Royal College of Nursing Response to NHS Improvement's Single Oversight Framework Consultation

Introduction

With a membership of around 435,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector.

The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

Background

NHS Improvement is consulting on how they will oversee providers using a Single Oversight Framework for both NHS Trusts and foundation Trusts and shaping the support they provide.

Key comments

The RCN fully supports any moves to reduce unnecessary regulatory burdens faced by health care providers, on the basis that they take their focus away from their most important task, that of treating and caring for patients, and their carers and families. We thus welcome the general direction outlined in the consultation proposals, to create a single, comprehensible, focused, and most importantly effective regulatory and improvement mechanism for NHS Trusts and Foundation Trusts.

However we are mindful of the direction of travel that Government and NHS England have set for the health and care system, with ever more integrated services, and a more joined up approach to planning how health and care services will be provided across populations; epitomised by the various devolution plans, and more recently the creation of forty-four 'Sustainability and Transformation plans'. We believe that it is vital that the Single Operating

Framework (SOF) actively supports these approaches, and enables individual providers to connect and engage effectively and efficiently with other health and care providers within their ambit.

A major and long-standing concern to the RCN and our members is that the quality of care in institutions relates to the number and skill mix of nursing staffing working in all sectors of health care. We would urge NHSI not to lose sight of the interdependencies between acute and community sectors and local authorities, which make it essential to look at deficiencies in relation to the whole health and social care economy, rather than focus being solely on the acute hospital sector.

It is the responsibility of boards to identify and put in place the right systems to ensure quality of care and we would wish NHSI to focus on full board accountability when Trusts are performing poorly, not solely on the single role of the director of nursing...

We have worked with the CQC and other statutory bodies to highlight services facing challenge on these fronts, and are now working with NHS England and NHS Improvement to develop solutions and mechanisms that will enable providers to ensure they have adequate and sufficient nursing staff as appropriate to the clinical environment. We believe this to be an important issue that cuts across all five of the proposed oversight framework, and would wish to see it reflected in the SOF's framework and implementation.

Responses to Consultation Questions

Question 1: What should we consider in seeking to ensure NHS Improvement and CQC's frameworks are as aligned as possible?

In our view it is necessary to be clear with those providing services who is assessing or inspecting the quality of services and finance, and who is tasked with intervening for improvement. The proposals in this consultation, of merging CQC and NHSI evidence gathering, provides the potential for confusion.

We would recommend that the outputs of this consultation provide more clarity on this point, and specifically that the thorny issue of who is inspecting financial / strategic intent and all failures is made clear. It may be appropriate that the responsibility to inspect is put into one place i.e. CQC, and the drive for improvement given to NHSI.

Further to this point, we recommend that there must be appropriate steps put in place to ensure that any NHS Trust considered to be failing by the CQC is subject to rapid intervention by NHSI, and that their risk rating as set by NHSI is consistent with that assessment.

We think it also important that any remedial actions recommended or imposed by this new process are clearly and efficiently communicated to staff, patients, and the communities being served by the Trust, in order to prevent unnecessary concerns being created.

Question 2:

(i) Do you agree with our proposed approach to the oversight of providers?

We agree with the proposed approach, in so far as the areas being addressed are important. However while we recognise that an initial inquiry may lead to further information being required those being assessed must be given clear indication of what is being assessed and how the assessment is to be conducted within boundaries.

(ii) Do you consider that regular reporting should be on a weekly/ monthly or quarterly basis? Are there circumstances where oversight should be more or less frequent than these intervals?

We would suggest that the answer to this very much depends on where a Trust is with respect to its outcomes and systems. In order to properly benchmark there must be some essential data reported by everyone at least annually. For Trusts in Special Measures and those with financial and quality difficulties this should be negotiated with them so that a sensible approach is taken to turn around. We would suggest that in setting the reporting timelines proper consideration be given to: a) other statutory reporting requests being imposed upon Trusts; b) the ‘shelf-life’ of any submitted data.

(iii) Do you have any further comments on our overall approach?

As we have stated earlier in the overall approach it is important for Trusts to understand who is identifying the issues related to quality and who is tasked with improving them. We would suggest that as a component of CQC there is a task force set up which is skilled to be able to undertake the identification of financial concerns and root cause of this, while for NHSI there is a task force set up that is able to work to improve this.

Question 3:

(i) Do you agree with our proposed approach to overseeing quality of care?

