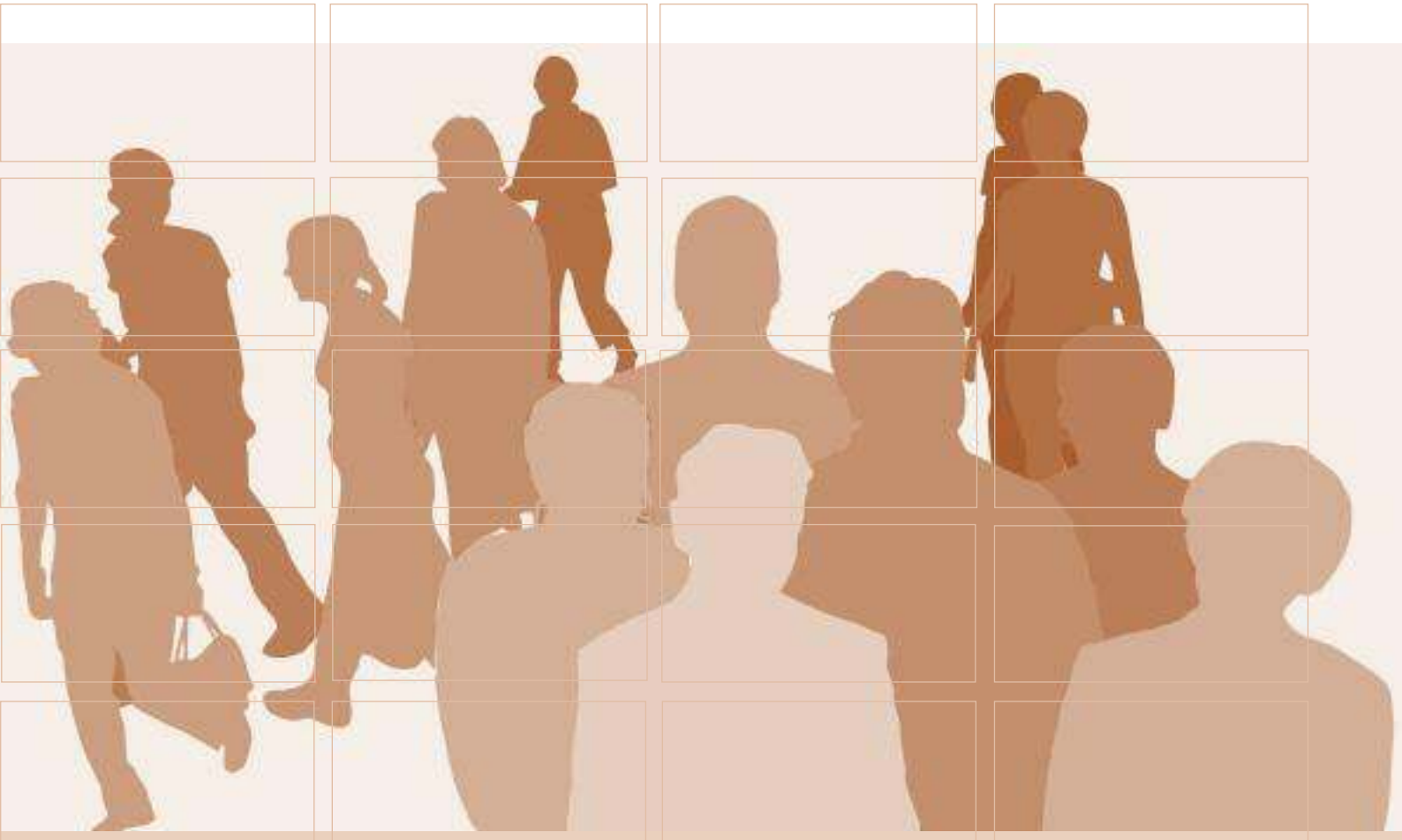
Inspecting Informing Improving

Healthcare Commission



Developing the annual health check in 2006/2007

Have your say

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About the Healthcare Commission

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

In England, we are responsible for assessing and reporting on the performance of NHS and independent healthcare organisations to ensure that they are providing a high standard of care. We also encourage providers continually to improve their services and the way in which they work.

Why we exist

Inspect
To inspect the quality and value for money of healthcare and public health

Inform
To equip patients and the public with the best possible information about the provision of healthcare

Improve
To promote improvements in healthcare and public health

How we work

We work closely with patients, carers, those who use and provide services, and with the public to maintain our focus on improving their experiences of healthcare

We promote the rights of all to opportunities to improve their health and to have good healthcare

Our approach to assessment 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

We are independent and fair in our decision-making and report what we do without fear or favour

We are accountable for our actions and for what we achieve in relation to our costs

Our responsibilities in England include:

- awarding annual performance ratings to NHS organisations
- carrying out reviews and investigations of healthcare
- coordinating reviews and assessments carried out by other bodies
- registering and inspecting providers of independent healthcare
- reviewing second stage complaints about the NHS
- reporting annually to Parliament on the state of healthcare in England and Wales

We are also required to pay particular attention to:

- the rights and welfare of children
- access to and the availability, quality and effectiveness of healthcare
- the availability and quality of information about healthcare
- the value for money of healthcare, including the economy and efficiency of services

The strategic goals of the Healthcare Commission

We have six strategic goals for 2005-2008.

1. To promote a better experience of health and healthcare for patients and the public through fair and credible systems for assessing and rating performance across the NHS and independent sector.
2. To safeguard the public by acting swiftly and appropriately on complaints, concerns and significant failings in the provision of healthcare.
3. To provide authoritative, independent, relevant and accessible information about what is going on in healthcare and opportunities for improvement.
4. To use our assessments and other activities to promote action to reduce inequalities in people's health and to improve their experiences of healthcare and access to services through greater respect for human rights and diversity.
5. To take a lead in coordinating and improving the impact and value for money of assessment and regulation in healthcare.
6. To support our people in creating an efficient, flexible and highly skilled organisation delivering world class assessment and regulation.

Introduction

The Healthcare Commission undertakes independent and patient-centred assessments of the performance of healthcare organisations, within a framework of national standards and targets set by Government.

On March 31st 2005, we launched the annual health check, an entirely new approach to assessing the performance of NHS organisations. The annual health check replaces the previous system of 'star' ratings and will provide a much richer picture of health and healthcare in England. It aims to:

- promote assurance that basic standards of care are being met
- ensure targeted, proportionate and local follow-up in response to causes for concern
- provide information to support better decision-making by individuals
- ensure that improvements in healthcare are always being sought and that healthcare services provide value for money

2006/2007 will be the second year of the annual health check. For 2005/2006, we have been focusing on whether healthcare organisations are 'getting the basics right', by measuring their performance in meeting the Government's targets and the core standards set out by the Department of Health in 2004 in *National standards, local action: Health and social care standards and planning framework 2005/2006-2007/2008*.

The Healthcare Commission recognises that the annual health check provides an important assurance that the basics are in place across the NHS. We also strongly believe that, in addition to providing a safeguard against poor performance, we should continue to promote improvement by stretching even the highest performing trusts.

From April 2006, we will therefore be looking more closely at whether NHS organisations are 'making and sustaining progress'. In line with the direction of travel set out in *National standards, local action*, this will for the first time include an assessment of trusts' performance in relation to the Department of Health's developmental standards.

> *"Service provision which only meets the core standards will be no more than acceptable. The focus of attention, both on the part of Healthcare Commission in its annual reviews and trusts themselves, will be on progress against the developmental standards."*
>
> ***Department of Health 2004***

We also carry out a small number of reviews as part of the annual health check, which provide a more in-depth view of areas of priority, such as community mental health services. The emphasis in these reviews is on services that are provided to particular groups of patients across different organisations. Where appropriate, we will work together with the Commission for Social Care Inspection to review services across health and social care.

This consultation document sets out our proposals for assessing the performance of healthcare organisations in England in 2006/2007 and asks for your comments on the different aspects of our approach. We would particularly like your feedback on our proposed approach to measuring improvement in NHS organisations by reference to the Government's developmental standards, which are designed to drive up the quality of care that patients receive.

This document also provides an update on how the annual health check has developed in 2005/2006 and provides details of some further developments that we are considering for future years.

In developing our proposals, for 2006/2007 we have taken account of changes in the Government's policy on health and social care, and in the structure and management of the NHS. These changes have been summarised by the Department of Health in *Health reform in England: Update and next steps* (December 2005).

The Department of Health's recent white paper, *Our health, our care, our say: A new direction for community services*, confirmed its intention to merge the Healthcare Commission and Commission for Social Care Inspection within the context of the wider review of regulation. The conclusions of this wider review are expected in the spring of 2006. The Department of Health has also confirmed that the Healthcare Commission and the Mental Health Act Commission will merge. We are already working closely with the Commission for Social Care Inspection and the Mental Health Act Commission, and will continue to do so throughout 2006/2007.

The Healthcare Commission is committed to collaborating with its partners in all aspects of its work. In particular:

- with respect to the annual health check, we aim to work in partnership to provide patients and the public with a richer picture of performance and to reduce unnecessary requirements on NHS trusts arising from the actions of a number of bodies
- we have a specific statutory duty to promote the effective coordination of reviews and assessments carried out in relation to the provision of healthcare. In June 2004, 10 bodies concerned with inspection, regulation and audit in healthcare published a Concordat, which aims to deliver these objectives (more information about the Concordat and the signatories is available on our website)
- we are working particularly closely with the Commission for Social Care Inspection, the Audit Commission and the National Audit Office in planning our work, to avoid duplication, maximise benefits and reduce unnecessary burdens
- as greater numbers of trusts achieve foundation trust status, we will continue to work closely with Monitor. Both parties recognise the need to ensure a clear and transparent regulatory environment for NHS foundation trusts, and to share each other's findings wherever possible. The Healthcare Commission uses Monitor's financial risk ratings for NHS foundation trusts in its assessments of use of resources. Further work is underway to ensure that other findings can be shared, particularly in relation to the clinical performance of NHS foundation trusts

Further priorities for next year include:

- strengthening our emphasis on how well organisations are commissioning services
- further developing our approach to reflect the Department of Health's plans to reform and improve services that are provided in primary care and community settings
- strengthening our approach to assessing value for money, with a focus on aspects of reform, such as the introduction of payment by results, and how individual trusts ensure value for money
- developing new tools to support the introduction of patient choice and continuing to produce information as part of our assessments that is readily accessible to patients and the public, as well as those who commission and provide services

Consultation question

1. Do you agree that these further priorities are the right ones for 2006/2007?

The Department of Health outlined the priorities and expectations for progress in implementing reforms and improving services in 2006/2007 in *The NHS in England: The operating framework for 2006/2007*. In addition to robust financial health, the framework identifies six specific areas of priority:

- reducing inequalities in health
- cutting waiting times for treatment for cancer
- reducing waiting times from GP referral to hospital treatment
- reducing levels of methicillin resistant Staphylococcus aureus (MRSA)
- improving patient choice
- improving sexual health

We will assess and report on the progress of NHS organisations in relation to each of these priorities as part of the annual health check and our wider assessments of health and healthcare (see appendix A for further details).

This document forms part of a wider consultation on the work of the Healthcare Commission, and builds on the previous consultation on our systems of assessment, which was crucial to shaping our approach in 2005/2006. We have also published a number of other documents in which we also asking for feedback. They are:

- *Aligning our assessments of the NHS and independent healthcare sectors*
- *Regulatory fees for the independent healthcare sector*
- *Engaging with patients and the public*

These three documents are available on our website at **www.healthcarecommission.org.uk/consultation.** For details on how you can 'have your say' see page 22.

Understanding the annual health check

Our annual health check is an entirely new information-led and risk-based approach to assessing and reporting on the performance of NHS organisations. It measures performance within a framework of national targets and standards published by the Government.

National standards, local action sets out 24 core standards and 13 developmental standards for NHS organisations. These standards were introduced in 2004 and cover seven 'domains' of activity:

- safety
- care environment and amenities
- clinical and cost effectiveness
- governance
- patient focus
- acœssible and responsive care
- public health

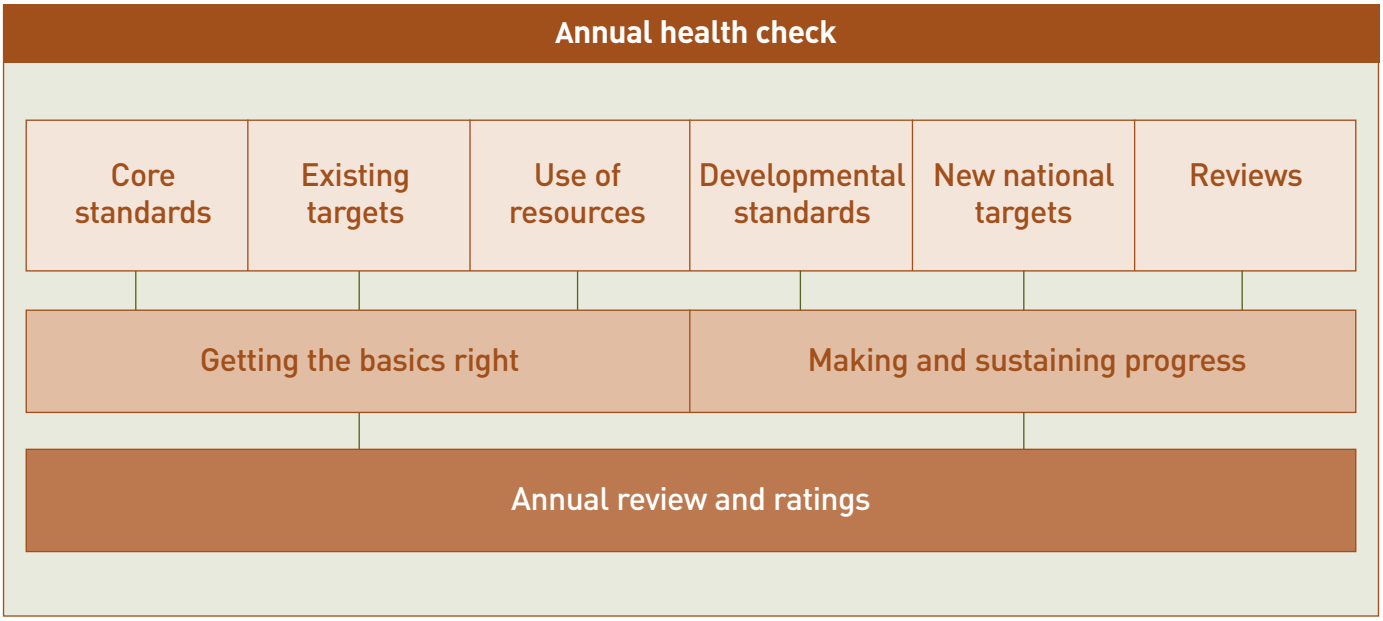
Our annual health check assesses whether healthcare organisations are meeting, or making progress in relation to, the standards that are relevant to these seven domains. It also looks at services that are provided across healthcare organisations, paying particular attention to issues relating to equality, diversity and human rights, and the experiences of children, older people, people with long term conditions, and people with mental health problems.

