Agenda No 5

AGENDA MANAGEMENT SHEET

Name of Committee	**Health Overview and Scrutiny Committee**
Date of Committee	**15th June, 2005**
Report Title	**North Warwickshire PCT – Baseline Assessment for Improvement**
Summary	Representatives of the North Warwickshire PCT will be present to give the Committee an overview of Standards for Better Health the framework against which the PCT will be undertaking a baseline assessment of its performance. The PCT will make a draft declaration of its position in October 2005. The following background documents are attached:- (1) Healthcare Commission: Measuring what matters. (2) Department of Health: National Standards, Local Action – Health and Social Care Standards and Planning Framework 2005/06 – 2007/08.
For further information please contact:	Alwin McGibbon Health Scrutiny Officer Tel: 01926 412075 alwinmcgibbon@warwickshire.gov.uk
Would the recommended decision be contrary to the Budget and Policy Framework?	No.
Background papers	None

Warwickshire County Council

Healthcare Commission

Assessment for improvement The annual health check

Measuring what matters

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Foreword

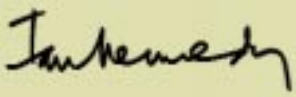
The Healthcare Commission exists to promote improvements in the quality of healthcare and public health in England. We are committed to making a real difference to the delivery of healthcare and to promote continuous improvement for the benefit of patients and the public.

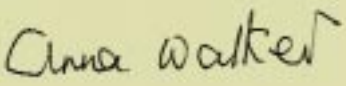
One of the ways we are doing this is by creating an entirely new approach to assessing and reporting on the performance of healthcare organisations. We have completed a wide ranging consultation on our proposed new system. Our thanks go to those who became involved – your feedback has been fundamental in shaping our approach. We are now ready to make it happen.

In the new system, or annual health check, we will be looking at a much broader range of issues in our assessments, enabling us to focus on measuring what matters. We aim to paint a richer picture than ever before of what is happening in healthcare. We will put the onus on healthcare organisations to make sure that they are meeting the expected standards of performance. However, we will check on that self assessment by talking to others in the local community and observers, and by using available information in a smarter way. If we need to follow up on any matter, our visits will be targeted and designed to support improvement. We will not, however, be afraid to speak as we find.

This is the beginning of an exciting and challenging journey to help to transform healthcare. It will demand that we work closely with other regulatory bodies, healthcare organisations, healthcare professionals, patients and the public. We will listen to what we are told, learn from experience and seek continuously to improve what we do.

We look forward to working with you.





Professor Sir Ian Kennedy
Chair

Anna Walker CB
Chief Executive

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Introduction

The Healthcare Commission exists to promote improvements in the quality of healthcare and public health through independent, authoritative, patient-centred assessments of the performance of those who provide services.

In England, we are responsible for reviewing the performance of each local NHS organisation and awarding an annual rating of that organisation's performance. We have developed a new approach for doing this from 2005/2006.

The new system, or annual health check, measures performance by reference to the Government's standards. The standards cover issues of concern to the public, patients and those who look after them – such as safety, patient focus and clinical effectiveness in the healthcare organisation. They are more broadly based than the targets previously used in assessments, providing a richer picture of how the healthcare organisation is performing, and are also concerned with the experience of patients when they move between different healthcare organisations.

Our aim is that the assessment of performance, and the information provided by the process, will promote improvements in a range of ways. It will help people to make better informed decisions about their care, lead to healthcare professionals developing and sharing better information on good practice, provide organisations with clearer expectations, enable managers to focus on areas of concern and learn from good practice, and tell the Government more about the quality and equity of services provided.

We are also aiming to make assessment less of a burden for those being inspected. We will make better use of the information readily available to us and focus our interventions on areas of concern.

We are also responsible for regulating the independent healthcare sector through registration and annual inspection. The care of patients is increasingly provided by a combination of NHS and independent services so, although the independent sector will not be assessed through the new health check, our eventual aim is to align assessments of the healthcare provided by these two sectors. In 2005/2006, to create a basis for this alignment, we will take a more risk-based approach to inspecting the independent sector.

Our proposed new system was the subject of a 12 week public consultation. The responses we received were crucial in shaping the final system presented in this document.

Key features of the annual health check

Our aim is that assessment of performance – and the information that is provided by the process – will promote improvements in healthcare in a range of ways.

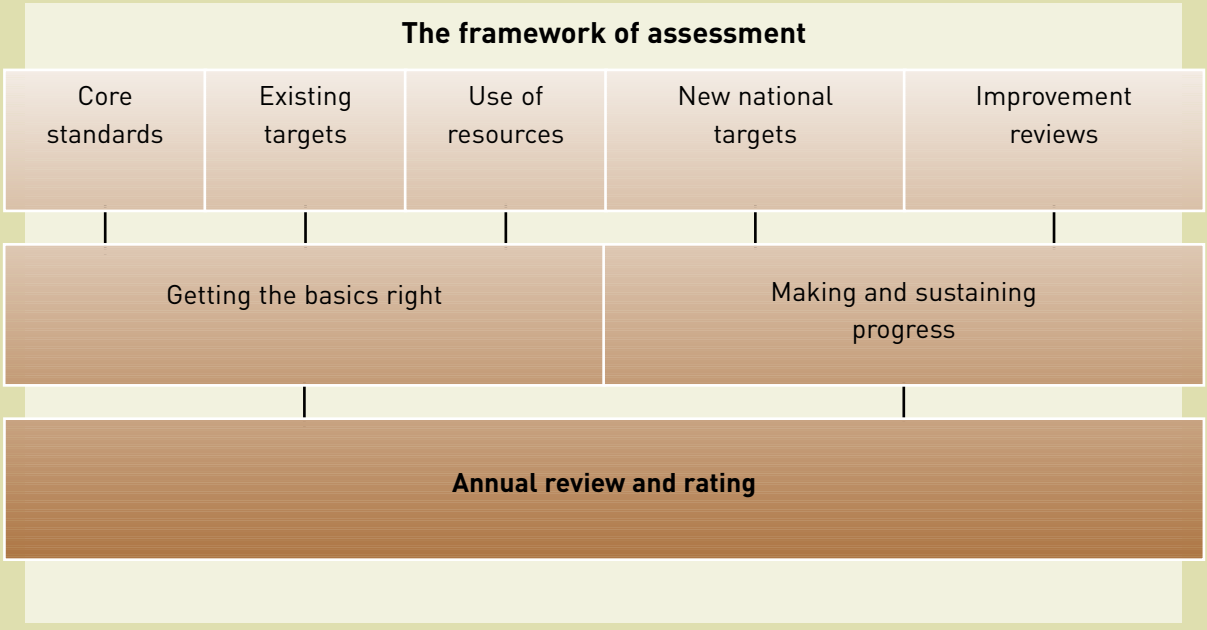
The new approach aims to help people to make better informed decisions about their care, promote information sharing and provide organisations with clearer expectations on standards of performance.

It aims to reduce regulatory burden while giving a more accurate picture of performance.

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

Is the organisation getting the basics right?
Is it making and sustaining progress?

To answer these questions, we are implementing a system of assessment with several components to be assessed and reported on separately. These components will be brought together for each trust's annual performance rating.



Information from 1,100 written responses and feedback from more than 300 events held during the consultation period fed into the new system of assessment. There was general support for our proposed approach. However, we have made significant refinements in response to the issues raised (see annex 1).

We will be taking account of the detailed responses to consultation as we develop more specific guidance on aspects of our approach for 2005/2006 and into the future. However, we want to confirm the main features of the system for 2005/2006 as early as possible so that healthcare organisations and groups representing patients and the public can plan effectively.

The new system aims to address issues that matter to patients, the public, clinicians and healthcare managers. It takes account of existing and new NHS targets as well as new standards for healthcare set by the Government.

It aims to reduce the burden of regulation and inspection on healthcare organisations. To do this, we will make better use of existing information to focus our interventions on areas of concern. The new system should cost less than the previous approach, while the attention to standards and targets should deliver a wider range of benefits. We will regularly evaluate the benefits and costs of the new approach and will complete a further formal assessment by autumn 2006.

The new system starts to align assessments of NHS services and those of the independent health sector.

It requires NHS trusts to make public declarations on the extent to which they meet the core standards. For this year only, draft declarations will be published in October 2005, identifying areas where standards are not being met or are at risk, as well as any improvements which need to be delivered by the end of March 2006. Final declarations will be published in April 2006. Declarations will be supplemented by comments from representatives of patients and the local community including local authorities. We will use the comments and a wide range of readily available information to carry out initial checks on performance and outcomes. We will follow up where there are concerns.

The new system uses findings from other regulators and other bodies to build a richer picture of performance, and to reduce the burden of regulation by not asking the same things more than once.

It strongly emphasises the delivery of existing targets and progress towards meeting new national targets.

It looks at progress with reference to developmental standards. Over time we aim to set out an improvement path so that organisations can see where they stand on a ladder of development. In 2005/2006, we will start this process through a programme of improvement reviews and discussions about measuring what matters in order to promote improvement. The reviews will focus on a range of areas, including particular aspects of the developmental standards (such as safety), population groups (such as children) and conditions (such as heart failure). All of these activities will look at progress made by healthcare organisations in ensuring continuous improvement in health and in the quality of care that people receive.

It aligns the overall timetable for NHS performance assessments with that of regulators of other public services (local government, social care, education) to improve coordination and working in partnership.

The Government has announced that the Healthcare Commission and the Commission for Social Care Inspection will merge by 2008. Over the next few years we will work together to further align our approaches to assessment.

The 2005/2006 assessment is just the start of a journey. The new system will be refined for future years in the light of experience and in discussion with all those involved.

Main changes following consultation

- we are introducing a two stage approach for the assessment of meeting core standards in 2005/2006, to give the health service and patients more time to understand the system
- we are changing the timetable for the assessment of meeting core standards to fit in with the NHS business cycle
- we are encouraging trusts to seek out the views of the wider community beyond patient and public involvement forums when assessing whether core standards are being met
- we have simplified and clarified the guidance on the Department of Health's *Standards for Better Health*
- we are introducing unannounced visits and spot checks in both the NHS and independent sectors
- the final performance rating will be published in September of each year, starting in September 2006
- we are phasing in the introduction of improvement reviews and the measurement of progress in meeting developmental standards
- we will not introduce our assessments of meeting local targets and of leadership and organisational capability until after 2005/2006

Our approach

Our approach for 2005/2006 is intended to be the start of a process that will provide a broad and rich assessment of performance. The objective is to improve outcomes for patients and the public now and in the future by:

- actively involving and engaging patients and the public in our assessments and reviews
- ensuring that basic standards are being met for everyone
- promoting improvements in health and healthcare
- bringing together relevant information to support better informed decisions
- promoting the narrowing of inequalities in the health of different groups in the population
- promoting respect for human rights and diversity in the delivery of healthcare

We recognise that it will take time to develop systems of engagement and assessment that achieve all these goals. Therefore, in 2005/2006, we will focus on ensuring that basic standards are being met. At the same time we will ensure that we learn from what we do in 2005/2006, so that we can improve our activities in the future as part of a coherent long term programme.

