13 June 2024

NHS Oversight and Assessment Framework consultation – NHS Providers response

Background

NHS Providers is the membership organisation for the NHS acute, mental health, community and ambulance services that treat patients and service users in the NHS. It helps those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in England in voluntary membership, collectively accounting for £115bn of annual expenditure and employing 1.4 million people.

Introduction

We welcome the opportunity to respond to NHS England (NHSE)'s formal consultation on an updated NHS oversight and assessment framework for 2024/25. We also appreciated the opportunity to take part in your pre-consultation engagement on the proposals, the candid discussions with our members, and the ability to shape the draft for consultation through our initial submission last month. We have been encouraged by your willingness to listen to our concerns and by your commitment to engage with us further around the implementation and evaluation of the approach.

This formal response builds on our earlier contribution and has been informed by the comments and perspectives on the draft framework shared by trusts at the two roundtables we hosted in April 2024, which were attended by NHSE. It also reflects the findings of our latest regulation survey, published in July 2023 – *Improving regulation for the future* – and the conversations we have held with our members over the past year.

Overarching comments

We are grateful for NHSE's interactions with us and some of our members during the pre-consultation period, and have been encouraged to see that some of our suggestions and recommendations have been taken on board in the updated draft.

However, despite the early engagement on the proposals, which was positive and collaborative, we are disappointed at the short timeframe for responses to the formal consultation, and the restrictive word limits on the online form. Unlike the approach taken in pre-consultation, the list of consultation questions is selective and limited: overall we feel that the very positive approach taken in the initial stages has been lost to some extent during this formal consultation phase. This is regrettable given how important and substantial the changes being consulted upon this year are.

The absence of the oversight and assessment metrics from the consultation document is notable, and without them it is impossible to say whether assessments will be fair, consistent, and whether they would lead to improvement. The document refers to "a separate technical document" (34, p.15), which would detail the scoring model for each metric – however, there is no clear indication as to whether the metrics would also be consulted on later, or how providers can engage with NHSE on these.

We would be happy to facilitate such engagement, but would appreciate further clarity on the timeline for publication and provider engagement on these metrics, given the intended launch of the new framework in July this year.

Consultation questions

To what extent do you agree or disagree that the proposed approach to oversight outlined in this document meets the purposes and principles outlined in paragraph 6?

Neither agree nor disagree

The overall approach

The draft framework is positively framed around the aim to empower systems to work collaboratively to plan, design and deliver healthcare that meets the needs of populations now and in the future, and the aim to enable the sharing of good practice to support mutual improvement. It also looks to introduce a "robust process of oversight, transparency and accountability" (4(a), p.3), which would allow greater objectivity in decision-making. Additionally, it aims to address the issue (highlighted by us and our members continuously in the past) of insufficient clarity on the respective roles and responsibilities of integrated care boards (ICBs) and NHSE regional and national teams with regard to oversight.

We acknowledge that NHSE has heard and is responding to the concerns of those it regulates. We are also encouraged to see the explicit links in the document with the NHS operating framework, NHS IMPACT, and the findings of the Messenger Review with regard to developing leadership capability.

However, we are not convinced that the proposed approach to oversight, described in the draft framework, would meet the purposes and principles outlined in the document.

As we wrote in our recent report on *Good quality regulation*, we believe that good regulatory practice should invariably comply with the principles of 'right-touch regulation', as defined by the Professional Standards Authority. This advocates the "right amount of regulation… needed for the desired effect. Too little is ineffective; too much is a waste of effort." The principles of right-touch regulation include: proportionality; consistency; targeted nature; transparency; accountability; and agility.

Our understanding is that NHSE wants the framework to be exhaustive (by accounting for every scenario), to build in transparency (by articulating multiple new measures), and to ensure mutual accountability (by linking organisations' assessments and moderating these against one another). This approach, however, brings additional risks. The new framework introduces significant complexity and, depending on how it is implemented, could result in increasing the regulatory burden. For example, the proposed quarterly self-certification, complex scoring model, new and potentially contentious capability ratings, and the proposed quarterly publications of these, will increase complexity compared with the existing framework. This, in turn, risks a system of oversight and assessment which is not proportionate, targeted and agile enough to be optimal.

Comments from trust leaders during the earlier stages of engagement suggested that the framework risked being 'over-engineered'. The final draft does not overcome these challenges.

Metrics, scoring model and moderation

Metrics

A consistent area of feedback from the engagement events was around "balancing the need to deliver against immediate priorities and longer-term sustainable improvement" (4, p.3). It is welcome that this is now explicitly referenced in the framework. However, the absence of the metrics from the consultation document makes it difficult to judge whether the resulting assessments are likely to be fair and useful to support improvement.

It will be important to consult on the metrics appropriately prior to publication, as they are integral to the approach. It is very difficult to form a judgement about an assessment approach without knowing the quantitative measures proposed for such assessment. It would therefore be useful to know what the planned next steps for the metrics development are, and to know more about the technical document referenced in the framework.

Scoring model

We note that this updated version of the framework also outlines the new scoring model NHSE will use for segmentation.

We welcome the alignment of the metrics with the four core purposes of integrated care systems (ICSs), the ideas behind the individual and domain metric scores, as well as the intention to use these "in their own right to support the diagnosis of issues that could benefit from targeted support or interventions on specific pathways" (34, p.15). However, we are conscious that the scoring model was

not included within the scope of our earlier discussions, and we feel that it raises a number of questions that we would welcome further discussion on. These include:

- How will "a quartiled approach where there is no defined benchmark or standard" (34(a), p. 15) work in practice? We are unclear which metrics this might apply to or how such assessment could be objective and consistent across regions and systems.
- Where tertiles are determined based on the degree of progress or improvement, will that be measured relative to starting position, previous quarterly position, or another measurement? Will these judgements take into account factors outside of the organisation's or system's control that may be hampering progress?

