CONSULTATION ON USE OF RESOURCES AND WELL-LED ASSESSMENTS - NHS Providers' response

ABOUT NHS PROVIDERS

NHS Providers is the membership organisation and trade association for the NHS acute, ambulance, community and mental health services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high quality, patient focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has 96 per cent of all NHS foundation trusts and aspirant trusts in membership, collectively accounting for £65 billion of annual expenditure and employing more than 928,000 staff.

USE OF RESOURCE ASSESSMENTS

Integration with CQC's overall trust-level ratings

NHS Providers welcomes and supports the joint approach the CQC and NHSI are taking to creating a use of resources assessment and that the proposals will be refined and tested over time.

It is correct that issues of quality and finance should not be looked at in isolation but as part of a whole assessment of a trust's performance. Ultimately, it could be useful to bring these ratings together to ensure that use of resources is seen in terms of its impact on quality of care and vice versa, but this warrants careful consideration both in terms of how it would be achieved but also the implications for the role ratings play. The value of a use of resources rating will vary across patients, public, commissioners, providers and other audiences, so it is important for this to also be borne in mind when considering how ratings might be combined into an overall rating.

We note the consultation document suggests two possibilities for how combining the use of resources and the existing quality ratings might be done: one option (option 1) would be to for use of resources to be added to CQC's current key questions as a sixth question to be combined into a single overall trust rating. Another option (option 2) 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. We recognise that these reflect CQC's early thinking and strongly welcome the CQC's intention to further consult on this.

In considering potential options to pursue, consideration should be given to the fact that the construction of ratings is already complex for NHS trusts, more so than for any other sector that the CQC regulates. In our view, the use of resources rating risks adding further complexity because it would imply aggregating different 'tiers' of ratings – for example, in relation to option 1, trust-level ratings for each of the key questions are currently derived from aggregating up the ratings awarded for each key question at core service level, as opposed to the rating for the use of resources key question which will only be awarded at trust level. There are also complexities in relation to option 2, which fundamentally would add a seventh aggregation layer on top of the existing six. In addition, leadership and use of resources ratings would be refreshed more regularly because they would depend on an annual assessment,

while given that only a proportion of core services would be inspected annually, it would take longer for this to be reflected in overall ratings.

In terms of how the overall rating would be generated, there is a concern that this risks putting quality and financial performance in direct tension or cause inappropriate trade-offs between financial issues and quality of care – for example, if a trust scored a 'good' rating in all other respects but a score of 'inadequate' on the use of resources key question (option 1) or on the use of resources element (option 2), would current aggregation rules apply so as to limit its overall rating which would drop down to 'requires improvement'?

We believe there would be a need to factor in how trusts' financial restrictions (many of which may be out their direct control, due to issues such as under-performing CCGs, workforce issues, resource allocation and demand increases) affect a rating, rather than, for example, through a simple weighting given to use of resources, which then contributes to the overall quality rating.

It is also worth noting that the construction of a combined rating would need to align with the wider direction of travel for the CQC's approach to rating providers in the future. For example, the CQC's consultation on next phase of regulation signals a potential shift in terms of allowing greater flexibility in terms of the best level at which to award an aggregated overall rating or potentially only having some elements (e.g. well-led) rated at the overall trust level. We would strongly argue that changes to the rating system, including those necessary to incorporate a use of resources rating, should be considered in the round, rather than in isolation and would welcome supporting further work the CQC might undertake in this respect.

While the consultation focuses on the introduction of a use of resources assessment for NHS acute trusts only, we would strongly urge the CQC and NHSI to start developing sector-specific approaches for the specialist, community, mental health and ambulance sectors as soon as possible. We would be happy to assist in this process as much as possible.

The assessment process

It appears sensible for NHS Improvement (NHSI) to lead on the rating and assessment of a trust's use of resources: they have the right expertise to carry out the assessment much of it overlaps with their remit of overseeing the Single Oversight Framework Use of Resources (SoF) assessment. Using NHSI in this manner should avoid duplication of effort and also the potential for different organisations to make widely different interpretations on the same information.

We would also support the proposal that the assessment is carried out annually at the same time as the well led assessment. It would be useful if NHSI and CQC could provide further information to the sector as how long the assessment would take and the likely resource implications this would have for providers.