The new system aims to deliver more improvement and less red tape. To achieve this, we will make more intelligent use of the very wide range of information that is already available to us. We will use this information for continuing 'surveillance' of the performance of healthcare organisations – as the public would expect from a modern regulator. Because this surveillance information is already in our possession or easily available from national sources, its collection will not place any additional burden on healthcare organisations.

Taking account of standards in assessing performance

We have a statutory requirement to take account of the Department of Health's *Standards for Better Health* in our assessments of the performance of NHS organisations. These standards include a number of existing targets which the Government expects trusts to continue to meet. The Government has also set out a number of new national targets that the NHS is working towards.

Our approach in assessing whether healthcare organisations are meeting these standards is to realise that they are not ends in themselves. Their purpose is to ensure that healthcare organisations can best serve the public and patients. We will be keeping this purpose in mind throughout the process.

The standards, covering all aspects of healthcare, are split into seven domains:

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

Within these domains, there are two types of standards:

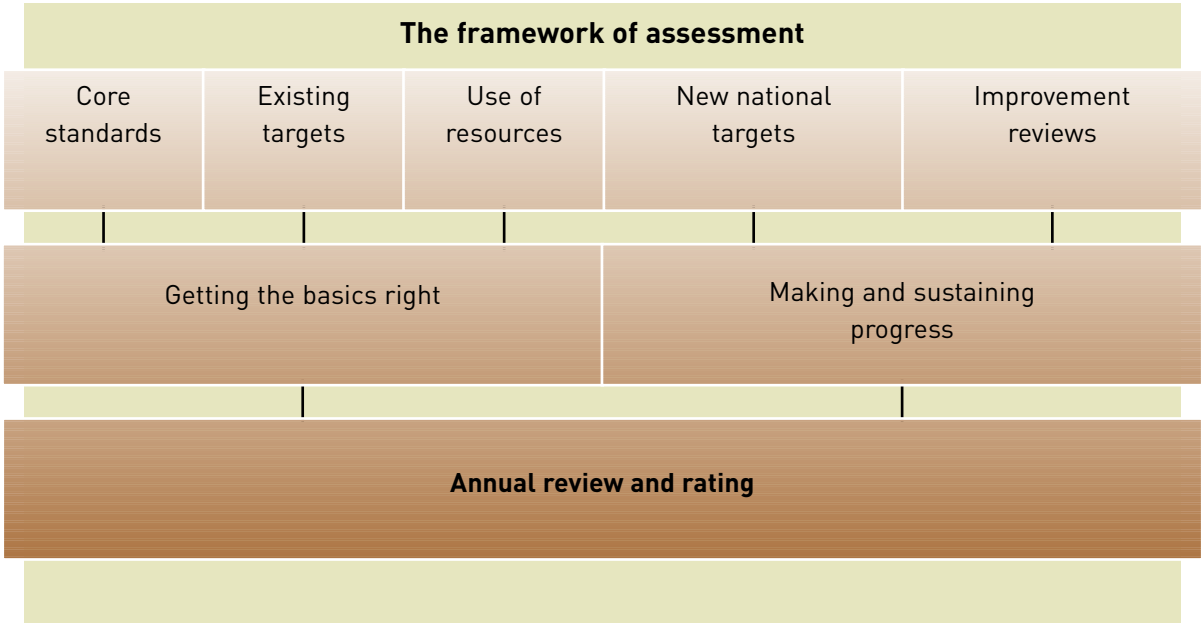
- core standards – the basic standards of care which the Department of Health says all healthcare organisations should be meeting at the moment
- developmental standards – standards of good practice which healthcare organisations should be increasingly aiming to deliver

What will we be assessing?

Our assessments of performance should help to answer two questions:

- firstly, is the organisation getting the basics right?
- secondly, is it making and sustaining progress?

Our approach is to identify, assess and report on several components separately, and then bring these components together in an annual performance rating. The responses to our consultation process generally supported this approach. For 2005/2006, this framework will be:



Getting the basics right

We will assess how well healthcare organisations are getting the basics right by looking at three areas:

1. Meeting core standards

We will require the boards of trusts to make public declarations on the extent to which their organisation meets the core standards. We will expect these declarations to be supplemented by comments from representatives of patients and other partners in the local health community, particularly patient and public involvement forums, local authorities' overview and scrutiny committees and strategic health authorities. We will check the declarations against a wide range of surveillance information and follow up where there are concerns.

However, in light of the responses to the consultation, we will make some significant changes to the approach to the declaration and to the overall timetable in 2005/2006 (see page 14 and annexes 2 and 7).

2. Meeting existing targets

We will assess the performance of NHS trusts in meeting the existing targets as described in *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/2006-2007/2008*, published by the Department of Health in July 2004 (see annex 3). The approach will be broadly similar to that used for the key targets in the 2004/2005 performance rating. We will assess the performance of organisations that provide services and, where appropriate, primary care trusts (PCTs) will also be assessed on the services they commission from other providers.

3. Use of resources and other regulatory findings

We will assess trusts' use of resources separately from other aspects of core standards, working in partnership with other regulators who provide the relevant information (see annex 4). For all NHS trusts, except foundation trusts, we will use the results of the Audit Commission's external audit to assess the organisation's use of resources. For foundation trusts we will use Monitor's financial risk assessment that provides a judgement on the financial sustainability of the trust.

We will also be using the findings of other regulators as part of our wider 'surveillance' information used to check trusts' declarations on core standards. Where appropriate, these findings will be included on the 'dashboard' – which is the profile of a trust's performance broken down into the different components of assessment. The dashboard will be published on our website (www.healthcarecommission.org.uk). On the

dashboard, we will also publish information about complaints that have been referred to us and about our investigations into serious service failures.

Making and sustaining progress

This part of the process will assess the progress made by healthcare organisations in ensuring continuous improvement in the quality of care that people receive. The developmental standards are the starting point for these assessments. In 2005/2006, we will do this by looking at two areas:

4. New national targets

We will assess the performance of PCTs in working towards new national targets that have been set by the Government (see annex 5) and, where appropriate, we will assess the performance of other trusts as well. We will publish the detailed construction of the performance indicators to be used for the different trust types in the summer. The approach will be broadly similar to that used for existing targets.

5. Improvement reviews

Our programme of improvement reviews will assess the quality of healthcare and action in respect of public health with reference to the developmental standards. These will assess performance from a range of different starting points, including in relation to particular domains (such as safety), particular population groups (such as children) or particular conditions (such as heart failure).

These reviews will be mainly concerned with experiences of patients and the public across and between healthcare organisations, and between healthcare and other public services. Where appropriate, we will incorporate assessments from improvement reviews directly in the annual performance rating. This will generally be the case where we can assess performance for all relevant organisations providing services for patients and the public. Subject to satisfactory evaluation of the current pilot reviews, we intend that six improvement reviews will be direct components of the annual performance rating in 2005/2006 (see annex 6).

We also intend to bring the existing acute hospital portfolio into the framework of assessment. It will provide a rating for acute trusts in 2005/2006 covering admissions, diagnostic services and medicines management.

In other cases, improvement reviews may feed indirectly into ratings. This will be done by using information from these reviews as surveillance information to check a trust's declaration on core standards. Reviews may also form the basis of national reports.

We recognise the need for the programme of improvement reviews to be relevant to all healthcare sectors. It is also important that the number of improvement reviews affecting a sector – particularly PCTs – is manageable.

During 2005/2006, we will also be working to identify the steps necessary to maintain a path of continuous improvement which organisations providing healthcare must take in order to make progress towards meeting developmental standards.

Overall annual performance rating

We will publish the scores for the individual components of the framework of assessment to provide a richer picture of the performance of healthcare organisations. We will report performance using the form of a dashboard on our website (see page 12). This will provide an overview of performance for each component, as well as the details that lie behind each score.

In line with our statutory duties, we will aggregate the scores for each component of a trust's assessment into an overall annual performance rating.

This rating will be on a four point scale, so that it is broadly aligned with the approach used for local government. We are developing rules for arriving at this single rating.

The approach to assessing whether trusts are meeting core standards and the overall timetable for 2005/2006 assessments

In the consultation document, we proposed that trusts would be responsible for ensuring that they meet the core standards and that we would expect them to make a declaration in September each year. In light of a wide range of responses to the consultation, we have decided to make significant changes to the assessment of core standards and the overall timetable for the 2005/2006 assessments (see annex 7).

Assessing whether trusts are meeting core standards

During consultation, many of those who responded expressed concerns that the levels of performance required to meet the Department of Health's core standards were not clear and would only become clear when the new system of assessment came into operation.

As part of the process of consultation, we published draft guidance, *Understanding the standards*, to help organisations to think through how they satisfy themselves that they are meeting core standards. The guidance outlined the component parts, or 'elements', that make up the standards, suggested prompts or questions that trusts could ask themselves in the process of self

St Someone's University Hospitals NHS trust

Annual Review 2005 / 2006

Healthcare Commission

Getting the basics right

Core standards Progress in meeting core standards developed by the Department of Health (DH) more...	*Fully met*	The trust achieved core DH standards in all domains. The trust has achieved clinical negligence scheme for trusts level 2. This is the middle level of the scheme which assesses a trust's approach to risks relating to patients details of assessment
Existing targets Progress in meeting existing targets set out in DH national standard C7f more...	*Fully met*	The trust has achieved all existing targets details of assessment
Use of resources An assessment of how efficiently the trust uses public money more...	*Fair*	The trust has achieved minimum standards in all areas. A detailed review of the day surgery unit shows that the trust is highly efficient in this area details of assessment

Making and sustaining progress

New national targets Progress in achievement of national public service agreement targets more...	*Fair*	The trust has made reasonable progress in meeting all new targets details of assessment
Improvement review: Hospital acquired infections Progress in meeting developmental standards set out in framework for reviewing hospital acquired infections more...	*Good*	The trust was commended for the action it has taken in ensuring high standards of cleanliness throughout the hospital. It has experienced a notable fall in the levels of hospital acquired infections details of assessment
Improvement review: Children's services Progress in meeting developmental standards set out in the National Service Framework (NSF) for Children more...	*Excellent*	The trust has scored highly in the improvement review to assess children's access to safe care. It was particularly commended for its high standard of child-centred services in A&E details of assessment

assessment, and identified potential sources of information that we would use for checking. This guidance attracted a lot of attention and a wide range of views.

