Care Quality Commission

Delivering cost effective care in the NHS

Working together to develop how CQC will assess the use of resources in NHS acute trusts

The Care Quality Commission 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 and introduction

Foreword

Effective use of resources is fundamental to enable health and social care providers to deliver and sustain high quality services for people. As the quality regulator, it is important that CQC should reflect this when we inspect and rate them. Pressures on public spending, and NHS England's projection of a significant gap in NHS funding by 2020 – much of which will need to be addressed by increasing efficiency – make this more important than ever.

Assessing how providers use their resources will be part of our five-year strategy. This will ensure that the next phase of quality regulation in England takes account of how well providers use their available resources, alongside assessing how safe, effective, caring, responsive and well-led their service is.

We will start this approach in NHS acute trusts and foundation trusts, and then extend it to all mental and community health trusts. We do not currently have plans to introduce the assessment in other sectors and we will consult separately if we develop proposals.

CQC's role is, and will continue to be, focused on monitoring and promoting high-quality health and social care for people. Our approach to assessing use of resources will be from that perspective. It will engage providers in demonstrating to us that they manage their resources at all levels so that services are organised efficiently to reflect the needs and wishes of patients, risks, and guidance on good practice and clinical effectiveness.

The key value that we will add is to ensure that trusts consider quality and efficiency together – not as separate, or even conflicting, agendas. To achieve our aim, we need engagement and input from providers and other stakeholders so that our approach will be rigorous and credible.

We will listen to stakeholders and reflect what they tell us, and we will design our approach so that it directly joins up with other roles and processes for NHS oversight, in particular those of NHS Improvement. This document starts our engagement with stakeholders. The dialogue will continue on the same timetable as the engagement and consultation on our five-year strategy up to the launch date of April 2016, and will continue thereafter as we pilot and evaluate this new assessment.

David Behan
Chief Executive

Introduction

Rating hospitals on the quality of their services has had a big impact in focusing attention on quality, right across the NHS. We will complete inspections of all acute trusts by April 2016, and all mental health, specialist acute and ambulance trusts by July 2016. Now is the right time to start seeking views and planning ahead, so that we can build on these foundations and develop the next phase of inspection.

Earlier this year, the Secretary of State asked us to begin assessing how economically and efficiently NHS trusts are using their resources, as part of our inspections of hospitals. I believe that adding an assessment for use of resources alongside our existing quality ratings gives an opportunity to make our assessments even more relevant to the operational challenges that trusts need to manage in order to maintain high-quality care. It will ensure that our assessments are relevant and meaningful across all aspects of providers' work.

Professor Sir Mike Richards
Chief Inspector of Hospitals

We will build the new assessment into the changes to inspection that we introduce from April 2016 onwards.

However, April 2016 will be the beginning, when we start piloting – not the completion date for fully rolling out the new approach. We need to make sure that our assessment will join up directly with the outputs of Lord Carter's review of operational productivity and the development of NHS Improvement's approach, as both of these will continue to develop between now and next April. And most importantly, we need to ensure that we have sufficient time to develop and test a robust process, and to co-produce our approach with providers and experts.

With that in mind, I hope that you will contribute to the early thinking that we set out in this document, and help us to refine it into detailed proposals for formal consultation.

1. The rationale for assessing use of resources

The Health and Social Care Act 2008 recognises that there is a relationship between quality of care and the efficient and effective use of resources. The legislation requires CQC to have regard to providers' use of resources within our overall purpose as a quality regulator.

CQC's statutory objectives – Health and Social Care Act 2008

"The main objective of the Commission in performing its functions is to protect and promote the health, safety and welfare of people who use health and social care services.

The Commission is to perform its functions for the general purpose of encouraging:

- The improvement of health and social care services
- The provision of health and social care services in a way that focuses on the needs and experiences of people who use those services, and
- The efficient and effective use of resources in the provision of health and social care services."

So far, we have assessed health and social care providers on the quality of their services. We have established a framework for rating the quality of care, based on whether services are:

- Safe
- Effective
- Caring
- Responsive to people's needs
- Well-led.

Given the environment of unprecedented financial pressures in health and social care, we believe it makes sense to broaden our approach so that we will assess providers' use of resources, as well as the quality of care that they provide.

