

# Building on strong foundations

Shaping the future of health and care quality regulation

October 2015



## The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve

### Our role

- We register care providers.
- We monitor, inspect and rate services.
- We take action to protect people who use services.
- We speak with our independent voice, publishing regional and national views of the major quality issues in health and social care.

### Our values

- Excellence – being a high-performing organisation
- Caring – treating everyone with dignity and respect
- Integrity – doing the right thing
- Teamwork – learning from each other to be the best we can.

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# Foreword

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Our strategy for 2013-16 set out the case for change in quality regulation, leaving behind a model in which people had lost confidence. Over the last three years health and social care quality regulation has been improved, with intelligence-led, expert, rigorous inspections and ratings of services. However there is much further to go. Our strategy for 2016-21 will set out the case for developing our approach – building on the strong foundations we now have in place.

Our purpose remains the same – to make sure services provide safe, high-quality, effective, compassionate care and to encourage services to improve. We will complete comprehensive inspections of all services that we rate by the end of 2016 – this will provide a powerful baseline understanding of the quality of health and adult social care services in England for the first time.

Regulation alone cannot drive the change needed but it has a crucial role to play in encouraging improvement, alongside other influences on quality – such as providers and their staff, people who use services, professionals, and commissioners and funders. It also helps provide transparency so people know how good the services are that they use. But we recognise that it is first and foremost providers themselves who can and must bring about improvements for people who use services. Quality regulation, while a crucial influence on quality, can never be a guarantee.

Quality regulation cannot stand still as the health and social care landscape changes. We must be flexible and responsive – able to register and inspect new models of care, and to comment on quality for specific population groups and across local areas whilst providing information for the public which supports them to choose between individual care services. We must play our part in the productivity challenge across public services by supporting providers to use resources as efficiently as possible to deliver high quality care, and by looking at how we can deliver our own purpose with fewer resources.

This document sets out the challenges as we see them and, because we do not have the resources to do everything we would like to do, some of the choices we face in considering how we carry out our role. We want you to help us decide what our priorities should be. It is part of a conversation we began in March this year with our publication *Shaping the future*.

Many of you have contributed to the thinking set out here. We would like to thank you for your feedback, and for your commitment to helping us continue to improve and make a real difference. We want to keep listening and would like to hear your views on this document. We will then look at this feedback and use it to set out our views for consultation on our strategy in January 2016.

**David Behan, Chief Executive**  
and **Michael Mire, Acting Chair**

# 1 Introduction



This document is the basis for developing the new Care Quality Commission (CQC) strategy, which will start in April 2016. It sets out our thinking so far on the next phase of our approach to the quality regulation of health and social care services. It does not cover everything we will need to do in the next five years, but asks for your views on the main strategic choices. It is written with the assumption that our statutory role stays unchanged for the period up to 2021.

In January we will publish a strategy document that reflects your reactions to this paper and sets out for further consultation how CQC will operate over the strategic plan period. In April we will publish our final strategy for 2016-21 that will tell you what we have decided to do, with your help. We will set out in our business plan for 2016/17 how we will implement our new strategy in its first year.

People have a right to expect safe, effective, compassionate and high-quality care. As the quality regulator of health and social care in England, we play a vital role in assessing the quality of care so that these expectations are met and in providing information to support people to choose care services.

