To:	The Board
For meeting on:	29 September 2016
Agenda item:	7
Report by:	Patrick Fraher, Senior Policy Adviser Cathy Corrie, Policy Adviser Catherine McDonald, Project Director, Policy Ben Dyson, Executive Director of Strategy
Report on:	NHS Improvement's Single Oversight Framework

Introduction

1. The May 2016 Board meeting considered the paper 'NHS Improvement oversight framework', which set out proposals for NHS Improvement's Single Oversight Framework for NHS trusts and foundation trusts.

2. NHS Improvement subsequently published its proposals and undertook a consultation exercise with the sector. Following that consultation, NHS Improvement has revised and published the Single Oversight Framework (Appendix 1) and consultation response (Appendix 2) – both documents were shared with Board members on the day of publication.

3. The Board is asked to give its approval for NHS Improvement to start overseeing providers using the Single Oversight Framework (Appendix 1) on 1 October and at the same point to stop overseeing NHS foundation trusts using Monitor's Risk Assessment Framework and NHS trusts using NHS Trust Development Authority's (NHS TDA's) Accountability Framework, subject to any final comments from the sector on changes resulting from further policy development (see paragraph 14).

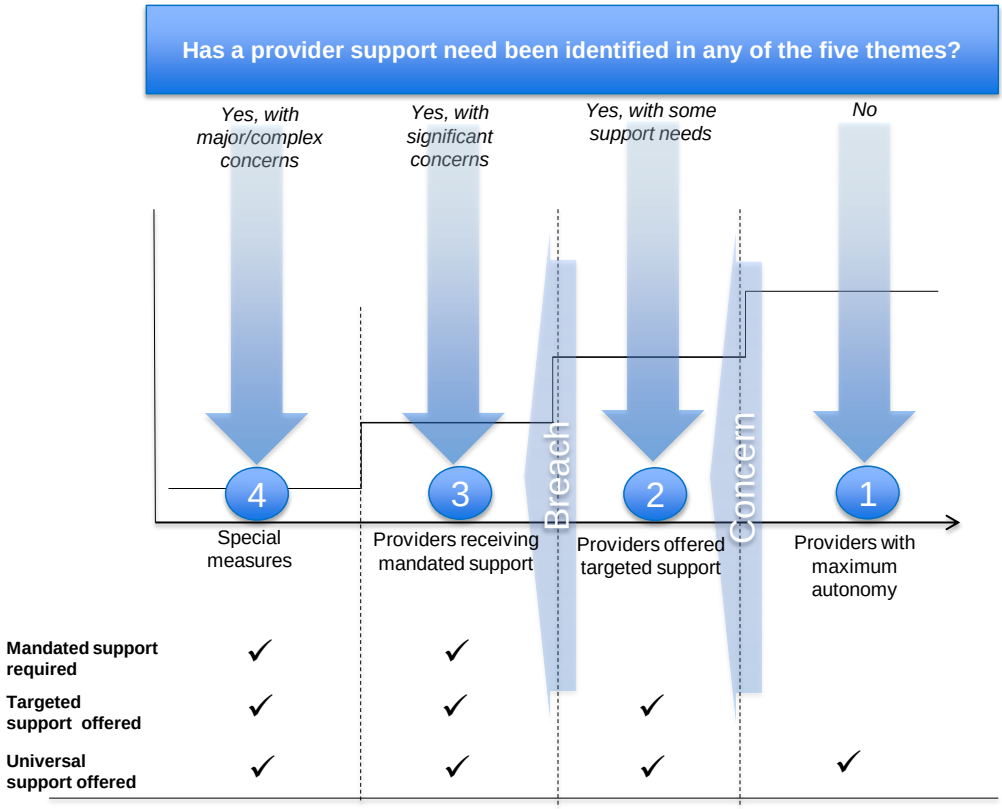
Background

4. The Framework sets out how NHS Improvement will oversee providers in order to identify where they need support across five themes:
    - Quality of care
    - Finance and use of resources
    - Operational performance
    - Strategic change

- Leadership and improvement capability.

5. NHS Improvement will use this information to segment the sector in line with the level of support providers need (see Figure 1 below). This segmentation will allow NHS Improvement to offer targeted support to providers before serious concerns arise, as well as identifying and acting on more serious concerns (where there is a breach of licence). The framework treats NHS trusts and NHS foundation trusts in comparable circumstances similarly unless there is sound reason not to do so. Both types of provider will be held to account against the standards in the NHS Provider Licence, with a particular focus on the governance condition. Our oversight will be based on the principle of earned autonomy – with providers in segments 1 and 2 experiencing higher autonomy and those in segments 3 and 4 receiving mandated support.

Figure 1: Summary of our approach



6. It is proposed that NHS Improvement start overseeing the sector using the Single Oversight Framework, starting to gather data and insights using the measures set out in it, on 1 October 2016. NHS Improvement's teams will receive in November the first set of data gathered under the Single Oversight Framework, which will help to inform decisions on support and (where necessary) regulatory interventions from that point onwards. A series of training and engagement events with NHS Improvement teams is nearly completed. This includes how support will be prioritised and arranged, including the interplay between the regional teams and other directorates when supporting providers in different segments.

Changes since the proposals taken to May's Board

7. NHS Improvement received 157 responses to the consultation. The response to the overall proposed approach was broadly positive:
    - 71% said they supported the overall approach to provider oversight; only 7% were not supportive.
    - There was particularly strong agreement with the proposals regarding oversight of providers, quality of care and providing support.

8. In addition to the formal consultation, NHS Improvement conducted an extensive range of well-attended engagement events, including webinars, presentations, focus groups and workshops, where similar feedback and comments were received.

9. Appendix 2 sets out full details of the changes made since the consultation. Some key changes that respond to consultation feedback are set out below.

10. The revised Framework places more emphasis on autonomy – noting that the Single Oversight Framework is based on the principle of earned autonomy and being clear that, unless a provider is in segment 3 or 4 (in breach of licence), support will not be mandated.

11. NHS Improvement and the Care Quality Commission (CQC) have a shared aim to align their approaches as much as possible. Following further engagement with CQC, the revised Framework makes clearer the alignment between NHS Improvement and CQC's approaches. The five themes of the Single Oversight Framework now link more overtly to CQC's key questions (Safe, Effective, Caring, Responsive and Well-Led). It also makes clear that segmentation is not an indicator of where providers might be on CQC's assessment framework: it is a framework for NHS Improvement to identify providers' support needs. NHS Improvement is continuing to develop with CQC a shared approach to Finance and Use of Resources (which will build on the metrics in the Single Oversight Framework) and to develop a shared 'Well-Led' Framework.

12. The Single Oversight Framework uses language that describes identifying support needs rather than identifying concerns. The four segments have been re-named to reflect the type of support providers will have, rather than level of concern, ie Segment 1: maximum autonomy; Segment 2: targeted support; Segment 3: mandated support; Segment 4: special measures.

13. In line with the principle of earned autonomy, data for providers in segment 1 will be collected monthly but will be reviewed for segmentation purposes only on a quarterly basis, unless there is other evidence to suggest that the provider may be in breach of licence.

14. The revised Framework incorporates a small number of changes based on further policy development since launching the consultation. The sector has been asked for any comments on these changes by Friday 23 September 2016. The changes are:

Quality of Care

- Removing a small number of quality of care indicators proposed in the consultation - Never Events rate of incidence, Serious Incidents rate, National Reporting and Learning System (NRLS) medication errors: % of harmful events, NRLS proportion of reported patient safety incidents that are harmful, Safety Thermometer percentage of harm-free care and Safety Thermometer percentage of new harms. NHS Improvement will work with CQC to decide how best to incorporate these topics in identifying support needs for quality of care.

Finance and Use of Resources

- Incorporating agency spend as a financial metric in the Finance and Use of Resources theme from the start of the Single Oversight Framework (instead of from next year).
- Using Income and Expenditure (I&E) margin, rather than the Earnings Before Interest, Taxes Depreciation and Amortisation (EBITDA) margin, as an efficiency metric – representing continuity with previous Monitor and TDA practice and consistent with the use of I&E in financial control totals for providers.
- Adding measures to identify where providers have not agreed a control total.

Next steps

15. Subject to the Board's approval, NHS Improvement will start overseeing providers using the Single Oversight Framework on 1 October – and at the same point stop overseeing NHS foundation trusts using Monitor's Risk Assessment Framework and NHS trusts using NHS TDA's Accountability Framework.

16. It is proposed to publish the first formal segmentation of the sector in November, using the first set of data collected under the Single Oversight Framework. In the meantime, a shadow segmentation has been carried out based on current data. Regional teams are discussing the results of this shadow segments with the individual providers, ahead of NHS Improvement publishing the whole sector's shadow segmentation in October.

Public Sector Equality Duty:

NHS Improvement has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. We have thought about how the issues dealt with in this paper might affect protected groups. We believe the paper will not have any adverse impact upon these groups and that NHS Improvement has fulfilled its duty under the Act.

Annex 1 – The Single Oversight Framework

Annex 2 – Consultation response document

NHS Improvement

Single Oversight Framework

September 2016

About NHS Improvement

NHS Improvement is responsible for overseeing NHS foundation trusts, NHS trusts and independent providers. We offer the support NHS trusts and NHS foundation trusts 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.

Contents

1. Introduction

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).