Adding use of resources to our assessments will encourage providers to consider resources and quality together, and to demonstrate their performance on both counts. We will focus on both areas to help drive culture and behaviours that treat quality of care and efficiency as complementary, not as separate or conflicting agendas.

As we have learned from our new approach to assessing the quality of care of providers, one of the most important aims and ways our assessment adds value will be in working with providers to help build capability and share improvement in managing use of resources, not as another set of imposed targets. When we assess quality, we will also understand how the provider manages its financial realities; and when we assess use of resources, we will also better understand how the provider is managing quality and safety. This should have more relevance, and more value, for providers than a narrow or 'purist' view of quality.

We expect this approach will enable providers to identify where improvement creates synergy. For example, organising a service to make it more efficient can also make it more responsive to the people who use it, and we know from our assessments of well-led that the culture and behaviours needed to improve productivity are likely to be the same as those that are important for quality of care.

We also aim to add value through this assessment by increasing the transparency of public information on how well providers use their resources, and by recognising and sharing good practice.

"CQC's role is, and will continue to be, focused on monitoring and promoting high-quality health and social care for people. Our approach to assessing use of resources will be from that perspective."

2. The scope and development of our assessment

We want to explore with providers and other stakeholders how ambitious the scope of our assessment should be in order to achieve our aims. In particular, we want to make sure that our assessment adds value without creating undue administrative costs or duplicated effort.

CQC's assessment of NHS trusts' use of resources will evolve over time. It could include a wide range of aspects of the economy, efficiency and effectiveness, and the overall value for money, of care delivery.

We are working with the Carter review team (reviewing operational productivity in NHS providers), Monitor, the NHS Trust Development Authority and the Department of Health to design a practical assessment approach to enable pilot assessments to start from April 2016. Our initial focus would be on the more technical aspects of economical and efficient service delivery. As data and analysis methods evolve, including the Carter review being completed, we would look to include wider analysis in the assessment.

We will not make any substantive changes to our existing quality framework, and, initially at least, we intend to treat our use of resources assessments and ratings separately from our quality ratings. We will continue to assess the quality of care on the five key questions so that providers will be able to demonstrate their improvements in quality over time. The assessment of their use of resources will be in addition to this.

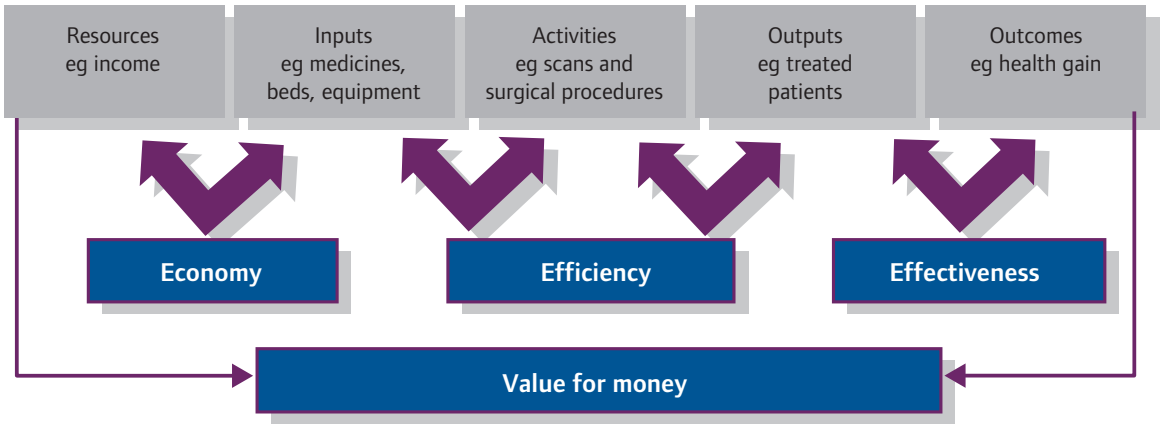
What do we mean by use of resources?

When we refer to a provider's use of resources, we mean the ways in which resources are converted into inputs, activities and outputs – and ultimately outcomes – as illustrated in figure 1.