In general, many groups felt the guidance helped to make sense of the standards and to hold organisations to account. However, there were significant concerns that the prompts could be misinterpreted to suggest that there is a single correct approach for achieving the standards and so could end up being seen as a new form of targets.

There were also concerns – both from groups representing patients and the public, and from the NHS – that some core standards are not being met and that the system of assessment needs to offer effective incentives for improvement. The system should encourage trusts, with their local communities, to identify areas of concern and take action towards achieving the standards.

There were widespread reservations about the capacity of many patient and public involvement forums to comment effectively on a trust's overall performance, including from the forums themselves. There was a desire that there should be other ways of feeding in the views of patients and the public.

A further concern – particularly from the NHS – was that our proposed timetable, where trusts make a declaration in the autumn, did not fit into the business cycle of the NHS and that this would impose an additional burden on trusts.

We are addressing these concerns in the ways described below.

Guidance to trusts

We are publishing revised guidance to trusts entitled *Defining core standards*. We have removed the prompts from this guidance. Instead, wherever possible within each element, we have included the key pieces of national guidance or legislation that trusts should consider during the process of self assessment. These describe what trusts should already be doing and therefore do not constitute new requirements or targets.

This guidance also identifies the most relevant items of information to be used for an initial check on the performance, outcome and output relating to each core standard.

The valuable feedback we received on the prompts will be used to inform the development of detailed inspection manuals to be used by our local teams to check whether core standards are being met. These manuals make it clear that there is normally no single correct approach for achieving the standards and that trusts may have other ways of meeting the required standard of health and healthcare.

Changing the timetable

The assessment of whether trusts are meeting core standards will be introduced in two stages in 2005/2006, in order to develop a common understanding of what constitutes satisfactory levels of performance, to encourage improvement and to align the process with the NHS business cycle. We will be working further with healthcare organisations and groups representing patients and the public over the next few months to build this common understanding.

For this year only, in October 2005 we will require trusts to make a draft declaration of how far they are meeting core standards. We will expect them to identify areas of concern where they may not be meeting standards, or are at risk of not meeting them, and outline the action being taken to address these risks and the progress that is expected before a final declaration in April 2006. We will expect trusts to seek comments from their patient and public involvement forums, the local authorities' overview and scrutiny committees and strategic health authorities, which must be reproduced as part of their draft declarations.

Patient and public involvement forums

The Government has announced plans to combine all patient and public involvement forums within one PCT area and to focus their work more closely on reviewing the delivery of NHS services. These new forums will monitor every NHS trust in the area and will be offered adequate support geared to this role. This needs legislation and is not likely to happen before summer 2006. Therefore, this year, we are still offering forums the opportunity to comment on trusts' declarations, but they are under no obligation to do so. We will only expect them to comment on areas that they already know about from their own work.

We will also encourage trusts to take account of the views of the local community when preparing the declaration and will require them to publish the final declaration. During 2005/2006, we will be developing new ways of feeding the views of patients, the public and staff into the system of assessment.

Checking the declaration

To cross check the declarations, we will use the wide range of existing information that we already have. As this surveillance information is readily available from central databases, its collection will not impose an additional burden on trusts. This process will allow us to identify trusts most at risk of not meeting core standards and to target our follow up action, including selective visits. We will also have a programme of conducting spot checks through visits to trusts. Some of these spot checks will be

unannounced, as requested by patients' groups during consultation.

The final declaration

We will require trusts to publish a final declaration in April 2006. This should include comments from the overview and scrutiny committee of the relevant local authority, as well as from the strategic health authorities and the patient and public involvement forums. There will then be a process of cross checking and selective visits, which will be informed by the earlier draft declaration. The final declaration will be the basis for assessment as part of the overall performance rating.

Timetable for 2005/2006 assessments

We want the new approach to take the perspective of patients and the public into account – particularly the ways patients experience services (the patient's journey) across healthcare organisations and between health and social care. We also want to work in partnership with other regulators.

To respect these principles, and to enable the changed approach for declarations on core standards, the overall annual performance rating for 2005/2006 will be published during September 2006 (see annex 7). This will allow better alignment with the ratings of other regulators, particularly with the Commission for Social Care Inspection (CSCI) in respect of performance across the boundaries of health and social care, with the Audit Commission in respect of performance in relation to issues across health and local government (such as public health) and with both the Audit Commission and Monitor in respect of financial performance drawing on audited final accounts.

It is important to stress that the slightly later date for publishing the overall rating does not mean that there will be any delay in taking action when we find that standards are slipping or when we have concerns about performance. In such cases we will act immediately, irrespective of the timetable for assessment.

How will assessment allow for the different needs of different sectors?

A consistent message from the consultation was that the standards were very general in their approach and did not capture the different activities in different types of healthcare organisations, particularly outside the acute sector.

Core standards apply to all NHS organisations. We recognise, however, that some elements of the standards will not be applicable to all healthcare organisations and that some will need to be applied differently to reflect the activity of that

particular organisation. In our guidance, *Defining core standards*, we have sought to tailor the elements, where appropriate, to particular sectors of healthcare, such as PCTs.

Primary care

Some primary care trusts (PCTs) felt that their role as commissioners of healthcare was not sufficiently covered in the standards. They also asked whether the standards applied to their independent contractors, such as GPs and dentists and their staff.

The standards will apply to all the activities of PCTs, whether provided directly by the PCT's staff, commissioned from other providers or provided by independent contractors such as GPs. We would therefore expect the standards to be reflected in the arrangements for commissioning that a PCT makes. PCTs will be expected to use all available means to promote compliance with the standards by their independent contractors and those organisations from which services are commissioned, and to take appropriate action when the standards are not being met.

We recognise that the standards do not currently address the issue of commissioning very well and we will be working with PCTs in the coming year to develop ways of measuring and assessing commissioning more effectively. We are also planning an improvement review into commissioning and, where relevant, will examine how effectively services are commissioned as part of the reviews.

Ambulances

Ambulance trusts pointed out that they operate differently from other trusts in that their work is generally mobile, and much is unscheduled and needed immediately. They cannot deliver services except in partnership with others (PCTs commission their services and hospitals need to take their patients). We recognise these important characteristics and will be working with the Department of Health and the Ambulance Service Association to agree a relevant set of indicators to measure performance. We will also consider how these indicators can be shared with partners reflecting the increasing development of networks for emergency care covering PCTs, GPs, hospitals and ambulance trusts.

Mental health

Mental health trusts also highlighted their particular characteristics. Their work is often spread geographically and not always based in hospitals. They also need to work closely with partners, such as local authorities and social services, to provide their services. They pointed out the

historical problems with the information systems and data quality within the sector. The Mental Health Act Commission was also concerned that routine and unannounced visits should continue as part of the process of assessment, particularly in the case of patients detained under the Mental Health Act 1983.

We recognise these points. There is a significant amount of information on mental health activity and outcomes, which can be used to cross check performance in meeting core standards (*Defining core standards* sets this information out in detail). We are also conducting an improvement review into community services for mental health and will continue a programme of announced and unannounced visits to mental health trusts. As a large part of the treatment of individuals with mental health needs involves working in partnership with others, we will examine ways of assessing performance in this area, by reference to the developmental standards, as quickly as possible.

Public health

Public health specialists also commented on the importance of working in partnership to provide better public health (for example with local authorities and schools) and that many determinants of public health (for example, poverty, unemployment and education) are largely outside the control of the health sector. Again, we recognise these points. We are working with the Audit Commission to develop local area reviews of public health in order to capture the activities of both local authorities and healthcare organisations and the degree to which they are working in partnership.

What is the approach in the case of independent healthcare providers?

For 2005/2006, our statutory requirement is to assess the independent sector by reference to the National Minimum Standards for Independent Health Care and to carry out annual visits to inspect independent providers (see annex 9).

In the light of progress made in the last two years in the proportion of independent providers meeting the standards, we have already begun to target inspections according to risks identified at previous inspections. We will also place the national minimum standards within the domains of the Department of Health's *Standards for Better Health* as a first step towards closer alignment of standards.

We recognise the independent healthcare sector's concern that the national minimum standards should not be diluted. We agree that this is in patients' best interests. We are already in discussion with the Department of Health on how to retain the detail of the national minimum standards within the

broader framework of the *Standards for Better Health*, so that there will be no reduction in clarity for providers and no reduction in our ability to enforce standards where necessary.

As with the NHS, there will be a greater emphasis on self assessment by independent healthcare providers. All providers will be required to fill in self assessment forms, and we will use data analysis to identify which standards to focus on during our visits. We will also carry out spot checks, some of which will be unannounced.

The consultation demonstrated that aligning the system of assessment for the NHS and independent sectors is complex. During 2005/2006, in the light of our experience, we will develop and consult on a strategy for our approach to independent healthcare.

We are also likely to take responsibility from the Department of Health for setting the fees charged for inspection and registration. The way we approach this issue will also be a part of our consultation with independent providers.

How will we ensure that the new approaches add value and reduce the costs of regulation for healthcare organisations?

During the consultation period, we carried out an initial impact assessment, which looks at the costs and benefits of the new approach. This has involved discussions with a small sample of NHS trusts.

For the NHS, the work is necessarily tentative, as the final shape of the new system was not established and trusts wanted more details of the components in order to establish what work would be required. The additional costs of the new approach also depend on the strength of trusts' existing systems of assurance and management, as well as on the extent to which they have already reorganised their internal management in response to the publication of *Standards for Better Health*.

Our new approach has been developed in such a way as to maximise the benefits of improving outcomes for patients and the public, while minimising additional costs for healthcare organisations. It includes:

- ensuring that core standards are met through an approach which builds from self assessment
- making more intensive use of the information we already possess in checking declarations
- using that information to ensure that our visits and other interventions are targeted and proportionate
- taking a staged approach to assessing progress in respect of developmental standards
- using other regulators' findings directly in providing a broader and richer picture of performance

In broad terms, the initial work suggests that the additional costs of the new systems of assessment should be less than the regime associated with clinical governance reviews and star ratings – though there will be some transitional costs for the first year. At the same time, the broader approach looking at standards and targets should deliver a wider range of benefits.