NHS Improvement

Part of the national response to the ambitious and stretching tasks highlighted in the 5YFV was the creation of NHS Improvement, reflecting the similar challenges faced by both NHS trusts and NHS foundation trusts. 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] As NHS Improvement we will build on the best of what these organisations did but with a change of emphasis in relation to NHS trusts and NHS foundation trusts to one primarily focused on helping them to improve.

We will provide strategic leadership, oversight and practical support for the trust sector. We will support NHS trusts and NHS 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. The Single Oversight Framework does not give a performance assessment in its own right, nor is it intended to predict the ratings given by the Care Quality Commission (CQC). Our aim, however, is to help providers attain, and maintain, 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 CQC, NHS England and other partners, at national, regional and local levels.

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[1] NHS Improvement is clear which duties and powers of Monitor and the TDA it is exercising at 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 use the term 'provider' to mean NHS trusts and NHS foundation trusts. This document does not apply to independent sector providers: *Risk assessment framework for independent sector providers of NHS services* (available at 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).

The five themes of the Single Oversight Framework

In carrying out our role we will work across five themes:

- **Quality of care (safe, effective, caring, responsive)**: we will use CQC's most recent assessments of whether a provider's care is **safe**, **effective, caring** 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, reflecting the approach taken in *Strengthening financial performance and accountability.*[3] We are co-developing this approach with CQC.
- **Operational performance:** we will support providers in improving and sustaining performance against NHS Constitution standards and other, including A&E waiting times, referral to treatment times, cancer treatment times, ambulance response times, and access to mental health services. These NHS Constitution standards may relate to one or more facets of quality (ie safe, effective, caring and/or responsive).
- **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 (well-led):** building on the joint CQC and NHS Improvement well-led framework, we will develop a shared system view with CQC of what good governance and leadership look 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. Strategic change recognises that organisational accountability and system-wide collaboration are mutually supportive. Leadership and improvement capability are crucial in ensuring that providers can deliver sustainable improvement. These five themes are also reflected in NHS Improvement's 2020 Objectives.[4] The Single Oversight Framework will support the delivery of NHS Improvement's 2020 objectives, including helping more providers achieve CQC 'good' or 'outstanding'

[3] Published in July 2016 and available at https://improvement.nhs.uk/uploads/documents/Strengthening_financial_performance_and_accountability_in_2016-17_-_Final_2.pdf

[4] Available at https://improvement.nhs.uk/uploads/documents/NHSI_2020_Objectives_13july.pdf

ratings, reducing numbers of trusts in special measures and achieving aggregate financial balance from 2017/18 as well as meeting NHS Constitution standards.

2. The Single Oversight Framework

This document sets out NHS Improvement's approach to overseeing both NHS trusts and NHS foundation trusts and shaping the support we provide.

Section 3 Summary of our approach: sets out a high level description of the framework

Section 4 Monitoring providers: describes how we will collect the information we require from providers

Section 5 Identifying potential support needs: sets out how we will identify potential support needs across each of the five themes described above

Section 6 Segmentation: outlines how we will segment the provider sector according to the level of support each provider needs.

The purpose of the 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 set out in detail the improvement support we will provide in each case as this will be tailored to individual provider needs.

The Single Oversight Framework replaces Monitor's Risk Assessment Framework and TDA's Accountability Framework. It applies to both NHS trusts and NHS foundation trusts. As far as possible, we have combined and built on the previous approaches of Monitor and TDA, adapting them to reflect and enable our primary improvement role. Any changes from these frameworks are intended as far as possible to be incremental. 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 and should be read in the light of this document.

Ongoing statutory roles of Monitor and the NHS Trust Development Authority

The Single Oversight Framework works within 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 exercises functions via directions from the Secretary of State).

Alignment with the Care Quality Commission

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.

While our five themes are linked to CQC's key questions, they are not identical. This is because CQC's questions do not yet incorporate use of resources; because 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 systems that will be needed to assure the delivery of high quality services by providers in the longer term.

We will continue to work with CQC to align approaches more fully as we move towards a single combined assessment of quality and use of resources. We will work with CQC to develop the well-led framework, to help identify support needs for leadership and improvement capability. We will work together to share data and develop common data sets where possible. We will also continue to develop close operational working, for example aligning the way we and CQC work together in engaging with individual providers.

Alignment with recommendations from the Carter review

Lord Carter's review, *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations,*[5] 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, NHS England and 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.

Links between the Single Oversight Framework and the Model Hospital

The Carter review also recommended the creation of a 'model hospital' – a nationally available online information system, with a series of themed compartments which present key performance metrics for different areas across the hospital, and best practice guidance. We will ensure that the metrics used in the Single Oversight Framework are included in the Model Hospital. This will enable providers to access them easily, compare performance against their peers and national benchmarks, and identify areas where they need to improve. The prototype Model Hospital online portal is already live to users in acute providers, and is being populated in stages with data and metrics across a hospital's work.

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

3. Summary of our approach

NHS Improvement's Single Oversight Framework:

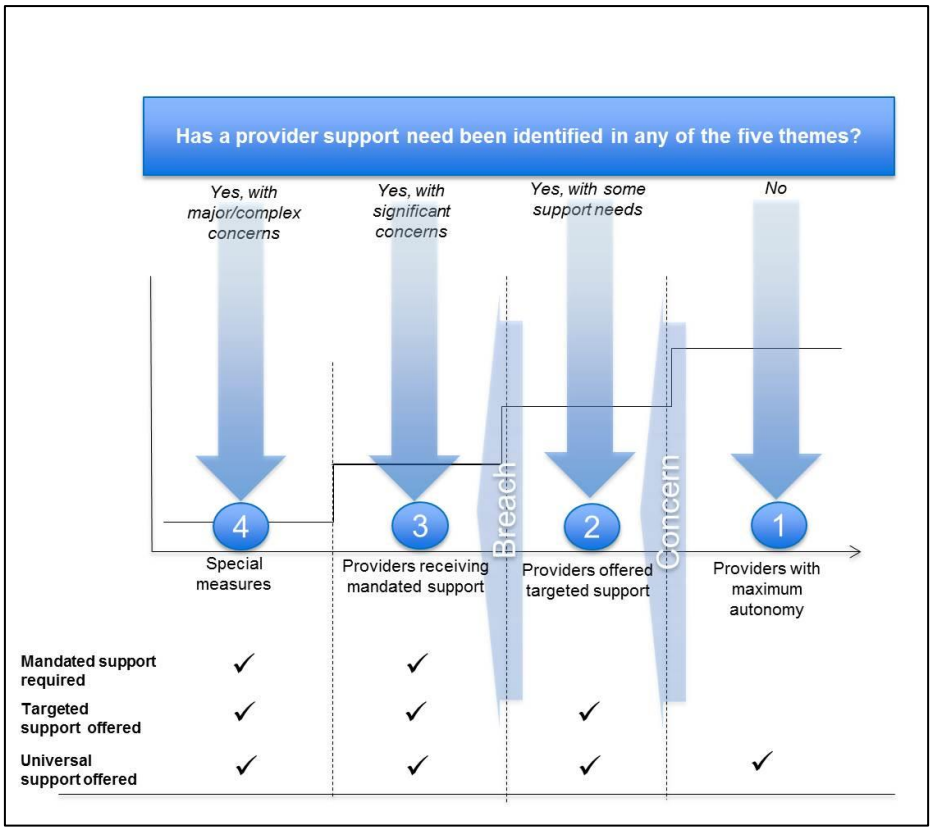
- provides one framework for overseeing providers, irrespective of their legal form
- helps us identify potential support needs, by theme, as they emerge
- allows us to tailor our support packages to the specific needs of providers in the context of their local health systems, drawing on expertise from across the sector as well as within NHS Improvement
- is based on the principle of earned autonomy.

We will 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 national policy changes. We may, therefore, from time to time, adjust the approach set out in this document, 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 will segment the provider sector according to the scale of issues faced by individual providers. This segmentation will be informed by data monitoring and, importantly, judgement based on an understanding of providers' circumstances (see Figure 1).

Figure 1: Summary of our approach



The segment a provider is in determines the *level* of the support we provide but not the precise support package. We have identified three levels of support – universal offers, targeted offers and mandated – which will link to the segments (see section 7).

NHS Improvement teams will work with providers to determine the appropriate, tailored, support package for each support need identified, including directly provided support and support facilitated by, for example, other parts of the sector.

The legal basis for actions in relation to 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 NHS foundation trusts[6] continues to follow existing policy set out in the *Enforcement guidance*.[7]

[6] Based on s.105, s.106 or s.111 of the Health and Social Care Act 2012
[7] Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/284474/ToPublishEnforcementGuidance28March13_0.pdf

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. The NHS provider licence[8] forms the legal basis for Monitor's oversight of NHS foundation trusts and can be found here. While NHS trusts are exempt from the requirement to apply for and hold the licence, 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. We aim to treat all providers in comparable circumstances similarly unless there is sound reason not to. We will therefore base our oversight, using the Single Oversight Framework, of all NHS trusts and NHS foundation trusts on the conditions of the NHS provider licence.[9]

4. Monitoring providers

We use information from our data monitoring processes and insights gathered though our work with providers, to identify where providers have a potential support need under one or more of the five themes (which indicates they are not in segment 1). We will also use judgement, based on consistent principles, to determine whether or not providers are in breach of licence – or the equivalent for NHS trusts – and to determine, as part of that judgement, if providers should go into special measures (segment 4).

