AUDIT AND GOVERNANCE COMMITTEE AGENDA

Thursday 19 January 2017

at 10.00 am

**in Committee Room B,
Civic Centre, Hartlepool.**

MEMBERS: AUDIT AND GOVERNANCE COMMITTEE

Councillors S Akers-Belcher, Belcher, Cook, Hamilton, Harrison, Martin-Wells and Tennant.

Standards Co-opted Members; Mr Norman Rollo and Ms Clare Wilson.

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS**

3. **MINUTES**

   3.1 To confirm the minutes of the meeting held on 8 December 2016.

4. **AUDIT ITEMS**

   No items.

5. **STANDARDS ITEMS**

   No items.

6. **STATUTORY SCRUTINY ITEMS**

   6.1 Investigation into Mortality Rates:-
   (a) Covering Report – *Scrutiny Manager*
   (b) Presentation - *Representatives from North Tees and Hartlepool NHS Trust*

   6.2 Health and Wellbeing Board Referral - Reporting Arrangements for Delayed Transfers of Care – *Scrutiny Manager*

6.3 Urgent and Emergency Care – Update – *Representatives from Hartlepool and Stockton-on-Tees Clinical Commissioning Group*

6.4 Adult Services Committee's Response to the Investigation into Access to Transport for People with a Disability – *Adult Services Committee*

7. **MINUTES FROM THE RECENT MEETING OF THE HEALTH AND WELLBEING BOARD**

No items.

8. **MINUTES FROM THE RECENT MEETING OF THE FINANCE AND POLICY COMMITTEE RELATING TO PUBLIC HEALTH**

8.1 Minutes from the Finance and Policy Committee meetings held on 31 October 2016 and 2 December 2016

9. **MINUTES FROM RECENT MEETING OF TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE**

No items.

10. **MINUTES FROM RECENT MEETING OF SAFER HARTLEPOOL PARTNERSHIP**

No items.

11. **REGIONAL HEALTH SCRUTINY UPDATE**

No Items.

12. **ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT**

Date/time next meeting – Thursday 16 February 2017 at 10.00 am in the Civic Centre, Hartlepool.

AUDIT AND GOVERNANCE COMMITTEE

MINUTES AND DECISION RECORD

8 December 2016

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool.

Present:

Councillor: Ray Martin-Wells (In the Chair).

Councillors: S Akers-Belcher, Belcher, Cook, Hamilton, Harrison and Tennant.

Co-opted members:
Norman Rollo and Clare Wilson.

Also Present:Catherine Andrew, Mazars

Officers: Chris Little, Chief Finance Officer
Peter Devlin, Chief Solicitor
Noel Adamson, Head of Audit and Governance
Joan Stevens, Scrutiny Manager
Laura Stones, Scrutiny Support Officer
Angela Armstrong, Principal Democratic Services Officer

88. Apologies for Absence

None.

89. Declarations of Interest

Councillor Martin-Wells declared a personal interest in minute 101 (SCO3/2016) and indicated that he would take further advice prior to the consideration of that item. Councillor S Akers-Belcher declared a personal interest in minute 102 (SC07/2016).

There were no further declarations of interest at this point in the meeting, see minute 102.

90. Minutes of the meeting held on 17 November 2016

Confirmed.

91. Mazars Report – Annual Audit Letter (*Chief Finance Officer*)

The Mazars' representatives presented their Annual Audit Letter for 2015/16. The report summarised the main findings which included an unqualified opinion on the Council's financial statements and an unqualified Value for Money conclusion.

Members' attention was drawn to Sections 1, Key Messages and 4, Future Challenges.

Recommended

The report of Mazars was noted.

92. Mazars Report – Audit Progress Report (*Chief Finance Officer)*

A representative from Mazars presented the report which updated the Committee on Mazars' progress in meeting their responsibilities as the Council's external auditor. It also highlighted key emerging issues and national reports which may be of interest to the Audit and Governance Committee.

It was highlighted that the Public Sector Audit Appointments had recently published its consultation on the work programme and scale of fees for 2017/18, however there was no suggestion that there would be any changes to the scale fees.

Recommended

The report of Mazars was noted.

93. Treasury Management Strategy (*Chief Finance Officer*)

The Chief Finance Officer gave a presentation to the Committee setting out the key elements of the Council's Treasury Management Strategy. The detailed report submitted to the Committee covered the strategy in detail. The presentation highlighted:

Economic Environment and Outlook for Interest Rates;
Treasury Management Outturn Position 2015/16;
Treasury Management Strategy 2017/18;
Investment Strategy 2017/18; and the
Minimum Revenue Provision and Interest Costs and Other Regulatory Information 2017/18.

It was highlighted that it was proposed to increase investment limits in order to provide more flexibility with existing high quality counterparties and further details were included within the report. The Chair confirmed that he had discussed the above proposals with the Chief Finance Officer and the proposals were prudent in view of the deterioration in the market conditions.

Recommended

It is recommended that Members approve the following proposals:

(1) **Treasury Management Outturn Position 2015/16**

i) The 2015/17 Treasury Management Outturn detailed in section 4 and Appendix A was noted.

(2) **Treasury Management Strategy 2016/17 Mid-Year Review**

ii) The 2016/17 Treasury Management Mid-year Position detailed in section 5 was noted.

(3) **Treasury Management Strategy 2017/18 (Prudential Indicators)**

iii) It was noted that the detailed prudential indicators will be reported to full Council in February 2017.

(4) **Borrowing Strategy 2017/18**

iv) **Core borrowing requirement** – following the securing of exceptionally low interest rates it was approved that the remainder of the under borrowing be netted down against investments.

v) It was noted that in the event of a change in economic circumstances that the Chief Finance Officer may take out additional borrowing if this secures the lowest long term interest cost.

vi) **Borrowing required for business cases** – The strategy of internally investing in business cases to mitigate counterparty risk, reduce borrowing costs and generate an internal investment return was approved. It was noted that if this strategy was adopted, action may be taken by the Chief Finance Officer to externally borrow for these schemes if an interest rates rise is expected.

(5) **Investment Strategy 2017/18**

vii) The increase of the Counterparty Limit for Svenska Handelsbanken from £3m to £5m was approved.
viii) The increase of the Counterparty Limit for County, Metropolitan or Unitary Councils from £5m to £8m was approved.

ix) The increase of the Counterparty Limit for District Councils, Police or Fire Authorities from £2m to £3m was approved.
x) The increase of the overall Local Authority Limit from £35m to £40m was approved.
xi) The Counterparty limits as set out in paragraph 8.8 were approved.

(6) **Minimum Revenue Provision (MRP) Statement**

xii) The MRP statement outlined in paragraph 9.6 above was approved.
xiii) The establishment of a phasing reserve as detailed in paragraph 5.7 of Appendix B was approved. The recommended revised MRP policy was a long term strategy covering a 50 year period and to ensure the annual recurring saving detailed in the report can be achieved a phasing reserve will be required. This reserve can be funded from small annual contributions from the existing budget.

94. Internal Audit Plan 2016/17 Update (*Head of Audit and Governance*)

The Head of Audit and Governance updated the Committee on the progress made to date to complete the internal audit plan for 2016/17. The Head of Audit and Governance highlighted that all but one of the completed audits had received a satisfactory assurance level. However, Stores was judged as limited assurance due to procedural inadequacies, Members were reassured that stock was secure at all times. Actions had been introduced to rectify this and was progressing well.

It was noted that the work completed and currently ongoing was in line with expectations at this time of year.

Recommended

The content of the report was noted.

95. Draft Anti-Fraud and Corruption Strategy (*Chief Finance Officer)*

Members were asked to consider and endorse the Anti-Fraud and Corruption Strategy and the report included a copy of the guidance produced by the Better Governance Forum to assist Members in their role in relation to assessing and reviewing counter fraud arrangements. A checklist of 20 questions was included in the report which can be used by those responsible for governance to assess their contribution to the fraud defences of their organisation and determine what action is needed.

It was noted that the strategy had been updated in line with CIPFA code of practice and covers the five key principles of the code which were:

- Acknowledge responsibility;
- Identify risks;
- Develop a strategy;
- Provide resources; and
- Take action.

In response to clarification sought by a Member, the Chief Finance Officer confirmed that the Council had adequate processes in place to combat and deal with instances of fraud leading to potential financial loss and reputational damage.

Recommended

The updated Anti-Fraud and Corruption Strategy attached at Appendix A was endorsed.

96. Draft Code of Corporate Governance (*Chief Finance Officer)*

Members were asked to consider and endorse the Council's Draft Code of Corporate Governance. The CIPFA/SOLACE guidance, Delivering Good Governance in Local Government has been updated and the draft code meets the new requirements within the framework.

It was noted that the Council did comply with statutory requirements and best practice in the design of its governance arrangements.

Recommended

The updated Code of Corporate Governance attached at Appendix A was endorsed.

97. Minutes of the meeting of the North East Joint Health Scrutiny Committee held on 2 June 2016

Received.

98. Any Other Items which the Chairman Considers are Urgent

The Chairman ruled that the following items of business should be considered by the Committee as a matter of urgency in accordance with the provisions of Section 100(B) (4)(b) of the Local Government Act 1972 in order that the matter could be dealt with without delay.

99. Any Other Business – Delayed Discharge of Care

Members were reminded of the referral from the Health and Wellbeing Board on the matter of changes to the reporting arrangements for Delayed Transfers of Care (DToC). The Committee was provided with a tabled paper which outlined the following actions that had been agreed:

- In context of current capacity pressures in the care sector at present, it is likely that there will be some delays attributable to social care, these will be reviewed on a monthly basis to ensure accuracy of reporting.

- Any delays relating to people awaiting nursing home placements should be attributable to the NHS, as the CCG is the responsible commissioner.

- A piece of work to be undertaken to agree what constitutes a 'reasonable alternative' for people linked to the Trust's Patient Choice Policy. Until additional capacity is available in Hartlepool it is reasonable and acceptable to promote out of area placements, within a reasonable travelling distance, as an alternative to someone remaining in an acute hospital bed when they are medically fit for discharge. Work has commenced on preparing a set of principles to support this approach.

- The September return submitted by the Trust is to be revised and resubmitted to NHS England on the basis of the criteria agreed above.

- NTHFT will send all future returns to HBC for sign off prior to submission to NHS England on basis of criteria agreed above.

It was noted that based on the implementation of the agreed actions, this satisfactory resolved the initial concerns raised by the Health and Wellbeing Board on this matter.

Recommended

(1) That the update was noted and accepted as a satisfactory outcome in relation to the referral from the Health and Wellbeing Board.
(2) That the outcome of the referral be reported back to the Health and Wellbeing Board on 16 January 2017.

100. Local Government (Access to Information) (Variation Order) 2006

Under Section 100(A)(4) of the Local Government Act 1972, the press and public were excluded from the meeting for the following items of business on the grounds that they involved the likely disclosure of exempt information as defined in the paragraphs referred to below of Part 1 of Schedule 12A of the Local Government Act 1972 as amended by the Local Government

(Access to Information) (Variation) Order 2006.

Minute 101 – Consideration of Investigation Report – SC03/2016 – *Chief Solicitor and Monitoring Officer* This item contains exempt information under Schedule 12A Local Government Act 1972 as amended by the Local Government (Access to Information) (Variation) Order 2006 namely information relating to an individual (para1).

Minute 102 – Consideration of Investigation Report – SC05/2016 – *Chief Solicitor and Monitoring Officer* This item contains exempt information under Schedule 12A Local Government Act 1972 as amended by the Local Government (Access to Information) (Variation) Order 2006 namely information relating to an individual (para1).

Minute 103 – Consideration of Investigation Report – SC06/2016 – *Chief Solicitor and Monitoring Officer* This item contains exempt information under Schedule 12A Local Government Act 1972 as amended by the Local Government (Access to Information) (Variation) Order 2006 namely information relating to an individual (para1).

Minute 104 – Consideration of Investigation Report – SC07/2016 – *Chief Solicitor and Monitoring Officer* This item contains exempt information under Schedule 12A Local Government Act 1972 as amended by the Local Government (Access to Information) (Variation) Order 2006 namely information relating to an individual (para1).

101. Consideration of Investigation Report – SC03/2016

(*Chief Solicitor/Monitoring Officer)* This item contains exempt information under Schedule 12A Local Government Act 1972 as amended by the Local Government (Access to Information) (Variation) Order 2006 namely information relating to an individual (para1).

Further details were contained within the confidential section of the minutes.

Recommended

Further details were contained within the confidential section of the minutes.

102. Consideration of Investigation Report – SC05/2016

(*Chief Solicitor/Monitoring Officer)* This item contains exempt information under Schedule 12A Local Government Act 1972 as amended by the Local Government (Access to Information) (Variation) Order 2006 namely information relating to an individual (para1).

Further details were contained within the confidential section of the minutes.

Recommended

Further details were contained within the confidential section of the minutes.

103. Consideration of Investigation Report – SC06/2016

(*Chief Solicitor/Monitoring Officer)* This item contains exempt information under Schedule 12A Local Government Act 1972 as amended by the Local Government (Access to Information) (Variation) Order 2006 namely information relating to an individual (para1).

Further details were contained within the confidential section of the minutes.

Recommended

Further details were contained within the confidential section of the minutes.

104. Consideration of Investigation Report –SC07/2016

(*Chief Solicitor/Monitoring Officer)* This item contains exempt information under Schedule 12A Local Government Act 1972 as amended by the Local Government (Access to Information) (Variation) Order 2006 namely information relating to an individual (para1).

Further details were contained within the confidential section of the minutes.

Recommended

Further details were contained within the confidential section of the minutes.

The meeting concluded at 11.30 am

CHAIR

AUDIT AND GOVERNANCE COMMITTEE

19 January 2017

Report of: Scrutiny Manager

Subject: INVESTIGATION INTO MORTALITY RATES – COVERING REPORT

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1. PURPOSE OF REPORT

1.1 To introduce representatives from the North Tees and Hartlepool NHS Foundation Trust (the Trust) who will be in attendance at today's meeting to provide members with information in relation to mortality rates.

2. BACKGROUND INFORMATION

2.1 The Audit and Governance Committee at their meeting on 17 November 2016 agreed the aim, terms of reference and timescale for their investigation into Mortality Rates.

2.2 Subsequently, representatives from the Trust will be in attendance at today's meeting to provide Members with information on the following:-

- how mortality rates are calculated and how the Trust compares locally, and nationally, in terms of performance; and
- To look at mortality data/rates for the Trust on a condition by condition basis (including stroke) and explore data trends/areas of improvement or concern

3. RECOMMENDATIONS

3.1 That the Audit and Governance Committee consider the evidence presented at this meeting and seek clarification on any relevant issues where required.

Contact Officer:- Joan Stevens – Scrutiny Manager
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BACKGROUND PAPERS

The following background paper was used in the preparation of this report:-

Mortality Scoping Report presented to the Audit and Governance Committee on 17 November 2016

AUDIT AND GOVERNANCE COMMITTEE

19 January 2017

Report of: Scrutiny Manager

Subject: HEALTH AND WELLBEING BOARD REFERRAL - REPORTING ARRANGEMENTS FOR DELAYED TRANSFERS OF CARE

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1. PURPOSE OF REPORT

1.1 To update the Committee on the current position in relation to the implementation of actions agreed in order to address concerns regarding changes to the reporting arrangements for Delayed Transfers of Care.

2. BACKGROUND

2.1 On 19 September 2016, the Health and Wellbeing Board received notification that the North Tees and Hartlepool Foundation Trust (FT) intended to review the way in which monthly delayed transfers of care were recorded. The basis for this being a review of guidance from NHS England 'Monthly Delayed Transfers of Care: Situation reports' and direct discussions with NHS England.

2.2 The Health and Wellbeing Board agreed that the proposal, and its resulting implications, required further exploration and requested that it be referred to the Audit and Governance Committee for further investigation.

2.3 The Audit and Governance Committee, at its meeting on the 20 October 2016, was advised that the interpretation of the Guidance by the Trust had been challenged in a joint letter from Hartlepool and Stockton on Tees Directors of Adults Services. In addition to this, an urgent meeting had been requested to discuss the decision and areas of dispute.

2.4 The Committee accepted the referral and agreed that further consideration should be deferred pending:

- A response to the joint letter, sent by Hartlepool and Stockton on Tees Directors of Adults Services, to the Chair of the FT's Board; and

- The outcome of the meeting with the FT, requested by the Directors of Adult Services.

2.5 The Audit and Governance Committee was advised at its meeting held on 8 December 2016, that two meetings had been held with the Trust in November 2016 to seek resolution to the areas of dispute. These meetings resulted in the following actions being agreed:

- In the context of current capacity pressures in the care sector, it is likely that there will be some delays attributable to social care; these will be reviewed on a monthly basis to ensure accuracy of reporting.

- Any delays relating to people awaiting nursing home placements should be attributable to the NHS, as the CCG is the responsible commissioner.

- A piece of work to be undertaken to agree what constitutes a 'reasonable alternative' for people linked to the Trust's Patient Choice Policy. Until additional capacity is available in Hartlepool it is reasonable and acceptable to promote out of area placements, within a reasonable travelling distance, as an alternative to someone remaining in an acute hospital bed when they are medically fit for discharge. Work has commenced on preparing a set of principles to support this approach.

- The September return submitted by the Trust is to be revised and resubmitted to NHS England on the basis of the criteria agreed above.

- NTHFT will send all future returns to HBC for sign off prior to submission to NHS England on basis of criteria agreed above.

2.6 On the basis that this would satisfactorily resolve the initial concerns raised by the Health and Wellbeing Board on this matter, the Committee was of the view that the matter required no further exploration. It was agreed that a report detailing the outcome of the Audit and Governance Committee's consideration of the referral, and the agreed actions, should be sent to the next meeting of the Health and Wellbeing Board.

2.7 Further to the decision of the Audit and Governance Committee on 8 December 2016, it was noted that the actions outlined in Section 2.5 had not been implemented in the production of the most recent figures in relation to Delayed Transfers of Care.

- The September 2016 return, which was submitted with the caveat that figures were disputed by the Local Authority, has not yet been reviewed and resubmitted. The guidance allows for this to happen within six months of the original return being submitted.

- It is the understanding of HBC officers that returns for October and November 2016 have been submitted using the same method for attributing delays as the September 2016 return and the figures are

disputed by the Local Authority. There is an opportunity to review and resubmit returns, as outlined above.

- The principle that delays relating to people awaiting nursing home placements should be attributable to the NHS, as the CCG is the responsible commissioner, which HBC officers and a representative of the CCG understood had been agreed, is not being applied.

- The piece of work reviewing 'reasonable alternatives' for people, linked to the Trust's Patient Choice Policy has commenced. It is accepted that, until additional nursing home capacity is available in Hartlepool, it is reasonable and acceptable to promote out of area placements, within a reasonable travelling distance, as an alternative to someone remaining in an acute hospital bed when they are medically fit for discharge. The piece of work has identified that people are being supported on a regular basis to access out of borough placements, predominantly in Durham and, to a lesser extent, Stockton. However, there are a small number of people who have significant delays as they are exercising choice and will not accept an out of borough placement.

Further discussions with the Trust are taking place during January 2017 to ensure that actions are implemented and an update confirming the position in relation to each action will be provided to Audit & Governance Committee in March 2017.

3. RECOMMENDATIONS

3.1 Members are requested to note the report and updated information provided, with a view to receiving a further update in March 2017.

4. REASONS FOR RECOMMENDATIONS

4.1 To confirm the Committee's response to the referral from the Health and Wellbeing Board.

5. CONTACT OFFICER

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AUDIT AND GOVERNANCE COMMITTEE

19 January 2017

Report of: CHIEF OFFICER, HARTLEPOOL AND STOCKTON CLINICAL COMMISSIONING GROUP

Subject: URGENT AND EMERGENCY CARE UPDATE

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1. PURPOSE OF REPORT

1.1 To provide the Audit and Governance Committee with an update on initiatives that are being implemented to manage the demands on urgent and emergency care systems and how we are developing services in order to improve outcomes and experience for patients.

2. BACKGROUND

2.1 NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (the CCG) have a responsibility to commission high quality, effective, urgent and emergency care services for patients in line with national and local priorities.

2.2 Based on guidance available, the CCG has developed plans to address current challenges across the urgent and emergency landscape with one key scheme being the development and implementation of integrated urgent care services.

3. INTEGRATED URGENT CARE SERVICES

3.1 The CCG has engaged with the Health and Wellbeing Board throughout 2015 and 2016 to advise on plans for an Integrated Urgent Care Service (IUCS). The proposal for the service was in response to national guidance and best practice and also in response to local intelligence which outlined that service users are often confused about where and when to attend for urgent care needs and continued to present at accident and emergency services.

3.2 The new service will bring together a range of urgent care services including GP out of hours, minor injuries and walk in centre services to avoid service users making decisions and choices as to where the best place to attend will

be and will be delivered in two localities from 1 April 2017; University Hospital of Hartlepool and University Hospital of North Tees.

3.3 In November 2016, the procurement process concluded and the CCG Governing Body agreed the recommendation following a robust procurement process to award the new contract to North Tees and Hartlepool NHS Foundation Trust who will be working in partnership with North East Ambulance Services and Hartlepool and Stockton Health (GP Federation) to deliver the new Integrated Urgent Care Service (IUCS).

3.4 At the University Hospital of North Tees, the IUCS will be co-located at A&E and will ensure that service users are triaged and receive appropriate treatment in the most appropriate setting, to avoid unnecessary attendances at the A&E Department

4. MANAGING EMERGENCY CARE LOCALLY

4.1 The Accident & Emergency Delivery Board (A&EDB) replaces the Systems Resilience Group (SRG), a transformation that was mandated by NHS England in their correspondence to CCG Accountable Officers, dated July 26 2016.

4.2 The A&EDB will focus on the recovery of the 4 hour target but also A&E Delivery Boards and with Sustainable Transformation Plan (STP) groupings, will focus on the longer term delivery of the Urgent and Emergency Care Review. Additionally the Local A&E Delivery Board coordinates and oversees “Five Interventions” - developed by experts in the field of emergency care, with a focus on outcomes and processes, for which discharge to assess models is one key intervention.

4.3 The Hartlepool and Stockton-on-Tees A&E Delivery Board has allocated the SRG funding resource for 2016/17 to schemes identified through a process involving all then SRG members. The schemes are all developed with the vision to either address issues relating to hospital discharges (Delayed Transfers of Care), offer workforce resilience or to prevent avoidable/unplanned hospital admissions.

5. MANAGING PRESSURE - Operational Pressures Escalation Framework (OPEL)

5.1 System wide escalation plans have been developed and agreed in line with the new national framework with agreed local multi-agency triggers - including escalation and de-escalation. Both provider and commissioning organisations across the North East have plans in place which include triggers for both escalation and de-escalation built on a standardised framework (NEEP – North East Escalation Plans levels 1-6). These are monitored at a system level via the A&EDB

5.2 Delivery against the new A & E Improvement Plan is also reported upon at each A&E DB with monthly data collection responsibilities shared with providers.

6. RISK IMPLICATIONS

6.1 None for the Audit and Governance Committee.

7. FINANCIAL CONSIDERATIONS

71 None for the Audit and Governance Committee.

8. LEGAL CONSIDERATIONS

8.1 None identified.

9. CHILD AND FAMILY POVERTY CONSIDERATIONS

9.1 None identified.

10. EQUALITY AND DIVERSITY CONSIDERATIONS

10.1 None identified.

11. STAFF CONSIDERATIONS

11.1 No staff considerations identified.

12. ASSET MANAGEMENT CONSIDERATIONS

12.1 No asset management considerations identified.

13. RECOMMENDATION

13.1 It is recommended that the Audit and Governance Committee notes the contents of the presentation.

14. REASONS FOR RECOMMENDATION

14.1 Multi agency Local A&E Delivery Boards are responsible for co-ordinating and overseeing these initiatives which aim to improve outcomes and experience for local people.

15. CONTACT OFFICER

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Katie McLeod
Head of Strategy and Commissioning
HaST CCG

AUDIT AND GOVERNANCE COMMITTEE

19 January 2017

Report of: REPORT OF THE ADULT SERVICES COMMITTEE

Subject: ADULT SERVICES COMMITTEE'S RESPONSE TO THE INVESTIGATION INTO ACCESS TO TRANSPORT FOR PEOPLE WITH A DISABILITY

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1. PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide Members of the Audit and Governance Committee with feedback on the recommendations from the investigation into Access to Transport for People with a Disability, which was reported to the Adult Services Committee on 3 November 2016 (Final Report) and 5 January 2017 (Action Plan).