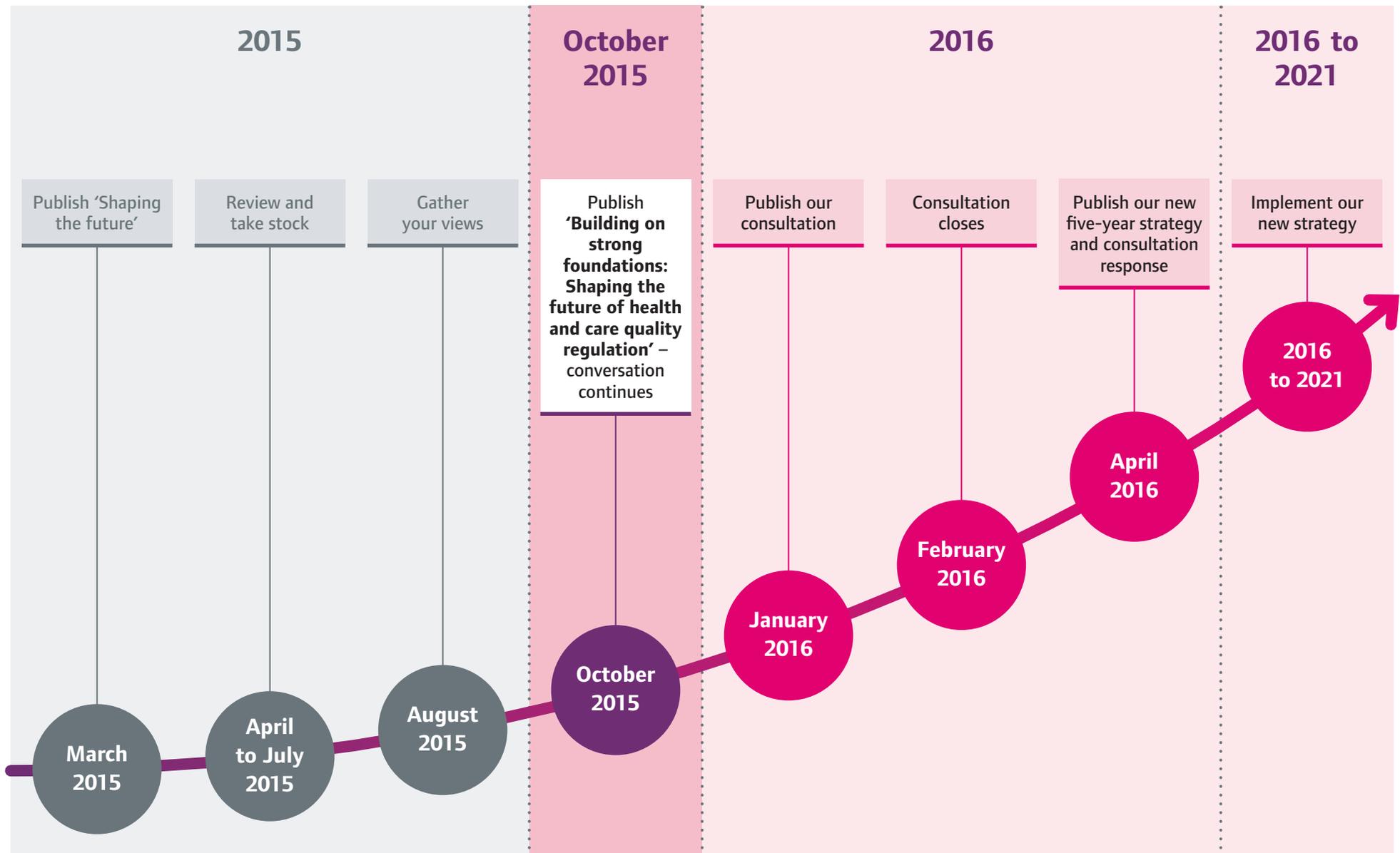
We would like you to tell us what you think about our ideas – what you think will have the most impact on the quality of care and what you think will not work. Your answers will be invaluable in helping us to develop our new strategy.

## How you have helped us so far

Over the last few months we have been asking for your views on our current strategy and what we could focus on in our new strategy. We have been talking to providers, the public, professionals, stakeholders, CQC staff and commissioners of care services. We ran an online survey in the summer and received more than 700 responses.

Your feedback has helped us shape the ideas in this document and will continue to help us. The 'You have said so far' boxes throughout the document indicate the key issues you have told us about.

We would like to hear your views at every stage of the process as we keep refining our strategy which we intend to publish in April. The next page shows our consultation and publication timeline.



