SHELFORD GROUP RESPONSE TO NHS IMPROVEMENT CONSULTATION ON THE PROPOSED SINGLE OVERSIGHT FRAMEWORK (PUBLISHED IN JUNE 2016)

About the Shelford Group

The Shelford Group comprises ten of the leading NHS multi-specialty academic healthcare centres in England:[1]

- Cambridge University Hospitals NHS Foundation Trust
- Central Manchester University Hospitals NHS Foundation Trust
- Guy's and St Thomas' NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- King's College London Hospital NHS Foundation Trust
- Newcastle-upon-Tyne Hospitals NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust

Our trusts are core stakeholders for this consultation, as large NHS providers delivering services worth in aggregate nearly £10bn p.a, which is around 10% of the total NHS England budget and over 13% of the NHS provider sector. Most of our organisations are NHS Foundation Trusts and have been accustomed to operating under Monitor's risk assessment framework. We have a track record of delivering excellent patient care, clinical research and education. Five of the world's top ten clinical research universities[2] and six of the country's 11 Biomedical Research Centres[3] are partnered with Shelford trusts.

After the recent round of CQC comprehensive inspections, we expect 70% of our trusts will have received one of the top two ratings of 'good' or 'outstanding', compared to around 50% in those categories nationally. Historically, our organisations have normally operated in financial balance or surplus. Since 2015/16, in common with the whole of the provider sector, the trusts in our group have been under unprecedented financial pressure.

Overall context

Before responding to the consultation document specifically, we make some observations about the overall context in which it has been published. These observations are heavily informed by the NHS 're-set' documentation published during the consultation period.[4]

[1] http://shelfordgroup.org/
[2] *The Times Higher Education* rankings 2015/16.
[3] http://www.nihr.ac.uk/about/biomedical-research-centres.htm
[4] NHS England and NHS Improvement, *Strengthening Financial Performance & Accountability in 2016/17* (21 July 2016).

Firstly, and most fundamentally, we are concerned by the implication running through the Oversight Framework and 're-set' that the main cause of the current provider sector deficit, and the overall NHS financial challenge, is insufficient financial discipline. A number of independent analyses[5] [6] [7] [8] [9] have found that there is a significant and growing mismatch between what the NHS and Social Care is expected to deliver and the amount of funding available. There are indeed opportunities to realise operational efficiencies and we must pursue these with vigour, but even if all of the savings helpfully identified by Lord Carter were to be achieved, there would still remain a substantial funding gap.[10] There are also undoubtedly some pockets of financial indiscipline and they should be tackled robustly.

Nevertheless, by international comparisons the NHS is relatively efficient and effective overall, achieving strong outcomes relative to investment.[11] This is a testament to its talented and dedicated workforce in organisations up and down the country. The financial challenges we face are caused more by insufficient funding to meet the high standards to which we aspire and which patients rightly expect, than by large scale financial indiscipline or inefficiency of local organisations. The amount that the country spends on health and social care will diminish as a proportion of GDP over the period of the Spending Review. We need an open and honest conversation with the government and the public about what can be achieved for the resources available in the face of rising demand, even with stretching efficiency gains, or how those resources can be increased so that we can achieve higher standards.

Secondly, the solutions in the re-set have been designed to address the problems as they are perceived. Taken together, the re-set documents and the Oversight Framework appear to herald a more centralised and interventionist approach to regulation, with a diminution of local commissioner authority and provider flexibilities. This seems to be a response to the perception that the main problem to be addressed is large scale financial indiscipline at the local level. That perception is having a detrimental effect on the morale of our many thousands of hard-working healthcare professionals. If, however, the greater problem is a lack of overall funding in the system to meet demand, then it will not be solved by moving towards even greater centralism and intervention. That might support more stringent cash controls, but with uncertain and potentially risky impacts on local service provision.