More clarity is needed on the process if the CQC does not fully agree with the use of resources assessment made by NHSI. The consultation recognises this and says a process will be established. We would argue if NHSI produce an assessment, this process will need to be clear, transparent and demonstrate why the CQC did not agree with NHSI's conclusion. We would be happy to contribute to work that ensures this is the case. Additionally, more detail is needed on what 'appropriate weight will be given by the CQC to NHSI's recommendations' means – 'appropriate weight' should not be used as a clause for the CQC to substantially disregard an NHSI assessment without going

through a transparent process. We would encourage the CQC to develop clear criteria that it will apply to reach a trust's final rating.

Relationship with the SoF

Providers consistently tell us they want to be held to account to one set of standards, and not to have competing demands from different regulators. Therefore ideally, all of the core metrics underpinning both the use of resources assessment in the SoF and the CQC's use of resource assessment would be identical, with one consistent level of oversight for trusts to respond to.

The consultation however does not make clear why the CQC use of resources assessment needs to have numerous additional core metrics beyond those in the SoF, or why the SoF does not seek to incorporate the additional metrics being proposed in the CQC use of resources assessment. This means there is in effect two standards that trusts will be held to, one annual (through the CQC's use of resources assessment), one on a 'rolling basis throughout the year' (through the SoF use of resources).

This is further complicated as the CQC use of resources rating takes precedence over the latest SoF use of resources ratings, due to how the annual CQC assessment 'feeds in' and becomes the most up to date SoF use of resources assessment. The CQC use of resources assessment holds trusts to higher standards through its numerous additional metrics. It should be the case that the SoF use of resources rating is based on a consistent set of standards - in the proposed approach however, it could be the case that a trust has its SoF use of resources rating reduced once it has been based on the additional metrics of its most recent CQC use of resources assessment.

The proposed CQC use of resources metrics

Many of the indicative metrics that have been selected do provide a reasonable starting point for assessing use of resources. The metrics specifically on 'finance' are the same as those in the SoF use of resources domain, and therefore provide consistency of measurement, mainly on absolute factors, that providers already have a deep understanding and familiarity with.

Other measurements in the CQC use of resources assessment however are not yet part of standard practice in assessing a trust's use of resources, and many are also more relative in their assessments and are therefore more problematic. There needs to be careful consideration between how the relative and absolute factors that are currently in the CQC use of resources assessment are weighted and how they interact in creating a trust's overall rating. There also needs to be careful consideration about how factors outside of a trust's control can impact on any of the rating based on the metrics.

For example in the operational metrics, cost per square metre of estates may be a useful benchmark to identify extreme outliers, but there may be very legitimate reasons why a trust has an above average cost of cost per square metre. If the reasons are legitimate, simply using an average to benchmark does not provide an answer to the relevant key line of enquiry (KLOE) 'How well is the trust maximising its operational productivity?'.

To answer this question, it would be necessary to take into account square metre spend of similar peer type trusts, trust location and other variables to such as PFI to fully assess how well a trust is performing in this area. As it stands, there is not a specific key line of enquiry prompt that that looks to identify this level of detail. However, this level of detail should be included in the final model hospital (on which this metric is based) which cohorts similar trust types.

Comparing trusts to peers within their cohorts should therefore be at a minimum explicitly referenced if this is included as a final metric.

More broadly, some of the metrics selected in other areas are heavily reliant on the performance of local organisations in the health economy and are inherently difficult to measure, and therefore need very careful consideration if they are to be used as an indicator of a single institution's use of resources.

For example delayed transfers of care and excess length of stay are often outside the control of a trust that cannot discharge a medically fit patient to social care or a more appropriate NHS setting. The indicator here says it will attempt to assess *how far* delays are within the trust's control, but our members indicate finding the level of 'fault' of a trust is very difficult to determine in isolation when looking at information at an institutional level, and would require instead a more in-depth system level approach involving multiple organisations

Going further, some of the metrics proposed are reliant to an extent on the performance of national bodies. For example the metric on vacancy and staff turnover rates will be affected by workforce supply issues, such as numbers of training places commissioned nationally and regionally, national pay negotiations and agency caps. Again, this will make any assessment of the level of culpability at a trust level very difficult to determine and undermines the effectiveness of this metric

Similarly, pharmacy spend is affected by NICE approvals and NHS England commissioning of high cost, specialised medicines, which removes elements of control in this spend area from trusts. Again therefore, rather than a simple assessment of 'spend' by quarter and identification of outliers, the reasons behind any change of spend by quarter should be assessed by specifically designed KLOE prompts to see if changes are truly within a trust's control.

