NHS Improvement

Single Oversight Framework
Consultation

June 2016

About NHS Improvement

NHS Improvement is responsible for overseeing NHS foundation trusts, NHS trusts and independent providers. We offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, we help the NHS to meet its short-term challenges and secure its future.

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

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1. Context

In recent years, the NHS has achieved improvements in care and delivered efficiencies during a time of increasing financial pressure caused by slowing growth in the NHS budget and rising demand. The need to respond effectively to this continuing increase in demand during a period of limited funding growth was the key impetus for the NHS Five Year Forward View (5YFV).

Part of the national response to the ambitious and stretching tasks highlighted in the 5YFV was to create NHS Improvement, reflecting that NHS trusts and foundation trusts face similar challenges. On 1 April 2016, NHS Improvement became the operational name that brings together Monitor, the NHS Trust Development Authority (TDA), Patient Safety, the Advancing Change Team and Intensive Support Teams. The specific legal duties and powers of Monitor and TDA persist.[1] We will build on the best of what these organisations did but with a change of emphasis to one primarily focused on helping NHS trusts and foundation trusts to improve. We will provide strategic leadership, oversight and practical support for the trust sector.

We will support NHS trusts and foundation trusts[2] to give patients consistently safe, effective, compassionate care within local health systems that are financially and clinically sustainable. We will work alongside providers, building deep and lasting relationships, harnessing and spreading good practice, connecting people, and enabling sector-led improvement and innovation. We will stimulate an improvement movement in the provider sector, helping providers build improvement capability, so they are equipped and empowered to help themselves and, crucially, each other. Our aim is to help providers attain, and maintain, Care Quality Commission (CQC) ratings of 'Good' or 'Outstanding'.

The challenges facing the system require a joined-up approach and increased partnership between national bodies. We are committed to working more closely with the CQC, NHS England and other partners, at national, regional and local levels.

2. This consultation

This document sets out the approach NHS Improvement proposes to take in overseeing providers using a Single Oversight Framework for both NHS trusts and

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[1] NHS Improvement will be clear on which duties and powers of Monitor and the TDA it is exercising at both Board and executive level. Non executive positions are joint and the executive decision-making structure accommodates appropriately constituted committees to enable the exercise of respective functions.

[2] For the purposes of this document and our framework, we will use the term 'providers' to mean NHS trusts and NHS foundation trusts. This document does not apply to Independent Sector Providers: *The Risk Assessment Framework for Independent Providers* (available at https://www.gov.uk/government/publications/risk-assessment-framework-independent-sector-providers-of-nhs-services) covers our statutory duty to assess financial risk at those organisations where they provide Commissioner Requested Services (CRS).

foundation trusts and shaping the support we provide. It describes our proposed approach to:

- the main areas of focus of our oversight
- how we will collect the information we require from providers
- how we will identify potential concerns with a provider's performance
- how we will segment the provider sector according to the level of challenge each provider faces.

The purpose of this framework is to identify where providers may benefit from, or require, improvement support across a range of areas (see below). This will inform the way we work with each provider. This framework does not detail the improvement support we will provide as in each case this will be individually tailored to address what a provider needs help with. We ask a number of specific questions on our proposed approach through the document, and these are collected together in Section 8 and at the survey website (see below for link).

We are still considering our approach to oversight in a number of areas, including how well a provider is managing strategic change, and we are using this exercise to invite views on how we should proceed.

The Single Oversight Framework will replace Monitor's risk assessment framework and TDA's Accountability Framework. It is a 'Single' Oversight Framework because it applies to both NHS trusts and foundation trusts. As far as possible, we will combine and build on the previous approaches of Monitor and TDA, but adapt them to reflect and enable our primary improvement role. Any changes from these frameworks are intended to be as much as possible incremental in nature. The changes we are making are intended to reflect the challenges providers face and initiatives to support them. All other related policies and statements, unless indicated, remain unchanged.

The Single Oversight Framework set out in this document reflects the continuing statutory duties and powers of Monitor with respect to NHS foundation trusts and of TDA with respect to NHS trusts (whereby the TDA exercised functions via directions from the Secretary of State).

Alignment with CQC

CQC sets out what good and outstanding care looks like, asking five key questions of all care services: Are they safe, are they effective, are they caring, are they responsive to people's needs, and are they well-led? These questions will be supplemented by a forthcoming assessment of the use of resources being jointly developed by CQC and NHS Improvement.

NHS Improvement will support providers in attaining and/or maintaining a CQC 'good' or 'outstanding' rating, covering the areas listed above. We will do this by focusing on five themes. As set out in the next section, these five themes are linked to CQC's key questions, but are not identical to those questions. This is because: CQC's questions do not yet incorporate use of resources; we have a particular role in supporting improvement in performance against the NHS Constitution standards for patients; and because our approach to improvement incorporates the strategic changes within local health economies that will be needed to assure high-quality services in the longer term.

We will continue to work with CQC to align our approaches more fully as we move towards a single combined assessment of quality and use of resources. We welcome views on this as part of the consultation.

Lord Carter's report, *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations*[3], recommended the development of an integrated performance framework to ensure there is a single set of metrics and approach to reporting, reducing the reporting burden in order to allow providers to focus on improving quality and efficiency. In line with this recommendation, we are working with the CQC and with the provider sector to ensure that we draw on a single, shared set of metrics both to review performance and to decide where to target support or oversight.

Responding to the consultation

We are looking forward to collecting the views of providers and stakeholders on our proposals. We ask all interested parties and stakeholders to respond to the consultation by **5pm on 4 August 2016**. To do so please use the survey link: https://www.surveymonkey.co.uk/r/JBCFCMY. If you have trouble accessing this please email us at NHSI.singleoversightframework@nhs.net. During the consultation period we will run engagement events to (i) get views, answer queries and clarify points; and (ii) get more detailed input from the sector on certain areas.

Confidentiality

Please let us know if your response is in confidence. Your name and/or that of your organisation will then not be given in our published summary of responses.

If you would like just part of your response (instead of or as well as your identity) to be confidential, please make this obvious by marking those parts we should keep confidential.

