IMPLEMENTING THE NHS PERFORMANCE FRAMEWORK

Application to mental health trusts

November 2009

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Description	This document informs mental health trusts, PCT commissioners and SHAs of the criteria against which mental health trust performance will be assessed
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For Recipient's Use	

This document should be read in conjunction with:

***Implementing the NHS Performance Framework* (April 2009):**
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098525

and

***Developing the NHS Performance Regime* (June 2008)**
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085215

Scope and implementation of the NHS Performance Framework

1. In *Developing the NHS Performance Regime* (June 2008), the Department set out its intention to implement a new national approach to assessing the performance of NHS providers and commissioners.

2. The NHS Performance Framework has been developed and will be implemented as follows:
   - April 2009 – acute and ambulance trusts
   - April 2010 – PCT commissioners and mental health trusts
   - April 2011 – PCT providers

3. The focus of this document is application of the NHS Performance Framework to mental health trusts.

4. The Framework will not initially apply to single speciality learning disability trusts but this extension will be considered in due course.

5. FTs will also not be assessed under this Framework, and will continue to be regulated by Monitor as set out in their Terms of Authorisation.

6. The three NHS Trusts that provide high secure services will be assessed under the NHS Performance Framework until such time as they attain FT equivalent status. As the high secure trusts are not eligible to apply for FT status an equivalent status has been developed specifically for their service model and to provide them with similar freedoms to FTs.

7. Attainment of this status will only occur once the trusts have satisfied the necessary requirements on finance, governance and quality/performance via a formal assessment process. The results of the NHS Performance Framework will inform this process. Subject

to being successful at assessment, the first of these trusts will be in a position to attain this status from the beginning of the next financial year (April 2010).

8. Subject to the availability of the required data, the NHS Performance Framework will formally apply to mental health trusts from Quarter 1 2010/11 and these results will be made public in the DH publication *The Quarter*.

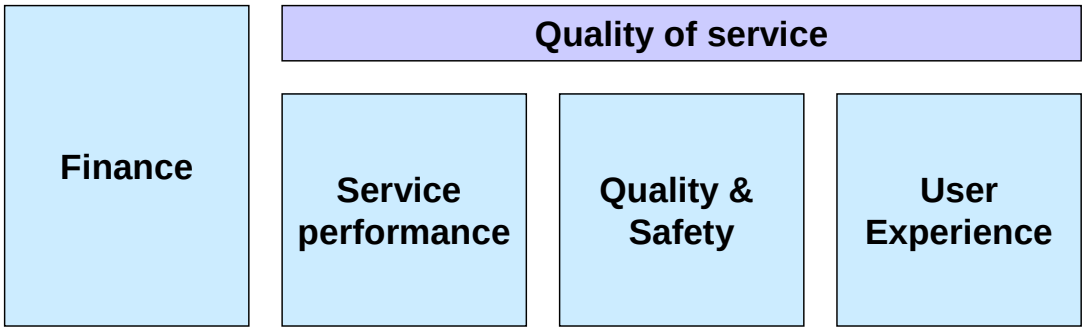
9. The NHS Performance Framework sits alongside the expected performance monitoring linked to the Standard National Contract by which PCTs hold provider organisations to account. The submission of information to support the Performance Framework is mandated in the Standard National Contract for trusts.

Performance domains

10. The Framework will fundamentally be the same for all types of providers to ensure greater parity in the way the performance of NHS providers is managed. However, the indicators of service performance will be tailored to the provider in question.

11. The NHS Performance Framework will continue to develop in line with the Operating Framework and as more, and more frequent, data becomes available.

12. Performance will be assessed across four key domains of organisational function:



13. Each domain is underpinned by a series of indicators, largely from existing sources, and a scoring system to determine performance thresholds.

Service Performance

14. The indicators in this domain are drawn from Existing Commitments and Tiers 1 and 2 of Vital Signs as they apply to mental health trusts. They have been supplemented by some additional indicators of service performance to give a more balance picture of organisational ‘health’. Furthermore, they have been tested with a wide range of NHS stakeholders.

