Royal College of Nursing

Royal College of Nursing response to NHS England and NHS Improvement consultation on Payment system reform proposals for 2019/20.

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.

Key issues

Years of underfunding and a failure to calculate service provision based on a robust assessment of population need has caused a crisis across the health and social care system. A lack of community provision means people are more likely to attend A&E inappropriately, inflating the activities figures and disrupting demand signals. We caution against any approach which further incentivises the delivery of activities above the need for levers and incentives which respond to population need.

There are some benefits of the current payment system, and the proposed changes. Currently, providers who consistently make efficiencies can reduce activity costs, therefore generating savings which can be spent elsewhere. However, when activity-based payment systems are seen to focus too heavily on reducing costs, there is a related disincentive to invest in preventative health initiatives, which may lower overall activity levels. The proposed changes to the payment system will blend payments for both assumed and actual activity levels. We believe the consequence of this will be a continued focus on reducing costs and maximising quantity, above a model which delivers quality and patient outcomes.

A number of iterative changes to payment models over the last few years have not been given the chance to embed, and for the impact to be observed or evaluated before another change is made. This short-term cost-saving focus risks patient outcomes and safety, and we cannot be assured that this is providing value for public money.

We need to see a shift to an overall funding model which is based on population need. Only once services are properly resourced, and funded, with the right number of registered nurses and nursing support staff with the right skills in the right place to provide safe and effective care, should further changes be made to the way in which providers are paid. Without this change, providers will be further incentivised to deliver activities within acute settings, compounding the focus on high-cost, intensive treatment, rather than preventative, community-based support.

Recommendations

- Within the context of national policy rhetoric focussing on delivering more care and support in the community, we ask NHS England and NHS

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Improvement to consider whether this proposal aids or hinders that shift. This type of system risks dis-incentivising providers from delivering safe, effective and timely care

- To provide safeguards which protect this type of payment system from being 'gamed' by providers who are highly performing, with unintended consequences for the system. For example, there are risks that project demand could be overinflated, giving providers more opportunities to ensure that they are receiving both parts of the payment.

- Likewise, safeguards need to be put in place to ensure that providers are not penalised when demand is much higher than anticipated. We know that the current health and social care system is not based on a robust assessment of population need, and demand signals do not inform service provision. As demand increases, and providers are required to meet the need, they should not be penalised for providing more care to more people.

- In order for this system to be effective, more robust mandatory data needs to be collected from providers. The nature of A&E in particular makes accurate predictions of demand complex, and serious incidents, accidents or outbreaks could immediately shift a department to a situation where they are under staffed and under resourced.

Supporting information

The health and social care system is in the midst of a crisis, and we need to see substantial changes to address these issues. Successive Governments in England have not made funding decisions for health and social care services based on a robust, transparent assessment of population need. This means that local decision-makers are faced with impossible choices, and members of the public requiring support from health services or social care do not have their needs met. During the winter, demand increases, placing additional pressures on already stretched acute services.

In turn, this then places more pressure on other services, particularly general practice and accident and emergency services. This means that funding for health services is spent supporting individuals whose needs would be better met in the community, if the provision was there. Overall, this is a poor use of public funds, and value for money would be better achieved if it was calculated to meet population demand, rather than the arbitrary figure currently selected by Government. While we recognise budget limitations exist, we need to establish the baseline of need to ensure we are meeting these needs.

Without comprehensive population-need and workforce data, decisions about provision and resource cannot be made effectively. Thresholds for individuals receiving support are increasing, and patients frequently stay in hospital longer than necessary due to a lack of appropriate service provision in the community.

There are not enough registered nurses and healthcare support workers to deliver safe and effective care. Nurses report working unpaid overtime to fill gaps, additional stress caused by a high-pressure environment, and describe occasions

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when vital care is left undone. We are concerned that inappropriate substitution of skills puts patient safety at risk.

Any future funding model should be based on an assessment of population need, and an identification of appropriate service provision and required resource. Funding should include provision to address gaps in the workforce, and extend the size of the workforce to be appropriate to meet population need. This will include a national recruitment campaign, a retention strategy, and incentives to increase supply of nursing staff.

Assurances needed

Before this payment system becomes operational, we expect NHS England and NHS Improvement to provide assurance on the following;

1. **Evidence**. There must be clear evidence to support the introduction of this new payment system, including evidence about how this approach will improve patient safety, quality of care, workforce, and finance. This evidence should include impact-assessments and modelling of potential impact on front-line services.

2. **Scrutiny**. The introduction of this type of payment system could lead to changes in the way services are designed and managed. We expect the introduction of this system to be accompanied by data collection and reporting at provider and commissioner levels to monitor the implementation and impact of this change. This should be accompanied by regular reporting from NHS England and NHS Improvement to allow opportunities for wider public scrutiny. Demand data should be made publically available.

3. **Data collection**. This type of system is entirely dependent on robust and comprehensive data related to demand predictions. We are not confident that this level of data current exists, and seek assurances that there is an accompanying plan for providers and commissioners to work together and address this gap. Due to the challenging context which providers and commissioners are operating within, this work should be supported (with resource and expertise) by national bodies, in particular NHS Digital.

4. **Safeguarding vulnerable patients**. We are concerned that the removal of the 30-day readmission rule will result in reduced information sharing related to patients who may be repeatedly attending A&E in a short space of time. This data is an important way to identify needs and design an appropriate package of care. We ask NHS England and NHS Improvement to explain how the impact on patients will be mitigated.

5. **Clarity on the ‘break glass’ clause**. Due to the broad way in which this principle was described, it is difficult to take a position on whether this is a positive or negative addition to the proposal. We need more clarity on whether this clause will or will not apply, and who would be involved in quantifying what is deemed to be ‘significantly higher or lower than assumed’.

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About the Royal College of Nursing

The RCN is the voice of nursing across the UK and the largest professional union of nursing staff in the world.

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