NHS Improvement

Single Oversight Framework 2017/18: change summary

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Delivering better healthcare by inspiring and supporting everyone we work with, and challenging ourselves and others to help improve outcomes for all.

Contents

1. Introduction

In September 2016 NHS Improvement published the first Single Oversight Framework (SOF). The purpose of the SOF is to help NHS Improvement identify where NHS trusts and NHS foundation trusts may benefit from, or require, improvement support if they are to meet the standards required of them in a safe and sustainable way. It sets out how we will identify providers' potential support needs under five themes, and determines the way we work with each provider to ensure appropriate support is made available where required.

In the first SOF we stated that we would be flexible in how we carry out our oversight role, and that we might from time to time adjust the approach set out in the framework. We might, for example, add or remove metrics from our oversight of providers or change the frequency of our data collection. Such adjustments to the framework could be in response to changes in:

- national policy, standards and performance expectations
- the availability and reliability of performance data
- pressures and risks across the sector
- the support offer available from NHS Improvement
- other oversight, regulatory or improvement frameworks that relate to or form part of the SOF, including the CQC inspection regime.

We identified some specific areas where we expected to update the framework during 2017/18 in response to known developments. In particular, we noted work that was underway at the time to develop a shared approach with the Care Quality Commission (CQC) to assessing and rating how well trusts use their resources, which would build and expand on the metrics used in the SOF. We also highlighted several aspects of operational performance where we were following the development of new metrics and indicators, with the intention of introducing these within the SOF once valid data sources and standards were available.

As the first SOF constituted a new approach to oversight of both NHS trusts and NHS foundation trusts, we anticipated there would also be learning from the first year of operation that we would want to feed in to future iterations of the framework.

In line with this undertaking we have reviewed the current SOF and identified a set of proposed changes to be introduced in 2017. These reflect changes in national policy and standards, data quality and other regulatory frameworks as well as our own learning from the last year.

As the SOF has been in place for less than a year, we are not proposing any changes to the underlying framework itself – ie the five themes under which we assess performance, the approach to monitoring, identifying and responding to support needs and the segmentation of providers.

We have made a small number of changes to the information and metrics we use to assess providers' performance under each theme, and the indicators that trigger consideration of a potential support need. We have also taken the opportunity to improve the structure and presentation of the document, to clarify certain processes and definitions and to correct some wording and figures where discrepancies have been identified.

In this document we summarise the changes we have made and invite feedback from stakeholders on whether these are clear and practicable.

This engagement process will run from 8 August to 18 September 2017.

We intend to publish the updated SOF in early October 2017, and introduce the changes during Q3 (October to December 2017).

To provide your feedback on the proposed changes, please visit https://improvement.nhs.uk/resources/updating-single-oversight-framework-share-your-views/ and complete our short survey.

If you have any queries about the consultation documents or process please contact NHSI.singleoversightframework@nhs.net

2. Summary of changes

Presentation

We have made the following changes to the presentation of the document:

- Updated and edited the introductory sections: for example, text explaining the establishment of NHS Improvement, or referring to activities that were in progress last year but no longer current, has been removed. We have also clarified the purpose of and audience for the document, what the SOF is, how it relates to NHS Improvement's duties and strategic objectives and how we apply it.
- Consolidated contextual or supporting information previously referenced across different sections of the document – for example, on the relationship between the SOF and the statutory obligations of Monitor and NHS Trust Development Authority (TDA).
- Updated references to the development of NHS Improvement programmes and products (eg Model Hospital) and joint work with CQC on the use of resources and well-led frameworks, reflecting the progress or completion of this work.
- Updated and consolidated tables and figures to summarise key information more succinctly.
- Provided a brief overview of NHS Improvement's support offer. We are considering adding further details summarising the main support resources available under each theme.
- Created a distinct section to introduce the five themes, and summarise for each what information is used to assess performance and what would trigger consideration of a potential support need.
- Moved the organisational health indicators relating to the Leadership and improvement capability (well-led) theme from Appendix 2: Quality of care to a new Appendix 4.

We are also considering how to make more information available about the source and definitions of the metrics used to monitor providers under the SOF in future – for example, through the Model Hospital.