15. The indicators of service performance for other types of NHS providers and PCT commissioners will simply be the Existing Commitments and Vitals Signs Tiers 1 and 2 as these are sufficient to provide a rounded view of performance.

16. The supplementary indicators cover the core business of mental health trusts and as such, represent established priorities. They all originate from existing legislation, guidance or CQC's Annual Health Check and therefore require no additional funding to deliver.

17. Although the indicators are relatively process focussed, and many of them relate to safety and effectiveness, this is appropriate for a Framework that is about ensuring national minimum standards are met. The indicators have been specifically selected to apply as broadly as possible, although there are a few that are service specific.

18. In time, there may be a case for developing some additional service specific indicators such as for Children's and Adolescent Mental Health Services (CAMHS), and the Framework will be reviewed with this in mind after the first year of operation.

19. The detailed indicator definitions and performance thresholds are still being developed and tested with the NHS, so will be published prior to implementation in April 2010.

20. For many indicators there are already data collections in place but there will also need to be some new or amended collections. These will be subject to approval via the Review of Central Returns (ROCR) as is usual Departmental policy.

	Indicator	**Rationale**
1.	Proportion of adults on Care programme Approach receiving secondary mental health services in settled accommodation*	This indicator was set out as a key priority for tackling social exclusion amongst vulnerable adults in the 2007 Comprehensive Spending Review. As such, it is an existing Vital Sign This is also a good outcome measure supported by considerable evidence
2.	Proportion of adults on Care programme Approach receiving secondary mental health services in employment*	This indicator was set out as a key priority for tackling social exclusion amongst vulnerable adults in the 2007 Comprehensive Spending Review. As such, it is an existing Vital Sign This is also a good outcome measure supported by considerable evidence
3.	The proportion of those patients on Care Programme Approach discharged from inpatient care who are followed up within 7 days	This is an indicator used in the CQC's Annual Health Check – the importance of which has been set out in the 'Refocusing CPA' guidance
4.	The proportion of those on Care Programme Approach reviewed in at least the last 12 months (formal/informal/ community)	This is a new indicator but is based on existing practice as set out in the 'Refocusing CPA' guidance
5.	The proportion of users on new	This is a new indicator but is based

	Care Programme Approach who have had a HoNOS assessment in last 12 months	on existing practice as set out in the 'Refocusing CPA' guidance. HoNOS is an established outcomes measure that is collected within the MHNDS. Moreover, it is the proposed basis for developing currencies for mental health
6.	Proportion of patients who had recorded incidents of physical assault to them	This already features in the 'Count Me In' census and is a good gauge of wider organisational performance The indicator will be constructed in such a way as not to diminish the benefits of allocating leave
7.	The number of episodes of absence without leave (AWOL) for the number of patients detained under the Mental Health Act 1983	This is a new indicator but a key aspect of the Mental Health Act and again is a good gauge of wider organisational performance
8.	The number of new cases of psychosis served by early intervention teams per year against contract plan+	This is an existing commitment currently monitored via PCT commissioners which will be collected directly from providers
9.	The number of admissions to the trust's acute wards that were gate kept by the crisis resolution home treatment teams	This is an existing commitment currently monitored via PCT commissioners and used by CQC in the Annual Health Check
10.	Provision of comprehensive CAMHS	This is an existing commitment currently monitored via PCT commissioners and used by CQC in the Annual Health Check
11.	The number of admissions to adult facilities of patients who are <16 years of age	This is an existing legal requirement as set out in the Mental Health Act 1983
12.	Delayed transfers of care to be maintained at a minimal level	This is an existing commitment and is also used in the CQC's Annual Health Check
13.	Data quality on ethnic group	This is an indicator used in the CQC's Annual Health Check
14.	Data completeness of the MHMDS	This is an indicator used in the CQC's Annual Health Check

*These two indicators are derived from the Vital Sign indicator set. In Year 1 of application of the Framework trusts will only be assessed on data completeness. Although it is important for mental health trusts to have a firm understanding of the accommodation and employment status of the people they treat, data completeness needs to improve before true performance can be robustly assessed.