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[3] Available at www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

We will do our best to meet all requests for confidentiality, but because we are a public body subject to freedom of information legislation we cannot guarantee that we will not be obliged to release your response (including potentially your identity) or part of it even if you say it is confidential.

3. Summary of our proposed approach to overseeing providers

NHS Improvement will use the new oversight framework to identify where providers need support in any of five areas (which we will refer to as themes):

- **Quality of care**: we will use CQC's most recent assessments of whether a provider's care is **Safe**, **Caring**, **Effective** and **Responsive**, in combination with in-year information where available. We will also include delivery of the four priority standards for 7 day hospital services.
- **Finance and use of resources:** we will oversee a provider's financial efficiency and progress in meeting its financial control total. We are co-developing this approach with CQC.
- **Operational performance:** we will support providers in improving and sustaining performance against NHS Constitution and other standards. These will include A&E waiting times, referral to treatment times, cancer treatment times, ambulance response times, and access to mental health services.
- **Strategic change:** working with system partners we will consider how well providers are delivering the strategic changes set out in the 5YFV, with a particular focus on their contribution to Sustainability and Transformation Plans (STPs), new care models, and, where relevant, implementation of devolution.
- **Leadership and improvement capability:** building on the joint CQC and NHSI well-led framework, we will develop a shared system view with CQC on what good governance and leadership looks like, including organisations' ability to learn and improve.

By focusing on these five themes we will support providers to improve to attain and/or maintain a CQC 'good' or 'outstanding' rating. Quality of care, finance and use of resources, and operational performance relate directly to sector outcomes. Leadership and improvement capability is crucial in ensuring that providers can deliver sustainable improvement. Strategic change recognises that organisational accountability and system-wide collaboration are mutually supportive.

We welcome the sector's views on how we can most effectively align NHS Improvement's approach to support and oversight with CQC's framework for assessing providers.

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

The Single Oversight Framework

NHS Improvement's Single Oversight Framework is intended to:

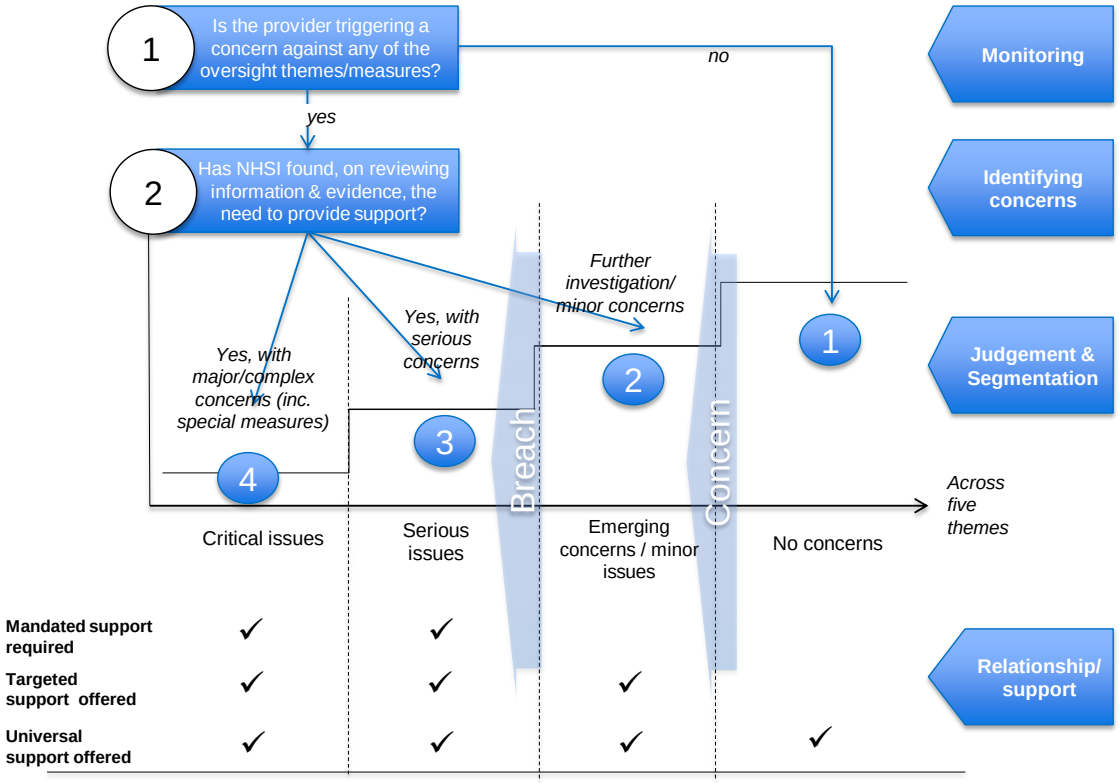
- provide one framework to oversee providers, irrespective of their legal form
- help us identify problems, and risks of problems, as they emerge
- pinpoint the source of the problem, allowing us to tailor our support packages to the specific needs of providers and local health systems. These packages will draw on expertise from across the sector as well as within NHS Improvement.

NHS Improvement will need to be flexible in how it carries out its role. For example, we may need to respond quickly and proactively to unexpected issues in individual providers or sets of providers, or to policy changes at a national level. We may, therefore, from time to time, adjust our approach, for example:

- add/remove some metrics from our oversight of providers
- increase the frequency of our data collection
- act sooner than the general threshold set in the framework.

We propose to segment the provider sector according to the scale of issues faced by individual providers. This will be informed by data monitoring and, importantly, judgement based on an understanding of providers' circumstances. Figure 1 sets out our proposed approach.

Figure 1: Summary of our approach



The segment a provider is in will determine the nature of the support we provide. While this will be tailored to the circumstances of providers, we have identified three broad categories of support for providers – universal offers, targeted offers and mandated – which will link to the segment they are in – see section 7.

Segmentation does not in itself constitute an assessment of provider performance. NHS Improvement teams will work with providers to determine the appropriate, tailored, support package for each, including directly provided support and support facilitated by, for example, other parts of the sector.