For the independent sector, while the new methodology requires additional time for planning at the beginning of the process of inspection, this will be more than offset by substantial savings of time at the end through a simplified process of reporting and conducting more focused inspection visits.

As well as demonstrating our commitment to quantifying the demands placed on healthcare organisations by inspection and regulation, our initial work provides a baseline. This will enable us to test and account for how far, over time, the assumptions made in the impact assessment are being met. Through the year, we will be routinely identifying our own costs and intend to work with trusts on following their assessment of costs and benefits. We will be evaluating this process through the year and thereafter. We will publish an initial assessment on the process for completing draft declarations in autumn 2005, and a further impact assessment by autumn 2006.

Last year, as part of our commitment to reducing the burden of inspection, we joined with the nine other leading bodies involved in the inspection and audit of healthcare in England to sign a Concordat on regulation. We are relaunching this Concordat to include an expanded membership. Processes are being developed to gather, share and use information more effectively and efficiently with our Concordat partners. Among other things, we are:

- investigating legislative barriers to better coordination and cooperation among inspecting bodies
- considering whether we can jointly reduce our need to collect data
- developing means of bringing greater consistency and coherence to the action planning that arises from the recommendations of reviews
- establishing a one stop site for the scheduling of reviews by the various bodies
- investigating the scope for a joint approach to cost/benefit analysis in the regulation of healthcare

Ensuring that our people do the right things in the right place

These proposals represent a new way of working, building on the skills and experience of Healthcare Commission staff.

We also need to structure our operations so that we are able to understand local issues and build local networks. The Healthcare Commission has organised itself on a regional basis since its inception in 2004. We have now taken further steps to develop a stronger regional presence to enable a stronger connection to the community and to healthcare providers throughout the country (see annex 10).

Our regional teams will be central to the system of assessment. Their role will include gathering information and intelligence on local organisations and carrying out visits and spot checks in both the NHS and independent sectors.

How will the approach develop in future years?

Moving to broader, richer assessments of performance will take time. During 2005/2006, we will work with groups representing patients and the public, healthcare staff, other regulators, the Government and others in developing our approach in a number of areas, which are set out below.

Core standards

We will use the experience of the first year of the system to refine the definitions of the elements of the standards and to develop a common understanding of the information that helps to differentiate performance by healthcare organisations in relation to particular standards and within specific domains. We may wish to make recommendations about changes to the standards themselves to the Secretary of State for Health. We will also consider how best to inform and work with other parties to follow up and drive improvement.

Other regulatory findings

We are developing criteria to assess the suitability of other bodies and regulators to contribute findings directly into our rating system, in the same way that Monitor and the Audit Commission will do in 2005/2006. Candidates we are looking at for future years include the Mental Health Act Commission and the National Cancer Action Team.

Progress in meeting developmental standards

In 2005/2006, we will begin work on assessing some of the progress made by organisations in meeting developmental standards. This will be achieved through our improvement reviews and we will also look at some of the developmental standards by domain.

At the same time, we will be developing a more complete programme for implementation from 2006/2007 onwards.

The developmental standards emphasise working in partnership and are aimed at continuous improvement. This improvement needs to reflect best practice in the UK and abroad. Healthcare organisations need to target this best practice and chart their journey towards it.

In 2005/2006, the Healthcare Commission will work with patients, the public and those who work in healthcare to consider how best practice should be measured under the developmental standards. We would expect to concentrate on one or two domains initially (for example safety and clinical effectiveness) and we will pilot our approach to ensure it adds value.

As part of this we will:

- agree the key high level features that indicate developmental performance in each domain of the developmental standards
- identify the high level indicators that are available, and those that would be desirable, which relate to those features

We will aim to measure trusts in relation to these indicators on a regular basis, setting out the framework for improving performance over time.

This work will take account of the Department of Health's better metrics project, which is developing more clinically relevant measures of performance.

Assessing leadership and organisational capability

The responses to the consultation recognised the importance of high quality processes of leadership and management in delivering consistently good services and sustaining improvements. Equally, there was recognition that developing objective methodologies for assessment, that did not have high costs, is very challenging.

We will therefore be developing and piloting our approach in 2005/2006. We will do so for all health sectors, but with relatively small numbers of trusts in the first instance.

Local targets

The Department of Health developed a framework of principles within which NHS organisations should identify their local needs and priorities and develop targets to address them. These local targets are being developed by local health communities alongside their local delivery plans.

Feedback from consultation suggested that people do not understand the local targets and therefore our role in assessing them. For example, there were concerns that local targets would increase the 'postcode lottery' and about consistency between our assessment and strategic health authorities' arrangements for managing performance.

We will work with NHS organisations and others in the health community to develop our approach as they implement the first local targets in 2005/2006. We will issue the results of this work in early 2006.

Aligning assessment of the NHS and independent sector

We are already liaising with the Department of Health about the timescale for revising the national minimum standards, so that we can assess the independent sector with reference to similar standards to those that are being used in the NHS, without detracting from the effectiveness of the national minimum standards.

The transition to the new standards will have wide implications. To deal with these, we will be developing and consulting on a broad strategy for the future regulation of independent healthcare in England.

Engaging with patients and the public

During 2005/2006, we will also be exploring new ways to gain access to the views of people from disadvantaged and excluded communities to feed into our assessments. We will build on the work done during consultation using community networks to organise qualitative research with a diverse range of communities. We will also continue to work with patient and public involvement forums and other patient groups. We will seek to identify and share best practice from trusts in developing innovative and effective engagement.

The start of a journey

We cannot expect the new system to operate perfectly immediately. We will continue to analyse the huge amount of valuable feedback we gained from consultation as we develop the system. The objectives for the new system however are clear – to improve outcomes for patients and the public. We look forward to working with local communities and healthcare organisations to ensure that we achieve this and that we refine and improve the system in the light of experience.

Annexes

Annex 1: Consultation and engagement

During the consultation on this new system of assessment we distributed 60,000 documents, attended over 300 consultation events and received more than 1,100 written responses. We greatly appreciated the time and effort that people gave to contribute to the consultation, and the very constructive spirit of that engagement.

We are very clear that to promote improvement, the systems of assessment must measure and assess what really matters to the public, patients and those who provide care. The engagement that we have had so far is an important start to that endeavour.

To build on this, we are developing a strategy to engage patients and the public to ensure that the views and experiences of a diverse range of people can effectively inform our assessments, as well as drive improvements in performance across healthcare. This engagement will involve our regional teams, working with local networks, community and voluntary groups. We will also specifically ensure that we hear the views of those whose opinions are not usually heard through traditional methods, such as our patient surveys.

In order to make sure that we focus on outcomes for patients, we also need the help of clinicians and others. We have already established an advisory group on clinical strategy, comprising acknowledged clinical leaders who provide a high level link between the clinical professions and the Commission. This work will soon be enhanced by the creation of four expert reference groups, specifically to advise on the processes and content of the system of assessment and, in particular, the development of the improvement reviews. These groups include representatives of patients and the public, and experts in the field including clinicians, practitioners, managers and academics.

We will be publishing separately a report on the responses to the consultation. The main messages are summarised below.

Positives

- general support for the direction of travel and principles set out in the consultation document
- the vast majority of respondents felt we are looking at the right things
- support for self assessment of core standards, with checks and balances
- belief that our proposals will lead to improvement
- support for strong engagement with patients and the public
- support for a stronger focus on outcomes – and for more attention to developmental standards over time
- support for alignment of assessments for the independent sector and the NHS
- support for using the findings of other regulators
- enthusiasm about assessing by reference to developmental standards and about the introduction of improvement reviews

Issues

- recognition of significant challenges in working through the details
- general view that the overall approach needed to be simplified
- the approach for 2005/2006 should not try to do too much too quickly
- a request to adjust our timetable to fit with the NHS business cycle
- widespread concern about the capacity of patient and public involvement forums to comment on a trust's overall performance
- while supporting our aim to reduce the burden of inspection, the service wanted details of how we would achieve this
- while supporting the principle of self assessment, there was a desire to make sure the cross checking process is robust
- a general desire by the public, patients, clinicians and staff to find ways to feed their views into the process of assessment, in particular to recognise the need to ask people who have the greatest problems in gaining access to good healthcare
- while many people felt the prompts in our guidance had the right level of detail, senior NHS managers said they were too prescriptive and could be interpreted as new targets
- we need to assess the extent to which healthcare organisations are working in partnership with other organisations
- assessments should be sensitive to local context
- we should include the extent to which education, research and training are fostered and encouraged by healthcare organisations in the assessment

Clarification requested

- sufficient indicators in the systems of assessment to identify the contribution or value added to performance by individual organisations
- a more tailored approach to particular issues in specific areas of health and healthcare – for example, how would GPs as independent contractors fit into the assessment
- what constitutes satisfactory performance and precisely how will this be measured
- guidance and clarification should be provided as soon as possible
- reassurance for independent providers that the clear requirements of national minimum standards will be retained when they are aligned with *Standards for Better Health*

Overview of the main changes and developments made in response to consultation

Issue from consultation: The system is trying to do too much too soon and does not fit in with the NHS's business cycle.

More time will be allowed for the assessment of whether trusts are meeting core standards, with only a draft declaration being required by October 2005. The final declarations will now be in April 2006 and will be based on information applying to the past financial year. As a result, the annual ratings will be published during September 2006 rather than July. This matches the business cycle of the NHS.

There will be a slower development of the component relating to leadership and organisational capability, which will not be introduced before 2006/2007 to allow more thorough testing with trusts.

Local targets will not be included in the 2005/2006 assessments. Over the next year we will work with local healthcare communities to decide on our approach to local targets and we will bring local targets into our assessments if and when we think we can make them work.

Improvement reviews will be phased in more slowly.

Issue from consultation: The public and NHS wanted clarification on what would constitute satisfactory performance in relation to core standards.

By asking trusts to make a draft declaration, we are giving them, the public and us time to develop a shared understanding of what constitutes satisfactory performance before the final declaration is due in April 2006.

Issue from consultation: Patients and operational managers liked many of the prompts suggested in *Understanding the standards*, our guidance for trusts on assessments of compliance with core standards. However many senior managers felt that they were too prescriptive. Both felt that they focused too much on processes rather than outcomes.