2. BACKGROUND INFORMATION

2.1 On 3 November 2016, the Adult Services Committee considered the Final Report into Access to Transport for People with a Disability. This report provides feedback from the Adult Services Committee's consideration of, and decisions in relation to the recommendations.

2.3 Following on from this report, progress towards completion of the actions contained within the Action Plan will be monitored through Covalent; the Council's Performance Management System; with standardised six monthly monitoring reports to be presented to the Committee.

3. SCRUTINY RECOMMENDATIONS AND DECISION

3.1 Following consideration of the Final Report, the Adult Services Committee approved the recommendations and actions. Details of each recommendation and action are provided in the Action Plan, attached as **Appendix A.**

4. RECOMMENDATIONS

4.1 That Members note the proposed actions detailed within the Action Plan and seek clarification on its content where felt appropriate.

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BACKGROUND PAPERS

The following background papers were used in the preparation of this report:-

(i) Final Report into Access to Transport for People with a Disability considered by the Adult Services Committee on 3 November 2016

(ii) Decision Record of the Adult Services Committee held on 3 November 2016

(iii) Action Plan into Access to Transport for People with a Disability considered by the Adult Services Committee on 5 January 2017

AUDIT AND GOVERNANCE SCRUTINY ENQUIRY ACTION PLAN

NAME OF COMMITTEE: Audit and Governance Committee

NAME OF SCRUTINY ENQUIRY: Access to Transport for People with a Disability

RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION	FINANCIAL / OTHER IMPLICATIONS
(a) That a mapping exercise be undertaken to explore the viability of a travel membership club for people with disabilities to access, as and when required, with a detailed exploration of the following areas:-	(a) A number of discussions have been held with local providers who expressed an interest. • A consortium of local businesses were considering the option of developing and investing in a scheme to support local citizens, however following due diligence concluded that there was little evidence to suggest it would be successful or cost neutral. • A private provider with experience of providing transport for adults with disabilities has expressed interest in purchasing a vehicle to set up an alternative travel service. • Community Travel Clubs - Clubs can be established in geographical areas by a number of community groups, Transport Champions, Parish Councils etc to consider the travel needs of individuals within their community. The travel club determines the needs of its members and the Local Authority can provide the service required The Council's Passenger Transport Service has a variety of vehicles available to support a Community Travel Club scheme, ranging from 67 seat coaches, 33 seat buses and 17 seat minibuses, including vehicles suitable for those using mobility aids. These vehicles would potentially be available to travel clubs outside of school travel times, evenings and weekends.	Previous 'Dial a Ride' running costs in excess of £250,000 per annum to operate. Cost to run service is unknown, provider is willing to contribute towards set up costs. Costs of journeys will vary depending on the needs of each group; the charge is made up of proportional costs of the vehicle, driver and fuel. Several community travel clubs are operating via Passenger transport none of which are subsidised routes. No cost to the Council Service is funded through a contract with Durham CCG an Durham CC (public health grant)

	Transport provision would be flexible and delivered on a demand lead basis across a varied geographical area. The cost of each journey will be predetermined and shared between the patrons using the service. There is interest from a provider operating a patient transport service in Durham (NHS - transport) which has a number of vehicles and volunteer drivers. The provider is interested in exploring options to extend into Hartlepool.	
(i) Identification of the actual number of people affected;	(i) Information provided from a number of sources, no definitive list of the number of people reliant on a wheelchair. • Office for National Statistics (2011 census) - 1.9% of the UK population uses a wheelchair (Hartlepool = 1,757). • Number of people claiming Severe Disablement Allowance (SDA) in Hartlepool = 480. • North Tees and Hartlepool NHS Trust has 3,709 adults and 452 children registered with wheelchair services (Hartlepool = 1,387). • Adult receiving Council provided day opportunities who are reliant on accessing a wheelchair accessible vehicle (WAV) = 14 per day.	No definitive number of people likely to be affected.
(ii) Membership fees for those wishing to access the service (exploring whether it could be funded from direct payments, independent living / mobility payments);	(ii) An adult meets the eligibility criteria if their needs arise from or are related to a physical or mental impairment or illness; as a result of those needs the adult is unable to achieve two or more of the outcomes specified below and as a consequence there is, or is likely to be, a significant impact on the adult's well-being. The specified outcomes are— • managing and maintaining nutrition;	Adult services currently have a service level agreement with HBC passenger transport to provide wheelchair accessible vehicles to people using its day services. The cost to support on average 61 people with a learning / physical

(iii) Funding from Ward Member Budgets, the CCG and NTHFT to help towards the running of the service; and (iv) The use of volunteer drivers	• maintaining personal hygiene; • managing toilet needs; • being appropriately clothed; • being able to make use of the adult's home safely; • maintaining a habitable home environment; • developing and maintaining family or other personal relationships; • accessing and engaging in work, training, education or volunteering; • making use of necessary facilities or services in the local community including public transport, and recreational facilities or services; and • carrying out any caring responsibilities the adult has for a child. (iii) Head of Service to work in partnership with prospective organisations to pull together a lottery bid to pump prime the running of a service. Meeting held with 'We are Supportive', which has 150 volunteer drivers in Durham. Subsidised service funded by public health and Durham CCG, provider is keen to expand into Hartlepool.	disability is circa £270,000 per annum. The service has access to 5 vehicles and on average 14 spaces are allocated to people who are reliant on a wheelchair. If the buses were only utilised for wheelchair users this would equate to a daily cost of £40.18, however the bus is also used by people who do not require a wheelchair and has been set at £10 per day, or £18 per day for those who require a passenger assistant. Potential to pump prime a new service, cannot guarantee bid would be successful and would not create sustainability in the long term
(b) That the potential of accessing / expanding existing Charity run schemes in the region be explored	RSVP (Retired and Senior Volunteer Programme) runs many driving schemes across the UK which provide free or low-cost door-to-door service for older or more vulnerable people NEAS - Ambulance Car Service Drivers (ACS) are volunteers who use their own vehicles to help with the transportation of patients to and from hospitals and clinics, thereby leaving ambulances free for emergencies and for patients too ill to travel by car. Over 150 volunteers helping out throughout the North East. Volunteers are not paid for their time, however they do receive out of pocket expenses for their mileage.	Cost is subject to individual requirements. Currently looking for any Ambulance Car Service volunteers in the Teesside area.

(c) As part of the review of transport services at NTHFT:- (i) A request is made to provide a hospital shuttle bus that is wheelchair accessible and can be used at all times including peak periods; and (ii) Explore whether this service could be included in a wider partnership scheme, such as the travel club	(c) Contact made with Brian Christleow, facilities manager at NT&HFT. (i) Highlighted the recommendations in the report and proposal that a WAV be considered when procuring hospital transport (ii) scheme already runs alongside the NEAS passenger transport service and volunteer ACS drivers scheme.	
(d) Examine whether a pre-bookable service could be put in place to provide transport to GP / hospital / dental appointments which is co-ordinated and booked by the health service, when appointments are made;	(d) Meeting held with Tracie Jacobs (H&ST CCG) and John Davison (CEO) of 'We are Supportive' who operate a Health Appointment Car Scheme (HACS) across Durham funded by Public Health and CCG. The provider is keen to expand into Stockton and Hartlepool.	Service is reliant on funding, and is subsidised by grants from Durham CCG and Durham CC. Further work required to identify the level of subsidy required.
(e) In relation to the Patient Transport Service, ensure that the assessment criteria includes arrangements for carers to travel with patients and that this is implemented on all journeys when needed;	(e) Discussed and shared the report with CCG and NT&HFT	Awaiting feedback re future plans linked to conveyance.
(f) Explore the potential of any financially viable options for drivers and taxi companies to provide wheelchair accessible transport along	(f) Discussion with local Transport Provider willing to provide a WAV vehicle. Provider has produced estimated costs of running a service.	(f) Initial discussions suggest an incentive of £2-£3 per journey may be sufficient to encourage Taxi Companies to provide WAV.

with the potential of any available funding streams	Provider agreed to await the outcome of further work to ascertain future demand.	Using the Severe Disablement Allowance SDA figure of 480 people. with an average of 6 journeys per week at £3, it would equate to around £449,000 in subsidies.

Minutes from the Finance and Policy Committee held on 31 October 2016

Consider Options to Deliver a 0-19 Healthy Child Programme (*Director of Public Health*)

63.

Type of decision

Key Decision test (i) and (ii) applies - Forward Plan Reference No PH03/16.

Purpose of report

To seek approval for a preferred option from the Finance and Policy Committee to
secure a 0 -19 Healthy Child Programme (HCP) to be funded
through the Public Health Grant to commence from 1 May 2017.

Issue(s) for consideration

The Director of Public Health reported that in January 2016, Public Health England published a range of guidance to support the commissioning of the Healthy Child Programme 0-19: Health Visiting and School Nursing Services. The guidance was designed to support local authorities in commissioning public health services for children and young people and in particular delivering the 0-5 and 5–19, highlighting the importance of giving every child the best start in life and in reducing health inequalities throughout life.

Since the transfer of responsibility from NHS England to the local authority, the Health Visitor and Family Nurse Partnership Service 0-5 and Children and Young People Health and Wellbeing (CYPHWB) Service 5-19 have been provided by North Tees and Hartlepool NHS Foundation Trust and contract managed by the Tees Valley Public Health shared Service, under two separate contracts.

Hartlepool Borough Council commission a Health Visitor (HV) Service and the Family Nurse Partnership (FNP) Service which included the statutory responsibilities of the five mandated development reviews and also a CYPHWB service which includes the mandated provision of the National Child Measurement programme. These services are funded through the public health grant.

The contract values of the current service provision was set out in a confidential appendix to the report which outlined the cost and savings projections of each option and contained exempt information under schedule 12A Local Government Act 1972 (as amended by the Local Government (Access to information) (Variation Order 2006) namely, (Para 3) information relating to the financial or business affairs of any particular person (including the authority holding that information).

Following a comprehensive review of preventative and early intervention services in Hartlepool, a set of proposals for the fundamental redesign of prevention and early intervention provision were agreed. It was proposed, based on the Better Childhood findings, that an integrated, preventative and early intervention service for children and young people aged 0-19 years is created.

The Better Childhood in Hartlepool Integrated Locality Teams became operational on 1st August 2016 and integrated Children's Services and

Health Staff. Currently the Health Staff had integrated into the Teams as part of their existing contract. The Teams consisted of: Family Support Workers, Social Workers, Community Nursery Nurses, School Nurses and Health Visitors including Family Nurse Partners.

Taking account of Public Health England guidance and recommendations to support the commissioning of the Healthy Child Programme, local considerations including budget constraints and feedback from consultation with stakeholders , the following options for the future provision of a children's 0-19 integrated public health service had been identified: -

Option A – Alignment of existing contracts

Option B – Re-procure through a competitive tender exercise

Option C – In house service

The options were appraised in detail within the report and the Director gave a brief overview of each to the Committee. The Director suggested that based on the detailed appraisal of the options, Option C, the development of an in-house service, had the most advantages for Hartlepool. An in-house service would provide increased operational management and control, improve information sharing, provide a fully integrated service, the flexibility to respond to changing needs and the service could be accommodated within the existing Integrated Locality Teams. Clinical Governance and safeguarding supervision would be required, which would be new to the local authority and the service would also be subject to CQC registration and inspection but the Director believed the service could be safely delivered and within the agreed resource envelope.

Following a comment by a Member the Director confirmed the Poverty Impact Assessment should show a positive impact for those from minority ethnic backgrounds.

The Chair questioned how the in-house service would integrate with the Council's proposed Community Hub structure. The Director indicated that through utilising the integrated locality model, the services would be targeted at those areas with highest need. The Director of Child and Adult Services added that as the Community Hub model developed, the locality model would align with the community hubs. Work was ongoing on the future structure of the integrated services and a further report setting out how this would be accomplished and the staffing structure would be brought to the Committee. The Chair indicated that all staffing structures that affected posts at Band 15 and above

were required
to be reported to Members.
Members questioned if the current provider had made comment on the Council's proposals.
The Director indicated that they had been made aware of the report but no response had
been forthcoming. Members questioned if there was an intention that teams would be
based within the community hubs or would operate from the centre out to the hubs. The
Director of Child and Adult Services stated that the locality teams already worked out of their
locality bases and not the Civic Centre.
The following recommendation was agreed unanimously.

Decision
That Option C, an in-house service, be supported as the preferred option for service delivery of a 0 -19 Healthy Child Programme.

Minutes of the Finance and Policy meeting held on 2 December 2016

Three Year Savings Programme – Public Health Department (*Director of Public Health*)

Type of decision
Budget and Policy Framework.

Purpose of report
The purpose of the report was to enable Members to consider the initial 2017/18 savings proposals relating to the Committees remit for public health to contribute towards achieving the overall savings requirement.

Issue(s) for consideration
The Director of Public Health reported that public health services were funded through a ring fenced public health grant. This grant had been provided to Local Authorities since 2013 when the Local Authority assumed responsibility for public health from the NHS. Since 2013 new responsibilities had been bestowed upon Councils such as the commissioning of 0-5 health visitor services. However, despite this, the current public health grant continued to be cut year on year.
In the Chancellors 2015 Autumn Statement, it was confirmed that LA's funding for public health would see a reduction in cash terms of 3.9% each year until 20/21. It had been necessary, therefore, to find significant savings to accommodate these grant cuts year on year. Public Health grant funding was expected to reduce by £1.244m in total by 2019/20.
The proposals in respect of the services in the Public Health Department reflected the overall approach adopted by the Corporate Management Team for identifying achievable savings, as part of an approach aimed at protecting front line services, recognising that not all areas could be protected in the current financial climate.
The savings proposals for the service areas in public health funded through the

ring fenced public health grant were set out in detail in the report. The savings that had been identified had been assessed for their sustainability. As with all others parts of the Authority the sustainability of the savings required by the ongoing cuts which the Authority faced became increasingly difficult as the compound affect of these savings impacts on services.
The Director highlighted the risks associated in the service changes, particularly taken in the context of previous savings which had been made.

At this time the proposals described were viewed as being manageable, but with there being a significant need to review workloads, priorities and for the potential scaling back of a number of current activities in line with the resources available. It was considered that these savings could be delivered, although not without difficulty or some degree of risk but that this could be managed in this year, however, achieving these savings becomes more difficult each year, which is the case in other departments.
The Chair highlighted that an appropriate child and family poverty assessment would be required when the savings proposals were forwarded to Council.

Decision
That the report be noted and the savings proposals be approved for submission to Council.

78. Community Hubs (*Director of Public Health*)

Type of decision
Key Decision (test (i)/(ii)) Forward Plan Reference No.PH05/16.

Purpose of report
The purpose of the paper was to present to Committee for approval a proposal to develop community hubs across the town.

Issue(s) for consideration
The Director of Public Health reported the concept of community hubs had emerged as part of the discussion, to shape the Hartlepool of the Future Programme. The project had been framed as part of the reducing demand through prevention and integration of health, social care and employability

services work streams. Political commitment to the project, as part of the Hartlepool of the Future Programme, was given at Finance and Policy Committee as part of the Medium Term Financial Strategy in January 2016.
The Director commented that much work had been given to identifying what the hubs would do and the range of services that would be delivered. Services offered out of the hub would not operate in silos, tackling single issue needs, but would be perfectly positioned to meet the diverse needs of each person. Community hubs would be a tangible resource that people can access to self help, seek help and offer help through volunteering and community action.
In the first instance, the following service areas were proposed to be in scope for the Community Hub project:

- Libraries
- Community centres
- Smoking Cessation service
- NHS health checks
- Health Trainers
- Public Health Resource Library
- Community Safety
- Hartlepool Adult Education
- Parenting Academy
- Digital inclusion team
- Hartlepool Working Solutions
- Advice and financial inclusion

The physical presence of Community Hubs would be driven by a number of basic, physical characteristics, which would necessarily drive the decision of where in the town they would be located.

- Hubs will be located in areas with demonstrated health AND employment inequality, however everyone in the town will be within 2 km of a hub.
-Hubs will be suitable to deliver the entire core service offer illustrated above.
-Hubs will be accessible to all and meet Equality Act standards
-Hubs will have appropriate infrastructure in place e.g. IT, telephony

Various buildings located in the town, had been assessed and matched against the criteria outlined in the report and around areas of inequality. They were allocated a score based on their ability to meet these requirements. In central Hartlepool, Central Library scored most highly, and in the south, Owton Manor Community Centre and Library. There was currently no HBC owned and run centre in the north of the town to meets the requirements as a Community Hub. However, the West View Advice and Resource Centre closely matched the physical criteria for a hub. If West View was identified as a suitable hub in the north of the town, then this option would allow for the continuation of specialist universal welfare benefits and financial Support to continue.

At this stage consultation regarding the development of community hubs had only been carried out with stakeholders. There was a risk that the public and specifically the communities we wish to target with this initiative would not engage. This risk may be mitigated to some degree with a considered and well developed communications plan. Communities which were actively engaged in development,

kept informed, and understand the potential benefits were more likely to support the project and use the resultant services.
The full financial impact of the proposals would need to be assessed as part of a full business case. This would include assessing the likely staffing costs associated with each Hub and this could only be calculated after the detailed workforce mapping exercise had been carried out.
The community hub proposals had the potential to generate the following savings:-
Library Service £150,000 - It is proposed that the provision of a library service was streamlined, focusing on development of a quality provision from fewer sites. The proposals that the Hub model would subsume the functions of the branch libraries would generate property savings which were estimated to total £50,000 p.a. It will be possible for the Library service to restructure its services further and it was anticipated that it would be possible to generate a further £100,000 over a three year period.
Contract Savings £50,000 - It would be possible to review contracts currently delivering health and wellbeing services and look at how these may be delivered as part of the Community Hub setting. It was expected that this will generate savings of £50,000 p.a. however further work was required as part of the full business case to fully assess this potential saving.
There would, however, be a consequent budget pressure if Owton Manor Community Centre was identified as the Community Hub in the south. Members will recall that one off funding had previously been approved to fund Community Centre running costs until 2016/17, on the basis that this service would be removed in 2017/18. The achievement of this saving was included in the updated budget forecasts considered by the Finance and Policy Committee on 20 June 2016. Funding would, therefore, need to be identified to cover the running costs associated with Owton Manor Community Centre in future years and this was estimated to be £60,000 p.a. It was proposed to use the savings identified to offset this budget pressure.

Members acknowledged that there was still a lot of work to be done to deliver the Community Hubs proposal but did question what the timescales were estimated to be. The Director commented that there was already a considerable amount of work underway and it was understood that Members wanted the Hubs brought forward at the earliest opportunity. The Chief executive added that as well as the Director of Public Health's discussions with partner organisations, there had been other discussions with Police and Health on delivering differently and the potential for developing the existing Children's Services Locality Teams.

A Member commented that the Credit Union was looking to re-establish itself in the south area of the town and it may be appropriate to look to the potential of them having services within the other two hubs proposed.

A Member of the public questioned if the impact on library users had been assessed. The Director of Regeneration and Neighbourhoods indicated that a full assessment of any changes to library provision would need to be undertaken and that would involve consultation with the public.

The Chair added that he had forwarded to the Director of Public Health the potential development of community pharmacies.

The following recommendations were agreed unanimously.

Decision

1. That the following sites be approved to ensure the development of community hubs across Hartlepool:-
• Central library to be developed as a community hub.
• Owton Manor Community Centre and Library to be developed as a community hub.
• West View Advice and Resource Centre to be commissioned as a community hub.
2. That as a consequence of the development of community hubs there potentially will be an alternative model of delivery for the functions of community centres and library services. Therefore, the Director of Regeneration and Neighbourhoods be authorised to commence the required process of consultation that would enable the authority to re-shape the Library Service.
3. That the development of community hubs, as reported, will lead to the decommissioning of some commissioned public health services and change in the delivery model of health improvement services.
4. That the development of an implementation plan and phased programme to establish community hubs commencing in April 2017 be approved.

AUDIT AND GOVERNANCE COMMITTEE

19 January 2017

HARTLEPOOL BOROUGH COUNCIL

Report of: Scrutiny Manager

Subject: CARE QUALITY COMMISSION - CONSULTATION ON THE NEXT PHASE OF REGULATION

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1. PURPOSE OF REPORT

1.1 To provide information on the Care Quality Commission's (CQC) consultation regarding their next phase of regulation.

2. BACKGROUND INFORMATION

2.1 The Care Quality Commission (CQC) is the independent regulator of all health and social care services in England. The CQC register, monitor and inspect services to make sure they provide safe, effective, compassionate, high quality care, and they encourage them to improve. In December the CQC launched its consultation on their next phase of regulation.

2.2 The consultation document, 'Our next phase of regulation: A more targeted, responsive and collaborative approach', (attached as **Appendix 1** – the annexes to the consultation are available to view on the following website http://www.cqc.org.uk/content/our-next-phase-regulation) follows their strategy for 2016 to 2021 , published in May 2016, which sets out an ambitious vision for a more targeted, responsive and collaborative approach to regulation, so that more people get high-quality care.

2.3 The CQC are seeking views on:

- principles for how they will regulate new models of care and complex providers
- changes to their assessment frameworks across all sectors to reduce complexity and create more consistency
- how they will register services for people with learning disabilities
- the way they will regulate NHS trusts and foundation trusts from April 2017 – including how they might change their approach to rating them.

2.4 The consultation questions are as follows:-

1a. Do you think our set of principles will enable the development of new models of care and complex providers? [Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]

1b. Please tell us the reasons for your answer.

2a. Do you agree with our proposal that we should have only two assessment frameworks: one for health care and one for adult social care (with sector-specific material where necessary)? [Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]

2b. Please tell us the reasons for your answer.

3a. What do you think about our proposed changes to the key lines of enquiry, prompts and ratings characteristics?

3b. What impact do you think these changes will have (for example the impact of moving the key line of enquiry on consent and the Mental Capacity Act from the effective to the responsive key question)?

4. We have revised our guidance Registering the right support to help make sure that services for people with learning disabilities and/or autism are developed in line with national policy (including the national plan, Building the right support). Please tell us what you think about this.

5. What should we consider in strengthening our relationship management, and in our new CQC Insight approach?

6. What do you think of our proposed new approach for the provider information request for NHS trusts?

7. What do you think about our proposal that our regular trust inspections will include at least one core service and an assessment of the well-led key question at trust level approximately annually?

8. What do you think about our proposal that the majority of our inspections of care services will be unannounced?

9a. What do you think about the changes we have proposed to inspecting the maternity and gynaecology core service?

9b. What do you think about the changes we have proposed to inspecting the outpatients and diagnostic imaging core service?

10a. Do you agree with our proposed approach to inspecting additional services (services that we do not inspect routinely) across a range of providers or sectors? [Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]

10b. Please tell us the reasons for your answer.

11a. Do you agree with our proposals for using accreditation schemes to both inform and reduce CQC inspections? [Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]

11b. Please tell us the reasons for your answer.

12. What do you think about our current approach to trust-level ratings and how do you think it could be improved (taking into account the new use of resources rating)?

2.5 Alongside this consultation, the CQC are consulting jointly with NHS Improvement on their approach to leadership and use of resources in NHS trusts (documents attached as **Appendix 2**). These plans reflect the priorities set out in the five year strategy for a more targeted, responsive and collaborative approach.

2.6 The CQC will publish a second consultation in Spring 2017, which will focus on how they regulate adult social care and primary medical services.

2.7 The consultation questions are as follows:-

1: Do you agree with the proposed process for assessing and rating trusts' use of resources?
Please tell us the reasons for your answer.

2: What are your views on how the Use of Resources rating could over time be combined with CQC's existing trust quality rating?

3: Do you think these initial indicative metrics provide a reasonable starting point for informing the assessment of a trust's performance on use of resources? Are there other metrics we should consider when assessing a trust's productivity?

4: What are your views on the indicative key lines of enquiry and prompt questions that we are proposing for the assessment of trusts' use of resources as set out in Annex A?
Please tell us if you think we should include something different or additional.

5: What are your views on the indicative characteristics we have proposed for the use of resources ratings of outstanding, good, requires improvement and inadequate as set out in Annex A?
Please tell us if you think we should include something different or additional.

6: Do you agree that the Use of Resources rating should be reflected in trusts' finance and use of resources scores in the Single Oversight Framework?
Please tell us the reasons for your answer.

7: Do you agree with the additions to the well-led framework?
Please tell us the reasons for your answer.

8: Are there additional areas we could consider on quality, operational and financial governance?

9: Do you have any views on NHS Improvement's proposals for developmental reviews?

