

Monitor

Making the health sector
work for patients

Detailed requirements for quality reports 2013/14



About Monitor

Monitor is the sector regulator for health services in England. Our job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit.

For example, we make sure foundation hospitals, ambulance trusts and mental health and community care organisations are well led and are run efficiently, so they can continue delivering good quality services for patients in the future. To do this, we work particularly closely with the Care Quality Commission, the quality and safety regulator. When it establishes that a foundation trust is failing to provide good quality care, we take remedial action to ensure the problem is fixed.

We also set prices for NHS-funded services, tackle anti-competitive practices that are against the interests of patients, help commissioners ensure essential local services continue if providers get into serious difficulty, and enable better integration of care so services are less fragmented and easier to access.

Introduction

Quality of care is vital to patient experience, and therefore closely connected to Monitor's core duty of protecting and promoting the interests of patients. In pursuit of this, we see great value in accurate and comprehensive quality reporting that allows an NHS foundation trust itself and all interested parties a clear view of the quality of care being delivered to patients.

To help achieve this, NHS foundation trusts must include a report on the quality of care they provide (the "**quality report**") within their overall annual report.¹ The quality report specifically aims to improve public accountability for the quality of care.

NHS foundation trusts must also publish **quality accounts** each year, as required by the NHS Act 2009, and in the terms set out in the NHS (Quality Accounts) Regulations 2010 as amended by the NHS (Quality Accounts) Amendments Regulations 2011 and the NHS (Quality Accounts) Amendments Regulations 2012 (collectively "the Quality Accounts Regulations").

The quality report incorporates all the requirements of the Quality Account Regulations as well as a number of additional reporting requirements set by Monitor.

This document

This document describes the detailed requirements for the **quality report**.

As there is overlap between the information to be included in the quality accounts and what Monitor needs to see in a quality report, within this document the requirements relating to the Quality Accounts Regulations are in black text, while **Monitor's additional reporting requirements are in red text**.

The quality report must contain (in the following order):

- Part 1 – Statement on quality from the chief executive of the NHS foundation trust;
- Part 2 – Priorities for improvement and statements of assurance from the board;
- Part 3 – Other information; and
- Two annexes
 - statements from NHS England or relevant clinical commissioning groups, local Healthwatch organisations, and overview and scrutiny committees
 - a statement of directors' responsibility in respect of the quality report.

In this document we explain the detailed requirements of each of the sections listed above, from Part 1 through to the annexes.

¹ For full guidance on annual reporting, please see our publication [NHS Foundation Trust Annual Reporting Manual 2013/14](#).

Part 1: Statement on quality from the chief executive of the NHS foundation trust

This section of the quality report should contain a statement summarising the NHS foundation trust's view of the quality of relevant health services that it provided or sub-contracted during 2013/14.

At the end of this section, there must be a declaration, signed by the chief executive, that to the best of his/her knowledge the information in the document is accurate.

Part 2: Priorities for improvement and statements of assurance from the board

2.1 Priorities for improvement

This section of the quality report should describe areas for improvement in the quality of relevant health services that the NHS foundation trust intends to provide or sub-contract in 2014/15.

The description must include:

- at least three priorities for improvement (agreed by the NHS foundation trust's board) indicating the relationship, if any, between the identification of these priorities and the reviews of data relating to quality of care referred to in the assurance statement numbered 1.1 below (see p.6);
- progress made since publication of the 2012/13 quality report – this should include performance in 2013/14 against each priority and, where possible, the performance in previous years²;
- how progress to achieve these priorities will be monitored and measured; and
- how progress to achieve these priorities will be reported.

Please include a rationale for the selection of the priorities and whether/how the views of patients, the wider public and staff were taken into account.

When the NHS foundation trust identifies its quality improvement priorities for 2014/15, it should do so with the expectation of reporting on them in future.

² The number of previous years to include is a decision for each trust.

2.2 Statements of assurance from the board

Part 2 of the quality report should also include a series of statements of assurance from the board of the NHS foundation trust on particular points (detailed in the “Prescribed information” column below).