The prompts have been removed from the revised guidance, *Defining core standards*. However this guidance has retained and clarified the 'must dos', the underlying requirements that trusts should meet to ensure they are meeting the standards. Many of these were identified through our consultation on the prompts and other engagement. Wherever possible, we have referred to existing legislation and other national service guidance to the NHS. These describe what trusts should already be doing and so do not constitute extra requirements or targets.

The valuable feedback we received on the prompts is informing the development of the detailed inspection manuals that our local teams will use when inspecting trusts following self assessment. This will be presented in a manner that will focus on the evidence that trusts have used to satisfy themselves that they are achieving the standards, and will not be prescriptive about the particular methods used by trusts to meet them.

When the standards require outcomes for patients, we will not consider the existence of processes as sufficient evidence that the standards are being met. In general, our approach is that the standards are not ends in themselves, but are there to ensure the provision of better outcomes for patients. Development of better measures of outcomes is a top priority for the Commission and we will work with patients, the public, professional bodies and others to achieve this.

Issue from consultation: There was widespread doubt about the capacity of many patient and public involvement forums to give representative or comprehensive views of an NHS trust's performance. There was a desire that there should be other means for patients, the public and staff to feed their views into the system of assessment.

While recognising the issues faced by patient and public involvement forums, we still want to give them the opportunity to contribute their views. We are not expecting the forums to comment on all aspects of a trust's performance, only on those aspects of which they have knowledge from their own work. The changes announced by the Department of Health about the composition and duties of forums should help them in carrying out this role in the future. We will continue talking to the forums and the Department about how best to support them in this role.

We are also encouraging trusts to consult more widely than forums. We will expect trusts to publish the draft declaration to give the local community, patients, staff and other interested parties the chance to feed back comments about it to the trust. In the future, we will use the NHS staff survey and our own surveys of patients to obtain information about how trusts are meeting the standards.

During 2005/2006, we will be developing new ways of feeding the views of patients, the public and staff into the system of assessment.

Issue from consultation: Trusts wanted clarification about how we will reduce the burden of regulation.

As a first step to reducing the burden on trusts by working with other regulators, we are using results from the Audit Commission and Monitor as direct feeds into the 'use of resources' component of assessment. Where relevant, we will also use the findings of other organisations as 'trump cards' in cross checking the declaration on core standards. This means that we will accept that a trust has met a particular standard (or part of it) if it has met relevant standards of these organisations.

We are relaunching our Concordat to reduce the burden of regulation to include a new group of members and we are carrying out specific work to help reduce the burden on healthcare organisations, for example establishing a one stop site for scheduling reviews.

We also aim to keep to a minimum the collection of data that we require from the NHS. For the assessments of compliance with core standards, trusts should be able to rely on data that they already routinely collect. When checking trusts' declarations, we will rely on the wide range of information that is already in our possession or easily available from central databases.

We are designing improvement reviews to keep the collection of data to a necessary minimum. We will only seek bespoke data when it is not available in other ways and we will identify and focus on the key indicators that have the biggest opportunity to help drive improvements in care. Moreover, improvement reviews will provide information that is helpful to trusts in improving the provision and management of services, as well as identifying useful indicators, new processes for collecting information and new diagnostic tools.

Issue from consultation: There are concerns about the lack of good data in some areas and that we should make allowances for the local context in which organisations work, such as the degree of deprivation.

Close attention will be given to issues of data quality. To make the most of the information we have available, we have to account for factors that we know are beyond the control of the individual organisation. For example, standardising for the age and sex of the local population, adjusting for deprivation or case mix adjusted measurement in acute care. These considerations need to be made specific to individual items of information. Different items will be adjusted in different ways. However, it is important to stress that core standards apply to all healthcare organisations across England. Particular issues of local context, such as deprivation, are not an excuse for standards of care to fall below the level set in the core standards.

Our spot check inspections in relation to core standards will give us the opportunity to look at those standards for which there is a lack of good data to help us in the process of checking information.

Issue from consultation: There was a desire to make sure that the new system does not overload independent providers and a concern that inspections will be consistent throughout the country.

We have simplified the self assessment forms for many providers, made visits more focused and cut down the process of reporting. In order to encourage

consistency, inspectors have been scheduled to focus inspections on certain types of provider each month. The lead inspectors involved will then be brought together to share experience and suggest improvements.

Issue from consultation: There was a feeling among PCTs that their role as commissioners of services was not taken into account when assessing compliance with core standards. There was concern that they would be penalised for the poor performance of providers.

Our approach to commissioning has now been included in the new version of the guidance, *Defining core standards*, so it is seen as integral to achieving all the standards. For the first year, we will focus on assessing how PCTs have taken into account the core standards, in the process of commissioning, rather than looking at how well the services they commission are meeting core standards. We will develop this approach over the following years. We are also planning an improvement review into commissioning.

Issue from consultation: The standards sometimes take no account of differences between sectors, for example, ambulance trusts.

The general principle is that the standards are common across all sectors of healthcare. However, we have included some sector specific elements in the new version of our guidance, *Defining core standards*, for example in the care environment and amenities domain.

Issue from consultation: There was particular concern about the lack of routine visits or unannounced spot checks for organisations caring for patients detained under the Mental Health Act 1983.

We have introduced unannounced spot checks into the process of assessing compliance with core standards. We will be using the inspections of the Mental Health Act Commission as surveillance data for checking the declarations of NHS trusts caring for detained patients.

Issue from consultation: There was a desire to ensure that the views of users of services were routinely fed into our assessments during improvement reviews.

Our pilot improvement reviews have already developed ways of gaining access to the views of users. We are building on this experience to ensure that the views of users of services are routinely taken into account in the design and execution of improvement reviews.

Issue from consultation: Respondents wanted the annual performance rating to contain more information than just the overall performance rating. They also wanted to get the results of assessments as soon as they became available, not just once a year.

In developing our new approach to annual performance ratings, we have emphasised the importance of the individual components of assessment having validity in their own right. We are committed to making the results of individual components of assessment publicly available as soon as possible.

Annex 2: Core standards

The assessment of compliance with core standards is designed to provide an annual overview of the extent to which each NHS trust is achieving the acceptable level of care defined by the Department of Health. The assessment acknowledges not only how well a trust is meeting these core standards at the time of the assessment, but also any improvements made in the preceding year and the prospect for further improvements in the forthcoming year.

Our approach to this assessment is based on the central principle that it is the responsibility of trust boards to satisfy themselves that they are meeting core standards and, where this is not happening, to take appropriate steps to correct the situation.

In light of this, our assessment of compliance with core standards will:

- build on trusts' own systems of assurance, rather than impose an additional system
- acknowledge both the degree to which trusts are meeting the standards, and their efforts to identify and address any lapses

As a matter of priority, we will be working with the NHS Appointments Commission to identify ways in which we can support the training and development of non-executive directors in meeting the responsibilities of the new system.

The process of assessment

Following consultation, we have decided to change our timetable of assessment to fit in with the NHS business cycle, and in particular with the operation of the assurance framework within trusts.

This assessment will cover all NHS trusts – acute trusts (including specialist trusts), primary care trusts (including care trusts), learning disability trusts, mental health trusts and ambulance trusts. It will assess whether trusts have met the core standards over the year to March 31st 2006, as well taking into account the plans they have to improve performance in the following 12 months.

April 2005 – Guidance published

Before making a public declaration, trust boards will wish to be clear that they and the Healthcare Commission share a common understanding of what they need to do to meet the core standards. To this end, we are publishing guidance, *Defining core standards*.

In this guidance we list approximately 80 elements, or component parts, of the standards that will form the basis of our assessment. The list of these elements does three things:

1. It breaks the 24 core standards down into their component parts.

2. It links each element, wherever possible, with the key pieces of national guidance and/or legislation that describe what trusts are required to do to meet this part of the standard. These are all things that trusts should already be doing. For a limited number of the elements, there is no underpinning guidance or it cannot be readily summarised. In these cases, we have identified explicitly the key aspects of what trusts should be doing.

3. It lists, against each of the elements, the items of information that we will use when checking the declaration.

It is not our intention to tell trusts how they should be meeting core standards – that is the responsibility of individual trusts. Therefore, our assessments will not be based on the presence or absence of particular *methods* for meeting core standards, but on the trust's own evidence that the methods which they are adopting are delivering the required level of care for patients. We will only judge organisations on the basis of whether *particular* methods are being used where those methods are prescribed by existing requirements or where there is, in principle, only one method for achieving a particular element.

We will be giving inspection manuals to our local teams to inform their inquiries. Use of these manuals will ensure that they seek and judge evidence in a consistent manner. Over the next few months, we will develop inspection manuals for each of the core standards, taking into account the many comments received during consultation. As the guides are developed, they will be available on the Healthcare Commission's website so that NHS organisations may understand the kind of evidence that our local teams will be gathering to arrive at their judgements.

Defining core standards also explains the application of the elements to the various sectors of the NHS and our approach to commissioned services, and emphasises that considerations of equality and human rights are relevant in relation to all the standards.

October 2005 – Each trust makes a draft declaration

For this year only, we will require trusts to make an interim declaration of how far they are meeting core standards. This draft declaration will give a further opportunity for us to develop a common understanding with healthcare managers, clinicians and patients of what constitutes satisfactorily meeting the standards. We will expect trusts to decide on priorities and implement their plans to achieve any progress necessary before the April 2006 final declaration.

The draft declaration should be in three parts:

- a short general statement that, other than for the exclusions noted below, the board has reasonable assurance that there have been no significant lapses in meeting core standards within the current financial year
- details of any standard/s for which a lack of assurance leaves the board unclear as to whether there have been significant lapses in meeting the standard/s
- details of any standard/s for which the assurances received by the board make it clear that there have been significant lapses in meeting the standard/s

In the case of any lapse, the details must be organised under headings relating to the standards involved. For each such standard, the details must include:

- a brief description of the nature of the lapse
- its timing, duration and whether the standard is still not being met
- a short outline of the action plan in place to correct the situation

- the predicted date by which the action plan will ensure that the standard is being met

It will be assumed that any standards not listed as the subject of a significant lapse will be covered by the general positive declaration.

In considering whether there has been a lapse in meeting any standards, boards may wish to consider our further guidance, *Defining core standards*.

It is for the board to decide whether a given lapse in meeting standards is significant or not. It is not our intention that the declaration be used to record isolated or trivial breaches of the standards. When determining whether a lapse should be declared, we anticipate that boards will wish to consider the extent of the risk presented to patients, staff or the public.