Our annual health check is designed to help us to answer two questions:

- are healthcare organisations getting the basics right?
- are healthcare organisations making and sustaining progress?

Figure 1 shows the framework of assessment for the annual health check.

Figure 1: The framework of assessment for the annual health check



Note: Assessment of progress in relation to developmental standards will be a new element of the annual health check in 2006/2007.

The components of the annual health check

The following three components help us to assess whether healthcare organisations are 'getting the basics right'.

1. Core standards – these are the basic standards of care that the Government says all healthcare organisations should meet. Our annual health check requires trusts' boards to make a public declaration on the extent to which their organisation meets these core standards. We then check their declarations against the views of overview and scrutiny committees, patient groups and the information that is already available in relation to performance.
2. Use of resources – this part of the annual health check assesses how well trusts are using their resources and whether they are achieving value for money.
3. Existing targets – the Government's existing targets are similar to core standards in that they set out the basic level of service that organisations should be providing. The targets measure a specific outcome for patients and the public (such as shorter waiting times), rather than a general standard (such as safe equipment). The majority of existing targets should be achieved before March 2006 and should continue to be met after this date.

Determining whether healthcare organisations are 'making and sustaining progress' also involves three components.

1. Developmental standards – these standards set a direction of travel for trusts, helping them to continuosly improve their services and to meet increasing expectations from patients and the public. Our annual health check will start to assess the progress of trusts in relation to the developmental standards and in adopting best practice.
2. New national targets – the Government's new national targets set out the future priorities for the NHS. They focus on improving health and healthcare and should be achieved between 2008 and 2010.
3. Programme of reviews – the programme of improvement reviews and reviews in the acute hospital portfolio provide more in-depth, patient-centred assessments of performance and outcomes in a small number of areas of priority. Improvement reviews are particularly concerned with the experience of patients as they move between healthcare organisations (for example, from a GP to a hospital) and between health and other sectors (especially social care).

An improvement review is a review of a particular aspect of healthcare that is carried out in relevant organisations. It can be carried out in a variety of settings, looking at the pathways of care that patients follow and services provided to groups of patients. Reviews in the acute hospital portfolio examine healthcare organisations at a local level by reference to value for money and quality of care. All of these reviews will identify key indicators, which we propose to measure regularly as part of the annual health check. This information will help us to build a better picture of health and healthcare, and to identify trends, areas for concern and good practice across the NHS.

Under the Health and Social Care Act 2003, the Commission is required to award performance ratings to each NHS body, by reference to criteria approved by the Secretary of State for Health. Our annual health check is the means by which we fulfil this duty.

The annual health check in 2005/2006

The annual health check is being carried out for the first time in 2005/2006.

In assessing whether NHS trusts are 'getting the basics right', trusts' boards were asked to complete a draft declaration in October 2005 which declared the extent to which they believed that they were meeting the core standards. Patient and public involvement forums and overview and scrutiny committees were also asked to comment on the performance of trusts in meeting core standards. The draft declaration was intended to build a shared understanding with patient groups, local communities, and the NHS of what the standards require and how the new assessment will operate. Trusts' boards will be asked to complete a final declaration on their performance in 2005/2006 by May 4th 2006.

A wide range of data will be used to cross check the declarations. Where concerns are raised as a result of declarations not matching the other information available to the Healthcare Commission, and in a random sample of declarations, we will carry out follow-up discussions and, in some cases, visits with trusts.

For 2005/2006, the annual health check also begins to assess particular aspects of improvement in healthcare. It does this by looking at the progress of trusts in meeting national targets, and through our programme of improvement reviews and the acute hospital portfolio. It does not include an assessment of progress in relation to developmental standards.

We are committed to delivering an annual health check that provides meaningful information for patients, the public, and those who commission and provide services. We have therefore agreed with the Secretary of State that in 2005/2006 we will publish performance ratings across two elements: 'use of resources' and 'quality'. We recognise that good financial management is absolutely necessary for the provision of good quality care and these elements will therefore be closely linked. However, by reporting across the two elements, we believe the ratings will provide more meaningful information for patients and the public about the quality of services while maintaining a strong emphasis on the use of resources.

Further information about how all the components of the annual health check will be scored and aggregated to produce the ratings which will be published on our website shortly. The full assessment of the performance of each organisation for 2005/2006 will be published in October 2006.

The Healthcare Commission has commissioned an independent evaluation of the impact of the annual health check. By impact, we mean the costs, benefits and any other direct or indirect consequences, whether they are planned or unplanned. We are asking trusts to distinguish (where possible) between the impact of compliance with the Department of Health's standards and any additional impact of the Healthcare Commission's assessment of performance. This evaluation will be approached in a variety of ways and will focus on the experiences of patients in NHS trusts because this is where improvement to care (the intended impact) will be felt.

We aim to learn, from the evaluation and from those affected by and interested in our work, how to make our process more effective, efficient and as risk-based as possible. Part of this means making sure that any changes to our system of assessment are evolutionary rather than revolutionary. This will ensure that no one has to grapple with radical change each year and will enable the annual health check to focus more strongly on improvements being made over time.

Our proposed approach in 2006/2007

In 2006/2007, we expect the main components of the annual health check to remain largely unchanged. We will continue to assess the performance of trusts in meeting core standards and targets set by the Government. We will also use the lessons that we have learned throughout this first year to ensure that the annual health check provides further improvement in health and healthcare and to improve the process for everyone involved. The main evolution for 2006/2007 is the inclusion of an assessment of progress in relation to some of the Government's developmental standards.

Key differences in 2006/2007

There will be some key differences in the annual health check in 2006/2007. In particular, we will:

- focus more on improvement – for example, by adding an assessment of progress in relation to some aspects of the developmental standards as part of the annual health check
- address more strongly the commissioning of services and the role of organisations that commission services throughout our work, linking with the work of other organisations where appropriate
- use more extensively the information, judgements and expertise of other bodies engaged in review, audit and inspection to feed into and enrich the annual health check
- be more proactive in our work – for example, by using surveillance information to ask questions about areas of risk during the year and by developing a review of leadership and organisational capability which we will use when there are systemic problems in an organisation

In awarding performance ratings for 2006/2007, we are considering ways in which the annual health check can continue to provide more meaningful information for patients, the public, commissioners and providers of services, building on our decision to publish ratings across two elements in 2005/2006, 'use of resources' and 'quality'.

We have identified four high level questions that we believe the annual health check should attempt to answer in 2006/2007:

- is care safe and clinically effective?
- are services accessible and patient focused?
- is public money used efficiently and effectively?
- is action being taken to improve and protect the health of local people and tackle inequalities?

We believe it would be possible to provide useful information with respect to each of these questions by drawing on the various components of the annual health check, including the seven domains of the core and developmental standards.

Consultation question

2. In the context of the proposal to publish ratings across different elements, have we identified the right questions for the annual health check to answer in 2006/2007?

The main changes to the annual health check in 2006/2007 are summarised in appendix B. More detailed information about our proposed changes and further questions for consultation are set out in the following sections of this document.

Getting the basics right

Core standards	Use of resources	Existing targets

Core standards

We are not proposing to make any significant changes to the assessment of compliance with core standards in 2006/2007. We will take account of what we have learned so far from the first year of the annual health check. We will also adjust the process in light of the changes in Government policy and in the structure of the NHS, for example, with respect to the commissioning of services.

As planned, we will not call for a draft declaration stage in October 2006. Our regional offices will use available data during the year to highlight areas of risk and to identify action already being taken to address these risks. The declaration in April 2007 will provide an overall statement of assurance by the trust that the standards are in place, with any standards that have not been met being reported by exception. In addition, we will require that this high-level statement include a declaration of the extent to which the trust can assure that it will continue to meet the core standards over the coming year, and that any major risks affecting compliance are being managed appropriately.

In April 2007, subject to Parliamentary approval of the Health Bill, the code of practice on the prevention and control of healthcare associated infections will come into effect. We will be considering how this will impact on subsequent declarations by trusts.

We appreciate that 2006/2007 will be a time of transition for many NHS trusts, particularly those facing organisational change. We recognise these challenges and aim to balance this with the continuing need for public assurance about the quality of services. It is essential that patients continue to get care that is of high quality while these organisational changes happen. That is why we will expect the boards of new organisations to provide assurance in respect of their predecessor organisations, as they did in 2005/2006. We will also encourage the 'shadow' boards to take early action to establish the risks for their new organisations in relation to compliance with core standards. We will consider whether we should be asking them to provide an appropriate assurance shortly after re-structuring.

In line with the Department of Health's recent white paper, we recognise that the views and experiences of patients and the public must play an important part in the regulation and inspection of healthcare.

Further to the proposals outlined in our 2005/2006 annual health check document, *Measuring what matters*, we will continue to strengthen our approach to engaging patients and the public. We will learn from the process of the draft declaration and will develop, through two pilot projects (in Yorkshire and the south west), new ways of involving a wider range of patient-led and community-based groups.

Working with people in the areas of the pilot projects, especially those whose voices are seldom heard, we will build models to engage effectively with local people as well as healthcare organisations. These models will be tested and adapted for use in other areas. Lessons from the pilots will help us to build effective partnerships between patients, the public and healthcare organisations, to strengthen the annual health check and to ensure that our assessments focus on what matters to patients and the public. We will also be looking to strengthen our approach in relation to equality and human rights as part of the assessment of compliance with core standards. This will include a review of trusts' compliance with the publication requirements

of the Race Relations (Amendment) Act 2000. We will work towards using the assessment of compliance with core standards to assess more rigorously commissioning and commissioners. We already hold commissioners to account to some degree, by assessing whether they have developed appropriate mechanisms through which they could identify and, where appropriate, respond to any significant concerns relating to the services that they commission.

Our aim is to achieve a set of measures that accurately reflect the quality of commissioning. Together with the Commission for Social Care Inspection, we will work with the Department of Health to develop a 'fitness for purpose' toolkit for primary care trusts (PCTs). This toolkit will take account of plans to restructure PCTs, the introduction of practice-based commissioning, and the need to ensure greater emphasis on joint commissioning by PCTs and local authorities. This will inform the development of our annual health check around commissioning.

Only when we have appropriate measures will we be able to measure the things that matter to patients as well as providing an independent view on whether commissioners are making good use of public money to improve the health of the populations that they serve. We will work more closely with other regulators (especially the commission for social care inspection (CSCI) and the Audit Commission) to ensure that our measures cover all methods of commissioning including joint commissioning and practice based commissioning.

During 2006/2007, we will also further develop our approach to reflect the Department of Health's plans, outlined recently in the Government's white paper, to reform and improve services that are provided in primary and community settings by enhancing our role in assessing the quality of primary care providers. We are considering how best to respond to the specific proposals relating to the assessment and possible accreditation of primary care practices and specialist services provided in the community.

Use of resources

A key element of how we will assess whether organisations are 'getting the basics right' is how well they use resources. We recognise that good financial management is absolutely necessary for good quality of care. We will reflect this in the strong emphasis on the use of resources in our assessment of organisations. Assessments of use of resources will be derived from the work of other regulators. The assessment of NHS foundation trusts will be provided by Monitor, based on its financial risk ratings. The Audit Commission will provide this assessment for other trusts and PCTs, based on the findings from the local evaluation assessments by auditors as part of its statutory external audits.

Although NHS organisations will be expected to 'break even' in 2005/2006, we have broadened the scope of the assessment to include other aspects of financial performance. For example, the local evaluation assessment includes an assessment of value for money and financial management (we have also incorporated assessments of value for money in other elements of the annual health check, for example, in the reviews of the acute hospital portfolio).

In 2006/2007, we will continue to use this methodology. To reflect the continued importance of financial standing within the NHS, we will continue to take a tough approach to this area of our assessment. We will also consider how we can provide comparative information on relevant matters relating to the use and management of the workforce alongside the financial rating. This will not affect the ratings provided by the other regulators.

Existing targets

As part of 'getting the basics right', we assess the performance of trusts in meeting the Department of Health's existing targets (see appendix C). The existing targets tend to focus on areas related to access to care, such as waiting times for inpatient and outpatient appointments or access to primary care services. It is important that trusts continue to maintain their performance in these areas, so that this will remain a key part of the annual health check in 2006/2007.

Making and sustaining progress

Developmental standards	New national targets	Reviews

In 2006/2007, the annual health check will assess the progress of healthcare organisations in relation to certain aspects of the developmental standards. This assessment, together with our assessment of progress in meeting new national targets and our reviews of particular services, will begin to provide a richer picture of how trusts are improving the services that they provide to patients.