We collect information on providers (see Figure 2) either directly or from third parties. We seek to ensure that the collection burden is proportionate and, where possible, we use nationally available information.[10]

Examples of information collected include:

- regular financial and operational information
- annual plans

[8] www.gov.uk/government/publications/the-nhs-provider-licence

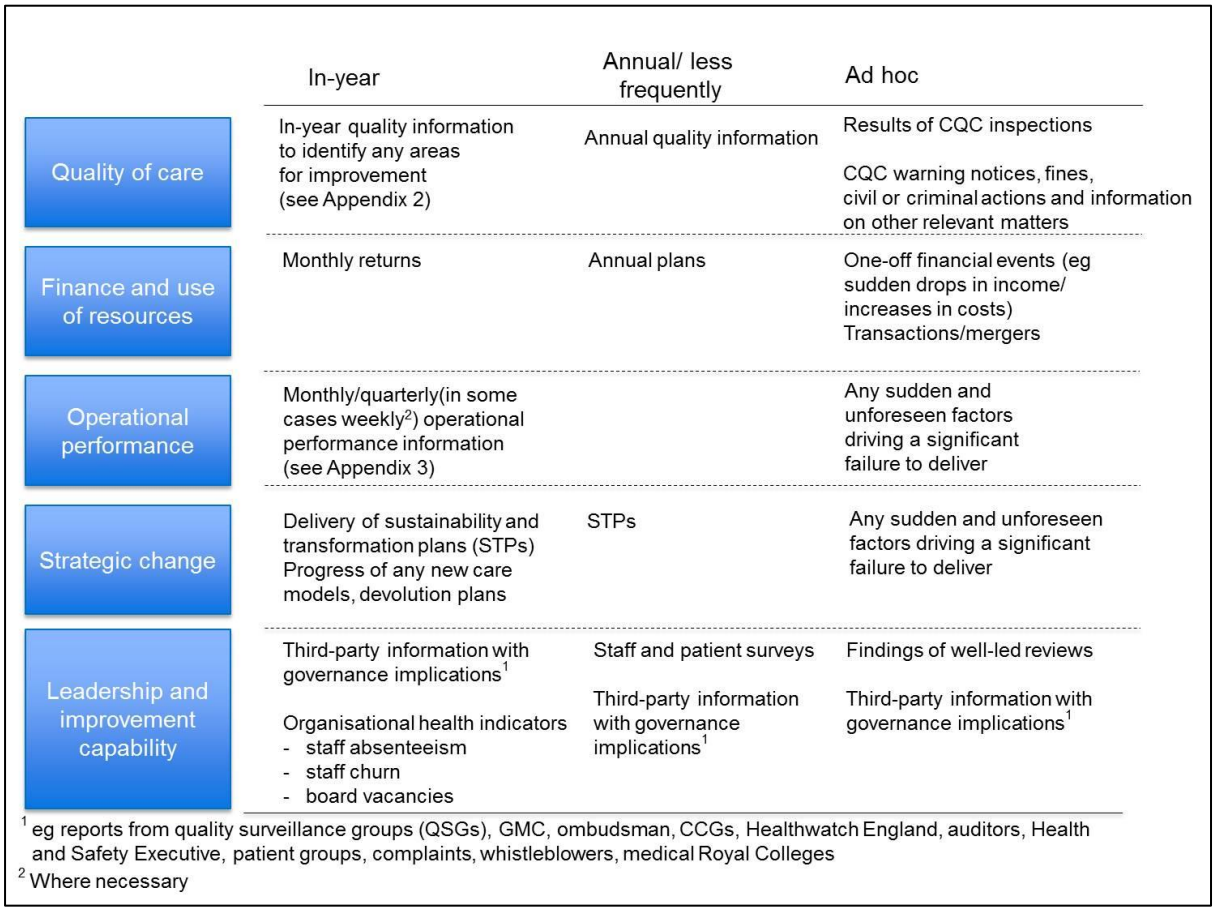
[9] For the most part, this is likely to entail holding trusts to account against the standards in condition FT4 – the NHS foundation trust governance condition, but other conditions such as those relating to continuity of services and integrated care could be engaged too. Our scope extends to the entire NHS provider licence (see www.gov.uk/government/publications/the-nhs-provider-licence). For completeness it should be noted that NHS Improvement has functions and powers in addition to those stemming from the Monitor provider licence in relation to both NHS trusts (through directions from the Secretary of State) and NHS foundation trusts (through statute). The Single Oversight Framework does not cover these additional matters.

[10] Eg assessing performance against national targets and standards

- third-party information
- any ad-hoc or exceptional information that can be used to oversee providers according to the five themes.

We will work with partners – including NHS England and CQC – to ensure, as much as possible, a shared dataset across the various oversight organisations.

Figure 2: Summary of information required 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 and 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[2]) operational performance information (see Appendix 3)		Any sudden and 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	STPs	Any sudden and unforeseen factors driving a significant failure to deliver
Leadership and improvement capability	Third-party information with governance implications[1] Organisational health indicators - staff absenteeism - staff churn - board vacancies	Staff and 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 and Safety Executive, patient groups, complaints, whistleblowers, medical Royal Colleges

[2] Where necessary

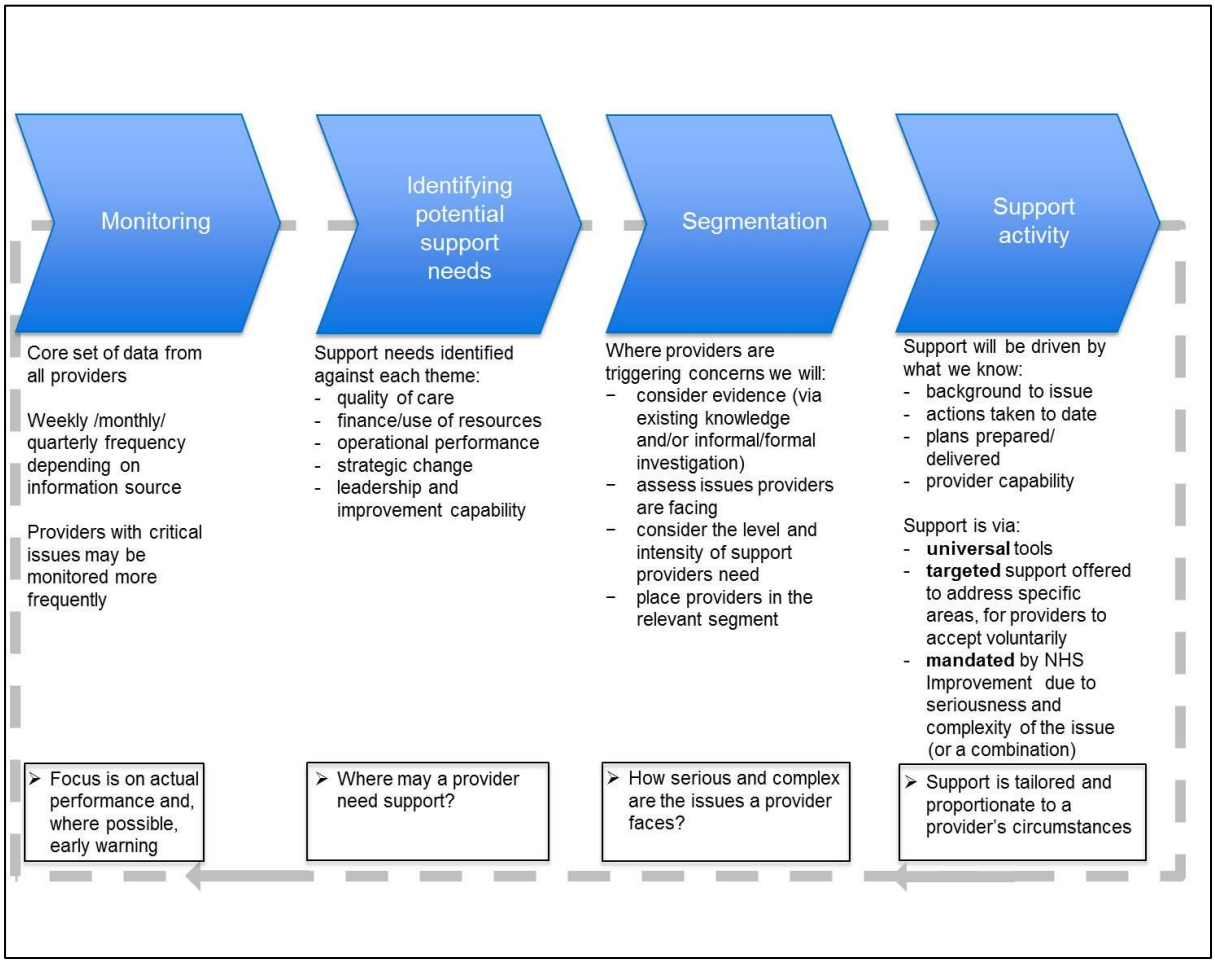
Collection is:

- **in-year**: following a regular in-year monitoring cycle (see Figure 3), using monthly, quarterly or lower frequency collections as appropriate. In extreme circumstances (eg where a provider is displaying critical problems) we will consider more frequent information
- **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 aims to be as agile as possible in responding to issues identified at providers. Where material events occur, or we receive information that triggers our concern outside the regular monitoring

cycle, we will take these into account when considering whether there are potential support needs at the provider.