10: Do you think that NHS Improvement's guidance should recommend developmental reviews (or equivalent activities):
(a) every three years, as with the current expectation for NHS foundation trusts?
(b) every five years, thereby reducing the current frequency for NHS foundation trusts?
(c) on the basis of risk, primarily informed by the outcome of CQC's well-led inspections or NHS Improvement's ongoing oversight under the Single Oversight Framework segmentation?

11: Are there any other ways in which CQC and NHS Improvement could further streamline and reduce duplication for trusts in respect of the oversight and assessment of well-led?

12: Do you agree with our plans to develop, test and roll out our use of resources and well-led assessments?
Please tell us the reasons for your answer.

13: Are there other ways in which we should be engaging on our proposals for assessing and overseeing use of resources and well-led?

2.8 The deadline for responses for the consultation is 14 February 2017.

3. RECOMMENDATION

3.1 That the Audit and Governance Committee consider the consultation documents and formulate a response to the consultation.

BACKGROUND PAPERS

The following background paper was used in the preparation of this report:-

1) Care Quality Commission - Our next phase of regulation - http://www.cqc.org.uk/content/our-next-phase-regulation

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Consultation

Our next phase of regulation

A more targeted, responsive and collaborative approach

Cross-sector and NHS trusts

December 2016

Contents

Separate annexes

Foreword

Our strategy for 2016 to 2021, published in May 2016, set out an ambitious vision for a more targeted, responsive and collaborative approach to regulation, so that more people get high-quality care.

Demand for care has increased as more people live longer with more complex needs. Providers are meeting the challenges this creates by breaking down the traditional boundaries between hospital care, community-based services, primary medical services and adult social care services. They are turning to new ways to deliver care and using technology so that they can deliver person-centred care efficiently. CQC will respond to this changing environment in a way that facilitates and supports improvement and sustainability, and that continues to make sure people have access to safe, effective, compassionate, high-quality care.

We want your views on how we should develop our approach further as we implement our five-year strategy and move into the next phase of our regulatory model.

Some of our proposals apply to all regulated sectors, and include how we will regulate new and complex types of providers. We will evolve our assessment framework, which we use to make judgements about the quality of care. Our proposals aim to simplify our assessments, but also strengthen them using what we have learned over the last three years to make sure we continue to find out whether services are safe, effective, caring, responsive and well-led.

Our other proposals focus on how we will monitor, inspect, rate and report on NHS trusts from April 2017. These proposed changes are designed to enable CQC to be more responsive to risk and improvement, as well as to be more efficient and effective – by working more closely with our partners to increase alignment and reduce duplication. They also have a stronger focus on the importance of leadership to drive improvement.

Alongside this consultation, we are consulting jointly with NHS Improvement on our approach to leadership and use of resources in NHS trusts. CQC and NHS Improvement are committed to working together to recognise that effective use of resources is fundamental to enable health and social care providers to deliver and sustain high-quality care.

We will publish a second consultation in Spring 2017, which will focus on how we regulate adult social care and primary medical services.

As we update our approach, we want to keep the elements that we know people value and to improve what people tell us we can do better. We will continue to work with people who use services, providers, professionals and our other local and national partners to co-produce what we do.

We are grateful for your feedback to this consultation, which we will use to develop the next phase of our regulatory work.

David Behan
Chief Executive

Introduction

CQC's purpose is to make sure health and social care services provide people with safe, effective, compassionate high-quality care and we encourage care services to improve. Our strategy, *Shaping the future*, set out an ambitious vision for a more targeted, responsive and collaborative approach to regulation. We have four strategic priorities, which are to:

1. Encourage improvement, innovation and sustainability in care
2. Deliver an intelligence-driven approach to regulation
3. Promote a single shared view of quality
4. Improve our efficiency and effectiveness.

The accompanying 'sector by sector' publication to our strategy described how we would regulate and encourage improvement in each sector. In this consultation, we set out further detail about how we propose to update our approach and our assessment framework to reflect the changing provider landscape. We want to hear your views on these proposals, which are aimed at achieving:

- a more integrated approach that enables us to be flexible and responsive to changes in care provision
- a more targeted approach that focuses on areas of greatest concern, such as safety, and where there have been improvements in quality
- a greater emphasis on leadership, including at the level of overall accountability for quality of care
- closer working and alignment with NHS Improvement and other partners so that providers experience less duplication.

This year's State of Care report showed that, despite increasingly challenging circumstances, much good care is being delivered and many services have improved. However, it also painted a varied picture of quality, with some evidence of deterioration and some providers struggling to improve their rating beyond 'requires improvement'. Safety continued to be our biggest concern across all sectors – often influenced by the quality of leadership.

CQC has an important role to play in encouraging improvement and sustainability, and we will continue to highlight good and outstanding care and to share our unique insight. Where we have evidence of poor care, and the fundamental standards of care set out in our regulations are not met, we will take regulatory action. Again, we want to encourage improvement in the quality and safety of care, but we will take action to protect people where necessary.

We are considering what more we need to do when a provider has been unable to improve from a 'requires improvement' rating. We also want to explore how we might recognise a provider that has made improvements, but has not yet managed to move from a 'requires improvement' rating to a 'good' rating or from a 'good' to an 'outstanding' rating. We will include further details on this in our consultation in Spring 2017, which will also focus on how

we will regulate adult social care and primary medical services, and include further detail on the changes we want to make to how we register providers.

Alongside this current consultation, we are consulting jointly with NHS Improvement on our approach to leadership and use of resources in trusts. We would encourage trusts to read both consultation documents before responding.

This consultation seeks your views on specific proposals for:

1. how we will regulate new models of care and complex providers
2. changes to our assessment frameworks across all sectors, and including an updated well-led key question for health services, which has been developed jointly with NHS Improvement
3. how we will register services for people with learning disabilities
4. how we will regulate NHS trusts and foundation trusts (referred to throughout as trusts) from April 2017, including how we might change our approach to rating.

Sections 1 and 2 of this consultation apply to all providers. Our Spring consultation will include the detail of how we propose to regulate adult social care and primary medical services.

When we publish our final assessment frameworks next year, we will make them available as online information, as well as documents. This will mean you can find the information you need by searching or navigating our website on whichever devices you use, as well as printing or saving the information to share with colleagues. The information will be in sections of the website for each type of service we regulate so that services and staff can easily access the information relevant to them. We will clearly show which information is generic to all services.

We are grateful for your feedback on this consultation, which closes on **14 February 2017**. See page 35 to find out how to respond.

1. Regulating new models of care and complex providers

Our inspections have found that many health and care services in England are providing good quality care despite a challenging environment, but that substantial variation remains. Maintaining quality while demand increases and budgets are under pressure is going to be challenging, even for the best-led services. Some local areas are responding by starting to shift towards new models of providing care.

National initiatives, such as the Sustainability and Transformation Plan process, devolution and the new care models programme, are supporting and enabling progress. However, we also know there are many commissioners and providers, beyond these national programmes, that are innovating and collaborating to improve care for the people they serve. CQC understands and supports these changes. We need to be flexible so that we continue to assure quality, encourage improvement and give people the information they expect from the regulator.

We know that innovation and change can lead to periods of uncertainty. We will support providers during this period, and make sure that regulation is not a barrier to innovation. In order to help us achieve that, we will expect providers to have clearly thought through how they will maintain quality through a period of transition, and how they will manage any identified risks to people who use services. In any new and complex models of care we will want to establish who is accountable for the provision of care. Our focus will continue to be on assessing the quality and safety of frontline services and providing information that is meaningful for the public.

CQC already regulates diverse and complex organisations, including trusts that provide services that span hospital care, community services, primary care and adult social care ('combined trusts') and corporate providers in health and adult social care – some of which provide diverse and geographically dispersed services across sectors. Our regulatory approach to combined trusts has been guided by six aims, outlined in our current sector provider handbooks. These aims continue to be relevant, and we have developed them further into a set of principles that will underpin our future approach to all types of complex providers, including new models.

Our principles

We have developed a set of principles to guide our approach to regulating in a changing landscape of care provision:

1. We will always take action to protect and promote the health and well-being of people using services where we find poor care.
2. We will hold to account those responsible for the quality and safety of care.
3. We will be proportionate, and will take into account how each organisation is structured and its track record to determine when and how to inspect.
4. We will align our inspection process, where possible, to minimise complexity for providers that deliver more than one type of service.

5. We will be transparent about our approach and about how we make regulatory decisions.
6. We will not penalise providers that have taken over poor services because they want to improve them.
7. We will deliver a comparable assessment for each type of service, regardless of whether it is inspected on its own or as part of a complex provider.
8. We will rate and report in a way that is meaningful to the public, people using services and providers.
9. We will bring together inspectors who have specialist knowledge of different sectors to inspect jointly, where this is most appropriate for the provider.

Many of the changes we are consulting on in this document, and the consultation we have planned for Spring, are designed to support the changes we see providers making.

Registration

Registration represents the start of the regulatory relationship and is the beginning of a process where providers commit to delivering care to defined quality and safety standards. If we do not register a provider correctly, it will affect our ability to monitor, inspect and rate a service and take regulatory action in the future.

Since starting our new approach to inspection across health and social care in 2014, we have seen that good leadership is critical in ensuring that people receive safe, high-quality care in a way that is sustainable. Apart from our assessments of trusts, we have focused our attention on leadership at the individual service level. But if we are to truly encourage improvement, innovation and sustainability in care in a way that maximises our efficiency and effectiveness, we need to consider whether this is always the right approach.

Some of the emerging models of integrated care and existing large and complex organisations present challenges for our current approach to registration. We therefore need to make sure that providers are clear about who has accountability for quality and that, where relevant, we adequately reflect the role of head office or board-level leadership when registering these types of organisation.

We will be working with stakeholders to develop proposals for consultation in Spring 2017 about how we can change the way we register providers at the level of the organisation's 'guiding mind' to better reflect new and more complex organisational structures. Currently the way we register providers is not always flexible enough; for example, our use of physical locations is more relevant for care homes than online providers.

We encourage any provider who is thinking through a change to let us know early in the process so we can offer support where it is needed. We want to build and maintain ongoing relationships with providers so that we are able to provide advice where changes to registration status are needed. We also expect providers to ensure that their Statement of Purpose is up to date at all times, as this is a core document that enables CQC to offer a consistent and coordinated approach to regulation.

Some innovations will not require changes to a provider's registration status, but we want to encourage providers to tell us about any innovative practices they are adopting, including by

using an improved provider information return and better ways to provide and update information through our online portal. This will help CQC take account of these changes, for example in our schedule of inspections across sectors. We will encourage improvement by recognising and reporting the innovations we find, while making sure that care continues to be safe, effective, caring, responsive and well-led.

Assessment framework

We have previously published 'handbooks' for providers that set out how we regulate and inspect each sector, which resulted in 11 separate handbooks and accompanying assessment frameworks (key lines of enquiry, prompts and ratings characteristics) for specific types of service.

To reflect the way providers are changing, we now propose to move from 11 separate assessment frameworks to just two – one for health care, and one for adult social care. We will continue to provide additional sector-specific material, such as core service inspection frameworks (currently used for acute hospitals) and brief guides (currently used for specialist mental health services).

We think this will reduce complexity and confusion for providers that deliver more than one type of service, for example, a trust that delivers acute or mental health care and community health services, and also runs several care homes. We want to ensure that our end-to-end approach from registration through monitoring and inspection to rating and reporting provides a single high-level process that can be tailored to individual providers.

Inspection

Our inspection teams will continue to specialise in a particular type of service, and inspections will still involve professional advisers and, where appropriate, people who have personal experience of using services (Experts by Experience). When a provider delivers a wide range of services or a more integrated model of care, we need to be able to bring these specialist inspection teams together, and a single high-level process will enable us to do this.

We are also exploring how we can schedule our activity in a way that recognises where providers are working together in less formal partnerships or as an entire local health and care economy. This would enable us to offer a coordinated approach to inspections in a local area or to provide a broader assessment of the quality of care in a place. We are continuing to develop and test approaches to assessing the quality of care for specific population groups or areas, through our thematic inspection activity and our quality in a place pilots.

Rating

As services become larger and more complex, with a mix of service types delivered at different scales, we need to consider how best to present our ratings at overall organisational level. We do not currently produce an organisational level rating for any provider other than trusts, but we may wish to in the future. The assessment of leadership, through our well-led key question, will be of particular interest to us for such new or complex models, given its

significance for the sustainability, quality and safety of services. At the same time, we have been clear in the principles we have set out that we will not penalise providers that have taken over poor services because they want to improve them. We therefore need to consider how to ensure that an overall organisational level rating does not act as a disincentive. We describe these challenges in the context of trusts in section 4 and ask for views.

Our consultation in Spring will seek further views on how we register and rate new models of care and complex types of providers, in line with the principles we have set out here.

Consultation questions

1a Do you think our set of principles will enable the development of new models of care and complex providers?
[Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]

1b Please tell us the reasons for your answer.

2. Our assessment framework

This section describes the changes we are proposing to our assessment frameworks across all the health and adult social care services that we regulate. Our assessment frameworks include our five key questions, the key lines of enquiry (KLOEs) and prompts, and ratings characteristics.

Our proposals (set out in Annex A1 for healthcare services and Annex A2 for adult social care services) are intended to support the implementation of our strategic priorities by more closely aligning our assessment frameworks for all sectors, enabling providers to more easily understand what we expect of them. They are also intended to reflect new or emerging themes in health and social care, such as the increasing integration of care and the use of technology to enhance care delivery.

Where we have evidence of poor care and the fundamental standards of care set out in our regulations are not met, we will take regulatory action. We want to encourage improvement in the quality and safety of care, but we will take action to protect people where necessary.

Why we propose changes to our assessment framework

Care providers and other oversight bodies welcomed the clear way that we assess quality by asking each service the same five key questions: Is it safe, effective, caring, responsive and well-led? Some providers have aligned their own governance processes around these questions. We are not proposing a significant shift in what we already ask of providers; rather, our proposals for change represent an evolution of our framework.

Our proposals are intended to **strengthen** our assessment by:

- reflecting changes in the sectors
- incorporating what we have learned over the past three years and from new good practice guidance
- using the feedback we have received from internal and external stakeholders.

Our proposed changes are not intended to 'raise the bar' or make it more difficult for providers to achieve a good or outstanding rating. The majority of content is very similar to the frameworks we introduced in 2014. However, CQC's role in encouraging improvement means that we will look to providers to be able to demonstrate how they are developing and adapting to new evidence of good practice as well as the changing care landscape to improve the quality of that care.

The proposals are also intended to **simplify** the process by more closely aligning the questions we ask of different sectors and the characteristics that reflect a rating. A simpler process will reduce the regulatory burden on providers that deliver care across traditional health and social care boundaries, by working better with shared governance systems. It should also make it more straightforward for providers to respond to our regulatory requests and for statutory and local groups to collect evidence to support our work.

Our assessments of combined providers and new care models, and thematic or place-based inspections will also be made simpler, and our internal systems and processes will be more efficient. The proposed changes will also support our strategic priority, shared by our stakeholders, to promote a single shared view of quality – a consistent approach to defining and measuring quality and to collecting information. Through greater alignment of our frameworks, we will move closer to agreeing a definition of quality based around our five key questions, which means we can be clear and consistent about how we assess the quality of care across different types of service.

In our strategy for 2016 to 2021 we also committed to improving our registration process by using a framework based around our five key questions. The revised framework will inform the evidence that we will look for when registering providers, making the links between registration and the rest of our operating model more explicit.

We recognise that some providers and other stakeholders may have developed internal quality assurance or monitoring processes that reflect our current assessment framework and that any change to our framework may require these to be updated.

We have made some minor wording changes across the frameworks for clarity of language, which are not explicitly highlighted in our consultations proposals. However, we have made clear where we have introduced new KLOEs or prompts, made significant changes to wording of existing KLOEs or prompts, or moved a prompt or KLOE between key questions. We will also make this clear when we publish the final versions, so that it will be straightforward to update any systems that providers may be using. The changes we have made to the ratings characteristics reflect the changes we have made to the KLOEs or prompts.

The changes we propose

One overarching framework for health care and one for adult social care

We have combined 11 sets of KLOEs, prompts and ratings characteristics that we have been using for each different type of health and social care service into two overarching frameworks: one for healthcare services, and one for adult social care services. We have retained these two separate frameworks to reflect that, while the types of care provided are not mutually exclusive, the purposes, settings and nature of care are sufficiently different to require a different focus in our assessments.

We have reviewed common themes across both the health and adult social care sectors to ensure that they are assessed under the same key question (unless there is a clear rationale for why they should be different). Where possible, we use common or similar wording. The majority of the KLOEs, prompts and ratings characteristics in each of the two frameworks will be relevant to all health or adult social care sectors[1] and we have made some wording more

1. **Healthcare** includes: NHS and independent acute hospitals, community health services, specialist mental health services, hospice services, NHS and independent ambulance services, specialist substance misuse services, NHS GP practices and GP out-of-hours services, NHS 111 services, primary care dental services, independent doctors (non-hospital acute services), independent doctors (primary medical services). **Adult social care** includes: community and residential adult social care services.

generic to achieve this. The only sectors that are not covered by the revised frameworks are those that we inspect jointly with other organisations.[2] We will continue to develop additional sector-specific material, such as core service inspection frameworks (currently used for acute hospitals and ambulance services) and brief guides (for specialist mental health services), which clearly link to the overarching frameworks.

There are some types of providers that we regulate but do not currently rate, including primary care dental services, independent doctor services, independent substance misuse services and some independent community services. For these services, our inspectors will use the KLOEs and prompts in the healthcare framework to ensure consistency in our judgements about the quality of care. We recognise that not all of the KLOEs and prompts will necessarily be applied in all settings. We will only use the ratings characteristics for services that we rate.

Hospices assessed under the new healthcare framework

Since 2014, hospices for adults and children have been assessed using the adult social care methodology and assessment framework. However, feedback has suggested that this arrangement is not satisfactory because of the varying nature and complexity of the services, the care pathways involved and the extent of clinical knowledge and experience required to inspect them. A report by the former National Clinical Director for Children, Young People and Maternity at the Department of Health on CQC's new approach to inspection in 2014 recommended that children's hospices would sit better within the portfolio of the Chief Inspector of Hospitals or Chief Inspector of General Practice. However, as the new inspection approach had just started, we decided not to make any changes at that time.

In early 2016, CQC created a national team of inspectors with the specialist knowledge and understanding required to assess hospices. In 2017/18, after we have completed the first round of inspections under our current model, we will start assessing hospices under the healthcare assessment framework and they will become part of the responsibility of the Chief Inspector of Hospitals.

In moving hospices to the Hospitals portfolio, we propose to make a minor administrative change to the definition section of our fees scheme. The change is to describe hospice providers as providers of 'healthcare services' rather than as providers of 'care services'. Our proposal to make this simple, technical amendment to the scheme is to better reflect the changed emphasis of how we will assess hospices in future. This change will have no impact on the current hospice fee bands or charges. If you wish to make any comments about our proposal to amend the definition of hospices in our fees scheme, please send them to: hospicefeesconsultation@cqc.org.uk

2. This includes health and social care services provided in prisons and young offender institutions, and health care in immigration removal centres, police custody centres, secure training centres and youth offending teams in the community. We conduct this work with HMI Prisons, HMI Probation, HMI Constabulary and Ofsted.

Our five key questions

We will continue to use the five key questions in our assessments of quality, and we will give each question equal weight. While our focus for all of the key questions will remain broadly the same, we have made particular changes to aspects of some key questions to improve and strengthen our focus on the provision of safe, high-quality care, based on the learning from our inspections so far.

Safe

We are not proposing to make any changes to the focus of the safe key question, which looks at whether people are protected from abuse and avoidable harm. As the area where our inspections have highlighted the greatest concerns to date, safety will be an important focus of our future targeted approach. We have used the learning from our inspections to strengthen a number of elements of safety, including recruitment practices, safeguarding, discrimination, medicines management, information sharing and management, and responding to external alerts and reviews.

Effective

We are not proposing to make any changes to the focus of the effective key question, which looks at whether people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence. We have strengthened some elements of effectiveness, as detailed in the section on new and strengthened themes below.

Caring

In our current assessment frameworks, the caring key question focuses on compassion, kindness, involvement and emotional support, with interaction between staff and people using services tending to be a key factor. While the kindness of staff is a vital aspect of how caring the service is, we have also strengthened our assessments to look at how the service supports a caring culture. We have amended the KLOEs to reflect this, and in doing so have improved the alignment between health and adult social care. We now have three KLOEs in health and adult social care that cover:

- how staff treat people
- how the service supports people to express their views and be involved in decision-making
- how people's privacy and dignity is respected and promoted.

Responsive

In our current healthcare frameworks, the responsive key question includes the assessment of both service planning for population needs and being responsive to individuals and groups of people with specific needs (such as people with complex needs or in vulnerable circumstances). We received feedback that this was confusing, so we have removed service planning for population needs and moved this into well-led. This means we are clear that a responsive health or adult social care provider is one that delivers services that meet people's individual needs (including those with specific needs). A well-led healthcare provider is one that is organised and that plans for the benefit of the population it serves.

Well-led

We are proposing a new single framework for well-led for all healthcare providers, which we have developed jointly with NHS Improvement as part of our commitment to promoting a single shared view of quality. In strengthening our assessment of well-led, we are clear that there is a demonstrable link between leadership, culture and the delivery of safe, high-quality care, and our focus on well-led is intended to support and reinforce this link.

The well-led framework for healthcare providers includes changes to the structure of KLOEs, increasing the number from five to eight. The changes are intended to allow us to support a clearer and more detailed assessment of well-led, especially for larger organisations, and to better align with NHS Improvement's approach. We intend the KLOEs to apply across all healthcare services, but recognise that not all of the prompts will necessarily be applied in all settings, for example small GP practices.

We have included a number of new prompts within the well-led framework for all healthcare providers, and made changes to the wording of existing prompts. The changes have been made to align our approach across the health sectors, to make our assessment approach clearer, and to reflect developments in policy and practice. In addition to the themes highlighted below, the updated framework reflects recent research on culture, improvement systems and leadership behaviour. The framework has also been aligned to the principles articulated in *Developing People – Improving Care: a national framework for action on improvement and leadership development in NHS-funded services* published on 1 December 2016.

The well-led framework for healthcare providers now also includes a clearer emphasis on ensuring the sustainability of services, reflecting the approach set out by the National Quality Board in its forthcoming Shared Commitment to Quality.

We have also updated the well-led framework for adult social care providers, aligning this where possible with the healthcare framework. The majority of adult social care providers will require a different approach to that for a healthcare service and so, while we have largely aligned the adult social care framework at the KLOE level with the healthcare framework, the underlying prompts draw out what each KLOE means across the breadth of the adult social care sector.

Furthermore, in our strategy for 2016 to 2021, *Shaping the future*, we said we want to improve our local activity by better understanding leadership at the head office or 'guiding mind' across more complex services, and how this affects quality where providers operate across multiple sites. Aligning the adult social care well-led framework with the healthcare framework is an important first step towards achieving this, especially as many of the larger providers span the traditional boundaries of health and social care in the services they deliver.

Greater alignment of the adult social care KLOEs, prompts and characteristics

The characteristics that inform adult social care ratings have been revised to clarify how they relate to each of the KLOEs and associated prompts and to reflect what we have learned over the last two years of inspections under the new approach. This does not represent a shift in terms of the 'bar' that providers must reach for each rating. But it does mean we can be much

clearer on what good and outstanding practice looks like, based on evidence from our inspections and on what people have told us through engagement and co-production. Providers, commissioners, inspectors, people who use and want to choose services, and the wider public should find that the revised characteristics bring greater clarity to our expectations of what good-quality care looks like.

The introduction of new and strengthened themes

We considered a range of proposals on new themes that we could include in the assessment framework, or themes that could be strengthened. We used the following principles to decide which proposals to include in our overarching assessment framework:

- High level and generic: our frameworks should be relevant to the majority of sectors in health or social care, have longevity and reflect the broad health and social care landscape. They should not be so specific that innovation is stifled or they go out of date too quickly.
- Proportionate: we should avoid duplicating themes over several key questions.
- Mandatory: all KLOEs should be mandatory to be assessed in an inspection of the relevant key question unless they are not applicable, for example because of the type of service being provided, or the context or premises care is provided in.

We will further consider the proposals that did not meet these principles for inclusion in sector-specific material, such as core service inspection frameworks (currently used to support our assessments of acute hospital services).

We have introduced six new and strengthened themes in our assessment framework (the codes provided refer to KLOEs or prompts in Annex A1 and A2):

System leadership, integration and information-sharing

As the Five Year Forward View sets out, better outcomes for patients will be delivered by sustainable organisations operating as part of successful health economies. Providers need to collaborate with each other and work across their local system to find ways to improve the quality and sustainability of services. It is increasingly vital that organisations are well-led within the context of local systems.

