NHS System Oversight Framework 2021/22 consultation

NHS Confederation response

About the NHS Confederation

The NHS Confederation is the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Northern Ireland and Wales. We represent hospitals, community and mental health providers, ambulance trusts, primary care networks and federations, clinical commissioning groups and integrated care systems.

We have three roles: to be an influential system leader; to represent our members with politicians, national bodies, the unions and in Europe; and to support our members to continually improve care for patients and the public.

All of our work is underpinned and driven by our vision of an empowered, healthy population supported by world-class health and care services; and our values of voice, openness, integrity, challenge, empowerment.

Question 1: (a) Do you agree that the proposed approach to oversight set out in this document meets the purposes and principles set out above? (b) If not, how could the proposed approach be improved?

Yes, partly agree.

In general, NHS Confederation and our members believe that the proposed approach to NHS oversight seems to meet the purpose and principles of what the System Oversight Framework sets out to do. One ICS chair, for instance, noted that "the notion of working *with and through* ICS with greater emphasis on system performance and outcomes is clear and welcomed" - although other members were less assured on the clarity of this principle.

Our members are supportive of the direction of travel towards a systems approach to oversight and welcome the fact that the framework is less focused on performance management than previous years.

There are certain improvements our members would like to see in terms of clarity around accountabilities both when this version of the framework is published and looking forward to its 2022/23 iteration. Whilst much of the statutory arrangements regarding accountabilities will be clarified in the coming months, the momentous shift towards system working will have reverberations for systems and the NHS organisations working within them in the here and now.

The framework does not cover all NHS organisations - for instance, it is silent on primary care. This is concerning given that primary care plays a huge role in managing long-term

conditions and joining up services, especially as primary care capacity is at an all-time low in the wake of the pandemic. The framework's focus on "providing an expectation for evidence of effective provider collaboration" will exclude primary care providers as they are not considered to be included in provider collaboratives. Members believe that this should be reviewed given their key role in supporting integrated care pathways. Our members understand that the process of drawing up accountabilities for oversight is complex and evolving, and our PCN Network is keen to work with you to develop a system oversight framework for 2022/23 that incorporates primary care.

One of the purposes of the framework is to "align the priorities of ICSs and the NHS organisations within them". Members from across the Confederation expressed concern about how this will work given that there is limited provision for other non-statutory organisations within the ICS partnership, who are already central players within the system. Furthermore, the framework is largely silent on social care. Whilst we recognise that the framework is an NHS one, to deliver on the ambition of fully integrated care pathways, social care elements need to be fully considered alongside health. Our members are clear that the success of the integration agenda won't be realised if social care is not put on a sounder footing. Social care provides crucial support in the community that enables people to stay well and out of hospital. Without an alignment of regulatory approaches, along with significant investment, our members believe that the system will struggle to deliver the holistic management of the people's health that we aspire to.

Importantly, members are concerned that the omission of other key stakeholders in the system architecture will undermine the ability of systems to achieve some of the national themes, including reducing inequalities. NHS England and Improvement (NHSEI) could help members and manage expectations by providing practical examples of what this framework hopes to achieve and which direction you are moving in for the next iteration.

In our view, the framework should seek to clarify accountabilities within ICSs and we would therefore implore NHSEI to make the following changes to the "system" oversight framework:

- Amend the wording where practical to encompass other system partners, with an upfront acknowledgement that you cannot hold them to account in the same way as NHS organisations.
- Provide a brief description and examples of what you hope to achieve through this framework and what it aspires to be in real terms.

Question 2: (a) Do you agree that oversight arrangements for place-based systems and individual organisations within the ICS should reflect both the performance and relative development of the ICS? (b) If not, please give your reasons.

Yes, mostly agree.

Our members broadly agree that oversight arrangements for place-based systems and individual organisations within the ICS should reflect both the performance and relative development of the ICS. ICSs vary massively in demography, size and level of maturity and we support an approach to oversight that will reflect the autonomy and relative maturity of ICSs.

Systems continue to face operational pressures related to COVID-19 and recovering elective services, and we support the approach to implementing this framework in a phased and flexible manner. We ask that NHSEI implement this framework as flexibly as possible. We also appreciate that this framework is a stepping stone during a transitional year and believe that local flexibility through the locally-agreed memorandum of understanding (MOU) could

be useful to allow local delivery and governance and to account for local variation in ICS development and priorities.