The exact form of each of these statements, as specified by the Quality Accounts Regulations, is laid out below (under “Form of statement”). Within the wordings, italics indicate information that must be inserted by the trust.

| | Prescribed information | Form of statement |
|-----|--|--|
| 1. | The number of different types of relevant health services provided or sub-contracted by the provider during the reporting period, as determined in accordance with the categorisation of services— (a) specified under the contracts, agreements or arrangements under which those services are provided; or (b) in the case of an NHS body providing services other than under a contract, agreement or arrangements, adopted by the provider. | During [<i>reporting period</i>] the [<i>name of provider</i>] provided and/or sub-contracted [<i>number</i>] relevant health services. |
| 1.1 | The number of relevant health services identified under entry 1 in relation to which the provider has reviewed all data available to it on the quality of care provided during the reporting period. | The [<i>name of provider</i>] has reviewed all the data available to them on the quality of care in [<i>number</i>] of these relevant health services. |
| 1.2 | The percentage that the income generated by the relevant health services reviewed by the provider, as identified under entry 1.1, represents of the total income for the provider for the reporting period under all contracts, agreements and arrangements held by the provider for the provision of, or sub-contracting of, relevant health services. | The income generated by the relevant health services reviewed in [<i>reporting period</i>] represents [<i>number</i>] per cent of the total income generated from the provision of relevant health services by the [<i>name of provider</i>] for [<i>reporting period</i>]. |
| 2. | The number of national clinical audits(a) and national confidential enquiries(b) which collected data during the reporting period and which covered the relevant health services that the provider provides or sub-contracts. | During [<i>reporting period</i>] [<i>number</i>] national clinical audits and [<i>number</i>] national confidential enquiries covered relevant health services that [<i>name of provider</i>] provides. |
| 2.1 | The number, as a percentage, of national clinical audits and national confidential enquiries, identified under entry 2, that the provider participated in during the reporting period. | During that period [<i>name of provider</i>] participated in [<i>number as a percentage</i>] national clinical audits and [<i>number as a percentage</i>] national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. |

| | Prescribed information | Form of statement |
|-----|--|---|
| 2.2 | A list of the national clinical audits and national confidential enquires identified under entry 2 that the provider was eligible to participate in. | The national clinical audits and national confidential enquiries that [<i>name of provider</i>] was eligible to participate in during [<i>reporting period</i>] are as follows: [<i>insert list</i>]. |
| 2.3 | A list of the national clinical audits and national confidential enquiries, identified under entry 2.1, that the provider participated in. | The national clinical audits and national confidential enquiries that [<i>name of provider</i>] participated in during [<i>reporting period</i>] are as follows: [<i>insert list</i>]. |
| 2.4 | A list of each national clinical audit and national confidential enquiry that the provider participated in, and which data collection was completed for during the reporting period, alongside the number of cases submitted to each audit, as a percentage of the number required by the terms of the audit or enquiry. | The national clinical audits and national confidential enquires that [<i>name of provider</i>] participated in, and for which data collection was completed during [<i>reporting period</i>], are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. [<i>insert list and percentages</i>] |
| 2.5 | The number of national clinical audit reports published during the reporting period that were reviewed by the provider during the reporting period. | The reports of [<i>number</i>] national clinical audits were reviewed by the provider in [<i>reporting period</i>] and [<i>name of provider</i>] intends to take the following actions to improve the quality of healthcare provided [<i>description of actions</i>]. The reports of [<i>number</i>] local clinical audits were reviewed by the provider in [<i>reporting period</i>] and [<i>name of provider</i>] intends to take the following actions to improve the quality of healthcare provided [<i>description of actions</i>]. |
| 2.6 | A description of the action the provider intends to take to improve the quality of health care following the review of reports identified under entry 2.5. | |
| 2.7 | The number of local clinical audit(a) reports that were reviewed by the provider during the reporting period. | |
| 2.8 | A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.7. | |
| 3. | The number of patients receiving relevant health services provided or sub-contracted by the provider during the reporting period that were recruited during that period to participate in research approved by a research ethics committee within the National Research Ethics Service(a). | The number of patients receiving relevant health services provided or sub-contracted by [<i>name of provider</i>] in [<i>reporting period</i>] that were recruited during that period to participate in research approved by a research ethics committee [<i>insert number</i>]. |

