



## Working in partnership

Getting the best from inspection, audit, review  
and regulation of health and social care

May 2006



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# Foreword

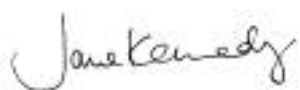
The Government's continuing programme of investment and reform in healthcare is delivering more and improved services through a mix of public and private sector providers.

We want to make sure that this investment is maximised and that standards are consistent right across healthcare. Regulation is an important element of this. It helps provide assurance to the public and to improve services. But to get the best out of the system, effective and targeted regulation is vital. The regulatory regime must be uncomplicated. It must be transparent and independent. But independence does not mean that there is no dialogue between organisations. We have to make sure that the inspection regime for healthcare is joined up, to remove duplication and overlap.

The Government believes that the potential gains from stripping away unnecessary regulation and duplication of activity are enormous. The Concordat was developed to provide a code of objectives and practices for both Government and independent inspectorates to deliver smarter, more joined up inspection programmes that reduce the burdens of inspection on healthcare staff. We have already announced that the number of public services inspectorates will reduce from 11 to four by 2007 and the merging of inspectorates will cut down repeat requests for information and the number of visits from inspectors.

So Government is developing the future landscape. But inspectorates must also seize the initiative. That is why the Concordat is so important. It sets out a number of principles and priorities to which all inspectorates should work. Since the Concordat was launched in June 2004 good progress has been made on implementation. Under the leadership of the Healthcare Commission there has been a significant amount of work to get the basics in place. There have been some notable examples of better practice. However, there needs now to be a step change towards demonstrable action.

We welcome the addition of the new members, the enhancement of the code of objectives and practices by further guidance and the new web-based scheduling tool for signatories and healthcare organisations. The developing links between the English and Welsh Concordats are very encouraging. Inspectorates are increasingly moving to more risk-based approaches to inspection that shift resources away from routine inspection in safer areas with a proven track record, towards services in areas of higher risk, regulating only where necessary, and in a light touch way that is proportionate to risk. Inspectorates must continue to identify and remove overlap and duplication created by the system of inspection as experienced by frontline staff.



**Rt Hon Jane Kennedy MP**  
Department of Health

# Introduction

## The Concordat

The Concordat is a voluntary agreement between organisations that regulate, audit, inspect or review elements of health and social care in England. It was launched in June 2004 by 10 organisations, led by the Healthcare Commission. There are now 20 signatories working together to coordinate their activities such as audits, reviews and inspections. By streamlining their activities, these signatories are supporting the improvement of health services for the public.

The Concordat sets out what bodies providing healthcare in England can expect from the main inspecting bodies. It forms the basis of a programme to develop and implement policies for inspection that are based on sound objectives and practices. By inspection, we mean audits, reviews, assessments and the regulation of services. The Concordat is designed to support the improvement of services for the public and to reduce unnecessary burdens on frontline staff.

The Concordat:

- has been agreed by the signatories, which are listed in Appendix B, and the Cabinet Office
- is led by the Healthcare Commission, which has a statutory responsibility to promote the effective coordination of reviews or assessments relating to the provision of healthcare by or for the NHS including cross border special health authorities
- fulfils a commitment in *Making a difference: reducing burdens in healthcare inspection and monitoring*, Department of Health, Cabinet Office (2003). Action one of this report announced the development of a Concordat on the inspection of healthcare between reviewing bodies and providers of healthcare.

This Concordat is concerned predominately with the inspection of organisations providing health and social care. However, the signatories recognise that patients and clients often receive care or support from several agencies and that the effective delivery of social care is an important aspect of their overall care and experience. The Commission for Social Care Inspection (CSCI) is a signatory to this Concordat and will ensure that arrangements are developed for social care services that are consistent with its principles. In order to develop 'holistic' approaches, CSCI is developing substantial programmes of joint inspection with the Healthcare Commission, as well as with bodies such as Office for Standards in Education (Ofsted) and the Audit Commission. It intends to shape those programmes in line with the principles of the Concordat and will keep its progress in this area under close review.

## Objectives

The Concordat has been developed by the inspecting bodies, in conjunction with health services. It is made up of 10 objectives that enable organisations to work together to remove unnecessary burdens associated with inspections, audits or reviews. Each objective is underpinned by a number of practices that are aimed at ensuring that the objectives of the Concordat are being met.

It identifies 10 objectives that are aimed at:

- delivering more consistent and coherent programmes of inspection
- improving services for patients, clients and their carers
- reducing unnecessary burdens of inspection on staff providing healthcare

Underpinning these objectives are a number of practices that will help to secure effective implementation. The development and operation of such practices will take account of:

- formal and informal agreements between inspecting bodies
- inspecting bodies' respective statutory remits and relevant professional standards
- the extent to which particular practices would enable bodies to fulfil their individual or collective functions

The aim is to achieve greater consistency and cohesion in the inspection of health and healthcare. However, while the closer alignment of methodologies may often be beneficial, the Concordat's intention is not to impose a single inspection methodology or to replace the existing methodologies that best meet the needs of the services for which they have been developed. Equally, the Concordat does not affect the statutory remit of individual inspecting bodies. Where there is any overlap or conflict in statutory remits, the bodies concerned will seek to manage this effectively.

