comprehensive programme of patient and staff surveys (described in appendix 3). In 2008/09 we will also use the commentaries obtained from the new local involvement networks and the views of the public through local government overview and scrutiny committees. This year, we will also be asking our regional staff to engage with local and national voluntary groups and to make particular efforts to reach vulnerable and marginalised groups and to feed this information back into our databases.

On the basis of this information, we form an assessment of the risk of any undeclared non-compliance with the standards by a trust. We then identify a group of trusts for a visit from this assessment and another group that are identified at random.

Since these visits will not be conducted until after April 2009, we expect that the Care Quality Commission will take the responsibility for carrying them out.

The inspections are primarily designed to detect areas of undeclared non-compliance by trusts and, in doing so, safeguard the interests of patients. If an inspection detects an area of lack of assurance of compliance and the trust had declared that it was assured of compliance for that standard, the declaration is qualified. Performance on compliance with the standards is scored and aggregated with the score on national priorities forming the quality of services score.

**Figure 7: How the annual health check rating is derived**



## Section 6: How the annual health check process works (Continued)

### **Following up on non-compliance with standards**

Just asking for a declaration at the end of the year on compliance with the standards is, we believe, insufficient to safeguard the interests of patients. Following the publication of the 2006/07 ratings in October 2007, we visited all trusts that scored “weak” on both their quality of services and quality of financial management score. We invited representatives of the relevant strategic health authorities to these meetings. The meetings were to ensure that strategic health authorities were aware of action plans for addressing non-compliance and to ensure that they would follow up with the trusts concerned.

It is important that we maintain our focus on driving compliance with the current standards over the next year in preparation for the new regulatory arrangements planned by the Government. We therefore intend, once more, to visit all trusts that score “weak” on the quality of services score in the 2007/08 annual health check and follow up on declared non-compliance with standards. We will again involve Monitor and the strategic health authorities in these meetings to ensure that they are engaged through their performance management role for trusts in driving compliance with the standards.

### **Monitoring performance through the year**

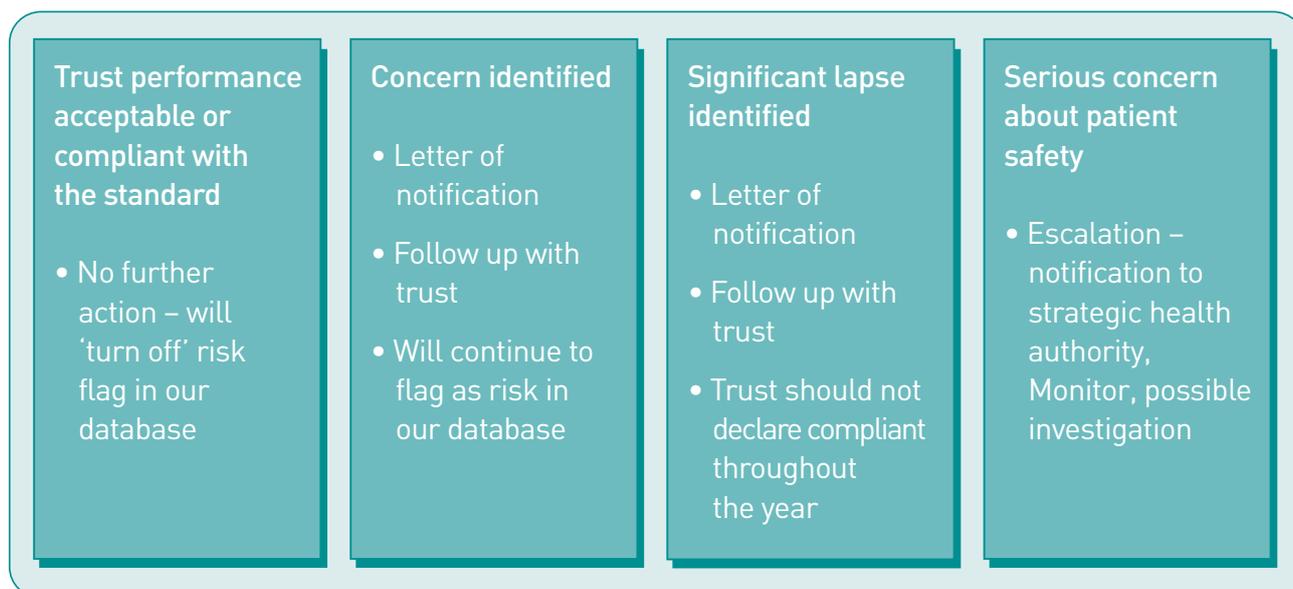
We also use all the information that we hold to monitor the performance of trusts during the year. We keep it up to date, feeding in new data as it becomes available. We analyse hospital episode statistics, looking particularly for unusual results, such as unexpectedly high mortality rates given the type of patients being treated, or for trends where performance appears to be deteriorating. Sometimes this information is produced via our work on services and topics. A particularly important source is the views of patients and the public that are fed in through our local representatives.