| | Prescribed Information | Comment |
|-----|---|---|
| 4. | Whether or not a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals under the Commissioning for Quality and Innovation payment framework(b) agreed between the provider and any person or body they have entered into a contract, agreement or arrangement with for the provision of relevant health services. | Either: (a) A proportion of [<i>name of provider</i>] income in [<i>reporting period</i>] was conditional on achieving quality improvement and innovation goals agreed between [<i>name of provider</i>] and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for [<i>reporting period</i>] and for the following 12 month period are available electronically at [<i>provide a weblink</i>]. Or: (b) [<i>name of provider</i>] income in [<i>reporting period</i>] was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because [<i>insert reason</i>]. |
| 4.1 | If a proportion of the provider's income during the reporting period was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation Payment framework the reason for this. | |
| 4.2 | If a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation Payment framework, where further details of the agreed goals for the reporting period and the following 12 month period can be obtained. | |

NHS foundation trusts **may** choose to expand further upon their agreed goals and the rationale behind them (eg, how they fit with local and/or regional strategies).

NHS foundation trusts **must** include a statement that includes a monetary total for income in 2013/14 conditional upon achieving quality improvement and innovation goals, and a monetary total for the associated payment in 2012/13.

Table continues below.

| | Prescribed Information | Comment |
|-----|--|---|
| 5. | Whether or not the provider is required to register with the CQC under section 10 of the Health and Social Care Act 2008(c). | [<i>name of provider</i>] is required to register with the Care Quality Commission and its current registration status is [<i>insert description</i>]. [<i>name of provider</i>] has the following conditions on registration [<i>insert conditions where applicable</i>]. |
| 5.1 | If the provider is required to register with the CQC— (a) whether at end of the reporting period the provider is— (i) registered with the CQC with no conditions attached to registration, (ii) registered with the CQC with conditions attached to registration, (b) if the provider’s registration with the CQC is subject to conditions what those conditions are; and (c) whether the CQC has taken enforcement action against the provider during the reporting period. | The Care Quality Commission (has/has not) taken enforcement action against [<i>name of provider</i>] during [<i>reporting period</i>]. |
| 6. | Removed from the legislation by the 2011 amendments | |
| 6.1 | | |
| 7. | Whether or not the provider has taken part in any special reviews or investigations by the CQC under section 48 of the Health and Social Care Act 2008 during the reporting period. | Either: [<i>name of provider</i>] has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during [<i>reporting period</i>] [<i>insert details of special reviews and/or investigations</i>]. [<i>name of provider</i>] intends to take the following action to address the conclusions or requirements reported by the CQC [<i>insert details of action</i>]. |
| 7.1 | If the provider has participated in a special review or investigation by the CQC— (a) the subject matter of any review or investigation, (b) the conclusions or requirements reported by the CQC following any review or investigation, (c) the action the provider intends to take to address the conclusions or requirements reported by the CQC, and (d) any progress the provider has made in taking the action identified under paragraph (c) prior to the end of the reporting period. | [<i>name of provider</i>] has made the following progress by 31st March [<i>insert year</i>] in taking such action [<i>insert description of progress</i>]. Or: [<i>name of provider</i>] has not participated in any special reviews or investigations by the CQC during the reporting period. |