## Signatories

So far 20 organisations involved in the regulation, audit or review of health and social care have signed up to the Concordat. There are two types of signatories:

- **full signatories**  
Full signatories are those organisations that directly or indirectly regulate, audit or review health or social care in England and/or routinely request data from, or carry out inspections of, NHS organisations and providers of independent healthcare.

- **associate signatories**

Associate signatories are those organisations that may not directly undertake inspection, audit or review of health or social care in England but whose work is closely associated with the principles and objectives of the Concordat.

A full list of signatories is available in Appendix B.

## **The Government's approach**

The Concordat is consistent with the Government's policy on the inspection of public services, and the 10 principles that support that policy, which are found in *Inspecting for improvement: Developing a customer focused approach* (Office of Public Services Reform, July 2003).

Audits of financial statements are not covered by the Concordat.

## **Commitment**

The signatories will work with the Department of Health, the Cabinet Office, other inspecting and interested bodies, and those who use, provide or otherwise contribute to the quality, safety and cost effectiveness of healthcare continuously to improve and review the Concordat and the practices it promotes. They will seek ways of including the practices of the Concordat in their work with other bodies and to encourage relevant bodies to adopt the Concordat. The signatories have established the Health and Social Care Inspection Forum to oversee the effective implementation of the practices in the Concordat. The forum will work closely with the Local Services Inspectorates Forum, which coordinates practice in relation to local government. The Local Services Inspectorates Forum is chaired by the Audit Commission and considers strategic issues relating to the inspection of local authorities.

## **Geographical coverage**

The Concordat currently applies to England, but signatories with a remit in Wales will extend its principles to their principalities.

The implications for those signatories (including potential signatories) that have a UK wide remit will be addressed.

# Objective one

## Inspections are coordinated with other reviews and collections of data

### Practice 1.1

#### **Define and explain remit to ensure clarity and effective coordination**

Inspecting bodies define their remit, avoiding any inappropriate expansion and explaining in annual plans and reports how they aim to cover that remit. This is communicated to professional, patient and client groups and others, including other inspectorates. The annual plan sets out the inspecting body's annual goals and objectives.

As inspecting bodies develop their annual plans and reports, they share them with other inspecting bodies to assist the development of coordinated programmes of work, including, where necessary, methodologies of inspection.

### Practice 1.2

#### **Use existing data sets**

Inspecting bodies consider the suitability of existing data sets, which are sets of information that can be analysed, and maximise their legitimate use of information from other inspecting bodies. Inspecting bodies do not request further information until the adequacy of existing information has been taken into account.

Inspecting bodies coordinate their core data, information and developmental requirements. They communicate these to inspected bodies and coordinate their collection arrangements.

Inspecting bodies put in place processes for managing and rationalising communications with the NHS about inspection programmes and requests for information.

### Practice 1.3

#### **Share information with other bodies**

Subject to agreed protocols (for example, regarding the use of confidential personal information), inspecting bodies share relevant information with each other to ensure there is no duplication of collection and that maximum value is obtained from the information collected. Where there are legal, regulatory or organisational barriers, inspecting bodies follow the principles set out in the Department for Constitutional Affairs' toolkit for the sharing of data<sup>1</sup> and/or consider referring it to the relevant Government department with a recommendation for a Regulatory Reform Order (RRO)<sup>2</sup>.

## **Practice 1.4**

### **Planning inspections**

Inspecting bodies coordinate their inspections, reviews and monitoring activity and, where appropriate, develop shared methodologies and inspect jointly. They develop mechanisms to support these procedures. When inspections take place separately, inspecting bodies consult each other and inspected bodies as to how and with whom information and findings will be shared.

Inspecting bodies develop means for sharing their plans for inspection in order to create a unified schedule. This is communicated to the NHS and other relevant bodies. Subject to maintaining the effective use of unannounced inspections in certain circumstances, inspecting bodies provide advance notice of routine inspections.

## **Practice 1.5**

### **Reliance on other inspecting bodies' findings**

Subject to their statutory remit, inspecting bodies develop a reliance on the results of reviews carried out by other competent organisations. They aim to avoid replicating inspections in areas that have been inspected recently by others. To support this process, inspecting bodies demonstrate the robustness of their processes and findings.

Where there are regulatory or organisational barriers, bodies consider if these could be overcome by referring them to the relevant Government department with a recommendation for a Regulatory Reform Order (RRO)<sup>2</sup>.

## Objective two

### Inspections focus on the experiences of patients, other people who use services and carers

#### **Practice 2.1**

##### **Involve those who use services**

The planning, delivery and evaluation of inspections of healthcare take account of views expressed by patients, other people who use services and their carers. Arrangements are in place to gather such views, to make effective use of them and, as appropriate, to engage people who use services more directly.

#### **Practice 2.2**

##### **Focus on patient 'pathways'**

A patient pathway is the route that patients take from their first contact with the health service through to the completion of their treatment. Where relevant, inspecting bodies focus on services provided to patients and other people who use services as part of their pathway of care.