We make periodic checks on this data to see if it raises concerns about particular standards or aspects of performance and, if necessary, visit a trust.

We also visit trusts to check on compliance with the hygiene code. We will visit all acute trusts during the year and will extend the programme to cover the non-acute sector on a risk basis.

Any of these visits may result in one of the outcomes shown in figure 8.

**Figure 8: Possible outcomes of visits to trusts**



**Assessment based on indicators: existing commitments and national priorities**

In 2008/09 we have developed rounded sets of indicators that we will use to rate trusts. For PCTs these are (with one exception) drawn from the vital signs framework and existing commitments. For all the other trusts, the indicators have been developed to be compatible with the vital signs framework. We have already published the rationales for our choice of indicators together with the sources. Detailed constructions however, will be published later in the year. In some cases this is because we are working to ensure that common constructions are used for all partners in the comprehensive area assessment.

The scores for these rated indicators are aggregated with the score from the standards-based assessment to provide the quality of services part of the rating.

We expect the results of the annual health check to be published by the new Care Quality Commission in the autumn of 2009.

# Appendix 1: Indicators\*\*

## Primary care trusts – commissioning indicators

### Existing commitments

Diabetic retinopathy screening\*

Access to GUM clinics\*

Category A calls meeting 19 minute standard\*

Category A calls meeting 8 minute standard\*

Category B calls meeting 19 minute standard\*

Time to reperfusion for patients following a heart attack\*

Delayed transfers of care\*

Commissioning of early intervention in psychosis services\*

Commissioning of crisis resolution/home treatment services\*

Total time in A&E\*

Outpatients waiting longer than the 13 week standard\*

Inpatients waiting longer than the 26 week standard\*

Patients waiting longer than three months for revascularisation\*

Data quality on ethnic group\*

### National priorities

Stroke care

Teenage pregnancy rates\*

Chlamydia screening (as a proxy for chlamydia prevalence)

Childhood obesity rate

Four week smoking quitters\* (as a proxy for smoking prevalence)

Reduction in <75 CVD mortality rate\*

Reduction in <75 cancer mortality rate\*

All age all cause mortality

Suicide and injury of undetermined intent mortality rate: we are continuing to explore possible data sources to assess this commitment

Commissioning a comprehensive CAMHS\*

## Primary care trusts – commissioning indicators (continued)

### National priorities

Incidence of Clostridium difficile

18-week referral to treatment times\*

All cancers: two week wait\*

All cancers: one month diagnosis to treatment\* (including new cancer strategy commitment)

All cancers: two-month GP urgent referral to treatment\* (including new cancer strategy commitment)

Breast cancer screening\*

Access to primary care\*

Experience of patients\*

Drug users in effective treatment

NHS staff satisfaction

Access to primary dental services

Prevalence of breastfeeding at 6-8 weeks from birth: data coverage

Pregnant women: 12-week maternity appointment

Immunisation coverage (children)

\* Indicators that were in place for the 2007/08 targets assessment. Please note that there may be changes to the constructions.

\*\* There are a small number of indicators in this list that were not in our consultation. They are included to reflect the requirements for trusts set out in the Department of Health's operating framework for the NHS.

## Appendix 1: Indicators (Continued)

### Acute and specialist trusts

The scoring methodology, including the potential weighting of individual indicators, is to be developed. The methodology will reflect a balance across the indicators set in line with the national priorities set out in the operating framework.