Our approach will be from the perspective of how the use of resources supports high-quality care. This means that, for example:

- We will not base our assessment on a provider's financial position (such as the provider's surplus/deficit position).
- We will not assess financial management which is already overseen by internal and external auditors and NHS Improvement.
- Our assessment framework could focus on how clinical and support processes are managed to deliver care which offers value for money.

FIGURE 1



Our focus, at least initially, will be on assessing the economy and efficiency of service delivery. That is, as reflected in the diagram: how well providers are able to manage their available resources to acquire the appropriate mix of 'inputs' (such as, staff, equipment and medicines) at the lowest cost (**economy**); and how well they are able to use those inputs and manage their activities to produce the best mix of good quality 'outputs' – that is, patients who have received treatment (**efficiency**).

We will also explore ways of investigating the overall **value for money** provided by NHS trusts' and foundation trusts' services, through linking to our quality assessments of the **effectiveness** of care and looking at whether clinical and management decisions are being made in ways that support the cost-effective delivery of care.

We do not propose to include a trust's financial balance or position, or their financial management, in our assessment. These are issues for NHS Improvement, auditors and commissioners. Our current approach to rating hospitals for their quality of care, as set out in the appendix to our existing provider handbook, also already includes a principle that normally limits a trust rating where Monitor or the NHS Trust Development Authority are taking formal action, including related to a trust's financial position or management. For assessing use of resources, CQC's focus therefore is on identifying ways in which trusts can improve the economy, efficiency and value of their services – not the income the trust receives, and hence not the underlying surplus or deficit position. However, we would not generally expect a trust with a substantial deficit to achieve a rating of outstanding for its use of resources.

We will introduce assessments of use of resources at a manageable pace, which will allow time for CQC together with its national partners to build capability in this area, alongside the NHS overall. We will start with NHS acute trusts and acute foundation trusts (including combined acute and community trusts), aligned with the Carter review and the emerging role of NHS Improvement, with the intention of extending to all NHS trusts and foundation trusts in time. We recognise the importance of use of resources across the hospitals sector, and plan to start piloting assessments of NHS mental and community health service trusts in 2017. This will enable us to add elements and additional sophistication over time, as and when we and the sector have the necessary capacity and capability.

We do not plan to assess independent healthcare providers on their use of resources. We have no current plans for assessing use of resources in primary medical services, dental providers or adult social care providers (beyond our existing market oversight role). However, we recognise that good use of resources is relevant across all health and social care sectors, including across pathways and local areas, and we will engage and consult with partners if we develop proposals.

3. Our process for assessing NHS trusts' use of resources

Within the context of building up the assessment at a manageable pace, starting with piloting and progressively building from that, we intend to base our approach on the model that we have established for quality ratings. The same key elements of our approach to assessing quality – as set out in figure 2 – would be in place for assessing use of resources.

FIGURE 2

Our approach to assessing use of resources will also share other key features with our current approach to assessing quality:

- While our focus in assessing use of resources will be on the work of trusts as a whole, we will investigate the value of money of individual services as much as possible, as it is the operational and clinical processes at this level that particularly drive costs, as well as the leadership and oversight 'from ward to board'.
- We will set out an assessment framework of key lines of enquiry (KLOEs), within which we will use a combination of data and inspection fieldwork to reach a judgement.
- The outcome of the assessment will be a rating on our existing four-point scale. It will include looking for and recognising good and outstanding practice.

What would an assessment framework for use of resources include?

We will develop and consult on an assessment framework for use of resources. As for our quality assessments, this will include information on KLOEs and prompt questions, sources of evidence, and descriptions of the characteristics of each level of the four-point rating scale.

KLOEs, which would structure the assessment process at provider and service levels, could cover areas such as:

Patient pathways

This theme might incorporate issues such as:

- Are the right clinical activities being carried out according to patient need?
- Are unnecessary clinical activities avoided? (for example, avoiding unnecessary admissions and avoiding carrying out unnecessary tests or interventions)
- Are staff being deployed efficiently to deliver care?
- Is the flow / throughput of patients being maximised?