## 2 The changing health and care landscape



Regulation cannot stand still as the health and social care landscape is changing. As demand increases and needs change, care has to respond to this in a context of constrained resources. The NHS has to achieve sustained efficiency savings over the next five years, more than ever before. And adult social care services will have less total funding even though more people will need care. Dealing with these pressures, by saving money and transforming models of care, will be a major focus for all services over the coming years. At the same time, the continued period of low public spending means that CQC needs to find ways to deliver its purpose with fewer resources. The upcoming spending review will set the context for the entire health and care sector, including regulators and other national bodies.

There is a consensus in the NHS on the transformation needed to respond to these pressures, based on the *Five Year Forward View* plan for prevention, joined-up person-centred care, new models of care, and productivity improvements including increasing use of digital technology.

For adult social care, there is less national consensus on how to ensure the sector is able to deliver the care people need. Across sectors, we are likely to see varied responses, as different services and systems adapt to an increasingly challenging environment. Innovation, including technological advances, has the potential to change current models of care in new ways that are hard to predict. This means that we need to develop flexible models and ways of working that help us to make changes quickly and easily as we go.

Although most services continue to deliver good or outstanding care, there is still inadequate care, and there are quality challenges across all sectors as described in our 2014/15 *State of Care* report. As services focus on financial issues as well as the need for innovation and transformation, there is a risk that quality may suffer – even if benefits are delivered in the long term.

There is a debate over the best way to drive change in a time of transformation. We recognise that change should be led from inside organisations, drawing on learning from peers rather than solely through regulation. This raises the question of how CQC as the quality regulator can work with others to get the right balance between encouraging providers to improve and controlling quality by taking enforcement action. We expect, and welcome, challenge from providers and partners as to the value that we bring to the sector.

The changing health and social care context does not change our fundamental purpose. But we need to think how best to deliver this purpose in the future, so that people who use services continue to have a strong, independent regulator on their side – encouraging improvement, providing information about quality, and taking action against poor care.

## What we now know about quality

Our new inspection and ratings approach means that we now know more about quality of care than ever before.

- Many of the services we have rated deliver good or outstanding care, although this differs by sector. The quality of care provided in the primary medical services sector was particularly high, with over 85% of GP practices we have rated being good or outstanding.
- A substantial proportion of services received a rating of requires improvement.
- Seven per cent of services were rated inadequate. In 2014/15 we carried out 1,179 enforcement actions.
- More than 70% of providers say that CQC inspections gave them information that helped them to improve their service.
  - Half of re-inspections have resulted in improved ratings.
  - Almost all of the 11 NHS trusts that were put into special measures in 2013 had demonstrated some improvement when we inspected eight to 10 months later. Five had improved sufficiently to exit special measures.



Source: CQC *State of Care* 2014/15

# 3 Building on strong foundations



The regulation of the quality of care has been improved, but we need to do more.

Three years ago our approach to regulation was not working. There was learning for CQC from failings at Mid Staffordshire NHS Foundation Trust, Winterbourne View and University Hospitals of Morecambe Bay NHS Foundation Trust. At the same time there was heavy criticism from the Health Select Committee and others of our strategy, performance and leadership.

In response to these events, and through wide-ranging and in-depth co-production with our stakeholders, we developed our 2013-16 strategy, *Raising standards, putting people first*, which includes our current purpose and role. We later developed our values.

- **Our purpose** is to make sure health and social care services provide safe, effective, compassionate, high quality care and encourage care services to improve.
- **Our role** is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety. We publish what we find, including performance ratings to help people choose care.

- **Our values** are excellence (being a high-performing organisation), caring, (treating everyone with dignity and respect), integrity (doing the right thing) and teamwork (learning from each other to be the best we can).

We put in place an approach to deliver comprehensive, expert-led inspections in adult social care, hospitals and primary medical services, that are trusted by the public and seen as robust by those we regulate. These inspections are carried out by teams of specialists in their field, like hospital consultants or GPs. We ask the same five questions about every service we inspect:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well-led?

We listen more to people who use services and their families and carers about their experiences of care. These include concerns about poor care either from people using services or staff who work in services. On our inspections we

use Experts by Experience, people who have had experience of recently using a service. Any changes to our methods are made through a process of co-production that includes taking advice from groups representing people who use services.

