Health Foundation's response to NHS Improvement's consultation on a Single Oversight Framework

August 2016

1. Summary

1.1. Thank you for the opportunity to respond to NHS Improvement's proposed approach to overseeing and supporting NHS trusts and foundation trusts. In responding we wanted to draw your attention to a few points from our recent work that you may wish to consider when finalising the framework or as NHS Improvement's role develops.

1.2. We welcome NHS Improvement's intention to bring NHS trusts and foundation trusts into the same oversight framework and are supportive of the general approach. In particular, we welcome the offer of support to providers, which represents a positive shift in the proactive support NHS providers receive from national bodies.

1.3. We are supportive of the general approach to identifying concerns relating to the quality and financial performance of NHS providers. On financial performance, we welcome NHS Improvement's decision to introduce metrics in a phased way, as this will allow providers to raise any concerns and for the metrics and performance thresholds to be developed further. The indicators for identifying quality and safety concerns are reasonable, but we think that it would be beneficial to include an unequivocal statement in the framework that trusts should not interpret these metrics as 'hard targets' unless a clear national standard has been mandated.

1.4. Overall, NHS Improvement will need to be clear about how they plan to strike the balance between support and oversight and to ensure this approach is aligned with the performance and regulatory regimes of the Care Quality Commission (CQC) and NHS England – all of which need to be clear for providers and commissioners. Effective oversight must balance the need for the NHS to maintain quality and contain costs during a time when the scale and pace of change is unprecedented. In exercising its functions NHS Improvement must ensure that solutions to problems are conducive to the long-term vision providers and local health economies are working towards.

2. About the Health Foundation

2.1. The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. Our aim is a healthier population, supported by high quality health care.

3. Alignment

3.1. Bringing together the accountability frameworks for NHS trusts and foundation trusts into a single regime is overall a welcome step, given the challenges facing the entire NHS provider sector and the narrowing of the performance differentials between the two types of trust over the last few years, both in terms of financial and operational performance but also performance on quality.

3.2. It is vital that the regulation and oversight of NHS providers by national bodies is consistent. Therefore, we also welcome NHS Improvement's commitment to work closely with CQC to ensure consistency between their respective approaches. Our recent report, *A clear road ahead: Creating a coherent quality strategy* for the English NHS, highlighted that the various frameworks used to oversee the performance of local commissioners and providers contain a number of differences in how national priorities are translated into local action[1].

3.3. Through the Five Year Forward View, NHS England, Monitor and the NHS Trust Development Authority (TDA) committed to working together to create greater alignment between their respective local assessment, reporting and intervention regimes. The proposed Single Oversight Framework is progress towards delivering on this commitment for foundation trusts and NHS trusts, but it would be helpful to have clarity on how the framework will provide greater alignment between trusts and the parallel regime for clinical commissioning groups operated by NHS England. This is particularly important given the shared expectations already placed on commissioners and providers to deliver on sustainability and transformation plans, which is acknowledged within the framework.

4. Support

4.1. In our report, *Constructive Comfort: accelerating change in the NHS*, we set out three broad ways in which national bodies effect change in organisations. These types are described in the table below.

[1] Molloy, A. Martin, Gardner, T and Leatherman, S. (2016) *A clear road ahead: creating a coherent quality strategy for the English NHS*. Available from: http://www.health.org.uk/sites/health/files/AClearRoadAhead.pdf

Types of approaches national bodies use to accelerate change

Type	Explanation
Prod organisations	This approach aims to direct, prod or nudge providers of care from the outside. Familiar tools here include: legislation; targets; command and performance management; payment (currency and price) incentives; regulation; and competition. This approach could be loosely termed a 'deficit management' or 'compliance' approach to improving performance reliant upon 'extrinsic motivation' for change.
Proactive support	This approach focuses on enabling organisations more directly to make the changes needed. In the past, prods have been described as offering 'constructive discomfort' for change. By contrast, proactive support efforts offer 'constructive comfort'. This could be loosely termed an 'asset management' or 'commitment' approach to improving performance, reliant upon 'intrinsic motivation' of staff to make the right changes.
People-focused approaches	This approach includes both prods and proactive support, targeting NHS staff rather than organisations, as well as actions to inspire, engage and involve staff. Approaches include using policy mechanisms such as education and training, national contracts, professional regulation and clinical standards.