Developmental standards

Our assessments aim to focus increasingly on the achievement of healthcare organisations in relation to the Government's developmental standards. This is a significant task and we want to make sure that we get it right. That is why, as part of the evolution of the annual health check, we do not propose to look at all of the standards in each of the seven 'domains' covered by the standards. We propose to focus in 2006/2007 on the following four domains:

- safety
- clinical and cost effectiveness, concentrating on stroke, cancer, coronary heart disease, mental health and research and development
- patient focus, concentrating on the handling of complaints
- public health

We are focusing on these areas because of their importance to the quality of care that patients receive, and to ensure that the health needs of the population are understood and being addressed. Within the domain of clinical and cost effectiveness, we are focusing on the clinical areas that are covered by the earliest national service frameworks, and in which the NHS should have made the most progress. These clinical areas are also major causes of early loss of life and a poor quality of life. In addition, we are looking at how indicators of the quality of nursing care can contribute towards our assessment of clinical effectiveness. This will build on the principles outlined in 'Essence of Care'.

Our approach to assessing performance in relation to each domain has been developed as a result of extensive consultation involving expert reference groups and a series of workshops with clinicians, patients, interest groups and members of the public. We are currently reviewing our approach to ensure that we have an explicit focus on inequalities, diversity and human rights in each domain.

We are taking these initial steps to ensure that we learn from this new approach, that we avoid placing an unreasonable burden on healthcare organisations, and that we provide patients and the public with a richer picture of how healthcare organisations are improving the quality of their services. To support this approach, we will also work with other bodies to see how their findings might better inform

the levels of performance that should be required of organisations, so as to achieve a good assessment.

Our proposed approach to assessing progress in relation to the developmental standards aims to be as efficient and risk-based as possible. In a process similar to that used in the assessment of compliance with core standards, trusts' boards will continue to be responsible for assessing their compliance and making a declaration of their performance (see appendix D for more details). Trusts will make their declaration in April 2007 with an extension of the declaration form used in 2005/2006 (see appendix E for an example of a declaration form for 2006/2007).

To assess qualitative performance beyond a minimum level, trusts will declare their performance in relation to the developmental standards on a scale from 'excellent' to 'weak'. To support trusts in making this declaration, we intend to provide additional guidance through a series of developmental ladders (see appendix F for illustrative examples).

Alongside the score for developmental standards, we also intend to publish a set of supporting data that, when viewed together, provide meaningful information about how trusts are progressing in relation to the themes for declaration (see appendix F). The supporting data will not be used to derive a rating for progress in relation to developmental standards but will be used in three distinct ways:

- to help us to identify those trusts that we will want to talk to further as part of our selective inspection
- to provide trusts with a range of information which they will be able to use to support continual improvement
- to provide patients, the public, commissioners of services and trusts with a richer picture of performance

To minimise the burden on trusts, we will use supporting data that is nationally available and already collected directly from other organisations and bodies. Where possible, this data will already be available to trusts' boards. There will be no additional collection of data from trusts.

Detailed guidance on the developmental ladders and additional information on the process for assessing progress in relation to developmental standards will be published as soon as possible after the completion of the consultation.

Consultation questions

3. Have we got the right approach for assessing progress in relation to developmental standards?
4. Have we got the balance right between quantitative and qualitative measures of progress in relation to developmental standards and, in particular, are there any outcome measures or quantitative indicators that we could use to inform the rating directly?
5. Are we measuring the right things through our themes for declaration (see appendix F) and supporting data, and are there any areas of priority within these themes that we should focus on?
6. What sources of data, including the findings of other inspection and regulatory bodies, and what themes of declaration should we use for specific sectors of healthcare?
7. Have we described the right levels of performance required to demonstrate 'excellent', 'good', 'fair' and 'weak' progress?

New national targets

Appendix G lists the new national targets set out by the Government in *National standards, local action*. The new national targets differ from the existing targets in that they are primarily about improvements in public health. The existing targets tend to focus on areas, such as waiting times for hospital treatment or on ambulance response times, and generally measure performance at an organisational level. The new national targets, however, are phrased in national terms and set out a level of performance for the entire NHS to achieve, such as reducing rates of mortality from cancer or halting the rise in obesity among children.

The targets should be delivered between 2008 and 2010. Their success will rely on effective joint working across all organisations in the NHS and with other bodies. In 2005/2006, we will, where possible, assess the contribution of commissioners to these new national targets, by assessing their actual performance in relation to their planned level of performance as set out in their local delivery plans (and agreed by key local bodies in health and social care). We will also assess the performance of providers in relation to new national targets in 2005/2006, although, in many cases, we will rely on measures of process rather than measures of outcomes to determine their contribution.

We are not proposing any significant changes to the way that we assess performance in meeting new national targets in 2006/2007. However, where possible and appropriate, we will develop indicators for healthcare organisations that focus on outcomes rather than processes.

We are examining the ways in which we can accurately assess the contribution of providers to the improvement of public health and will continue to do this as the date of delivery for the new national targets draws closer.

Consultation question

8. As we develop our approach for 2007/2008, how could we improve the way we measure the contribution of organisations that provide and/or commission services to the delivery of new national targets?

Local targets

We do not propose to provide a separate assessment of progress in meeting local targets in 2006/2007. However, local targets will be important as local organisations are given more control of decisions around commissioning. We propose to:

- consider the process of setting local targets as part of the developmental standards for public health in relation to assessments of health needs
- explore options for factual reporting of local targets and progress against them as part of our work to make information more accessible to patients, the public, and those who commission and provide services

Our programme of reviews

The new national targets and developmental standards will provide an overview of whether trusts are 'making and sustaining progress'. In addition, as part of the annual health check, we are also carrying out a small number of reviews, which provide more in-depth, patient-centred assessments of performance and outcomes in a small number of areas of priority.

In 2006/2007, the programme of reviews will include:

- improvement reviews
- the acute hospital portfolio

We recognise the need to ensure that the overall system of assessment adds value and reduces the costs of regulating healthcare organisations. Given the introduction of an assessment of progress in relation to developmental standards in 2006/2007, we propose to reduce our planned programme of reviews by a third (compared to plans for 2005/2006). We will also continue to develop and test new approaches to improvement, with a view to moving to a new system of reviews in 2007/2008 that builds on the best of the improvement reviews and the acute hospital portfolio.

Improvement reviews

Our programme of improvement reviews assesses the progress made by healthcare organisations in ensuring continuous improvement in a small number of areas of national priority. The reviews assess performance from a range of different starting points – for example, in relation to a particular domain (such as safety), group of the population (such as children or older people) or condition (such as heart failure or diabetes) – and they look at how care is provided across organisational boundaries. Where appropriate, we work with the Commission for Social Care Inspection to look at services provided across health and social care.

The areas of priority that we have selected for improvement reviews reflect the need to address different areas, and different sectors, of health and healthcare. In 2006/2007, this will include reviews of diabetes, substance misuse, mental health services and race equality. We also want to learn lessons from the first set of improvement reviews so that we can enhance our impact in promoting improvement. We propose to identify, through each review, some high level indicators that could be used as supporting or screening data for future assessments. This will be a small subset of the total range of indicators and will not result in additional collection of data. These indicators, for example, may strengthen our capacity to measure progress in relation to the developmental standards.

Appendix H sets out a complete list of improvement reviews, and the reasons why certain areas of priority were chosen.

Consultation question

9. As our programme of improvement develops beyond 2006/2007, what further areas of priority should we consider for improvement reviews?

The acute hospital portfolio

The acute hospital portfolio primarily focuses on our responsibilities to monitor value for money in the NHS. It consists of in-depth reviews undertaken in key areas, selected on a similar basis to the improvement reviews. They all cover the experience of patients, quality of care, clinical effectiveness and overall efficiency, although the emphasis for each review varies.

In 2006/2007, the acute hospital portfolio will focus on maternity services (see appendix H). We will also commence a review of emergency care looking at ambulance services and care provided in primary and community care settings, and building on our previous work in relation to A&E services. This review has been delayed in light of the restructure of ambulance services scheduled to take place during 2006/2007. It will not feed into the annual health check until 2007/2008.

Other recent reviews in the acute hospital portfolio have covered previously reviewed topics, so that any evidence of improvement can be identified. The portfolio also provides computer software tools and guides for trusts so that they can use data from the reviews in

their own benchmarking exercises and build on their reports of local performance.

The feedback that we have received about the portfolio from chief executives of NHS acute trusts is very positive, with about 70% rating their local reports as useful or very useful. Consultants in A&E have also responded positively to the clinical indicators for care in A&E that we developed jointly with the British Association for Emergency Medicine. Given their value, we intend to develop these indicators further with a view to including them in the annual health check.

Consultation questions

10. Should we continue to review past topics so that progress can be monitored? If so, which topics should we revisit? (Visit our website for details of past topics: **www.healthcarecommission.org.uk/acutehospitalportfolio**)
11. What elements of our existing approach are most valuable to you? Are there ways in which we could provide more support in working with groups of patients, clinicians and trusts to help to improve services?

Taking a wider view of assessment

To ensure that we have as full a picture as possible of how organisations are performing, our annual health check takes account of a wide range of information in addition to that gathered for declarations and reviews, and for assessing progress against targets. This includes:

- the national clinical audit and patients' outcome programme
- information from screening and surveillance
- information from other regulators and bodies
- intelligence from our local staff
- information from a closer look at organisational capability when this has been necessary
- information from following up specific areas of concern

All of these sources provide useful information to support our assessments of trust performance, though they do not currently feed directly into the ratings.

The national clinical audit and patients' outcome programme

Through our national clinical audit and patients' outcome programme, the Healthcare Commission provides around £4 million annually to leading clinicians, supported by project management and IT, to audit the quality of the care that they provide. The projects provide information that allows:

- patients to understand the factors that may affect the quality of their care and to make informed choices
- local bodies to identify and make improvements for patients
- the Healthcare Commission to corroborate the declarations made by healthcare organisations on their performance in relation to standards, particularly core standards
- the Healthcare Commission's local teams to check whether local action plans have been created and implemented
- the Healthcare Commission to identify any issues relating to performance that need to followed up or investigated

- the Department of Health and the Welsh Assembly Government to assess the progress of national initiatives

The programme complements improvement reviews and the acute hospital portfolio because:

- the projects collect rich information about the quality of care delivered to individual patients, by comparing actual performance with that called for by, for example, NICE guidance
- where necessary, rates of survival of patients are 'case-mix adjusted' (to take account of, for example, how ill patients are when they receive care or how old they are), ensuring that accurate information about survival can be given to trusts and the public
- clinicians take the lead in designing the measures – they collect the data and take a leading hand in analysing it, which means that clinicians trust the information and take responsibility for assessing their own performance
- the projects are a good example of how the Healthcare Commission fosters the involvement of clinicians in improving the quality

Further information on the national clinical audit and patient's outcome programme is included in appendix I.

Consultation questions

12. What do you think the priorities are for the national clinical audit and patients' outcomes programme for 2007/2008?
13. What elements of our existing approach are most valuable to you? Are there ways in which we could provide more support in working with groups of patients, clinicians and trusts to help improve services?

Screening and surveillance

The Healthcare Commission is keen to make the most of the information that is available to us. We are also keen to reduce the need to ask for more information.

Our work in screening identifies items of information that relate (to a varying extent) to particular standards in *National standards, local action*. This information does not constitute a judgement of performance, but helps us to give priority to areas where we might ask further questions. It also helps us to be risk-based in targeting the resources we have available for local follow-up. As a result of our screening and surveillance, we have built up a large set of data that includes information from many different sources. For example, it includes information from our handling of complaints and investigations, relevant bodies in local communities, our surveys of patients and staff, and our own operational staff. We will also continue to explore how to improve the range and quality of sentinel indicators (factors which may indicate underlying issues relating to performance), using the findings of others to help to identify poor performance.

Working with other regulators and using the findings of others

We will continue to work closely with regulators in other sectors to maximise the benefits of our activities for patients, users of services and the public, and to streamline regulation. This joint work includes the assessment of services for children and young people. For example:

- the joint inspection of all youth offending teams in England and Wales – led by HM Inspectorate of Probation, the programme involves the Healthcare Commission, the Audit Commission, Commission for Social

Care Inspection, the Office of Her Majesty's Chief Inspector of Education and Training in Wales (Estyn), HM Inspectorate of Constabulary, HM Inspectorate of Prisons, Office for Standards in Education (Ofsted) and Social Services Inspectorate for Wales

- joint area reviews of services in each of the 150 local authority areas for children's services – led by Ofsted, this work also involves the Commission for Social Care Inspection and, where appropriate, the HM Inspectorate of Probation, the Adult Learning Inspectorate and the Audit Commission

The findings from these joint reviews, and a large amount of information from other bodies will be used by the Healthcare Commission to feed into the process of cross checking that takes place as part of assessments of compliance with core standards and progress in relation to the developmental standards, and to improve the knowledge of the Healthcare Commission's operational staff locally. We recognise that there is an opportunity to make better use of the capacity and expertise of others in reaching our assessments of performance.

During 2006/2007, we will therefore consider how the findings of others might be used to influence more directly the ratings which organisations are given. We will work with a number of other bodies, including Cancer Peer Review, to test some options for how this might operate, and to explore what findings could best be used in this way and where they might have the most effect. We will consider whether findings from other bodies that result in sanction, such as prosecution, should also be able to impact the rating that an organisation can achieve.

Consultation questions

14. Whose findings would you like to see used, and how, so as to further reduce duplication and overlap in regulation and review?
15. Are there aspects of the respective roles of the Healthcare Commission and other bodies, such as Monitor, which it would be helpful to clarify further?

Review of leadership and organisational capability

An organisation that experiences continuous problems in performance is likely to have underlying systemic weaknesses in its leadership and organisational capability. These weaknesses need to be dealt with before performance can improve in a sustainable way. That is why we are developing a way of reviewing the leadership and organisational capability of a trust, which can be implemented in response to concerns about the overall performance of particular organisations.

Such reviews will be triggered by under-performance in relation to a range of factors, which we will keep under surveillance throughout the year, or where other assessments by the Healthcare Commission indicate that there may be systemic problems. The reviews will, therefore, have a different focus from other elements of our assessment.

Rather than examining the current performance of an organisation, these reviews will assess the features of an organisation that affect its ability to maintain and improve services in the future. They will constitute a 'forward looking' review, assessing an organisation's ability to bring about and manage change in the future.

Such a review is designed to help organisations to recognise when their capability to cope with future challenges is declining, while things can still be done to address them.