We have developed Intelligent Monitoring systems that use national and local data to inform our decision making, and enable quick responses to identified risks. This includes making increasing use of people's experiences of care, as well as statistical information. We use this intelligence to help us decide when, where and what to inspect to make sure we are looking at the right places at the right time.

We have introduced four ratings to make it easier for people to find out about the quality of local services, and to encourage improvement among providers. These are: outstanding, good, requires improvement and inadequate. We are open and transparent about how we work and we publish all of our information, including ratings and reports. We believe that transparency is essential for improving quality as it makes it possible to learn from others.

We take enforcement action when fundamental standards of care are not met. When services are found to be inadequate we normally apply a process of 'special measures', which sets out a clear timeframe within which we expect the service to improve, and we assess whether this has happened by re-inspecting.

We are applying our new approach to regulation to more than 40,000 health and social care services across England. We will complete our programme of comprehensive inspections next year. For the first time we will be able to compare the quality of health and social care services across England, based on an agreed definition of what good quality care looks like.

We know from our inspection findings so far that our approach has been effective in driving improvement in services and protecting people using services from poor quality care, including taking enforcement action when this is necessary. Our approach has also helped us to identify and share examples of good practice so others can benefit, and to find and take action against poor care.

Part of our purpose is to encourage improvement. Although the primary responsibility for delivering good care lies with the organisations providing care, we have a crucial role in assessing the quality of care and intervening when necessary to support improving care. However we cannot do this alone and so we work closely with our partners – providers and their staff, people who use services, professionals and commissioners and funders, as well as other national bodies such as NHS England, NHS Improvement, National Institute for Health and Care Excellence (NICE), professional regulators and professional bodies, to influence quality.

## We need to do more

Our shift from being a regulator that focused purely on legal compliance with standards, to one with robust, intelligence-driven, expert-led inspections and ratings has been widely welcomed. In general, the people we work with support our more rigorous inspections and the actions we take if we find poor care. The majority of services say that they identify areas for improvement following a CQC inspection.

## You have said so far

Our new inspection and ratings model, and especially its increased focus on people who use services and their carers, is a major achievement. You also said that we have achieved a higher level of transparency and accountability through our new approach. However you said consistency needs to improve in terms of how our model is applied by different sectors and between inspection teams.

We have engaged well with stakeholders across the health and care system to design our new approach. You said that as an organisation we are now more open about our work, but that improvements could be made about how we work with our partners, especially around engaging with the services we inspect.

As a result of our work, providers have seen improvements in quality of care and you or your organisation has changed the way you work as a result of our inspections.

Over the last three years, we have become a source of advice and support rather than just an authority, and we have provided useful guidance that helps providers to understand and drive improvement.

We need to focus on being a more efficient and effective regulator. You suggested focusing more on certain areas during inspection, for example the skills of staff providing specific services, and having a more robust approach to inspection in mental health and domiciliary care (care at home). You also said that we need to make improvements to the way we inspect, for example responding quickly when there are concerns raised.

We have listened closely to our partners and those who use services and we know there are a number of areas where we need to improve and do more. For example:

- We have made some major operational changes, but many of the supporting systems and processes we use are not yet efficient enough. This means we are not consistently delivering the standards of excellence we demand of others, for example publishing reports quickly following inspections.
- Our current inspection model does not yet fully reflect people's experiences as they move between services. The exceptions to this are our thematic reports, for example *Cracks in the pathway* looked at the experiences of people with dementia as they move between hospitals and care homes. Also, where we cannot easily observe care being delivered, for example in services in the community and in people's homes, we need to think of additional ways to gather the views of people receiving those services.
- Our new approach involves more use of data but we need to work on ensuring this is always easy for inspectors to use, and that the data clearly informs inspection planning, decisions and judgements.
- Despite the introduction of Intelligent Monitoring, we need to do more to bring together the full range of information, including what we know from people who use services, those close to them and staff, to identify risks quickly and systematically.
- We need to work more closely with local authorities and NHS commissioners, as well as other partners.