The legal basis for actions in respect of NHS trusts and NHS foundation trusts remains unchanged. This means that, for example, a foundation trust will only be in segments 3 or 4 where it has been found to have been in breach or suspected breach of its licence. Mandated support for foundation trusts[4] continues to follow existing policy set out in the Enforcement Guidance.[5]

3.1. Other considerations

The NHS Provider Licence

The statutory obligations of Monitor and TDA continue within NHS Improvement. Therefore, NHS Improvement must ensure the operation of a licensing regime over all eligible NHS providers. The NHS provider licence[6] forms the legal basis for Monitor's oversight of foundation trusts and can be found here. While NHS trusts are exempt from the requirement to apply for and hold the Monitor provider licence itself, Directions from the Secretary of State require TDA to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. This includes giving directions to an NHS trust where necessary to ensure compliance.

The Single Oversight Framework applies equally to NHS foundation trusts and NHS trusts, and we aim to treat all providers in comparable circumstances similarly unless there is sound reason not to. Consequently NHS Improvement will base our oversight of all providers – NHS trusts and foundation trusts – on the conditions of the NHS provider licence.[7]

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[4] Based on s.105, s.106 or s.111 of the Health and Social Care Act 2012
[5] We will look to update the Enforcement Guidance in due course and consult as appropriate
[6] https://www.gov.uk/government/publications/the-nhs-provider-licence
[7] For the most part, this is likely to entail holding providers to account against the standards in condition FT4 – the NHS foundation trust governance condition, but our scope extends to the entire NHS provider licence (see www.gov.uk/government/publications/the-nhs-provider-licence). For completeness it should be noted that NHSI has functions and powers in addition to those stemming from the Monitor provider licence in relation to both NHS Trusts and Foundation Trusts and the Single Oversight Framework does not cover these additional matters.

4. Monitoring providers

We will use information from our data monitoring processes to identify where providers are triggering a potential concern in one or more of the five themes (which indicates they are not in segment 1 and may benefit from support) and judgement, based on consistent principles, to determine whether or not they are in breach of licence – or the equivalent for NHS trusts – and, if so, whether the issues are serious or very serious/complex.

We will collect information on providers (see Figure 2) – either directly or from third parties. We will seek to ensure that the collection burden is proportionate and, where possible we will use nationally available information.[8] We will collect, for example:

- regular financial and operational information
- annual plans
- third-party information
- any ad-hoc or exceptional information that can be used to oversee providers according to the five themes.

Figure 2: Summary of information requirements for monitoring

	In-year	Annual/ less frequently	Ad hoc
Quality of care	In-year quality information to identify any areas for improvement (see Appendix 2)	Annual quality information	Results of CQC inspections CQC warning notices, fines, civil or criminal actions and information on other relevant matters
Finance & Use of Resources	Monthly returns	Annual plans	One-off financial events (eg sudden drops in income/ increases in costs) Transactions/mergers
Operational performance	Monthly/quarterly(in some cases weekly) operational performance information (see Appendix 3)		Any sudden & unforeseen factors driving a significant failure to deliver
Strategic change	Delivery of Sustainability and Transformation Plans (STPs) Progress of any new care models, devolution plans	Sustainability and Transformation Plans (STPs)	Any sudden & unforeseen factors driving a significant failure to deliver
Leadership & improvement capability	Third-party information with governance implications[1] Organisational health indicators - staff absenteeism - staff churn - board vacancies	Staff & patient surveys Third-party information with governance implications[1]	Findings of well-led reviews Third-party information with governance implications[1]

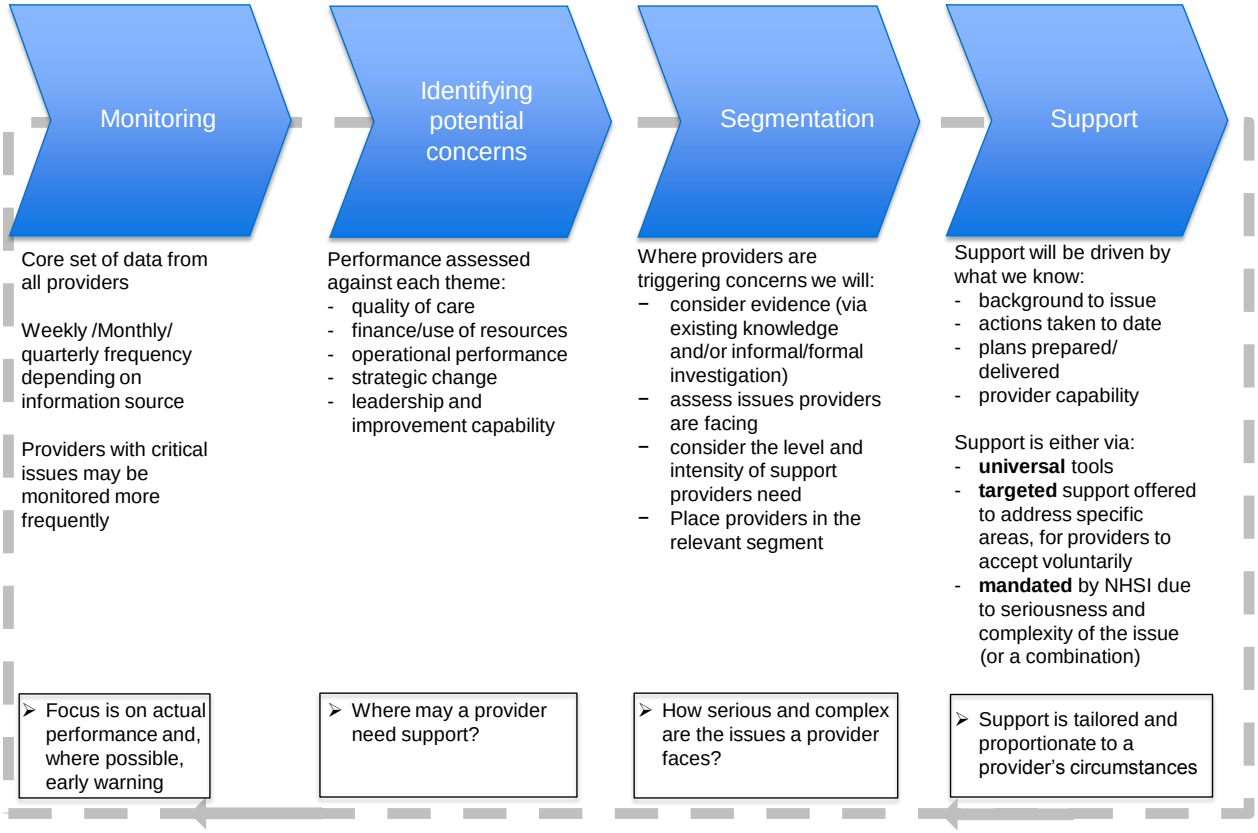
[1] eg reports from Quality Surveillance Groups (QSGs), GMC, Ombudsman, CCGs, Healthwatch England, auditors, Health & Safety Executive, Patient groups, complaints, whistleblowers, Medical Royal Colleges