The review is designed to uncover sufficient detail to make recommendations. It is not within the scope of such reviews to implement solutions to the problems that are uncovered. However, we will work closely with other organisations, such as strategic health authorities and Monitor, to ensure that others integrate this process of review and assessment effectively.

We also recognise that similar reviews of organisational effectiveness are periodically conducted for other reasons by other national organisations. In the case of NHS foundation trusts, we will work with Monitor to ensure there is no duplication in the aims or process of our respective functions. We will also work to ensure that we use the findings of other reviews, where appropriate, to inform relevant parts of our assessment.

Consultation question

16. Do you agree with our suggested way forward on the review of leadership and organisational capability?

Following up specific areas of concern

We will maintain our ability to respond quickly to matters of current concern, particulary where there is public concern about health and healthcare. Any action that we take may provide relevant information in assessing the declarations made by trusts in relation to their compliance with core standards and progress in relation to developmental standards, as well as leading to reports in their own right. For 2006/2007, we plan to follow up:

- the audit of cleanliness in hospitals carried out in 2005, which we undertook as a result of heightened public concern about the cleanliness of hospitals and to gain a better understanding of the nature and extent of the problem
- national studies of, for example, sexual health and healthcare associated infection
- issues on how the handling of complaints works locally, due to the substantial rise in the number of second stage complaints received by the Healthcare Commission
- concerns about services for people with learning disabilities, in response to concerns raised by investigations of services in the NHS and the independent healthcare sector
- any other areas of specific concern that arise during the year

Have your say

We are seeking your views on the proposals in this paper. Copies of all of the consultation papers and questionnaires are available on our website at **www.healthcarecommission.org.uk/consultation**.

For more information, or to provide feedback on our proposals, you can:

- e-mail:
  feedback@healthcarecommission.org.uk
- write to:
  Consultation
  Healthcare Commission
  FREEPOST LON 15399
  London
  EC1B 1QW
- phone: **0845 601 3012**

Your response should reach us by June 5th 2006.

Appendix A: Assessment relating to Government priorities

The table below summarises how the Healthcare Commission will assess and report on progress in relation to each of the priorities outlined in recent guidance from the Department of Health, *The NHS in England: the operating framework for 2006/2007*.

Area of priority	Annual health check 2006/2007	Wider assessments
Inequalities in health	• new national targets • assessment of compliance with core standards, particularly in relation to the standards in the domain for public health • assessment of progress in relation to developmental standards (and in particular the developmental standards relating to public health) will look specifically at inequalities in the health of local communities • improvement reviews and acute hospital portfolio reviews of: – substance misuse – diabetes – race equality – inpatient mental health – maternity services	• national studies on sexual health and chronic obstructive pulmonary disease will look specifically at inequalities in health
Cancer 31 day and 62 day waits	• existing national targets	
18 week maximum wait	• new national target	
MRSA	• new national target	• national study on healthcare associated infections
Patient choice and booking	• existing national target: new enhanced indicators introduced	• annual health check information used in Department of Health leaflets on patient choice

continued

Area of priority	Annual health check 2006/2007	Wider assessments
Sexual health and access to genito-urinary medicine (GUM) clinics	• new national target • assessment of compliance with core standards, particularly in relation to the domain for public health	• national study on sexual health
Financial performance	• use of resources • improvement reviews and acute hospital portfolio reviews	• assessments of value for money

Appendix B: Key changes to the annual health check in 2006/2007

Focus	Component	Carried out in 2005/2006	Proposed in 2006/2007	Key changes from 2005/2006
Getting the basics right	Assessment of compliance with core standards	Yes Draft declaration October 2005 Declaration April 2006	Yes Declaration April 2007	• greater focus on commissioning • greater involvement of patients and the public
	Use of resources	Yes	Yes	• exploring ways to include comparative information on matters relating to workforce
	Existing targets	Yes	Yes	• similar approach to 2005/2006
Making and sustaining progress	Assessment of progress in relation to developmental standards	No	Yes, for aspects of four domains: • safety • clinical and cost effectiveness • patient focus • public health	• first assessment of progress in relation to developmental standards (see appendix D)
	New national targets	Yes	Yes	• similar approach to 2005/2006
	Improvement reviews and acute hospital portfolio reviews	Yes	Yes	• one third reduction in planned number of reviews

Appendix C: Existing targets

Extract from the Department of Health's *National standards, local action: Health and social care standards and planning framework 2005/2006-2007/2008*.

Commitments due to be achieved before March 2005:

- reduce to four hours the maximum wait in A&E from arrival to admission, transfer or discharge
- guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours
- all ambulance trusts to respond to 75% of Category A calls within eight minutes
- all ambulance trusts to respond to 95% of Category A calls within 14 (urban)/19 (rural) minutes
- all ambulance trusts to respond to 95% of Category B calls within 14 (urban)/19 (rural) minutes
- maintain a two week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals
- maintain a maximum two week wait standard for rapid access chest pain clinics
- three month maximum wait for revascularisation by March 2005
- from April 2002 all patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days or fund the patient's treatment at the time and hospital of the patient's choice

Commitments due to be achieved after March 2005:

- improve life outcomes of adults and children with mental health problems by ensuring that all patients who need them have access to crisis services by 2005, and a comprehensive child and adolescent mental health service by 2006
- ensure that, by the end of 2005, every hospital appointment will be booked for the convenience of the patient, making it easier for patients and their GPs to choose the hospital and consultant that best meets their needs. By December 2005, patients will be able to choose from at least four to five different healthcare providers for planned hospital care, paid for by the NHS
- ensure a maximum waiting time of one month from diagnosis to treatment for all cancers by December 2005
- achieve a maximum waiting time of two months from urgent referral to treatment for all cancers by December 2005
- 800,000 smokers from all groups successfully quitting at the four week stage by 2006
- in primary care, update practice-based registers so that patients with coronary heart disease and diabetes continue to receive appropriate advice and treatment in line with national service framework standards and, by March 2006, ensure practice-based registers and systematic treatment regimes, including appropriate advice on diet, physical activity and smoking, also cover the majority of patients at high risk of coronary heart disease, particularly those with hypertension, diabetes and a body mass index greater than 30

- a minimum of 80% of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy by 2006, and 100% by 2007
- achieve a maximum wait of three months for an outpatient appointment by December 2005
- achieve a maximum wait of six months for inpatients by December 2005
- deliver a 10 percentage point increase per year in the proportion of people suffering from a heart attack who receive thrombolysis within 60 minutes of calling for professional help
- delayed transfers of care to reduce to a minimal level by 2006

Appendix D: Developmental standards

What is a developmental standard?

National standards, local action: Health and social care standards and planning framework 2005/2006-2007/2008 states that the 13 developmental standards "signal a direction of travel and provide a framework for NHS bodies to plan the delivery of services that continue to improve in line with increasing patient expectations".

For 2006/2007, we will be limiting our focus to aspects of the developmental standards set out under the following domains:

- safety
- clinical and cost effectiveness
- patient focus
- public health

We have also limited our focus on clinical and cost effectiveness to stroke, cancer, coronary heart disease, mental health, and research and development. We have limited our attention on patient focus to the measurement of progress in the handling of complaints.

What will we use to assess performance?

In many cases, performance addressed by the developmental standards is of a complex qualitative nature (for example, working in partnership or developing a 'safety culture') and is not always able to be measured (or summarised) by a limited set of quantitative indicators.

For the purposes of deriving ratings for healthcare organisations, therefore, we intend to put the onus on healthcare organisations to declare how they are performing in a process similar to that used in the assessment of core standards. However, unlike core standards, to assess qualitative performance beyond a minimum level, trusts will declare their performance on a scale from 'excellent' to 'weak'.

Alongside this, however, we also intend to publish a set of supporting data that, when viewed together, tells us something about how trusts are progressing in relation to the themes for declaration. The supporting data will not be used to derive a rating for progress in relation to developmental standards but will be used in three distinct ways outlined on page 29.

The process for assessing performance

The proposed process for assessing the performance of trusts in relation to developmental standards includes five steps.

1. Guidance published.
2. Trusts complete a declaration.
3. Analysis of data and cross checking.
4. Selective inspection.
5. Publish:
    - a rating
    - supporting data

Guidance

To support trusts, we intend to publish written information on how the assessment of progress in relation to developmental standards will be undertaken. In particular, we will publish:

- guidance on how to complete the declaration
- detailed guidance on each developmental ladder to further support trusts in completing the declaration. We anticipate that, where possible, this will indicate the policy and guidelines that are relevant to each theme. For example, a trust

declaring its performance in relation to the domain of clinical and cost effectiveness may want to consider how it takes account of *How to put NICE guidance into practice*

Trusts complete a declaration, analysis of data and cross checking

We intend to use data from two sources:

1. A declaration. Trusts will need to declare their performance in relation to a small number of themes derived from the outcomes set out in the Department of Health's *National standards, local action*. Unlike core standards, which measure the extent to which trusts have met a minimum level of performance, trusts will declare developmental progress beyond this level on a four point scale from 'excellent' to 'weak'. For example, a trust may wish to declare an overall rating of 'good' in relation to the themes for declaration for the safety domain. An example of a declaration is included in appendix E.
2. Supporting data. We will use nationally available data that, when taken together, provides an indication of the performance of trusts in relation to the themes for declaration. The supporting data will not be used to derive a rating but will be used in three distinct ways (outlined below). To minimise the burden placed on trusts, we will use supporting data that is collected directly from national organisations and bodies. Where possible, this data will already be available to trusts' boards.

Supporting data will be used to:

- help us to identify those trusts that we will want to talk to further as part of our selective inspection
- provide trusts with a range of information which they will be able to use to support continuous improvement
- provide patients, the public, commissioners of services and trusts with a richer picture of performance

In some cases, information from other parts of the annual health check will be used to cross check declarations by trusts.

The supporting data that we propose to use to cross check declarations by trusts are set out in appendix F. This data has been brought together in consultation with clinicians, patients, members of the public and representatives of interest groups. We expect to update this list continuously as data changes and as a result of learning from trusts about what information they already use to assure themselves of their progress in relation to the developmental standards.

Selective inspection

When we have cross checked the declarations made by trusts, we will undertake selective inspections. We intend to undertake these:

- where we have identified a potential risk to the continued improvement of a trust by:
  - cross checking the declarations that have been made against supporting data which is available nationally
  - using local knowledge from our regional teams, and drawing on the views of local bodies including patient and public involvement forums and overview and scrutiny committees
- randomly – this will help us to assure the quality of our processes for identifying risk

Selective inspection will be undertaken by our regional staff using a range of methods, from discussions to formal visits, depending on the level of risk identified.

Where on-site inspections are appropriate, they may be announced beforehand, conducted at short notice or unannounced. The focus of these inspections will be on the adequacy of the evidence that the trust has used to assure itself of its performance in making its declaration in relation to developmental standards.

The findings of a selective inspection may result in a qualification to the declaration. Where necessary, this qualification will be published and will affect the final rating that the trust will receive for its progress in relation to developmental standards.

Publish a rating and supporting data

On completion of our selective inspections, we will publish:

- a rating, based on the extent to which trusts are making progress in relation to developmental standards, including any qualification made as a result of a selective inspection. Levels of performance will be aggregated to rate trusts on a four point scale:
  - excellent
  - good
  - fair
  - weak
- a subset of the supporting data, to support continued improvement of trusts and provide patients and the public with a richer picture of performance

While action planning and improvement remain the responsibility of trusts, our regional teams, through their routine contact with trusts, will focus our follow-up activity on those organisations that are identified as 'weak'. This will allow us to target those trusts where there is the greatest risk of limited progress in relation to the developmental standards. It will also enable us to help these trusts to target their resources to where action planning would yield the greatest improvement in services in future years.

Appendix E: Example of a declaration form for 2006/2007

Trust self-declaration
Assessment of compliance with core standards Format of the declaration will be reviewed after completion of the 2005/2006 annual rating.
Assessment of progress in relation to developmental standards

Safety

The trust's overall progress in relation to the themes for declaration for the safety domain is:	**Excellent** **Good** **Fair** **Weak**
Themes for declaration	
1. The healthcare organisation enhances safety, and patients and staff feel safe. a. The healthcare organisation is committed to building 'a safety culture', which is supported by strong and effective leadership (requires self-assessment in relation to steps one and two of the National Patient Safety Agency's (NPSA) *Seven steps for patient safety)*. b. The perceptions of staff and patients on the quality of health and safety management are improving (requires self-assessment in relation to step five of the NPSA's *Seven steps for patient safety)*. c. The healthcare organisation embeds lessons learnt from incidents affecting the safety of staff and patients into its culture and practice. This is supported by effective policies to encourage and support staff to report such incidents, and to identify those incidents which should be investigated (requires self-assessment in relation to steps four, six and seven of the NPSA's *Seven steps for patient safety)*.	
2. The healthcare organisation continuously and systematically reviews its actions in relation to safety and the management of risk. a. Arrangements for effective management of risk are integrated for the safety of patients and staff, complaints, clinical negligence, and financial and environmental risk (requires self-assessment in relation to step three of the NPSA's *Seven steps for patient safety)*. b. The investment in safety and the management of risk is sufficient to ensure continuous improvement.	

3. The healthcare organisation applies best practice to the management of risk and safety.
   a. Programmes are in place to enhance actions from safety alert bulletins with broader learning from activities related to risk and improvement.
   b. The healthcare organisation has adopted and embedded relevant tools for managing safety, best practice and guidance, such as the NPSA's *Seven steps for patient safety* and the Health and Safety Executive's *Successful health and safety management*.

4. The healthcare organisation integrates its approach to the management of risk to enhance the safety of patients as they move between organisations and staff to receive care.
   a. Patients' records help to ensure that patients receive care that is safe and of high quality when they are transferred between organisations.
   b. The healthcare organisation has integrated approaches to risk management that enhance the safety of patients as they move between organisations and staff to receive care.