4.2. One of the key findings from the report was that the national 'proactive support' approach holds significant potential to accelerate change, and that there needs to be much more thinking about action in this space than has been the case to date. Similarly, we argued that the prod approach can, at most, produce only very partial change relative to the totality of what is now needed.

4.3. Investment in the proactive support approach means a commitment to developing the medium-term capacity, skills and resilience of NHS providers, not just focusing on the need for short-term 'payback'[2].

4.4. We strongly support the notion of developing and offering a range of tools to support improvement. Not only do we think that this is a positive step towards a more proactive support approach at a national level, but that there is evidence that local providers see the valuable role national bodies could play in this space.

4.5. We conducted a survey of NHS providers, including acute, community, mental health and ambulance trusts, in collaboration with Monitor and the TDA to explore the progress the NHS had made following Professor Don Berwick's review in 2013, *'A Promise to Learn – a Commitment to Act'?* Respondents told us that national bodies could make a valuable contribution by providing practical support and resources. For

[2] Allock, C, Dorman, F. Taunt, R, and Dixon, J. (2015) Constructive comfort: accelerating change in the NHS Available from: http://www.health.org.uk/sites/health/files/ConstructiveComfortAcceleratingChangeInTheNHS.pdf

example, by sharing learning and evidence of best practice from across the system and by making improvement tools, resources and benchmarking data available[3].

4.6. While this is a helpful step forward, tools on their own are not enough to ensure they achieve the maximum impact. Genuine lasting change also benefits from a number of complementary mechanisms which we have identified through funding and supporting quality improvement projects across the NHS over the last 15 years. These include:

- using networks to facilitate the cross-fertilisation of ideas
- creating opportunities for providers to share learning and benchmark their performance with neighbouring organisations
- providing guidance to support the effective implementation of improvement work, including an understanding of the role that environment[4] and context plays in its success.

4.7. We recommend that NHS Improvement identifies these current sources of information and opportunities, and considers ways of encouraging providers to take advantage of them.

4.8. In our report *Building the foundations for improvement* we looked at five organisations of varying sizes and remits which have well-developed, or developing, methods for using quality improvement techniques in front line care[5]. There are five case studies within the report that describe the journeys different trusts have been on - East London NHS Foundation Trust, Royal Devon and Exeter NHS Foundation Trust, Salford Royal NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust and South Eastern Health and Social Care Trust.

4.9. While this report identifies a number of lessons outlining what trusts can do, one of the lessons that shone through at a national level was the need for arm's-length bodies to give organisations the time and space to develop and embed quality improvement programmes. System leaders in arm's-length bodies, particularly those with regulatory roles, need to ensure that organisations developing quality improvement programmes have the time and space to do so.

4.10. A number of trusts made the point to us that by investing in capability, focusing on quality and safety, and showing a constancy of purpose over time, they have managed to meet, and frequently exceed, their mandated targets. However, they also recognised that normal variation happens, and that there will be occasions when their approach and methods will be subject to intense scrutiny. Staying true to their original intent can

[3] Infographic: commitment to act? (2014) Available from: http://www.health.org.uk/infographic-commitment-act

[4] Using health care settings as an example, a recent book by Charles Vincent and Rene Amalberti provides a compendium of safety strategies, which stress the need to recognise that different health care environments are amenable to different tools and techniques. For example, standardisation techniques are better applied in 'ultra-safe' environments like diagnostics than in 'ultra-adaptive environments' like emergency surgery.