NHSEI will need to consider any complexities arising for organisations spanning multiple ICSs, such as mental health trusts and ambulance services. As one leader from an ambulance service NHS trust stated: “We might end up in a complex situation where we report to ICPs, or perhaps even more local bodies, as well as ICSs – and say from large geographical to small geographical areas. That could lead to a significant additional workload in supplying data, which could result in data issues in terms of how we transfer data around to achieve the goals we’re being asked to achieve.” NHSEI should provide greater clarity for organisations working across multiple ICSs about what this will mean for them. Local determination should be given in planning for these complexities, but NHSEI regional leads should also ensure they maintain a clear line of sight.

Our members are clear that much of the success of systems will depend on the culture and relationship fostered between place-based systems and individual organisations - namely NHS providers and ICSs, and local government partners. While we are assured that the intention of the framework is to create a permissive environment, we believe it should go further in its recognition of the fundamental shift systems are undergoing by overtly recognising behaviours and culture as system barriers to ICS development, especially from within NHSEI itself. We see this dynamic as central to the success of the framework.

Primary care members welcome the proposal that there should be a ‘line of sight’ from system to place to individual provider so that there is assurance that all providers in the system are supporting delivery of system objectives but acknowledge that “there does however need to be room for flexibility at place level to address local priorities and population health need.”

Looking ahead, Clinical Commissioning Groups (CCGs) would welcome keeping CCG assurance metrics as simple as possible before the transition of commissioning functions to statutory ICSs, particularly as specific measures for CCGs will be short-lived. They emphasised the need to align regimes across the system, including aligning trusts and commissioners on the support offer. Some CCGs raised concerns around requests for subject matter expertise negatively impacting on perceptions of quality of leadership. There is a limit to how much the system oversight framework can codify, and there is a benefit to not being too prescriptive as ICSs work hard to adapt to the new system architecture - in some cases building from the ground up. However, we believe it will be imperative for NHSEI to consider the interplay between culture and trust in their implementation of the framework. We encourage NHSEI to acknowledge that recognition of where support is needed is a hallmark of good leadership. Moreover, we believe that regional colleague discretion could be used to make a decision on segmentation and support needs based on an organisation and ICSs’ ability to foster positive and collaborative culture and work well with other system partners.

The potential for varying adoption of the framework within NHS England, and between different teams is a significant area of concern. Members have noted in particular that NHSEI’s regional teams approach their relationship with ICS and provider teams in different ways, and with different leadership styles. A number of regions are held up as already working in ways which recognise the principles of localised leadership. However, there are others who still have significant work to do to develop this approach. Finally, regional teams (as well as some specialist teams within NHS England centrally) risk duplicating work, often with additional requirements placed on system and provider leaders. Achieving a balance

between consistency and local flexibility will be important if you want to secure the credibility of the framework.

In acknowledging the differing context and stages of development of systems, NHSEI should also be cognisant of the organisation or system's relationship with NHSEI regional colleagues. It could be useful to set out how you will factor in this dynamic in the final version of the framework. We would strongly recommend setting out regular processes which provide feedback to Regional Directors and the NHS England COO about the role of regional functions in supporting and working through and with systems.

In summary, we recommend:

- Provide practical examples and case studies of good system working.
- The framework could go further in its recognition of the differing level of ICS development in terms of behaviours and culture.
- Keep CCG assurance metrics as simple as possible before the transition of commissioning functions to statutory ICSs.
- When implementing the framework, NHSEI regional colleagues should use discretion to make decisions based on culture/system working.
- Regional teams should receive further development to understand their role and approach in the light of the new framework and legislation.
- Include quality of ICS/NHSEI relationship, including explicit and regular feedback mechanisms.

Question 3: (a) Do you agree that the framework's six themes support a balanced approach to oversight, including recognition of the importance of working with partners to deliver priorities for local populations? (b) If not, how could the proposed approach be improved?

Yes, partly agree.

Overall, our members agree that the framework's six themes support a balanced approached to oversight. The five national themes are aligned with the NHS Long Term Plan, as well as (largely) to the CQC's new regulatory approach and the provider selection regime. Our members appreciate the flexible approach adopted by this framework during a transitionary period and in view of ongoing COVID-19 challenges. Given that we are halfway through 2021, we would like to see NHSEI exercising as much flexibility as possible in the implementation of this framework as organisations and systems come to terms with their new partnership arrangements and accountabilities and continue to grapple with COVID-19 and the growing elective care backlog, increased demand for mental health services, vaccination programmes and the impact of post-covid syndrome(s).