Questions

1. Is the document clear and easy to read?
2. Does the document provide enough information about the purpose of the SOF and how we use it to oversee and support providers?
3. Do you have any suggestions on how we could improve the content, presentation and format of the document?

Monitoring providers and identifying support needs under our five themes

The following sections list the material amendments that have been made to the metrics used to monitor performance under each theme and the indicators that will trigger consideration of a support need. Other small changes have also been made to correct wording and figures in the five theme sections and the appendices, to improve clarity and ensure consistency (for example, in how metrics are described in the SOF and in data-source documents). These are not listed here as they do not represent any actual change in what or how data is used to monitor and assess providers or identify potential support needs. In addition, we have:

- made explicit that providers are expected to notify NHS Improvement of significant actual or prospective changes in performance or risk outside routine monitoring
- noted under all themes that in addition to specific triggers, other material concerns arising from intelligence gathered by or provided to NHS Improvement could trigger consideration of a support need.

Quality of care

- The CQC rating trigger under this theme has been changed from 'inadequate' or 'requires improvement' against any of the safe, effective, caring or responsive key questions to CQC rating of 'inadequate' or 'requires improvement' in overall rating.

- ‘Aggressive cost reduction plans’ has been removed from the metrics list and is referred to instead in the main narrative as an example of other relevant data that may be taken into account when considering support needs under this theme.
- Hospital Standardised Mortality Ratio – Weekend (DFI) has been removed from the metrics list as a new indicator is currently being developed.
- *Escherichia coli* (E. coli) bacteraemia bloodstream infection (BSI) rate has been added to the metric list in addition to Methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* (C.diff), in line with the national target to reduce healthcare-associated Gram-negative bloodstream infections (GNBSI) by 50% by March 2021.

Finance and use of resources

When we first published the SOF in September 2016, we noted that we were developing a shared approach to assessing providers’ use of resources with CQC. We indicated that we might revise the finance and use of resources metrics in the SOF as a result, following consultation.

We consulted on a new use of resources (UoR) framework earlier this year and published the final version, alongside our consultation response,[1] on 8 August 2017. We have updated the finance and use of resources section in the SOF to reflect the new framework, which is due to be rolled out from September 2017. Specifically, we have:

- Replaced the existing term SOF ‘finance and use of resources score’ with ‘finance score’ to make a clear distinction between this and the new use of resources ratings. We have not changed any of the metrics or rules used to calculate the finance score.
- Explained that once a provider has undergone a UoR assessment and been given a proposed rating, we will use the draft UoR report and proposed rating, alongside the finance score, to inform our consideration of the provider’s support needs at that point in time. NHS Improvement will continue to monitor a trust’s finances and operational productivity – and associated support needs – between UoR assessments, using the finance score and metrics available through the Model Hospital, alongside other

[1] https://improvement.nhs.uk/resources/use-resources-assessment-framework

relevant evidence. We will consider changes in the monthly finance score and other indicators of financial performance and operational productivity in the context of the last UoR assessment when considering support needs. The finance score and use of resources rating will not be combined into a single score.

- In the original SOF, we stated that we would be introducing two other metrics – capital controls and change in cost per weighted activity unit – in shadow form in 2016/17. We have not yet implemented these metrics in shadow form and will not be including them in the finance score in 2017/18.

Questions

4. Is the explanation of how the new use of resources assessments will inform SOF monitoring and assessment of support needs clear?

Operational performance

When we first published the SOF in September 2016, we highlighted several aspects of operational performance where we were following the development of new metrics and indicators, with the intention of introducing these within the SOF monitoring once valid data sources and standards were available. These included indicators assessing the expansion of liaison mental health services in acute hospitals; access for children and young people to eating disorder services; delayed transfers of care and out of area placements for adult mental health services; response times for urgent and emergency mental healthcare; and mental health services data quality.

Reliable indicators in some of these areas are now available, and we have updated the SOF accordingly. We have also added or revised metrics in other areas to reflect new policy priorities or resolve issues with the original definitions or data sources being used. These changes are summarised in the table below.