Providers are also changing the way they deliver services, breaking down the boundaries between hospital care, community and primary care services, and adult social care services, and developing new models to deliver person-centred care. A central focus for many of these new models is working collaboratively with external partners to understand and plan for the needs of people who use services and to integrate services to improve how people experience care.

To reflect these developments and to encourage information-sharing and coordinated care, both within and across services, organisations and local health economies, we have strengthened and added several KLOEs and prompts as follows:

- safe (healthcare S4.3, S6.2)
- effective (healthcare E4 and adult social care E5 – new prompt)

- responsive (healthcare R2.6 – new prompt)
- well-led (healthcare W2.5 – new prompt, W4.4, W7.4 – new prompt, and adult social care W5.1 and W5.2 – new prompt).

Information governance and data security

Having secure access to valid, robust and relevant information underpins the efficiency and effectiveness of all health and social care organisations. While there is widespread commitment across providers to keep data secure, we know there are areas where more can be done to protect against potential risks. In July 2016 we published the report on whether personal health and care information is being used safely and is appropriately protected in the NHS, and we committed to strengthening our assessment framework in relation to information governance. We have made changes as follows:

- safe (healthcare S4 – existing prompts from safe and effective have been merged into a single KLOE, and adult social care S1.6 – new prompt)
- well-led (healthcare W6.7 – new prompt, and adult social care W2.8).

Technology

Services are increasingly innovating, using technology and digital services to deliver care that is efficient, accessible and more person-centred. We have widened the applicability of some prompts to other service types, and added prompts as follows:

- effective (healthcare E1.3 – new prompt also now applicable to GPs and NHS 111, and adult social care E4.5 – new prompt)
- responsive (healthcare R3.8 – new prompt, and adult social care R1.6 – new prompt)
- well-led (healthcare W6.5 – new prompt, and adult social care W4.6 – new prompt).

Medicines

Medicines are the most common form of healthcare intervention in all care settings and are crucial to almost all care pathways. We have found through our inspections across different types of services that where services have problems with safety, we often find problems with how they manage medicines. We have therefore strengthened our assessment of a provider's systems, processes and practices to ensure proper and safe handling of medicines as follows:

- safe (healthcare S3 – new KLOE and prompts, and adult social care S4.6 – new prompt added to the pre-existing KLOE).

End of life care

Delivering good quality care at the end of life is integral to many services that CQC regulates across health and adult social care settings, including hospitals, community health services, GPs, hospices and care homes. In May 2016, we published our thematic review of inequalities in end of life care, which found that many people face continuing inequalities at the end of their life. We committed to strengthening our regulatory approach across sectors to encourage improvement in the quality of care at the end of life for everyone, including people from equality groups and people whose circumstances may make them vulnerable. In July 2016, the Government published its commitment that every person approaching the end of

their life receives care that is personalised and focused on their individual needs and preferences. We have reflected the importance of good end of life care as a key component of good quality health and social care through changes to our assessment framework. End of life care continues to be a core service in our inspection approach for acute hospitals and community health services. We have strengthened our assessment in this area as follows:

- responsive (healthcare R2.9, R2.10 and R2.11 – new prompts, and adult social care R3 – KLOE moved from caring and added three new prompts).

Personalisation, social action and the use of volunteers

Personalisation, social action and the use of volunteers can improve the quality of care and overall outcomes for people who use services. Healthcare systems that are organised around supporting people's lives and involving families, carers and social networks, can release the full potential of communities in supporting people's health and well-being. Reflecting the focus already present in our adult social care assessments, we have strengthened our assessment in healthcare settings of community and advocacy, and how services are coordinated to support this as follows:

- effective (healthcare E3.7 – new prompt)
- caring (healthcare C2.3, C2.4)
- responsive (healthcare R2.7, R2.8 – new prompt).

Change to the key question for consent and the Mental Capacity Act

The Mental Capacity Act (2005) (MCA) is a crucial safeguard for the human rights of adults who might (or may be assumed to) lack mental capacity to make decisions, such as whether to consent to proposed care or treatment. We have retained a specific KLOE on consent, which takes account of the requirements of the MCA and other relevant legislation. This KLOE has been part of the effective key question in all sectors since the introduction of the assessment frameworks in 2014. The legal authority for intervening in someone's life in a health or care setting is consent, or if the person lacks the mental capacity to make the relevant decision, a best interests decision. Effective practice in this area is linked to good outcomes for people in this regard. However, it may fit better with the responsive key question, to reflect the importance of services being responsive to each person's capacity, wishes and interests. We have made this change in our proposals, but acknowledge that a case could be made for either key question and there are disadvantages to moving this KLOE in terms of comparability of ratings over time. We welcome views on this potential change.

Other new priorities

As well as the themes above, we have also strengthened, or made more explicit, our assessments in a number of other areas. We have increased our emphasis on equality for staff as an important issue relating to the quality of care across the well-led key question. We have expanded the relevance to all health sectors of a KLOE that was previously only in the assessment framework for GPs, which asks how the provider supports people to live healthier lives and improve the health of their population (E5). For acute hospital services only, we have added a prompt on the availability of seven day services, to support this national priority (E4.5).

When will we introduce the revised frameworks?

We will introduce the revised assessment frameworks over a phased period, to align with the introduction of our next phase inspection methodology:

Sector	Implementation date
NHS and independent acute hospitals Community health services Specialist mental health services Hospice services NHS and independent ambulance services Specialist substance misuse services Independent doctor services (non-hospital acute services)	from April 2017
Community adult social care services Residential adult social care services	from July 2017
NHS GP practices and GP out-of-hours services NHS 111 services Independent doctor services (primary medical services)	from October 2017
Primary care dental services	from April 2018

Consultation questions

2a Do you agree with our proposal that we should have only two assessment frameworks: one for health care and one for adult social care (with sector-specific material where necessary)?
[Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]

2b Please tell us the reasons for your answer.

3a What do you think about our proposed changes to the key lines of enquiry, prompts and ratings characteristics?

3b What impact do you think these changes will have (for example the impact of moving the key line of enquiry on consent and the Mental Capacity Act from the effective to the responsive key question)?

3. Registering services for people with learning disabilities

In October 2015, NHS England, the Local Government Association and the Association of Directors of Adult Social Care Services published a national plan (*Building the Right Support*) that stated the intention to develop community services and to close inappropriate inpatient facilities for people with a learning disability and/or autism. The plan also contained a service model for health and social care commissioners.

In our 2015 reports, *A Fresh Start for Registration* and *State of Health and Adult Social Care in England 2014/15*, we made a commitment to take a firmer approach to the registration and variation of registration for providers who support people with learning disabilities. In February 2016, we published *Registering the right support* to set out our expectation that providers would have regard to the national plan and service model when developing services for people with learning disabilities. It also set out the factors that would make it more likely that we would refuse applications to register or vary registration.

We now have eight months' experience of applying the policies in this guidance and are using our experiences, legal advice, and some helpful challenge from providers to develop the guidance to ensure providers are clear about our expectations and our commitment to the national plan and service model.

A legal review of the guidance found that, while clearly intended to encourage providers to make the right choices when developing services in accordance with national policy, the language used in the guidance was open to interpretation. For example, providers were asked to "have regard to" *Building the Right Support* and accompanying service model. This opened up the possibility of CQC receiving applications from providers that had taken *Building the Right Support* into account in their decision-making processes, but did not design their services to reflect the guidance.

We have therefore revised our guidance to strengthen our policy position and make it clear that we expect providers to comply with the national plan and accompanying service model. We have done this by:

- Being clear that providers who apply to register services in new premises that do not comply with *Building the Right Support* and other key national policy or good practice guidance may find that registration is refused.
- Setting out our legal powers through which we will decide to refuse such registrations.
- Demonstrating that we understand the current challenges within commissioning in health and social care, but being clear that we will not compromise on what 'good' looks like (as defined by *Building the Right Support* and other national guidance).
- Strengthening the language used in the case studies to show where applications are likely to be refused and which regulations would apply.

- Defining 'small-scale housing' as housing for six or fewer people using services, therefore adopting the NICE Guidance, *Autism spectrum disorder in adults: diagnosis and management* (2012).

Our revised *Registering the right support* guidance can be found at the separate Annex B to this document.

Consultation question

4 We have revised our guidance *Registering the right support* to help make sure that services for people with learning disabilities and/or autism are developed in line with national policy (including the national plan, *Building the right support*). Please tell us what you think about this.

4. Next phase of regulation – NHS trusts

This section describes our proposed changes to how we regulate and inspect NHS trusts and foundation trusts (referred to throughout as trusts), and how we propose to implement our new approach. This includes acute, mental health, community and ambulance NHS trusts. It builds on what we set out in our strategy and reflects what we have learned from our comprehensive inspections and the feedback we have had from the public, people using services, providers, other stakeholders and CQC staff over the last three years. Where possible, we have also trialled elements of our new approach in recent inspections to inform these proposals.

The changes we set out in May in *What our strategy means for the health and adult social care services that we regulate* represent an evolution of our approach, building on the information we now have about the quality of all trusts across England, a more comprehensive baseline of quality than we have ever had before. Our strategy set out our plans for a more responsive, collaborative, targeted approach. In NHS trusts we are proposing to focus our inspections on those core services where we have greatest concerns or where we believe quality might have improved. Our inspections will continue to look at all five key questions at core service level and, as the area where our inspections have so far highlighted the greatest concerns, safety will inevitably be an important focus. Where we find care that falls below fundamental standards we will always follow this up and take regulatory action where required.

In addition to the core services at a trust that we select to inspect (and we will inspect at least one core service approximately annually), we are also proposing to assess the overall leadership of the trust based on our learning of the importance of leadership for the delivery of safe, high-quality care. This will include an assessment of how well trusts assure themselves that basic systems underpinning safe care are in place, for example learning from incidents. These changes are designed to enable CQC to continue to make sure services provide people with safe, effective, compassionate, high-quality care and to encourage improvement by introducing:

- A more responsive, intelligence-driven approach to regulation, with improved monitoring and inspection activity focused where risk is greatest or quality is improving.
- An increased focus on leadership, based on the evidence that effective leadership and a positive, open culture are important drivers for improvement and the delivery of safe, high-quality care.
- Closer working with NHS Improvement to increase alignment and reduce duplication, and support trusts to meet the dual challenges of quality and efficiency.
- Improving our own efficiency and effectiveness by rationalising our processes.

We have now inspected every trust in England and will complete the first phase of our inspections of most independent healthcare providers during 2017. We intend to start inspections using our next phase approach for the majority of providers in the independent sector in 2018/19. We anticipate the main elements of our regulatory approach will be the same for all providers, regardless of whether they are NHS or independent. However, this

section of the consultation is solely for NHS trusts. We will continue to work closely with independent providers to agree the timing and nature of any changes, and will consult as appropriate during 2017/18.

Working with NHS Improvement

We are working closely with NHS Improvement to support trusts to give patients consistently safe, effective and compassionate care within local health systems that are financially and clinically sustainable.

CQC and NHS Improvement are committed to working together to support strong leadership and governance, and to recognise that effective use of resources is fundamental to enable trusts to deliver and sustain high-quality services for patients. A joint consultation being published in parallel describes in detail how we will work with NHS Improvement on these two aspects. Trusts should refer to that document when considering the proposals in this consultation.

Summary of proposed changes

The nature and timing of our interactions with trusts is evolving, and the changes to our monitoring and inspection activity are intended to reduce the overall time required from trusts in their interactions with us. In particular, we are shifting our emphasis by strengthening our ongoing monitoring and relationship management, and adopting a more targeted approach to inspections – carrying out far fewer comprehensive inspections. Figure 1 summarises our new approach.

Provider information request

Our new provider information request (PIR) will not be as detailed as the current one, to reduce the reporting requirements on trusts. For example, we are unlikely to request provider policies, or information that is available from other sources, such as Hospital Episode Statistics (HES) data or national audits. This will reduce the number of information items we request overall, in line with our more targeted and tailored approach. We will hold an internal planning meeting using the PIR information to determine our inspection activity.

Inspection and reporting

We will inspect every trust regularly, and are moving to a more targeted and tailored approach to inspection where we focus on core services and the leadership of a trust. Our regular scheduled inspections will include at least one core service – assessed against all five key questions. In addition, we will always include an assessment of well-led at trust level approximately annually. As the area where our inspections so far have revealed the greatest concerns, safety will inevitably be an important focus.

This means we will only carry out comprehensive inspections (where we simultaneously inspect all core services with a large inspection team) for newly registered providers or where we have significant concerns. Our inspections will be built on previous inspection findings and ratings, or using wider intelligence about the quality of care defined in our new CQC Insight model (see below) and information gathered through our relationship management activities.

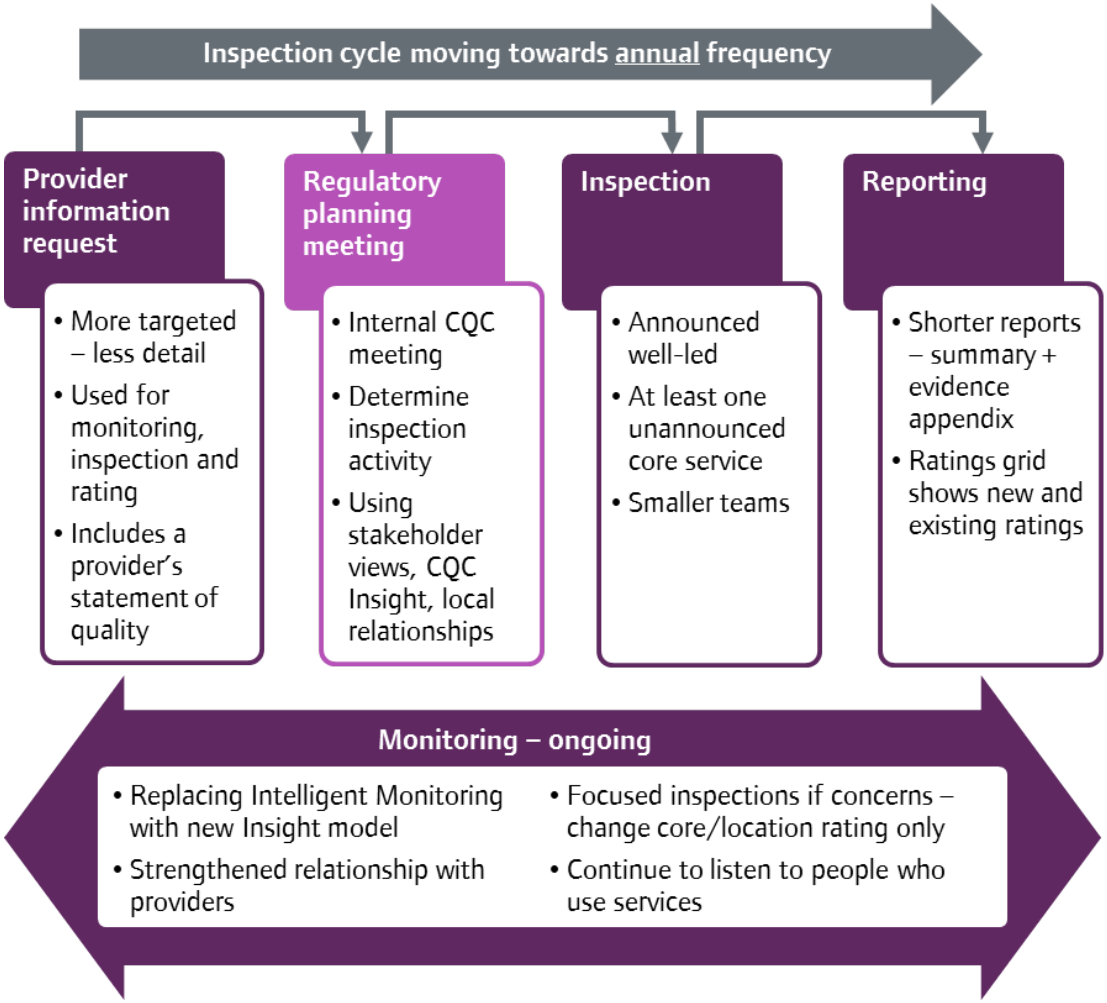
Once our new approach is fully embedded we will move to an approximately annual cycle, although the time of inspection will vary for a trust year-on-year.

Our inspection teams will continue to include specialist advisers and, where appropriate, Experts by Experience. Unless we are carrying out a comprehensive inspection, our focus on one or more core services and the trust's leadership means that the overall team involved in inspection will be smaller. We will produce timely, shorter, more succinct reports that will be quality assured and published with a revised rating grid consisting of new and existing ratings, and supported by a separate evidence appendix.

Monitoring

Our ongoing monitoring activity[3] will inform inspection activity as well as reports and ratings. It will also be used to identify new concerns and improvement. Where we take enforcement action or need to respond to a new concern we will continue to carry out a focused inspection that looks at the specific concern.

Figure 1: Our approach to monitoring and inspecting NHS trusts (acute, community, mental health and ambulances)



3. Including regular Mental Health Act monitoring visits to places where people are detained under the Mental Health Act 1983. Such visits are a requirement of CQC's duties under the Mental Health Act itself and as a part of the UK's National Preventive Mechanism against torture, inhuman or degrading treatment.

The changes we propose

Monitor

Introduction of CQC Insight

We are replacing our Intelligent Monitoring with the introduction of a new Insight model. The model has been designed to identify potential changes to quality since the previous inspection and will look at different organisational levels of data – for example, at trust level, and service location, core service and key question level. The Insight model builds on what we have learned from the Intelligent Monitoring model. It will include a number of the indicators that were used in Intelligent Monitoring but also use a wider range of data sources. For example, in addition to national datasets we will build in qualitative information from people who use services, from relationship management, from national partners and from the new style provider information request, which is described below. It will be updated regularly and will provide our inspectors with more timely information about a provider's performance.

CQC will use this information to support how we monitor services, to highlight improvements in outcomes or risks to quality of care. We will use the intelligence to inform our decisions about when and what to inspect, as well as to support our findings and ratings when we report. Providers will be able to access their own Insight dashboard and we will also share outputs with key system partners, including NHS Improvement and NHS England.

Current approach to monitoring	New approach to monitoring
Intelligent Monitoring • Focused set of indicators • Updated 2-3 times a year • Used to decide when to schedule inspections only	**CQC Insight** • Wider set of information sources and indicators including more qualitative information • Updated regularly • Presents information at trust, location, core service and key question level • Focuses on changes since the previous rating – improvements and areas of risk

Strengthened relationship management

Strengthening how we manage our relationships with providers is key to reaching a single shared view of quality. We will have more regular contact with trusts and key partners, such as NHS Improvement, NHS England and Healthwatch, throughout the year. Our approach will be developed in collaboration with them to ensure we avoid duplication, share appropriate information and minimise the requirements we make of providers where possible.

This is largely a shift of emphasis; rather than focusing all our activity around a single comprehensive inspection, this regular contact will be an opportunity to share information in a more timely and manageable way. Equally, activities that previously formed part of inspections, such as focus groups with staff, will be arranged during the year, rather than at a single time during inspection. This should build on the relationships we have already

established with trusts and develop more mature relationships so that providers feel they can be open and highlight challenges or concerns as they occur. We will continue to ensure, however, that we maintain our independence and scrutiny as the regulator, on behalf of people using services.

Current approach to relationship management with providers	New approach to relationship management with providers
• Regular engagement meetings • Additional focus on engagement around the point of comprehensive inspections	• Regular engagement meetings to continue building openness and transparency to enable providers to be open and highlight challenges or concerns as they occur • Evidence gathering throughout the year (e.g. focus groups with staff, observations of patient settings) in addition to engagement meetings

Provider information requests

We are replacing the two-part provider information request (PIR) initiated 20 weeks ahead of a comprehensive inspection with a more streamlined request for information that will be required, on average, once a year for each provider. It will enable providers to set out their view of the quality of care they provide, as well as to provide a focused set of information relating to well-led and for each of the core services we rate. The new PIR will not be as detailed as the current one, to reduce the reporting requirements on trusts. For example, we will not request data that is available from other sources, such as HES data or national audits. Only information that supports CQC's monitoring, inspection and rating of services will be requested, and the information returned will be added as an important source to the Insight intelligence model described above. Additional items of information may still be required and collected as part of the inspection, but will be fewer in number in line with our more targeted and tailored approach.

Providers will be asked to set out their view of the quality of services against the five key questions, including changes in quality since their last inspection. Alongside the statement of quality, providers will be asked to supply a limited amount of key information not otherwise available through national datasets – for example, indicators of quality for location and core service levels.

To support CQC's assessment of well-led, trusts will also be asked to use the PIR to report information about their leadership, governance and organisational culture, against the new well-led KLOEs.

We aim to keep additional information requests from providers to a minimum, although we anticipate some additional requirements are likely to occur following inspection activity, led by our observations and findings. In addition, we plan to move to a single online collection mechanism. Providers will use this to submit and update information needed for both CQC monitoring and inspection and to help NHS Improvement identify support needs under its Single Oversight Framework.

Current approach to PIRs	New approach to PIRs
Provider information request before a comprehensive inspection • Two-part request • Sent 20 weeks before inspection • Detailed, large request with significant number of documents required	**Routine provider information request** • On average, an annual request • Focused on key information for well-led and each of the core services • Providers to describe their own quality against our five key questions

Consultation questions

5 What should we consider in strengthening our relationship management, and in our new CQC Insight approach?

6 What do you think of our proposed new approach for the provider information request for NHS trusts?

Inspect

Our future inspections will be more intelligence-driven and targeted. They will include at least one core service and an inspection of the well-led key question at trust level approximately annually. We will only carry out comprehensive inspections (where we simultaneously inspect all core services) for newly-registered providers or where we have significant concerns. We will use the most recent ratings for a trust to inform the number of core services that would be inspected during the yearly inspection programme. This will mean that the number of core services inspected in addition to well-led will vary for each organisation. Overall, we expect our contact with trusts to be more frequent, but far more targeted, so that the overall requirement on trusts as a result of our regulation will be less.

We will hold an internal regulatory planning meeting to review the available information and to plan our inspection activity. Core service inspections will be very similar to our current approach (which will reflect refinements to our assessment framework being consulted on in Annex A1 and A2). However, they may happen at different times and will mostly be unannounced to enable us to observe routine activity. The well-led inspection will be announced to ensure that the appropriate interviews can be scheduled.

Core service inspections

Core services

Our experience from comprehensive inspections suggests that the core services we have inspected for acute, community, mental health and ambulance services, are largely the right ones. We are therefore not proposing any changes to the core services we assess in

community, mental health or ambulance services, and only proposing two minor changes to acute core services to ensure that the focus of the inspection is appropriate. We will continue to assess against all five key questions.

> **Change 1: Separating diagnostic imaging from the core service of outpatients**, with outpatients remaining as a core service. We may inspect diagnostic imaging as an additional service, depending on the individual provider and on the level of risk. We will use relevant diagnostic accreditation schemes where possible to reduce or replace regulatory review. If a provider is not accredited under an appropriate scheme, we will consider this as a factor when deciding whether to include diagnostic imaging as an additional service in our inspection.
>
> **Change 2: Separating maternity and gynaecology.** Maternity will remain a core service and will include, where carried out, termination of pregnancy. However, gynaecology will be a separate additional service, which we may inspect on a provider-by-provider basis.

The purpose of both these changes is to enable us to take a more balanced and proportionate approach to inspecting gynaecology and diagnostic imaging services. We have often found it challenging to fully and clearly inspect and report on each of these services when combined into a single core service. Under our proposals, we will be able to provide a clearer and more focused report of our findings for outpatients and maternity services as part of our core service inspections, while taking a proportionate risk-based approach to inspecting gynaecology and diagnostic imaging services as additional services (see section below).

Frequency of core service inspections

Once our new approach is embedded, we will inspect at least one core service in each trust approximately annually alongside the well-led assessment. We will decide which core services to inspect based on previous inspection findings and ratings, wider intelligence about the quality of care captured in CQC Insight, information from the provider, and information gathered through our relationship management. By targeting our inspections, we are aiming to focus on protecting people from poor care where there are greatest concerns, and to assess where improvements have been made.

For planning purposes, we will use previous ratings as a guide to setting maximum intervals for re-inspecting core services as follows:

- one year for ratings of inadequate
- two years for ratings of requires improvement
- 3.5 years for ratings of good
- five years for ratings of outstanding.