One of the major challenges for this framework is simultaneously empowering leaders to develop their own shared approaches to system accountability and ensuring national consistency. NHSEI has addressed this tension through the sixth theme of local strategic priorities and the nationally-facilitated MOU process.

However, opinion among our members was more split over whether the sixth theme of local strategic priorities would go far enough in enabling the NHS organisations falling under the framework to work collaboratively with local partners. This, we believe, would determine their ability to perform under the other five themes underpinning the framework - especially preventing ill health and reducing inequalities. For instance, one CCG leader stated that "the

inclusion of local strategic priorities feels like an important step in recognising ICS variation and supporting systems to feel like they have some local determination". While the acknowledgement of local priority-setting is welcome, the ability of the framework overall to support this is disputed. Again, the role of regional teams seems an important factor in the confidence that this vital sixth theme will be properly considered.

The move towards a culture of improvement is not clearly set out in the framework. As one member, a chair of a mental health foundation trust, put it: "The intention is correct about supporting partnership/collaborative working at local level through national framework, but there is concern that there is not enough of a description or guidance on the organisational development approach needed to facilitate culture and ways of working and having a focus on quality, improvement and outcomes at system level." We believe this oversight should be rectified in the framework.

Some members are not convinced that these provisions will go far enough in enabling local leaders to effectively hold other partners within the system accountable as it is a framework for (some) NHS organisations. As one ICS chair put it: "It seems like tying our hands and asking us to do the job anyway."

We would also stress the importance of having local authorities as equal partners with mutual accountability to make the place-based assurance regime within the ICS feel as comprehensive as possible. Some of our ICS leads highlighted the need to strike a better balance between top-down accountability from NHSEI and the population accountability that working with local government and communities brings. A framework that allows us to do both things in one place is the aim. As one ICS lead stated: "We have a set of NHSEI must dos, then we have some partnership ambitions around addressing inequality issues – as a place we want them to take ownership of all of it".

There was clear concern that accountability exercised through ICSs does not lead to everything then being the accountability of the ICS. Leaders emphasised the need to make much clearer the accountability for individual organisations to ensure that they contribute to issues affecting the system, and to ensure that the ICS is only held to account when reasonable and appropriate.

This tension will be particularly apparent when it comes to tackling health inequalities. The approaches taken by systems and the programmes/approaches adopted by individual organisations to reduce health inequalities should be as closely aligned as possible to make the greatest progress. NHSEI should be able to assuage these concerns via the local oversight MOU process/localisation and by exercising flexibility to enable systems to explain themselves rather than rigidly enforcing the framework. Although much of the detail of the system accountabilities will be announced in the forthcoming legislation, a central component of the statutory framework will be the duty on system partners to collaborate. However, this will not come into force until next year. Our members are clear that they may not be able to pull all the levers needed to address prevention and health inequalities if local government is not a willing partner – especially as the NHS Long Term Plan was not written in collaboration with local authorities. This could have a negative bearing on the performance assessment of ICSs and NHS bodies working within them.

We would therefore strongly recommend that NHSEI take this dynamic into account when overseeing systems. Moreover, NHSEI central and regional teams should work closely with local government and other system partners to ensure they are aligned with the framework,

and work with the LGA to ensure there is an accountability mechanism. It may be worth clarifying how the framework will work together with Health Overview and Scrutiny Committees.

During engagement sessions for this framework, our members again raised the role of peer assessment and review. Members of our Primary Care Network said: “We would like to see the introduction of a peer review approach which will support a more collaborative approach, reduce top-down performance management and improve accountability across systems.” We suggest that peer self-evaluation and setting targets around tackling health inequalities at the local level within the ICS would be an effective approach.

When the statutory arrangements come into place, we have concerns about the implications it will have for our members. Specifically, our members are concerned about the idea of a duty to collaborate making the ICS a ‘judge, jury and executioner’, as this would significantly alter the dynamics of trust and cooperation that have developed in many systems over recent years. We have advocated for assessment of performance against the duty focused on self-regulation, peer assessment and, where possible, local user input – to enable ICSs to enable, rather than regulate.

Lastly, and importantly, as NHSEI develops the oversight metrics that the framework will use to measure quality, it will be important to keep them as simple as possible. The success of the regime – and indeed in large part of the elective recovery which will come to dominate much of the next 2 years - may hinge on these as yet undefined metrics. It will also depend on the approach taken to reviewing these metrics in practice and through the ‘performance management’ approaches being taken, whether by regional or national teams. The present management paradigm of daily or weekly updates on progress does not command the confidence of members and should be urgently reviewed.