Clinical and cost effectiveness

The trust's overall progress in relation to the themes for declaration for the domain of clinical and cost effectiveness is:	**Excellent** **Good** **Fair** **Weak**

Themes for declaration

1. The healthcare organisation is delivering services in accordance with nationally agreed best practice.
   a. The healthcare organisation is meeting the requirements for developing services covered by the national service frameworks (NSF) for coronary heart disease, older people (chapters on stroke and older people's mental health), mental health, children, young people and maternity services (standard 9) and any subsequent relevant national guidance, such as the *NHS cancer plan* and *National clinical guidelines for stroke*.
   b. The healthcare organisation is meeting the timescales for delivery in the NSFs (above) where specified and, where not specified, has implemented a plan for delivery within reasonable timescales.
   c. The healthcare organisation is meeting reasonable timescales, as set out in the organisation's action plan, for implementation of National Institute for Health and Clinical Excellence (NICE) clinical guidelines, in particular:
      - cancer (breast, colorectal, head and neck, urological, lung, gynaecological, haematological, upper gastrointestinal and supportive and palliative care for adults with cancer)

- improving outcomes for people with mental health problems (depression, anxiety, eating disorders, schizophrenia, self-harm and violence)

2. The healthcare organisation ensures that healthcare is provided in ways that meet the individual needs of patients.
   a. The extent to which the healthcare organisation identifies the individual needs and preferences of patients and ensures that care is provided on the basis of those requirements.

3. The healthcare organisation works with other organisations to provide a coordinated and seamless service for patients.
   a. The extent to which the healthcare organisation has worked with other health and social care organisations to ensure that a seamless service is being delivered as patients move between providers of services.

4. Clinical decisions are based on evidence-based practice.
   a. The extent to which organisations ensure that their staff are up to date with current research and contributing to the building of knowledge.

Patient focus (handling complaints)

The trust's overall progress in relation to the themes for declaration for the domain of patient focus (handling of complaints) is:	**Excellent** **Good** **Fair** **Weak**

Themes for declaration

1. The healthcare organisation ensures that the process of handling complaints promotes equal access by being prepared for and successfully meeting the diverse and large range of needs of the people who could and do use it.
   a. The demographic profile of complainants is systematically compared with the demographic profile of the local population of patients and action is taken to help ensure that all members of the population have equal access.
   b. The extent to which information for patients contains details of client support services, including links to the service for handling complaints, the patient advice and liaison service and independent complaints advocacy services, and how widely this information is made available.
   c. The extent to which the healthcare organisation works in partnership with groups representing patients to ensure equal access to the complaints process.

2. The healthcare organisation has a patient-led system that seeks to provide a simple and clear process for dealing with complaints or concerns regardless of whether it cuts across NHS services, bodies or social care organisations.
   a. How well the healthcare organisation takes account of the views and feedback of complainants in the development of the process for handling complaints.
   b. The extent to which the healthcare organisation works in partnership with staff and other organisations to promote best practice in handling complaints.
   c. Whether the healthcare organisation has agreed protocols and arrangements embedded within the organisation to ensure coordinated and seamless collaboration where there is a complaint about more than one service or organisation, including social care organisations.

3. The healthcare organisation ensures that individual complaints and concerns are taken seriously and investigated thoroughly and effectively.
   a. The extent to which the healthcare organisation ensures effective investigation of complaints, including whether it assigns a priority to them based on their severity.

4. The healthcare organisation invests in providing sufficiently competent and senior staff who are supported to deliver an effective system for handling complaints.
   a. The extent to which the healthcare organisation uses information from complaints to help to improve delivery of services, invests in training and support in handling complaints, and routinely audits performance to assess the effectiveness of the system in terms of lessons learned and improvements made as a result of complaints.
   b. Whether the handling of complaints is linked to arrangements for integrated governance.
   c. Whether the PCT gathers information on complaints made about its primary care contractors (e.g. GPs, dentists, pharmacists and opticians) and commissioned services, and the extent of support provided by the organisation

Public health

The trust's overall progress in relation to the themes for declaration for the domain of public health is:	Excellent Good Fair Weak
Themes for declaration	

1. The healthcare organisation collects and uses information to plan and deliver improvements in health for local people and to determine local health services.
   a. The extent to which local services are commissioned on the basis of local needs in relation to health, the proportionate distribution of resources and evidence-based interventions

b. Whether the healthcare organisation provides information on the health of the local community to support the work of a range of different audiences including the public, patient and public involvement forums, local overview and scrutiny committees and neighbourhood committees

2. The healthcare organisation works to improve health and tackle inequalities through its services and programmes, and plans and working in partnership.
   a. The healthcare organisation is improving health and tackling inequalities in health through its programmes and services aimed at preventing disease and improving and protecting of health.
   b. Whether the healthcare organisation has plans to develop its workforce to deliver improvements in health and to reduce inequalities in health.
   c. The extent to which the healthcare organisation works in partnership with clinicians, patients, the local population and appropriate agencies to develop a strategic approach to tackling inequalities in health.

3. The healthcare organisation works to improve the health of its workforce and local people through its approach to the procurement of goods and services, and in its role as an employer and provider of services.
   a. Whether the healthcare organisation has an action plan to increase opportunities for employment for groups in the NHS who are under-represented and marginalised.
   b. The extent to which the organisation has implemented plans to improve the health and wellbeing of its workforce.
   c. The extent to which the organisation has created opportunities for the local procurement of goods and services.

4. The health of the local population is protected through plans, which have been tested, to respond to major incidents and emergencies.
   a. The healthcare organisation is fully aware of the range of major incidents and emergency situations to which it may have to respond, understands its role and is prepared for such eventualities in partnership with other organisations.

5. The health of the local population is protected through the effective prevention and management of outbreaks of infectious diseases.
   a. Whether the healthcare organisation undertakes surveillance and prevention of infectious diseases and has comprehensive plans in place for the effective control of future outbreaks.

Appendix F: Supporting data and developmental ladders

Our approach to assessing performance within each domain, including the proposed supporting data and ladders, has been developed as a result of extensive consultation including:

- a series of workshops focused on the views of clinicians, patients, interest groups and members of the public
- the comments and guidance of an expert reference group for each of the four domains being assessed

This appendix outlines, with respect to each domain, the data that will be used to cross check declarations by trusts, and the developmental ladders that set out the levels of performance that a trust may wish to consider when making its declaration. The domain of public health is separated into four different areas: intelligence in public health, improvement in health and prevention of disease, investment in health in the local community, and protection of health and emergency planning. We have provided a ladder for each of these areas.

The outcome for each domain and the developmental standards have been set by the Department of Health.

1. Supporting data that is nationally available

To minimise the burden on trusts, we will use data collected directly from national bodies. Wherever possible, this data will already be available to trust boards. There will be no additional collection of data from trusts.

The data will not be used to derive a rating for progress in relation to developmental standards, but will be used in three ways:

- to help us to identify those trusts that we will want to talk to further as part of our selective inspection
- provide trusts with a range of information which they will be able to use to support continuous improvement
- provide patients, the public, commissioners of services and trusts with a richer picture of performance

We expect to update this list as data changes, and as we learn what information trusts already use to assure themselves of progress in relation to the developmental standards.

2. Developmental ladders

The developmental ladders outline the factors which may contribute to a rating of excellent, good, fair or weak in each of the domains, indicating the levels of performance that a trust may consider when making its declaration. The ladders in this appendix are illustrative. We intend to publish more detailed guidance regarding these ladders to support trusts in declaring their performance.

To achieve a specific rating, the healthcare organisation will have:

- achieved most of the factors relating to that rating in each domain. This would include, where stated, all the primary factors for that rating and most of the supporting factors. Achievement of the supporting factors alone will not be sufficient to attain a specific rating
- achieved all of the ratings lower than the one awarded (i.e. to achieve a rating of excellent, they will also have met the factors necessary to achieve a rating of good)
- met the relevant core standard(s). Failure to do so will limit a trust to a rating of 'weak' for the relevant developmental standard

Further guidance will be published on how to complete the declaration.

Safety

Outcome

Patient safety is enhanced by the use of healthcare processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.

Developmental standard

Healthcare organisations continuously and systematically review and improve all aspects of their activities that directly affect patient safety and apply best practice in assessing and managing risks to patients, staff and others, particularly when patients move from one organisation to another.

Approach

The proposed approach centres on a self-assessment of progress in relation to the National Patient Safety Agency's *Seven steps for patient safety*. Healthcare organisations may use an alternative system for managing safety provided that they are able to establish that it is as equally effective as the *Seven steps* in ensuring safety. The standard also requires that both the safety of staff, and the safety of patients, as they move from one organisation to another, be included in the assessment.[1]

A self-assessment tool for *Seven steps for patient safety* is in the early stages of development. Assessment of progress in relation to the developmental standard for safety is largely based on a number of declarations on the extent to which the *Seven steps for patient safety* are embedded in the healthcare organisation. Some healthcare organisations are likely to have only the basic framework for managing safety in place, whereas others will have very resilient systems for managing safety.

Themes for declaration – see appendix E

1 The proposed approach is in line with recommendations of the National Audit Office set out in, *A safer place for patients: Learning to improve patient safety*, November 3rd 2005.

Safety *continued*

Theme for declaration	Potential supporting data that is nationally available
1a	• Department of Health: Estates Return Information Collection (ERIC) returns – for example, percentage of staff receiving health and safety training and percentage receiving fire training and total number of reported injuries, diseases and dangerous occurrences regulations (RIDDOR) incidents • Counter Fraud and Security Management Service – for example, violent incidents • Health and Social Care Information Centre: Hospital episode statistics – for example, the number of inpatients that suffered bed sores (decubitus ulcers) and the number of patients that acquired post-operative hip fractures • Health and Social Care Information Centre: Quality and outcomes framework – for example, policies on the employment of staff • Medicines and Healthcare Products Regulatory Agency – for example, safety alert bulletins • Serious Hazards of Transfusion (SHOT) scheme – for example, the number of events that occurred where the incorrect blood component was transfused • Healthcare Commission – for example, data on complaints
1b	• Healthcare Commission: Surveys of staff – for example, errors and incidents – and surveys of patients – for example, questions on quality of care and treatment • NHS Litigation Authority: Clinical negligence scheme for trusts[2] – for example, staff interviews on violence and aggression, harassment and bullying, slips/trips and falls, moving and handling, workplace stress, security and learning from patient enquiries and complaints • Health and Social Care Information Centre: Quality and outcomes framework – for example, patient experience • Healthcare Commission – for example, data on complaints
1c	• National Patient Safety Agency: National reporting and learning system – for example, the volume of reports and distribution across specialities • Healthcare Commission – for example, data on complaints • NHS Litigation Authority: Clinical negligence scheme for trusts – for example, learning from experience

2 Also known as risk management standards.

Theme for declaration	Potential supporting data that is nationally available
	• Healthcare Commission: Surveys of staff – for example, errors and incidents • Health and Social Care Information Centre: Quality and outcomes framework – for example, reviews of significant events, a review of patient complaints and medicines management
2a	• NHS Litigation Authority: Clinical negligence scheme for trusts – for example, risk management training and governance • Health and Social Care Information Centre: Quality and outcomes framework – for example, practice management and review of complaints
2b	• Department of Health: Estates Return Information Collection (ERIC) returns – for example, investment to reduce backlog maintenance • National Audit Office – for example, patient safety study questions • NHS Litigation Authority: Clinical negligence scheme for trusts – for example, training in risk management • Health and Social Care Information Centre: Quality and outcomes framework – for example, education and training
3a	• NHS Litigation Authority: Clinical negligence scheme for trusts – for example, dissemination and implementation of safety alert bulletins
3b	• Health and Safety Executive: Corporate health and safety performance index (CHaSPI)
	• NHS Litigation Authority: Clinical negligence scheme for trusts – for example, learning from national guidance
4a	• NHS Litigation Authority: Clinical negligence scheme for trusts – for example, health records • Health and Social Care Information Centre: Quality and outcomes framework – for example, records and information about patients • enhanced surveillance data on MRSA (methicillin resistant Staphylococcus aureus), from October 2005 • Healthcare Commission: Surveys of patients – for example, referrals

Safety *continued*

Theme for declaration	Potential supporting data that is nationally available
4b	• NHS Litigation Authority: Clinical negligence scheme for trusts – for example, communication among agencies, and policies for arrangement of discharge of patients

Proposed developmental ladder: Safety

Factors that may contribute to a rating of **excellent**	
Primary factor	*Seven steps for patient safety*[3] is fully embedded within the organisation, and systems for managing safety are fully resilient. Patients and staff feel very safe and actively identify risks, confident that changes will be made to address their concerns.
Supported by at least five of these factors	Implementation of robust protective and preventative measures is reviewed and improved. Active encouragement of the reporting of incidents[4]: The organisation systematically monitors the profile of reported incidents and can demonstrate the effectiveness of campaigns targeted at groups with a lower degree of reporting. Evidence of frequent learning and changes which reduce risk, as a consequence of reporting of incidents, complaints and claims. Evidence that there is a sustained reduction in the numbers of incidents, causing harm to staff and patients in an organisation.[5] A level of three has been reached in the clinical negligence scheme for trusts. A strong commitment to the safety of patients and staff is supported through appropriate resourcing, an organisation-wide assessment of clinical and other risks has been conducted, and action plans to continuously reduce risk are developed, implemented, monitored and reviewed. The organisation can demonstrate the application of integrated risk management to enhance the safety of patients across pathways of care, and participates in sharing learning with other organisations.

3 Healthcare organisations may use an alternative safety management system provided they are able to establish that it is as equally effective as the *Seven steps* in ensuring safety.

4 This should include reporting of unintended or unexpected incidents that could have led to harm, as well as those that did lead to harm. A high level of such reporting probably indicates a safety conscious environment.

5 The numbers of incidents of actual harm must be within tolerable limits when compared to organisations of a similar nature.