This could mean that in a single year we inspect areas where we have identified new risks, all core services rated inadequate, and a proportion of core services that are rated requires improvement, good, or outstanding. The following table gives an illustrative example.

Figure 2: Illustrative example of how we could use the information we hold about core services to plan our inspections

Information we hold about core services	Inspection plans
Inadequate: urgent and emergency care; surgery	**This year:** inspect urgent and emergency care; surgery
Requires improvement: medical care; critical care	**This year:** inspect medical care **Next year:** inspect critical care
Good, but new risks identified: maternity	**This year:** inspect maternity
Good: end of life care	**Within following 2.5 years:** inspect end of life care
Outstanding: services for children and young people; outpatients	**Within following 4 years:** inspect services for children and young people; outpatients
	Overall plans: inspect four core services this year

We will continue to test and confirm the maximum intervals as we implement our new approach.

The majority of core service inspections will be carried out unannounced or at short notice. The inspections will be planned using the information collected in the routine PIR but there may be additional requests for information generated by our findings at inspection, although we will aim to minimise such requests.

Additional services

An 'additional service' is a service that we do not inspect routinely for all providers as a core service, but which we may choose to inspect for an individual provider because it represents a significant part of the range of services delivered by that provider and/or it has been identified as potentially outstanding or high risk. As well as identifying additional services to inspect in individual providers, we are considering whether we could select additional services for inspection across a range of providers or sectors, to provide a broader view of the quality of services. The chosen additional service would be inspected either within or across service sectors, or among a selection of providers (for instance on a place-based approach).

We propose that where we conduct an inspection across a range of providers, we would report and provide a rating of the service where appropriate. We are proposing that our aggregation rules would not be applied to these ratings, meaning that the ratings for additional services inspected under this approach would not affect the overall trust-level ratings. We would always take appropriate enforcement action where required.

For example, we are currently developing our approach to inspecting cancer services, and intend to inspect them in 2018/19. We are also exploring how we can assess mental health services in NHS acute trusts and will be piloting our approach in early 2017. Other possible additional services might include stroke or diabetes care.

Current approach to core services	New approach to core and additional services
Core services in acute services • Maternity and gynaecology • Outpatients and diagnostic imaging • No separate framework for assessing mental health in acute settings	**Separating core and additional services in acute services** • Maternity • Outpatients • Gynaecology becomes an additional service (included in inspection when it meets specific criteria) • Diagnostic imaging becomes an additional service (included in inspection when it meets specific criteria) **Possible additional services in acute** • Cancer • Mental health services in acute settings

Effective use of accreditation schemes

As with our proposed approach to outpatients and diagnostic imaging, we are keen to make better use of relevant accreditation schemes across all core and additional services. We propose to reflect participation in accreditation schemes in the provider well-led key question, as evidence of a commitment to quality improvement and assurance. The achievement of accreditation under a specific scheme would be reflected in the effective key question of the relevant core service.

Where an accreditation scheme itself meets key quality standards and has a good level of uptake among NHS providers, we propose to move towards using accreditation under that scheme to reduce, or over time in some areas potentially replace, CQC inspection of the accredited service.

The intention of this approach would be to support our overall aim to adopt a more targeted and proportionate approach to regulation, to assist in avoiding duplication across the health and social care system and to reduce requirements on providers where appropriate.

Trust well-led inspection

The well-led framework for healthcare providers now also includes a clearer emphasis on ensuring the sustainability of services, reflecting the approach set out by the National Quality Board in its forthcoming Shared Commitment to Quality.

The trust-level inspection of well-led will be an evolution of our current approach to assessing and reporting on our key questions at the overall provider level. It will also support our commitment to ensuring that we are holding complex organisations to account for the quality of care they provide at the right level. In any new or complex models of care we will want to establish who is accountable for the provision of care.

Our provider-level reports for trusts currently include a report on what we found through assessment and inspection of trust-wide leadership under the well-led key question. This assessment is used to corroborate and, where necessary, modify the trust-level rating of well-led that would be generated through aggregation from the location-level ratings. In future, our assessment of trust-wide leadership, governance, management and culture will be the starting point for the trust-level rating of well-led. This will consider improvements and changes since the last inspection. It will take into account the findings for well-led at location level, but will not be a simple aggregation of these.

In strengthening our assessment of well-led, we are clear that there is a demonstrable link between leadership, culture and the delivery of safe, high-quality care and our focus on well-led is intended to support this link. The proposed updated framework (see Annex A1 and Annex A2) has been jointly agreed between CQC and NHS Improvement, and both organisations will use it to assess well-led. We will also work closely with NHS Improvement to coordinate our respective uses of the well-led framework and ensure we do not duplicate information requests or activity. As with our existing approach, the trust-level inspection of well-led will be conducted by a small, senior team of inspectors and specialist advisors. This team will draw on a range of evidence applicable at the overall trust board level, including interviews with board members and senior staff, focus groups, analysis of data, review of strategic and trust-level policy documents, and information from external partners.

The scope and depth of our regular trust-level well-led inspections will vary according to the individual provider. In deciding on the nature of the inspection approach, we will consider factors such as the size of the trust, the findings of previous inspections, and information gathered from the provider, external partners and other sources on performance and risks in the trust. We will be developing and further piloting our approach to inspecting well-led at trust level in the coming months, in collaboration with trusts and NHS Improvement.

Current approach to inspecting well-led	New approach to inspecting well-led
A dedicated team within the comprehensive inspection to look at well-led • A small trust-wide team responsible for corroboration of all ratings from service to trust-wide level, with a focus on well-led at trust level	**An assessment of well-led at trust level** • An assessment focusing solely on well-led at trust level, which will draw on our wider knowledge of quality in the trust at all levels

Consultation questions

7 What do you think about our proposal that our regular trust inspections will include at least one core service and an assessment of the well-led key question at trust level approximately annually?

8 What do you think about our proposal that the majority of our inspections of core services will be unannounced?

Consultation questions (contd)

9a What do you think about the changes we have proposed to inspecting the maternity and gynaecology core service?

9b What do you think about the changes we have proposed to inspecting the outpatients and diagnostic imaging core service?

10a Do you agree with our proposed approach to inspecting additional services (services that we do not inspect routinely) across a range of providers or sectors? [Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree]

10b Please tell us the reasons for your answer.

11a Do you agree with our proposals for using accreditation schemes to both inform and reduce CQC inspections? [Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree]

11b Please tell us the reasons for your answer.

Reporting

We will introduce a shorter, more succinct report, which will be more accessible and user friendly. It will provide the information that the public and people who use services want, including a summary of our findings, ratings, contextual information and any enforcement activity we have taken. We will explore how we can better present information for large community, mental health and ambulance services that provide care across a large geographical area.

We will continue to follow current factual accuracy processes to ensure that providers have the opportunity to check the evidence that informs our reports. We will have a peer review process and will quality assure our findings at a national level. We plan to publish an appendix of all the evidence that supports the findings and the ratings. This will make the evidence available in a structured way and help our inspectors to gather the evidence they need to reach a robust judgement.

Current approach to reporting	New approach to reporting
Report Includes all evidence, findings, ratings, contextual information and any enforcement action we have taken Presented in a narrative style	**Separate report and evidence appendix** Report includes a summary of findings , contextual information and ratings Evidence appendix includes all the evidence presented factually

Rating

In its 2013 report *Rating providers for quality: a policy worth pursuing?*, the Nuffield Trust reviewed the role of ratings in health and social care. This review recommended that any approach to ratings should allow complex organisations to be assessed and rated at different levels, with organisational and service-specific ratings. Building on the findings of the review, it is our view that the key purposes of any quality rating should be to:

- inform choice for people using services
- incentivise improved performance in delivering safe, high-quality care
- increase accountability and transparency.

Quality ratings should also enable comparisons of performance over time and enable comparisons across organisations. We recognise that different audiences use our reports and ratings differently – for example to a patient, the core service or location report is more meaningful than a provider-level report. Meeting the needs of different audiences will be a key consideration for any refinements to our trust-level assessments and ratings. We are not proposing any changes to how we rate at core service and location level.

This section describes:

- how we will update ratings in future
- our separate consultation about introducing a use of resources assessment
- issues we need to consider for the future as the trust landscape changes.

How we will update ratings

Overall trust ratings will only be reviewed and updated following a trust-level well-led assessment and planned core service inspections. Where we have not carried out an on-site inspection the previous rating will stand. Reports will make clear whether a rating is based on the most recent or a previous inspection. Aggregated ratings will be a combination of previously allocated and new ratings from recent on-site inspection activity. Providers will then be required to display an updated grid. Focused inspections that look at a specific concern may result in a change to a core service or location-level rating.

Use of resources assessment

NHS Improvement and CQC are working together to develop an assessment and rating of use of resources. This will enable a comprehensive view of trusts' performance, reflecting the fact

that effective use of resources is an important determinant of high-quality and sustainable care. Our joint consultation sets out the process and indicative metrics for future use of resource assessments. We will be further testing and refining that approach in 2017. If you would like to offer views on this, please see the joint consultation.

Future considerations

Although our current rating approach has worked well in the majority of cases, there are two situations in which we are aware of issues with our approach to aggregating ratings to determine an overall trust rating. These are:

1. Where trusts provide more than one service type
2. Where trusts take over other providers to improve their quality.

1. Where trusts provide more than one service type
Many trusts already provide a complex set of services that cross traditional care boundaries, and we expect to see this increase. For example, trusts may provide a combination of acute or mental health care and community health services, and also run care homes or provide GP services. We have found that, in larger and more complex organisations, it is challenging to show how we have balanced the scale and quality of different services in our aggregated ratings at provider level. For example, where a trust delivers a wide range of community health services, as well as two GP practices, our aggregation rules do not take account of the relative size of these different service types. Future trust-level assessments of well-led are intended to be more comprehensive and capture organisation-wide leadership – we will continue to review and refine this approach as organisations evolve.

2. Where trusts take over other providers to improve their quality
There are already examples of trusts taking over other trusts or other types of services in order to improve their quality – for example, Frimley Health NHS Foundation Trust's acquisition of Heatherwood and Wexham Park Foundation Trust. The Acute Care Collaborations new care model programme is intended to drive more of this activity to improve care for patients. We have been clear in the principles set out on page 6 that we do not want trusts to be disincentivised from taking on providers with poorer quality because this could impact on their overall CQC rating.

We expect to see more of both of the situations given above. As we introduce the use of resources assessment and rating (for acute trusts initially, and then all trusts), we will also consider how we might address these issues. Potential options include:

- Introducing greater professional judgement to moderate aggregated ratings at the trust level, for example to take account of the relative size of different services and the duration of ownership.
- Being flexible about the best level at which to provide an overall aggregated rating, for example at overall trust-level or site/location-level.
- Continuing to rate recently acquired or merged providers separately for a period of time, for example two to three years to allow the trust time to address quality issues.

The changes we make should be sufficiently flexible to accommodate any organisational form where we wanted to rate at provider level now and in the future, including combined

providers with rated and unrated services, independent sector providers, corporate providers, chains and federations, and new models of care.

We do not currently produce an organisational-level rating for any provider other than trusts, which are also unique in that they will have a use of resources rating as well. We want to introduce this new use of resources rating and test how to combine it with our quality ratings before making any further changes to respond to the issues raised above.

We welcome general views and suggestions for changes we should consider to provider-level ratings, and we will continue to engage with providers and people who use services to determine any changes.

Consultation question

12 What do you think about our current approach to trust-level ratings and how do you think it could be improved (taking into account the new use of resources rating)?

Introducing our new approach

We will introduce our new assessment framework and approach for NHS trusts from April 2017. This means that the first new provider information requests will be sent out from April 2017, and the associated inspections will take place within the following two to six months and be informed by CQC Insight. We will roll out the new approach over two years to allow us to evaluate, improve and refine it. We expect the approach to be fully embedded by April 2019, and at that point all trusts will have a well-led inspection and at least one core service inspection approximately annually.

How to respond

You can respond through our online form at: **www.cqc.org.uk/nextphase** or by email: **nextphase@cqc.org.uk**

You can write to us at:
Freepost RTTE-JTBT-ZTHH
Next Phase Consultation
Care Quality Commission
151 Buckingham Palace Road
LONDON
SW1W 9SZ

You can also tweet us your thoughts at: **#CQCNextPhase**

Please reply by 14 February 2017.

Thank you for taking the time to contribute to the development of our future work.
Your feedback and comments are important to getting this right.

Summary of consultation questions

1a Do you think our set of principles will enable the development of new models of care and complex providers?
[Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]

1b Please tell us the reasons for your answer.

2a Do you agree with our proposal that we should have only two assessment frameworks: one for health care and one for adult social care (with sector-specific material where necessary)?
[Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]

2b Please tell us the reasons for your answer.

3a What do you think about our proposed changes to the key lines of enquiry, prompts and ratings characteristics?

3b What impact do you think these changes will have (for example the impact of moving the key line of enquiry on consent and the Mental Capacity Act from the effective to the responsive key question)?

4 We have revised our guidance *Registering the right support* to help make sure that services for people with learning disabilities and/or autism are developed in line with national policy (including the national plan, *Building the right support*). Please tell us what you think about this.

5 What should we consider in strengthening our relationship management, and in our new CQC Insight approach?

6 What do you think of our proposed new approach for the provider information request for NHS trusts?

7 What do you think about our proposal that our regular trust inspections will include at least one core service and an assessment of the well-led key question at trust level approximately annually?

8 What do you think about our proposal that the majority of our inspections of care services will be unannounced?

9a What do you think about the changes we have proposed to inspecting the maternity and gynaecology core service?

9b What do you think about the changes we have proposed to inspecting the outpatients and diagnostic imaging core service?

10a Do you agree with our proposed approach to inspecting additional services (services that we do not inspect routinely) across a range of providers or sectors?
[Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]

10b Please tell us the reasons for your answer.

11a Do you agree with our proposals for using accreditation schemes to both inform and reduce CQC inspections?
[Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]

11b Please tell us the reasons for your answer.

12 What do you think about our current approach to trust-level ratings and how do you think it could be improved (taking into account the new use of resources rating)?

How to respond to this consultation

Online

Use our online form at:
www.cqc.org.uk/nextphase

By email

Email your response to:
nextphase@cqc.org.uk

By post

Send your response to:
Freepost RTTE-JTBT-ZTHH
Next Phase Consultation
Care Quality Commission
151 Buckingham Palace Road
LONDON
SW1W 9SZ

Please contact us if you would like a summary of this document in another language or format.

If you have general queries about CQC, you can:

Phone us on: 03000 616161

Email us at: enquiries@cqc.org.uk

Write to us at:
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CQC-359

Consultation on use of resources and well-led assessments

Issued on 20 December 2016

Deadline for responses: 14 February 2017

Contents

1. Introduction

1. The NHS continues to deliver many high quality services in spite of increasing pressure from slowing growth in the NHS budget and from the increasing complexity associated with the demographics of an ageing population, increasing levels of co-morbidity, higher patient expectations, and a desire for an expanding range of treatments. As set out in *Implementing the Forward View: Supporting providers to deliver*, these challenges require strong and inclusive leadership, engaging staff to maximise their contribution, stabilising finances and improving efficiency. They also require the national oversight and regulatory bodies to play their part by reducing burdens on providers and behaving more consistently.

2. Strong and effective leadership and governance is a key component in addressing the challenges facing the sector. Both the Care Quality Commission (CQC) and NHS Improvement have seen what a difference a positive culture, open and transparent leadership, and good governance and processes to oversee care quality, finances and operational performance can make. We have built on the aligned well-led framework developed by CQC and Monitor and the NHS Trust Development Authority (the latter two organisations now operating as NHS Improvement) following the Francis Inquiry,[1] to set out a single vision of what good leadership looks like. This document seeks views on the new well-led framework, building on the strengths of the previous version, and how this will be used for CQC's assessment of well-led, within NHS Improvement's Single Oversight Framework, and by trusts themselves for development purposes.

3. Every day, leaders of NHS trusts and NHS foundation trusts (referred to throughout as 'trusts') have to meet the related challenges of maintaining and improving quality, operational performance, finance and efficiency. How effectively a provider uses its resources is one of the factors that determines the quality and responsiveness of its care. As one trust chief executive has said "Quality without efficiency is unsustainable, efficiency without quality is unthinkable". The Health and Social Care Act 2008 already recognises the relationship between quality of care and the efficient and effective use of resources, and requires CQC to have regard to the latter within its overall purpose as a quality regulator. CQC and NHS Improvement are committed to working together to recognise the fact that effective use of resources is fundamental to enable health and care providers to deliver and sustain high quality, including safe, services for patients. This joint consultation sets out our plans to do so, including introducing an assessment of trusts' use of resources as

[1] See www.gov.uk/government/publications/well-led-nhs-foundation-trusts-a-framework-for-structuring-governance-reviews

part of CQC ratings, starting with acute trusts, in line with the Secretary of State for Health's request in June 2015.[2]

4. CQC's purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care, and encourage care services to improve. CQC's role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and it publishes what it finds, including performance ratings to help people choose care. NHS Improvement is responsible for overseeing NHS foundation trusts, NHS trusts and independent providers. It offers the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, it helps the NHS to meet its short-term challenges and secure its future.

5. CQC and NHS Improvement are independent organisations with distinct legal duties. In particular, CQC carries the power to provide ratings of trusts and all final judgements about ratings of well-led and use of resources remain with CQC. NHS Improvement oversees trusts, forming views of their support needs in areas including quality, operational performance, finance and use of resources, leadership and improvement capability, and strategic change. We are committed to reducing duplication between our organisations and minimising the requirements we place on trusts. In line with our duty to co-operate, CQC and NHS Improvement will operate according to the following principles:

    - **working together** in the effective discharge of our respective functions,[3] while recognising that each organisation is legally and operationally **independent**
    - greater **alignment** between our organisations so that our definitions, measurement and operations are based on a single shared view of quality
    - working to remove **duplication** between our organisations
    - focusing on **quality,** and demonstrating that it should and can be maintained and improved alongside **financial sustainability**.

1.1. Effective use of resources

6. Delivering high-quality care means using resources as efficiently as possible to deliver the best outcomes for patients. Leaders at all levels of trusts need to deliver high quality, including safe, patient care within financial balance, while striving to operate more efficiently and effectively. This requires meeting financial

[2] www.cqc.org.uk/content/cqc-begin-work-assessing-use-resources-nhs-hospitals
[3] The references to 'we' in this document refer to the respective functions of both the CQC and NHS Improvement.

controls and eliminating unwarranted variation at trust level, and working strategically with local partners to ensure the long-term sustainability of the health and care system. Trusts must also optimise their use of resources by improving leadership and governance of finances and use of resources.

7. As public sector organisations, trusts are expected[4] to demonstrate to their patients and the public that they are delivering value for money through optimal use of all available resources (including workforce, finances, estates and facilities, informatics and procurement). Efficient use of these resources enables more to be channelled into frontline services to maintain and improve the quality of care for patients.

8. Lord Carter's review identified considerable efficiency opportunities for acute hospitals in these areas. As part of implementing this work, NHS Improvement is proposing to assess how trusts are using the resources available, to identify further efficiency opportunities to maximise patient benefit and to inform a rating by CQC. One area where this link is perhaps most often articulated is the optimal use of staff time and expertise. This might mean, for instance, fully engaging staff in operational delivery of the trust's strategic objectives, minimising sickness and turnover rates, and making best use of job planning and e-rostering. There is evidence that engaged staff, working in well-led organisations, are more productive.[5]

1.2. Effective leadership and governance

9. NHS Improvement and CQC are committed to supporting strong and effective leadership and governance. We know that the well-led framework has been a helpful resource both for CQC and NHS Improvement, as well as for trusts that use it as a self-assessment and improvement tool. This is why we have been working together to create a new well-led framework for trusts, building on the strengths of the previous version, and streamlining and updating it to cover system governance and leadership, leadership behaviours, culture, and finance and resource governance. By 'well-led' we mean that the leadership, management and governance of the organisation ensure the delivery of sustainable, high quality, patient-centred care, support learning and innovation, and promote an open and fair culture.

1.3. How NHS Improvement's and CQC's responsibilities relate to one another

10. The challenges facing the NHS require increased partnership working between health and social care providers to ensure that care is provided in the most

[4] The expectations are set out in relevant legislation, the NHS provider licence and guidance.
[5] See Developing people – Improving care and https://improvement.nhs.uk/resources/culture-and-leadership/

appropriate setting. This principle underpins the NHS Five Year Forward View and many of the policy initiatives that have arisen as a result, including multi-year, place-based sustainability and transformation plans (STPs). This expectation of closer partnership working must equally be reflected in how the national bodies responsible for the health and care sector operate. We will continue to align our approaches to overseeing provider organisations and understanding where support is needed.

11. CQC regulates quality based on how safe, effective, responsive, caring and well-led services are and will continue to provide these five ratings at overall trust level. The responsibility and ownership of all ratings will remain legally with CQC. NHS Improvement uses these ratings as part of its quality theme under the Single Oversight Framework. As currently, the well-led rating will include an assessment of trust-wide leadership, which will draw on input from, and be utilised by, NHS Improvement as appropriate. NHS Improvement also plans to undertake trust-level Use of Resources assessments, initially for acute trusts. NHS Improvement will utilise this to identify support needs under the finance and use of resources theme in the Single Oversight Framework as well as the basis for generating a proposed use of resources rating for consideration by CQC.

2. This consultation

12. This consultation seeks views on:

- The new Use of Resources assessment:
    - the proposed approach to carrying out Use of Resources assessments, initially for acute trusts only, including how we will assess trust performance and reach a rating (sections 3.1 and 3.2)
    - how NHS Improvement's Single Oversight Framework will reflect use of resources in its finance and use of resources theme (section 3.3).
- The new well-led framework:
    - the joint structure of the well-led framework for acute, mental health, community and ambulance trusts (section 4.2)
    - the proposed changes to the content, which includes more detail on themes such as compassionate, inclusive leadership, system leadership, and financial and resource governance (section 4.3)
    - how CQC and NHS Improvement will make use of the well-led framework in our regulatory and oversight activities (sections 4.4 and 4.5)
    - the relationship between the CQC well-led assessment and rating and the Single Oversight Framework (section 4.6).

13. Responses to this consultation, engagement events and iterative testing in early 2017 will shape our final approach and how it is implemented. Thirteen specific questions on our proposed approach appear throughout this consultation document. See Annex C and the survey website (see below for the link) for a complete list of the questions.

14. CQC is currently consulting on the next phase of its regulatory approach: www.cqc.org.uk/nextphase. We encourage trusts to read both consultations before responding.

2.1. Responding to the consultation

15. We look forward to receiving the views of providers and other stakeholders on our proposals. We ask all interested parties to respond to the consultation by **5pm on 14 February 2017** via our survey: https://www.surveymonkey.co.uk/r/CQCNHSIconsultation. Please email NHSICQC.Consultation@nhs.net if you have any difficulty accessing the survey.

2.2. Confidentiality

16. Please let us know if all or part of your response or identity is confidential so that we can exclude this from our published summary of responses. We will do our best to meet all requests for confidentiality, but because NHS Improvement and CQC are public bodies subject to freedom of information legislation we cannot guarantee that we will not be obliged to release your response (including potentially your identity) or part of it even if you say it is confidential.

3. Use of resources

3.1. Proposed approach to generating Use of Resources ratings

17. In considering how to bring together our respective oversight and regulatory approaches, we have agreed the following principles:

    - trusts must have due regard to both quality and financial objectives in delivering services
    - the assessment and rating of trusts' use of resources must be meaningful for patients and the public, as well as useful for providers, CQC and NHS Improvement
    - the assessment and approach to ratings should be simple, robust and transparent
    - providers must be able to achieve 'outstanding' and 'good' ratings and the approach must continue to incentivise improvement
    - the assessment must minimise regulatory burden for providers as far as possible.

18. We will start by assessing use of resources for non-specialist acute trusts only, because they currently have better productivity data. As metrics are developed for NHS specialist acute, mental health, community and ambulance services, for instance through NHS Improvement's work on encouraging better productivity, such as through the Model Hospital,[6] we will gradually incorporate them as appropriate. We therefore do not intend to assess the use of resources relating to non-acute activity in acute trusts at this stage, but will use information gathered during the assessments to help inform our future approach. Trusts currently classed as non-acute that deliver some acute services are also currently out of scope. We intend to revise our assessment approach and process as needed, for example when new organisational forms emerge.