	2008/09 acute indicator	Existing commitment	National priority
Health and wellbeing	Infant health and inequalities: smoking during pregnancy and breastfeeding initiation*		✓
	Access to genito-urinary medicine (GUM)*	✓	
	Data quality on ethnic group*	✓	
	Experience of patients – health and wellbeing domain(s)		✓
Clinical quality	Participation in heart disease audits		✓
	Time to reperfusion for patients following a heart attack*	✓	
	Engagement in clinical audits		✓
	Stroke care*		✓
	Experience of patients – clinical quality domain(s)		✓
	Maternity Hospital Episode Statistics: data quality indicator		✓
Safety	Incidence of MRSA*		✓
	Experience of patients – safety domain(s)		✓
	Incidence of <i>Clostridium difficile</i> *		✓

## Acute and specialist trusts (continued)

	2008/09 acute indicator	Existing commitment	National priority
Patient focus and access	Delayed transfers of care*	✓	
	18-week referral to treatment times*		✓
	All cancers: two-week wait*		✓
	All cancers: one month diagnosis to treatment (including new cancer strategy commitment)*		✓
	All cancers: two-month GP urgent referral to treatment (including new cancer strategy commitment)*		✓
	Total time in A&E*	✓	
	Experience of patients – patient focus and access domain(s)		✓
	Outpatients waiting longer than the 13-week standard*	✓	
	Inpatients waiting longer than the 26-week standard*	✓	
	Patients waiting longer than three months for revascularisation*	✓	
	Waiting times for rapid access chest pain clinic*	✓	
	Cancelled operations and those not admitted within 28 days*	✓	
	NHS staff satisfaction		✓
	<b>Total</b>		<b>10</b>

\* Denotes indicator that was an indicator in 2007/08. Please note that there may be changes to the construction.

2007/08 total number of indicators: 25

## Appendix 1: Indicators (Continued)

### Ambulance trusts

2008/09 ambulance indicator	
Clinical quality	Management of acute myocardial infarction
	Management of hypoglycaemic attacks
	Management of asthma
	Management of patients with cardiac arrest
	Management of stroke and transient ischaemic attack
	Time to reperfusion for patients who have had a heart attack*
Safety	Repair and safe environment of ambulances
Patient focus and access	Category A 8 minute ambulance response times*
	Category A 19 minute ambulance response times*
	Category B 19 minute ambulance response times*
	Experience of patients/users
	NHS staff satisfaction

\* Denotes indicator that was an indicator in 2007/08. Please note that there may be changes to the construction. Given the importance of meeting the targets on response times, we envisage that an ambulance trust will not receive a score of "excellent" if it is not meeting these targets.

2007/08 total number of indicators: 9

## Mental health trusts (including PCTs that provide mental health services)

The scoring methodology, including the potential weighting of individual indicators, is to be developed. The methodology will reflect a balance across the indicators set in line with the national priorities set out in the Operating Framework.

2008/09 mental health indicator	
Health and wellbeing	Data quality on ethnic group*
	Experience of patients – health and wellbeing domain(s)
Clinical quality	Patterns of care from the Mental Health Minimum Dataset (MHMDS)
	Completeness of the mental health minimum data set (MHMDS)
	Access to crisis resolution home treatment (CRHT)*
	Child and adolescent mental health services (CAMHS)
	Experience of patients – clinical quality domain(s)
Safety	Proportion of people receiving follow-up contact within seven days of discharge from hospital
	Experience of patients – safety domain(s)
Patient focus and access	Delayed transfers of care
	Best practice in mental health services for people with a learning disability (green light toolkit)
	Experience of patients – patient focus and access domain(s)
	Drug users in effective treatment*
	NHS staff satisfaction

\* Denotes indicator that was an indicator in 2007/08. Please note that there may be changes to the construction.  
2007/08 total number of indicators: 10

## Learning disability trusts (and all trusts that provide learning disability services)

### 2008/09 learning disability indicator

---

Number of people with a care plan

---

Campus provision

---

Delayed transfers of care

---

Data quality on ethnic group

### Amendments to thresholds – general rounding principle

The Healthcare Commission has, along with Monitor, historically applied a general rounding principle to the thresholds used to assess performance on indicators. For example, a trust would be deemed to have achieved a 98% target if its performance was 97.5% or above.