Other measures used to identify a final CQC use of resources rating

It is reasonable that 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. However the specific approach to using 'additional evidence' and 'local intelligence' to give a more rounded views of trust performance needs careful consideration and further work to safeguard a transparent approach.

To ensure that trusts know they are being assessed as part of a fair and consistent process, the types of additional evidence they could be assessed on, and equally importantly the weight assigned to any additional evidence in their final rating need to be defined in more detail. The overall rating needs to ensure that subjective judgements are not given undue weight over evidence or objective measures.

WELL LED FRAMEWORK

Changes to the well led framework

The version of the well led framework was distinctive in that it addressed the various elements of corporate governance and came very close to providing an objective framework by which good corporate governance could be measured. Given that measurement of governance, as opposed to measuring the effects of governance had hitherto proven to be elusive the introduction of the framework was and is to be welcomed. A significant weakness however, was that while the CQC sought to ascertain whether the actions of boards had a positive effect at the front line and NHS Improvement sought to assess what boards did to lead their organisations there was no clear join between the two. So the changes the framework to enable a unified view of leadership is to be welcomed.

There is a danger, however, evident in some of the prompt questions, to move away from attempting to measure governance – how well boards lead their organisations – and instead to measure management; the allocation and deployment of resources. The two are different and while there is often strong correlation between the two, management and governance should not be conflated.

We note the intention to introduce system leadership into the framework. We believe this should be considered, but with some caution. Good system leadership is not within the gift of any one board. Rather it relies on the interaction of all of the players within the system. It would be all too easy to look at the functioning of the system in a particular locale and form a blanket view on the leadership of provider organisations that bears no relation to the actual contribution they make.

While there might be a distinction between operation, quality and financial management, we see no such distinction in terms of governance. Governance is the methodology of leadership and will by definition address all aspects of the leadership of an organisation.

Development reviews

We believe that it is useful for boards to review their effectiveness as a board annually. However this does not necessarily imply a review against the domains of the well led framework each year. Good chairs, Senior Independent Directors (SIDs) and boards themselves will have a view on areas of strength and weakness and will wish to use the framework to help them improve where they most need to rather than simply conduct a blanket review of their performance. Having said that boards like any other groups can be prone to optimism bias and like systems' can be prone to group think. Periodic external input is therefore vital. However this does not necessarily need to be an all out review carried out to a formula and standard methodology by a predetermined consultancy. It could be a peer review, a review focussed on one aspect of well led or a combination of different approaches. One size is unlikely to fit all. The same is true in respect of the frequency of reviews. In some cases once every four to five years to conduct a validation of local internal reviews will be fine. In others every two or three years will be a better fit to where the board and organisation are.

This is where the principle of comply or explain comes into its own. Boards should give serious consideration to an external review if it has been more than two years since the last one and should be able to explain why it is or is not appropriate to take a given course of action. Indicators that boards may wish to take into account could be issues such as NED and executive turnover/refresh, organisational performance, stakeholder and regulator feedback, whether there has been significant organisational change over the last period and assessments of organisational culture including, but not exclusive to staff surveys. It should be noted here that the fact that the Code of Governance does not apply to NHS trusts does not negate the concept of comply or explain, but rather suggests that the Code should be amended to incorporate NHS trusts.

Streamlining arrangements

Ultimately our preference would be for a single regulator to take responsibility for oversight of the well led framework. In the short term it is important to streamline data requests by asking for data once and using it many times and for work to correlate the bottom up approach of the CQC with the top down approach of NHS Improvement. A well functioning board should not only be one that understands its organisation and makes the right decisions, sets the right strategy, and oversees the executive effectively within a positive working culture. It should also be one that can visibly effect change within the organisation that staff understand originates from the

board, but which takes staff with it so that it is not a top down exercise. A CQC assessment that does not take account of this will only have a limited view of what it means to be well led.

Rolling out the framework

We think it will take time and effort to get this right, not just in terms of what is measured and how, but also in working collaboratively to form views on well led that are owned by organisations. We therefore welcome an approach that allows the revised framework to be rolled out and amended as necessary. We would also hope that NHSI and the CQC will keep arrangements under review in the longer term since changes to the way in which the provider sector is configured are bound to lead to new and unexpected challenges.

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