Our third overall observation is that the important and necessary service changes that are emerging across the health service are increasingly out of step with the legislative and organisational framework of accountability. There will need to be a sharper focus on which organisations are charged with leading change locally and they will need to have the tools and formal accountability to do so, if necessary backed by legislation. It is right that we should take a view of what is best for patients and

[5] Health Select Committee, *Impact of the Spending Review on Health and Social* Care (July 2016).
[6] The King's Fund, *Deficits in the NHS 2016* (July 2016).
[7] Nuffield Trust, The Health Foundation and The King's Fund, *The Spending Review: what does it mean for health and social care* (December 2015).
[8] Nuffield Trust's response to NHS 're-set' (21 July 2016) (http://www.nuffieldtrust.org.uk/media-centre/press-releases/our-response-nhs-improvement-and-nhs-england-reset-and-department-health).
[9] The Health Foundation, *A Perfect Storm: an impossible climate for NHS providers' finances?* (March 2016).
[10] Lord Carter of Coles, *Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variations* (February 2016).
[11] The Commonwealth Fund, *Mirror, Mirror on the Wall* (June 2014).

populations across health economies. Equally, it is still the case, as it was when Foundation Trusts were introduced, that we need **successful organisations to be free to innovate and lead for the benefit of the system**. There is an evolving ambiguity between the heavy emphasis on 'organisational and personal accountability for…financial and performance commitments'[12] in the re-set document and the emphasis on system-wide responsibilities across organisational and professional boundaries in the STP processes. The two imperatives are not necessarily incompatible, of course, but there will be tensions between them at times and the legislative and accountability framework needs better to keep pace with the fast moving policy and operational environment.

NHS Improvement proposed Single Oversight Framework

Within that important overall context, the Shelford Group welcomes the opportunity to engage with NHS Improvement and to comment on the proposed Single Oversight Framework. We make the following points in response.

1. ***We support the need for much greater coordination between NHS Improvement and the Care Quality Commission, and with NHS England, so that there will be a single definition of success.***

   The consultation document sets out how NHSI and the CQC will work together to ensure consistency of their approaches. That is also explained to some extent in the CQC's Strategy for 2016-2021.[13] The definition of quality of care in the consultation document is close to the CQC's definition, although with some additions. The document explains that NHSI and the CQC will work together on a shared definition of finance and use of resources and governance and leadership, although both are forthcoming so it is not possible to respond to them at this stage. We assume that there will be another consultation when they are developed. Operational performance and strategic change are additional to the CQC assessment approach.

   Whilst we strongly support the aim of a shared and accurate assessment of provider performance, there remains the potential for CQC and NHSI (plus NHSE and others) to send different signals about priorities, and for providers to face 'double jeopardy'. We urge the national bodies to work closely together to eliminate this risk, so that providers know clearly what they are aiming to achieve and how they will be assessed consistently and objectively. There must be a **single version of the truth** in performance assessment, which is reliable and credible.

2. ***There must be a more realistic and relative assessment of what is achievable in terms of performance targets within the current challenging financial circumstances of NHS providers and the service overall.***

[12] NHS England and NHS Improvement, *Strengthening Financial Performance & Accountability in 2016/17* (21 July 2016), para 1.17.
[13] Care Quality Commission. *Shaping the Future: CQC's Strategy 2016-2021* (May 2016).

Returning to the context set out above, there is an increasing recognition from independent analyses of the significant shortfall in total resources available to meet rising demands for activity, standards of quality and access, safe levels of staffing and new drugs and technologies. Whilst commissioners are also coming under greater financial pressure (though holding 1% risk reserve), the disposition of deficits suggests that financial risk and pressure sits overwhelmingly with NHS and social care providers.