In summary, we recommend:

- NHSEI should exercise as much flexibility as possible in the implementation of this framework as organisations and systems come to terms with their new partnership arrangements and accountabilities and recover from COVID-19.
- The framework should be amended to clearly set out the move towards a culture of improvement at local level.
- A clearer explanation of accountability for individual organisations in terms of their role in addressing issues affecting the system.
- When overseeing systems, NHSEI should consider the willingness of non-NHS system partners to work within the system as a key barrier, in particular when it comes to addressing health inequalities.
- NHSEI central and regional teams should work closely with local government and other system partners to ensure they are aligned with the framework, and work with the LGA to ensure there is an accountability mechanism.
- NHSEI should consider the use of peer self-evaluation and setting targets around tackling health inequalities at the local level within the ICS.
- Keeping the oversight metrics that the framework will use to measure quality as simple as possible.

Question 4: (a) Do you agree that the proposed approach will support NHS England and NHS Improvement regional teams to work together to develop locally appropriate approaches to oversight? (b) If not, how could the proposed approach be improved?

Yes, partly agree.

The proposed framework will largely support NHSEI regional teams to work together to develop locally appropriate approaches to oversight. However, we have concerns around the perceived primacy of NHSEI regional teams in this framework. There is a strong feeling that oversight should be driven by ICSs. One member, an ICS leader, was concerned about regional NHSEI colleagues being given primacy over the system/ICS: “this feels like NHSEI holds greater responsibility of oversight rather than colleagues that are part of system. That keeps us exactly where we are rather than take us forward”. Members from our PCN Network are concerned that the proposed framework will lead to “a top-down approach that stifles the development and locally driven focus of ICS”.

We have long heard from members that performance management, or ‘oversight’, processes through the NHSEI regional teams are unclear and time-consuming, often with duplication in how reporting works. A concern raised by local leaders in 2018 in our ‘Letting local systems lead’ report rings true today: “We need to ensure that regional teams do not become the mechanism by which national clinical teams direct and performance manage the activities of ICS partnerships”.

Members have concerns about the balance between local flexibility and national consistency. We were assured during engagement sessions with NHSEI that this important balance is being addressed through the nationally mandated local oversight MOU process, and we would like to see this flexibility in practice. As we have described, ICS Leaders consistently report experiences of regional offices taking fundamentally different approaches to oversight, and emphasised the need for direction from the centre as well as negotiation at the local level. It will be crucial that NHSEI maintains a single line of sight. These comments are reinforced by the full range of members across trusts/foundation trusts, CCG and PCN leaders. For example, members of our PCN network commented: “The recognition of the importance of working with partners to deliver local priorities is welcome. The support that is provided by NHSEI regional teams should not stifle where progress is being made”.

With the growing influence of NHSEI regional teams, we must ensure that performance management and assurance are not duplicated. The reduction of duplicative unnecessary assurance, and the creation of lean, light and agile forms of oversight is a key aim for our members. One member, a chair of a community health and care NHS foundation trust was keen to see the continued reduction of costs for regulation and scrutiny due to COVID-19 being a priority for future planning. The locally-determined MOU process may be a way to ensure this happens. When agreeing MOUs with NHS partners, NHSEI regional teams will need to ensure that MOUs do not compromise on governance arrangements but add value to them, and ensure the MOU is seen as something that operates within the wider system. As one chair of an NHS mental health foundation trust put it: “Across the country, we need to reduce governance and accountability to its simplest form, need a governance system that reaches the lightest touch that enables us to progress on behalf of our communities”. NHSEI should work closely with colleagues at CQC to ensure the costs and administrative burden of regulation are kept to a minimum to allow NHS services to recover. Our conversations with the CQC and other regulators show a real appetite for this alignment and co-ordination, particularly regarding data collection and service improvement.

Finally, there must be a recognition that different ICSs have different relationships with NHSEI regional teams. Some of the more developed ICSs in the North benefit from having a fully embedded NHSEI team. NHSEI should also consider sharing examples of where this embedded model works well to able others to follow suit. This again reinforces the need to

review ways of working for regional teams in the light of this framework and best practice across the country, and to make that a routine process going froward. It also highlights the need for NHS England to set out a narrative which makes clearer how all ICSs can more directly access capacity currently vested in national teams and regional offices into ICSs.