Collection will be:

[8] Eg in reviewing performance against national targets and standards.

- **in-year**: following a regular in-year monitoring cycle (see Figure 3), using weekly/monthly/quarterly/six-monthly collections as appropriate
- **annual:** using annual provider submissions (eg Annual Plans, Annual Statements on Quality) or other annually published data (eg staff surveys)
- **ad-hoc/by exception:** NHS Improvement will be as agile as possible in responding to issues identified at providers. Where material events occur, or we receive information that triggers our concerns outside the regular monitoring cycle, we will consider these in our view as to whether there are potential concerns at the provider and the steps we need to take.

Figure 3: NHS Improvement's oversight cycle



During 2016/17, we will use the existing Monitor and TDA oversight templates to collect information. We will give notice of changes to the collection as we develop our processes to gather information from providers.

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?

5. Identifying potential concerns

We will use the information we collect on provider performance to identify where providers need support. Our oversight focuses on identifying 'triggers' of potential concern in each theme.

Our approach in each theme is set out below and summarised in Appendix 1. Where providers are triggering any of these potential concerns, we will consider the circumstances surrounding the triggers to determine the nature of any support required. Practically, we are likely to consider:

- the **extent** to which the provider is triggering a potential concern
- any **associated circumstances** the provider is facing
- the degree to which the provider **understands what is driving the issue**
- the provider's **capability** and the **credibility of plans it has developed** to address the issue
- the extent to which the provider **is delivering against a recovery** trajectory.

We will engage with providers on an ongoing basis. When providers trigger potential concern, we will consider whether the level of interaction needs to change to monitor the issue and the provider's response to it. How we propose to identify potential concerns against each theme is set out below.

5.1. Quality of care

Where CQC's assessment identifies a provider as 'inadequate' or 'requires improvement' against any of the **Safe**, **Caring**, **Effective** or **Responsive** key questions, this will represent a potential concern and we will consider what support is appropriate for the provider.

We will supplement CQC's inspection findings with warning notices, any civil or criminal actions or changes to registration conditions to ensure that we use the most up to date CQC views of quality and also that their views on quality at providers yet to be inspected can be incorporated.

In a continuation of TDA's approach, we will use a number of additional in-year quality-related metrics to identify emerging issues and/or scope for improvement at providers – see Appendix 2. If necessary, we will use this information to identify any improvement needs and support needed.

In addition we will oversee delivery of 7 day hospital services across providers in order to identify where organisations need support. This will include assessing whether providers are delivering against an agreed trajectory to meet the four priority standards for 7 day hospital services. We may, in time, extend this to monitoring other 7 day services standards and metrics where appropriate.

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?

5.2. Finance and use of resources

We will oversee and support providers in improving financial sustainability, efficiency and controls relating to high profile policy imperatives such as agency staffing, capital expenditure and the overall financial performance of the sector. We are, with CQC, co-developing the approach to overseeing providers' use of resources. This builds on the approaches taken by Monitor and TDA, which aimed to identify financial distress rapidly, while introducing a greater focus on efficiency as recommended by the Carter Review. As the Model Hospital develops, we may include further efficiency metrics in the Single Oversight Framework.

We propose to use financial metrics to oversee financial performance (see Table 1) by:

- scoring providers 4 (poorest) to 1 (best) against each metric (see Figure 4)
- using provider performance average across all the metrics to arrive at an overall view of the provider.[9]

Identifying potential financial concerns

Providers scoring 4 or 3 against this overall financial assessment will trigger a potential concern, as will providers scoring a 4 (ie significant underperformance) against **any** of the individual metrics.[10]

[9] Scores are rounded to the nearest whole number. Where a provider's score is exactly in between two whole numbers, it is rounded to the lowest whole number (eg both 2.2' and 2.5 are rounded down to 2). This follows Monitor's prior approach where financial scores were rounded positively, ie towards the 'best' score for providers, which in the Single Oversight Framework is lower.

[10] The best overall score a provider scoring '4' for any of the individual metrics can obtain is a '3'

Table 1: Finance and Use of Resources Metrics

Metric	Rationale/considerations
Capital Service Capacity	Assess how much financial headroom providers have over interest or other capital charges (eg PFI payments).
Liquidity	Assess providers' short-term financial position, ie their ability to pay staff and suppliers in the immediate term.
Distance from control total or financial plan	As part of our role in providing sector-wide financial oversight, we are working with providers to agree control totals that will help the sector achieve financial balance. We will track providers' positions against these through the year.
EBITDA[11] margin	Assess providers' operating efficiency independent of capital structure or other factors.
Cost/Weighted Activity Unit - efficiency metrics (to be run in shadow form in 2016/17 – we will track but not incorporate in the financial rating)	We are introducing a proposed efficiency metric, cost per weighted activity unit (WAU), developed as part of the Carter Review. This estimates provider efficiency by measuring the average cost of an average episode of care, taking into account different types of treatments (HRGs) and modes of delivery (eg elective, outpatient). The metric relates to a provider's efficiency improvement and will exclude factors that affect costs but are outside its control. Because reference costs are reported annually, we will use different, more frequently reported, activity and cost datasets to calculate in-year costs per WAU[12]
Capital Controls (as above, to be run in shadow form in 2016/17)	NHS Improvement has a responsibility to ensure that capital expenditure remains within the system's means and we will track providers' positions against their set capital limits over the year.
Agency spend (as above, to be run in shadow form in 2016/17)	Monitor and TDA introduced controls on agency spend in 2015 in response to the sharp increases in agency costs seen since 2012. We will continue to track agency spending at providers. Where we have potential concerns, we will consider how best to support the provider in addressing them.