We support a sharp and stretching focus on a small number of the most important priorities for patients and taxpayers. If these are for financial control and Accident & Emergency access, then those elements must be prioritised above all else throughout the Oversight Framework. However, there need to be wider tolerances for other performance requirements and no increase in their number. We are fundamentally concerned as to whether or not all of the performance requirements in the re-set documentation are achievable, especially if there are new requirements to come in relation to Cancer, Dementia, Diabetes, Learning Disabilities, Maternity and Mental Health.[14] These would add new costs into an already overstretched system. It would be helpful to revisit the previous 'NHS Gateway' arrangements which endeavoured to consider the impact on providers of new guidance and prevented excessive or uncosted requirements.

In recognition of the financial constraints, providers must be judged as much on relative performance as absolute measures. Judgments about temporary fluctuations should be flexible and made in dialogue between regional teams and providers, recognising the scale and complexity of their operations, rather than a one-size-fits-all mechanistic approach to triggering intervention. This is something that generally worked well and was to be commended between Monitor and NHS Foundation Trusts and which we hope will be retained under the new framework so that the 'baby is not thrown out with the bath water'.

Performance assessments should be calibrated to take account of unintended pressures in the local health economy outside the control of a provider and, where necessary, should hold others to account (with NHSE) for their impact on providers. For example, in spite of planned commissioning intentions, GPs will often refer to a high quality trust, bypassing a less successful trust, and leading to increased pressure on elective activity at the more successful organisation. Another example we have experienced across our organisations is where temporary closure of an urgent service in one trust might create a surge in unplanned activity in a larger, neighbouring trust.

In essence, these are not arguments against the overall structure of the proposed framework and the themes to be assessed, which seem sensible, but a plea for reasonable tolerances and relative judgments about what is achievable even by good organisations in the current financial climate. It is also a plea for a sharper focus on the small number of priorities that

[14] NHS England and NHS Improvement, *Strengthening Financial Performance & Accountability in 2016/17* (21 July 2016), para 1.13.

matter most to patients and taxpayers above all else, and for consistency in those priorities between the national system leaders. The alternative would be a recipe for failure.

3. ***We believe it is essential to achieve a more proportionate burden of reporting and oversight of providers.***

We recognise the essential role played by proportionate, risk-based regulation in healthcare. In recent years, the burden of regulatory oversight has often felt disproportionate and overly burdensome, diverting providers' resources from delivering frontline care.

However, the Oversight Framework could potentially increase the burden, even for organisations that are performing relatively well. If unrealistic expectations are set across a broad range of performance measures, then the risk is that the proposed segmentation in the Oversight Framework will become too punitive, with a majority of providers in segments 3 and 4. This is foreshadowed by the (different) four tier assessment framework of the CQC, where half of providers are already in the bottom two tiers, but with financial pressures set to increase in the middle years of the spending review period. If the same thing happens with the NHSI Oversight Framework, it is likely to significantly increase the total burden of regulation on providers. Challenged performance on that scale would be a systemic issue, not a series of unrelated organisational failures, and there will be little value in progressively increasing pressure on systemically underfunded organisations.

The CQC's strategy envisages significantly lighter touch regulation for those organisations or core services that are assessed as 'good' or 'outstanding' and where there is no reason to suspect a material change.[15] That is welcome and would apply to the majority of Shelford trusts, and we consider it essential that the NHSI Oversight Framework should be consistent with that approach in deed as well as in word. Page 8 of the consultation document sets out circumstances in which reporting and intervention may increase. These are not in themselves unreasonable, but could lead to a creeping and disproportionate expansion of the regulatory burden on providers.

May we suggest that a formal impact assessment is undertaken by an independent third party of the proposed reporting requirements in the framework and that they are regularly reviewed to ensure that the reporting burden is not increasing despite the stated intention in the document. There is a clear need for streamlined and integrated data collection systems between regulators to reduce the burden of reporting, and so that providers do not need to complete separate and tailored returns for different regulatory bodies on largely the same questions and datasets.

[15] Care Quality Commission. *Shaping the Future: CQC's Strategy 2016-2021* (May 2016).