+ This is the only indicator which is likely to require a new data collection

Quality and Safety

21. From April 2010/11, this will be assessed using the CQC's ongoing judgement as to providers' compliance with registration requirements. These cover all services undertaken by providers on the CQC's list of registered services[1] and constitute the current essential levels of quality and safety.

22. We are working with the CQC to calibrate the improvement conditions that it may attach to a provider's registration across to the performance categories used in the NHS Performance Framework. Further information about how this domain will be assessed will follow in advance of implementation.

User Experience

23. The CQC is undertaking a new Community Mental Health Services survey that builds upon a similar survey that has been conducted since 2003/04[2]. The results of this survey will be used to underpin the User Experience domain.

24. The overall aim is to adopt, as far as is possible, an approach that is comparable to that used in the assessment of acute trusts[3]. This will involve identifying a subset of around 15-20 survey questions from the final questionnaire that capture issues that are important to patients, cover key policy and service delivery issues, and constitute a good discriminator for evaluating the performance of organisations on this domain. This subset of questions will be retained in future Community Mental Health Services surveys to provide continuity over time.

25. National data on User Experience is currently collected annually. To balance the importance of the views of service users against this fact, the results of the User Experience domain will be used as a moderator of overall organisational performance. This means that if a provider is *Underperforming* on User Experience, it cannot be categorised overall as better than having its *Performance under review*. This level of performance on User Experience would indicate shortcomings in the way the organisation related to its users and could indicate real failings in performance more widely.

26. It is possible that a provider could be persistently categorised as poorly performing in the absence of new nationally coordinated User Experience data. Under these circumstances,

1 http://www.cqc.org.uk/_db/_documents/The_scope_of_registration_FINAL.pdf
2 Background information on these previous surveys can be found on the CQC website:
http://www.cqc.org.uk/usingcareservices/healthcare/patientsurveys.cfm
http://www.nhspatientsurveys.org.uk/
3 See Annex 3 in the Performance Framework Implementation Guidance for a summary of this approach:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098525

the SHA should continue to intervene to tackle the root cause until improvements have been made, and evidence is available to demonstrate that the experience of users has also improved – for example, via the use of local surveys (including local replication of the CQC methodology[4]) and/or other feedback mechanisms (including 'real time' approaches). If the results from these local initiatives are sufficiently encouraging then no further intervention would be required. Performance would then be formally re-assessed when the next national survey data becomes available.

27. Performance thresholds will be published in advance of implementation.

Finance

28. A working group drawn from across the NHS developed the finance indicators, which cover the key financial requirements set out in the Operating Framework. The data will be sourced and calculated from the Financial Information Management System (FIMS), which is submitted quarterly.

29. The indicators are divided into five sub-domains covering key areas of financial performance for NHS providers:
    - Initial planning
    - Year to date financial performance
    - Forecast outturn
    - Underlying financial position
    - Financial processes and balance sheet efficiency

30. Some of the indicators in these sub-domains may be new to providers as they rely on information the Department does not currently performance manage. Therefore, there may initially be some data quality issues relating to these new indicators, but these should be rapidly resolved.

31. The overall Finance score is the sum of the weighted indicator scores for each trust. However, all providers are subject to over-riding rules that dictate the maximum score they can achieve (see Annex 2 at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098525).

Conclusion

32. This document provides an overview of the way in which the performance of mental health trusts will be assessed. It is an annex to the original implementation guidance[5] and should

4 DH is working with CQC and the Patient Survey Coordination Centre to develop a localised support package for organisations who wish to monitor the quality of services from the patients' point of view on a more frequent basis than afforded by the national snapshot. In this way, results from local surveys (using the CQC methodology) can be directly compared to those obtained in nationally coordinated surveys. This has been recently launched for acute patient surveys, and it includes the setting up of an advice centre (contactable by telephone and e-mail), and making available a range of survey support materials online. A similar package will be put in place to support mental health trusts in 2010. Further information on this support package will be made available in due course, but details in how it has been deployed in acute settings is available from the survey coordination website (via the following link): http://www.nhssurveys.org/localsurveys

5 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098525

be read alongside it. This document contains details of performance categories; scoring; the escalation process; system accountability; and links with the regulatory framework.