#### **Practice 2.3**

##### **Equality and diversity**

Inspecting bodies ensure that inspections are undertaken with proper regard to issues of equality and diversity, including the needs and interests of people with disabilities and black and minority ethnic groups. Inspections demonstrate cultural relevance.

#### **Practice 2.4**

##### **Consultation**

When consultation is needed, inspecting bodies follow the principles set out in the Government's code of practice on consultation<sup>3</sup>.

## Objective three

### Inspections support improvements in quality and performance

#### **Practice 3.1**

##### **Recognise improvement and good practice**

Inspecting bodies ensure, through objective assessment, that improvement and best practice in the provision of health and social care are identified and recognised.

#### **Practice 3.2**

##### **Spread good practice, encourage innovation and learn from experiences**

Inspecting bodies ensure that information about the best and/or most innovative practices they identify during inspections is communicated to relevant agencies. They draw attention to areas of improvement, and how that has been achieved, and share views and information about how improved performance might be encouraged. Inspecting bodies identify unsatisfactory practices so that others can take corrective action where necessary.

#### **Practice 3.3**

##### **Focus on improving care and outcomes for people who use services**

Inspecting bodies focus as far as possible on outcomes for health and social care. Where relevant, this includes the contribution and needs of staff and trainees, minimising risks to staff and securing better value for money.

#### **Practice 3.4**

##### **Contribute to the development and delivery of policy**

Relevant information from inspections is used to inform the development of policy and the evaluation of its delivery. The Department of Health and inspecting bodies form partnerships with national, regional and local policy makers, performance managers, supporting organisations (such as the Modernisation Agency) and those responsible for delivery.

#### **Practice 3.5**

##### **Facilitate self assessment and continuous improvement of services**

Where appropriate, inspecting bodies provide support and guidance to healthcare bodies and their staff to develop tools for self assessment that can contribute to the continuous measurement, improvement and cultural suitability of services.

## Objective four

### Inspecting bodies continuously improve their methods

#### **Practice 4.1**

##### **Evaluating and revising standards/criteria**

There are regular and defined processes for evaluating and revising the standards, criteria, questions and relevant information used by inspecting bodies. Inspecting bodies seek ways of aligning their approaches where it is consistent with the effective discharge of their functions and assists shared or coordinated programmes of inspection. Any legislative barriers are referred to the relevant Government departments.

#### **Practice 4.2**

##### **Long term evaluation of cost and benefit**

Inspecting bodies instigate a continuing programme to evaluate the broad impact of inspections, including the impact on healthcare bodies and the wider community. These take into account direct and indirect operational costs and benefits, as well as the costs and benefits of compliance<sup>4</sup>. Inspecting bodies put procedures in place to evaluate the extent to which inspection has contributed to improving healthcare and/or other relevant (for example, operational, value for money or environmental) improvements. Published reports help to inform the planning and revision of methodologies.

#### **Practice 4.3**

##### **Pilot and assessment of major changes or new inspections**

Inspecting bodies fully assess the costs and benefits of major changes to inspections and, where appropriate, pilot new processes to ensure that they are practical, efficient and effective and contribute to service or other relevant improvements.

#### **Practice 4.4**

##### **Gather and act on feedback from those who receive or provide healthcare**

Inspecting bodies collect feedback from inspected bodies, and those who use the services and/or the outputs of inspections, to help inform future methodologies for inspection.

### **Practice 4.5**

#### **Use an external reference board or advisory panel**

Inspecting bodies ensure that the views of those receiving and providing care are taken into account in reaching decisions about methods of inspection. They develop ways of managing the relevant processes in conjunction with other inspecting bodies.

### **Practice 4.6**

#### **Share good practice with other inspecting bodies**

Inspecting bodies share their methodologies and learn from other inspecting bodies.

### **Practice 4.7**

#### **Benchmarking costs and performance**

Inspecting bodies have benchmarking processes in place<sup>5</sup>. These will assess the impact of inspection on similar bodies (for example acute trusts) to be compared within a sector, and also the impact on different sectors of public services that are subject to comparison.

### **Practice 4.8**

#### **Innovation and research**

Inspecting bodies support worthwhile innovation and the development of joint research strategies and projects in areas relevant to the practices in the Concordat.

# Objective five

## Inspections are independent, consistent and fair

### Practice 5.1

#### **Consistent standards for those providing care**

Inspecting bodies inspect against transparent standards and criteria for assessment that apply, as far as practical, to all providers of health and social care within the remit of inspections.

### Practice 5.2

#### **Consistent standards for inspecting bodies**

Inspecting bodies determine their criteria for assessment in line with national standards and take account of the standards or criteria set by other inspecting bodies. Inspecting bodies use existing groups and mechanisms to coordinate their standards in particular areas, or establish arrangements for ensuring maximum consistency in the use of standards and criteria. As noted in 1.5, where standards or criteria overlap, inspecting bodies develop reliance on each others' findings, or review their inspection requirements or remit.