Summary of changes to operational performance metrics

Providers	Metric	Change	Rationale
Acute	Dementia assessment and referral (see Appendix for details)	Added	Existing policy where maintenance of standards is a priority
Mental health	Inappropriate adult mental health out of area placements (see Appendix for details)	Added	Existing policy priority with improved data reliability
Mental health	Patients requiring acute care who received a gatekeeping assessment by a crisis resolution and home treatment team	Removed	New indicator being developed to provide a more sensitive measure of performance against this standard
Mental health	Data Quality Maturity Index (DQMI) – Mental Health Services Data Set (MHSDS) Data Score (see Appendix for details)	Amended	Original metric not supported by NHS Digital

We have not changed the metrics and standards to reflect the recently announced changes in ambulance response time targets, as the timetable and process for introducing these has not yet been confirmed. We will include the new standards if the implementation plan is available before the SOF updates are published. Otherwise, we will note that these changes will be updated in a future version of the SOF.

We have updated the list of areas where we are looking at new data sources and indicators for mental health providers, for potential inclusion in future iterations of the SOF.

The operational performance triggers have been amended so they are linked to quarterly Sustainability and Transformation Fund (STF) trajectories for A&E performance only, in line with changes to the focus of the STF in 2017/18. The triggers are now:

- A&E performance:
  (1) performance below threshold for STF quarterly trajectory (quarter to date)
  (2) breach of absolute threshold of 95% for two months
- failure to meet any other standard for at least two consecutive months
- 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
- any other material concerns about a providers' operational performance arising from intelligence gathered by or provided to NHS Improvement.

We have noted that where it is identified that a provider has a support need under this theme, one of the issues we will work with providers to understand and address is the efficiency of patient flow through the organisation, in particular local progress in minimising delayed transfers of care (DToC).

Questions

5. Are the proposed changes to the metrics used to monitor providers' operational performance clear?

6. Do you agree that the new metrics have clear data sources and definitions and provide a valid indicator of performance against a national priority?

7. Do have any other comments on the proposed changes to the operational performance metrics?

Strategic change

We have added a note in the narrative that we will review the assessment of system-wide leadership in relevant sustainability and transformation partnership (STP) ratings when considering providers' performance under this theme. These ratings will be used as one part of the broad intelligence used by NHS Improvement to understand a provider's circumstances and to inform our judgement of a provider's performance under this theme.

Leadership and improvement capability

When we first published the SOF in September 2016, we noted that we were working with CQC to bring together our respective approaches to assessing whether services are well led. This work has resulted in a new, fully joint well-led framework structured around eight key lines of enquiry. In June 2017 we published guidance[2] for providers on how they should carry out developmental reviews of their leadership and governance using the framework, as part of their own continuous improvement. We have updated the SOF to reflect this.

Questions

8. Do you have any other comments on the changes we are proposing to make to the SOF in 2017?

[2] https://improvement.nhs.uk/uploads/documents/Well-led_guidance_June_2017.pdf

Appendix: New metric details

Dementia assessment and referral	
Scope	**Acute providers**
Description of indicator	This measure has three associated indicators: case finding, diagnostic assessment and referral for specialist services. Three measures are reported: the number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours: i) who have a diagnosis of dementia or delirium or to whom case finding is applied [Find] ii) who, if identified as potentially having dementia or delirium, are appropriately assessed [Assess/Investigate] iii) where the outcome was positive or inconclusive, are referred on to specialist services. [Refer]
Rationale for inclusion	This is an existing Standard Contract Indicator. This indicator, in three parts, is the same as used in the 2014/15 CQUIN. It has now been retired as a CQUIN indicator but retained in the standard contract as a mandatory, BAAS-approved data submission for all acute providers. It aims to maintain the identification of patients with dementia and delirium at a high level, to prompt appropriate referral and follow-up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia.