Use of Resources assessment: the overall process

19. CQC and NHS Improvement have agreed that NHS Improvement will undertake the use of resources assessment in line with an agreed methodology and propose a rating. NHS Improvement will carry out an assessment to determine how effectively providers are using their resources to deliver high quality, including safe, efficient and sustainable care for patients. It will do this by

[6] As part of the Carter Review, a 'model hospital' has been developed to give trusts information on key performance metrics, from board to ward, advise them on the most efficient allocation of resources and allow them to measure performance against one another using data, benchmarks and good practice to identify what good looks like.

assessing how well they are meeting financial controls, how financially sustainable they are, and how efficiently they use their resources more broadly while still delivering high quality care to patients. NHS Improvement will use this assessment to inform its oversight of trusts.

20. CQC will place appropriate weight on the evidence provided by the NHS Improvement assessment and the proposed rating, derived according to the final approved process and methodology. The decision on the rating will remain legally with CQC. This is a similar model to that used by NHS Improvement currently in drawing on CQC's quality ratings in the Single Oversight Framework.

21. NHS Improvement is best placed to lead on this assessment because of its role overseeing the financial performance and governance of the sector, and its existing skills and activities in these areas.

Timing

22. As part of a separate consultation, CQC is proposing to move to a more targeted approach that involves inspecting selected core services and assessing leadership at trust-level, approximately annually. The assessment of trusts' use of resources will be aligned with the regular scheduling of CQC assessments of well-led at trust level. We acknowledge that as Use of Resources assessments may be carried out at any point in the financial and operational year, this may affect the assessment of trusts' relative performance. We are therefore actively considering ways of taking this into account in producing the assessment, for example by looking at data over a 12-month averaged period.

23. We recognise that a trust may have improved, although its overall CQC rating, including the Use of Resources rating, will remain the same until its next assessment. This is consistent with current practice as set out in CQC's wider inspection methodology.

Assessment approach

24. The Use of Resources assessment methodology (see Figure 1) will consist of a qualitative and quantitative assessment based on a set of metrics that will include all the current finance and use of resources metrics in the Single Oversight Framework and a number of additional productivity metrics (see section 3.2). NHS Improvement will use these metrics and structured questions under a brief series of key lines of enquiry (KLOEs) and prompts (see Annex A) to help assess performance and identify potential scope for better use of resources. The methodology is designed to structure NHS Improvement's engagement with trusts and ensure consistency, but will not preclude additional questions, data or information from being used where relevant to the areas being explored. This methodology, alongside CQC's inspection approach, is currently being developed and will be finalised following testing in 2017.

Rating and reporting

25. NHS Improvement will analyse productivity metrics and existing Single Oversight Framework finance metrics, together with the KLOEs used to probe the trust's performance on finance and use of resources and local intelligence. Having carried out this Use of Resources assessment, NHS Improvement will write a brief report based on the evidence collected. This report will be shared with trusts to give an opportunity to provide feedback before it is finalised, at which point CQC will also receive the report for information. The report and proposed rating will be subjected to internal quality assurance through an NHS Improvement committee. NHS Improvement will provide CQC with the report on its Use of Resources assessment, together with its proposed rating.

26. CQC will consider this report and NHS Improvement's proposals regarding the rating as part of the process of preparing and finalising its trust-level inspection report. CQC will give appropriate weight to NHS Improvement's report and recommendations in determining the trust's final Use of Resources Rating, and will report that evidence in the trust's inspection report.

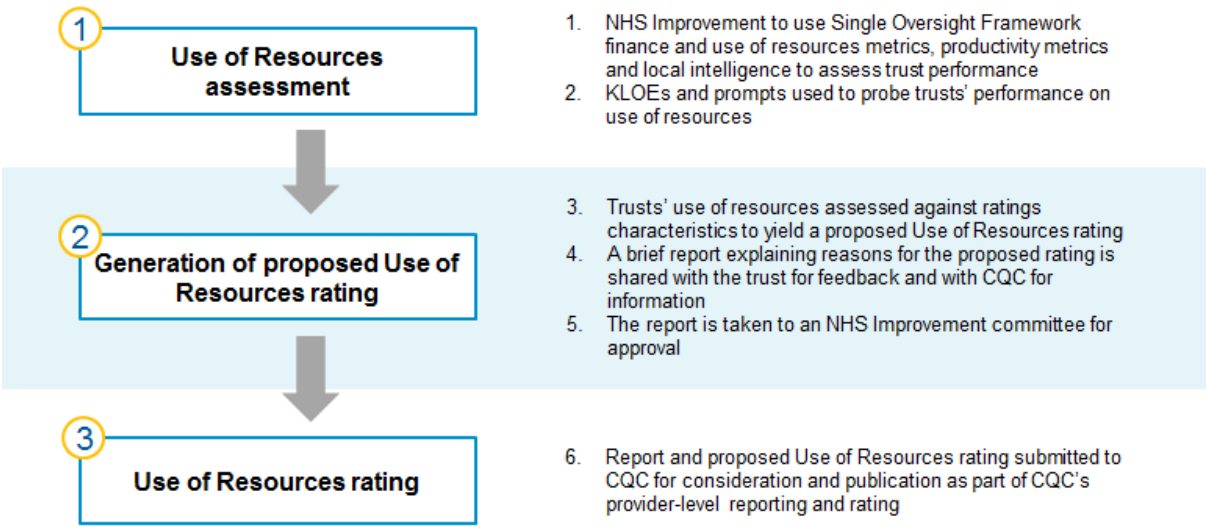
27. Providers will be given a rating for their use of resources at the overall trust level, rather than at core service level, against CQC's four ratings levels of outstanding, good, requires improvement or inadequate. The rating will be generated by comparing the evidence gathered in the Use of Resources assessment against published ratings characteristics for the four ratings levels. We have proposed ratings characteristics as part of the Use of Resources assessment framework (see Annex A).

28. In the event that CQC does not agree with NHS Improvement's recommendation regarding the rating, we will set out a process for discussion between the two organisations.

Challenges to the evidence and CQC ratings

29. As at present, providers will have an opportunity to provide feedback on the factual accuracy of the CQC inspection report at the final draft stage (which will include the findings of the Use of Resources assessment and rating). If a provider challenges evidence relating to the Use of Resources assessment, CQC will work with NHS Improvement to review the evidence (and, where necessary, the rating) in light of the information received from the trust.

Figure 1: Use of Resources assessment methodology



Consultation question 1: Do you agree with the proposed process for assessing and rating trusts' use of resources?

Please tell us the reasons for your answer.

Presenting quality and use of resources ratings together

30. Work to date has primarily focused on developing the Use of Resources framework and assessment process. CQC will initially present the Use of Resources rating alongside its existing trust quality rating, but as we finalise the assessment methodology, the next step will be considering whether and how to combine the quality and Use of Resources ratings within CQC's overall trust-level ratings.

31. If we were to combine the Use of Resources rating with the current quality ratings, there are a number of different ways that this could be achieved. For instance, use of resources could be added to CQC's current key questions (safe, effective, caring, responsive and well-led) as a sixth question to be combined into a single overall trust rating. Another option would be to create an overall rating based on three elements: quality (aggregating the safe, effective, caring and responsive key questions), leadership (reflecting the well-led key question) and use of resources. Any combined options would initially only be for acute trusts. We will consult on proposals for this at a later date.

Consultation question 2: What are your views on how the Use of Resources rating could over time be combined with CQC's existing trust quality rating?

Enforcement and improvement action following the assessment

32. The finance and use of resources theme of the Single Oversight Framework helps to identify a trust's potential support needs in relation to improving financial sustainability, efficiency and compliance with sector controls such as agency staffing and capital expenditure (see Figure 2 for metrics). The use of resources assessment will feed into this. The Single Oversight Framework already provides the flexibility to take into account qualitative evidence to assess how trusts may be supported to improve. So where there are triggers of concern, NHS Improvement considers the relevant circumstances, including the provider's local context, the credibility of its plans, and its capacity and capability for improvement, to decide whether to offer targeted support on a voluntary basis or whether to take regulatory action to mandate support.[7] NHS Improvement has a further set of criteria that it uses to determine if a trust should be placed in financial special measures.[8] NHS Improvement and CQC are considering whether changes are needed to the special measures regimes, given the evolution of our respective oversight and regulatory approaches.

3.2. Use of Resources assessment framework

33. The aim of the new Use of Resources assessment is to understand how effectively providers are using their resources to provide high quality, efficient and sustainable care for patients. We will do this by assessing how well trusts are meeting financial controls, how financially sustainable they are, and how efficiently trusts use their finances, workforce, estates and facilities, data and procurement to deliver high quality, including safe, care for patients and service users. Initially, our approach will focus largely on acute non-specialist services, due to the availability and quality of data in this area. As metrics are developed for specialist acute, ambulance, mental health and community services, we will include them in this framework.

34. Consistent with the CQC approach to assessing providers, we will use a framework of key lines of enquiry (KLOEs) and prompt questions to help probe trust performance in a consistent way. The assessment framework (see Annex A) will have four themes, aligned with the Model Hospital to ensure that it is easy for trusts to understand:

[7] Support is mandated where there is actual or suspected breach of the provider licence and formal enforcement action, ie mandated support, is considered appropriate.
[8] See Strengthening financial performance and accountability in 2016/17

- **Finance:** How effectively is the trust managing its financial resources?
- **Clinical services:** How well is the trust maximising patient benefit, given its resources?
- **People:** How effectively is the trust using its workforce to maximise patient benefit?
- **Operational:** How well is the trust maximising its operational productivity?

35. In assessing trusts' use of resources we will draw on a range of financial and productivity metrics, including:
    - the current finance and use of resources metrics in the Single Oversight Framework (see Figure 2)
    - wider productivity metrics largely drawn from the Model Hospital that cover clinical services, workforce, finance, estates and facilities, and procurement (see Figure 3 for the full shortlist of indicative metrics).
36. NHS Improvement is working through the current shortlist of metrics testing data quality, timeliness and definitions to ensure they are credible and robust. The metrics will continue to evolve, as will the data available through the Model Hospital, for example allowing a metric reflecting change in cost per weighted activity unit (WAU)[9] to be included in due course.

[9] The cost per WAU is a relative measure of efficiency at trust level comparable between trusts in-year. The cost per WAU compares inputs (costs) to outputs (the amount of work trusts do for the NHS) to obtain a measure of productivity, or value for money: trusts that use fewer inputs per unit of output are more productive.

Figure 2: Finance and use of resources metrics in the Single Oversight Framework

Area	Weighting	Metric	Definition	Score			
				1	2	3	4[1]
Financial sustainability	0.2	Capital service capacity	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75-2.5x	1.25-1.75x	< 1.25x
	0.2	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)
Financial efficiency	0.2	I&E margin	I&E surplus or deficit / total revenue	>1%	1-0%	0-(1)%	≤(1)%
Financial controls	0.2	Distance from financial plan	Year-to-date actual I&E surplus/deficit in comparison to Year-to-date plan I&E surplus/ deficit	≥0%	(1)-0%	(2)-(1)%	≤(2)%
	0.2	Agency spend	Distance from provider's cap	≤0%	0%-25%	25-50%	>50%

37. Figure 3 sets out indicative metrics likely to form a core part of the Use of Resources annual assessment. These are for illustrative purposes and are not the final shortlist, as we expect this will change and improve as further data becomes available. The metrics will form the basis for engagement with trusts and no one metric will determine a trust's rating. NHS Improvement's regional teams' local intelligence and day-to-day interactions with trusts will also be used to understand the context in which the trust operates. Additional evidence, such as the metrics trusts use themselves, will be used to give broader insight into trust performance. NHS Improvement teams will also consider any additional available Model Hospital data.

Figure 3: Indicative use of resources metrics

Area of use of resources	Key lines of enquiry (KLOEs)	Indicative metrics
Finance	How effectively is the trust managing its financial resources?	• Capital service capacity • Liquidity (days) • Income and expenditure margin • Distance from financial plan • Agency spend (performance against agency ceiling)

Clinical services	How well is the trust maximising patient benefit, given its resources?	• Pre-procedure non-elective bed days • Emergency readmissions • Cancelled operations • Proportion of beds occupied by those with an average length of stay of over seven days
People	How effectively is the trust using its workforce to maximise patient benefit?	• Vacancy and staff turnover rates • Sickness absence
Operational	How well is the trust maximising its operational productivity?	• Purchase Price Index Benchmark tool top 100 index • Estates cost per square metre • Pharmacy spend – quarter-on-quarter change

Consultation question 3: Do you think these initial indicative metrics provide a reasonable starting point for informing the assessment of a trust's performance on use of resources? Are there other metrics we should consider when assessing a trust's productivity?

Consultation question 4: What are your views on the indicative key lines of enquiry and prompt questions that we are proposing for the assessment of trusts' use of resources as set out in Annex A?

Please tell us if you think we should include something different or additional.

Consultation question 5: What are your views on the indicative characteristics we have proposed for the Use of Resources ratings of outstanding, good, requires improvement and inadequate as set out in Annex A?

Please tell us if you think we should include something different or additional.

3.3. Use of Resources ratings and the Single Oversight Framework

38. It is important to distinguish between a trust's finance and use of resources score (measured monthly in the Single Oversight Framework), its Single Oversight Framework segmentation and its annual Use of Resources assessment rating. They are related, but not the same.

39. On a rolling basis throughout the financial year, trusts are given a finance and use of resources score, derived from the metrics set out in the Single Oversight Framework. The score is intended to provide an assessment of the trust's financial performance. The score feeds into, but does not on its own determine, decisions on the level of support that a trust needs and its resulting segmentation.

40. Segmentation reflects NHS Improvement's judgement of the seriousness and complexity of the issues the trust faces and the level of support required (including whether that support should be targeted or mandated).[10] A trust's finance and use of resources score may not necessarily align to its segment, where, for example, it has greater support needs in a theme other than finance and use of resources. There is a further set of criteria to determine whether, as part of the process for determining mandated support, a trust should go into special measures for finance and there is a well-established process for determining if a trust should go into quality special measures.

41. Where an annual Use of Resources assessment has been carried out, the proposed rating will be used to determine the trust's monthly finance and use of resources Single Oversight Framework scores for the month in which the assessment takes place – where 'outstanding' is equivalent to 1 and 'inadequate' equivalent to 4. The score produced on this basis will remain until there are relevant changes in a trust's financial performance identified by the monthly metrics and other relevant information. NHS Improvement will engage as necessary early next year on any other changes to the Single Oversight Framework.

Consultation question 6: Do you agree that the Use of Resources rating should be reflected in trusts' finance and use of resources scores in the Single Oversight Framework?

Please tell us the reasons for your answer.

[10] Please see the Single Oversight Framework for more information on segmentation.

4. Well-led

4.1. Our approach to well-led

42. One of the key questions that CQC and NHS Improvement use to oversee and assess services is whether they are 'well-led'. By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

43. As part of the further development and alignment of our respective oversight and regulatory regimes, CQC and NHS Improvement have been working on a new well-led framework for trusts, which builds on CQC's current well-led assessment and Monitor's previous well-led framework for governance reviews. The revised approach to well-led for trusts will bring together the existing aligned well-led framework published by CQC, the NHS Trust Development Authority and Monitor in 2015 into a common structure.

44. In fully integrating our well-led framework, we are creating a single structure through which the leadership, management and governance of an organisation can be assessed or reviewed (including self-review). We also intend to integrate the ways we ask organisations to provide evidence to support our inspection and oversight.

45. As separate bodies with distinct legal duties and obligations, NHS Improvement and CQC will continue to set out individually their respective policies and operating procedures for using the well-led framework. This will be through NHS Improvement's Single Oversight Framework and well-led framework for developmental reviews (which NHS Improvement will be updating next year), and through CQC's handbooks for providers and other policies and guidance. The new well-led framework will not replace these individual policies and procedures, but will ensure they are consistent.

46. We are also working with NHS England so that our views of good leadership and governance are aligned across commissioners and providers. NHS England plans to look at similar areas to those covered under well-led for providers and will reflect some aspects of the well-led framework in its updates to the Clinical Commissioning Group Improvement and Assessment Framework.

4.2. Structure and content of the new well-led framework

47. The new proposed well-led framework for trusts has resulted in changes to the structure of KLOEs in CQC's well-led key question. The new framework integrates the structure and content of CQC's current five KLOEs with the ten

questions in Monitor's well-led framework to create a new set of eight KLOEs (see Annex B).[11]

Figure 4: **Well-led framework key lines of enquiry**

48. By integrating our frameworks, we aim to:

- minimise the burden on trusts
- minimise the potential for duplication of effort between NHS Improvement and CQC
- approach the assessments from the same perspective
- provide greater consistency in our judgements against the framework.

49. We have also updated the content of the well-led framework to make our approach clearer and to reflect developments in policy and practice.

4.3 New and strengthened themes in well-led

Compassionate, inclusive and effective leadership

50. The new well-led framework for trusts reflects recent research and evidence on effective leadership, and the principles articulated in Developing people – Improving care, an evidence-based national framework to guide action on improvement skill-building, leadership development and talent management for

[11] Feedback on Annex B is welcome via the CQC consultation *Our next phase of regulation: A more targeted, responsive and collaborative approach* at www.cqc.org.uk/content/cqcs-next-phase

people in NHS-funded roles. These include the five conditions common to high quality systems that interact to produce a culture of continuous learning and improvement. The five conditions are (see KLOEs in Annex B for reference):

- leaders are equipped to develop high quality local health and care systems in partnership (included in prompts W1.4, W2.5, W4.4 and W7.4)
- leaders at all levels demonstrate inclusion and compassion in all their interactions (included in prompt W1.4 and throughout W3)
- individuals and teams at every level know established improvement methods and use them in partnership with patients, communities and citizens to improve their work processes and systems (included in prompt W8.2)
- there are support systems for learning at local, regional and national levels (included in prompts W3.5, W3.6 and throughout W8)
- the regulation and oversight system gives local organisations and systems control of driving learning and improvement (included in prompt W8.5).

51. There is stronger alignment with the critical leadership capabilities identified in *Developing People – Improving Care*, namely systems leadership skills, improvement skills and compassionate, inclusive leadership skills. NHS Improvement and CQC are currently working with other national healthcare bodies to develop resources and guidance to support providers in these areas.

Financial and resource governance

52. Under well-led, CQC already assesses aspects of the sustainability of service provision and whether financial issues are affecting the quality of care. The well-led framework takes an integrated approach to leadership and governance across quality, finance and operations, including resource governance. The KLOEs and prompts have been updated to provide a greater emphasis on financial and resource governance (for example, W2.1, W5.3, W6.1). This new, more comprehensive assessment of leadership and governance will enable and encourage provider boards to consider holistically how to drive necessary continuous improvements in the leadership and governance of their organisation, including a clearer emphasis on ensuring the sustainability of services (both clinical and financial).

System leadership

53. As set out in the Five Year Forward View, sustainable organisations operating as part of successful local health and care economies will deliver better outcomes for patients. Such collaboration, which has already begun between providers and their local system partners through the development of STPs, needs to be further developed and embedded to improve the quality and sustainability of services. It

is therefore increasingly important that organisations are well-led in the context of their local systems. We have strengthened several prompts to reflect good system leadership and information sharing across local systems (included in prompts W2.10, W3.3, W3.5, W4.4, W4.5, W7.4).

Consultation question 7: Do you agree with the additions to the well-led framework?

Please tell us the reasons for your answer.

Consultation question 8: Are there additional areas we could consider on quality, operational and financial governance?

4.4. CQC's well-led assessments

54. CQC and NHS Improvement are committed to using the same framework to oversee and assess trusts' leadership and governance across all aspects of quality, finance and operations, including resource governance. This will also help to ensure we do not duplicate information requests or activity.

55. CQC's trust-level assessment of well-led will be an evolution of its current approach to assessing and reporting on the key questions at the overall provider level. CQC's provider-level reports for trusts currently include a report on what it finds through assessment and inspection of trust-wide leadership under the well-led key question. This assessment is used to corroborate and, where necessary, modify the trust-level rating of well-led that would be generated through aggregation from the location-level ratings.

56. As set out in CQC's consultation on the next phase of its inspections, Our next phase of regulation: A more targeted, responsive and collaborative approach, from 2017 CQC proposes to assess well-led at trust board level on a regular basis for all trusts, approximately annually, alongside a more targeted and risk-based approach to inspecting a selection of core services.

57. CQC's assessment of trust-wide leadership, governance, management and culture will be the starting point for the trust-level rating of well-led. This will take into account the findings for well-led at location-level, but will not be a simple aggregation of these. In strengthening its assessment of well-led, CQC is clear that there is a demonstrable link between leadership, culture and the delivery of safe, high-quality care and the focus on well-led is intended to support this link.

58. As with CQC's existing approach, the trust-level inspection of well-led will be conducted by a small, senior team of inspectors and specialist advisors. This team will draw on a range of evidence applicable at the overall trust board level, including interviews with board members and senior staff, focus groups, analysis

of data, review of strategic and trust-level policy documents, and information from external partners. In assessing financial management and resource governance aspects of the updated well-led framework, CQC will seek input from NHS Improvement where appropriate, building on NHS Improvement's work in the assessment of trusts' use of resources. The final judgement and responsibility and ownership of the well-led rating will remain with CQC.

59. The scope and depth of CQC's regular trust-level well-led inspections will vary according to the individual provider. In deciding on the nature of the inspection approach it will consider factors such as the size of the trust, the findings of previous inspections, and information gathered from the provider, external partners and other sources on performance and risks in the trust.

60. Where significant concerns are identified in CQC's inspections, NHS Improvement would commission more detailed governance reviews.

61. CQC will be developing and further testing its approach to inspecting well-led at trust level in the coming months, in collaboration with trusts and other stakeholders, including NHS Improvement.

You can provide feedback on the proposals for changes to the way that CQC will assess well-led in CQC's consultation Our next phase of regulation

4.5 Developmental reviews and board self-reviews

Developmental reviews by trusts

62. It is good practice for all trusts to regularly review their own leadership and governance. In line with good governance practice across all industries, they should carry out some form of external review of their governance arrangements on a regular basis, typically every three years.[12]

63. Developmental reviews will complement CQC's trust-level well-led reviews. Developmental reviews are both greater in scope and depth, forward-looking, preventative and focused on improvement. They aim to identify early any factors which may lead to future failings and provide insight into areas for further development.

64. Research has indicated that reliance on self-assessment may lead to positive bias or a lack of insight by some trust boards. An external perspective can provide more rigour, independence and objectivity. It supports boards to

[12] See for example the UK Corporate Code of Governance

challenge their self-reviews and more fully identify and overcome barriers that may impede their future effectiveness.

65. Trusts will assure themselves of their leadership and governance through a range of different means, such as external governance reviews (including peer review or consultancy support), advice from professional bodies, and feedback and guidance from regulators; these will be supported by self-reviews, internal audit, CQC inspections and board development programmes. Such developmental reviews reflect our view of good practice. As such, NHS Improvement proposes that, as for NHS foundation trusts now, developmental well-led reviews should be conducted on a 'comply or explain basis', meaning that trusts should be able to give a robust explanation if they use alternative means to assure themselves. As these reviews are for development purposes, trusts need only feed back that a review has been completed and if it identified any material governance concerns. Trusts' approach to learning from past developmental reviews, and planning for future reviews, would be a source of evidence that would be considered in CQC's regular trust-level well-led assessments.

66. In practice, providers in NHS Improvement's Single Oversight Framework segments 1 and 2 are already likely to be operating good governance practice, including seeking external assurance. These providers would generally need to explain to NHS Improvement's regional teams how they have assured themselves of the robustness of their governance arrangements. These reviews are likely to inform trusts' Annual Governance Statements[13]. Providers in Single Oversight Framework segments 3 and 4 may be required to commission developmental reviews as part of the support package agreed with NHS Improvement.

Consultation question 9: Do you have any views on NHS Improvement's proposals for developmental reviews?

Consultation question 10: Do you think that NHS Improvement's guidance should recommend developmental reviews (or equivalent activities):

(a) every three years, as with the current expectation for NHS foundation trusts?

(b) every five years, thereby reducing the current frequency for NHS foundation trusts?

(c) on the basis of risk, primarily informed by the outcome of CQC's well-led inspections or NHS Improvement's ongoing oversight under the Single Oversight Framework segmentation?

[13] NHS trusts are required to prepare an Annual Governance Statement as set out by the Department of Health Group Accounting Manual and NHS foundation trusts are required to prepare one, as set out in the NHS foundation trust Annual Reporting Manual (please see here for draft).

Board self-reviews

67. Self-reviews are an important part of good governance, helping to promote transparency, self-reflection and development. Although they do not provide an independent perspective, they help trusts scope their developmental reviews by identifying areas of focus.