### Practice 5.3

#### **Evidence-based standards and criteria**

Inspecting bodies base their standards or criteria on published research where this is available. They explain how compliance with criteria will meet the needs of patients, carers, other people who use services or, where appropriate, staff or bring about other improvements such as better value for money. Standards and criteria are continuously reviewed and revised, as necessary, in consultation with others who have an interest.

# Objective six

## Inspections are targeted and proportionate

### Practice 6.1

#### Targeted to capacity and performance

In developing work programmes, inspecting bodies take into account the nature, size and performance of the body being inspected. If necessary, they vary their requirements.

### Practice 6.2

#### Weighted to risk

Inspecting bodies develop an assurance framework that helps them to plan their activities according to the level of risk to the service and/or other risks. Methods are developed to define and grade risks. Consideration is given to reducing requirements in areas that carry lower risk to patients, carers, other people who use services or staff, or where recent inspections have reported favourably.

### Practice 6.3

#### Earned autonomy

Earned autonomy is where good performers receive less regulation. Options for earned autonomy are considered where the results of inspections justify these. They may include regular intervals between inspections, less frequent or less intensive monitoring and greater freedoms. In reaching such decisions, the degree of risk is assessed and account is taken of the continuing need to identify and learn from best practice, to safeguard the public and to support effective thematic studies.

### Practice 6.4

#### Range of mechanisms and levels of action

Inspecting bodies develop a range of activities and levels of action capable of responding to the differing requirements of a range of organisations. Inspectors use the minimum response that is necessary in the circumstances. On site inspection is only one option. Others include remote information analysis and self assessment.

### Practice 6.5

#### Assessing the impact of inspecting bodies' policies

Inspecting bodies assess and, where appropriate, seek to anticipate the impact of their policies and/or new initiatives on those they inspect. Where relevant, significant changes would usually be subject to a regulatory impact assessment<sup>6</sup>.

# Objective seven

## Inspections are transparent and accountable

### **Practice 7.1**

#### **Published standards and methodology**

Inspecting bodies publish clear methodologies, including evidence, value-based assessments and statistical tools that are used to reach conclusions.

Subject to any statutory changes, revisions to standards and/or criteria are published in advance and timescales are given for consultation and implementation.

### **Practice 7.2**

#### **Draft findings**

Inspected bodies are normally provided with draft findings in advance of publication and have the opportunity to comment on factual accuracy.

### **Practice 7.3**

#### **Complaints and appeals process**

Inspecting bodies publicise processes for handling complaints and appeals.

### **Practice 7.4**

#### **Publishing findings**

Where inspecting bodies publish their findings, they do so in ways that are accessible to those affected by them, as well as to the wider public. Publication is timely and other relevant inspecting bodies are informed in advance of the timetable. Reports and/or summaries of findings are in plain language and, as necessary, in a range of formats and relevant languages to meet diverse needs. The impact on people who use services is identified. In certain circumstances, such as to preserve the confidentiality of patients or to allow for due legal process, findings may be fed back in confidence to those providing healthcare.

# Objective eight

## Inspecting bodies use coordinated and proportionate methods of enforcement

### **Practice 8.1**

#### **Action planning and monitoring**

Recommendations and action plans are aligned with those of other inspecting bodies where appropriate and there is coordinated monitoring of their implementation through the inspected bodies' business plans. Inspecting bodies develop a mechanism to help with effective action planning, to do relevant costings and follow ups (see 8.3)<sup>7</sup>.

### **Practice 8.2**

#### **Range of enforcement mechanisms**

Inspecting bodies develop a range of mechanisms for enforcement that can respond to the differing requirements of inspected bodies. Bodies with enforcement powers use the most straightforward mechanisms that are consistent with effective action.

### **Practice 8.3**

#### **Cost recommendations and actions**

Inspecting bodies, in consultation with those who provide health and social care, consider, where practical, the balance of costs and benefits, distinguishing, where necessary, between basic compliance and best practice. Cost is addressed in published reports.

### **Practice 8.4**

#### **Enforcement powers**

Inspecting bodies that have enforcement powers adopt the Government's enforcement concordat<sup>8</sup>.

## Objective nine

### Inspectors are suitably qualified, trained and skilled

#### **Practice 9.1**

##### **Inspectors with suitable skills**

Arrangements made for determining the number of inspectors, their location, skills, background, cultural mix and cultural understanding are documented and monitored. Selection criteria are clearly stated, applied fairly, reviewed regularly and available publicly.

#### **Practice 9.2**

##### **Training and qualifications**

Inspecting bodies ensure that inspectors are suitably trained and subject to certification where relevant. The continuing competence of inspectors is reviewed regularly and inspectors are properly supported to retain and develop the necessary skill and knowledge.

#### **Practice 9.3**

##### **Feedback about inspectors**

Inspecting bodies regularly collect and, as necessary, take account of comments about inspectors from inspected bodies, patients and others. This includes attention to their skills and training needs. Complaints are dealt with according to set procedures.

# Objective 10

## Inspecting bodies continuously monitor their practices in line with the Concordat

### Practice 10.1

#### Implementation of practices

Inspecting bodies implement the practices in the Concordat individually or, where agreed, together. They recognise that each signatory has its own specific functions and take account of implications of particular practices for other inspecting bodies.