Numerator	Number of patients aged 75 and over admitted as an emergency, with length of stay >72 hours, who are reported as having a known diagnosis of dementia or clinical diagnosis of delirium, or who have been asked the dementia case-finding question within 72 hours of admission. Number of above patients reported as having had a diagnostic assessment including investigations. Number of above patients referred for further diagnostic advice in line with local pathways agreed with commissioners.
Denominator	Number of patients aged 75 and over admitted as an emergency, with length of stay >72 hours, excluding those for whom the case finding question cannot be completed for clinical reasons (eg coma). Number of above patients with a known diagnosis of dementia or clinical diagnosis of delirium or who answered positively on the dementia case finding question. Number of above patients who underwent a diagnostic assessment for dementia in whom the outcome was either positive or inconclusive.
Data source and construction	UNIFY2 - Dementia assessment and referral data collection Guidance available at: www.england.nhs.uk/statistics/statistical-work-areas/dementia/dementia-assessment-and-referral-2017-18/
Organisation responsible for data collection	NHS England
Frequency of data publication	Quarterly
Standard/ performance threshold	At least 90% on each part of the indicator

Out of area placements

Scope	Mental health providers
Description of indicator	Demonstrable reduction in total number of bed days patients have spent inappropriately out of area against rolling annual baseline, working towards elimination of inappropriate out of area placements by 2020/21.
Rationale for inclusion	As recommended in the *Five year forward view for mental health* (FYFVMH), NHS England has committed to eliminating inappropriate placements (those due solely to local acute bed pressures) for non-specialist adult acute care by 2021. This commitment, which was announced by ministers to Parliament in May 2016, supports the overarching 5YFVMH aim that the acute mental health system should promote the provision of accessible, high quality care in the least restrictive setting and as close to home as possible. Out of area placements can be an indicator of under-commissioned community mental health, housing or social care services, but effective bed management is also a major factor in addressing out of area placements. The use of bed days rather than number of placements will reflect efforts to repatriate people and reduce length of stay for people who have been sent out of area.
Numerator	Total number of inappropriate out of area placement days over the current period
Denominator	Total number of inappropriate out of area placement days over the baseline period
Data source and construction	CAP monthly data collection of acute out of area placements[3] http://content.digital.nhs.uk/oaps
Organisation responsible for data collection	NHS Digital
Frequency of data publication	Monthly

[3] NB: CAP collection is running for an interim period only to allow necessary changes to the Mental Health Services Dataset (MHSDS) to be implemented. The MHSDS is the chosen mechanism for the long-term collection of this data.

Standard/performance threshold	Annual reduction in number of inappropriate out of area placement bed days from 2018/19, in line with locally set trajectories for elimination of inappropriate out of area placements by 2020/21 (or maintain performance if at zero). During 2017/18, providers should assure themselves on the data quality of submissions to CAP data collection on out of area placements. In particular, they should ensure they are being measured in line with the national definition: https://www.gov.uk/government/publications/oaps-in-mental-health-services-for-adults-in-acute-inpatient-care/out-of-area-placements-in-mental-health-services-for-adults-in-acute-inpatient-care, in preparation for demonstrating reductions from 2018/19.

Data Quality Maturity Index (DQMI) – Mental Health Services Data Set (MHSDS) Score (to replace MHSDS identifier metrics and priority metrics indicator)

Description of indicator	As per published guidance: http://content.digital.nhs.uk/media/24162/DQMI-5-Methodology/pdf/DQMI-5_Methodology.pdf MHSDS scores are composite metrics assessing compliance with the following data items: - For MHSDS: • ethnic category • general medical practice code (patient registration) • NHS number • organisation code (code of commissioner) • person stated gender code • postcode of usual address MHSDS dataset score = mean of all the data item scores for percentage valid and complete for the applicable dataset multiplied by the coverage score for the applicable dataset: ie ((Coverage)*(mean proportion valid and complete for each data item)*100)
Rationale for inclusion	FYFVMH Recommendation 41: The Department of Health, HSCIC and MyNHS, working with NHS England, should improve transparency in data to promote choice, efficiency, access and quality in mental healthcare, ensuring that all NHS-commissioned mental health data is transparent (including where data quality is poor) to drive improvements in services. Aligns with expectations laid out within NHS standard contract. DQMI metrics to be supplemented with placeholder pathway DQ metric
Numerator	Proportion valid and complete (This is calculated by ((Coverage)*(mean proportion valid and complete for each data item)*100))
Denominator	
Data source and construction	NHS Digital Quarterly DQMI reporting http://content.digital.nhs.uk/dq
Organisation responsible for data collection	NHS Digital
Frequency of data publication	Quarterly

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