In 2008/09, again in common with Monitor, we are not intending to apply this principle in general. For example, a trust would have to reach performance at or above 98% to achieve the four-hour total time in A&E target. This is a particularly meaningful example, as significant numbers of patients are involved. Allowing 0.5% rounding means that large number of patients may wait longer than four hours.

Exceptions will however be considered on an individual indicator basis, taking into account issues such as low activity or thresholds that have little or no tolerance, such as those set at 99-100%.

## Appendix 2: Our programme of work on services or aspects of care

Reviews and studies provide detailed probes into areas not specifically covered in the annual performance rating. They are instrumental in bringing about improvement and providing information that patients want. We have different approaches to carrying out reviews and studies for specific services and topics. The approach selected depends the nature of the topic, on the availability of data and other issues.

Reviews include assessment of individual organisations and range from service reviews that provide a score for every organisation involved to targeted inspections. Findings from reviews are not used to calculate the annual performance ratings, but are published separately. Studies are aimed at assessing performance from a national rather than a local perspective and at disseminating guidelines for good practice.

Detailed information from reviews and studies is also used to assess risk as part of our ongoing assessment of standards.

We propose to carry out in-depth reviews in the following areas:

### **Learning difficulties**

This will be joint work with the Commission for Social Care Inspection on the commissioning arrangements for the care of people with learning difficulties. It aims, among other things, to assess the degree of good partnership working across health and social care. We are planning this work because of concerns identified in our recent audit of the provision of learning disability services in healthcare organisations.

### **Medicines management within general practice after discharge**

This work will assess primary care trusts' (PCTs') effectiveness at promoting the safe care of patients following their discharge from hospital (for example the extent to which they analyse GP performance and improve it through such things as commissioning and better use of pharmacists). It will test the action GPs take in response to discharge information (the arrangement for monitoring for side-effects and interactions and altering repeat prescriptions). We are planning this work because available information suggests that this is a key area of risk for patients.

National studies are planned in the following areas:

### **Patient and public engagement**

The work will explore the range of approaches and methods healthcare organisations (including independent healthcare) currently use to engage patients and the public in designing, delivering and improving health services. It will comment on how effective and useful patients and the public find these various techniques. It will also seek to identify

## Appendix 2: Our programme of work on services or aspects of care (Continued)

what things help organisations to achieve effective engagement and the impact this engagement can have on creating more personalised healthcare services. We plan to undertake this work because of the importance of patient input to healthcare services.

### **Disabling factors in health**

This work will explore the physical and attitudinal barriers that are faced by disabled people when accessing healthcare. It will do this from the perspective of individual services rather than individual groups of people affected, so that the complex solutions needed for each service can be properly explored. This work is being undertaken to provide assurance that services are effectively taking on the needs of all groups of patients.

### **Health inequalities**

This work will focus on the performance of PCTs in the reduction of health inequalities using coronary heart disease (CHD) as an example. The study will look at the prescribing of statins and achievement of smoking quit rates at PCT level in relation to the prevalence of CHD and life expectancy for each PCT. It will be based on newly available CHD prevalence estimates calculated by the Eastern Health Observatory.

### **Access to psychological therapies**

This will draw together existing information from previous work, ongoing clinical audit work and from other significant work outside the Healthcare Commission, such as the London School of Economics, report on depression and recent Department of Health initiatives. It will highlight gaps in the information available. This is being done to summarise the current position in this important area and the actions that healthcare bodies should be taking.

We will also be working with the National Audit Office on its end-of-life care project and plan to follow up selected previous service reviews using small sets of indicators.

In 2008/09 this will apply to:

- children's hospital services
- medicines management (acute sector)
- community mental health services.

## Comparative information

We also recognise that publishing comparative information about services can be instrumental in bringing about improvement.

In 2008/09 we will develop, in liaison with clinicians and service providers, structured sets of benchmark indicators in two different service areas:

### Children's health and healthcare services

The indicators will cover four main themes.

- Promoting health and wellbeing. These will include indicators on services such as screening provided to all children in order to promote health.
- Hospital care. These will be the indicators described above as follow up to our review of children's hospital services.
- Services for vulnerable children. These will include indicators in such areas as mental health and teenage pregnancy.
- Services for sick children. These will include indicators about children with long-term conditions or disability.