### Practice 10.2

#### Demonstrating implementation

Inspecting bodies demonstrate how they are implementing the practices of the Concordat. They prioritise action as necessary and identify, with reasons such as statutory remit, any practices that do not require specific action by them. Inspecting bodies measure the impact of implementation on inspected bodies, on the services they provide, on frontline and other staff, on patients, clients and carers, and on value for money.

### Practice 10.3

#### Communication to those providing or receiving healthcare

Inspecting bodies need to ensure that all those with an interest in healthcare are made aware of the practices that the Concordat promotes. Consistent with their statutory rights and responsibilities, inspecting bodies invite those inspected to comment on or challenge implementation of practices where they have concerns or suggestions to make.

### Practice 10.4

#### Monitoring implementation

Inspecting bodies establish processes for monitoring the implementation and demonstration of practices in the Concordat. There is a forum of inspecting bodies, which reviews and discusses the outcomes, as well as addressing the level of compliance with the practices.

### Practice 10.5

#### Review of the Concordat

The Concordat is reviewed by its signatories at least annually. Lessons learned and good practice identified are shared to maximise the benefits for bodies providing healthcare and for people who use services, carers and frontline staff.

# Appendix A

## Background

### **The Concordat**

The purposes of the Concordat are consistent with the Government's policy on inspection and will:

- give momentum to improving coordination
- ensure that reviewing organisations implement agreed effective inspection practices to reduce burdens on the NHS
- facilitate sharing of good practice and continuous improvement in health and social care inspection

The Concordat is aimed initially at the main inspecting, auditing and review bodies in health and social care. Beyond that, there is the expectation of developing the Concordat and the practices that underpin it to encompass other bodies that undertake peer review, accreditation and audit programmes in the public, independent and voluntary healthcare sectors. There are also potential implications for those at local level who have auditing and inspecting roles.

### **Fragmented inspection**

Inspection of healthcare in England has, in general, evolved through incremental growth rather than by overall design. For the public and patients, for staff working in the NHS and independent healthcare, and for inspectors themselves, the system often seems fragmented and, taken as a whole, too inefficient. Referring to inspection processes, the Bristol inquiry report concluded that, "Apart from putting an unnecessary administrative burden on trusts in dealing with these activities, there is inconsistency and an inevitable fragmentation of the process... There is no effective coordination of the various external inspections and assessments that trusts are required to undergo, or of the generic standards they are required to follow"<sup>9</sup>.

### **Direction – rationalised inspections**

In order to improve the regulation of healthcare, the inspection regime is being rationalised and consolidated. This will strengthen public accountability, provide for a more efficient system of regulation and make an important contribution to improving standards of care.

The Government's aim was set out in its response to the Bristol report, *Learning from Bristol: the Department of Health's response* (2002) and the white paper, *Delivering the NHS plan: next steps on investment, next steps on reform* (2002). The next, and more tangible, stage in achieving a more rationalised inspection regime was the Health and Social Care (Community Health and Standards) Act 2003.

The 2003 Act and other measures have brought together functions of healthcare inspection that had been carried out by a number of bodies, including:

- the former Commission for Health Improvement
- the Audit Commission (national value for money studies)
- the former National Care Standards Commission (independent healthcare regulation)
- the Department of Health (performance ratings)

The Healthcare Commission took over these functions when it was established in April 2004. It also has additional functions as described in the 2003 Act. The Healthcare Commission will independently review, inspect and assess the management, provision and quality of healthcare and be a driving force for continuous improvement in public and private health services. Subject to legislation, the Mental Health Act Commission's independent oversight of the use of compulsory powers would be transferred to the Healthcare Commission.

The rationalisation of these bodies points to a transformation of healthcare inspection, providing for a more integrated and streamlined system of the regulation of health and social care services.

Across the health and social care community there is an appetite for better coordination and cooperation to improve inspection and reduce overlapping burdens, allowing frontline staff to concentrate on delivering services. While there is evidence of a shared desire to move in this direction, there has been a need for one body to take the lead in coordinating this activity.

Building on its statutory remit to coordinate reviews of healthcare, the Healthcare Commission will spearhead the move to more integrated arrangements for inspection. The Commission for Social Care Inspection has been set up to provide similar leadership in social care, working closely with the Healthcare Commission to synergise approaches to the inspection of services in health and social care.

## **The Government's policy on inspection**

In July 2003, the Government published its *Policy on inspection of public services*. This followed a wide ranging review of inspection of public services, undertaken as a result of concern at the marked expansion in the depth and scope of inspection, and the impact that this was having on frontline organisations. In this publication, the Government made clear its commitment to inspection, clarified what it means by effective inspection, outlined the arrangements through which effective inspection can be achieved, and set out its expectations of inspectors in 10 statements of principle. These are that public services inspection should:

- pursue the purpose of improvement
- focus on outcomes
- take a user perspective
- be proportionate to risk
- encourage self assessment by managers
- use impartial evidence, wherever possible
- disclose the criteria used for judgement
- be open about the processes involved
- have regard to value for money, including that of the inspecting body
- continually learn from experiences

The Concordat builds on these principles in respect of health and healthcare. The Cabinet subcommittee on inspection will be receiving reports on its implementation.