Leadership and supporting systems

This theme might incorporate issues such as:

- Is there a clear vision and robust governance approach to managing resources economically and efficiently?
- Are overheads being managed in an economical manner?

Under these broad themes the assessment framework would include indicators and sources of evidence to enable us to make an assessment of how well clinical and supporting processes are being managed to deliver cost-effective care.

This could include looking at patient and service level measures, such as admissions, waiting times, out of area referrals, prescribing and agency staff usage, as well as data on the overall cost of delivering particular treatments and the service as a whole. We would work with partners to identify the most appropriate sources of measures and guidance to include in the framework.

We will be changing some aspects of our inspection approach from mid-2016, as we complete the first full round of assessment and rating of all regulated service providers. This is to incorporate learning and therefore improve the efficiency and effectiveness of our process. We will consult on these changes early in 2016. Our description of assessing use of resources reflects our current thinking; but where there are changes (for example, to the way we collect data to monitor services or to the frequency of inspection activity or information requests) these will be reflected as we develop our approach to assessing use of resources.

We will be working with other bodies with related roles to align our use of resources assessment, to avoid duplication and minimise the administrative implications of the assessment. We want our approach to be one of expecting providers to explain their use of resources with whatever information they have developed to assure it, rather than imposing extensive new data requirements.

Within that context, there is a range of options for how CQC could assess providers' use of resources. For example:

- The focus could be on providers demonstrating their use of resources through the information they provide to CQC on request, with direct inspection by CQC on an exceptional basis. The rating for use of resources could, to a large extent, be derived from data. This has the benefit of clarity about expectations and accountability for providers to demonstrate performance, and it avoids additional costs. However, we would need to test the minimum amount of specialist review required to assure rigorous analysis and validation of data.
- Alternatively, a more comprehensive approach – in which we inspect all use of resources KLOEs in every core service – would create higher levels of scrutiny and therefore pressure for improvement, greater public assurance, and a consistent baseline from which providers can show improvement over time. However, we would need to test the cost and burdens of such an approach, including the information that would need to be collected.

Variants of these examples, plus different options, may also be possible. We will engage with providers and others to test and model options, with a view to consulting in early 2016 on a single way of setting the scope of our assessment.

Data monitoring

For our quality ratings, we developed a system of Intelligent Monitoring. This allows us to track indicators from existing datasets that we have identified as important 'smoke alarms' to alert us to potential risks to the quality of care. We use Intelligent Monitoring to decide how to prioritise providers in our inspection schedule. We intend to develop a similar system for tracking providers' use of resources. We could regularly publish our analysis of each provider's performance on these indicators. As with Intelligent Monitoring, we would only use existing data and would not introduce new information requirements.

Lord Carter's review of operational productivity in the NHS is developing a number of metrics to calculate an 'adjusted treatment cost' for each provider (a measure of productivity) and to enable trusts to compare their performance on a range of specialty-level indicators (known as the Model Hospital). We will review what metrics we need to assess NHS trusts and foundation trusts' use of resources, and where Lord Carter's metrics might help, we would not wish to duplicate effort. Therefore, wherever the Carter review's metrics are appropriate, we would look to incorporate them within our assessment approach – both through our monitoring work and through requests for more detailed information from providers, as discussed in the following section. As Lord Carter publishes his metrics, we will engage with providers on how we could use them.

Information request

When we undertake a comprehensive inspection of a trust or foundation trust – currently every two to three years in most cases – we precede it with a Provider Information Request (PIR) and other requests for information as part of our pre-inspection planning and analysis. We will coordinate the development of our information requests for use of resources with providers as well as our national partners, to reuse existing information wherever possible and appropriate. Unlike our current PIR, which asks for specific information items, we expect that the information we request on trusts' use of resources would have a stronger focus on providers demonstrating performance and management through whatever data they use, some of which may be locally developed rather than national datasets, and

some of which may be re-use of information originally collected for other oversight bodies. Our requests for information would have an emphasis on expecting providers to explain why this is appropriate information and how they use it, and to explain variations between service lines and changes over time in costs and productivity.