For providers in segment 1, although some data will be collected monthly and reviewed as for providers in other segments, we will – in line with the principle of earned autonomy – generally review the segmentation of the provider on a quarterly basis, unless there is information giving cause for concern.

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.

Rather than require providers to make bespoke data submissions, wherever possible we will use nationally collected and evaluated datasets, in particular for operational performance. Appendix 3 lists the metrics we will use and the frequency of their collection across acute, mental health, ambulance and community trusts. We may revise this list – introducing new metrics or varying the collection frequency – as necessary and appropriate, particularly as the Model Hospital work develops.

In line with Lord Carter's recommendations, we are also working with NHS England, the Department of Health, CQC and NHS Digital to rationalise the reporting requirements on providers, aiming to demonstrate a clear reduction in burdens over time.

5. Identifying potential support needs

We will use the information we collect on provider performance to identify where providers need support across the five themes.

Our approach in each theme is set out below and the triggers are summarised in Appendix 1. Where providers have a potential support need, based on the triggers, we will consider the circumstances to determine the level of support required. Practically, we will consider:

- the **extent** to which the provider is triggering a Single Oversight Framework measure under one, or more, of the five themes
- 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 have a potential support need, we will consider whether the level of interaction needs to change to monitor the issue and the provider's response to it. How we will identify potential support needs against each theme is set out below.

5.1. Quality of care (safe, effective, caring and responsive)

Where CQC's assessment identifies a provider as 'inadequate' or 'requires improvement' against any of the **safe**, **effective, caring** or **responsive** key questions, this will represent a potential support need.

We will supplement CQC's inspection findings with other relevant information such as 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 we incorporate their views on quality at providers yet to be inspected. We will also use extra 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 and support needs. We will also work with CQC as it develops its new insight tool around the use of data and information and its relationship with quality of care.

In addition we will oversee delivery of 7-day hospital services across providers 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. We will work closely with NHS England to co-ordinate our respective support offers and oversight.

5.2. Finance and use of resources

We will oversee and support providers in improving financial sustainability, efficiency and compliance with sector controls such as agency staffing and capital expenditure. We are also, with CQC, co-developing a shared approach to assessing and rating how well trusts use their resources. This will build and expand on the metrics used in the Single Oversight Framework, and be consulted on separately if needed.

The finance and use of resources score

We will use a few financial metrics to assess financial performance (see Table 1) by:

- scoring providers 1 (best) to 4 against each metric (see Figure 4)
- averaging individual providers' scores across all the metrics to derive a use of resources score for the provider.[11]

Where providers have a score of 4 or 3 in the financial and use of resources theme, this will identify a potential support need under this theme, as will providers scoring a 4 (ie significant underperformance) against **any** of the individual metrics.[12] Providers in financial special measures will score a 4 on this theme.

[11] Scores are rounded to the nearest whole number. Where a trust's score is exactly between two whole numbers, it is rounded to the lower whole number (eg both 2.2 and 2.5 are rounded down to 2). This follows Monitor's method in assessing best performance where financial scores were rounded positively, ie towards the 'best' score for trusts.

[12] The best overall finance and use of resources score that a provider scoring 4 on any individual metric can obtain is a 3.

Table 1: Finance and use of resources metrics

Area	Weighting	Metric	Definition	Score			
				1	2	3	4[1]
Financial sustainability	0.2	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
	0.2	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	0.2	I&E margin	I&E surplus or deficit / total revenue	>1%	1-0%	0-(1)%	≤(1)%
Financial controls	0.2	Distance from financial plan	Year-to-date actual I&E surplus/deficit in comparison to Year-to-date plan I&E surplus/ deficit	≥0%	(1)-0%	(2)-(1)%	≤(2)%
	0.2	Agency spend	Distance from provider's cap	≤0%	0%-25%	25-50%	>50%

Note: brackets indicate negative numbers

[1] Scoring a '4' on any metric will mean that the overall rating is at least a 3 (ie either a 3 or a 4), triggering a concern.

Broader value-for-money considerations

In addition to using the metrics above, we may consider whether there is, more broadly, any evidence that suggests a provider is failing to operate effective systems and/or processes for financial management and control, and not operating economically, efficiently and effectively.

Such evidence would come from, for example, national benchmarking, including the Model Hospital work. We may also consider other factors linked to whether a provider is delivering good value for money, such as management consultancy spend. We may also look at, for example, paybill growth, consolidation of back office and pathology services, and the extent to which providers are addressing unsustainable services through consolidation, and change or transfer to a neighbouring provider.

The Carter review

Lord Carter's review *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations* described methodologies to improve productivity at NHS providers. Work to implement the various recommendations – including the Model Hospital – is underway. During 2016/17 NHS Improvement will, as part of this effort, consider change in cost per weighted activity unit as part of this.

Finance and use of resources metrics and weighting

The overall finance and use of resources score is a mean average of the scores of the individual metrics under this theme, subject to any support needs being identified in value for money – except that:

- if a provider scores 4 on any individual finance and use of resources metric, their overall use of resources score is at least a 3 – ie cannot be a 1 or 2 – triggering a potential support need
- if a provider has not agreed a control total:
    - where they are planning a deficit their use of resources score will be at least 3 (ie it will be 3 or 4)
    - where they are planning a surplus their use of resources score will be at least 2 (ie it will be 2, 3 or 4).

As we continue to develop a shared approach to use of resources with CQC we may seek to revise the finance and use of resources metrics used in the Single Oversight Framework. If we do so, we will consult as needed.

Phasing in the new finance and use of resources metrics

We are currently considering two other metrics – change in cost per weighted activity unit and capital controls. We will share specifics as we develop them. We would introduce them in 'shadow' form in 2016/17, to assess how best to use them thereafter. As a result, we will not use this information to identify any concerns or consequent support needs at providers in 2016/17. We can then consider how best to introduce them formally, with detailed definitions and thresholds if appropriate, in 2017/18. For 2016/17 our oversight for identifying a potential financial support need will be based on the metrics in Figure 4.

5.3. Operational performance

NHS providers must strive to meet key national access standards, including those in the NHS Constitution. We will track providers' performance against, and support improvements in, a number of NHS standards. 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 will use and how frequently they are collected 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 there is a potential support need:

- 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 support needs across other standards and/or other themes) indicate we need to get involved before two months have elapsed.

We will then consider the issues, use this to identify the appropriate segment for the provider (see section 6) and develop the support offer.

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.

We will develop our approach to identifying support needs under this theme. In the interim, we will consider providers' contribution to developing, agreeing and delivering sustainability and transformation plans (STPs) − including providers' relationships with local partners, the plans, and how far these plans have been implemented − as well as, in some cases, the implementation of new care models and implementation of devolution.

We have produced 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 engage 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 across a local health system.

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

5.5. Leadership and improvement capability (well-led)

Similar standards of governance were set out in the NHS foundation trust governance condition (FT4), the TDA Accountability Framework and the TDA general objective. Governance issues can provide early warnings of problems that have yet to manifest themselves in, for example, quality issues or financial underperformance. We expect providers to demonstrate three main characteristics – effective boards and governance, continuous improvement capability and effective use of data − as part of this theme.

1. **Effective boards and governance:** We will use several 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
    - delivering Workforce Race Equality Standards (WRES)
    - CQC 'well-led' assessments.

    We will also draw on the existing well-led framework and associated tools to identify any potential support needs concerning 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 continuous improvement capability.