# Appendix B

## Signatories to the Concordat

### **Full members**

Healthcare Commission

Audit Commission

National Audit Office

Mental Health Act Commission

Commission for Social Care Inspection

Health and Safety Executive

NHS Litigation Authority

Academy of Medical Royal Colleges

Postgraduate Medical Education and Training Board

Conference of Postgraduate Deans

General Medical Council

Human Fertilisation and Embryology Association

NHS Counter Fraud and Security Management Service

Skills for Health

### **Associate members**

NHS Confederation

NHS and Social Care Information Centre

Quality Assurance Agency for Higher Education

The Department of Health

Council for Healthcare Regulatory Excellence

Health Inspectorate Wales

## The full signatories to the Concordat

### **The Healthcare Commission**

The Healthcare Commission's legal name is the Commission for Healthcare Audit and Inspection. It was formed by the Health and Social Care (Community Health and Standards) Act 2003 and launched on April 1<sup>st</sup> 2004. The Healthcare Commission promotes improvement in the quality of both the NHS and independent healthcare across England and Wales.

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

### **The Audit Commission**

The Audit Commission is an independent public body. It appoints auditors in the areas of local government, housing, health and criminal justice services and quality assures auditors' work under the Code of Audit Practice. The Commission seeks to drive improvement in public services through effective audit and inspection, and by promoting good practice through a programme of national studies, which in health focuses on financial management.

[www.audit-commission.gov.uk](http://www.audit-commission.gov.uk)

### **The National Audit Office**

The National Audit Office scrutinises public spending on behalf of Parliament. It is independent of the Government. It audits the accounts of all Government departments and agencies, as well as a wide range of other public bodies, and reports to Parliament on the economy, efficiency and effectiveness with which Government bodies have used public money.

[www.nao.gov.uk](http://www.nao.gov.uk)

### **The Mental Health Act Commission**

The Mental Health Act Commission was established in 1983. Its functions are:

- to keep under review the operation of the Mental Health Act 1983 in respect of patients liable to be detained under the Act
- to visit and interview, in private, patients detained under the Act in hospitals and mental nursing homes

- to investigate complaints which fall within the Commission's remit
- to review decisions to withhold the mail of patients detained in high security hospitals
- to appoint medical practitioners and others to give second opinions in cases where this is required by the Act
- to publish and lay before Parliament a report every two years
- to monitor the implementation of the code of practice prepared under the Act and propose amendments to Ministers

[www.mhac.org.uk](http://www.mhac.org.uk)

### **The Commission for Social Care Inspection**

Launched in April 2004, the Commission for Social Care Inspection is the single, independent inspectorate for social care in England. The Commission was created by the Health and Social Care (Community Health and Standards) Act 2003. The Commission's primary function is to promote improvements in social care in the public and independent sectors in order to make social care better for people.

[www.csci.org.uk](http://www.csci.org.uk)

### **The Health and Safety Executive**

The UK Health and Safety Commission (HSC) and the Health and Safety Executive (HSE) are responsible for the regulation of almost all the risks to health and safety arising from work activity in the UK. Their mission is to protect people's health and safety by ensuring that risks in the changing workplace are properly controlled.

The HSC and HSE look after health and safety in nuclear installations and mines, factories, farms, hospitals and schools, offshore gas and oil installations, the safety of the gas grid and the movement of dangerous goods and substances, railway safety, and many other aspects of the protection both of workers and the public. Local authorities are responsible to the HSC for enforcement in offices, shops and other parts of the services sector.

[www.hse.gov.uk](http://www.hse.gov.uk)

## **The NHS Litigation Authority**

The NHS Litigation Authority (NHSLA) is a special health authority and thus part of the NHS. The authority provides an indemnity to NHS organisations under clinical and non-clinical risk pooling schemes. In addition to managing the claims which are made under these schemes, the NHSLA encourages the effective management of risk within the NHS by assessing organisations against defined standards with the objective of reducing the number and cost of claims.

[www.nhsla.com](http://www.nhsla.com)

## **Academy of Medical Royal Colleges**

The Academy of Medical Royal Colleges brings together the president of each of the medical royal colleges in the United Kingdom, as well as the faculties of A&E, medicine, dental surgery, occupational medicine, pharmaceutical medicine and public health. The academy regularly meets ministers, senior members of the Department of Health and other national organisations to discuss generic health issues.

The Academy is undertaking work to harmonise revalidation schemes for colleges and faculties and is also working with staff at Modernising Medical Careers in order to ensure that the proposed reformed training programme is ready to launch in August 2007. The academy also coordinates the list of nominees for platinum awards that are submitted to the Advisory Committee on Clinical Excellence Awards.

Recent examples of documents produced by the academy can be found on its website.