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Inspection

We would expect to carry out some inspection activity to help us assess providers' use of resources, alongside and as part of our inspections of the quality of their care. The purpose of inspecting their use of resources would be to validate the information we have collected and to 'drill down' into specific areas of potential concern or potential best practice. As such, it could have a relatively smaller and lighter role than it does in our quality ratings. We may include specialist advisors with financial and operational management backgrounds in inspection teams. Additional topics may need to be introduced into some of the interviews that we already carry out, and some additional interviews may be needed.

"We will be working with other bodies with related roles to align our use of resources assessment, to avoid duplication and minimise the administrative implications of the assessment."

Rating

Similar to our quality ratings, ratings of providers' use of resources will be derived by comparing evidence from data, information and inspection against what we will set out as the characteristics of:

- Outstanding
- Good
- Requires improvement
- Inadequate

Our assessment will lead to a rating on use of resources at trust level. Ratings at service level would also be of value, and we need to explore further with providers and others how this could be achieved.

Our intention is to rate and report on use of resources separately and alongside our existing quality ratings. Once our use of resources rating is fully established, we could consider whether and how it might be appropriate to aggregate the use of resources rating into our quality ratings – either through the quality rating as a whole or possibly as part of a provider's ratings on well-led.

Follow-up

Our assessment of use of resources will not be designed as a purely standalone rating. We want it to directly join up with, and lead into, other activity to promote efficiency and good use of resources in the NHS. This is discussed further later on in this document.

4. How our assessment will fit with other oversight of NHS trusts

Monitor and the NHS Trust Development Authority will be working together as NHS Improvement from April 2016. As NHS Improvement publishes detail on its role and approach, we will engage with providers and others on how we will make sure that our role joins up closely with theirs, especially in relation to our assessment of use of resources.

This will include clarifying the roles of NHS Improvement and CQC in taking forward the work of the Carter review, and how our assessment of use of resources could trigger actions by NHS Improvement. We are already working in partnership to make sure our assessment of use of resources joins up as closely as possible with NHS Improvement, so that where appropriate we use the same metrics; the same view of good, bad or indifferent performance; and even the same staff to analyse and interpret data. We, and NHS Improvement, will engage with providers and others on how best to make this alignment of our roles work in practice.

The other key oversight system where we will coordinate our approach is internal audit. We expect that auditors will have an important role in supporting NHS trusts and foundation trusts to demonstrate good use of resources to us, and they could be an invaluable source of evidence to inform our ratings. We will particularly want to engage with auditors to make sure our roles join up appropriately, and we will engage with providers and others to help inform those discussions.

5. Ensuring our assessment has impact

Our quality rating has had a significant effect on the NHS in terms of focusing attention and giving priority to ensuring good quality of care. Given the financial environment and the importance of the NHS demonstrating efficient and effective use of resources, we believe we should aim for an equivalent impact from our rating of use of resources.

Clearly the rating's impact will stem from its credibility and rigour, including where we set the bar for each rating level. Beyond that, we would like to engage with providers and others on what would incentivise providers to strive for an outstanding rating, and what sanctions should follow a rating of inadequate. Incentives do not need to be put in place by CQC and may be part of the way in which our assessment joins up with other oversight bodies such as NHS Improvement or NHS England.

Examples of areas that we would like to explore include:

- How practice from providers that are performing well on use of resources can be shared widely so that others can learn.
- Whether there could be any incentives, beyond reputational benefit, for achieving ratings of good or outstanding.
- The kinds of support that should be given to providers who are found to be inadequate in their use of resources, and what enforcement or other action might be appropriate.

6. Next steps and future time line

- **November 2015 onwards:** Ongoing engagement and meetings with internal and external stakeholders. Development of framework and methodology for assessing use of resources.
- **January to March 2016:** Full consultation on proposals for assessing and inspecting hospitals.
- **April to June 2016:** Piloting assessment of providers' use of resources in NHS acute trusts.
- **July 2016 onwards:** Evaluation and refinement of process.
- **By January 2017:** Full roll-out in NHS acute trusts starts.
- **During 2017:** Piloting in NHS mental health and community health service trusts, with full roll-out in 2017/18.

Although this is not a formal consultation, we would like to hear your views on any of our proposals that we have set out in this document. If you would like to get in touch, please contact us at **hospitalsconsultation@cqc.org.uk**

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