We expect these indicators to:

- Provide an overview of the risk profile of the PCT with respect to improving children's health and healthcare services.
- Inform trust boards about their comparative performance on a range of important indicators and trigger discussions about children's services at board level to foster improvement across the service.

### Stroke care and prevention

We will carry out exploratory work with clinicians, patients and other key stakeholders with the aim of developing a set of comparative indicators following the pathway of care experienced by patients with stroke.

We have been grateful for the support received for these topics from our consultation prior to this publication and also for other topics suggested for future work, which we will feed into our forward planning.

## Appendix 3: The programme of surveys of NHS staff and patients

Surveys of the experiences of patients are an important part of our work programme. Obtaining feedback from patients and taking account of their views and priorities is vital for bringing about improvements in the quality of care, and keeping patients at the centre of health services. In 2008/09, the survey programme is expected to include the following:

- People who use primary care services.
- Adults attending hospital accident and emergency departments.
- Adults recently discharged from inpatient care in acute or specialist hospitals.
- People in, or recently discharged from, mental health inpatient services.
- Subject to piloting, a survey of Category C ambulance service users.

We will also develop and pilot patient surveys in several new areas for possible roll-out in 2009/10. These might, for example, include a survey of outpatients.

We are also currently exploring the possibility of carrying out a survey of patients with long-term neurological conditions, for example, epilepsy. This will be a sample survey, so is not designed to assess the performance of organisations. We are planning however, to publish a report on the findings, giving a general assessment of service provision.

We will also coordinate the national NHS staff survey. This provides individual employers in the NHS, policy makers and national regulators with information about the attitudes and experiences of staff in the NHS. The information is used to assess the performance of NHS organisations as employers, and to monitor the implementation of national policies designed to improve the working lives of staff and, ultimately, to provide better care for patients.

### **How the findings contribute to the annual health check**

What patients and staff tell us through these surveys contributes to our system of ongoing performance assessment in relation to core standards. Each survey will contribute to one or more of our priority areas. The results from the surveys of patients' experience also form part of our assessment of performance in relation to Government targets.

We give the trusts detailed results from each survey. We also publish benchmark reports enabling the results to be compared between organisations over time, and a national summary of findings.

## Appendix 4: Summary of our assessments by sector

	Assessments used directly to calculate the annual performance rating	Assessments to give a broader picture of performance
<b>Mental health trusts</b>	<ul style="list-style-type: none"> <li>Standards (including hygiene code compliance)</li> <li>National priorities</li> <li>Quality of financial management</li> </ul>	<ul style="list-style-type: none"> <li>Survey of people in or recently discharged from mental health inpatient services</li> <li>Report on national study of access to psychological therapies</li> </ul>
<b>Ambulance trusts</b>	<ul style="list-style-type: none"> <li>Standards (including hygiene code compliance)</li> <li>National priorities</li> <li>Quality of financial management</li> </ul>	
<b>Acute trusts</b>	<ul style="list-style-type: none"> <li>Standards (including hygiene code compliance)</li> <li>Existing commitments and national priorities</li> <li>Quality of financial management</li> </ul>	<ul style="list-style-type: none"> <li>National Inpatient Survey</li> <li>Survey of adults attending hospital A&amp;E departments</li> </ul>
<b>Learning disability trusts</b>	<ul style="list-style-type: none"> <li>Standards</li> <li>Indicators</li> <li>Quality of financial management</li> </ul>	
<b>NHS Direct</b>	<ul style="list-style-type: none"> <li>Standards</li> </ul>	
<b>NHS Blood and Transplant</b>	<ul style="list-style-type: none"> <li>Standards</li> </ul>	
<b>Health Protection Agency</b>	<ul style="list-style-type: none"> <li>Standards</li> </ul>	

Appendix 4: Summary of our assessments by sector (Continued)

	Assessments used directly to calculate the annual performance rating	Assessments to give a broader picture of performance
Primary care trusts	<ul style="list-style-type: none"> <li>• Standards (including hygiene code compliance)</li> <li>• Existing commitments and national priorities</li> <li>• Quality of financial management</li> </ul>	<ul style="list-style-type: none"> <li>• Survey of people who use primary care services</li> <li>• End-of-life care</li> <li>• Prescribing medication for patients after their discharge from hospital</li> <li>• Commissioning of learning disability services</li> <li>• Health inequalities</li> </ul>





This publication is available in other formats and languages on request. Please telephone 0845 601 3012.