We are also working to understand the impact of our regulatory activities and how the cost of our activities to CQC and others compares with the benefits delivered. We are assessing the impact on all sectors of registration, monitoring, inspection, ratings, reporting, enforcement and

using our independent voice. We are looking at evidence from surveys of providers, the public, and inspection teams as well as performance measures. This is very important as an increasing proportion of our budget comes from the fees we charge services that are regulated by us, and so we must demonstrate evidence of our impact and value for money.

To deliver our purpose we must understand and focus on what matters to people, build trust and confidence in our work, empower people to understand the quality of care they should expect, and help them to choose between services if they want to. We will continue our work to raise awareness and understanding of CQC's role and purpose, including improving our public website so it is easier to find information. We remain committed to listening to and acting on people's views and experiences of care, working with the public to develop and improve our approach, and providing high quality information about care services.

### **Tell us what you think**

- 1** Are there any other important issues, relating to our approach to regulation and the context in which we are working, that we need to consider?

## 4 The next phase in CQC's regulatory approach



We believe a well-functioning health and care system needs improvement to be led by providers and encouraged through quality regulation. In our inspections so far we have seen many high-performing, well-led services that are continuously learning and improving.

We have also, however, found significant variation in quality and we know that leadership appears to have a strong influence on all other aspects of quality, particularly safety. This variation shows that there continues to be a need for independent quality regulation, alongside improvement led by providers, professionals, managers and staff. People who use services need CQC to identify what needs improvement and to encourage it.

This leads us to the next phase in CQC's regulatory approach, one in which we maintain our responsibilities towards ensuring high quality care but begin to build a more collaborative approach where responsibility for quality improvement is increasingly shared with providers and our partners. National and local organisations must actively find ways to reduce overlapping regulation by working together more effectively.

We need to make any changes to how we work while maintaining and improving what we do now. In the challenging context that health and care services are facing, it is more important than ever that CQC, as the independent quality regulator, maintains its focus on taking tough action to protect people where we find poor care.

### Tell us what you think

- 2 Given that regulation is just one influence on care quality, how do you think CQC can best work with others to encourage improvement in the quality of care over the next five years?

## What this next phase means for you

While writing this document, we reflected on the potential impacts that any changes to our approach could have on you, whether you are a provider, a member of the public or a CQC staff member. This is not a complete list of all the potential impacts and we welcome your feedback.

### The public

We want the next phase in the development of our approach to give you increased confidence that we are on your side. We want to make sure we are providing you with the right information to help you choose care. That could be about how individual services are performing or about care across your area, or your care pathway. We also will make more use of feedback on the quality of care from people who use services.

We will continue to develop how we inspect services which we think pose the greatest risk first and we will prioritise our inspections to target where we think there may be problems, while still encouraging and making sure there is good care across all services.

### Providers

As a provider you should be confident that we will improve the way we work with you and make sure we continue to find better ways to do our work. If you have improved the way you work and you have successfully maintained a good level of care, we will take this into account in our registration and inspection, while still giving you the right information to keep improving. We want you to be confident that although we know the sector is facing some critical pressures, we are thinking about ways of working which may help alleviate these.

We outline later in this chapter the potential to move towards co-regulation. This means that for providers who have had a comprehensive inspection, we could make greater use of the information about quality that they provide us with, and verify this with other information sources, including people's experiences of care, to help us to target our inspections.

### CQC staff

As a CQC staff member, you should feel confident that our future approach will continue to identify poor care and encourage better care. We remain committed to listening to your views, and the views of other stakeholders as we develop as an organisation. We want to be more targeted in our work and to use our resources better, including through improving our processes and systems.

## Making our model more efficient and effective

Our findings so far have demonstrated the need for strong, independent quality regulation. In the next phase of our development, we want to focus on making our approach more efficient and effective. This is so that we are better able to deliver our purpose of ensuring services provide people with safe, high-quality, compassionate care and that we encourage services to improve, and also so that we can demonstrate the value for money we deliver.

This section sets out some of the choices that we are facing as we continue to embed and refine our approach. These have been informed by our discussions with you. They are not mutually exclusive and we need to strike the right balance between them. This balance is likely to differ between the sectors we regulate, depending, for example, on the availability of data. Later on we look at potential new areas of activity for CQC that we may be required to respond to in the changing health and care landscape.