The academy also has a number of subcommittees, usually chaired by a President or a coopted member. Membership of these subcommittees is made up of the 'experts' in each of the colleges and faculties. They are:

- directors of continuing professional development
- education committee
- foundation subcommittee
- health inequalities forum
- medical assessment partnership board
- patient/lay group
- specialty training subcommittee
- trainee doctors' group

[www.aomrc.org.uk](http://www.aomrc.org.uk)

### **The Postgraduate Medical Education and Training Board**

The Postgraduate Medical Education and Training Board was formed in 2002 to supervise postgraduate medical education and training. It acts as an independent statutory governing body and has been designed to be flexible, so that it may respond to changing circumstances in the provision of education or regulatory legislation. The board:

- improves the supervision of postgraduate medical education and training
- consolidates and strengthens the position of the medical royal colleges and faculties as essential elements of the education and training process
- raises standards and quality in postgraduate medical education and training
- provides robust arrangements for assuring the continued high quality of postgraduate medical education in the UK
- provides managed structures and processes to ensure all interests are represented in postgraduate medical education
- works closely with related educational and regulatory bodies
- regulates specialist and general training under the same guidelines

[www.pmetb.org.uk](http://www.pmetb.org.uk)

### **Conference of Postgraduate Deans**

The Conference of Postgraduate Deans provides a forum in which postgraduate deans meet to discuss current issues, share best practice and agree a consistent and equitable approach to medical training in all deaneries across the UK. Through inspection visits to trusts, GP training practices and health authorities, the postgraduate deans ensure the provision of suitable learning environments for doctors and dentists in training that meet the defined standards for specialist and generalist medical and dental training.

[www.copmed.org.uk](http://www.copmed.org.uk)

### **General Medical Council**

The General Medical Council is an independent statutory body responsible for the regulation of the medical profession. Its purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. Its functions are:

- defining the standards and ethics that society and the profession expect doctors to follow throughout their working lives

- encouraging high quality training of new doctors in the UK and coordinating all stages of medical education
- registering and licensing doctors for practice in the UK
- dealing firmly and fairly with doctors whose fitness to practise is questioned

[www.gmc-uk.org](http://www.gmc-uk.org)

### **Human Fertilisation and Embryology Authority**

The Human Fertilisation and Embryology Authority (HFEA) was established in August 1991 following the passing of the Human Fertilisation and Embryology Act 1990 (HFE Act). The HFEA's principal tasks are to:

- license and monitor clinics that carry out *in vitro* fertilisation (IVF) and donor insemination
- license and monitor research centres undertaking human embryo research
- regulate the storage of gametes and embryos

The HFEA's other statutory functions include:

- producing a code of practice which gives guidelines to infertility clinics about the proper conduct of licensed activities
- maintaining a formal register of information about donors, treatments and children born as a result of those treatments
- providing relevant advice and information to patients, donors and clinics in the UK
- reviewing information about human embryos and any subsequent development of such embryos, and the provision of treatment services and activities governed by the HFE Act
- advising the Secretary of State on relevant developments in treatments and research

Underlying all these activities is the HFEA's desire to safeguard the interests of patients, children, the general public, doctors, providers of services, the scientific community, and also future generations. The HFEA ensures that all UK treatment clinics offering IVF or donor insemination, or storage of eggs, sperm or embryos, conform to high medical and professional standards and are also inspected regularly.

[www.hfea.gov.uk](http://www.hfea.gov.uk)

## **NHS Counter Fraud and Security Management Service**

The NHS Counter Fraud and Security Management Service is a special health authority with the statutory responsibility for all policy and operational matters relating to the prevention, detection and investigation of fraud and corruption and the management of security, which can broadly be defined as the protection of people and property in the NHS.

The Service has implemented comprehensive national frameworks and has an extensive counter fraud quality assurance and inspection programme, which is also being developed for security management, to assist health bodies in consistently meeting the highest possible standards and levels of professionalism in countering fraud and NHS security management. This will ensure that valuable resources are safeguarded and that staff, visitors and professionals are protected, so that the best possible care can be delivered to patients.

[www.cfsms.nhs.uk](http://www.cfsms.nhs.uk)

## **Skills for Health**

Skills for Health aims to help the whole sector develop solutions that deliver a skilled and flexible UK workforce in order to improve health and healthcare. To do this, it works with its partners, stakeholders and customers to:

- develop and manage national workforce competences
- profile the UK workforce
- identify and articulate sector workforce needs
- improve workforce skills
- influence the education and training supply and facilitate the quality assurance and enhancement of healthcare education and training

Skills for Health was established in April 2002 and licensed by the Department for Education and Skills in May 2004. It covers the whole UK health sector – NHS, independent and voluntary sector employers – and is funded through four UK health departments, the Sector Skills Development Agency, the Education Act regulatory bodies and by the health sector employers and providers.

[www.skillsforhealth.org.uk](http://www.skillsforhealth.org.uk)

# The associate signatories to the Concordat

## **NHS Confederation**

The NHS Confederation brings together the organisations that make up the modern NHS across the UK. The Confederation helps its members to deliver better health and healthcare by:

- influencing policy and the wider public debate
- supporting health leaders through information sharing and networking
- working for employers to improve the working lives of staff and so to provide better care for patients.