Proposed developmental ladder – safety *continued*

Factors that may contribute to a rating of **good**	
Primary factor	Evidence of sustained commitment to *Seven steps for patient safety*, and systems for managing safety are reliable. Patients and staff feel safe, and feel that their views are actively sought to drive improvements.
Supported by at least five of these factors	Protective and preventative measures are developed and implemented. Active encouragement of reporting of incidents: Specialties and groups of staff with a lower degree of reporting are identified and campaigns are in place to increase reporting in those areas. Evidence of actions by management arising from the reporting of incidents, complaints and claims. Evidence that the numbers of incidents causing harm to staff and patients has fallen and that measures are in place that are likely to ensure a sustained reduction. A level of two has been reached in the clinical negligence scheme for trusts. A strong commitment to the safety of patients and staff is supported through appropriate resourcing, an organisation-wide assessment of clinical and other risks has been conducted, and action plans are in place to mitigate all identified risks. The organisation can demonstrate the application of integrated risk management to enhance the safety of patients across pathways of care.

Factors that may contribute to a rating of **fair**	
Primary factor	Evidence of implementation of *Seven steps for patient safety*, and a framework for managing safety is in place. Patients and staff are slightly concerned about their safety, and feel that their views are valued and listened to when they raise them.
Supported by at least five of these factors	A framework for developing protective and preventative measures is in place. There are reports of adverse events and near misses from all groups of staff and from all departments. Root cause analysis is undertaken when appropriate in response to incidents. Evidence that the numbers of incidents causing harm to staff and patients has fallen, but the number of reports of incidents is increasing. A level of one has been reached in the Clinical Negligence Scheme for Trusts. The commitment to the safety of patients and staff is supported through appropriate resourcing. Integrated risk management to enhance the safety of patients across pathways of care are in place.

Factors that may contribute to a factor of **weak**	
Primary factor	Failure to achieve a rating of fair. Patients and staff feel unsafe, and that concerns that they raise are ignored or dismissed.
Supported by	There is little evidence of commitment to the reporting of incidents involving staff. There is little evidence of root cause analysis. There is little or no evidence of attempt to implement integrated risk management to enhance the safety of patients across pathways of care.

Clinical and cost effectiveness

Outcome

Patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services based on what assessed research evidence has shown provides effective clinical outcomes.

Developmental standard

Patients receive effective treatment and care that:

a. conform to nationally agreed best practice, particularly as defined in national service frameworks, National Institute for Health and Clinical Excellence (NICE) guidance, national plans and agreed national guidance on service delivery

b. take into account their individual requirements and meet their physical, cultural, spiritual and psychological needs and preferences

c. are well coordinated to provide a seamless service across all organisations that need to be involved, especially social care organisations

d. is delivered by healthcare professionals who make clinical decisions based on evidence-based practice

Approach

Assessment of progress in relation to the developmental standard for clinical and cost effectiveness will focus on four clinical areas:

1. stroke
2. cancer
3. coronary heart disease
4. mental health

The approach considers the delivery of services in relation to the requirements of national service frameworks and NICE, and the extent to which the individual requirements of patients have been met. We acknowledge that there may be conflicts between declaration themes one and two and will assess organisations accordingly.

The Healthcare Commission is working with the research and development directorate of the Department of Health and UK Clinical Research Collaboration Joint initiative (UKCRC) to promote the importance of research and governance in the overall assessment of an organisation's performance.

Research is relevant to all of the developmental standards and, in the longer term, we will ensure that it is embedded in all of the criteria that we develop. In 2006/2007, we have identified a preliminary number of measures, relevant to the enhanced assessment of performance in research in the domain of clinical and cost effectiveness, to ensure that all healthcare organisations are fully committed to supporting research to improve health. These measures are relevant to all sectors, including the role of PCTs in commissioning.

Themes for declaration – see appendix E

Clinical and cost effectiveness

Theme for declaration	Potential supporting data that is nationally available
1a, b	Stroke including diagnosis, secondary prevention, acute clinical management and rehabilitation: • Health and Social Care Information Centre: Quality management and analysis system (QMAS) – for example, STROKE 2: the percentage of new patients who have been referred for further investigation • Royal College of Physicians: Stroke audit – for example, key 12 indicator score Coronary heart disease including primary prevention, diagnosis, acute clinical management, secondary prevention, chronic disease management, surgical management and rehabilitation:[6] • Health and Social Care Information Centre: Quality management and analysis system (QMAS) – for example, CHD9: the percentage of patients with coronary heart disease with a record in the previous 15 months that aspirin, an alternative anti-platelet therapy or an anti-coagulant is being taken (unless a contrindication or side effects are recorded) • Healthcare Commission: National targets – for example, GPs' recording body mass index status • Royal College of Physicians: Survey of access to facilities – for example, routine provision of troponin T or I tests for patients with acute coronary syndromes[7] • Myocardial Infarction National Audit project (MINAP) – for example, for a continuous patient-based indicator (percentage of patients with ST– segment elevation for whom a troponin T or I test is recorded) • Health and Social Care Information Centre: Hospital episode statistics – for example, rates of readmission after implantation of a pacemaker • British Heart Foundation: Rehabilitation audit – for example, percentage of patients following myocardial infarction or revascularisation procedure who receive an appropriate rehabilitation programme

6 We are currently reviewing the possibility of identifying relevant supporting data through the 2005/2006 heart failure improvement review.

7 Data available in spring 2006.

Clinical and cost effectiveness *continued*

Theme for declaration	Potential supporting data that is nationally available
	Cancer including early detection of cancer, patient outcomes, extent to which patients' preferences for care at the end of life are met and the quality of palliative care provided[8]: • Department of Health: Data standards central returns – for example, KC53: percentage of eligible women aged 25 to 49 in a PCT population with an adequate cervical screening test result in the last three years • Office for National Statistics – for example, cancer mortality trends and one year mortality rates • strategic health authorities' baseline reviews – for example, percentage of GP practices which have implemented the gold standards care framework • compendium of clinical and health indicators 2003/clinical and health outcomes knowledge base – for example, deaths at home from all cancers (ICD10 C00-C97) as a percentage of all deaths from cancer, all ages **Mental health** • Durham University: Adult mental health service mapping – for example, availability of assertive outreach, crisis resolution, early intervention in psychosis services, model fidelity and persons served and the availability of community development, graduate, gateway, carer support, support time and recovery workers • Durham University: Older people's mental health service mapping – for example, availability of components of mental health services for older people • Healthcare Commission: Survey of users of mental health services – for example, crisis care • Healthcare Commission: National targets – for example, care programme approach seven day follow-up • Mental Health Act Commission: Count me in census – for example, the proportion of hospital occupied bed days on adult psychiatric wards by under 16s and by 16 or 17 year olds

8 Discussions are continuing with those carrying out the national cancer audits about the possibility of using audit data for some of these items, including for case-mix adjustment where relevant.

Theme for declaration	Potential supporting data that is nationally available
1c	Cancer including availability of optimal treatments appropriate to patients' conditions and patient outcomes: • Health and Social Care Information Centre: Hospital episode statistics – for example, hospital volumes for breast cancer operations including surgeon specific volumes • National cancer audits – for example, rates of participation in national audits of lung cancer, head and neck and colorectal cancer • Healthcare Commission: National targets – for example, rates of mortality from cancer **Mental health** • Healthcare Commission: Community mental health services improvement review – for example, the proportion of users of services, provided by assertive outreach teams and community mental health teams, who are on regimes of medication that meet the recommendations as set out in the NICE guideline for schizophrenia • Prescribing Analysis and Cost Tabulation (ePACT) – for example, rates of prescribing for antipsychotics and selective serotonin reuptake inhibitors (SSRI) antidepressants • Department of Health: Data standard central returns – for example, KH09: rates of did not attends for outpatient services • Healthcare Commission: Surveys of users of mental health services – for example, cancelled appointments, continuity of healthcare professionals • Department of Health – Section 31 Health Act 1999 notifications • Durham University: Older people's mental health service mapping – for example, the availability of an A&E liaison team for older people
2a	• Healthcare Commission: Surveys of patients – for example, questions relating to involvement in care planning, choice, waiting times, access to useful information and quality of relationships between patients and healthcare professionals

Clinical and cost effectiveness *continued*

Theme for declaration	Potential supporting data that is nationally available
	Mental health • Healthcare Commission: National targets – for example, emergency bed days • Healthcare Commission: Survey of users of mental health services – for example, the proportion of users of services, provided by assertive outreach teams and community mental health teams, assessed and receiving psychological therapies as recommended by NICE guideline on schizophrenia • Health and Social Care Information Centre: Mental health minimum data set – for example, extent to which services are collecting data to routinely measure outcomes • Health and Social Care Information Centre: Quality and outcomes framework – for example, the proportion of users of services with severe long term mental health problems who have had a physical health review in line with recommended good practice in the last 15 months
3a	**Mental health** • Health and Social Care Information Centre: Mental health minimum data set – for example, MH9: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses with a review recorded in the proceeding 15 months. In the review there should be evidence that the patient has been offered routine health promotion and prevention advice appropriate to their age, gender and health status.
4a	**Research and development** **Appraisal and use of evidence** • Department of Health: Research and development directorate – policy and procedures in place which ensure use of research evidence in the decision-making process governing the introduction of new technologies/new procedures **Research** • Department of Health: Research and development directorate – externally funded peer reviewed research: (a) total number of projects, (b) number which involve working with clinical research networks, (c) number which involve working with industry, (d) number of patients recruited into studies, and (e) proportion of activity by disease/condition including public health

Theme for declaration	Potential supporting data that is nationally available
	Patient focus • Department of Health: Research and development directorate – policy and procedures in place governing the involvement of patients and the public in research, including procedures for ensuring that patients are aware of research in the organisation, providing opportunities to take part in research, and providing feedback of results to participants in studies Governance of research • Department of Health: Research and development directorate – time interval between application for permission for research to proceed, and the granting of permission and satisfaction with the efficiency of governance procedures through a survey of researchers and the funders of research (focusing on permissions for research)

Proposed developmental ladder: Clinical and cost effectiveness

Factors that may contribute to a rating of **excellent**	
	Evidence that the healthcare organisation is on track with timescales for delivery either specified by the national service frameworks or as determined locally. Evidence that the healthcare organisation is meeting all of the standards or requirements relating to quality in the national service frameworks as required at that point in time. Data for the purpose of monitoring, including data on clinical audit on clinical decisions by individual practitioners, clearly demonstrate that all requirements in relevant guidance from NICE are being met. The healthcare organisation routinely reviews information on health outcomes as the basis for decisions about the effectiveness of services. Surveys of patients and other consultation with patients clearly demonstrate that patients' individual needs and preferences are being met in all but the occasional instance. Evidence that the healthcare organisation has worked in partnership with other health and social care organisations to ensure that a seamless service is being delivered as patients move between providers of care – supported by evidence from surveys of patients and other consultation with patients, which clearly demonstrate that services are seamless in all but the occasional instance. Data for the purpose of monitoring, including data from individual clinical audits, clearly demonstrates that practitioners' decisions are based on the best evidence except where there are explicitly stated and acceptable reasons for deviations.
Research	Evidence that the organisation is aware of the need to carry out research and systematically makes available and draws attention to the findings of national research. The organisation is fully committed to supporting research as appropriate, enabling all relevant staff to engage in research and applying the findings of research.

Factors that may contribute to a rating of **good**	
	Evidence that the healthcare organisation is on track with most of the timescales for delivery either specified by the national service frameworks or as determined locally. Evidence that the healthcare organisation is meeting most of the standards or requirements relating to quality in the national service frameworks as required at that point in time, and has plans in place to ensure that those standards where progress has been less good will be met in the future. Data for the purpose of monitoring, including data from clinical audits on clinical decisions by individual practitioners, indicates that most requirements in relevant NICE guidance are being met. Surveys of patients and other consultation with patients indicate that patients' individual needs and preferences are being met most of the time. Evidence that the healthcare organisation has worked in partnership with other health and social care organisations to ensure that a seamless service is being delivered as patients move between providers of care – supported by evidence from surveys of patients and other consultation with patients which clearly demonstrate that services are seamless most of the time. Data for the purpose of monitoring, including data from individual clinical audits, indicates that practitioners' decisions are based on the best evidence most of the time.
Research	Some evidence that the organisation is aware of the need to carry out research and systematically makes available and draws attention to the findings of national research. The organisation is committed to supporting research as appropriate, enabling most of its relevant staff to engage in research and applying findings from research.

Proposed developmental ladder: Clinical and cost effectiveness *continued*

Factors that may contribute to a rating of **fair**	
	Evidence that the healthcare organisation has strategies in place and is making progress on meeting timescales for delivery, either specified by the national service frameworks or as determined locally. Evidence that the healthcare organisation is meeting some of the standards or requirements relating to quality in the national service frameworks as required at that point in time. Data for the purpose of monitoring, including data from clinical audits of clinical decisions by individual practitioners, indicates that some requirements in relevant NICE guidance are being met. Evidence that patients' individual needs and preferences are being met only some of the time. Evidence that services are seamless only some of the time. Some evidence that practitioners' decisions are based on the best evidence most of the time.
Research	Some evidence that the organisation is aware of the need to carry out research and systematically makes available and draws attention to the findings of national research. The organisation appropriately supports research, enabling some staff to engage in research and applying findings from research.

Factors that may contribute to a factor of **weak**	
	Evidence that the healthcare organisation has strategies in place but is making limited progress on meeting timescales for delivery either specified by the national service frameworks or as determined locally. Little evidence that the healthcare organisation is meeting the standards or requirements relating to quality in the national service frameworks as required at that point in time. The healthcare organisation is taking into account relevant NICE guidance, but there is little evidence that the requirements are being met. Evidence that patients' individual needs and preferences are frequently not met. Evidence that services are frequently not seamless. There is little evidence that practitioners' decisions are based on the best evidence.
Research	There is little evidence that the organisation is aware of the need to carry out research and systematically distribute the findings from national research. There is little evidence the organisation appropriately supports research and applies findings from research.

Patient focus: Handling complaints

Outcome

Healthcare is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient wellbeing.

Developmental standard

Healthcare organisations continuously improve the patient experience, based on the feedback of patients, carers and their relatives.