We welcome your views on whether the following are the right areas to focus on when improving our current regulatory model:

- Risk-based registration
- Smarter monitoring and insight from data
- A greater focus on co-regulating with providers
- More responsive and tailored inspections

## Risk-based registration

We could develop a more proportionate, risk-based approach to each new registration application and to registration changes. This would mean handling lower risk changes to registration, such as a high performing GP practice group opening a new GP practice, in a more streamlined way. We would handle higher risk changes, such as a new provider opening a brand new care home for people with a learning disability, with appropriate expertise in order to keep people safe. We would also encourage innovation and ensure we can register new models of care in a fair way. We would use a range of tools to make expert judgements and appropriately respond to different risks, including using Experts by Experience and sector specialist inspectors. The approach would include:

- Developing a more differentiated approach based on what we know about the relative risks to the public of different services and types of registration change.
- Strengthening and clarifying the links between our approach and expectations at registration and at inspection, including how we use sector specialist inspectors and registration inspectors.
- Improving how we gather the right information from registration to use for our monitoring and inspection.
- Making sure guidance for providers is clear about what our ongoing quality expectations are and what they need to do to register.
- Improving our approach to handling the greater diversity of providers and new models of care including joint enterprises, 'vanguard' projects and national collaborations, particularly the appropriate level to register the organisation.

### Tell us what you think

- 3 We have described what **risk-based registration** could look like.
  - a What do you like about this?
  - b What do you not like about this?
- 4 What impact would risk-based registration have on you?

## Smarter monitoring and insight from data

Our 2015-16 business plan sets out our intention to develop and extend our existing Intelligent Monitoring into a comprehensive surveillance model – ‘CQC Insight’. This will combine numerical data with feedback from people who use services. The existing data, however, is not yet robust enough across all sectors to be a reliable measure of quality without inspections alongside it. We will therefore work with others to improve our data, and to develop a shared view of the most important quality and risk indicators in health and social care. As a result, CQC will be better able to protect people who use services by triggering action where concerns are raised, and targeting inspection resources where the risks to the public are greatest. Specifically, this would include:

- Increasing analysis of short and long-term trends in the performance of providers.
- Developing data that predicts risks and builds on the evaluation of our existing intelligence.
- Improving use of inspector intelligence and risk assessment.
- Using feedback better from people who use services and improving the use of other qualitative data.
- Improving the interpretation and dissemination of our risk intelligence products.
- Identifying key intelligence triggers for regulatory action.

### Tell us what you think

- 5 We have described what **smarter monitoring and insight from data** could look like.
  - a What do you like about this?
  - b What do you not like about this?
- 6 What impact would smarter monitoring and insight from data have on you?

## A greater focus on co-regulating with providers

We could move towards an approach of co-regulation, which would mean CQC supporting providers to assess and share evidence on their own quality of care against each of our key questions. We could explore this further for providers who have already been through a comprehensive inspection under our new approach and who could, using detailed key lines of enquiry, report on any changes to the quality of care provided since their previous inspection.

We could compare this evidence from the provider with the monitoring data we hold about them and other data including the views of people who use services, staff and local partners. We could use all of this information to target our activity so we make sure we prioritise the right things on inspection. We would never rely solely on the information that providers give us without challenge.

Co-regulation could encourage providers to develop their own systems and processes for understanding quality, which we know is an essential step in developing a culture of continuous improvement. While CQC must always act swiftly where risks emerge, it is providers who deliver improvements, and we want to encourage and support them to do so.

### Tell us what you think

- 7 We have described what a **greater focus on co-regulating with providers** could look like.
  - a What do you like about this?
  - b What do you not like about this?
- 8 What impact would a greater focus on co-regulating with providers have on you?

## More responsive and tailored inspections

Developing our inspection approach so it is more responsive to risk and tailored to the particular situation of each service would have a number of benefits. It would help us target our resources better towards providers that are higher risk, and strengthen how we identify and share good practice. This would only be possible if the previous three areas – risk-based registration, smarter monitoring and insight from data and a greater focus on co-regulating with providers – are taken forward.