Broader value for money considerations

In addition to using the metrics above, we may investigate whether there is, more broadly, sufficient evidence to suggest inefficient and/or uneconomical spending at a provider. Such spending may indicate that a provider is failing to operate effective

[11] Earnings Before Interest, Tax, Depreciation and Amortisation
[12] The data in these datasets are already provided by providers. There is therefore no new additional reporting burden associated with the calculations.

systems and/or processes for financial management and control, and not operating economically, efficiently and effectively.

Such evidence would come from, for example, published national benchmarking. We will notify the sector when appropriate benchmarks become available nationally. We may also look at whether a provider is delivering good practice with respect to value for money, for instance regarding management consultancy spend. In the absence of appropriate benchmarks we may still consider investigating a provider if there is material evidence to suggest it is delivering poor value for money.

Figure 4: Financial rating metrics

Area	Metric	Definition	Score			
			1	2	3	4[1]
Financial sustainability	**Capital service capacity**	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75-2.5x	1.25-1.75x	< 1.25x
	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)
Financial efficiency	**EBITDA margin**	EBITDA/total revenue	≥5%	3-5%	0-3%	≤0%
	Change in Cost per Weighted Activity Unit[2]	Assessing provider efficiency by measuring its average cost increase for an average episode of care (smaller is better)	≤1.1%	1.1%-2.1%	2.1%-3.1%	>3.1%
Financial controls	**Capital controls[2]**	Distance above capital control total	<5%	0-5%	5-15%	≥15%
	Distance from Control Total or financial plan	**Providers with control totals:** Ytd actual surplus/deficit vs. Ytd trajectory **Providers without control totals :** Ytd actual I&E surplus in comparison to the Ytd plan I&E surplus[2]	≥0%	(1)-0%	(2)-(1)%	≤(2)%
	Agency spend[2]	Distance from provider's cap	≤0%	0%-25%	25-50%	>50%

Note: brackets indicate negative numbers

[1] Scoring a '4' on any metric will cap the overall rating to at most 3, triggering a concern.

[2] To be used on a shadow basis - ie monitored not evaluated - in 2016/17.

Phasing in the new metrics

We propose to use three of these metrics – change in cost/weighted activity unit, capital controls and agency spend – in 'shadow' form during 2016/17. As a result, we will not use those in calculating providers' average financial score during 2016/17, nor will scoring a 4 against the thresholds for these metrics lead to an override. This will allow us to assess the quality of data underpinning them and calibrate them across providers. We can then consider how best to introduce them formally in 2017/18. For 2016/17 our oversight for the purpose of identifying a potential financial concern will be based on the remaining four metrics in Figure 4.

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?

5.3. Operational performance

We will track providers' performance against, and support improvements in, a number of NHS Constitution standards and other metrics. Rather than require providers to make bespoke data submissions, wherever possible we will use nationally collected and evaluated datasets. Appendix 3 lists the metrics we propose to use and their collection frequency across acute, mental health, ambulance and community providers. We may revise this list – introducing new metrics or varying the collection frequency – as necessary and appropriate, particularly as the Model Hospital work develops. We will consider whether a potential concern has been triggered if:

- for a provider with one or more agreed Sustainability and Transformation Fund trajectories against any of the metrics in Appendix 3: it fails to meet any trajectory for at least **two consecutive months**
- for a provider with no agreed Sustainability and Transformation Fund trajectory against any metrics: it fails to meet a relevant target or standard in Appendix 3 for at least **two consecutive months**
- where other factors (eg a significant deterioration in a single month, or multiple potential concerns across other standards and/or other themes) indicate we need to get involved **before two months have elapsed**.

We will then consider the nature of the issues and use this to identify the appropriate segment for the provider (see below) and develop the support offer.

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?

5.4. Strategic change

The 5YFV sets out the agenda for the change necessary to support a sustainable NHS. We will consider the extent to which providers are working with local partners to address local challenges and improve services for patients. This will include their contribution to developing, agreeing and delivering Sustainability and Transformation Plans (STPs) as well as in some cases the implementation of new care models and implementation of devolution.

To begin with we will use our forthcoming STP assurance process and associated reviews of STPs as our principal approach to oversight of this theme across providers. We are working with NHS England to develop a consistent approach and are likely to consider:

- providers' relationships with local partners
- their plans (including STPs they are involved in)
- how far these plans have been implemented.

We have published draft guidance on how we expect well-led providers to work with partners and collaborate locally to improve the quality and sustainability of services for patients.[13] In this guidance we set out the expectation that providers should be engaging constructively with local partners to

- build a shared understanding of local challenges and patient needs
- design and agree solutions
- implement improvements.

It will be important in our oversight and our support offer to acknowledge the interplay between individual provider outcomes and delivery of aggregate outcomes

[13] Available at www.improvement.nhs.uk/uploads/documents/Guidance_on_good_governance_in_a_LHE_context_final.pdf

across a local health economy. As we are still developing our approach under this theme, we invite input from the service on what other information we should collect and how we could identify where a provider may need support in this area. We will look to hold engagement events on this theme during the consultation period.

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

5.5. Leadership and improvement capability

Shared standards of governance were set out in the NHS foundation trust governance condition (FT4), TDA Accountability Framework as well as TDA general objective (which covers much of the same ground as FT4). We expect providers to demonstrate three main characteristics as part of this theme:

1. **Effective boards and governance:** We will use a number of information sources to oversee provider leadership as used previously by Monitor and TDA, including:
   - information from third parties
   - staff/patient surveys
   - organisational metrics
   - information on agency spend
   - CQC 'well-led' assessments.

