Royal College of Physicians of Edinburgh's response to NHS Improvement on Single Oversight Framework Consultation

[response submitted online on 26/7/16]

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

a. Avoiding duplication where possible by ensuring dialogue between the two. Where there is an overlap, one organisation should accept the evidence prepared for the other to be submitted to them by the providers.
b. Creating a seamless environment of improvement and quality assurance, through combining the efforts of the two bodies and ensuring that the demands of one do not in any way contradict the other.
c. Instead of asking organisations to produce reports that inevitably result in extra work, consider standardisation of documentation of the evidence that constitute parts of these reports, so that these documents become an integral part of the care provided by the providers rather than being an extra-burden. This would ensure that the standards in individual trusts are improved structurally and permanently. This could help the trust maintain excellence, rather than achieving this through extra efforts just before a CQC visit/NHS Improvement inspection.
d. Attempt to target the improvement projects to not only allow trusts to cope with pressures, but also to improve the care standards, thus trusts will be working towards satisfying the expectations of both entities while achieving the best care for the patients.
e. CQC's inspection frameworks appear to ask the right questions but it is unclear to some as to how the answers then translate into ratings. For CQC reports to have validity and inter-report consistency a clear methodology must be in place (this may be the case) – without this NHS Improvement cannot rely upon the ratings.

Consultation question 2: (i) Do you agree with our proposed approach to the oversight of providers? (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? (iii) Do you have any further comments on our overall approach?

i. Agree.
ii. Regular reporting should be an integral part of the trust's routine work. The mandatory reporting should not be less frequent than quarterly in order for it to become an integral part of routine work, rather than being an extra burden. Having a culture of openness and routine reporting may drive standards up, while not distracting from the core activities of providing the patients with the care they need and deserve, and the staff with the appropriate environment to deliver the care they are tasked to do.
iii. No further comment.

Consultation question 3: (i) Do you agree with our proposed approach to overseeing quality of care? (ii) Given our and CQC's respective roles in the NHS, are there other approaches we could consider? (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? (iv) Do you have any further comments on our proposed approach to overseeing quality of care?

i) Yes

ii) It is important that NHS Improvement has the ability to address or help a trust to address what they think are their deficiencies. These approaches should be regarded as preventative measures designed to minimise failure rather than wait until an organisation (Trust) had failed somewhere and then introducing an expensive plan to rectify the problem.

iii) Yes, by disseminating good practice, and solutions adopted by other organisations so that everyone can learn from these, particularly practices that have led to improvement through proper efficiency (as opposed to financial efficiency).

iv) Linked to Q1 response re CQC reliability. There is a need to ensure that robustly obtained patient feedback on services (eg percentage of "recommend care" or percentage "positive" to Friends and Family) is based on an agreed return rate from which conclusions can be drawn. Quality of care should be a measure of PREMs (Patient Reported Experience Measure) and clinical outcome, not based on time to be seen or receiving treatment.

Consultation question 4: (i) Do you agree with our proposed approach to overseeing finance and use of resources? (ii) Do you agree with the chosen metrics? (iii) Do you agree with the proposal to weight the metrics equally, or should some, eg distance from control totals and change in cost/WAU receive a higher weighting? (iv) Are there any other metrics you consider we should use? (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? (vi) Do you have any further comments on overseeing finance and use of resources?

i) In general, yes.

ii) We would question the blanket use regarding agency spend. Appointing an agency consultant is wrong when there is a mechanism to advertise of a locum consultant while waiting for the (often long) process of ratifying a new post for a consultant in the specialty. On the other hand, there are national shortages in some departments and some specialties/levels of expertise which may not be possible to fill. An example of this is the sonographers doing echocardiography where there is a recognised national shortage. Not filling these positions to avoid agency spend results in prolonging waiting lists for a relatively essential test for patients, which can also delay implementation of important treatments. In other words, we need to apply the principles here intelligently.

iii) Agree with giving them equal weighting.

iv) No

v) No comment

vi) No comment

Consultation question 5 : (i) Do you agree with our proposed approach to overseeing operational performance? (ii) Do you agree with the metrics proposed in Appendix 3? (iii) Are there other metrics or approaches we should also consider? (iv) Do you have any further comments on overseeing operational performance?

i) Yes
ii) The proposed metrics are acceptable for measuring organisational effectiveness but not quality of care
iii) Other metrics may be suggested by other Royal Colleges or national specialist societies.
iv) No.

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

As suggested in the consultation document it is appropriate to seek the opinions of the providers and their local partners to identify the major obstacles against the implementation of the strategic changes so that help, support and advice can be tailored to those local needs and challenges.

The measurement of strategic change is locality and organisationally dependent. However, best practice for comparable organisations can be used to benchmark and thus this can be measured. Metrics should include the level of engagement in a transformation agenda.

Consultation question 7: (i) Do you agree with our proposed approach to overseeing providers' leadership and improvement capability? (ii) Are there other factors we should incorporate to identify where providers may require support? (iii) Do you have any further comments on overseeing leadership and Improvement capability?

i) One exception is the agency spend which has already featured as an essential component of the financial position of the organisation.
ii) The staff/patient survey should be designed in a statistically and scientifically sound way.
iii) No.

Consultation question 8: (i) Do you agree with our proposed approach to segmentation? (ii) Do you have any further comments on segmentation?

i) Yes, it is sensible, though segments 2 and 3 slightly overlap.
ii) No.

Consultation question 9 : Do you agree with our proposed approach to supporting providers?

Yes. NHS Improvement staff should have such expertise in improvement science that it prevents individual Trusts having to spend large sums on management consulting firms.