[5] Jones, B. and Woodhead, T (2015) Building the foundations for improvement: how five UK trusts built quality improvement capability at scale within their organisations, available from: http://www.health.org.uk/sites/health/files/BuildingTheFoundationsForImprovement.pdf

be difficult in such situations, especially if an executive team are still finding their feet, which is why trusts need breathing space.

4.11. This point was also echoed in our survey of NHS providers (referenced in paragraph 4.5), as many felt that national bodies need to offer 'moral support' in addition to 'practical support', by recognising that lasting improvements take time to achieve, and that when they have been achieved they should be acknowledged. The range of support offered illustrates the delicate balance that NHS Improvement will have to strike between improvement support and performance management and oversight, particularly when the mandated support offer is being considered in particular cases. Therefore, it would be helpful if the framework could provide greater clarity on how NHS Improvement intends to implement these different offers of support in practise.

5. Identifying concerns

5.1. The Health Foundation also welcomes the overall approach to 'identifying potential concerns' but, there are a few areas relating to quality, safety and finance where we would welcome clarity on how this approach will be applied in practise.

5.2. The overall approach to identifying concerns relating to the quality and safety of care is sensible, particularly the consideration given to the circumstances surrounding any triggers of potential concern. As we discussed previously, an understanding of the setting and context is crucial for improvement.

5.3. The selection of metrics as a range of 'tin-openers' that may indicate quality and safety concerns is reasonable. However, our work on target-setting[1] reiterated that 'what gets measured gets managed' and trusts may interpret such metrics as new national priorities to be delivered. There is also a risk that the proposed set of indicators is assumed to provide an exhaustive view of quality and safety that may be reflected in trust governance and board reporting. To mitigate these risks, it would be helpful to have an unequivocal statement in the framework that trusts should not interpret these metrics as 'hard targets' unless a clear national standard has been mandated, and that the indicators used in the framework are not a comprehensive blueprint for local governance. We would also appreciate further information on how the metrics fit with CQC's intelligent monitoring regime, which shares a similar purpose.

5.4. On the oversight of financial performance, the decision to phase in the use of metrics is welcome, as this will allow time for providers to raise any questions and for any subsequent improvements to be made. This is particularly important as some of the proposed measures, such as cost per weighted activity, are relatively crude and require some development to ensure they are reliable measures of performance.

5.5. We would appreciate assurance from NHS Improvement that they will invest time in developing the proposed metrics further, including the appropriate thresholds of performance, before they are fully implemented. We recommend that NHS Improvement undertakes this development as it phases in the metrics and that the

[1] http://www.health.org.uk/publication/targets-how-targets-can-be-most-effective-english-nhs

development process is communicated to NHS providers and other interested stakeholders.

5.6. While it is phasing in the metrics, NHS Improvement should also consider the stage at which it is appropriate to judge the financial performance of NHS trusts and foundation trusts in the same way, given that both types of provider have been operating with different degrees of autonomy and, in particular, that a number of foundation trusts have been able to build-up surplus funds.

6. Conclusion

6.1. Overall, we welcome NHS Improvement's intention to bring NHS trusts and foundation trusts into the same oversight framework. Our view is that the general approach to identifying problems with the quality and financial performance of NHS providers is sensible, although it is important that metrics are used in a way that recognises the different circumstances facing providers. We would encourage NHS Improvement to use to the time available during the phased approach to develop the metrics relating to the financial performance of NHS providers and to set out clearly how the respective thresholds of performance are set.

6.2. Similarly, while it's helpful to make tools available, these are unlikely to be successful on their own. With this in mind, NHS Improvement might look at how it can use its role as a national body – with oversight of all NHS providers – to create an environment that supports improvement, while recognising the autonomy and ownership local providers need to have for their own improvement.

6.3. NHS Improvement will need to be clear about how they plan to strike the balance between support and oversight and to ensure their approach is aligned with the performance and regulatory regimes of CQC and NHS England – all of which need to be clear for providers and commissioners. Finally, NHS Improvement must consider that when providing support it is essential that short-term solutions to problems are in keeping with the longer-term vision providers and other areas of the local health economy are working towards.

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