One ICS chair was buoyed by their experience of working with their NHSEI regional team. They said: “We are trying to do something the NHS has never done before – we’re trying to restructure in difference. Creating something where we have fundamentally different organisations sitting adjacent to each other. We will need flexibility for the regional teams as well. We need to build in and recognise that difference helps us as long as it’s appropriate variation - rather than inappropriate. Let’s argue for understanding what’s different in each region and therefore how the regional office will work within the system”. Different operating models in different regions might therefore be justified and appropriate, but this should be determined by what ICSs need and want, rather than the approach taken by individual NHSEI regional colleagues.

In summary, we recommend:

- As far as possible, oversight should be driven by ICSs.
- The MOU process should be used as flexibly as possible and NHSEI should maintain a clear line of sight via regional NHSEI colleagues.
- NHSEI should ensure that performance management and assurance are not duplicated, by working closely with national regulators.
- NHSEI should work closely with CQC colleagues to ensure the costs and administrative burden of regulation are kept to a minimum as services recover.
- There must be a recognition of variety in ICSs’ relationships with regional teams, but operating models should be determined by ICSs, and there should be regular reviews of ways of working and best practice.

Question 5: (a) Do you support the proposed approach to segmentation across ICSs, trusts and CCGs? (b) How could the proposed approach be improved to better inform oversight arrangements and effectively target support capacity?

Yes, mostly agree.

We generally support the proposed approach to segmentation across ICSs, trusts and to some extent CCGs, as elucidated in the system oversight framework. We support the initial focus on segments 3 and 4 and the Recovery Support Programme. CCGs welcome the focus on segmenting ICSs rather than CCGs given their focus on transition and are happy for this to happen where CCGs are co-terminus with ICS on a case-by-case basis.

Our members have some concerns and would like to offer some views on how segmentation could work in practice.

Culture and behavioural change will be crucial to the success of segmentation. One ICS lead was concerned about the idea of “segmenting a partnership” – something which may undermine partnership working at a time when “we’re building our partnerships against a principle of equal partnership with the voluntary sector, business, local govt, etc.” NHSEI should be wary of the interplay between culture, behavioural change and partnership working when allocating partnered organisations into a segment. There is a feeling that the real measure of success for ICSs is what difference they are making to a population and its ability to tackle health inequalities. NHSEI should consider how to measure this when there is as yet limited performance management metrics for an ICS. For many ICSs and NHS

organisations within them, there will be a tension between addressing the elective backlog and at the same time securing the outpatient transformation opportunity and tackling health inequalities that have been accelerated by the pandemic. NHSEI must ensure that the planning guidance and oversight framework enables organisations and systems to maintain this balance and does not solely encourage chasing “quick wins” - for example, to access elective care recovery incentives.

There may be situations where there are very strong ICSs with very challenged organisations within it. It will therefore be important for NHSEI to consider the totality of the system during segmentation. To avoid legacy financial challenges of an individual organisation shifting a whole, otherwise high-performing ICS into a lower segment, the framework should assess systems by the strength of their financial improvement plans and demonstrable progress they are making against such plans, rather than just headline metrics (such as deficits) which may take some time to improve. This should include how system partners are working together to address the key issues faced by a particularly challenged organisation. As one chair of a mental health NHS foundation trust illuminated: “As a provider with a good segmentation ranking, we are nervous that we may get allocated a segmentation ranking that is less. If we have a big acute in a place setting, with issues, do you allocate place-based leadership to a more competent lead provider of place-based anchor? As a provider with a good segmentation ranking in a patch that has tremendous variability, it is a big question.” When implementing the framework, NHSEI should be cognisant of the fact that sometimes systems and organisations both struggle to deal with the same issues by supporting successful leaders to deliver improvement across systems and not punishing them for legacy problems when they are making progress.

We firmly believe segment 4 should be reserved for a small number of most challenged organisations who should be enabled to progress up swiftly with the help of NHSEI and other system partners.

Our members had some concerns about the criteria for segment allocation. Not meeting financial targets may result in organisations being allocated a particular segment. Agreeing financial targets that are achievable will be key to this working, otherwise whole swathes of the health system may end up in segment 3. We have concerns around the clarity of oversight arrangements for systems that are neither lower or higher performing. CCGs expressed concerns that some of the criteria for segment 1 in paragraph 32 is too subjective. They also raised concerns about the earned autonomy and greater control of deployment of improvement resources via regional hubs only being afforded to segment 1; “systems in Segment 3 might also want something similar to support improvement”. This could lead to regional variation in management of ICSs. NHSEI could overcome this by peer review between regions to ensure similar levels of judgment are applied.