   We will also draw on the existing well-led framework and associated tools to identify any potential concerns with the governance and leadership of a provider. Many providers have already used this framework to assess their governance.

2. **Continuous improvement capability:** We are working with CQC to consider how the current shared well-led framework needs to evolve to better reflect the theme of improvement.

3. **Use of data:** Effective use of information is an important element of good governance. Well-led providers should collect, use and, where required, submit robust data. Where we have reason to believe this is not the case, we will consider the degree to which providers need support to do so in this area.

Our approach in 2016/17

We will review our approach to leadership and well-led, working with the CQC. In the meantime, we propose using the same information previously collected by Monitor and TDA, augmented by other information where available, to identify potential leadership concerns at individual providers. These can provide early warnings of issues that have yet to manifest themselves in, for example, quality issues or financial underperformance, as well as evidence of serious governance failings.

Consultation question 7:

(i) Do you agree with our proposed approach to overseeing providers' leadership and improvement capability?

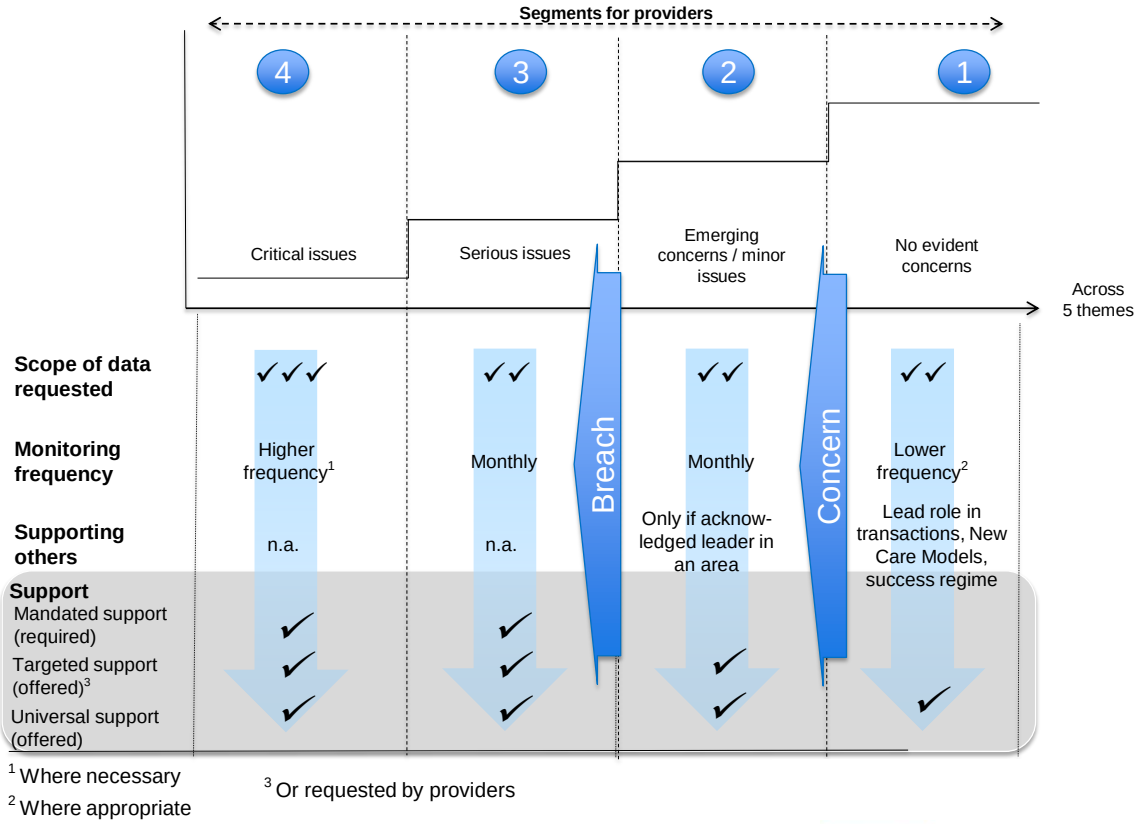
(ii) Are there other factors we should incorporate to identify where providers may require support?

(iii) Do you have any further comments on overseeing leadership and Improvement capability?

6. Segmentation and the segmentation process

Segmentation helps NHS Improvement determine the nature of the appropriate support relationship with a provider (see Section 7). It does not give an overall assessment of a provider's performance, for which the CQC's rating is the benchmark; nor does it determine the specifics of the support package needed, which is tailored by teams working with the provider in question. We propose segmenting the sector into four, depending on the extent of any issues identified in the oversight process.

Figure 5: Segmenting the provider sector



Segment	Description
1	No potential concerns identified across our five themes – lowest level of oversight
2	Triggering criteria of concern in one or more of the five themes – but not in breach of licence (or equivalent for NHS trusts) and/or formal licence action not needed
3	Serious issues – the provider is in actual/suspected breach of the licence (or equivalent for NHS trusts)
4	Critical issues - the provider is in actual/suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues (eg including providers requiring major intervention on multiple issues to return to sustainable performance).

6.1. Segmentation process

The segment a provider is placed in will reflect, in our judgement, the seriousness and complexity of the issues it faces. We will base our decision on the appropriate segment for a provider by:

- considering all available information on providers – both obtained directly and from third parties
- identifying those providers with one or more triggers of potential concern
- using our judgement, based on relationship knowledge and/or the findings of formal or informal investigations, consideration of the scale of the issues faced by a provider and whether it is in breach or suspected breach of licence conditions.

Providers will then be segmented as follows:

- no potential concerns identified (per section 5 of this document): **segment 1**
- provider in licence breach (or equivalent for NHS trusts): **segment 3 or 4** depending on the seriousness and/or complexity of the issues faced
- provider not in breach but still triggering a potential concern: **segment 2**.

Segmentation needs to be as timely and rigorous as possible, without becoming a bureaucratic or complex process. We plan to carry out a segmentation exercise before going live with this new framework, identifying which segment a provider is in at the time the framework goes live. Subsequently, where our in-year, annual or ad-hoc monitoring of a provider flags a potential concern, we will review the provider's situation and consider whether we need to change its allocated segment.