The confederation's work is underpinned by the involvement of members. Confederation membership covers all types of statutory NHS organisation. Members are the organisations themselves, while the individuals actively involved in the Confederation on behalf of their organisation are from board level – chief executives, chairs, non-executives and directors. There is also an affiliate membership scheme for commercial and not for profit organisations providing frontline care services on behalf of the NHS.

[www.nhsconfed.org](http://www.nhsconfed.org)

## **NHS Health and Social Care Information Centre**

The Health and Social Care Information Centre was established as a special health authority in April 2005. It is working to make information more accessible to the public, regulators, health and social care professionals and policy makers, leading to improvements in knowledge and efficiency.

The information centre's focus is to put quality information at the heart of decision making and to ensure information is used at different levels for different aspects of improvement.

By working in partnership with health and care professionals, including clinicians and managers, the organisation builds understanding of information needs across all levels of the health and social care system. As a leading and independent authority on statistical data the information centre is setting standards in the collection and use of data. By ensuring data is collected once only it aims to reduce the burden on those providing direct care, managers and administrators, releasing more resources for direct care.

[www.ic.nhs.uk](http://www.ic.nhs.uk)

### **Quality Assurance Agency for Higher Education**

The Quality Assurance Agency for Higher Education (QAA) was established in 1997. Its role is to safeguard the public interest in sound standards of higher education qualifications and to encourage continuous improvement in the management of the quality of higher education.

It carries out reviews of the quality and standards of UK higher education and provides nationally agreed reference points that help to define clear and explicit standards for higher education.

QAA is an independent body, which is funded by subscriptions from universities and colleges of higher education, and through contracts with government departments and the main higher education funding bodies.

[www.qaa.ac.uk](http://www.qaa.ac.uk)

### **The Department of Health**

The Department's role is to help improve the health and wellbeing of the population of England. The Department provides strategic leadership to the NHS and social care organisations in England. It has overall responsibility for:

- setting the direction of health and social care services in England
- setting and monitoring standards for health and social care services
- ensuring NHS and social care organisations have the resources they need
- ensuring patients and the public can make choices about the health and social care services they use.

The Department does not run the NHS or social services. It works with health and social care organisations, arm's length bodies and other public and private sector organisations to deliver health and social care.

[www.dh.gov.uk](http://www.dh.gov.uk)

### **Council for Healthcare Regulatory Excellence**

The Council was set up in April 2003 by the National Health Service Reform and Health Care Professions Act 2002. Its responsibilities are to:

- promote the interests of the public and patients in relation to regulating healthcare professions

- promote best practice in regulating healthcare professions
- develop principles for good, professionally-led regulation of healthcare professions
- promote cooperation between regulators and other organisations

The Council's work covers the following nine regulators currently responsible for healthcare professionals throughout the UK:

- General Chiropractic Council
- General Dental Council
- General Medical Council
- General Optical Council
- General Osteopathic Council
- Health Professions Council
- Nursing and Midwifery Council
- Pharmaceutical Society of Northern Ireland
- Royal Pharmaceutical Society of Great Britain

More information on the Council for Healthcare Regulatory Excellence, the regulators and the professions they regulate, is available from the Council's website.

[www.chre.org.uk](http://www.chre.org.uk)

### **Healthcare Inspectorate Wales**

Healthcare Inspectorate Wales (HIW) was established on April 1<sup>st</sup> 2004 by the National Assembly for Wales under the terms of the Health and Social Care Act 2003. HIW is an independent unit within the Assembly. HIW is responsible for the inspection and investigation of NHS bodies in Wales and Welsh NHS funded care with regard to patient safety and the quality of services and that clinical governance requirements and national standards are being complied with.

[www.hiw.wales.gov.uk](http://www.hiw.wales.gov.uk)

Sefydlwyd Arolygiaeth Gofal Iechyd Cymru (AGIC) ar 1 Ebrill 2004 gan Gynulliad Cenedlaethol Cymru i gyflawni'r cyfrifoldebau a bennwyd ar gyfer y Cynulliad yn Neddf Iechyd a Gofal Cymdeithasol (Iechyd a Safonau Cymunedol) 2003. Sefydlwyd AGIC fel Uned o fewn y Cynulliad gydag annibyniaeth ffurfiol wedi'i darparu trwy ddirprwyaethau a wnaed o dan Ddeddf 2003 i Brif Weithredwr AGIC. Cyfrifoldeb craidd AGIC yw cynnal adolygiadau ac ymchwiliadau i ddarpariaeth gofal a ariennir gan y GIG naill ai gan neu ar gyfer sefydliadau'r GIG yng Nghymru er mwyn darparu sicrwydd annibynnol ac i gefnogi gwelliant parhaus yn ansawdd a diogelwch gofal iechyd a ariennir gan y GIG yng Nghymru.

[www.agic.cymru.gov.uk](http://www.agic.cymru.gov.uk)

[www.hiw.wales.gov.uk/content/template.asp?ID=/content/about-us-e.asp](http://www.hiw.wales.gov.uk/content/template.asp?ID=/content/about-us-e.asp)

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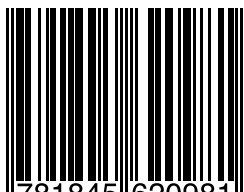
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