Approach for handling complaints

In England, the Healthcare Commission is responsible for reviewing complaints about the NHS that have not been resolved locally – these are called 'second stage complaints'. From August 2004 to October 2005, the Commission received more than 9,600 complaints covering all aspects of people's experiences of healthcare. However, many complaints can be resolved through an organisation's existing systems if these are working effectively.

Nearly one third of the complaints received by the Commission were sent back for local organisations to deal with, either because not enough was done locally to resolve the complaints in the first place or because complainants approached the Healthcare Commission before local resolution had been concluded. Our work on complaints has highlighted the importance of designing systems, including systems to investigate complaints, from the point of view of users of services. For this reason, we have decided to give priority to the handling of complaints in the domain of patient focus for the 2006/2007 assessment of progress in relation to developmental standards.

Themes for declaration – see appendix D

Patient focus: Handling complaints

Theme for declaration	Potential supporting data that is nationally available
1a, b, c	• Department of Health: Data central returns – for example, KO41A and KO41C: number of formal complaints • Healthcare Commission: Second stage complaints • Health and Social Care Information Centre: Hospital episode statistics – for example, ethnic coding
3a	• Healthcare Commission – for example, second stage complaints
4a, b, c	• NHS Litigation Authority: Risk management standard for the provision of pre hospital care in the ambulance service – for example, complaints and claims reporting and management • NHS Litigation Authority: Risk management standard for primary care trusts – for example, complaints management • NHS Litigation Authority: Clinical risk management standards (general) – for example, learning from experience

Proposed developmental ladder: Handling complaints

Factors that may contribute to a rating of **excellent**	
Primary factors	Strong evidence that the demographic profile of complainants is comparable with that of the population of patients using the service – demonstrating that no particular group is being excluded or is not represented. The organisation has the capacity and willingness to investigate complaints thoroughly with few formal complaints that are referred to the Healthcare Commission for second stage resolution either being returned for further local resolution or resulting in the complainant's concerns being upheld. Strong evidence that demonstrates that agreed protocols and arrangements for handling complaints relating to the care received across health and social services are effective. Strong evidence that demonstrates leadership and a culture of learning in the handling of complaints, with complaints and feedback from complainants being used to improve the delivery of services, and demonstrates that links between the complaints manager, the chief executive, the board, and key staff are well established.
Supported by	Strong evidence that staff handling complaints work with voluntary and advocacy groups to support people who may not have the capacity to complain effectively. Results of feedback/surveys of complainants indicate a high rating of the service provided to complainants and of the outcomes achieved. Evidence of improvements to the process of handling complaints as a result of feedback from complainants. The staff handling complaints participate in sharing of learning with other organisations. Complaints are routinely assessed as to their priority on the basis of severity. The effectiveness of monitoring complaints and making improvements as a result of complaints is routinely audited. Quarterly and annual reports on complaints are sent to patients' representatives and scrutiny bodies. Strong evidence that PCTs are monitoring complaints about primary care contractors and commissioned services.

Factors that may contribute to a rating of **good**	
Primary factors	Evidence that action has been taken to ensure the demographic profile of complainants is comparable with that of the local population of patients using the service – demonstrating that no particular group is being excluded or not represented. Some formal complaints that are referred to the Healthcare Commission for second stage resolution are either returned for further local resolution or result in the complainant's concerns being upheld. Evidence that agreed protocols and arrangements for handling complaints relating to the care received across health and social services are in place and overall compliance with them is being monitored. Strong evidence that complaints are used to improve the delivery of services, and that the complaints manager has access to the chief executive, the board, and key staff.
Supported by	Information for patients provides relevant details of the service for handling complaints, the patient advice and liaison service (PALS) and the independent complaints advisory service (ICAS). Evidence that staff handling complaints work with voluntary and advocacy groups to identify structures to support people who may not have the capacity to complain effectively. Evidence that mechanisms for obtaining feedback from complainants on the process for handling complaints are in place. Complainants are offered face to face meetings to resolve their complaints. Systems to determine the severity of complaints and to prioritise them are under development. Clinical staff and staff handling complaints have received training in how to handle complaints and are provided with appropriate support to enable them to deal with complaints efficiently and effectively. A framework for routinely auditing the effectiveness of monitoring complaints and for making improvements as a result of complaints is in place. Annual reports on complaints are sent to patients' representatives and scrutiny bodies. Evidence that PCTs have mechanisms in place to monitor complaints about primary care contractors and commissioned services.

Proposed developmental ladder: Handling complaints *continued*

Factors that may contribute to a rating of fair	
Primary factors	Evidence that action is planned to ensure that the demographic profile of complainants is comparable with that of the local population of patients. An average proportion of formal complaints that are referred to the Healthcare Commission for second stage resolution are either returned for local resolution or result in the complainant's concerns being upheld. Evidence that protocols and arrangements for handling complaints relating to care across health and social services are under development. Some evidence that complaints are used to improve delivery of services, and that the complaints manager has access to the chief executive.
Supported by	Information for patients on the process of handling complaints includes relevant information on PALS and ICAS. Evidence that mechanisms are in place to link staff handling complaints with voluntary and advocacy groups. Mechanisms for obtaining feedback from complainants on the handling complaints are being developed. Some complainants are offered face to face meetings to resolve their complaints. Most clinical staff and staff handling complaints have received training in how to handle complaints and are provided with appropriate support to enable them to deal with complaints efficiently and effectively. The development of systems to determine the severity of complaints and to assign priorities to them is planned. Development of a framework for auditing the effectiveness of monitoring complaints and for making improvements as a result of complaints is under way. Evidence that PCTs are developing mechanisms to monitor complaints about primary care contractors and commissioned services.

Factors that may contribute to a rating of **weak**	
Primary factors	There is little evidence of comparison of the demographic profile of complainants with that of the local population of patients. Many formal complaints referred to the Healthcare Commission for second stage resolution are returned for local resolution and many result in the complainant's concerns being upheld. There is limited evidence of progress in relation to agreed protocols and arrangements for handling complaints relating to care across health and social services. There is limited evidence that complaints are used to improve the delivery of services.
Supported by	Relevant information on the service for handling complaints, PALS and ICAS is not provided to patients. There is little evidence of mechanisms for obtaining feedback from complainants on the proccess for handling complaints. There is little evidence of mechanisms that link staff handling complaints with voluntary groups or interested organisations. Complainants are unlikely to be offered face to face meetings to resolve their complaints. Few clinical staff and few staff handling complaints have received training in how to handle complaints, and few are provided with appropriate support to enable them to deal with complaints efficiently and effectively.

Public health

Outcome

Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population serviced and reduce health inequalities between different groups and areas.

Developmental standard

Healthcare organisations:

a. identify and act upon significant public health problems and health inequality issues, with primary care trusts taking the lead role

b. implement effective programmes to improve health and reduce inequalities

c. protect their populations from identified current and new hazards to health

d. take fully into account current and emerging policies and knowledge on public health issues in the development of their public health programmes, health promotion and prevention services for the public, and the commissioning and provision of services

Approach

For 2006/2007, the developmental standard for public health (D13) will be assessed through analysis of progress in four key areas:

1. Intelligence in public health
2. Improvement in health and prevention of disease
3. Investment in health in the local community
4. protection of health and emergency planning

Themes for declaration – see appendix E

Public health

Theme for declaration	Potential supporting data that is nationally available
1a	• Hospital Episode Statistics – for example, proportion of international classification of disease (ICD) codes valid or blank
2a	A composite marker of performance using two parts: 1. Performance of PCTs with local populations that have similar socio-economic status. • Within the appropriate benchmarked group, the PCT demonstrates high proportions of, for example: – breast cancer screening for women aged 50 to 70 years, infant mortality and rates of breast feeding (Healthcare Commission: National targets) – KC53: Proportion of women aged 25 to 64 years screened for cervical abnormalities (Department of Health: Data standards central returns) • Within the appropriate comparative group, the primary care trust demonstrates low proportions of, for example: – rates of mortality for cancer and cardiovascular disease (Healthcare Commission: National targets) – rates of hospital admission for serious accidental injury for people under 20 years (Health and Social Care Information Centre: Hospital episode statistics) – incidence of common cancers (National Centre for Health Outcomes Development) 2. Absolute performance measured for each PCT, for example: • access to contraception (Healthcare Commission: National targets)
2c	• Healthcare Commission: Surveys of staff – for example, proportion of respondents to the survey of staff who disagreed that, or were unsure whether, senior management in their organisation built strong, cooperative links with other organisations

Theme for declaration	Potential supporting data that is nationally available
3a	• Health and Social Care Information Centre: Quality and outcomes framework – for example, practice management. There is a written manual of procedures that includes equal opportunities, bullying, harassment and absence through sickness (including through use of illegal drugs, alcohol and stress) to which staff have access • Healthcare Commission: Surveys of staff – for example, options for flexible working and physical violence
4a	• data collected to meet the Civil Contingencies Act 2005
5a	A composite marker of performance using benchmarked performance for PCTs with local populations that have similar socio-economic status: • Within the appropriate benchmarked group, the PCT demonstrates **high** proportions of: - uptake of diphtheria, tetanus and pertussis immunisation at two years (better metrics) - uptake of MMR immunisation at two years (Department of Health cover) • Within the appropriate comparative group, the PCT demonstrates **low** proportions of: - mumps, measles, TB, meningitis and hepatitis B and C (Health Protection Agency) - incidence of measles by local authority (National Centre for Health Outcomes Development)

Proposed developmental ladder: Public health

Public health intelligence – the generation and use of data of high quality

Factors that may contribute to a rating of **excellent**	
	Intelligence systems are comprehensive and robust, draw upon a range of sources of data, and are fully integrated into decision-making at all levels of strategy and operations. There is full engagement of representatives of patients and other local people (especially those from deprived neighbourhoods), managers (including commissioners and finance personnel) and clinicians in continuously building knowledge of the local area. Comprehensive assessment of needs enables fair and proportionate commissioning of services to be achieved, inequalities in health to be reduced and inequities in the use of services to be minimised. This includes comprehensive audit of health equity, rural proofing and other tools. Joint commissioning with local strategic partners and children's trusts is in place across all relevant service areas/care groups. The 'health equity audit' is a comprehensive part of the annual framework for planning and commissioning.

Factors that may contribute to a rating of **good**	
	Local targets are set and progress is monitored. Investments and disinvestments in services are systematically informed by what is needed and what is effective. There is systematic involvement of clinicians, the public and patients in defining priorities for commissioning. Joint commissioning with social services and children's directorates in local authorities on priorities for services/care groups is in place. Evidence that information is available in a variety of forms and used by different audiences. Decisions on commissioning are monitored and evaluated. Joint plans, including local area agreements, are developed in light of strong local intelligence. 'Health equity audits' are conducted on areas of priority.

Proposed developmental ladder: Public health *continued*

Factors that may contribute to a rating of **fair**	
	Local data are drawn from a wide range of sources, including local authority's data on services (including social services, education and leisure), local intelligence on economic/regeneration and demographics, data from the police, and dialogue with patients and local people. Evidence that local data are pooled and analysed, and that local intelligence widely influences decision-making (including boards' decisions). Public health personnel support others in making sense of intelligence and systematically use it to improve decision-making, including for local regeneration schemes.

Factors that may contribute to a rating of **weak**	
	Comprehensive assessments of needs use many methods to build a picture of local needs, assets and inequities in the use of services. Systems are in place to capture and analyse routine data on health and services. The data are used to inform strategies about services. Regular assessments of equity, need and assets are undertaken using a range of techniques to generate information, including techniques to assess the impact of proposals in terms of health, equality, and race. Other techniques are applied where appropriate, such as the 'health equity audit', health needs assessment and health impact assessment. Production of annual report on public health. There is evidence of regular review of business plans and priorities for commissioning in light of up to date intelligence about local populations, current and predicted health status of the local population, current best practice, and clinical effectiveness. Requirements of national service frameworks and national plans have been addressed and implementation plans are in place and reviewed regularly. Priorities set out in *Choosing health* are being addressed. There is some evidence that the views of local people are taken into account. Changes in the commissioning of services reflect shifting patterns of need. A 'health equity audit' has been conducted.

Improving the overall health of local people and reducing differences in health between groups and communities

Factors that may contribute to a rating of **excellent**	
	Sustained improvements in health and reductions in inequalities in health can be demonstrated as a result of activities aimed at improving health, including desired changes in the use of healthcare services. Joint strategies for health improvement are in place (for example, through the local strategic partnership, local area agreements and local targets); joint commissioning and delivery of action aimed at improving health are evident; joint appointments for senior public health personnel are established between PCTs and local authorities where appropriate; and resources are pooled to deliver shared strategic priorities. Evidence that action aimed at improving and protecting health have had sustained positive effects on the health of local people, in line with national and locally defined targets, and have contributed to the reduction of inequalities in health.

Factors that may contribute to a rating of **good**	
	Shared priorities across sectors are identified, and what is expected of contributors has been clearly articulated and understood. Partnerships are showing sustained progress. Early improvements in the health of the local population are evident. Programmes aimed at improving and protecting health are developed, implemented and monitored.

Factors that may contribute to a rating of **fair**	
	Early improvements in activities aimed at improving the health of the local population can be demonstrated (e.g. statin prescriptions, smoking cessation). Partnership arrangements are productive and reflect the diversity of the local community and the voluntary, statutory and private sectors. The 'public health cycle' is used to develop, implement and monitor programmes of work. There are agreed priorities for improving health and reducing inequalities.

Proposed developmental ladder: Public health *continued*

Factors that may contribute to a rating of **weak**	
	Evidence of effective working in partnership, limited primarily to other healthcare organisations and the local authority. Representation on the local strategic partnership, the crime and disorder reduction partnership and national service framework local implementation teams. The working in partnership is limited to topics set out in the *Choosing health* (for example, weight loss and smoking cessation). NICE public health guidance is used. Local intelligence, requirements of *Choosing health*, national service frameworks and other national initiatives, plans and targets are used to identify priorities for improving and protecting health.