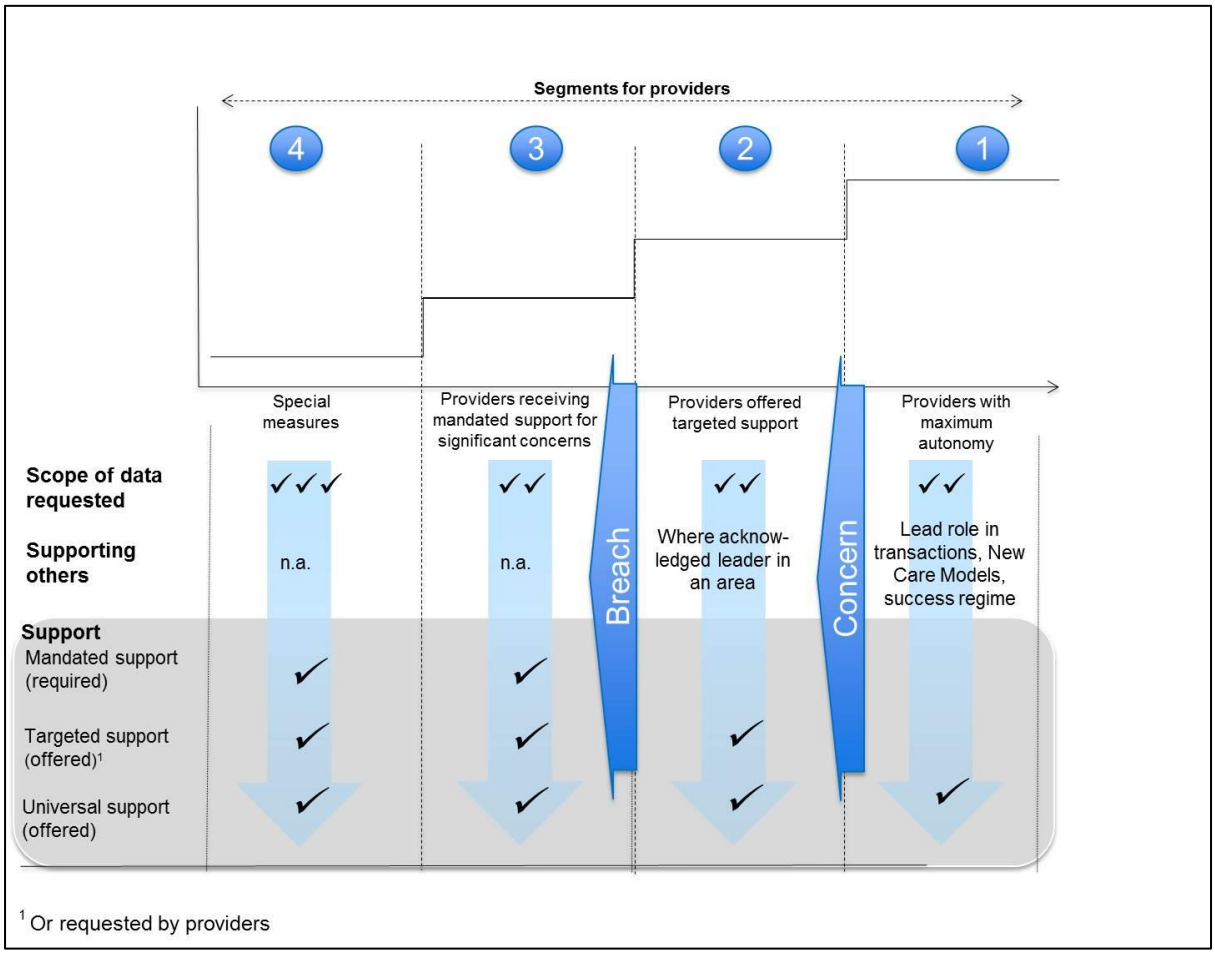
3. **Use of data:** Effective use of information is an important element of good governance. Well-led providers should collect, use and, where required, submit robust data. Where we have reason to believe this is not the case, we will consider the degree to which providers need support in this area.

As we develop the well-led framework we will build on this approach to identifying support needs under all aspects of this theme, including potentially culture and engagement, particularly through working with CQC. We will look to incorporate the principles and findings of the National Leadership Development and Improvement Board.

6. Segmentation

Segmentation helps NHS Improvement determine the level of support required (see section 7). It does not give a performance assessment in its own right, nor is it intended to predict the ratings given by CQC. It also does not determine the specifics of the support package needed − this is tailored by teams working with the provider in question. We are segmenting the sector into four, depending on the extent of support needs identified through the oversight process.

Figure 5: Segmenting the provider sector



6.1. Segmentation process

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

- considering all available information on providers – both obtained directly and from third parties
- identifying providers with a potential support need in one or more themes

- using our judgement, based on relationship knowledge and/or the findings of formal or informal investigations, or analysis, 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 placed in a segment as per Table 2 below:

Table 2: Segment description

Segment	Description
1	**Providers with maximum autonomy** – no potential support needs identified across our five themes – lowest level of oversight and expectation that provider will support providers in other segments
2	**Providers offered targeted support** – potential support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or formal action is not needed
3	**Providers receiving mandated support for significant concerns** – the provider is in actual/suspected breach of the licence (or equivalent for NHS trusts)
4	**Special measures** – the provider is in actual/suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues that mean that they are in special measures

Segmentation needs to be as timely and rigorous as possible, without becoming over bureaucratic or complex. Where our in-year, annual or ad-hoc monitoring of a provider flags a potential support need, 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 the incentives for providers 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.

7. Support activities

Our teams will co-ordinate and oversee tailored support for providers to support sustainable improvement. Under the Single Oversight Framework, we may identify support needs in more than one theme where there is a shared underlying cause in more than one theme. In these cases, we will not 'double count' identified support needs and will ensure that the support activity is appropriate to the underlying cause.

Individual support packages will be provider-specific, and tailored to the support needs identified, but comprise one or more of three **levels** of support:

- **Universal support offer:** tools that providers can draw on if they wish to improve specific aspects of performance – its use is voluntary.
- **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 introduce a mandated series of improvement actions, eg appoint an improvement director, or agree a recovery trajectory and support providers to deliver this. In these serious cases, providers are required to comply with NHS Improvement's actions/expectations.

Table 3 below outlines how these types of support link to the segment a provider is in.

Table 3: Support offer by segment

Segment	Levels of support
1	**Universal** support • eg tools, guidance, benchmark information • made available for providers to access
2	**Universal** support (as for segment 1) **Targeted** support as agreed with the provider • to address issues and help move the provider to segment 1 • either offered to provider (and accepted voluntarily) or requested by provider
3	**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, help move the provider to segment 2 or 1 • compliance required
4	**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 help minimise the time the provider is in segment 4 • compliance required

Appendix 1: Summary of information used and triggers

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 in one or more of: - 'safe' - 'effective' - 'caring' - 'responsive' • CQC warning notices • Any other material concerns identified through, or relevant to, CQC's monitoring process, eg civil or criminal cases raised, whistleblower information, etc • Concerns arising from trends in our quality indicators (Appendix 2) • Delivering against an agreed trajectory for the four priority standards for 7-day hospital services
Finance	• **Sustainability** o Capital service cover o Liquidity • **Efficiency** o I&E [14] margin • **Controls** o Performance against plan 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] Income and expenditure, or surplus/deficit margin

Theme	Information used	Triggers
Operational performance	NHS Constitution standards Other national targets and standards	For providers with Sustainability and Transformation Fund (STF) trajectories in any metric: failure to meet the trajectory for this metric in more than two consecutive months (quarterly for quarterly metrics) For providers without STF trajectories: failure to meet any standard in more than two consecutive months
Strategic change	Review of sustainability and transformation plans 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: Quality of care (safe, effective, caring, responsive) monitoring metrics

NHS Improvement will use the 39 indicators below to supplement CQC information in order to identify where providers may need support under the theme of quality.

Quality indicators

Measure	Type	Frequency	Source
Organisational health indicators – all providers			
Staff sickness	Organisational health	Monthly/quarterly	NHS Digital (publicly available)
Staff turnover	Organisational health	Monthly/quarterly	NHS Digital (publicly available)
Executive team turnover	Organisational health	Monthly	Provider return
NHS Staff Survey	Organisational health	Annual	CQC (publicly available)
Proportion of temporary staff	Organisational health	Quarterly	Provider return
Aggressive cost reduction plans	Organisational health	Quarterly	Provider return
Written complaints - rate	Caring	Quarterly	NHS Digital (publicly available)
Staff Friends and Family Test % recommended - care	Caring	Quarterly	NHSE (publicly available)
Occurrence of any Never Event	Safe	Monthly	NHS Improvement (publicly available)
NHS England/NHS Improvement Patient Safety Alerts outstanding	Safe	Monthly	NHS Improvement (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)
Emergency c-section rate	Safe	Monthly	HES

Measure	Type	Frequency	Source
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)
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	NHS Digital (publicly available)
Potential under-reporting of patient safety incidents[15]	Safe	Monthly	NHS England (dashboard)
Emergency re-admissions within 30 days following an elective or emergency spell at the provider	Effective	Monthly	HES
Community providers			
CQC Community Survey	Organisational health	Annual	CQC (publicly available)
Community scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)
Mental health providers			
CQC inpatient/mental health 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 old	Safe	Monthly	NHS Digital (publicly available)

[15] NHS England dashboards have monthly provisional data. This indicator is valid only at the level of extreme outliers for under reporting as per CQC IM methodology and only in non-specialist acute trusts.

Measure	Type	Frequency	Source
Care programme approach (CPA) follow up - proportion of discharges from hospital followed up within 7 days - MHMDS	Effective	Monthly	NHS Digital (publicly available)
% clients in settled accommodation	Effective	Monthly	NHS Digital (publicly available)
% clients in employment	Effective	Monthly	NHS Digital (publicly available)
Potential under-reporting of patient safety incidents[16]	Safe	Monthly	NHS England (dashboard)
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 minutes	Effective	Monthly	NHSE (publicly available)
Stroke care	Effective	Monthly	NHSE (publicly available)
ST Segment elevation myocardial infarction (STeMI) 150 minutes	Effective	Monthly	NHSE (publicly available)

[16] NHS England dashboards have monthly provisional data. This indicator is valid only at the level of extreme outliers for under reporting as per CQC IM methodology.

Appendix 3: Operational performance metrics

Standard	Frequency	Standard[17]
Acute and specialist providers[18]		
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[19]		
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[20]		
Patients requiring acute care who received a gatekeeping assessment by a crisis resolution and	Quarterly	95%

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

[18] NHS Improvement is following the development of indicators assessing the expansion of liaison mental health services in acute hospitals, including routine analysis of (i) numbers of presentations at A&E of people of all ages with a mental health condition or dementia and liaison mental health service response times; (ii) numbers of emergency admissions of people of all ages with a mental health condition or dementia; (iii) length of stay for people of all ages admitted with a mental health condition or dementia; (iv) delayed transfers of care for people of all ages with a mental health condition or dementia. These may be incorporated in future iterations of this framework.