| | Prescribed Information | Comment |
|------|---|---|
| 8. | Whether or not during the reporting period the provider submitted records to the Secondary Uses service(a) for inclusion in the Hospital Episode Statistics(b) which are included in the latest version of those statistics published prior to publication of the relevant document by the provider. | Either: [<i>name of provider</i>] submitted records during [<i>reporting period</i>] to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data: |
| 8.1 | If the provider submitted records to the Secondary Uses service for inclusion in the Hospital Episodes Statistics which are included in the latest published data: (a) the percentage of records relating to admitted patient care which include the patient's— (i) valid NHS number; and (ii) General Medical Practice Code; (b) the percentage of records relating to out patient care which included the patient's— (i) valid NHS number; and (ii) General Medical Practice Code; (c) the percentage of records relating to accident and emergency care which included the patient's— (i) valid NHS number; and (ii) General Medical Practice Code. | — which included the patient's valid NHS number was: [<i>percentage</i>] for admitted patient care; [<i>percentage</i>] for out patient care; and [<i>percentage</i>] for accident and emergency care. — which included the patient's valid General Medical Practice Code was: [<i>percentage</i>] for admitted patient care; [<i>percentage</i>] for out patient care; and [<i>percentage</i>] for accident and emergency care. Or: [<i>name of provider</i>] did not submit records during [<i>reporting period</i>] to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. |
| 9. | The provider's Information Governance Assessment Report overall score for the reporting period as a percentage and as a colour according to the IGT Grading scheme. | [<i>Name of provider</i>] Information Governance Assessment Report overall score for [<i>reporting period</i>] was [<i>percentage</i>] and was graded [<i>insert colour from IGT Grading scheme</i>]. |
| 10. | Whether or not the provider was subject to the Payment by Results clinical coding audit at any time during the reporting period by the Audit Commission(b). | Either: |
| 10.1 | If the provider was subject to the Payment by Results clinical coding audit by the Audit Commission at any time during the reporting period, the error rates, as percentages, for clinical diagnosis coding and clinical treatment coding reported by the Audit Commission in any audit published in relation to the provider for the reporting period prior to publication of the relevant document by the provider. | [<i>name of provider</i>] was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were [<i>percentages</i>]. Or: [<i>name of provider</i>] was not subject to the Payment by Results clinical coding audit during [<i>reporting period</i>] by the Audit Commission. |

NHS foundation trusts should include an explanatory note for clinical coding stating:

- that the results should not be extrapolated further than the actual sample audited; and
- which services were reviewed within the sample.

| | Prescribed Information | Comment |
|-----|---|---|
| 11. | The action taken by the provider to improve data quality. | [<i>name of provider</i>] will be taking the following actions to improve data quality [<i>insert actions</i>]. |

2.3 Reporting against core indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the trust by the Health and Social Care Information Centre (HSCIC).

For each indicator the number, percentage, value, score or rate (as applicable) for at least the last two reporting periods should be presented in a table. In addition, where the required data is made available by the HSCIC, a comparison should be made of the numbers, percentages, values, scores or rates of each of the NHS foundation trust's indicators with:

- a) the national average for the same; and
- b) those NHS trusts and NHS foundation trusts with the highest and lowest for the same.

This information should be presented in a table or graph (as seems most appropriate).

For each indicator, the NHS foundation trust must also make an assurance statement in the following form (words in italics indicate information which must be inserted by the trust):

The [*name of trust*] considers that this data is as described for the following reasons [*insert reasons*].

The [*name of trust*] [*intends to take/has taken*] the following actions to improve this [*indicator/percentage/score/data/rate/number*], and so the quality of its services, by [*insert description of actions*].

The core indicators are listed in the table below. The numbering scheme used in the table corresponds with the numbering of the indicators in the Regulation 4 Schedule within the Quality Accounts Regulations.

Some of the indicators will not be relevant to all NHS foundation trusts, for instance, ambulance response times. NHS foundation trusts are only required to report on indicators that are relevant to the services that they provide or sub-contract in the reporting period.

| | Prescribed information | Comment |
|------|--|---|
| 12. | (a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and (b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. | In the table showing performance against this indicator, both the SHMI value and banding should be shown for each reporting period. |
| 13. | The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period | |
| 14. | The percentage of Category A telephone calls (Red 1 and Red 2 calls) resulting in an emergency response by the trust at the scene of the emergency within 8 minutes of receipt of that call during the reporting period. | In the table showing performance against this indicator, Red 1 and Red 2 calls should be separate. |
| 14.1 | The percentage of Category A telephone calls resulting in an ambulance response by the trust at the scene of the emergency within 19 minutes of receipt of that call during the reporting period. | |
| 15. | The percentage of patients with a pre-existing diagnosis of suspected ST elevation myocardial infarction who received an appropriate care bundle from the trust during the reporting period. | |
| 16. | The percentage of patients with suspected stroke assessed face to face who received an appropriate care bundle from the trust during the reporting period. | |
| 17. | The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period. | |
| 18. | The trust's patient reported outcome measures scores for— (i) groin hernia surgery, (ii) varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery, during the reporting period. | |
| 19. | The percentage of patients aged— (i) 0 to 14; and (ii) 15 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period. | It has been acknowledged that an error was made in the drafting of the regulations and that the split of patients for this indicator should be (i) 0 to 15; and (ii) 16 or over |

| | Prescribed information | Comment |
|-----|--|---------|
| 20. | The trust's responsiveness to the personal needs of its patients during the reporting period. | |
| 21. | The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends. | |
| 22. | The trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period. | |
| 23. | The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period. | |
| 24. | The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period. | |
| 25. | The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death. | |

To ensure consistency in understanding of these indicators, NHS England will be publishing a "data dictionary" for the quality accounts (see the [quality accounts](#) area of the NHS Choices website). The data dictionary will include a definition for each indicator.