We agree in principle with the approach.

We would recommend the addition of two further metrics to the list given in appendix 2:

- **RIDDOR reports** – these are submitted to the Health and Safety Executive, and would give an indication of workplace health and safety standards, particularly in relation to recording the number of workplace injuries resulting in seven or more days being taken off, any dangerous occurrences, and any occupational diseases such as work related dermatitis in nurses.
- **Reported Physical Assaults** – these returns are gathered annually by NHS Protect, and related to physical assaults to healthcare employees.

There is much to learn from organisations that ensure that quality of care is the organising principle of service delivery. We would favour that both CQC and NHSI remind Trust boards of their duty to devise with their populations' good quality care, and that greater clarity is given about NHSI's oversight role as part of its licencing provisions.

While guidance is welcomed we would urge caution be exercised in respect of some of the worrying pronouncements of which we have been made aware, it is important that those leading the delivery of services are charged with identifying resources within their means and context. While we welcome your 'challenge' role, some of the pronouncements, such as prescribing numbers and placement of where nursing staff should be, gives rise to situations where accountability and responsibility is removed from Trust boards, and this should not happen until intervention is necessary.

To reiterate our point on safe staffing we make this point against a wealth of evidence that demonstrates the positive association between the number of nursing staff deployed and the quality and safety of the care delivered to patients. The RCN has consistently campaigned that provider, commissioner, and regulator organisations must all have safe staffing arrangements embedded at the core of their wider quality and assurance systems.

The experience of the Mid Staffordshire NHS Foundation Trust serves as a bleak warning of the consequences of not having a robust, evidence-based strategy in place for planning nurse staffing or proactively listening to nurse leaders on the impact of changes on quality of care and patient safety and where achieving financial targets were allowed to take priority.

(ii) Given our and CQC's respective roles in the NHS, are there other approaches we could consider?

As we have said, clarity about who is responsible for the identification of poor performance and who is responsible for the improvement in all of the domains needs to be clear and we would proffer that CQC with enhanced skills on strategy and finance should identify concerns and NHSI should work on the improvement aspects.

(iii) Are there other ways in which we could use this framework to identify where providers may need support to meet 7 day services requirements?

Many provides are aware of their needs in this area. In the spirit of co-production we would urge you to ask them how to improve. Delivering seven day services will in a number of circumstances require more resources or at least re-modelled services. It is important to ensure engagement as staff are our main asset for providing services in a safe way.

We would re-iterate our concerns regarding the need to monitor staffing levels and skill mix, as these are key to delivering services across the four priority standards, and the full ten as and where they are brought into service.

(iv) Do you have any further comments on our proposed approach to overseeing quality of care?

We are concerned that while quality of care should be understood as being the responsibility of the full board of a service provider, it is too often in reality ascribed to one director, who is given responsibility often without the budgetary control necessary to make and ensure the improvements.

To address this issue we recommend that NHSI develop improvement teams who can work with Trust Boards to support them to work on these issues with their services and staff. However it is important to ensure that transference of skills is the aim, so that there isn't confusion about accountability, particularly for Trusts who are on a recovery trajectory, as opposed to being taken over for improvement.

Question 4:

(i) Do you agree with our proposed approach to overseeing finance and use of resources?

We welcome the approach. It is important to compare 'like with like' for benchmarking purposes, including taking note of some of the historical issues and to ensure any

improvement is tracked. We would wish to see acknowledged as this process is developed that many places find it difficult to retain staff (not only because they are not well led) but as a consequence of workforce planning failures and particularly with respect to geography.

We believe it vital to ensure that metrics are based on robust and appropriate data that have been systematically collected and appropriately interpreted. The success of quality care at provider level will depend on whether their internal systems act as an enabler to incentivise high quality care, and even detailed systems for providing assurance to the Board on finances are themselves unlikely to be sufficiently robust enough to ensure that quality remains at the heart of all provider activities. However derived, they must not be allowed to become the sole focus of board attention, and distract from the overall quest for quality care.

With regards to the metric proposed for the 'agency cap', we would note our long history of involvement with this issue, starting with our report, 'Runaway Agency Spend[1]' in 2015, which highlighted the unsustainable growth in agency spend across the system, and was followed by the Government's imposition of the mandatory cap later in that year.

We note this because we did warn that of its potential to negatively impact patient care, and more importantly, would do nothing to address the issue of a domestic shortage of nurses in the UK. We made it very clear in our campaigning work that only a long-term approach to workforce planning will make the NHS less dependent on agency spending.