આ માહિતી વિનંતી કરવાથી અન્ય રૂપે અને ભાષાઓમાં મળી શકે છે.  
મહેરબાની કરી ટેલિફોન નંબર 0845 601 3012 પર ફોન કરો.

GUJARATI

ਇਹ ਜਾਣਕਾਰੀ ਬੈਨਤੀ ਕਰਨ 'ਤੇ ਹੋਰਨਾਂ ਰੂਪ 'ਚ ਅਤੇ ਜ਼ਬਾਨਾਂ 'ਚ ਮਿਲ ਸਕਦੀ ਹੈ।  
ਕ੍ਰਿਪਾ ਕਰਕੇ ਟੈਲਿਫੋਨ ਨੰਬਰ 0845 601 3012 'ਤੇ ਫੋਨ ਕਰੋ।

PUNJABI

यह जानकारी बिनती करने पर अन्य रूप में और भाषाओं में मिल सकती है।  
कृपया टैलिफोन नम्बर 0845 601 3012 पर फ़ोन करें।

HINDI

Akhbaartan waxaa lagu helaa iyadoo  
siyaabo iyo luqado kale ku qoran haddii la  
codsado. Fadlan soo wac lambarka telefoon  
ee ah 0845 601 3012.

SOMALI

Οι παρούσες πληροφορίες διατίθενται και σε  
άλλες μορφές ή γλώσσες εάν ζητηθεί.  
Τηλεφωνήστε στο 0845 601 3012

GREEK

المعلومات متاحة أيضاً لدى طلبها بعدد من الأشكال واللغات الأخرى.  
الرجاء الإتصال بهاتف رقم 0845 601 3012.

ARABIC

یہ معلومات درخواست کرنے پر دوسرے فارمیٹ یعنی شکلوں میں بھی دستیاب کی جاسکتی ہے۔  
برائے مہربانی فون کیجئے 0845 601 3012

URDU

如有需要，本信息还有其他格式和语言的版本。  
请致电 **0845 601 3012**。

CHINESE-SIMPLIFIED

如有需要，本信息還有其他格式和語言的版本。  
請致電 **0845 601 3012**。

CHINESE-TRADITIONAL

অনুরোধ করলে এই তথ্যগুলি অন্য ভাষা ও আকৃতিতে পাওয়া যাবে।  
অনুগ্রহ করে এই নাম্বারে ফোন করুন 0845 601 3012

BENGALI

Arzu edildiği takdirde bu bilgi değişik  
formatlarda ve dillerde verilebilir.  
Lütfen 0845 601 3012 numaralı  
telefonu arayınız.

TURKISH

Tin tức này có bằng những hình thức và ngôn  
ngữ khác theo yêu cầu.  
Hãy gọi phôn số 0845 601 3012

VIETNAMESE

È possibile richiedere le presenti informazioni  
su altri supporti o in altre lingue. A tal fine,  
telefonare allo 0845 6013012.

ITALIAN

Informacje te są dostępne na życzenie w  
innych formatach i językach.  
Prosimy zadzwonić pod numer 0845 601 3012

POLISH

## Healthcare Commission

Finsbury Tower  
103-105 Bunhill Row  
London  
EC1Y 8TG

Maid Marian House  
56 Hounds Gate  
Nottingham  
NG1 6BE

Dominions House  
Lime Kiln Close  
Stoke Gifford  
Bristol  
BS34 8SR

Kernel House  
Killingbeck Drive  
Killingbeck  
Leeds  
LS14 6UF

5<sup>th</sup> Floor  
Peter House  
Oxford Street  
Manchester  
M1 5AX

1<sup>st</sup> Floor  
1 Friarsgate  
1011 Stratford Road  
Solihull  
B90 4AG

Telephone 020 7448 9200

Facsimile 020 7448 9222

Helpline 0845 601 3012

Email [feedback@healthcarecommission.org.uk](mailto:feedback@healthcarecommission.org.uk)

Website [www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk)

This publication is printed on paper made  
from a minimum of 75% recycled fibre

ISBN 1-84562-195-7



9 781845 621957



Corporate member of  
Plain English Campaign  
Committed to clearer communication.

341