68. Currently, trusts undertaking developmental well-led reviews will assess themselves against the well-led framework to shape the depth and breadth of the areas for investigation. NHS foundation trusts should also already be doing annual self-assessments, as the NHS foundation trust Code of Governance requires that their annual reports state that they have reviewed the effectiveness of their systems of internal controls.

69. As currently, trusts will be asked by CQC to provide a commentary and any supporting evidence against the new well-led framework, which will be submitted as part of the Provider Information Request (PIR) issued by CQC ahead of its trust-level well-led assessments. This self-review process can therefore be used as the basis for the PIR and to support the developmental reviews as described above, thereby minimising the burden on trusts.

Consultation question 11: Are there any other ways in which CQC and NHS Improvement could further streamline and reduce duplication for trusts in respect of the oversight and assessment of well-led?

4.6. Link to Single Oversight Framework

70. CQC's rating of well-led under the new well-led framework, and any material concerns arising from developmental reviews, will feed into the leadership and improvement capability theme of the Single Oversight Framework, helping NHS Improvement to identify and deploy the appropriate support. The Single Oversight Framework also draws on other evidence, rather than relying wholly on an annual assessment, enabling NHS Improvement to respond to any emerging challenges facing individual providers. NHS Improvement will engage as necessary early next year on any updates to the Single Oversight Framework.

5. Next steps and testing

71. As part of this consultation, NHS Improvement and CQC will continue to engage with a wide range of stakeholders on our proposals. As part of this, we plan to test the options for the assessment of use of resources and well-led with a number of trusts in Quarter 4 2016/17.

72. After the consultation, CQC and NHS Improvement will further test the KLOEs, prompts and characteristics (across both use of resources and well-led) and the metrics, including data quality, to make sure they appropriately reflect trust performance.

73. We propose to begin the Use of Resources assessments with a period of extended piloting from Quarter 1 to Quarter 3 2017/18. This will include the generation of 'shadow' or 'indicative' use of resources ratings for trusts assessed during this period. This would be a similar approach to that taken by CQC in introducing its new assessments from 2012. This will mean that CQC and NHS Improvement can refine the approach and ensure the end-to-end process is robust and benefits trusts when it goes live. CQC and NHS Improvement will publish full guidance on the assessment and ratings approach when the methodology is fully developed and assured, before beginning full implementation.

74. CQC will introduce its new assessment framework and approach for trusts from April 2017. This means that the first new Provider Information Requests will be sent from April 2017, and the associated assessments will take place within the following two to six months and be informed by CQC Insight.[14] CQC will roll out its new approach over two years to allow this to be evaluated, improved and refined. It expects that the approach will be fully embedded by April 2019, and at that point all trusts will have a well-led inspection and at least one core service inspection approximately every year.

Consultation question 12: Do you agree with our plans to develop, test and roll out our use of resources and well-led assessments?

Please tell us the reasons for your answer.

Consultation question 13: Are there other ways in which we should be engaging on our proposals for assessing and overseeing use of resources and well-led?

[14] As set out in *Our next phase of regulation: A more targeted, responsive and collaborative approach*, this is intended to replace CQC's Intelligent Monitoring and has been designed to identify potential changes to quality since the previous inspection and will look at different organisational levels of data.

Annex A: Draft Use of Resources assessment framework

1. Introduction

As public sector organisations, NHS trusts and NHS foundation trusts (here together referred to as trusts) are expected to demonstrate to their patients, communities and taxpayers that they are delivering value for money, evidencing both efficiency and effectiveness. This is even more important in times of fiscal austerity. NHS Improvement and CQC believe there is significant potential for more productive use of resources across the NHS, which would improve quality of care for patients.

The aim of NHS Improvement's new annual Use of Resources assessment (see Figure A1) is to understand how effectively providers are using their resources to provide high quality, efficient and sustainable care for patients. We will do this by assessing how well trusts are meeting financial controls, how financially sustainable they are, and how efficiently trusts use their finances, workforce, estates and facilities, data and procurement to deliver high quality care for patients and service users. Initially, our approach will focus largely on acute non-specialist services, due to the availability and quality of data in this area. As metrics are developed for specialist acute, ambulance, mental health and community services, we will include them in this framework.

The principles that underpinned the development of the framework are:

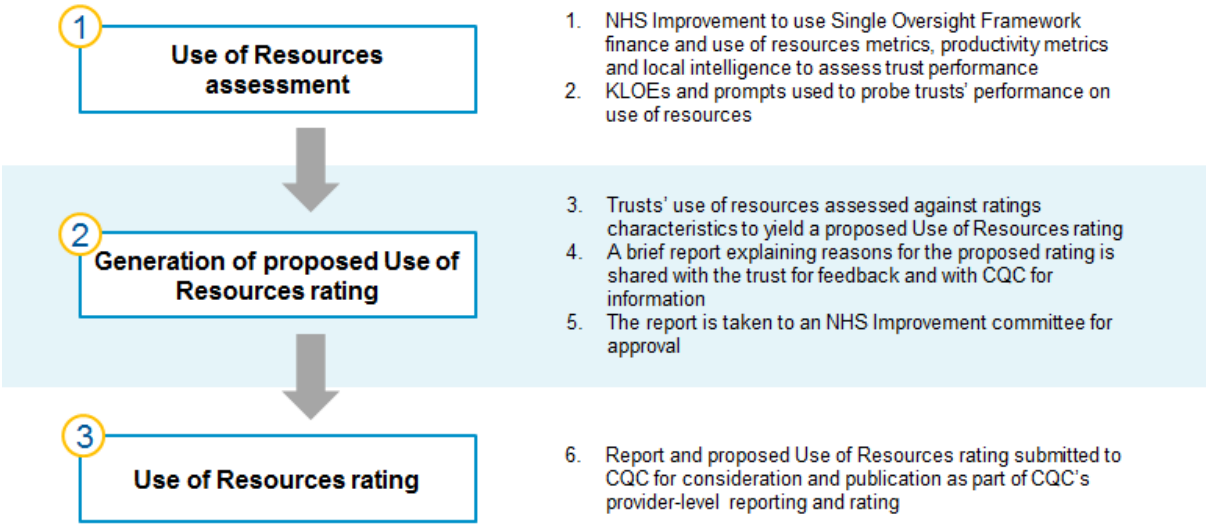
- the framework will link back to the Single Oversight Framework and will help NHS Improvement to identify trusts' support needs, as well as being a useful improvement tool for organisations
- there should be a focus on better quality of care and outcomes for patients
- the framework should align with and complement other national initiatives, in particular the Model Hospital dashboard developed following the Carter Review
- the assessment should be proportionate, minimising regulatory burden, and draw on existing data collections
- the prompts should promote good practice to aid beneficial innovation and improvement
- it should be apparent to trusts what information we will look for and what 'good' looks like.

The Use of Resources assessment framework broadly mirrors the structure of the well-led framework, with key lines of enquiry (KLOEs) and prompts (sub-questions) used to probe providers' performance on use of resources. The assessment is structured according to the compartments in the Model Hospital dashboard, with the

KLOEs corresponding to the following main areas of productivity – finance, clinical services, people and operational.

The proposed Use of Resources rating will be reached by examining performance against a small number of core metrics, and the related qualitative evidence from NHS Improvement's day-to-day interactions with trusts and dedicated site visit(s) and engagement with key staff using agreed KLOEs and prompts. This evidence will subsequently be assessed against ratings characteristics, which outline what constitutes outstanding, good, requires improvement or inadequate for use of resources.

Figure A1: Use of Resources assessment process



2. Use of resources: the evidence

The Use of Resources assessment centres on performance at a trust level; leadership and governance of finance and resources will be considered as part of the well-led framework. NHS Improvement will draw on a wide range of evidence in its assessments (see Figure A2) with the starting point being a basket of core metrics (see below). Additionally, NHS Improvement will consider a wider set of relevant data and local intelligence. The metrics and suggested evidence outlined here help structure the assessment of trusts. Where appropriate, additional questions, data or information in the relevant areas will be used to form the overall judgement.

Use of Resources assessments will be conducted by:

- reviewing performance against the core metrics

- reviewing relevant additional evidence from dedicated site visit(s) against a set of KLOEs and prompts
- considering evidence emerging from day-to-day interactions with the trust.

Figure A2: Evidence for Use of Resources assessments

Core metrics	• How is the trust performing on each core metric? • Are there any outliers in the core metrics?
All metrics	• Are there any outliers in the wider set of metrics (e.g. Model Hospital)?
Local intelligence	• Are there any areas of finance and productivity not covered by the metrics, where the trust's performance is notable? • Are there any areas where good or less good use of resources by the trust is impacting on quality or operational performance? • Are there any areas of unrealised efficiencies?

Core metrics

The core metrics that form part of the Use of Resources assessment are the focal point of the Use of Resources assessment (Figure A3). The starting point is the finance and use of resources theme metrics currently found in NHS Improvement's Single Oversight Framework. The other core metrics are productivity metrics drawn largely from the Model Hospital, covering finance, clinical services, operational and people. We are also seeking to develop the cost per weighted activity unit (WAU) metric so that it can be included in these core metrics.[15]

Technical guidance associated with the metrics, in particular what it means to perform well on any one of the core metrics, will be published in due course but see Appendix 1 to this annex for further details about our rationale for their inclusion.

The metrics will be used as the basis for the engagement with trusts as part of the assessment and no single metric will determine a trust's rating. Local intelligence and engagement with trusts will help us to understand the context in which the trust is operating. Additional relevant evidence, such as any metrics the trust is using to assess its productivity, will also give a broader picture of performance.

[15] The cost per WAU is a relative measure of efficiency at trust level comparable between trusts in-year. The cost per WAU compares inputs (costs) to outputs (the amount of work trusts do for the NHS) to obtain a measure of productivity, or value for money: trusts which use fewer inputs per unit of output are more productive.

There is ongoing work to develop productivity metrics relating to specialist, mental health, community and ambulance trusts, as well as to develop additional metrics for acute trusts. It would not be appropriate or practicable to replicate the full range of productivity metrics available in the Model Hospital in this assessment. Rather, we will consider whether new metrics provide broader insight into the productivity of trusts and should become part of the core metrics.

Figure A3: KLOE themes and indicative metrics

Area of use of resources	Indicative metrics
Finance	• Capital service capacity • Liquidity (days) • Income and expenditure margin • Distance from financial plan • Agency spend
Clinical services	• Pre-procedure non-elective bed days • Emergency readmissions • Cancelled operations • Proportion of beds occupied by those with an average length of stay of over seven days
People	• Vacancy and staff turnover rates • Sickness absence
Operational	• Purchase Price Index Benchmark tool top 100 index • Estates cost per square metre • Pharmacy spend – quarter-on-quarter change

For all metrics that we consider in assessing trusts' use of resources, our approach will be to ask the following general questions:

- Is the trust monitoring its performance against this measure?
- How does the performance compare to a relevant benchmark or target?
- Has the measure improved or deteriorated in the last 3-6 months?
- Is there a reason or relevant context for the trust's performance?
- Has the trust implemented any activities or interventions in order to improve performance as appropriate in the given area? Are they effective?

Additional evidence

Additional evidence will give a more rounded view of trust performance. It will help to give context to the trust's performance and identify where improvements can be made in areas that may have been missed by examining core metrics alone. In addition to the suggested metrics, we will also consider any metrics that the trust was using to assess or benchmark its performance.

When considering further evidence during Use of Resources assessments, additional data sources and metrics could for instance include metrics available through Better Care Better Value and the Model Hospital, such as care hours per patient day and more granular cost per working activity unit metrics.

Local intelligence

Local intelligence gathered during day-to-day interactions with trusts gives NHS Improvement a more rounded view of trust performance and the context in which the trust operates. It will help identify areas of poor performance, unrealised efficiencies and areas for improvement.

When considering local knowledge of the trust, we will particularly reflect on the following questions:

- Are there any areas of finance and productivity not covered by the metrics, where the trust's performance is notable?
- Are there any areas of quality or operational performance that could help provide a view on how well the trust is using its resources?
- Are there any areas of unrealised efficiencies?

3. Use of resources: the assessment

The aim of the Use of Resources assessment is to understand how effectively providers are using their resources to provide high quality, efficient and sustainable

care for patients. The KLOEs, prompts and performance against core metrics will serve as a basis for dialogue with trusts to come to a judgement on the trust's use of resources.

Building on the day-to-day interaction with trusts, NHS Improvement will also undertake a site visit(s) to obtain input from the key board members/executives who have responsibility for productivity and financial control. In conducting the assessment, we will use the KLOEs and prompts to help probe trust performance in a consistent way.

Key lines of enquiry

KLOEs are the basis for all engagement with trusts and are the lens through which the core metrics and trust performance should be seen (Figure A4). KLOEs serve to keep focus on the themes of the assessment throughout the process.

The KLOEs of the assessment are aligned with the Model Hospital, which is made up of four dashboards: clinical services, operational, people and a board-level dashboard, which includes finance.

Figure A4: Overview of key lines of enquiry

Area of use of resources	Key lines of enquiry (KLOEs)
Finance	How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?
Clinical Services	How well is the trust maximising patient benefit, given its resources?
People	How effectively is the trust using its workforce to maximise patient benefit?
Operational	How well is the trust maximising its operational productivity?

Prompts

The aim of the prompts (Figure A5), or sub-questions, is to get a better understanding of trust performance, contextual information and remedial actions undertaken by the trust. NHS Improvement will rely on these during the interview stage of the assessment.

Figure A5: Indicative prompts for key lines of enquiry

KLOE	Prompts
Finance: How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?	• Is the trust delivering, or on target to deliver, its control total and annual financial plan? • Is the trust maintaining positive cash reserves? • Is the trust able to adequately service its debt obligations? • How far does the trust rely on non-recurrent cost improvement plans (CIPs) to achieve financial targets? • What is the trust's track record of delivering CIP schemes? • Is the trust taking all appropriate opportunities to maximise its income? • Is the trust operating within the agency ceiling? • How does the trust use costing data across its service lines?
Clinical services: How well is the trust maximising patient benefit, given its resources?	• How far are delayed transfers of care that are within the trust's control leading to a lack of bed capacity and/or cancellations of elective operations? • Is the trust improving clinical productivity by doing what could reasonably be expected of it in co-ordinating services across the local health and care economy? • What is the rate of emergency readmissions? • What is the rate of DNAs (did not attend)? • What percentage of elective and non-elective cases is admitted on the day of surgery for each specialty? • What percentage of planned activity is cancelled on the day of surgery for each specialty and for what reasons?
People: How effectively is the trust using its workforce to maximise patient	• How is the trust tackling excessive pay bill growth, where relevant? • How well is the trust reducing its reliance on agency staff? • Are there significant gaps in current staff rotas? What is the trust doing to

benefit?	address these? • To what extent does the trust rely on management consultants or other external support services? • Is the trust making effective use of e-rostering or similar systems, for nurses, midwives, healthcare assistants and other clinicians? How many weeks in advance are the trust's rosters signed off? • Is there an appropriate skill mix for the work being undertaken? Are beneficial alternative or non-traditional staffing models of care delivery being investigated? • Is the trust an outlier in terms of sickness absence and/or staff turnover? • What proportion of consultants have a current job plan? How is job plan data captured? • What is the average number of sessions per consultant in the trust and what proportion involve direct clinical care?
Operational: How well is the trust maximising its operational productivity?	• What progress is being made towards meeting the estates and facilities CIP productivity efficiencies? • How effectively is backlog maintenance being managed? • Is the trust using technology in innovative ways to improve efficiency? For example, patients receive telephone or virtual follow-up appointments after elective treatment. • What is the trust doing to consolidate its corporate service functions? Which functions are being consolidated and how? • Is the trust collaborating appropriately with other service providers to deliver non-urgent pathology services? • Is the trust an outlier in terms of its procurement costs, including medicines spend? • Is the trust looking for and implementing appropriate efficiencies in its procurement processes?

4. Ratings characteristics

We have developed indicative characteristics to describe what outstanding, good, requires improvement and inadequate use of resources look like (see below for indicative areas and wording). This framework, when applied using judgement and taking into account good practice and recognised guidelines, will guide NHS Improvement and CQC when assessing trusts' use of resources and determining ratings. The characteristics set out the kinds of factors that will be taken into account in making our overall assessment. A trust will not have to demonstrate all the attributes in a ratings characteristic to have it applied to them nor will a characteristic be applied purely because the majority of the attributes are considered to be present. Ratings will be proportionate to all the available evidence and the specific circumstances.

NHS Improvement will write a brief report based on the assessment and evidence collected and use the ratings characteristics to come to a proposed Use of Resources rating. The report will be shared with trusts to given an opportunity to provide feedback before it is finalised, at which point CQC will also receive the report for information. The report and proposed rating will be subjected to internal quality assurance, through an NHS Improvement committee. A NHS Improvement committee will ratify the final proposed rating. NHS Improvement will provide CQC with the report on its use of resources assessment, together with its proposed rating.

CQC will consider the report and the proposed rating as part of the process of preparing and finalising its trust-level inspection report. CQC will give appropriate weight to NHS Improvement's report and recommendations in determining the trust's final Use of Resources rating and report that evidence in the trust's inspection report.

As at present, providers will have an opportunity to provide feedback on the factual accuracy of the CQC inspection report at the final draft stage (which will include the findings of the Use of Resources assessment and rating). If a provider challenges evidence relating to the Use of Resources assessment, CQC will work with NHS Improvement to review the evidence (and, where necessary, the rating) in light of the information received from the trust.

Outstanding (1)

The trust is performing strongly, well above minimum acceptable requirements, achieving excellent value for money.

The trust takes a proactive, and often innovative, approach to anticipating and managing finances and other resources, which supports the delivery of high quality care and demonstrates that value for money is being achieved. It has an excellent track record of managing spending within available resources.

The trust manages its resources in a way that allows it to exceed its financial obligations on a sustainable basis. The trust is likely or planning to be on course to deliver a sustainable surplus in the next 12 months.

Overall, resources are used as efficiently and effectively as possible to provide the best possible value (that is, quality and cost) to patients and taxpayers, for example around the income and expenditure margin.

Use of resources is actively planned and managed to meet the operational and financial objectives of the hospital, for example performance against financial plan, well-managed cost improvement programmes (CIPs) (with long-term plans to transform clinical and non-clinical services resulting in permanent cost savings and improvements in care) and management consultancy spend.

There is effective control over staff costs, including regarding pay bill growth, operating below or at its agency cap, and low vacancy and staff turnover levels. There are examples of staffing innovation replacing traditional models of care delivery (for example, use of nursing associates).

The organisation plans, organises and deploys its workforce effectively to maximise productivity.

Overall cost-effectiveness of the estates management function is regularly monitored and managed, for example by keeping estates and facilities running costs low and addressing the property maintenance backlog with plans to reduce this over time.

The trust can demonstrate the use of technology in innovative ways to improve efficiency, for example through telephone and virtual follow-up appointments, real-time monitoring and reporting of operational data, medical staff job planning through e-rostering systems, e-prescribing, basic electronic catalogues for procurement and electronic payments.

The trust is actively looking for and implementing appropriate efficiencies across the majority of its procurement processes, and consolidation of back office and pathology services is underway.

There is a holistic approach to planning patient discharge, transfer or transition to other services that are more appropriate for the delivery of their care or rehabilitation, resulting in reduced lengths of stay. Additionally, clinical productivity improvements are achieved by appropriately co-ordinating services across the local health and care economy, leading to low rates of emergency readmissions.

Good (2)

The trust is performing well and consistently above minimum acceptable levels.

The trust is actively managing resources to meet its financial obligations on a sustainable basis to deliver high quality care and good value for money. There are few additional efficiencies to be realised.

The trust is meeting its operational and financial objectives, demonstrated by being on target to deliver its financial plan, well-managed consultancy spend and CIPs. Staffing costs are generally well controlled, for example regarding pay bill growth, acceptable vacancy and turnover rates, and distance from the trust's cap on agency controls.

Total estates and facilities running costs per area (£/m^2) are relatively low and a plan is in place to reduce property maintenance backlog over time.

While not fully mature, the trust is using technology in some areas to improve productivity and effectiveness, for example by better utilisation of existing digital systems and introducing medical staff job planning through e-rostering systems.

The trust is actively looking for and implementing some efficiencies in its procurement processes, and consolidation of back office and pathology services is underway.

There are good attempts to have a holistic approach to planning patient discharge, transfer or transition to other services that are more appropriate for the delivery of their care or rehabilitation, resulting in reduced lengths of stay. There are good attempts to achieve clinical productivity improvements through appropriately co-ordinating services across the local health and care economy, leading to low rates of emergency readmissions.

Requires improvement (3)

The trust is demonstrating adequate performance and operating at only minimum acceptable levels of performance to operate effectively.

The trust does not consistently manage its resources in a way that allows it to meet its financial obligations on a sustainable basis and to deliver high quality care and good value for money. Many unmet efficiency opportunities have been identified.

Use of resources is not always actively planned and managed to meet both the trust's operational and financial objectives, as evidenced, for example, by being behind on

delivery of the financial plan, and exceeding the trust's cap on agency controls.

Resources are not being used as efficiently as possible to maximise possible value to patients and taxpayers.

There is little management of the maintenance backlog, CIPs are failing to deliver recurrent efficiencies or are cutting resources without sufficient consideration of the potential impact on quality, and management consultancy spend is not well managed. Opportunities have not been taken to consolidate back office or pathology functions.

There is inadequate control over staff costs, with high vacancy and staff turnover rates as a percentage of the average total staff and poor job planning, indicating reduced effectiveness of human resources.

A material number of patients are receiving care in the wrong clinical setting and the trust is not doing enough to address the delayed transfers of care for patients out of the acute hospital setting. Poor discharge planning and a lack of collaborative working are resulting in high rates of emergency readmissions.

The trust is using minimal, if any, innovative technology to improve efficiency, with little use made of its existing digital systems. For example, there are no basic electronic catalogues for procurement.

Inadequate (4)

The trust demonstrates inadequate performance and is operating below minimum requirements, raising very serious and/or complex concerns.

The trust is not managing its finances and other resources in a way that supports the delivery of high quality care or demonstrates value for money is being achieved. As such, the trust's operation is significantly worse than similar trusts.

The trust consistently fails to manage its resources in a way that allows it to meet its financial obligations.

Resources are not used as efficiently as possible, so good value to patients and taxpayers is rarely achieved. Significant and wide ranging unmet efficiency opportunities have not been identified or there is clear evidence that quality of care is being compromised by the implementation of efficiency initiatives.

There is minimal or no active planning and management of resources to meet both the trust's operational and financial objectives, evidenced, for example, by it failing to deliver the submitted financial plan and being more than 50% above its cap on agency controls.

The workforce is not being used effectively, demonstrated by substantial or frequent

staff shortages, high vacancy and turnover rates and poor job planning.

There is over reliance on agency staff, inappropriate use of management consultancy and undue pay bill growth.

There is no effective programme in place to repair and maintain the trust's estate.

Little or no work is being undertaken on consolidation of back office and pathology services. Plans for patient discharge or transfers are incomplete or significantly delayed, and as such patients are not moved into settings that are more appropriate for the delivery of their care or rehabilitation, or are being cared for in the wrong clinical setting. Poor discharge planning and a lack of collaborative working are resulting in unacceptably high rates of emergency readmissions.

The trust is not utilising its existing digital systems and is doing little to use technology in innovative ways to improve efficiency, for example no use of basic electronic catalogues for procurement and no payments made electronically.

Appendix 1: Use of resources metrics and rationale

We will publish a set of technical definitions with the final assessment framework.

Area	Indicative metrics	Rationale
Finance	• Capital service capacity	This metric assesses the degree to which the organisation's generated income covers its financing obligations.
	• Liquidity (days)	This metric measures the days of operating costs held in cash or cash equivalent forms. This reflects the provider's ability to pay staff and suppliers in the immediate term. Providers should maintain a positive number of days of liquidity.
	• I&E margin	This metric measures the degree to which an organisation is operating at a surplus or deficit. Operating at a sustained deficit indicates that a provider may not be financially viable or sustainable.

	• Distance from financial plan	This metric measures the variance between the trust's annual financial plan and its actual performance. Trusts are expected to be on, or ahead, of financial plan, so as to ensure that the sector achieves, or exceeds, its annual forecast. Being behind plan may be the result of poor financial management, poor financial planning or both.
	• Agency spend	Over reliance on agency staff can significantly increase costs without increasing productivity. Organisations should aim to reduce the proportion of their pay bill spent on agency staff.
Clinical services	• Pre-procedure non-elective bed days	This metric looks at the length of stay between admission and an emergency procedure being undertaken – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
	• Emergency readmissions	This metric looks at the number of emergency readmissions within 30 days of the original procedure/stay, and the associated financial opportunity of reducing this number. Better performers will have a lower rate of readmission.
	• Cancelled operations	This metric looks at the number of (emergency) operations cancelled (for a second time) – and the associated opportunity of reducing the rate of cancellation. Better performers will have a lower rate of cancellation.
	• Proportion of beds occupied by those with an average length of stay of over seven days	This metric looks at the proportion of beds occupied by those with a length of stay of more than seven days ('stranded patients'), and the associated financial opportunity of discharging patients at the point when inpatient hospital care is no longer required. This is looked at as a daily rate.