Examples of how we might develop our approach in this way include:

- Reducing the number of large comprehensive inspections we do of all the services offered by a provider at the same time.
- Inspecting services we have already found to be of good or outstanding quality less frequently or less intensively than other services, or relying more on other sources of information and assurance besides inspection.
- Exploring how we can use random sampling in the selection of providers to inspect alongside our assessment of risk.
- Further aligning our inspection activity with other partners in the sector to remove duplication of effort.
- Making sure we look carefully at the way care for specific conditions provided by different services is being delivered.
- Ensuring that we inspect in ways that take account of and support the development of new models of care.

### Tell us what you think

**9** We have described what **more responsive and tailored inspections** could look like.

a What do you like about this?

b What do you not like about this?

**10** What impact would more responsive and tailored inspections have on you?

### Tell us what you think

**11** In this section we have detailed four areas which will help successfully achieve the next phase of our regulatory approach. In order of importance, which will have the most impact in encouraging improvements in the quality of care?

## Looking at the quality of care for populations and places

The previous section focused on making our approach to regulation more efficient and effective. This section on populations and places, and the next section on use of resources consider potential new areas of activity for CQC that may be required as a result of the changing health and care landscape. We do not have the resources to do everything we would like to do, so we are asking for your views to help us focus on the right priorities for the next five years.

People are living longer and with more and multiple long-term conditions. As a result, traditional ways of delivering health and care often no longer meet people's needs. We know that quality issues occur when care is not coordinated or person-centred. Too often people find themselves receiving poor quality care, or no care, as they fall through the gaps in the system. The NHS *Five Year Forward View* sets out a strong vision for the future of health and care, and the sector is already responding by developing new models of integrated care and stronger local partnerships.

In our *Shaping the future* document, which accompanies our 2015/16 business plan, we set out our intention to develop an approach to regulating new models of care and to assessing the quality of care for specific populations and across local areas.

### You have said so far

You had mixed views on whether we should assess the quality of care in an area.

You were supportive of an approach which focuses on care pathways and joined-up services, and the possibility that this approach could mean services better meet the needs of the local population. And you also expressed a desire to understand more about what was happening locally as well as the cost of care by local area.

However you were concerned about how useful a geographical view would be to you, and about the resources required to develop new methodologies.

Considering your views, we think there are a few choices about how we respond to this agenda.

## Improving our current inspection approach

We could assess how well providers are working in partnership in and across their organisations to deliver person-centred care. This could be backed up by more integrated working across our three inspection directorates, for example, enabling local cross-sector inspection teams to better share intelligence about provider risk. By the end of next year, our baseline of comprehensive inspections will help us bring together our findings across a local area and provide a joined-up view of the overall quality of health and adult social care services in that area.

## Going beyond our existing provider-based approach

We could continue the work we have begun this year to focus our thematic reports on the quality of care for specific populations (for example, older people) and in local areas. This would mean we could continue to develop approaches to assess quality beyond specific providers, for example following individuals' experiences of care across different services, and doing assessments of the quality of care that people receive in a particular place. We would develop this work with partner organisations, including to complement existing approaches such as NHS England's process for assuring clinical commissioning groups.

Additionally, there is the potential for a more radical shift in the long term that would involve reducing some aspects of comprehensive provider assessment, once all services have been inspected. If we followed this approach, we would need to consider who would be held to account for the quality of care when our assessment reaches beyond individual providers. This approach could improve information about the quality of care that groups, such as older people, experience as they move between different services, but could also lead to a corresponding reduction in information about individual providers meaning people might have less up-to-date information to help them choose services. The more we shift in this direction the more we will need to redirect resources away from our existing provider-based approach.

### Tell us what you think

- 12** We have described how we could assess how well organisations are working together to provide health and care services for specific populations and in specific local areas.
- a What do you like about this?
  - b What do you not like about this?
- 13** How useful would this information be for you?
- 14** Should it be a priority for CQC, given that it would mean allocating resources from other activities?