So while we support the metric's role in helping to identify and address the agency bill, this must be connected to clear, robust, and sustainable mechanisms that do not prevent Trusts from providing the levels of staffing necessary to provide safe, effective and quality care. We would also suggest that NHSI consider that ways of working are changing and future generations may want different types of contractual arrangements. That may mean that FTYE is not the only way that staff will work in the future. We would therefore recommend NHSI and CQC develop metrics to accommodate for changing work patterns.

(ii) Do you agree with the chosen metrics?

Yes, but we would recommend that consideration also be given to bank staff and how they are counted, as we anticipate that a number of employees will want the ability to work in this way.

(iii) Do you agree with the proposal to weight the metrics equally, or should some, e.g. distance from control totals and change in cost/WAU receive a higher weighting?

[1] RCN, 'Runaway Agency Spend', available at: https://www2.rcn.org.uk/__data/assets/pdf_file/0005/608684/FF-report-Agency-spending_final_2.pdf (2015)

If quality of care and finance and use of resources are equally important then they should be weighted equally.

(iv) Are there any other metrics you consider we should use?

No, we would not wish to see the SOF become overly complicated with metrics so that it becomes unclear as to their intent or benefit.

(v) Do you agree with our proposed approach to phasing in three of the metrics (change in cost/weighted activity unit, agency controls, capital expenditure controls) above?

We have no comments to offer on the phasing of the metrics, but would expect that this would be undertaken with the full engagement and involvement of all Trusts.

(vi) Do you have any further comments on overseeing finance and use of resources?

As already noted, we would not wish to see any measures imposed as a consequence of Trusts triggering action from NHS improvement (or CQC) that would deleteriously impact on the provision of safe, effective and quality care.

Question 5:

(i) Do you agree with our proposed approach to overseeing operational performance?

We agree with the proposed approach.

(ii) Do you agree with the metrics proposed in Appendix 3?

We agree with the proposed metrics.

(iii) Are there other metrics or approaches we should also consider?

We have no comments to offer on other metrics or approaches.

(iv) Do you have any further comments on overseeing operational performance?

As stated in our general comments, we believe it vital to ensure a Trust is encouraged and supported to operate as part of a whole health economy, as is envisaged with devolution plans and Sustainability and Transformation Plans. It will be important that the SOF is able to easily and clearly identify when there are mismatches or disparities between organisational and LHE priorities and objectives which may directly impact on quality of care, for instance high priority issues such as infection control.

The successful operation of the SOF will depend on the ability of the regulators to see 'failing' Trusts in the context of their surrounding service partners, and their ability to provide remedial measures that tackle their challenges across those systems, as far as is reasonably practicable.

We also believe it is important that the levels of intervention ensure that sustainability is embedded and hence we see the Trust board and executive team being the main recipients of intervention – clearly demonstrating how they will take ownership and accountability going forward.

Question 6: What should we consider to identify potential issues and/or potential support needs in the area of Strategic change?

We welcome the focus on Local Health Economies (LHE) given in the proposals, as we believe taking a whole healthcare economy approach will be vital to resolving the health and care challenges of the 21st century.

We would recommend engagement with Trade Unions and Professional bodies as being a vital part of ensuring regulators have a full and frank understanding of the challenges (and opportunities) of both Trusts and the LHE in which they operate. The RCN currently has a good working relationship with the CQC which is premised on these terms, and we would be happy to explore with NHS Improvement whether and how this might be of benefit to the implementation of the SOF.

Question 7:

(i) Do you agree with our proposed approach to overseeing providers' leadership and improvement capability?

We agree with the proposed approach.

(ii) Are there other factors we should incorporate to identify where providers may require support?

We have no further factors to add to those being proposed.

(iii) Do you have any further comments on overseeing leadership and Improvement capability?

We have no further comments to add.

Question 8:

(i) Do you agree with our proposed approach to segmentation?

We agree with the proposed approach.

However, we would re-iterate our previous concern regarding the need to ensure that any remedial actions recommended or imposed by this new process are clearly and efficiently communicated to staff, patients and the communities being served by the Trust, in order to prevent unnecessary concerns being created.

(ii) Do you have any further comments on segmentation?

We have no further comments to add.

Question 9:

Do you agree with our proposed approach to supporting providers?

We agree with the proposed approach to supporting providers.

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