People	• Staff turnover rates	This metric considers the stability of the workforce. Some turnover in an organisation is acceptable and healthy, but a high level can impact negatively on organisational performance (eg through loss of capacity, skills and knowledge). In most circumstances organisations should seek to reduce the percentage of leavers over time.
	• Sickness absence	High levels of sickness absence can impact negatively on organisational performance and productivity. Organisations should aim to reduce the number of days lost through sickness absence over time.
Operational	• Purchase Price Index Benchmark tool top 100 index	This metric is a proxy for the efficiency of the trust's procurement and its effectiveness in achieving savings. It compares a trust's spend on its top 100 items with the average for other trusts, to benchmark procurement spent, while taking into consideration the differences in trust profiles. The opportunity for trusts is in reducing spend to the average.
	• Estates cost	This metric examines the overall cost-effectiveness of the trust's estates, looking at the cost per m^2. The aim is to reduce property costs relative to those paid by peers over time.
	• Pharmacy spend (quarter-on-quarter change)	This metric looks at the percentage change in pharmacy/medicines spend from the last quarter to the latest reported quarter. Better performers will find ways to minimise spend.

Annex B: The Care Quality Commission and NHS Improvement's shared approach to well-led[16]

1. Introduction

One of the five key questions that the Care Quality Commission (CQC) uses to assess services is whether they are 'well-led'. By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

NHS Improvement and CQC have been working together to agree a shared definition of a well-led provider. We are also working to agree an integrated approach to assessing well-led, so that it minimises burden, while providing timely identification of any improvements needed. We are consulting on a new joint framework (the main document), which builds on CQC's current approach and Monitor's previous well-led framework published in 2014.[17]

2. Key lines of enquiry

The proposed new well-led framework is based on eight key lines of enquiry (KLOEs). This framework brings together CQC's current five KLOE and the ten questions asked in Monitor's well-led framework published in 2014.

Figure B1: Well-led framework key lines of enquiry

[16] Feedback on Annex B is welcome via the CQC consultation Our next phase of regulation: A more targeted, responsive and collaborative approach

[17] See www.gov.uk/government/publications/well-led-nhs-foundation-trusts-a-framework-for-structuring-governance-reviews

3. Prompts for each key lines of enquiry

Below we list the prompts for each KLOE. These can also be found in CQC's consultation on their next phase approach.

NHS Improvement will publish further guidance, including a good practice guide, to help trusts to:

- identify what good leadership and governance looks like
- structure their developmental reviews.

Code	Prompt	Core/ sector specific
W1	**Is there the leadership capacity and capability to deliver high quality, sustainable care?**	
W1.1	Do leaders have the skills, knowledge, experience and integrity that they need –both when they are appointed and on an on-going basis?	Core
W1.2	Do leaders understand the challenges to quality and sustainability, and can they identify the actions needed to address them?	Core
W1.3	Are leaders visible and approachable?	Core
W1.4	Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme, which includes succession planning?	Core
W2	**Is there a clear vision and credible strategy to deliver high quality sustainable care to people who use services, and robust plans to deliver?**	
W2.1	Is there a clear vision and a set of values, with quality and sustainability as the top priorities?	Core
W2.2	Is there a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care?	Core
W2.3	Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners?	Core

W2.4	Do staff know and understand what the vision, values and strategy are, and their role in achieving them?	Core
W2.5	Is the strategy aligned to local plans in the wider health and social care economy, and have services been planned to meet the needs of the relevant population?	Core
W2.6	Is progress against delivery of the strategy and local plans monitored and reviewed, and is there evidence to show this?	Core
W3	**Is there a culture of high quality, sustainable care?**	
W3.1	Do staff feel supported, respected and valued?	Core
W3.2	Is the culture centred on the needs and experience of people who use services?	Core
W3.3	Do staff feel positive and proud to work in the organisation?	Core
W3.4	Is action taken to address behaviour and performance that is inconsistent with the vison and values, regardless of seniority?	Core
W3.5	Does the culture encourage candour, openness and honesty at all levels within the organisation, including with people who use services in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised?	Core
W3.6	Are there mechanisms for providing all staff at every level with the development they need, including high quality appraisal and career development conversations?	Core
W3.7	Is there a strong emphasis on the safety and well-being of staff?	Core
W3.8	Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably?	Core
W3.9	Are there cooperative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?	core

W4	**Are there clear responsibilities, roles and systems of accountability to support good governance and management?**	**Core**
W4.1	Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services? Are these regularly reviewed and improved?	Core
W4.2	Do all levels of governance and management function effectively and interact with each other appropriately?	Core
W4.3	Are staff at all levels clear about their roles and do they understand what they are accountable for, and to whom?	Core
W4.4	Are arrangements with partners and third-party providers governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care?	Core
W4.5	Are there robust arrangements to make sure that hospital managers discharge their specific powers and duties according to the provisions of the Mental Health Act 1983?	Specialist MH services
W5	**Are there clear and effective processes for managing risks, issues and performance?**	**Core**
W5.1	Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved?	Core
W5.2	Are there processes to manage current and future performance? Are these regularly reviewed and improved?	Core
W5.3	Is there a systematic programme of clinical and internal audit to monitor quality, operational, and financial processes, and systems to identify where action should be taken?	Core
W5.4	Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what staff say is ‘on their worry list’?	Core
W5.5	Are potential risks taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities?	Core

W5.6	When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? Are there examples of where the financial pressures have compromised care?	Core
W6	**Is robust and appropriate information being effectively processed and challenged?**	Core
W6.1	Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is information used to measure for improvement, not just assurance?	Core
W6.2	Do quality and sustainability both receive sufficient coverage in relevant meetings at all levels? Do all staff have sufficient access to information, and challenge it appropriately?	Core
W6.3	Are there clear and robust service performance measures, which are reported and monitored?	Core
W6.4	Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified?	Core
W6.5	Are information technology systems used effectively to monitor and improve the quality of care?	Core
W6.6	Are there effective arrangements in place to ensure that data or notifications are submitted to external bodies as required?	Core
W6.7	Are there robust arrangements (including internal and external validation), to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches?	Core
W7	**Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?**	Core
W7.1	Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups?	Core

W7.2	Are people who use services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture? Does this include people in a range of equality groups?	Core
W7.3	Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include those with a protected characteristic?	Core
W7.4	Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs?	Core
W7.5	Is there transparency and openness with all stakeholders about performance?	Core
W8	**Are there robust systems and processes for learning, continuous improvement and innovation?**	Core
W8.1	In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes?	Core
W8.2	Are there standardised improvement tools and methods, and do staff have the skills to use them?	Core
W8.3	How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a service user? Is learning shared effectively and used to make improvements?	Core
W8.4	Do all staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance? Does this lead to improvements and innovation?	Core
W8.5	Are there systems in place to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work?	Core

4. Well-led ratings characteristics

Below we set out the ratings characteristics for each KLOE. These can also be found in the CQC consultation Our next phase of regulation: A more targeted, responsive and collaborative approach.

	Outstanding	Good	Requires improvement	Inadequate
WELL-LED	The leadership, governance and culture are used to drive and improve the delivery of high quality person-centred care.	The leadership, governance and culture promote the delivery of high quality person-centred care.	The leadership, governance and culture do not always support the delivery of high quality person-centred care.	The delivery of high quality care is not assured by the leadership, governance or culture in place.
W1 Is there the leadership capacity and capability to deliver high quality, sustainable care?				
Applicability	**Outstanding**	**Good**	**Requires improvement**	**Inadequate**
Core	There is compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrate the high levels of experience, capacity and capability needed to deliver excellent and sustainable care, and there is a deeply embedded system of leadership development and succession planning which aims to ensure that the leadership is representative of the diversity of the workforce. Comprehensive and successful leadership strategies are in place to ensure and sustain delivery and to develop the desired	Leaders have the experience, capacity, capability and integrity to ensure that the strategy can be delivered and risks to performance are addressed. Leaders at all levels are visible and approachable. Compassionate, inclusive and effective leadership is sustained through a leadership strategy or development programme and effective selection, development and succession processes. The leadership is knowledgeable about issues and priorities for the quality and sustainability of services, understands what the challenges are and takes action to address them.	Not all leaders have the necessary experience, knowledge, capacity, capability or integrity to lead effectively. Staff do not consistently know who their leaders are or how to gain access to them. The need to develop leaders is not always identified or action is not always taken. Leaders are not always aware of the risks, issues and challenges in the service. Leaders are not always clear about their roles and their accountability for quality.	Leaders do not have the necessary experience, knowledge, capacity, capability or integrity to lead effectively. There is no stable leadership team, with high unplanned turnover and/or vacancies. Leaders are out of touch with what is happening on the front line, and they cannot identify or do not understand the risks and issues described by staff. There is little or no attention to succession planning and development of leaders. Staff do not know who their leaders are, what they do, or are unable to access them. There are few examples of leaders making a demonstrable impact on the quality or sustainability of

	culture. Leaders have a deep understanding of issues, challenges and priorities in their service, and beyond.			services.
W2 Is there a clear vision and credible strategy to deliver high quality sustainable care to people who use services, and robust plans to deliver?				
Applicability	**Outstanding**	**Good**	**Requires improvement**	**Inadequate**
Core	The strategy and supporting objectives and plans are stretching, challenging and innovative while remaining achievable. Strategies and plans are fully aligned with plans in the wider health economy, and there is a demonstrated commitment to system-wide collaboration and leadership. There is a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans. Plans are consistently implemented, and have a positive impact on quality and sustainability of services.	There is a clear statement of vision and values, driven by quality and sustainability. It has been translated into a robust and realistic strategy and well-defined objectives that are achievable and relevant. The vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and, external partners. The strategy is aligned to local plans in the wider health and social care economy and services are planned to meet the needs of the relevant population. Strategic objectives are supported by quantifiable and measurable outcomes, which are cascaded throughout the organisation. The challenges to achieving the strategy, including relevant local health economy factors, are understood and an	The strategy and plans have some significant gaps or weaknesses that undermine their credibility, and do not fully reflect the health economy in which the service works. They may not have been recently created or reviewed. Staff do not always understand how their role contributes to achieving the strategy. The statement of vision and guiding values is incomplete, out of date, or not fully credible. Results of stakeholder consultation are not always taken into account in strategies or plans. Staff are not always aware of or supportive of, or do not understand, the vision and values, or have not been fully involved in developing them. Progress against delivery of the strategy and plans is not consistently or effectively monitored, reviewed or	There is no current strategy, the strategy is not underpinned by detailed, realistic objectives and plans for high-quality and sustainable delivery, and it does not reflect the health economy in which the service works. Staff do not understand how their role contributes to achieving the strategy. There is no credible statement of vision and guiding values. Key stakeholders have not been engaged in the creation of the strategy. Staff are not aware of or supportive of, or do not understand, the vision and values, or they were developed without staff and wider engagement. There is no effective approach to monitoring, reviewing or providing evidence of progress against delivery of the strategy or plans. The strategy has not been translated into meaningful and measurable plans at all levels of the service.

		action plan is in place. Staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them. Progress against delivery of the strategy and local plans is monitored and reviewed, and there is evidence to show this.	evidenced. Leaders at all levels are not always held to account for the delivery of the strategy.	
W3 Is there a culture of high quality, sustainable care?				
Applicability	**Outstanding**	**Good**	**Requires improvement**	**Inadequate**
Core	Leaders have an inspiring shared purpose, and strive to deliver and motivate staff to succeed. There are high levels of satisfaction across all staff, including those with particular protected characteristics under the Equality Act. There is a strong organisational commitment and effective action towards ensuring that there is equality and inclusion across the workforce. Staff are proud of the organisation as a place to work and speak highly of the culture. Staff at all levels are actively encouraged to speak up and raise concerns. There is strong collaboration, team-working and support across all functions and a common	Leaders model and encourage compassionate, inclusive and supportive relationships among staff so that they feel respected, valued and supported. Leaders at every level live the vision and embody shared values, prioritise high quality, sustainable and compassionate care, and promote equality and diversity. They encourage pride and positivity in the organisation and focus the attention on the needs and experiences of people who use services. Behaviour and performance inconsistent with the vision and values is acted on regardless of seniority. Candour, openness, honesty and transparency and	Staff satisfaction is mixed. Improving the culture or staff satisfaction is not seen as a high priority. Staff do not always feel actively engaged or empowered. There are teams working in silos or management and clinicians do not always work cohesively. Staff do not always raise concerns or they are not always taken seriously or treated with respect when they do. People do not always receive a timely apology when something goes wrong and are not consistently told about any actions taken to improve processes to prevent the same happening again.	There is no understanding of the importance of culture. There are low levels of staff satisfaction, high levels of stress and work overload. Staff do not feel respected, valued, supported or appreciated. There is poor collaboration or cooperation between teams and there are high levels of conflict. The culture is top-down and directive. It is not one of fairness, openness, transparency, honesty, challenge and candour. When something goes wrong, people are not always told and do not receive an apology. Staff are defensive and are not compassionate. There are high levels of bullying, harassment, discrimination or violence, and the organisation is

	focus on improving the quality and sustainability of care and people's experiences.	challenges to poor practice are the norm. The leadership actively promotes staff empowerment to drive improvement and the benefit of raising concerns is encouraged and valued. Staff actively raise concerns and those who do (including external whistleblowers) are supported. Concerns are investigated in a sensitive and confidential manner, and lessons are shared and acted upon. When something goes wrong, people receive a sincere and timely apology and are told about any actions taken to improve processes to prevent the same happening again. There are processes to support staff and promote their positive wellbeing. Behaviour and performance inconsistent with the values is identified and dealt with swiftly and effectively, regardless of seniority. There is a culture of collective responsibility between teams and services. There are positive relationships between staff and teams, where conflicts are resolved quickly and constructively and responsibility	Staff development is not always given sufficient priority. Appraisals take place inconsistently or are not of high quality. Equality and diversity are not consistently promoted and the causes of workforce inequality are not always identified or adequately addressed. Staff, including those with particular protected characteristics, do not always feel they are treated equitably.	not taking adequate action to reduce this. When staff raise concerns they are not treated with respect. The culture is defensive. There is little attention to staff development and there are low appraisal rates.

		is shared. There are processes for providing all staff at every level with the development they need, including high quality appraisal and career development conversations. Equality and diversity are actively promoted and work is undertaken to identify the causes of any workforce inequality and action taken to address these. Staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably.		
W4 Are there clear responsibilities, roles and systems of accountability to support good governance and management?				
Applicability	**Outstanding**	**Good**	**Requires improvement**	**Inadequate**
Core	Governance arrangements are proactively reviewed and reflect best practice. A systematic approach is taken to working with other organisations to improve care outcomes.	The board and other levels of governance within the organisation function effectively and interact with each other appropriately. Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective. Staff are clear on their roles and accountabilities.	The arrangements for governance and performance management are not fully clear or do not always operate effectively. There has been no recent review of the governance arrangements, the strategy, or plans. Staff are not always clear about their roles, what they are accountable for, and to whom.	The governance arrangements and their purpose are unclear, and there is a lack of clarity about authority to make decisions and how individuals are held to account. There is no process to review key items such as the strategy, values, objectives, plans or the governance framework. Staff and their managers are not clear on their roles or accountabilities. There is a lack of systematic performance management of individual staff, or appropriate use of incentives or

				sanctions.
Specialist mental health services		CQC Mental Health Act (MHA) reviewer reports are reviewed by non-executive members and the board is aware that any required action has been taken to address identified issues. Statistical information on MHA operation is monitored and statistical information on patterns of admission and length of stay is considered and compared with national data. The board receives reports on the performance of the MHA managers in reviewing detention and on second opinion appointed doctor (SOAD) requests and activity. Action is taken as required. The board makes sure that relationships with stakeholders, such as local authorities and the police, raise issues about MHA implementation.	Mental Health Act (MHA) reviewer reports are not routinely reviewed and statistical information on the MHA is not always monitored and compared with national data. There are relationships with stakeholders around the MHA, but they are not formalised to address any issues of implementation. Reports on the performance of MHA managers is gathered, but not reviewed at board level. Second opinion appointed doctor (SOAD) requests and activity are not routinely reported to the board.	Mental Health Act (MHA) reviewer reports are not reviewed by the board. Information relevant to monitoring the MHA, including performance of MHA managers and SOAD activity, is not robustly collected, not reviewed appropriately or action is not taken as a result.
W5 Are there clear and effective processes for managing risks, issues and performance?				
Applicability	**Outstanding**	**Good**	**Requires Improvement**	**Inadequate**
Core	There is a demonstrated	The organisation has the	Risks, issues and poor	There is little understanding or

	commitment to best practice performance and risk management systems and processes, regularly reviewing their operation, and ensuring the staff at all levels have the skills and knowledge to use those systems and processes effectively. Problems are identified and addressed quickly and openly.	processes to manage current and future performance. There is an effective and comprehensive process to identify, understand, monitor and address current and future risks. Performance issues are escalated to the appropriate committees and the board through clear structures and processes. Clinical and internal audit processes function well and have a positive impact in relation to quality governance, with clear evidence of action to resolve concerns. Financial pressures are managed so that they do not compromise the quality of care. Service developments and efficiency changes are developed and assessed with input from clinicians to understand their impact on the quality of care.	performance are not always dealt with appropriately or quickly enough. The risk management approach is applied inconsistently or is not linked effectively into planning processes. The approach to service delivery and improvement is reactive and focused on short term issues. Clinical and internal audit processes are inconsistent in their implementation and impact. The sustainable delivery of quality care is put at risk by the financial challenge.	management of risks and issues, and there are significant failures in performance management and audit systems and processes. Risk or issue registers and action plans, if they exist at all, are rarely reviewed or updated. Meeting financial targets is seen as a priority at the expense of quality.
W6 Is robust and appropriate information being effectively processed and challenged?				
Applicability	**Outstanding**	**Good**	**Requires improvement**	**Inadequate**
Core	The service invests in innovative and best practice information systems and processes. The information used in reporting, performance management and delivering quality care is	Integrated reporting supports effective decision making. There is an holistic understanding of performance, which sufficiently covers and integrates the views of people, with quality, operational and	The information used in reporting, performance management and delivering quality care is not always accurate, valid, reliable, timely or relevant. Leaders and staff do not always receive	The information that is used to monitor performance or to make decisions is inaccurate, invalid, unreliable, out of date or not relevant. Finance and quality management are not integrated to support decision making. There

	consistently found to be accurate, valid, reliable, timely and relevant. There is a demonstrated commitment at all levels to proactively sharing data and information to drive and support internal decision making as well as system-wide working and improvement.	financial information. Quality and sustainability both receive sufficient coverage in relevant meetings at all levels. Performance information is used to hold management and staff to account. The information used in reporting, performance management and delivering quality care is usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses. Staff receive helpful data on a daily basis, which supports them to adjust and improve performance as necessary. Integrated reporting supports effective decision-making. Data or notifications are consistently submitted to external organisations as required. There are robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Information technology systems are used effectively to monitor and improve the quality of care.	information to enable them to challenge and improve performance. Information is used mainly for assurance and rarely for improvement. Required data or notifications are inconsistently submitted to external organisations. Arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems are not always robust	is inadequate access to and challenge of performance by leaders and staff. There are significant failings in systems and processes for the management or sharing of data.
W7 Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?				
Applicability	**Outstanding**	**Good**	**Requires improvement**	**Inadequate**

Core	There are consistently high levels of constructive engagement with staff and people who use services, including all equality groups. Rigorous and constructive challenge from people who use services, the public and stakeholders is welcomed and seen as a vital way of holding services to account. Services are developed with the full participation of those who use them, staff and external partners as equal partners. Innovative approaches are used to gather feedback from people who use services and the public, including people in different equality groups, and there is a demonstrated commitment to acting on feedback. The service takes a leadership role in its health system to identify and proactively address challenges and meet the needs of the population.	A full and diverse range of people's views and concerns are encouraged, heard and acted on to shape services and culture. The service proactively engages and involves all staff (including those with particular protected equality characteristics) and ensures that the voices of all staff are heard and acted on to shape services and culture. The service is transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the population and to design improvements to meet them.	There is a limited approach to sharing information with and obtaining the views of staff, people who use services, external partners and other stakeholders, or insufficient attention to appropriately engaging those with particular protected equality characteristics. Feedback is not always reported or acted upon in a timely way.	There is minimal engagement with people who use services, staff, the public or external partners. The service does not respond to what people who use services or the public say. Staff are unaware or are dismissive of what people who use the service think of their care and treatment. Staff or patient feedback is inappropriately filtered or sanitised before being passed on.
W8 Are there robust systems, processes for learning, continuous improvement and innovation?				
Applicability	**Outstanding**	**Good**	**Requires improvement**	**Inadequate**
Core	There is a fully embedded and systematic approach to	There is a strong focus on continuous learning and	There is weak or inconsistent investment in improvement	There is little innovation or service development, no knowledge or

	improvement, making consistent use of a recognised improvement methodology. Improvement is seen as the way to deal with performance and for the organisation to learn. Improvement methods and skills are available and used across the organisation, and staff are empowered to lead and deliver change. Safe innovation is celebrated. There is a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care. There is a strong record of sharing work locally, nationally and internationally.	improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research. There is knowledge of improvement methods and skills to use them at all levels of the organisation. There are organisational systems to support improvement and innovation work, including, staff objectives, rewards, data systems, and ways of sharing improvement work. The service makes effective use of internal and external reviews, with learning shared effectively and used to make improvements. Staff are encouraged to use information and regularly take time out to review individual and team objectives, processes and performance. This is used to make improvements.	skills and systems among staff and leaders. Improvements are not always identified or action not always taken. The organisation does not react sufficiently to risks identified through internal processes, but often relies on external parties to identify key risks before they start to be addressed. Where changes are made, the impact on the quality and sustainability of care is not fully understood in advance or it is not monitored.	appreciation of improvement methodologies, and improvement is not a priority among staff and leaders. There is minimal evidence of learning and reflective practice. The impact of service changes on the quality and sustainability of care is not understood.

Annex C: Summary of consultation questions

Consultation question 1: Do you agree with the proposed process for assessing and rating trusts' use of resources?

Please tell us the reasons for your answer.

Consultation question 2: What are your views on how the Use of Resources rating could over time be combined with CQC's existing trust quality rating?

Consultation question 3: Do you think these initial indicative metrics provide a reasonable starting point for informing the assessment of a trust's performance on use of resources? Are there other metrics we should consider when assessing a trust's productivity?

Consultation question 4: What are your views on the indicative key lines of enquiry and prompt questions that we are proposing for the assessment of trusts' use of resources as set out in Annex A?

Please tell us if you think we should include something different or additional.

Consultation question 5: What are your views on the indicative characteristics we have proposed for the use of resources ratings of outstanding, good, requires improvement and inadequate as set out in Annex A?

Please tell us if you think we should include something different or additional.

Consultation question 6: Do you agree that the Use of Resources rating should be reflected in trusts' finance and use of resources scores in the Single Oversight Framework?

Please tell us the reasons for your answer.

Consultation question 7: Do you agree with the additions to the well-led framework?

Please tell us the reasons for your answer.

Consultation question 8: Are there additional areas we could consider on quality, operational and financial governance?

Consultation question 9: Do you have any views on NHS Improvement's proposals for developmental reviews?

Consultation question 10: Do you think that NHS Improvement's guidance should recommend developmental reviews (or equivalent activities):

(a) every three years, as with the current expectation for NHS foundation trusts?

(b) every five years, thereby reducing the current frequency for NHS foundation trusts?

(c) on the basis of risk, primarily informed by the outcome of CQC's well-led inspections or NHS Improvement's ongoing oversight under the Single Oversight Framework segmentation?

Consultation question 11: Are there any other ways in which CQC and NHS Improvement could further streamline and reduce duplication for trusts in respect of the oversight and assessment of well-led?

Consultation question 12: Do you agree with our plans to develop, test and roll out our use of resources and well-led assessments?

Please tell us the reasons for your answer.

Consultation question 13: Are there other ways in which we should be engaging on our proposals for assessing and overseeing use of resources and well-led?

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