## Assessing how providers use resources

On 15 July 2015, the Secretary of State announced that CQC would start to assess NHS trusts' use of resources. This means we will begin to check that hospitals are using their resources (for example staff, equipment and facilities) in the best way possible. We will begin to pilot our approach in NHS acute trusts from April 2016. We have published the initial proposals for our assessment approach, which can be found at [www.cqc.org.uk/useofresources](http://www.cqc.org.uk/useofresources)

CQC has an existing objective in the Health and Social Care Act 2008 to encourage “the efficient and effective use of resources in the provision of health and social care services”. Assessing how hospitals use resources is consistent with that objective, and an appropriate development in light of the efficiency challenges that NHS trusts face. In an environment of tight resources, providers will need to be more efficient and effective to sustain and improve quality. Poor quality care can introduce additional costs, while inefficient services can affect quality of care.

### You have said so far

We should use our position to highlight the challenges that the health and adult social care sector is facing in terms of resources. You also said we were well placed to monitor and encourage efficiency improvements in providers, while making sure there is still a focus on assessing the quality of care.

In line with CQC's purpose, we plan to look at how resources are being used efficiently and effectively to provide good quality care. Our approach will be consistent with, and may happen alongside, our existing inspections and ratings.

- We will develop a clear framework for our use of resources assessments based around key lines of inquiry and data given by providers in advance of inspection.
- We will use high-level monitoring to understand performance across NHS trusts on an ongoing basis. In developing the metrics we use for this monitoring activity, we plan to draw on the work of the Carter review.
- We will conduct some inspection fieldwork to test and validate the information and data we gather prior to an inspection.
- We will use this information to assess and rate providers on their use of resources on a four-point scale. This would be published with our inspection reports, but we do not currently plan to incorporate our use of resources rating into our quality ratings.

There will also be some differences from our approach to assessing quality: our assessments of use of resources will be based more heavily on data and monitoring, with limited fieldwork. We do not initially plan to rate individual services for their use of resources, only the trust as a whole.

CQC's assessment of use of resources will be of real benefit, as it will bring an increased focus on how resources can be used to deliver high quality healthcare as efficiently and economically as possible. We will ensure that a focus on the use of resources does not detract from our assessments of other aspects of quality, and in fact it may help us to highlight inefficiencies or resource shortages that impact on the access, experience and outcomes for particular groups of people. CQC's new role will also help increase transparency by making more information on how trusts use resources publicly available.

### Tell us what you think

**15** We have described how we could assess the use of resources in NHS trusts.

- a What do you like about this?
- b What do you not like about this?

In this chapter we have looked at the next phase in CQC's regulatory approach. We have described three ways we could develop our approach.

### Tell us what you think

**16** In terms of the three ways we could develop our regulatory approach, which one would you most like us to focus on, given that CQC has to prioritise where it allocates its resources?

Rank in order of importance:

- Making our model more efficient and effective
- Looking at the quality of care for populations and places
- Assessing how providers use resources

## Equality, diversity and human rights

The approaches in this document would all be likely to impact on the equality and human rights of people using the services that we regulate. We would like to hear your views on this issue.

### Tell us what you think

**17** As an organisation, we embed equality and human rights in our regulatory approach. What impact do you think the ideas in this document would have in terms of people's equality and human rights?

## 5 What happens next



We will look at the comments you send us and use them to set out our views for consultation on our strategy in January 2016. After analysing the responses and considering other information such as examples of good regulatory practice in the UK and internationally, we will finalise and publish the strategy in April 2016. This will set out our future direction for the next five years and be developed into costed options to be delivered through our annual business plan.

Thank you for taking the time to contribute to the development of our future work. Your feedback and comments are very valuable to us. **You can respond through our online form or by email: [strategyconsultation@cqc.org.uk](mailto:strategyconsultation@cqc.org.uk)**

## How to contact us

Call us on **03000 616161**

Email us at **enquiries@cqc.org.uk**

Look at our website **www.cqc.org.uk**

Write to us at

**Care Quality Commission**

**Citygate**

**Gallowgate**

**Newcastle upon Tyne**

**NE1 4PA**

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CQC-294