The criteria for trusts being allocated to segment 3 includes a designation by the Care Quality Commission (CQC) of ‘Requires Improvement’ on the well-led key question. We have concerns about the use of this key question as organisations move towards whole system and whole patient pathway thinking. Finessing the CQC’s definition of “well-led” will be crucial to the success of partnership working and allowing leadership teams to commit to long-term partnership working and population health approaches to tackle health inequalities. In particular, it will be important to our members to get the definition of well-led to a point where it balances organisational accountability for safety and resource management with the wider responsibility that providers will have to their ICS, place, or provider collaborative. The framework leaves unanswered the question of the wider role of

CQC in scrutinising ICSs, which will need to be resolved in the coming months. NHSEI should consider the implications of the well-led criteria on partnership working in its discussions with the CQC on their role in overseeing non-trust/ICS/CCG organisations within the system.

When developing the oversight metrics, a key question NHSEI should be asking is "Will this help to achieve the priorities set out in the Operational Planning Guidance 2021/22 whilst recognising the continued pressures on systems?" The metrics and decision-making about moving between tiers will be crucial and NHSEI needs to get the appropriate balance between objective and data driven approaches. As one ICS chair commented: "There should be a data set that comes from the system that is used to inform [their designation]. If the numbers don't work, then you shouldn't be top tier".

In summary, we recommend:

- NHSEI should consider the interplay between culture, behavioural change and partnership working when allocating partnered organisations into a segment.
- NHSEI should consider how to measure systems' work on population health/inequalities with the limited performance management metrics for ICSs.
- NHSEI must ensure that the planning guidance and oversight framework enables organisations and systems to balance their priorities over time to discourage the pursuit of "quick wins" like elective recovery incentives.
- When making segmentation decisions, NHSEI should consider the totality of the system and support successful leaders to deliver improvement across systems rather than punishing them for legacy problems when they are making progress.
- Peer review between regions should be used to ensure similar levels of judgment are applied to segmentation decisions.
- NHSEI should consider the implications of the well-led criteria on partnership working in its discussions with the CQC on their role in overseeing non-trust/ICS/CCG organisations within the system.

Question 6: (a) Do you have any additional suggestions that could improve the proposed approach to oversight, support and intervention?

We have several additional suggestions for improving the proposed approach to oversight, support and intervention for 2021/22.

Firstly, it would be pertinent for NHSEI to include practical examples of how you want the system to work under the proposed framework in the final document, which should be tailored to enable high performing systems to maintain their high performance and for others to progress to that level. Our members are supportive of this approach and believe some worked examples would help tease out the relationship between system assurance and NHSEI regional assurance. One ICS leader suggested stress testing on hypothetical scenarios which could test performance issues as a way of bringing the framework to life. Another ICS leader suggested that the vaccination programme would be a good example to run through an outcomes framework. A CCG suggested that looking at maternal health and in particular the first 1,000 days of a child's life could be an effective test of partnership working and how an ICS adds value - as a wicked issue which demands a population approach. The NHS Confederation would like to offer our support in scenario planning analysis of potential system issues under the new framework.

Secondly, alignment on assurance between NHSEI, CQC and other arms-length bodies and ICSs will be crucial. In the rapidly evolving health and social care landscape, national bodies must work in partnership to create a whole-system architecture for oversight, governance, performance management and regulation that is clear, simple and does not duplicate functions. NHSEI will need to develop your thinking and clarify where NHSEI oversight and CQC assessments of systems join to avoid 'marking the same homework'. Joining up, working across the system rather than duplicating functions and sharing of best practice will be key to effectively measuring system performance. We also need to avoid a situation where several different elements of un-coordinated support are going into a system.

Thirdly, restating and recalibrating the role of regional teams is an important one for Regional Directors and NHS England more generally to consider. Inconsistency between national and regional messaging approaches is a risk, and there must be mutual accountability between system and regional leaders as well as system and organisational leaders. There must of course be the ability for regions to adapt to the differing needs of their ICSs and local context.

Our members understand that this is a stepping stone and much more work will be done in the coming months to develop an oversight framework that works in the new system architecture. Therefore, we would also like to offer additional feedback for the next iteration of the framework in 2022/23.

A. There needs to be an evolution of the perceived role of the NHS within the totality of the system. ICS leaders are clear that the overall role of ICSs is around improving population health, reducing health inequalities, broader social and economic development, enhancing productivity and value for money. If ICSs are to make progress they must be enabled to push forward in a collaborative and integrated way with all system partners – including social care providers, voluntary and community organisations, local government, universities et al. As one ICS leader put it: "The framing as the "NHS bit of the ICS" needs crystallising as this moves forward."