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

[20] In addition to the MH indicators, NHS Improvement is following the development of metrics to assess: (i) access and waiting times for children and young people eating disorder services in line with evidence-based treatment guidelines (ii) providers' collection of data on waiting times for acute care (decision to admit to time of admission, decision to home-treat to time of home-treatment start), delayed transfers of care and out of area placements (OAPS) 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[17]
home treatment team in line with best practice standards (UNIFY2 and MHSDS)[21]		
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral (UNIFY2 and MHSDS)[22]	Quarterly	50%
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards b) early intervention in psychosis services	Quarterly	90% 90% 65%

[21] In line with the recommendation of the 5YFV for mental health, providers should be working with commissioners to ensure that crisis resolution home treatment teams are delivering care in line with best practice standards (www.ucl.ac.uk/core-resource-pack/fidelity-scale).

For 2016/17, commissioners have been asked to focus on the following key components of CRHTT care:

- rapid response to new referrals
- provision of a 24/7 gatekeeping function, assessing all people face-to-face within four hours of referral
- adequate staffing with caseloads in line with recommended practice
- provision of intensive home treatment in line with recommended practice (For example, by routinely visiting people at least twice a day for the first three days of home treatment, providing twice daily visits when required thereafter, and routinely offering visits that allow enough time to prioritise therapeutic relationships and help with social and practical problems)
- routine collection and monitoring of clinician and patient reported outcomes, as well as feedback from people who use the service.

These are reflected in NHS England's CCG Improvement and Assessment Framework mental health indicators.

[22] This standard applies to anyone with a suspected first episode of psychosis aged 14-65.Exclusions must not be made of people aged >35 who may historically not have had access to specialist EIP services. Technical guidance is available at: www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/02/tech-cyped-eip.pdf.

Provider boards must be fully assured that RTT data submitted is complete, accurate and in line with published guidance. Both 'strands' of the standard must be delivered.

- performance against the RTT waiting time element of the standard is being measured via MHSDS and UNIFY2 data submissions.
- performance against the NICE concordance element of the standard is to be measured via:
  - a quality assessment and improvement network being hosted by CCQI at the Royal College of Psychiatrists. All providers will be expected to take part in this network and submit self-assessment data which will be validated and performance scored on a 4-point scale at the end of the year. This assessment will provide a baseline of performance and will be used to inform the development of performance expectations for 17/18 and beyond.
  - submission of intervention and outcomes data using SNOMED-CT codes in line with published guidance. Provider boards must be fully assured that intervention and outcomes data submitted are complete and accurate.

Further information can be found in the implementation guidance published by NHS England here: www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/04/eip-guidance.pdf

Standard	Frequency	Standard[17]
c) community mental health services (people on Care Programme Approach) [23]		
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital: • identifier metrics[24] • priority metrics[25]	 Monthly Monthly	 95% 85%
Improving Access to Psychological Therapies (IAPT)/talking therapies • proportion of people completing treatment who move to recovery (from IAPT minimum dataset) • waiting time to begin treatment (from IAPT minimum data set) - within 6 weeks - within 18 weeks	 Quarterly Quarterly Quarterly	 50% 75% 95%
Community providers		
Any relevant mental health or acute metrics above		

[23] Board declaration but can be triangulated with results of CQUIN audit which will be for a sample of patients in each service area). People with psychosis should receive:

- a completed assessment for each of the cardio-metabolic parameters with results documented in the patient's records
- a record of interventions offered where indicated, for patients who are identified as at risk as per the red zone of the Lester Tool.

The cardio metabolic parameters based on the Lester Tool are as follows:

- smoking status
- lifestyle (including exercise, diet, alcohol and drug use)
- body mass index
- blood pressure
- glucose regulation (HbA1c or fasting glucose or random glucose as appropriate)
- blood lipids.

Information on the Lester Tool and the recommended key interventions and treatments can be found at: www.england.nhs.uk/2014/06/lester-tool/

This indicator aligns with the national CQUIN scheme for 2016/17: www.england.nhs.uk/nhs-standard-contract/cquin/cquin-16-17/

[24] Comprising: NHS number, date of birth, postcode, current gender, registered GP org code, commissioner org code

[25] For achievement by 2016/17 year-end. Comprising: ethnicity, employment status (for adults only), school attendance (for CYP only), accommodation status (for adults only), ICD10 coding. Note: ICD10 for CYP may be supplanted by capture of a problem descriptor, rather than a formal medical diagnosis.

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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.

This publication can be made available in a number of other formats on request.

 Publication code: C 05/16

NHS Improvement

Single Oversight Framework

Consultation response

September 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.

Contents

1. Introduction

NHS Improvement will use a Single Oversight Framework[1] to oversee NHS providers (both NHS trusts and NHS foundation trusts) to identify the support they need to deliver high quality, sustainable healthcare services. We have developed this framework around five themes:

In carrying out our role we will work across five themes:

- **Quality of care (safe, effective, caring, responsive)**: we will use the Care Quality Commission's (CQC's) most recent assessments of whether a provider's care is **safe**, **effective, caring** and **responsive**, in combination with in-year information where available. We will also include progress in implementing 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, reflecting the approach taken in *Strengthening financial performance and accountability.*[2] We are co-developing this approach with CQC.
- **Operational performance:** we will support providers in improving and sustaining performance against NHS Constitution standards and other standards, including A&E waiting times, referral to treatment times, cancer treatment times, ambulance response times, and access to mental health services. These NHS Constitution standards may relate to one or more facets of quality (ie safe, effective, caring and/or responsive).
- **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 (well-led):** building on the joint CQC and NHS Improvement well-led framework, we will develop a shared system view with CQC of what good governance and leadership look like, including organisations' ability to learn and improve.

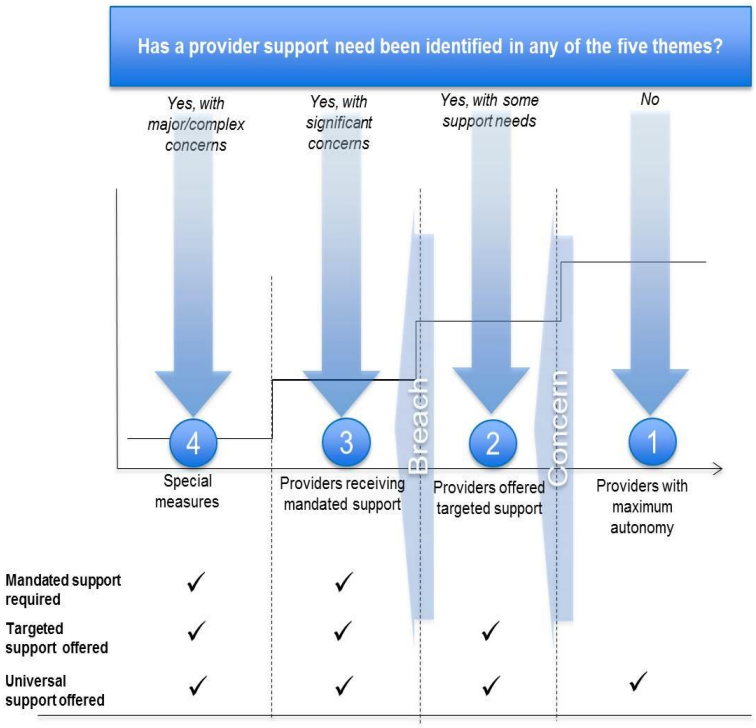
By focusing on these five themes we will support providers to attain and/or maintain a CQC 'good' or 'outstanding' rating. Quality of care, finance and use of resources, and operational performance relate directly to sector outcomes. Strategic change recognises that organisational accountability and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

[1] https://improvement.nhs.uk/resources/single-oversight-framework/
[2] Published in July 2016 and available at https://improvement.nhs.uk/uploads/documents/Strengthening_financial_performance_and_accountability_in_2016-17_-_Final_2.pdf

that providers can deliver sustainable improvement. These five themes are also reflected in NHS Improvement's 2020 Objectives.[3]

The Single Oversight Framework identifies providers' support needs across five themes: quality of care, finance and use of resources, operational performance, strategic change, and leadership and improvement capability. It segments the sector according to the level of support each provider needs. NHS Improvement teams will then offer or mandate tailored support as appropriate.

Figure 1: Summary of our approach



1.1. The Single Oversight Framework consultation

NHS Improvement published proposals for the Single Oversight Framework on 28 June 2016 and ran a five-week consultation exercise. The consultation used a combination of 'agree'/'disagree' and open-ended questions on detailed proposals underpinning the framework, covering:

- the overall approach taken in our oversight framework and its alignment with the CQC

[3] Available at https://improvement.nhs.uk/uploads/documents/NHSI_2020_Objectives_13july.pdf

- our approaches to identifying concerns against each of the five themes above
- segmenting the provider sector
- provision of support.

