Royal College of Nursing's Response

Care Quality Commission & NHS Improvement Consultation

Use of resources & well-led assessments

General Comments

We welcome the proposals contained in the consultation as a step-change in the way in which the healthcare system is analysed and regulated. A healthcare organisation's use of resources, including the most important resource, its staff, is a key indicator of how well it is providing safe, effective and cost-effective care.

We have had a number of projects over the past few years which have identified how better resource utilisation, from procurement to end use, can drive quality improvements, and reduce costs. Similarly in the area of leadership, our work to support the current and next generation of nurse-leaders is designed to ensure health and care services are well-led.

We also welcome the relationship that is being proposed between the Care quality Commission and NHS improvement to assess these two fundamental pillars of provision, where the findings of the latter inform and influence the reporting of the other, while respecting the separation of responsibilities between them. Providing modern healthcare is a complex business, and while we recognise the importance of considering inputs separately from outputs and outcomes, ultimately all three must be seen as part of a whole system. However, this must not become a means for 'role creep' to occur; regulation and quality improvement must remain distinctly separate, to ensure each is properly able to deliver what is expected of it.

In accepting this new paradigm however, we would wish to be firm in reiterating our well-rehearsed public statements on the need for more funding to be found for both the health and the care systems; as in the absence of appropriate levels of funding, the findings of these new assessments will be all too easy to predict.

Lastly but of equal concern, we would like to note the practical challenges for many senior nursing staff of a simple analysis of "well-led". Senior nursing staff often have lines of accountability (under the rubric of 'patient care') but little or no control of funding, and only the ability to make recommendations about resource deployment or usage. We would not want to see RCN members occupying such positions being held to account for failings that they have identified but have in reality been in no position to affect.

Response to consultation questions

1. **Do you agree with the proposed process for assessing and rating trusts' use of resources?**

   We agree with the proposed process as laid out in the consultation, but have some concerns regarding the mechanisms to be used.

Please tell us the reasons for your answer.

We believe that basing the process on the CQC's 'KLOE' approach will aid consistency of approach, and create better alignment between the two organisations' work.

However, we would like more detail on the way in which the NHSI's ratings will match-up with the CQC's, as it will be important for everyone to be able to understand how they relate, and for them not to be experienced by staff and providers as being in any way incompatible, or in competition.

We would also like to see more detail on how NHSI will approach setting workforce strategy and workforce planning, which are key elements in the effective use of resources.

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

While we understand the rationale for wishing to create an easy to comprehend 'overall score', we think more work will need to be undertaken on the Use of Resources rating first, in order to see how well it reflected the realities of an individual trust's activities.

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?**

We agree that the metrics proposed are a good starting point for further development.

We anticipate that in using the simple measures of vacancy/staff turnover rates and sickness absence further exploration will be made into any underlying causes.

We have two recommendations for additional metrics, both under 'people'. The first is a metric to capture any impacts on staff from change and restructuring programmes, as we believe these have a major impact upon productivity. This could be based on data from the NHS staff surveys.

The second is a metric to capture patient-experience, as this is can be good proxy for how well staff are deployed within a service. This could be based on patient survey data, for example from the 'Friends and Family Test'.

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?**

We are satisfied that they cover the right areas in an appropriate manner and to sufficient depth of analysis.

We would like to see a prompt included to inquire whether services that are suitable to be led by nurses are being so led, as this would be an excellent way of utilising the full skills and expertise of a trust's workforce.

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

Under W6 we would like to see a KLOE that asks whether IT systems been procured with clinical staff feedback, as this helps to ensure that clinical staff are part of the process, which is key to ensuring usability and uptake.

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?**

We are satisfied that they are sufficient in their ambit to differentiate between the four different categories.

However, we are concerned that the 'outstanding' description, references nursing associates, which are not yet in the system, and remain untested. We would recommended illustrating this point with something that is more applicable across the system, for instance nurse-led, occupational therapy, or pharmacy-led, services.

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

None of the definition sets make any direct reference to patient or user experience. This could be referenced via a proxy measure, such as the number of unresolved patient or carer complaints, with an outstanding service having very few or none.

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?**

We agree with this proposal.

Please tell us the reasons for your answer.

We believe this to be the simplest and most comprehensive way of managing the two parallel ratings systems such that they are able to complement each other in a sensible manner.

7. **Do you agree with the additions to the well-led framework?**

We are happy with the proposed additions.

Please tell us the reasons for your answer.

We welcome the development of a coherent system for providing analysis of this 'competence', and the reductions in administrative burden for trusts.

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

We have no additional areas to add.

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

While we welcome the intention of the proposals, we would not wish developmental reviews to become a 'licence to make money' for management consultants.

On that basis we would like to see guidance developed to support trusts when undertaking these reviews, which outline the full-range of options available to them, including peer reviews and advice (and support) from professional bodies, such as Royal Colleges.

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?*

On the basis of both reducing unnecessary burdens (and costs) to the healthcare system, while providing sufficient oversight, we recommend every three years for an initial period, with some consideration being given to allowing demonstrably good organisations to move to a risk-based arrangement, under the watch of regulators that were empowered to direct a review should circumstances change.

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?**

We have no recommendations at this point in time, however we would wish to see that any developments ensure clarity on either organisation's role.

We would welcome a further opportunity to comment on this point, as and when new arrangements have been introduced and had sufficient time to bed in.

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

We are happy to support the implementation plans as given in the consultation.

Please tell us the reasons for your answer.

N/A

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

We have no further comments to make.

Royal College of Nursing

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