In parallel with the development of the framework, we will consider providers' incentives to be in segment 1. While some conditions are fixed across the sector (eg control totals) others could vary from segment to segment in accordance with the principle of earned autonomy.

Consultation question 8:

(i) Do you agree with our proposed approach to segmentation?

(ii) Do you have any further comments on segmentation?

7. Our support of providers

While outside the scope of the Single Oversight Framework itself, our teams will co-ordinate and oversee tailored support for providers, to support sustainable improvement. Segmentation informs the oversight and support relationship we have with each provider, but does not determine the support package, which will be tailored to a provider's particular situation.

The support offered will be provider specific but we envisage that it will fall into three categories:

- **universal support offer** – tools that providers can draw on if they wish to improve specific aspects of performance. Optional for providers to draw on.
- **targeted support offer** – support to help providers with specific areas – eg intensive support teams to help in emergency care or agency spend. Programmes of targeted support will be agreed with providers. This support is offered to providers – its use is voluntary.
- **mandated support** – where a provider has complex issues, we may prepare a directed series of improvement actions to help it, eg appoint an improvement director, or agree a recovery trajectory and support providers to deliver this. In these serious and critical cases, providers are required to comply with NHS Improvement's actions/expectations.

Table 2 below outlines how these types of support link to the segment a trust is in.

Table 2: Support offer by segment

Segment	Relationship with provider
1 No concerns	**Universal** support • eg tools, guidance, benchmark information • made available for providers to access
2 Emerging issues/ minor concerns	**Universal** support (as for segment 1) **Targeted** support as agreed with the provider • to address issues and move the provider to segment 1 • either offered to provider (and accepted voluntarily) or requested by provider
3 Serious issues	**Universal** support (as for segment 1) **Targeted** support as agreed with the provider (as for segment 2) **Mandated** support as determined by NHS Improvement • to address specific issues, move the provider to segment 2 or 1 • compliance required
4 Critical issues	**Universal** support (as for segment 1) **Targeted** support as agreed with the provider (as for segment 2) **Mandated** support as determined by NHS Improvement • to minimise the time the provider is in segment 4 • compliance required

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

8. Summary of consultation questions

Consultation question 1:

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

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?

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?

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?

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?
Consultation question 6: What should we consider to identify potential issues and/or potential support needs in the area of Strategic change?
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?
Consultation question 8: (i) Do you agree with our proposed approach to segmentation? (ii) Do you have any further comments on segmentation?
Consultation question 9 : Do you agree with our proposed approach to supporting providers?

Appendix 1: Summary of triggers of potential concern

Theme	Information used	Triggers
Quality of care	• CQC information • Other quality information to inform our view of a provider (see Appendix 2) • 7 day services	• CQC 'inadequate' or 'requires improvement' assessment versus one or more of: - 'Safe' - 'Caring' - 'Effective' - 'Responsive' • CQC warning notices • Any other material concerns identified through CQC's monitoring process, eg civil or criminal cases raised • Concerns arising from trends in our Quality Indicators (Appendix 2) • Delivering against an agreed trajectory for the 4 priority standards for 7 day hospital services
Finance	• **Sustainability** o Capital Service Cover o Liquidity • **Efficiency** o EBITDA[14] margin o Efficiency metrics • **Controls** o Delivery of control totals or against plan o Capital expenditure controls o Agency spend • **Value for money information**	Poor levels of overall financial performance (average score of 3 or 4) Very poor performance (score of 4) in any individual metric Potential value for money concerns

[14] Earnings Before Interest, Tax, Depreciation and Amortisation

Operational performance	NHS Constitution standards Other national targets and standards	For providers with STF trajectories in any metric: failure to meet the trajectory for this metric in more than two consecutive months For providers without STF trajectories: Failure to meet any standard in more than two consecutive months
Strategic Change	Review of Sustainability and Transformation Plans (STPs) and other relevant matters	Material concerns with a provider's delivery against the transformation agenda, including New Care Models and devolution
Leadership and Improvement capability	Findings of governance or well-led review undertaken against the current well-led framework Third party information, eg Healthwatch, MPs, whistleblowers, Coroners' reports Organisational Health Indicators Operational efficiency metrics CQC well-led assessments	Material concerns CQC 'inadequate' or 'requires improvement' assessment against 'Well-led'.

Appendix 2: Proposed quality of care monitoring metrics

Quality indicators for quality surveillance and oversight
The 42 proposed indicators below are those previously used in either TDA's Assurance Framework, Monitor's Risk Assessment Framework or NHS England's quality dashboard. The latter mirrors the CQC Intelligent Monitoring Tool. The primary focus and CQC domain for these indicators are shown.

Proposed indicators

Measure	Type	Frequency	Source
Organisational Health Indicators – all providers			
Staff sickness(2)	Organisational Health	Monthly/Quarterly	HSCIC (publicly available)
Staff turnover(2)	Organisational Health	Monthly/Quarterly	HSCIC (publicly available)
Executive team turnover (3)	Organisational Health	Monthly	FT return/O&E
NHS Staff Survey	Organisational Health	Annual	CQC (publicly available)
Proportion of Temporary Staff (4)	Organisational Health	Quarterly	FT return
Aggressive Cost Reduction Plans (4)	Organisational Health	Quarterly	FT return
Written Complaints - rate	Caring	Quarterly	HSCIC (publicly available)
Staff Friends and Family Test Percentage Recommended - Care	Caring	Quarterly	NHSE (publicly available)
Never events	Safe	Monthly	NHSE (publicly available)
Never events - incidence rate	Safe	Monthly	NHSE (publicly available)
Serious Incidents rate	Safe	Monthly	StEIS
National Reporting and Learning System (NRLS) medication errors: Percentage of harmful events	Safe	Monthly (1)	NRLS (publicly available)
Proportion of reported patient safety incidents that are harmful	Safe	Monthly	NRLS (publicly available)
Potential under-reporting of patient safety incidents	Safe	Monthly	NRLS (publicly available)
Central Alerting System (CAS) alerts outstanding	Safe	Monthly	NRLS (publicly available)
Acute providers			
Mixed Sex Accommodation Breaches	Caring	Monthly	NHSE (publicly available)
Inpatient Scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)
A&E Scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)