We received 140 responses via a survey tool and a further 17 responses directly. The response to our approach was broadly positive: 71% said they supported our overall approach to provider oversight; only 7% said they did not (the rest either did not know or did not respond to this specific question). There was particularly strong agreement with our proposals regarding oversight of providers, quality of care and providing support – all receiving more than 70% agreement. The one area where opinion was divided was on proposals to equally weight the metrics in the finance and use of resources theme, with approximately equal numbers of respondents agreeing, disagreeing or expressing no opinion with the approach. In addition to the formal consultation, we also conducted an extensive range of engagement events, including webinars, presentations and focus groups, where we received similar feedback and comments.

For a detailed summary of responses to the 'agree'/'disagree' questions, see Appendix 1. For a list of respondents please see Appendix 2.

2. Summary of themes from the consultation and our response

We have summarised the principal themes of the response here − detailed responses to each question can be found in section 3.

2.1. Autonomy of NHS foundation trusts

Some NHS foundation trusts expressed some concern at the concept of targeted support for providers in segment 2 (which includes providers that are not in breach of their licence but the Single Oversight Framework has identified may benefit from agreed support directed at specific issues, as well as providers that may be in breach but where formal action is not needed). The Single Oversight Framework is based on the principle of earned autonomy. We will signpost, offer and make available support for providers in segment 2, but this support will not be mandated. Also, providers in segment 2 may wish to proactively seek support from NHS Improvement.

2.2. Alignment with CQC

Respondents supported our proposal to align our approach more closely with CQC, as it may provide opportunities to streamline data-gathering and oversight, considering that NHS Improvement and CQC should lead in their respective areas of expertise.

We are working closely with CQC to develop the Single Oversight Framework and have a shared aim to align the approaches of both organisations as much as possible.

Following the consultation, the themes of the Single Oversight Framework now link more overtly to CQC's key questions (safe, effective, caring, responsive and well-led). We are also making clear that the Single Oversight Framework is not an assessment framework in its own right, nor an indicator of where providers might be on CQC's assessment framework: it is a framework for NHS Improvement to identify providers' support needs. We are co-developing with CQC the approach to finance and use of resources (which will build on the metrics in the Single Oversight Framework) and we will consider relevant aspects of the Single Oversight Framework as we co-develop the well-led framework.

2.3. Framing the Single Oversight Framework more in terms of support, with recognition of autonomy

Following feedback, the revised Framework uses language that describes identifying support needs rather than identifying concerns. We also have renamed the four segments to reflect the type of support providers will have, rather than level of concern, ie Segment 1: maximum autonomy; Segment 2: targeted support; Segment 3: mandated support; Segment 4: special measures.

For providers in segment 1, although some data will be collected monthly, we will – in line with the principle of earned autonomy – only review the data for segmentation purposes on a quarterly basis, unless there is other evidence to suggest that the provider may be in breach of licence (or equivalent for NHS trusts).

2.4. Finance and use of resources – agency spend

Following feedback we will introduce agency spend into the finance and use of resources score immediately (ie from quarter 3 2016/17), without any shadow period. **We invite stakeholders with views on this specific change to inform us by 5pm on 23 September 2016.**

3. Other planned changes − opportunity to provide views

We also plan to make a small number of changes based on further policy development continuing during the consultation – specifically changes to the finance and use of resources score and the withdrawal of six proposed quality metrics. These are set out in more detail below: **we invite stakeholders with views on these specific changes to inform us by 5pm on 23 September 2016.**

3.1. Quality of care

We plan to remove the following metrics from the metrics proposed in the consultation:
Never Events rate of incidence, Serious Incidents rate, National Reporting and Learning System (NRLS) medication errors: % of harmful events, NRLS proportion of reported patient safety incidents that are harmful, Safety Thermometer percentage of harm-free care and Safety Thermometer percentage of new harms.

All other metrics for quality of care are as proposed. We will work with CQC to decide how best to incorporate these topics in identifying support needs for quality of care.

3.2. Finance and use of resources

On further consideration of the appropriate metric, we plan to use income and expenditure (I&E) margin, rather than the EBITDA[4] margin to monitor efficiency − this maintains continuity with previous Monitor and NHS Trust Development Authority (TDA) frameworks.

If a provider has not agreed a control total:

- where they are planning a deficit their use of resources score will be at least 3 (ie it will be 3 or 4)
- where they are planning a surplus their use of resources score will be at least 2 (ie it will be 2, 3 or 4).

After 12 months of overseeing agency spend in various forms and reviewing the nature of the available information, we consider that we have the data we need to calibrate thresholds and implement now, rather than wait until 2017/18.

We will also do further work to consider cost per weighted activity unit and capital controls, which were flagged in the consultation as being in shadow form. As such we are, for the time being, removing the specific thresholds previously put in the consultation document.

Following the approach set out in *Strengthening financial performance and accountability* [5] and alongside the introduction of financial special measures, we will expand our broader value-for-money approach to consider

- paybill growth

[4] Earnings Before Interest, Tax, Depreciation and Amortisation
[5] Available at https://improvement.nhs.uk/uploads/documents/Strengthening_financial_performance_and_accountability_in_2016-17_-_Final_2.pdf

- consolidation of back office and pathology services, where necessary
- addressing unsustainable services where necessary through consolidation, change or transfer to a neighbouring provider.

4. Next steps

We invite any comment on the specific changes highlighted above **by 23 September 2016** for us to consider in the course of implementing the Single Oversight Framework. We plan to implement the Single Oversight Framework from **1 October 2016**. From that date we will collect information from the provider sector using the Single Oversight Framework. Once we have collected data for October, we will carry out an initial segmentation of the sector in November and, from that point onwards, base our support and any regulatory interventions on this and subsequent segmentation decisions. Until the point of this first segmentation, we will have regard to the Monitor Risk Assessment Framework and TDA Accountability Framework.

5. Summaries of consultation responses to individual questions

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

Respondents were on the whole in favour of closer alignment to streamline oversight and minimise the data burden.

Our response
See section 2.2 above.

5.2. Consultation question 2: Do you agree with our proposed approach to the oversight of providers?

Respondents strongly supported our overall approach, with 71% of respondents in favour, 7% against. Responses appreciated the positive tone of our approach, emphasising improvement and support. While our proposals around use of judgment were generally welcomed, respondents considered that the level of judgement needed to be consistent and fair, and be able to work across providers while reflecting the autonomous nature of NHS foundation trusts.

Some respondents suggested that monitoring frequency should be linked to the segment a provider is in – providers in segment 1 should be less frequently monitored than those in segments 2, 3 or 4. This would reflect a degree of 'earned autonomy'.

Our response
As well as the points made in section 2.3 above, see below.

We will minimise data burden by collecting information centrally where possible and working with other bodies to share, not duplicate, collections. We will also continue to aim to be proportionate in collecting timely information without unnecessary burden. Financial and operational performance will, wherever possible, be collected via existing – not new – returns. Where metrics are only collected quarterly (eg mental health metrics) we will use these collections rather than require data more frequently unless that is needed.

5.3. Consultation question 3: Do you agree with our proposed approach to overseeing quality of care?

The response was highly positive, with 70% agreeing vs only 8% disagreeing. Respondents supported the principle that NHS Improvement uses CQC quality assessments. They also said there needed to be clearly defined roles for CQC and NHS Improvement to remove any duplication or confusion.

Our response
No changes are proposed based on consultation feedback. The planned changes – see section 3.1 – result from further policy development result.

5.4. Consultation question 4: Do you agree with our proposed approach to overseeing finance and use of resources?

There was a clear majority in favour of our proposed approach (59% in favour, 15% against) with the exception of the proposed equal weighting of financial metrics, where respondents were almost equally divided. Respondents opposed to equal weighting generally favoured emphasising core efficiency and sustainability measures while reducing the emphasis on agency and capital controls.

Our response
No changes are proposed based on consultation feedback. The planned changes – see section 3.2 – result from further policy development.

5.5. Consultation question 5: Do you agree with our proposed approach to overseeing operational performance?

The consultation response was broadly favourable, with 65% of those responding in agreement vs 14% disagreeing with the overall approach. 63% agreed with the proposed metrics vs. 19% disagreeing.

Some representative themes in the response included:

1. In the absence of any breaches of standards providers should remain on quarterly monitoring.

2. Failing standards may not be the fault of providers (eg a system issue) and NHS Improvement's response needed to reflect this

3. The measures could represent a ‘tightening’ of control over foundation trust performance – linked to the foundation trust autonomy point raised above.

4. Data burden needed to be minimised/streamlined to what is appropriate.

Our response

We will proceed as proposed, taking the above into account. We will look to reduce the reporting burden – particularly for NHS foundation trusts, which currently submit performance against each relevant target – by taking operational performance from validated national sources.

The consultation proposal that providers failing to meet a standard for two months would identify a potential support need, is consistent with our aim to offer support and work alongside providers. Support would only be mandated for providers in segments 3 and 4.

NHS Improvement teams will take into account all relevant information and factors, and will work with providers, to understand the causes of, for example, missed standards, so that any support offered (or for segments 3 and 4 mandated) addresses underlying causes.

5.6. Consultation question 6: What should NHS Improvement consider to identify potential issues and/or potential support needs in the area of strategic change?

Consultation responses – and points arising from specific provider workshops on this point − included:

- assessing planning capability
- quality/deliverability of plans
- progress on implementation
- alignment with system plans.

Respondents also suggested reviewing allocation of resources and financial balance across the local health system. Our oversight of this theme also needed to reflect providers’ perspectives as well as that of the wider sustainability and transformation plan (STP).