4. ***We are concerned about the* de facto *ending of a separate model of governance and regulation for NHS Foundation Trusts and the potential erosion of local flexibilities and accountability to communities.***

   We understand that it makes sense from the point of view of regulation to operate a single Oversight Framework, and that is an important part of the logic of bringing together Monitor and the NHS Trust Development Authority. We note that there continues to be *de jure* separation between the models for FTs and NHS Trusts, but this framework does come across as suggesting that *de facto* there will be little or no distinction. If this is not intended, then that perception should be corrected. If it is the intention, however, then the rationale for this significant change should be explained clearly.

   Needless to say, the Foundation Trust model was passed in an Act of Parliament,[16] after considerable political and public debate and scrutiny. Eroding the local autonomy of FTs will not help to improve their financial position, standards of quality and performance, or responsiveness to their patients and communities.

   For example, the new models of care that will need to emerge to support the Five Year Forward View will require providers to be dynamic and responsive to local needs and the FT model can be an important enabler of local change, but not if their freedoms, such as those over capital investment, are largely removed.

5. ***The balance between assessing health systems and individual organisations is evolving as the Sustainability and Transformation Plans roll out. In due course, the Oversight Framework will need to set out clearly the balance of responsibility and accountability to systems and organisations.***

   Linked to the point above about FTs, the current legislative and accountability framework sets clear responsibilities for governance, finance and performance at the organisational level. We recognise the evolving importance of STPs and the respective Shelford organisations are active participants, and in some cases their CEOs are leaders, of STPs. There will be some occasions where system imperatives require compromises at organisational level, for example, to manage financial pressures across a health economy.

   The re-set document places heavy emphasis on organisational accountability for finance and performance. In the interests of delivering the Five Year Forward View and new models of care, the Oversight Framework should incentivise innovation and should not lead to risk aversion.[17] As successful organisations, a number of Shelford Trusts are heavily engaged in various forms of merger, acquisition, buddying or collaboration with other organisations, often at the behest of the national regulatory bodies. This is resource intensive and complex

[16] Health and Social Care (Community Health and Standards) Act 2003.
[17] D. Dalton, *Examining new options and opportunities for providers of NHS care* (Dec. 2014)

work and will often raise the risk profile of their own organisation, at least temporarily, even though they are acting in the wider interests of the system and improving patient care across a broader area.

The Oversight Framework must incentivise these kinds of organisational changes and risks as beneficial to the system. Foundation Trust CEOs will not take on the heavy responsibility of Accountable Officer status for struggling organisations if the regulatory and oversight system becomes too punitive and that would be detrimental to overall system improvement.

It is understandable that in this rapidly evolving picture, further clarity will emerge and we shall be delighted to work with NHSI as the thinking develops. We would emphasise that in the reasonably near future, provider boards need to have clear and unambiguous guidance as to their responsibilities to their corporate body and their local health economy, especially where there can be an apparent contradiction between the two. That guidance needs to be consistent with the legislative framework in which they are constituted for both NHS Trusts and NHS Foundation Trusts in order for Executives and Non-Executives to fulfil their formal responsibilities.

Conclusion

The Shelford Group does agree it is essential for there to be much closer alignment between the national regulatory bodies and a single definition of success for providers. However, that definition of success must not only be stretching, but substantially more realistic in the current challenging financial context, with a clear focus on a limited number of priorities that matter most to patients and taxpayers. We are concerned that the Oversight Framework will bring about a significant increase in the burden of central reporting and intervention on providers, diverting resources from frontline care. We would argue for a robust impact assessment and regular review of that burden, with integrated systems for reporting wherever possible. We believe that the NHS Foundation Trust model of governance and local accountability can support dynamic service change in line with the Five Year Forward View. However, incentives need to allow FTs to innovate and to manage acceptable levels of risk in supporting other organisations. We appreciate and support the growing importance of planning across systems and health economies, hence we believe that further clarity is needed in the near future as to the balance between formal accountability at organisational and system levels. We would welcome the opportunity to work closely with NHSI to support the development of the Oversight Framework.

The Shelford Group

4th August 2016