We will provide facilities for trusts to make their declaration to the Healthcare Commission electronically. We will also require that a paper copy of the declaration be signed by all the members of the board and then forwarded to the Healthcare Commission.

For trusts other than foundation trusts, we will require the board to supplement its draft declaration with comments from the strategic health authority, the local authority's overview and scrutiny committee and the trust's patient and public involvement forum, on whether the trust is meeting core standards. We will also encourage foundation trusts to seek comments from their strategic health authority and, as with non-foundation trusts, we will expect them to seek contributions from their local overview and scrutiny committee and representatives of patients and the public.

We recognise that many patient and public involvement forums are not in a position to offer an overview of the trust's compliance, and we are working with the Department of Health to improve support for them. Some overview and scrutiny committees may also feel that they do not have the capacity to contribute at this stage. While we will require trusts to solicit relevant comments from these bodies, there is no obligation on the patient and public involvement forums or the overview and scrutiny committee to provide them. However, it does offer these organisations the opportunity to make a contribution based on their own activities by way of engagement or review.

We will also encourage all trusts to seek views from a diverse range of groups within the local community. We will be looking for new ways to feed the views of patients, staff and the wider community into the assessment in future years. One method we intend to use in the future will be to extend the range of questions relating to the core standards in the NHS staff survey and our own surveys of patients.

October to November 2005 – Checking the draft declaration

Following receipt of the trusts' draft declarations, we will identify those which we consider are most at risk of not meeting the core standards, using a wide range of information already available to us including:

- measures of outcome, output and process derived from nationally available sources of data
- the results of the Healthcare Commission's surveys of patients and the NHS staff survey
- intelligence from our own NHS second stage review of complaints, investigations into serious service failure and improvement reviews
- information obtained from other regulators and agencies conducting reviews
- any comments from third parties accompanying the declaration

This information will include indicators that in the past contributed to the calculation of the NHS annual performance ratings, known as star ratings.

Each item of information has been related to the relevant core standard and will be used to identify those organisations most at risk of not meeting the standard. In using this information to target our follow up activity, we want to do so in a way that is sensitive to local context. We will adjust for factors such as age, sex and case mix where appropriate. We will also apply rigorous statistical analysis to help interpret the information. But it is important to stress that core standards apply to all healthcare organisations across England. Particular issues of local context, such as deprivation, are not an excuse for standards of care to fall below the level set in the core standards.

We aim to use as wide a range of sources of data as possible – which means that the list of items of information will be very long. We expect this list to change during the year for many reasons such as:

- routine updating using the latest information
- inclusion of new items of information
- removing those that appear to have little value

The information available to us gives variable coverage of the core standards. For some standards, there is a relatively wide range of items to check against. For other standards, there may be very few or even no items of relevance currently available to us. The current list of items of information will be published on our website and updated as necessary. We would welcome suggestions for how this list may be improved.

We will summarise the patterns of performance derived from the information relating to individual standards and will make these summaries available to all trusts once the process of cross checking is complete. Through our local teams, we will be actively seeking local views on the accuracy of these summaries.

If a trust declares that it is meeting a given standard, but the results of our cross checking and the third party comments raises concerns, we will consider the need for follow up action to check further that the standard has been met.

The checking process will also refer to the views of internal and external auditors on the robustness of the governance processes that support the trust's year end (2004/2005) statement on internal control. Where there are concerns that these processes may be flawed, this will be taken to indicate a risk that the draft declaration on core standards might itself be flawed. This risk factor will be considered within the wider process of cross checking.

It is important to recognise that this process of cross checking does not tell us definitively whether a trust is meeting the core standards. Instead, it identifies the trusts most at risk of not doing so and identifies areas that we will want to investigate more thoroughly. These organisations will then be included in the programme of selective inspection described below.

December 2005 to April 2006 – Selective inspection

Following the receipt of trusts' declarations and the subsequent cross checking, we will conduct a programme of selective inspection.

Two groups of trusts will be included in the programme of selective inspection:

- the risk-based group identified by our cross checking
- a further, randomly selected spot check group

For the risk-based group, the subject of the inspection at a given trust will be those standards for which there are particular concerns, rather than all the core standards. We will discuss how the trust developed its draft declaration and establish shared expectations on what constitutes satisfactory performance. We believe that this will help these trusts make progress towards meeting the standards. The primary focus will be on the evidence that the trust has used as a basis for its positive declaration in respect of standard(s). It should be emphasised that, where the standards require outcomes for patients, staff or the public, evidence of a process being in place will not be sufficient. We will expect trusts to also provide evidence that the outcomes have been achieved.

For the spot check group, we will use the opportunity to look at some of those standards for which the cross checking process has little or no data to rely on. Following concerns raised during consultation, some of these visits will be unannounced.

The programme of selective inspection will be undertaken by members of our local teams so that inspections can be better informed by local knowledge and an understanding of the partners in the health community, including patients and voluntary groups, and the local activities of other inspectorates and agencies conducting reviews.

Where we identify significant lapses, they will be brought to the attention of the relevant strategic health authority, or Monitor where appropriate, so that action to rectify the problem can be planned and overseen. The trust will be responsible for producing an action plan and managing its implementation.

Where we have serious concerns about unsatisfactory performance, we may decide to launch a formal investigation.

April 2006 – Final declaration

In April 2006, trusts will be expected to publish their final declaration stating how well their organisation has met core standards over the previous 12 months. The declaration should record any significant lapse in meeting the standards during that period.

Trusts will be expected to report on progress they have made in areas of risk identified in either the draft declaration or through inspections. They should identify areas where there are still risks and the remedial action to be taken over the next year. Trusts will be required to invite comments from the same third parties as before. The trust must use specific questions supplied by the Healthcare Commission in obtaining comments from the third parties.

In the case of strategic health authorities, the invitation will be for comments on any aspect of the trust's performance in meeting core standards. In response to this request, we will welcome any comments that the strategic health authority wishes to make.

For the local overview and scrutiny committee and patient and public involvement forum, the invitation should additionally highlight a number of core standards that the bodies may particularly wish to comment on (including, for example, Standard C17 which requires the views of patients and others to be sought and taken into account by the trust). However, we do not expect any of the third parties to carry out additional inspections, reviews or engagement activities in order to contribute to the declaration.

There is no obligation on third parties to provide an overview of whether the trust is meeting all the standards. Instead, we are offering an opportunity to communicate any relevant views derived from the third party's own routine activities – which may relate to only a limited number of the standards. On

this basis, it would be entirely appropriate for an overview and scrutiny committee or patient and public involvement forum to decline the opportunity to comment. We would draw no conclusions from this refusal.

Any comments received must be reproduced verbatim in the appropriate section of the trust's declaration. There is no obligation on the trust to share the contents of the proposed declaration with the third parties when seeking their comments. However, we expect that trusts will wish to do so to help them develop a more rounded declaration.

We want the trust's declaration, including comments from third parties, to be made to the local community as well as to the Healthcare Commission. We will therefore expect trusts to include the declaration in the public session of their board meeting in April 2006 and to seek additional local publicity for the declaration. All declarations and third parties' comments will be published on the Healthcare Commission's website.

The declaration will be followed by a similar process of checking and selective inspection as that carried out for the draft declaration (although the process of checking will take into account updated opinions relating to the 2005/2006 statement on internal control).

Following our selective inspections, a judgement will be made as to whether a trust has provided adequate evidence that it has met the standards that we are examining. Where it is judged that there has been a significant lapse in meeting a standard, this judgement will be recorded and published as a qualification of the trust's declaration.

September 2006 – Scoring

The trust's score for the assessment of compliance with the core standards will be calculated on the basis of the contents of their declaration and the results of any inspection. In general, lapses that have been identified through inspection will be weighted more heavily in the overall calculation than lapses that have been declared. This reflects the additional risks associated with a trust not identifying a lapse that is judged to be significant by our local team.

Four categories of score are applicable: fully met, almost met, partly met and not met. These are based on the proportion of standards that have been met, taking into account both the position at the end of the year and the progress made during the year. The categories of 'almost met' and 'partly met' are only applicable if all lapses are the subject of an action plan.

Annex 3 – Existing targets

This component of the assessment aims to assess how well providers of NHS services and PCTs have met existing targets set by the Government, described in *National Standards, Local Action, Health and Social Care Standards and Planning Framework, 2005/2006-2007/2008* (page 35).

Timing	Activity
Spring 2005	Publication on our website of the details of how the indicators are constructed, the rationale for them and the sources of data used
Winter 2005	Guidance on extenuating circumstances Initial guidance on collection and ratification of data
June/July 2006	Ratification of data with healthcare organisations
To be agreed	Guidance on thresholds
September 2006	Publication of results

Some of the existing targets overlap with elements of core standards. Where this is the case, we will assess trusts' compliance under the component concerned with existing targets.

Time period for performance being assessed

The assessment will cover performance in the financial year April 1st 2005 to March 31st 2006.

How assessment is scored

The scoring process will be similar to that used to rate key targets in the existing star ratings, but we will explore the feasibility of giving organisations credit for improvement. However, the improving trusts will not receive as high a rating as those which do achieve the targets. The scores for individual indicators will be brought together to produce a score for all existing targets using a four point scale.

Annex 4 – Using the findings of others

The Healthcare Commission is committed to reducing the burden of regulation in healthcare. This has been a key element in shaping the new system. Where possible, we will use the findings and evidence of others in determining scores for the annual rating of healthcare organisations. We will be doing this in three ways:

1. Use of resources

For 2005/2006, we are taking a major step in this direction by relying on the findings of the Audit Commission and Monitor on how effectively a trust is using resources. The scores that the Audit Commission and Monitor give will be used directly in our scores for the annual performance rating[1].

The objectives of this are to:

- provide rounded assessments of the financial performance of NHS trusts
- include an assessment of how well money is spent (value for money)
- make use of existing information and not duplicate the work of other regulators
- provide equivalent assessments for foundation and non-foundation trusts, recognising that they operate under different financial regimes and that there are differences in the information which is available to inform the assessments

All trusts will be assessed annually. The assessments will relate to the financial year April 1st 2005 to March 31st 2006.

NHS trusts
For NHS trusts, we will use assessments in the audited 2005/2006 accounts made by external auditors appointed by the Audit Commission. These assessments will relate to financial standing, financial management, financial reporting, internal control and value for money.