Our response

NHS Improvement will, in the first instance, use the STP review process to consider the strategic change theme across providers. Working with partners, we will look at quality of plans, level of co-operation with partners and, in due course, implementation of plans. We will continue to develop this as our experience of STP dynamics, new care models and devolution grows.

5.7. Consultation question 7: Do you agree with NHS Improvement's proposed approach to overseeing providers' leadership and improvement capability?

Respondents supported our approach, with 57% agreeing vs 15% having concerns. While respondents welcomed the continuity with the past approaches of Monitor, TDA and CQC, there was a view that governance also needed to be linked to system leadership. Feedback referred to the view that leadership was a domain involving subjective consideration and, as far as possible, NHS Improvement needed to focus on ensuring consistent and objective judgements. Some respondents considered that agency spend (a proposed component of organisational efficiency) was not a governance matter. Feedback also emphasised the importance of including the NHS Workforce Race Equality Standard (WRES).

Our response

We will develop our approach to identifying support needs under all aspects of this theme, informed by consultation feedback, particularly through working with CQC, as we develop the Well Led Framework. In the meantime, we will proceed as proposed. We will use CQC well-led assessments, movements in organisational health indicators, findings of governance reviews and any relevant third-party information to identify where support may be needed.

We will also use the Single Oversight Framework to ensure that provider boards are aware of the need to ensure diversity and inclusion, including meeting the NHS Workforce Race Equality Standard (WRES).

5.8. Consultation question 8: Do you agree with NHS Improvement's proposed approach to segmentation?

Respondents were strongly in favour of the segmentation approach (65% vs 5%). Many considered it important that segmentation was carried out consistently. Some were concerned about some of the language which they considered to be negative (segment 1 being labelled 'no concerns') and that being in a lower segment might carry a stigma, making it harder for providers to attract staff. A small number (about 12%) found the reversal of the segmentation 'hierarchy' from Monitor's previous approach (1-4 scale, where 4 was best) confusing.

Our response

See sections 2.1 and 2.3 above.

5.9. Consultation question 9: NHS Improvement's proposed approach to supporting providers

Respondents were strongly in favour of the approach, with 74% in favour, only 4% against. While in favour, respondents sought greater clarity on the nature and context of our support offer and what was available under each category. Some foundation trusts sought reassurances on autonomy.

Our response

See section 2.1. The Single Oversight Framework identifies support needs and the level of support needed. It does not set out the precise nature of support packages; these will be tailored to individual providers' needs.

Appendix 1: Summary of responses by question

Do you agree with our approach to:	Yes	No	Undecided	Total	No response
Oversight of providers? (Question 2)	**77** (71%)	**8** (7%)	**24** (22%)	109	31
Overseeing quality of care (Question 3)	**69** (70%)	**8** (8%)	**22** (22%)	99	41
Overseeing finance and use of resources? (Question 4 (i))	**55** (59%)	**14** (15%)	**25** (26%)	94	46
Finance and use of resources: chosen metrics? (Question 4 (ii)	**46** (51%)	**23** (25%)	**22** (24%)	91	49
Finance and use of resources metric weightings? (Question 4 (iv))	**31** (34%)	**32 (**36%)	**27** (30%)	90	50
Phasing the introduction of financial metrics? (Question 4 (v))	**62** (70%)	**11** (13%)	**15** (17%)	88	52
Overseeing operational performance? (Question 5 (i)	**61** (65%)	**13** (14%)	**20** (21%)	94	46
Metrics monitored? (Question 5(ii))	**58** (63%)	**18** (19%)	**17** (18%)	93	47
Overseeing leadership and improvement? (Question 7)	**54** (57%)	**14** (15%)	**26** (28%)	94	46
Segmentation? (Question 8)	**60** (65%)	**5** (5%)	**28**(30%)	93	47
Supporting providers? (Question 9)	**71** (74%)	**4** (4%)	**21** (22%)	96	44

Appendix 2: Respondents to the consultation

NHS trusts and foundation trusts (104)

2gether NHS Foundation Trust

5 Boroughs Partnership NHS Foundation Trust

Aintree University Hospital NHS Foundation Trust

Airedale NHS Foundation Trust

Barking Havering and Redbridge University Hospitals NHS Trust

Berkshire Healthcare NHS Foundation Trust x2[6]

Birmingham Community Healthcare NHS Foundation Trust

Black Country Partnership NHS Foundation Trust x2

Bolton NHS Foundation Trust

Bradford District Care NHS Foundation Trust

Bridgewater Community Healthcare NHS Foundation Trust x2

Central and North West London NHS Foundation Trust

Central London Community Healthcare NHS Trust

Chelsea & Westminster NHS Foundation Trust

Chesterfield Royal NHS Foundation Trust

The Christie NHS Foundation Trust

County Durham & Darlington NHS Foundation Trust

Coventry & Warwickshire Partnership Trust

Croydon Health Services NHS Trust

Cumbria Partnership NHS Foundation Trust x2

Coventry and Warwickshire Partnership Trust

Dartford and Gravesham NHS Trust

Derbyshire Community Health Services NHS Foundation Trust

[6] In some cases we received two responses from specific organisations

Derbyshire Healthcare NHS Foundation Trust

Devon Partnership NHS Trust

Dorset County Hospital NHS Foundation Trust

Dorset HealthCare University NHS Foundation Trust

The Dudley Group NHS Foundation Trust x2

East Cheshire NHS Trust

East London NHS Foundation Trust

Great Western Hospitals NHS Foundation Trust

Harrogate and District NHS Foundation Trust

Heart of England NHS Foundation Trust

Hull and East Yorkshire Hospitals

Imperial College Healthcare NHS Trust

Isle of Wight NHS Trust

James Paget University Hospitals NHS Foundation Trust

Kent and Medway NHS and Social Care Partnership Trust

Kingston Hospital NHS Foundation Trust

Leicestershire Partnership NHS Trust

Lincolnshire Community Health Services NHS Trust

Lincolnshire Partnership NHS Foundation Trust

Liverpool Community Health NHS Trust

Liverpool Heart and Chest Hospital

Liverpool Women's NHS Foundation Trust

Manchester Mental Health and Social Care Trust

Mersey Care NHS Foundation Trust x2

Moorfields Eye Hospital NHS Foundation Trust

The Newcastle upon Tyne Hospitals NHS Foundation Trust x2

North East Ambulance Service NHS Foundation Trust

North Tees and Hartlepool NHS Foundation Trust

Northamptonshire Healthcare NHS Foundation Trust

Northumberland, Tyne & Wear NHS Foundation Trust

Northumbria Healthcare NHS Foundation Trust

Nottinghamshire Healthcare NHS Foundation Trust

Nottingham University Hospitals NHS Trust

Oxford University Hospitals NHS Foundation Trust

Oxleas NHS Foundation Trust x2

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust x2

Royal Berkshire NHS Foundation Trust

The Royal Bournemouth and Christchurch Hospitals

Royal Cornwall Hospitals NHS Trust

Royal Free London NHS Foundation Trust

The Royal Marsden NHS Foundation Trust

Royal United Hospital Bath

Salford Royal NHS Foundation Trust

Salisbury NHS Foundation Trust

Sheffield Teaching Hospitals NHS Foundation Trust

Shropshire Community Health NHS Trust

Solent NHS Trust

South East Coast Ambulance Service NHS Foundation Trust x2

South Essex Partnership University NHS Foundation Trust

South Staffordshire and Shropshire Healthcare NHS Foundation Trust

South Western Ambulance Service NHS Foundation Trust

Southern Health NHS Foundation Trust

Stockport NHS Foundation Trust

Surrey and Borders Partnership NHS Foundation Trust

Surrey and Sussex Healthcare NHS Trust

South West Yorkshire Partnership NHS Foundation Trust

Tameside Hospital NHS Foundation Trust

Tavistock and Portman NHS Foundation Trust

Tees, Esk and Wear Valleys NHS Foundation Trust

University College London Hospitals NHS Foundation Trust

University Hospitals Birmingham NHS Foundation Trust

University Hospitals Bristol NHS Foundation Trust

University Hospitals Coventry & Warwickshire NHS Trust

The Walton Centre NHS Foundation Trust

West London Mental Health NHS Trust

Western Sussex Hospitals NHS Foundation Trust

Wirral University Teaching Hospitals NHS Foundation Trust

Worcestershire Health and Care NHS Trust

Wrightington, Wigan and Leigh NHS Foundation Trust

Yeovil District Hospital NHS Foundation Trust

Yorkshire Ambulance Service NHS Trust

Department of Health and Arm's Length Bodies (5)

Care Quality Commission

Department of Health

Health Education England

The National Institute for Health and Care Excellence (NICE)

NHS England x2

Other organisations (17)

Alzheimer's Society

Association of Ambulance Chief Executives

Association of UK University Hospitals

Birmingham Cross City NHS Clinical Commissioning Group

The British International Doctors Association of UK

Greater Manchester NHS Provider Federation Board

Healthcare Financial Management Association

The King's Fund

National Community Hearing Association

NHS Employers

NHS Providers

Royal College of Nursing

Royal College of Physicians of Edinburgh

The Royal College of Psychiatrists

Salford NHS Clinical Commissioning Group

The Shelford Group

Tower Hamlets Council

27 individual responses

3 blank responses

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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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 Publication code: CR 03/16