Measure	Type	Frequency	Source
Emergency c-section rate	Safe	Monthly	HES
CQC Inpatient / MH and Community Survey	Organisational Health	Annual	CQC (publicly available)
Maternity Scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)
Percentage of Harm Free Care	Safe	Monthly	NHSE (publicly available)
Percentage of new Harms	Safe	Monthly	NHSE (publicly available)
VTE Risk Assessment	Safe	Quarterly	NHSE (publicly available)
Clostridium Difficile - variance from plan	Safe	Monthly	PHE (publicly available)
Clostridium Difficile - infection rate	Safe	Monthly	PHE (publicly available)
MRSA bacteraemias	Safe	Monthly	PHE (publicly available)
Hospital Standardised Mortality Ratio (DFI)	Effective	Quarterly	DFI
Hospital Standardised Mortality Ratio - Weekend (DFI)	Effective	Quarterly	DFI
Summary Hospital Mortality Indicator	Effective	Quarterly	HSCIC (publicly available)
Emergency re-admissions within 30 days following an elective or emergency spell at the Provider	Effective	Monthly	HES
Community providers			
CQC Inpatient / MH and Community Survey	Organisational Health	Annual	CQC (publicly available)
Community Scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)
Percentage of Harm Free Care	Safe	Monthly	NHSE (publicly available)
Percentage of new Harms	Safe	Monthly	NHSE (publicly available)
Mental health providers			
CQC Inpatient / MH and Community Survey	Organisational Health	Annual	CQC (publicly available)
Mental Health Scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)
Admissions to adult facilities of patients who are under 16 years of age	Safe	Monthly	HSCIC (publicly available)
Percentage of Harm Free Care	Safe	Monthly	NHSE (publicly available)
Percentage of new Harms	Safe	Monthly	NHSE (publicly available)

Measure	Type	Frequency	Source
Care Programme Approach (CPA) follow up - Proportion of discharges from hospital followed up within 7 days - MHMDS	Effective	Monthly	HSCIC (publicly available)
% clients in settled accommodation	Effective	Monthly	HSCIC (publicly available)
% clients in employment	Effective	Monthly	HSCIC (publicly available)
Ambulance providers			
Ambulance see and treat from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)
Return of Spontaneous Circulation (ROSC) in Utstein group	Effective	Monthly	NHSE (publicly available)
Stroke 60 mins	Effective	Monthly	NHSE (publicly available)
Stroke Care	Effective	Monthly	NHSE (publicly available)
ST Segment Elevation Myocardial Infarction (STeMI) 150 Mins	Effective	Monthly	NHSE (publicly available)

Notes

1. If we use published data NRLS data would be six monthly and publicly available.
2. Historically TDA used ESR and Monitor used HSCIC for these data, hence the difference in frequency in 2016-17
3. These data are readily available for NHS providers.
4. The data for NHS trusts has to be confirmed.

Appendix 3: Proposed operational performance metrics

Standard	Frequency	Standard[15]
Acute and specialist providers[16]		
A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge	Monthly	95%
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Monthly	92%
All cancers – maximum 62-day wait for first treatment from: - Urgent GP referral for suspected cancer - NHS cancer screening service referral	Monthly	 85% 90%
Maximum 6-week wait for diagnostic procedures	Monthly	99%
Ambulance providers[17]		
Maximum 8-minute response for Red 1 calls	Monthly	75%
Maximum 8-minute response for Red 2 calls	Monthly	75%
Maximum 19-minute response for all Category A calls	Monthly	95%
Mental health providers[18]		
Patients admitted to inpatient services who are given access to crisis resolution / home treatment teams in line with best practice standards (UNIFY2 and MHSDS)	Quarterly	95%

[15] Minimum % of patients for whom standard must be met

[16] NHS Improvement is following the development of indicators to assess the expansion and oversight of liaison mental health services in acute hospitals, including routine analysis of (i) numbers of emergency admissions of people with a diagnosis of dementia; and (ii) length of stay for people admitted with a diagnosis of dementia. These may be incorporated in future iterations of this framework.

[17] We will balance this oversight with the impact of dispatch on disposition and other pilots affecting performance reporting currently underway across ambulance providers

[18] In addition to the Mental Health indicators here, NHS Improvement is following the development of indicators to assess: (i) Access and waiting times for children and young people eating disorder services; (ii) Providers' collection of data on waiting times (decision to admit to time of admission, decision to home-treat to time of home-treatment commencement), Delayed Transfers of Care and Out of area placements(OATS); and (iii) Systems to measure, analyse and improve response times for urgent and emergency mental health care for people of all ages. These may be incorporated in future iterations of this framework.

Standard	Frequency	Standard[15]
People with a first episode of psychosis should commence treatment with a NICE-recommended package of care within 2 weeks of referral (UNIFY2 and MHSDS)	Quarterly	50%
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas[19]:	Quarterly	
a) Inpatient wards		90%
b) Early intervention in psychosis services		90%
c) Community mental health services (people on Care Programme Approach)		60%
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to the HSCIC:		
• identifier metrics[20]	Monthly	95%
• priority metrics[21]	Monthly	85%
IAPT / Talking Therapies		
Proportion of people completing treatment who move to recovery (from IAPT MDS)	Quarterly	50%
Waiting time to begin treatment (from IAPT MDS)		
- within 6 weeks	Quarterly	75%
- within 18 weeks	Quarterly	95%
Community providers		
Any relevant mental health or acute metrics above		

[19] Board declaration
[20] Comprising: NHS number, Date of birth, Postcode, Current gender, Registered GP org code,Commissioner org Code
[21] Comprising: Ethnicity, Employment status (for adults), School attendance (for CYP), Accommodation status, ICD10 coding. By 2016/17 year-end

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NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

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