For 2013/14, NHS England has written to all NHS providers asking them to consider reporting on the patient element of the friends and family test within the quality accounts ([gateway reference 00931](#)). As this is not a statutory requirement, the patient element of the friends and family test has not been included in the table of indicators above.

Part 3: Other information

The Quality Accounts Regulations specify that Part 3 of the quality accounts should be used to present other information relevant to the quality of relevant health services provided or sub-contracted by the provider during the reporting period.

NHS foundation trusts must specifically use Part 3 of the quality report to present the following:

1. An overview of the quality of care offered by the NHS foundation trust based on performance in 2013/14 against indicators selected by the board in consultation with stakeholders, with an explanation of the underlying reason(s) for selection. The indicator set selected must include:
 - at least three indicators for patient safety;
 - at least three indicators for clinical effectiveness; and
 - at least three indicators for patient experience.

For those indicators selected by the NHS foundation trust, the report should refer to historical data and benchmarked data where available, so readers can understand progress over time and performance compared to other providers.

References should be given for the data sources for the indicators, including whether the data is governed by standard national definitions. Where these indicators have changed from the indicators used in the 2011/12 report, the NHS foundation trust should outline the rationale for the change.

Where the quality indicators are the same as those used in the 2011/12 report and refer to historical data, the data reported should be checked to ensure consistency with the 2011/12 report. Where inconsistencies exist, NHS foundation trusts are required to include an explanatory note on any changes to the basis of calculation.

2. Performance against the relevant indicators and performance thresholds set out in Appendix A of our [Risk Assessment Framework](#). Where any of these indicators have already been reported on in Part 2 of the quality report, in accordance with the Quality Accounts Regulations, they do not need to be repeated here.

Annex 1: Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

Where 50% or more of the relevant health services that the NHS foundation trust directly provides or sub-contracts during the reporting period are provided under contracts, agreements or arrangements with NHS England, the trust must provide a draft copy of its quality accounts/report³ to NHS England for comment prior to publication and should include any comments made in its published report.

Where the above does not apply, the trust must provide a copy of the draft quality accounts/report to the clinical commissioning group which has responsibility for the largest number of people to whom the trust has provided relevant health services during the reporting period for comment prior to publication and should include any comments made in its published report.

NHS foundation trusts must also send draft copies of their quality accounts/ report to their local Healthwatch organisation and overview and scrutiny committee (OSC) for comment prior to publication, and should include any comments made in their final published report.

The commissioners have a legal obligation to review and comment, while local Healthwatch organisations and OSCs will be offered the opportunity to comment on a voluntary basis.

³ The quality accounts and quality report are interchangeable as far as this requirement is concerned, given that the quality report incorporates all the requirements of the quality accounts.

Annex 2: Statement of directors' responsibilities for the quality report

The quality report must include a statement of directors' responsibilities, in the following form of words (*italics indicate information that must be inserted by the trust*):

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare quality accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2013/14*;
- the content of the quality report is not inconsistent with internal and external sources of information including:
 - board minutes and papers for the period April 2013 to June 2014
 - papers relating to Quality reported to the Board over the period April 2013 to June 2014
 - feedback from commissioners dated [XX/XX/20XX]
 - feedback from governors dated [XX/XX/20XX]
 - feedback from local Healthwatch organisations dated [XX/XX/20XX]
 - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated [XX/XX/20XX]
 - [atesf] national patient survey [XX/XX/20XX]
 - [atesf] national staff survey [XX/XX/20XX]
 - the head of internal audit's annual opinion over the trust's control environment dated [XX/XX/20XX]
 - CQC quality and risk profiles dated [XX/XX/20XX].
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

NB: sign and date in any colour ink except black

.....Date.....Chairman

.....Date.....Chief Executive



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work for patients

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