The Audit Commission and the Healthcare Commission will use the same scale of assessment, so that the auditors' overall scores will be used directly in our scores for the annual rating.

Foundation trusts
For foundation trusts we will use financial risk assessments. These will be based on submissions made by foundation trusts to Monitor in April 2006. The rating will not include an assessment of value for money provided by foundation trusts.

Monitor has yet to announce its final regime of monitoring and regulation following consultation. When Monitor's scoring scale is decided, the Healthcare Commission and Monitor will agree how their scales for assessment relate to each other so that, if necessary, Monitor's scores can be converted to fit the scale used by the Healthcare Commission.

[1] This will take account of the judgment in the case of *Ealing LBC v The Audit Commission* of February 17th 2005.

Further guidance
The final versions of the Audit Commission's criteria for its assessments are planned for release by May 2005. Monitor will also be publishing its final framework for monitoring and compliance in spring 2005.

2. Checking the declaration on meeting core standards

The information we will use to check trusts' declarations on meeting core standards will include findings from a wide range of partners, such as the Mental Health Act Commission and the Health & Safety Executive. The joint work we are carrying out with others, such as Ofsted and the Commission for Social Care Inspection in the joint area reviews of children's services, will also be used to check the accuracy of trusts' declarations.

For some standards, we can consider weighting some items of information (from Improving Working Lives, the Criminal Records Bureau and the NHS Litigation Authority) as being particularly important. This means that we will accept that a trust has met a particular element of a standard if it has met the requirements of these organisations. For example, if we have recent information from the NHS Litigation Authority that an organisation is adhering to a particular process with regard to consent, then we need ask no follow up questions with respect to that element. We have indicated these items of information with an asterisk (*) in *Defining core standards*.

In this way, the Healthcare Commission will be undertaking a significantly reduced amount of inspection itself, which will be confined to checks where the accuracy of the self declaration is in doubt, and a number of random checks to assure the quality of the process overall.

Because the overall emphasis for 2005/2006 is on checking that NHS organisations are meeting the core standards, this year we have decided to use the findings of others such as the Mental Health Act Commission, the NHS Litigation Authority and the National Cancer Action Team to cross check trusts' declarations. In the future, the emphasis will move towards improving performance by reference to the developmental standards. With this shift we will seek to use the findings of these organisations, in similar ways to the Audit Commission and Monitor this year, to contribute directly to the scores in our performance rating. We are developing criteria to help select a range of other regulators who are best placed to contribute in this way. These criteria include:

- the type of body assessed by other inspectors
- the issues covered
- the scope to promote improvement through the issues covered
- the alignment of the other body with the principles and priorities of the Healthcare Commission

3. Dashboard commentary

We will provide a dashboard, which is a profile of a trust's performance, on our website (see page 12). This will cover all the components of the framework of assessment, with their ratings and commentary, as well as their overall performance rating. We will also include written commentary on some key areas of performance, which will not be rated separately. Where relevant, these will include:

- any trends in second stage complaints referred to us
- the findings of any investigations by the Healthcare Commission or the Mental Health Act Commission
- the assessments of the NHS Litigation Authority

We are currently developing criteria to select which other bodies' investigations or assessments can be used in this way for 2005/2006. Further details will be published in guidance.

Annex 5 – New national targets

This part of the assessment aims to assess the performance of PCTs and, where appropriate, NHS trusts in working towards meeting the new national targets set by Government, and described in *National Standards, Local Action, Health and Social Care Standards and Planning Framework, 2005/2006-2007/2008*.

The main steps and timing, including opportunities for trusts to comment on our assessment, are:

Timing	Activity
Summer 2005	Publication on our website of the lists of the indicators we will use to assess performance on the national targets for PCTs and provider trusts, together with the detailed constructions of the indicators, the rationale for them and the sources of data used
Winter 2005	Guidance on extenuating circumstances Guidance on collection and ratification of data
To be agreed	Guidance on thresholds
September 2006	Publication

Engagement

We will engage with healthcare providers, clinicians and those representing patients and the public throughout the process of assessment. Trusts will have the opportunity to check the data used to assess them in June/July 2006.

Time period for assessing performance

The assessment will cover performance in the financial year April 1st 2005 to March 31st 2006.

Annex 6 – Improvement reviews

The programme of improvement reviews will assess the progress made by healthcare organisations in ensuring continuous improvement in health and healthcare in a small number of priority areas each year.

Through the system of assessment, we aim to set out an improvement path where organisations and their local communities can see where they stand and make progress looking from a basic level towards best practice in performance.

To reflect the complexity of health and healthcare, the reviews will assess performance with reference to the core and developmental standards from a range of different starting points, for example, in relation to particular domains of the standards, particular population groups or particular conditions. These reviews will be particularly concerned with the experiences of patients as they move between healthcare organisations, and between health and other sectors. Many of our reviews are being carried out with other regulators, to allow an effective focus on the 'patients' pathway' and on the needs of patients and the public, as well as to streamline regulation and minimise duplication.

Where appropriate, we will incorporate assessments from improvement reviews directly into the scores for the annual performance rating. This will generally be the case where we can assess performance for all relevant organisations providing services for patients and the public.
For some issues, improvement reviews will provide national reports on progress and best practice in particular areas, or will focus on a sample of relevant healthcare communities. We will seek to respond quickly, using a flexible approach to areas of concern to patients and the public. The results from this type of review will often feed into our overall surveillance information, but will not provide a separate score in the annual rating.

Main steps

The detailed design of each improvement review will depend on the issues being addressed and the objectives of the review. We will learn from the current pilots in order to develop a range of approaches to enable us to make a rapid impact in promoting improved outcomes for patients and the public. For current work, when the review is intended to feed directly into the annual ratings, the main steps will be:

Developing the review – we will work with patients and the public, healthcare staff, the research community and the Government in priority areas to identify best practice and the factors that are critical to performance. In doing this, we will visit those trusts that perform exceptionally well. We will set these factors out in a framework of assessment,

which will also identify the key indicators that we will use in assessing performance and how we will take account of local context.

Collecting data – we will gather data for each review. We will ensure that, where possible, we use national data that is already available. This will help reduce the administrative costs on healthcare organisations.

Assessing performance – we will rate performance using the framework of assessment for each relevant organisation and report our assessment to each trust. For the majority of trusts, the review will end at this point.

Planning improvement – taking a targeted and focussed approach, we will only visit a small proportion of trusts (around 10%) whose performance has been assessed as having the greatest potential for improvement. We will work with the trusts to share best practice and identify the barriers holding back performance, and they will be expected to produce an action plan. As part of our visits we will generally seek views from groups representing patients and the public.

Monitoring improvement – we will monitor data to track improvement.

How assessment is rated

Where we intend to incorporate assessments from improvement reviews directly into the annual performance rating, the approach to rating is set out below.

Each review will identify the criteria critical to performance (through engagement with the NHS, groups representing patients and the public, and experts). For each criterion we will identify key indicators and measures, together with the expected levels of performance. Performance relating to each criterion will be graded separately. The performance for each criterion will then be combined into an aggregated rating for the organisation.

Where the improvement review adopts the perspective of the patients' journey or looks at how a system of care as a whole is performing, then we expect to give the same score to all healthcare organisations involved in that journey or system. The benefits of this approach are:

- it encourages local organisations to work in partnership to improve performance
- it strengthens relationships locally to the benefit of patients and the public

The programme of reviews for 2005/2006 and coverage by sector

We have already started to pilot improvement reviews. Subject to their being evaluated as satisfactory, they will be carried out in 2005/2006. Some of the action following up the trusts with the greatest potential for improvement may occur in 2006/2007.

We intend that different improvement reviews will focus on different sectors of healthcare, even when looking across organisational boundaries. Our intention is that the programme of reviews will be reasonably widely spread across the range of health and healthcare issues.

Reviews that will feed directly into ratings

The reviews that are expected to feed directly into the 2005/2006 ratings, subject to the evaluations of the pilots, are:

Public health (tobacco control)
This review will assess whether the commissioning and provision of NHS 'stop

smoking' services effectively targets groups most at risk. It will also examine the extent to which a PCT promotes a smoke free environment in which to provide healthcare, as well as its role in championing the agenda for tobacco control and the programmes for health promotion. It will cover all PCTs.

Children's hospital services (based on the national service framework)
This review will focus on safety and access in relation to outpatients and day care, accident, emergency and emergency ambulatory care, wards, and transfers for elective and emergency surgery between hospitals. It will cover all acute trusts providing children's services.

Substance misuse (with the National Treatment Agency)
This review will focus on two key themes – the planning and coordination of care (an issue which cuts across the whole system of healthcare) and community specialist prescribing (an issue relating to the provision of a particular service). It will cover all PCTs and mental health trusts involved in drug action teams.

Adult community mental health (with the Commission for Social Care Inspection)
This review will assess access to services, getting the services right, working in partnership and tackling social exclusion. It will cover all local implementation teams, including primary care trusts, mental health trusts and councils with responsibility for social services.

MRSA/hospital acquired infection/safety
This review will measure the extent of implementation of standards and guidelines on infection control. It will clarify the areas of developing good practice that are materially reducing the rates of incidence of hospital acquired infection. It will also assess the levels of cleanliness in acute hospitals and produce national reports on improvement. In 2005/2006 it will cover all acute trusts.

Heart failure
This review will assess the diagnosis, care, treatment and support of patients (and their carers) in primary care and in arrangements for discharge from hospital. It will also assess how well hospital and community services work together to support patients. It will cover all primary care and acute trusts.

Other reviews, including those that will feed indirectly into ratings

We will take forward work on other improvement reviews in 2005/2006 that will provide national reports on progress and best practice in particular areas, or will assess small samples of healthcare communities. These will often feed into our overall surveillance information, but will not provide separate scores in the annual rating. These reviews are:

- joint area reviews of children's services (with Ofsted, the Commission for Social Care Inspection, the Audit Commission and criminal justice inspectorates)
- joint inspection of older people's services based on the national service framework (with the Commission for Social Care Inspection and the Audit Commission)
- chronic obstructive pulmonary disease
- a cross inspectorate study of best practice on the implementation of schemes relating to equality, diversity and human rights
- public health (sexual health)

The acute hospital portfolio

The acute hospital portfolio reviews will continue in 2005/2006 and be delivered locally in cooperation with the Audit Commission. However, for the first time, we intend to feed the results into ratings on a

similar basis to improvement reviews. The portfolio will eventually merge with improvement reviews.