B. As stated above, NHSEI will need to consider statutory accountability arrangements in the next iteration of the framework. As a member of our Mental Health Network stated: "One of the frequent questions I hear between provider chairs and CEOs is do we now put our provider role first or system need first? In terms of time, task, priority, delegation. All our careers it has been 'sort your own house out and then go to the party'. Many of our houses need some attention this year. We are just coming up to the appraisal season. The balance matters." NHSEI will need to reassure those operating within the system that they can strike a balance between their organisational role and their role in the wider system. Ironing out accountabilities will open up several questions. Will the statutory framework align organisational board accountability with system accountability? How does this align with the conversation about system by default and local arrangements?

A key question will continue to be prominent: how will NHSEI keep local priorities,, partnership working and population health outcomes measures front and centre? There is a feeling among our ICS Network and other members that NHSEI should look towards outcome-based measures for 2022-23. How will population health management and inequalities be measured on a whole system basis? Are we looking at outcomes or processes, or a mixture of the two? It will be important to avoid penalising systems for not making headway on health inequalities if they have structures in place for doing so. Tackling

health inequalities is a complex long game and there will be differences in local priorities. This endeavour will be heavily reliant on effective partnerships with local government.

C. Members firmly believe NHSEI should explicitly include other partners in the next oversight framework – including non-statutory NHS providers as well as primary care and social care. You should also consider carefully how to hold partner organisations to account if their involvement (or lack thereof) may impact on system performance.

D. NHSEI must ensure that sufficient time and due process is given to consultation and engagement with system leaders (including local government) and representative bodies to input into the design process for the 2022/23 framework. NHSEI should set out a clear methodology and timescale for stakeholders in the development of the next framework as this will be a key piece of work. The NHS Confederation and its members would like to be active partners in this engagement process.

E. There will be a need for NHS England to be clearer as to how ICSs are supported to develop the capacity and capabilities to discharge the duties that legislation, guidance and this framework will place on them. This will need to include greater influence for ICSs over capacity and capability that is presently based in national and regional functions.

Question 7: (a) Do you agree that the current model of special measures for individual organisations should be replaced by a more system-focused support programme? (b) If not, please give your reasons.

Yes, fully agree.

We strongly support the move towards a more system-focused support programme. We have some suggestions for how this can best work in practice, and have touched elsewhere on the importance of proper co-ordination of support offers between national teams, as well as with their regional colleagues (and where relevant, other regulators).

To some extent, in practice, the existing special measures regime has evolved its thinking beyond the institution to the system. Reflecting on this evolution, a chair of a trust in financial special measures stated that “although the support has moved on the sanctions haven’t – even if there is cognisance of the system role and wider challenges, any remedial action is at an organisational level, not a system level.” NHSEI will need to give systems direction in terms of when penalties will apply, being conscious of the fact that at present all the levers are at the organisational rather than system level.

For the support programme to be truly supportive, NHSEI must take into consideration the cultural shift needed to implement the framework, as well as overcome some of the negative feeling towards the special measures regime. There needs to be a truly supportive, transparent framing, rather than one based on blame of individual organisations or leaders. As one CCG colleague stated: “We want it to be genuine transparent support, not a call for help. Just because we are asking for help don’t punish us, it means we are self-aware of our weaknesses, not failing”. A co-produced design package will be most effective as long as a genuine ask for help is not interpreted as a failure of leadership.

An ICS leader expressed their concern that where individual organisations are struggling (i.e. in segment 4), and when this rightly becomes a problem for the system to resolve, NHSEI must ensure this does not bleed into and negatively impact on the broader ICS endeavour.

NHSEI should seek to target support at the system level as well as at the individual level, by working to understand the root cause of issues, then implement the appropriate support at the appropriate level to support the organisation and/or system.

Finally, the support programme will need to involve non-NHS system partners with a view to supporting organisations within the system to make sustainable improvements. The success of the support regime will also rest on the discussions NHSEI has with the CQC on its role as a regulator across all system partners.

In summary, we recommend:

- NHSEI will need to give systems direction in terms of when penalties will apply, being conscious of the fact that at present all the levers are at the organisational level.
- There needs to be a truly supportive, transparent framing of the RSP, which is co-designed, rather than one based on blame of individual organisations or leaders.
- NHSEI should seek to target support at the system level as well as at the individual level.
- The support programme will need to involve non-NHS system partners with a view to supporting organisations within the system to make sustainable improvements.