Improving health through investment in the local community

Factors that may contribute to a rating of **excellent**	
	The workforce broadly reflects the local population, with proportionate representation of people from deprived areas and vulnerable groups, including black and ethnic minority communities, disabled people and users of mental health services. There is evidence of robust systems for reporting and monitoring. Comprehensive policies are implemented, including a strong active role for the occupational health service, in promoting health and wellbeing and reducing inequalities in health. 'Back to work' schemes and measures to manage absence through sickness are in place. Schemes extend to all staff, including those employed by contracted companies and organisations. There are comprehensive and embedded 'health at work' schemes which strive to improve the health of the workforce. This includes implementing the NHS' plans for healthy transport, green travel, and 'wheels to work' schemes. The local healthcare organisation works with others, especially local authorities, to reduce barriers to cycling, walking and use of public transport. Targets for percentage of goods and services procured locally are systematically met.

Factors that may contribute to a rating of **good**	
	Workforce planning, and training and development are in place to enable local people, especially those from deprived communities, to progress their careers through the trusts' structures. Incentives and structures are in place to encourage staff to walk and cycle to work (for example, provision of showers and adequate bicycle racks). The workforce is mapped against the local population and an action plan is in place with identified targets, with special regard for promoting proportionate representation of black and ethnic minority communities in the workforce. Local procurement of goods and services is evident.

Factors that may contribute to a rating of **fair**	
	There is evidence of promotion of healthy eating and physical activity to staff. A policy on tobacco control is in place. Evidence that staff are supported in reducing stress and countering bullying. A strategy on occupational health is developed and implemented to reduce accidents, incidents of violence, and absence through sickness. Local procurement of goods and services features in business planning.

Factors that may contribute to a rating of **weak**	
	There is evidence of systematic attempts to reduce smoking and protect workers from the effects of second-hand smoke. The local healthcare organisation audits the use of transport as a result of its business and seeks to improve the health of its staff by promoting lunch time walks, 'meetings on the go', walking time to get to meetings. Travel plans are developed and implemented. Opportunities for local procurement of goods and supplies are identified.

Proposed developmental ladder: Public health *continued*

Health protection and effective emergency planning

Factors that may contribute to a rating of **excellent**	
	Advanced training is delivered to key personnel, and basic training to all others, to ensure that all members of staff know how to respond when a major incident is declared. Specialist staff are in place to give expert advice on reducing the risk and spread of infection. Regular and appropriate training is provided for all staff on reducing the risk and spread of infection. The outbreak plan is regularly tested with key partners.

Factors that may contribute to a rating of **good**	
	The plans for major incidents is reviewed and updated to incorporate new potential hazards and is tested appropriately. Learning from the tests is incorporated into the revised plan and in the training of staff and resources. The healthcare organisation reviews its outbreak plans in consultation with other key agencies. Plans are regularly updated to deal with new infections based on local, national and international surveillance and horizon scanning, and national and international studies.

Factors that may contribute to a rating of **fair**	
	The plan for major incidents is tested as appropriate in collaboration with other key organisations. Learning from the tests is incorporated into the plan. The organisation has identified specialists who are trained in appropriate areas, and are aware of their responsibilities. Regular reviews of the range of major incidents and emergencies that the healthcare organisation may have to respond to are undertaken and plans are updated accordingly. Outbreak plans are reviewed and tested as appropriate in consultation with other key agencies. Plans are updated to reflect new emergent infections based on national guidance. Training is given to specialist staff on managing an outbreak and plans are tested. Training is given to all staff on how to reduce infection.

Factors that may contribute to a rating of **weak**	
	The healthcare organisation has a plan for major incidents in place, which outlines the range of major incidents and emergencies that it may need to respond to. The plan is written in consultation with key partners. There are clearly identified responsibilities for staff. The plans are reviewed regularly and regular testing of plans with partners are undertaken. Plans reflect new infectious agents and are written in partnership with other key agencies. Training is given to staff on managing an outbreak.

Appendix G: New national targets

Extract from *National standards, local action: health and social care standards and planning framework 2005/2006-2007/2008*.[9]

Priority 1: Improve the health of the population

- by 2010 increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women
- substantially reduce mortality rates by 2010 (from the Our Healthier Nation baseline, 1995-1997):
  - from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the 20% of areas with the worst health and deprivation indicators and the population as a whole
  - from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the 20% of areas with the worst health and deprivation indicators and the population as a whole
  - from suicide and undetermined injury by at least 20%
- reduce inequalities in health by 10% by 2010 (from 1997-1999 baseline) as measured by infant mortality and life expectancy at birth
- tackle the underlying determinants of ill health and inequalities in health by:
  - reducing adult smoking rates (from 26% in 2002) to 21% or less by 2010, with a reduction in prevalence among routine and manual groups from (31% in 2002) to 26% or less
  - halting the year on year rise in obesity among children under 11 (from the 2002-2004 baseline) in the context of a broader strategy to tackle obesity in the population as a whole
  - reducing the under 18 conception rate by 50% by 2010 (from the 1998 baseline) as part of a broader strategy to improve sexual health

Priority 2: Supporting people with long term conditions

- to improve health outcomes for people with long term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008 (from the 2003/2004 baseline), through improved care in primary care and community settings

Priority 3: Access to services

- to ensure that by 2008 no one waits more than 18 weeks from GP referral to hospital treatment
- increase the participation of problem drug users in treatment programmes by 100% by 2008 (from a 1998 baseline); and increase year on year the proportion of drug users successfully sustaining or completing treatment programmes

Priority 4: Patient/user experience

- secure sustained national improvements in NHS patient experience by 2008, ensuring that individuals are fully involved in decisions about their healthcare, including choice of provider, as measured by independently validated surveys (the experiences of black and minority ethnic groups to be specifically monitored as part of these surveys)

9 Published by the Department of Health in 2004. See appendix C.

- improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by:
  - increasing the proportion of older people being supported to live at home by 1% annually in 2007 and 2008
  - increasing the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care

Achieve year on year reductions in MRSA levels, expanding to cover healthcare associated infections as data from mandatory surveillance becomes available.

Appendix H: Programme of reviews

As part of the annual health check, we also carry out reviews that provide more in-depth, patient-centred assessments of performance and outcomes in a small number of priority areas.

During 2005/2006, the following reviews will contribute to the performance ratings for healthcare organisations.

Improvement reviews:

- tobacco control
- substance misuse services
- adult community mental health services
- heart failure
- services for children in hospital

Acute hospital portfolio reviews:

- admissions management
- medicines management
- diagnostic services

The programme of reviews for 2006/2007 is outlined below.

Improvement reviews 2006/2007

Our programme of improvement reviews assesses the progress made by healthcare organisations in ensuring continuous improvement in a small number of areas of priority each year. The reviews assess performance from a range of different starting points – for example, in relation to a particular domain (such as safety), groups of the population (such as children or older people), or particular conditions (such as heart failure, mental illness or diabetes) – and looks at how care is provided across organisational boundaries.

The topics are developed in light of the following criteria:

- is this topic a priority for:
  - patients and the public?
  - healthcare organisations and their partners?
  - Government?
- is this a critical area affecting:
  - a lot of people and/or significant resources?
  - a small number of people, but with significant risks to them?
- is there a reasonable basis for considering that our activities will promote significant improvement in the delivery of a service?
- is there a reasonable basis for considering that our action will promote activities to improve the health and wellbeing of the population and reduce inequalities in health?
- is the Healthcare Commission particularly wellplaced to lead this work? What are the options for working in partnership with other organisations?
- do we have the capacity and capability? What are the options in terms of scale and resources?

Diabetes

More than 1.3 million people in England have diabetes, and it is estimated that another one million are undiagnosed. The number of people with diabetes is increasing in all age groups and all populations, but in an uneven manner. There is an increasing prevalence of diabetes among older people, people who are overweight and obese, those with a family history of diabetes, people who are poor,

and people from south Asian, African and African-Caribbean backgrounds.

The improvement review will assess how the NHS supports adults with diabetes to care for themselves. Supporting people with diabetes to manage their own care has been a vital component of care for diabetes for some time. The national service frameworks, NICE guidance and the policy of the Department of Health have reinforced this position.

The review will begin in the summer of 2006 and be timed to enable information provided by the Healthcare Commission's national survey of people with diabetes, the diabetes clinical audit and the general medical services contract's quality and outcomes framework to be used. The amount of bespoke data that is collected will be limited. This review is part of a programme of work that aims to assess services for people who live with long term conditions.

Substance misuse

Substance misuse covers the misuse of illegal and prescribed drugs and alcohol abuse. There are an estimated 287,000 problem drug users nationally (not including alcohol) and around 160,000 people were treated for substance misuse in 2004/2005.

The National Treatment Agency (NTA) and the Healthcare Commission have agreed to work jointly to establish a review process for substance misuse services. The memorandum of understanding that governs this work is available at **www.nta.nhs.uk**.

In 2005/2006, the first improvement review of community prescribing services, care planning and care coordination was carried out.

The improvement review being developed for 2006/2007 will look at:

- the reduction of harm – focusing on the exchange of needles and blood borne viruses, reflecting the increase in the prevalence of hepatitis C among injecting drug users both in and out of treatment
- management of systems including commissioning where evidence suggests that effectiveness varies according to the commitment of local agencies and the quality of local leadership

Mental health services

Approximately one in six adults at any one time has a mental health disorder, and the World Health Organisation (WHO) predicts that depression will be the leading cause of disability internationally by 2020. Work related stress affects one in five workers (five million people), and is the commonest cause of days lost from work. Five per cent of people over 65 years and 10% to 20% of people over 80 years have some form of dementia. Dementia is present in 20% of medical admissions of people aged over 65 years and 40% of people aged over 85 years.

Historically, inpatient services for people with mental health problems have been neglected, while the emphasis in mental health services has shifted to treatment in the community. Pressures on inpatient services include falling numbers of beds, shortages of staff, high occupancy of beds, and inadequate arrangements for safety.

The recently published social exclusion unit report into mental health and social exclusion calculated that mental health problems cost the country an estimated £77 billion per year through costs of care, economic losses and premature death. The total cost of mental health problems in England (based on 1996/1997 prices) was estimated to be at least £32 billion. It is estimated that the figure for 2000/2001 was £38.5 billion.

Mental health remains a priority area for the Healthcare Commission and, building on the joint review with the Commission for Social Care Inspection (CSCI) of community mental health services in 2005/2006, we intend to assess the performance of acute inpatient services in 2006/2007. This work will be undertaken in partnership with colleagues from the National Institute for Mental Health in England (NIMHE), the National Mental Health Partnership and other key bodies. Work on developing the framework for assessment is under way and we intend to begin piloting the review in mid to late 2006.

Race and equality

We are proposing to undertake an improvement review with the Commission for Racial Equality, which will look at the performance of healthcare organisations in relation to race equality. Work to define the scope of this review is under way and we aim to complete this in spring of the 2006. The aim of this review will be to assess how well healthcare organisations are meeting their statutory obligations, including systematically addressing the needs of patients and users of services from black and minority ethnic groups. There will be potential to make the policies and procedures of healthcare organisations more inclusive of patients and users of services from black and minority ethnic groups, as well as highlighting some areas where significant progress has already been made in this regard.

Reviews in the acute hospital portfolio 2006/2007

Reviews in the acute hospital portfolio assess the performance of acute trusts in relation to value for money, including quality, efficiency and effectiveness. They also aim to provide trusts with benchmarking data to help them improve performance.

The topics are selected according to the criteria set out for improvement reviews for the purpose of comparison with others. The emphasis to date has been on assessing progress in areas of acute care that have been reviewed previously. However, during 2006/2007, the acute hospital portfolio will include a new topic: maternity services.

Maternity services

Recent investigations by the Healthcare Commission into maternity services at three separate trusts found worrying similarities in care and treatment. These investigations suggested that a national review of maternity services needed to be carried out. Among the main factors identified during the investigations are poor practices relating to shortages of staff and levels of staff. About one in 10 requests to the Healthcare Commission for investigation of particular trusts relate to maternity services.

The acute hospital portfolio review will be carried out jointly with a national survey of mothers who have recently given birth, ensuring that it is large enough to provide a robust sample at each trust. There will also be a smaller national survey carried out by the Department of Health to identify the matters of greatest importance for new mothers. As well as taking account of the information already available on maternity services, the review will look at the latest data on births

from the Department of Health's hospital episode statistics, the provision of antenatal care (for example, frequency and purpose of appointments), rates of caesarean section and immediate post natal care. It will include care in the community as well as care in hospital.

Emergency care

A review of emergency care will also commence during 2006/2007, looking at ambulance services and care not provided by hospitals, as well as building on our previous work on accident and emergency services. The review has been delayed in light of the reconfiguration of ambulance services scheduled to take place during 2006/2007. It will therefore not feed into the annual health check until 2007/2008.

Appendix I: The national clinical audit and patients' outcomes programme

In April 2004, the Healthcare Commission inherited responsibility for the national clinical Audit and patients' outcomes programme. Previously, the programme was commissioned by the Commission for Health Improvement, which, in turn, inherited it from NICE. Predating NICE, the programme also includes agreements entered into by the information policy unit and other policy teams in the Department of Health. The Welsh Assembly Government has asked the Healthcare Commission to extend the programme to Wales wherever possible.

The programme has the potential to deliver rich information about the quality of care and outcomes for individual care to patients. Local clinicians and managers can use the findings to improve the care they provide to patients. The Healthcare Commission can use information from participating trusts, and the findings, to corroborate self-assessments by trusts in relation to core and developmental standards, monitor progress against targets and inform improvement reviews. The projects are led by clinicians from specialist societies and royal colleges, and are a good example of how the Healthcare Commission can involve clinicians in improvements to the quality of care.

Monitoring findings from clinical audit and patients' outcomes should be vital parts of the cycle of continuous improvement in providing healthcare.

During 2006/2007, we will be commissioning a range of projects covering most aspects of healthcare. The projects are at different stages of development. A number of these projects are already delivering improvements for patients. We are also developing a website that will provide patients and their GPs with useful information about adult cardiac surgery to help inform their choice of hospital. More information about the national clinical audit and patients' outcomes programme and topics is available on the Healthcare Commission website.

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