The three topics for 2005/2006 are based on past topics, so that progress since the Audit Commission previously surveyed them can be assessed, but with a greater emphasis on patient experience. All three topics may explore the crossover of services with primary care and other areas outside acute trusts. The topics are:

Admissions management

This review is aimed at ensuring that patients requiring an admission are admitted quickly to areas that best meet their needs. It will include both emergency and elective inpatient admissions and will examine the extent to which waiting lists and beds are being properly managed. It will also look at how bed availability in the wider healthcare community can affect acute trust performance.

Diagnostic services

This review is aimed at ensuring fast, patient focused and cost effective access to radiology, pathology and endoscopy services. It will examine the extent and consequences of delay; the efficiency, organisation and management of these services; and the recent rapid growth in use of endoscopy services.

Medicines management

This review will assess progress in developing pharmacy staff roles, introducing 'best practice' initiatives and introducing pharmacy automation. It will also explore how new guidance from the National Institute for Health and Clinical Excellence (NICE), for example, is being managed and introduced within trusts. Patient experience will be assessed through exploring access to medication reviews, information and advice.

Development of future work

In 2005/2006, we will be developing a number of possible improvement reviews for future years (including responding to emerging issues), evaluating lessons from pilots and developing a wide range of approaches in taking forward the programme of reviews.

Further information on this programme is on our website. Further guidance will be published, together with the frameworks for assessment, once the development of each improvement review is complete.

Annex 7: Timetable for assessment in 2005/2006

The timetable for preparing each NHS trust's 2005/2006 annual review and performance rating is:

Spring 2005

- We will publish our revised guidance, *Defining core standards.*
- We will establish contacts with NHS organisations to build relationships at the local level.
- We will publish further guidance on how we intend to assess performance in the following areas:
  – use of resources
  – meeting core standards
  – meeting existing targets

Spring/summer 2005

- We will publish further guidance on the assessment of compliance with core standards.
- Subject to evaluation of the pilots, we will publish frameworks for assessment for the first improvement reviews, which will be carried out during 2005/2006, and invite views on them. Similar material will then be published on other improvement reviews throughout the year.
- We will publish the details of how the indicators for existing targets are constructed, the rationale for them and the sources of data used.
- We will publish detailed guidance on the performance indicators that we will use to assess performance in working towards meeting the new national targets (including details of how the indicators are constructed and the sources of data used).

October 2005

- NHS organisations will return their draft declarations on how far they are meeting core standards, identifying areas of concern where standards may not be being met or are at risk, the action being taken to address the risks and the progress expected by the end of March 2006.

October/November 2005

- We will begin our initial process of cross checking and inform NHS organisations about likely areas of risk that core standards may not be met.
- Those trusts involved in the first improvement reviews will work with us to carry out self assessment and collection of data.

Winter 2005

- We will publish further guidance on existing and new national targets (covering the timetable, extenuating circumstances, collection and ratification of data).

December 2005 to March 2006

- Those trusts involved in the first improvement reviews will receive our initial and then final assessments.

April 2006

- NHS organisations will return their final declaration on how well they have met core standards. This will report on progress made in relation to areas of risk identified in the earlier declaration or through inspection. Trusts should identify areas of continuing risk and remedial action to be taken over the next year.

April 2006 onwards

- We will begin the main process of cross checking to identify likely areas of risk to enable us to target our selective inspections and other checks.
- We will conduct checks on trusts when our information or evidence from others raises concerns about the trust's self assessment on how well it is meeting core standards. We will also spot check a further number of trusts at random.
- We will work with those trusts involved in the first improvement reviews to plan improvement as required.

August to September 2006

- We will share with all trusts the final results and the scores that will feed into the performance ratings for all assessments, including those for meeting targets, and verify them with the trusts.

September 2006

- We will publish the results of the performance ratings for all trusts.

Annex 8 – Calculating the annual performance rating

In developing our new approach to annual performance ratings, we have emphasised the importance of the individual components of assessment having validity in their own right. We believe that these give a more detailed and accurate picture of an organisation's activities.

We are committed to developing a system of information that makes the results of the individual components of assessment available publicly as soon as possible. We are proposing to continue to develop the dashboard approach as a basic template for this work. We are also exploring modifications to this picture that allow us to show where improvement in any one component has occurred in the previous year.

Each of the components will be scored on a four point scale. For assessments of meeting core standards and existing targets, we intend to use the following scale:

Fully met
Almost met
Partly met
Not met

For all other components in 2005/2006, and the overall rating, we intend to use the following scale:

Excellent
Good
Fair
Weak

These component scales are broadly aligned with those of the Commission for Social Care Inspection and other local government inspectorates, and are also appropriate for our regulatory work in the NHS and independent sectors.

In order to come to a single performance rating for the process of aggregation, we will use a series of rules. These rules are currently under discussion. We plan to undertake sensitivity testing on these rules, to avoid perverse incentives and to maximise improvement. Whatever the final set, we want to ensure that:

- no organisation that is failing to meet existing or national targets can get a final score of excellent
- the lowest score on core standards or existing targets will automatically lead to a weak overall rating
- for an organisation to get an overall score of excellent, it has to show consistently good results across our assessments
- the rules are simple to understand and use

Annex 9 – Independent healthcare

Over the last two years, the proportion of independent providers meeting the existing standards has risen dramatically. Our experience of regulation and feedback from inspectors and providers suggest that we can now safely move to a more targeted and risk-based approach, which encourages improvement as well as compliance.

Although the independent sector is still being assessed by reference to their national minimum standards, it is proposed that these be revised and restructured under the seven domains of the *Standards for Better Health* used in the NHS. However, unlike in the NHS, we still have a statutory duty to carry out visits to inspect independent providers every year.

For the purpose of inspection, independent providers are divided into four categories:

- acute hospitals and mental health establishments
- single specialty services (for example hospices, IVF clinics, cosmetic surgery clinics)
- private doctors
- services which do not require a clinical qualification (beauty salons and hyperbaric oxygen therapy for people with neurological disorders)

We have taken account of concerns from the independent sector that we should be careful not to increase their work as a result of inspections. Therefore we have tried, where possible, to reduce the time involved in the process of inspection.

The new regime of inspection starts, as previously, with a self assessment form. However, the forms used are now tailored to each type of provider, are substantially shorter and received positive comments during the consultation.

Following self assessment, we have inserted a new step called risk assessment. For complex organisations, this involves using documents and inspectorates' findings (including our own from the previous year) to corroborate self assessment. For small establishments and single practitioners, it involves using questions designed to trigger relevant responses. In general, areas of self assessment which are corroborated will not be inspected, unless we have targeted those areas for spot checks during the week of inspection. During the course of visits, however, inspectors will normally add areas for inspection to those selected initially. Inspections of newly registered establishments may cover all standards (depending on what is needed to establish a baseline for future more targeted and risk-based inspection).

One third of our inspections in 2005/2006 will be unannounced. Some of these will be targeted and others will be chosen at random. This is a higher proportion of spot

checks than we will be undertaking in the NHS. This is because there is a lack of readily available data at national level in the private sector compared to the NHS, which increases the need for inspection visits. During the consultation, many establishments welcomed the unannounced visits but others sought reassurance that it would not cause disruption. We have decided to proceed with it on the basis that establishments and inspectors who are familiar with unannounced inspections are confident that disruption can be minimised, and experience in the USA appears to reinforce this view. We will evaluate this approach at the end of 2005/2006.

Although these developments will tighten the focus of inspections, the lack of routine national data means that we still have to rely on self assessment and visits, although the intelligent use of information could potentially replace some of this for larger establishments. During 2005/2006, we plan to draw up plans for improving our access to data and the use we make of it. This will include specifying clinical and other indicators.

We endorse the views expressed in consultation that we should not do too much too fast. We do not expect clinical indicators to feature significantly in inspection before April 2006, although we do anticipate that we will request data before then in order to develop and test definitions of data and analytical models. We will only collect clinical performance data from larger establishments, and we will only use it for planning the focus of our inspections. And we will consult further on developing our use of data as part of our forthcoming strategy for regulating independent healthcare.

Some significant development of our approach is still going on (for example, to increase the use of web-based forms) and we believe that we can further refine inspection methods in the light of experience. We will do this on the basis of feedback from all providers following their inspections, and by quarterly incremental revisions of our methods.

We are already in discussions with the Department of Health about the implications that changing the standards used in assessment would have for registration, fees, enforcement and other issues. Together with the Department, we are committed to approaching these complex issues in discussion with providers. During 2005/2006 we will consult on a strategy for regulating independent healthcare with detailed proposals for taking this forward.

The consultation process raised some complex issues about aligning the standards applying to the NHS and independent healthcare including whether we will publish performance ratings for the independent sector and how we would do it.

We will be considering these issues in more detail in 2005/2006 and will consult the independent sector on our proposed way forward.

Annex 10 – Understanding the local area

The Healthcare Commission has organised itself on a regional basis since its inception in 2004. In order to support the new system of assessment, as well as meet the needs of the providers of healthcare, we have now further developed those arrangements to enable the Commission's work to be more strongly connected to the community and to healthcare providers in different parts of the country.

This expansion of our regional arrangements will enable us to work effectively with healthcare organisations (including strategic health authorities, NHS trusts, commissioning bodies, foundation trusts and independent providers) and local patients and community groups. It will also helps us to coordinate our work with the local arms of other inspecting bodies, in line with the principles in the Concordat between bodies inspecting, regulating and auditing healthcare. Our aim is to act locally and think nationally, following the principle of working locally whenever this will most efficiently achieve the Commission's goals.

Our operations group conducts most of the day to day interactions with patients, providers of healthcare and other stakeholders. The majority of the Commission's operations staff will be working through regional structures from April 2005. Our centres are:

- the south west region based in Bristol
- the London and south east region based in London
- the central region based in Nottingham
- the north region based in Manchester
- an additional office in the north region, based in Leeds

This regional approach will also provide an important focus for the rest of the Commission's staff to have a local view within a national perspective, of standards, provision of care and service to the community through both the NHS and the independent sector.

Our major roles are to inspect, inform and improve. Within this remit, we will further develop our approach on partnership through:

- local connections to the providers of services for assessments, reviews and the gathering of information
- supporting the exchange of learning to encourage improvement
- working with groups representing the community and other interests
- applying local knowledge and assessment of needs to a wider and comprehensive national perspective and agenda

The regional offices will be the primary source of information, advice and assistance to the providers of healthcare, as they assess their performance in accordance with the new system.

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