Question 8: (a) Do you support the proposed approach to the Recovery Support Programme? (b) How could the proposed approach be improved to better support systems, trusts and/or CCGs to address complex and/or longstanding challenges?

Yes, mostly agree.

We broadly support the proposed approach to the Recovery Support Programme (RSP). We are encouraged by the productive focus on “support” and addressing the underlying drivers of system and organisational problems, which is a welcome departure from the special measures regime. However, members want some clarity on what the programme will include – though they understood that this will need to vary and be tailored on an ad hoc basis. Our members would appreciate a specific engagement with NHSEI Improvement directorate on the content of the RSP.

We have some suggestions around how the proposed approach could be improved to better support systems, trusts and/or CCGs to address complex and/or longstanding challenges.

The exit criteria for segment 4 should be agreed on a bespoke basis and avoid being too prescriptive to prevent systems/organisations being under the RSP for an extended period. The exit criteria are largely silent on leadership and inequalities. Our members would like clarity on the expectations and trajectories of improvement with regards to these two important performance measures.

NHSEI should also be mindful of systemic barriers to performance, as elucidated above. One NHSCC colleague stated: “You need to recognise sustained improvement in system working and not get dragged back by long-term provider deficits which could drag systems down”.

The RSP will need to involve non-NHS system partners with a view to supporting organisations within the system to move forward in a sustainable way. This will avoid organisations and systems repeatedly finding themselves in segment 4. NHSEI can play a role in bringing system partners together so there is a common understanding of the issues.

We have concerns around the framework allowing NHSEI to review the capability of the ICS’s, trust's or CCG’s leadership and respond by making “changes to the management of

the system/organisation to ensure the board and executive team can make the required improvements." NHSEI should not seek to make a habit of removing leaders from struggling organisations or ICSs. This would merely bandage up issues and prevent interrogation of the key underlining issues facing that organisation or system. An emphasis on support and improvement should be the typical approach, with removal of leaders an exceptional occurrence.

In summary, we recommend:

- A specific engagement with our members run by NHSEI's Improvement directorate on the content of the RSP.
- The exit criteria for segment 4 should avoid being too prescriptive to prevent systems/organisations being under the RSP for an extended period.
- Provide clarity on expectations and trajectories of improvement for leadership and inequalities.
- NHSEI should actively bring system partners together to ensure there is a common understanding of system issues.
- An emphasis on support and improvement should be the typical approach, with removal of leaders an exceptional occurrence.

Question 9: (a) Do you support the proposed approach to CCG assessment? (b) If not, how could the proposed approach be improved?

Yes, mostly agree.

Our members are generally supportive of the approach to CCG assessment as set out in the system oversight framework. As one CCG leader commented: "it seems broadly fair. It will probably be a bit subjective, but this is probably inevitable to some extent this year." Another commented that "the proposed approach to CCG assessment seems proportionate given everything else that is going on." The focus for NHSEI and system stakeholders should be to implement the System Oversight Framework for the dawn of ICSs, balancing the need for appropriate transitionary arrangement in the meantime with the need for stability during the COVID-19 recovery.

When developing the range of clinical indicators as metrics for the CCG assessment, our members would appreciate streamlining where possible the total number of metrics, keeping these simple and aligned to existing goals. NHSCC would be pleased to support NHSEI on the development of these metrics and to identify 'what good looks like.'

Members from our Mental Health Network welcome the inclusion of the Mental Health Investment Standard within the proposed key lines of enquiry for the assessment. They would like to see something more specific added into the key lines of enquiry around the physical health of people with severe mental illness and learning disabilities and autism, given the huge inequalities that exist, and the big drop off in physical health checks this year for people with severe mental illness – and asked for: "How has the CCG helped primary care to improve the health of people with serious mental illness and learning disabilities."

In summary, we recommend:

- When developing the range of clinical indicators as metrics for the CCG assessment, our members would appreciate streamlining where possible the total number of metrics, keeping these simple and aligned to existing goals.

- A question should be added to the key lines of enquiry for the CCG assessment on the physical health of people with severe mental illness and learning disabilities and autism.

Next steps

We would like to thank NHSEI for their open engagements on this important piece of work and for the opportunity to contribute to the development of the framework. We would like to offer our support in any way we can over the coming months, as the framework is developed and implemented, and as plans progress towards a framework for 2022/23.