The suggested quartiling/tertiling approach would enable NHSE to rank providers and identify those most in need of support and/or intervention, while recognising that the majority will not be meeting national targets and standards at this current time. If the judgements regarding measurement can be made objectively and consistently across regions and systems, and properly accounting for the wider context and challenges the NHS is experiencing nationally, we understand the reasons for this approach.

In our pre-consultation response, we commented strongly that moderation across systems will present significant challenges, and that it is unlikely to be a panacea for encouraging partnership and system working. We have two additional comments related to this new draft:

- In the sentence "Where system performance is challenged in more than one of the additional consideration areas, each relevant organisation in the system indicative delivery score may deteriorate by one" (37, p.16), we assume that "relevant" refers to the organisations regulated by NHSE and that such moderation would apply to all in that category across the system. The sentence might currently be understood to mean that moderation would only apply to some providers, and if that were the case, it would be important to explain how relevance is determined in this context.
- That section remains opaque as to how the performance of providers spanning two or more ICBs will be moderated against that of "the system".

Moderation

The process of moderation and calibration (41, p.17) also remains opaque. The complex nature of these considerations can only mean that a degree of judgement will be required from those assessing and then calibrating. Care will need to be taken that such judgements are consistent across NHS regions, and NHSE regional colleagues may require training and guidance to enable this. The framework seeks to articulate an objective process, while including criteria where subjective judgements will necessarily need to be made.

Publication of metrics data

Finally, it would be useful to understand your plans for publication of the metrics data by organisation, and, in particular:

- how and where the metrics data will be published
- whether this will be done on a quarterly or an annual basis
- whether the metrics data will sit as a further level of detail to the current information on segmentation, or whether it will be separate
- whether it will be published alongside the capability ratings and whether it will be accompanied by any relevant commentary.

There is a risk that, without additional explanation, this information might be difficult to interpret by members of the public; they might struggle to make meaningful judgements or comparisons between data sets, or might draw wrong conclusions about the safety of their services.

Resource and capability

Additionally, and as mentioned in our earlier response, we share concerns raised during the pre-consultation phase around the capacity and capability of both NHSE and ICBs to effectively oversee and support providers. Some trusts have reported insufficient support by ICBs, particularly for providers in segment three. Considering the varying maturity of ICBs and the significant number of struggling trusts and systems, it should be considered whether NHSE will have the resource, capacity and capability to oversee directly a potentially large number of trusts and systems in segments three and four. This would inevitably impact on the success of the proposed approach to oversight in meeting the outlined purposes and principles of the new framework.

Does the updated framework provide a clear explanation of the role that ICBs and providers play in NHS oversight?

Neither agree nor disagree

In previous conversations around improvements to the framework we have consistently advocated for greater clarity around the respective roles and responsibilities of NHSE and ICBs in the oversight of providers. While this version of the framework attempts to provide that further clarity and positions itself much closer to the definitions in the operating framework, we believe there remains ambiguity in the interpretation of the respective roles and responsibilities of ICBs and NHSE regional teams, particularly around the performance management of trusts. Such clarity is necessary, given the inherent tension in ICBs' roles as partners and conveners in systems, alongside day-to-day oversight of providers.

ICBs' statutory function is to arrange the provision of health services in their geographical area, and they are responsible for ensuring their populations have access to good quality care. This means they have an important role as system leaders, and as part of this they should act alongside providers within their ICS and hold them to account for playing their part in achieving system objectives. However, they have no regulatory power over providers under the 2022 Health and Care Act. There are already inherent tensions and conflicts of interest built into how ICBs are constituted (for example,

partner members). Giving ICBs a formal performance management role over providers, whose income they largely control, significantly compounds these tensions. We do not agree that ICBs should be given quasi-regulatory powers over providers in their systems, and believe that pushing their reasonable oversight of providers (for example via commissioning and contracting) into performance management on behalf of NHSE is both inappropriate, and risks undermining the essentially collaborative nature of good system working.

Our latest regulation survey showed the overwhelming support of providers of ICBs' role in fostering a sense of shared responsibility and collective endeavour among system partners (98% agreed), in bringing system partners together to solve problems and share practice (96% agreed), and in improvement and peer support (89% agreed). At the same time, only 37% were comfortable with ICBs' role as provider managers. Respondents also often associated the introduction of statutory ICBs in 2022 with an increased burden, and highlighted confusion and duplication between NHSE and ICBs. These perceptions are often linked to ICBs' varying maturity, variable experiences of support and demands from ICBs, differing behaviours and relationships in different systems.

The arrangements set out in the framework for when NHSE will lead provider oversight and intervention, and when it will be working 'with' or 'through' ICBs, are inherently complex, and there will be a risk of duplication between NHSE and ICBs.

To what extent do you agree or disagree with the approach to ICB assessment which considers their capability and delivery?

Neither agree nor disagree

We agree that it is important to ensure that segmentation takes into account the capability of organisations as well as their delivery against objectives. This will support NHSE, as well as organisations themselves, to reflect on their direction of travel, as well as on their current performance.

Provider capability assessments and ratings

We address provider capability assessments here, since this question only deals with the capability assessment of ICBs, rather than that of both ICBs and providers. Given that the proposals for provider capability were not yet developed during the pre-consultation period and were not brought to the attention of trust leaders during the engagement sessions, we would strongly suggest additional time is devoted to seeking, and carefully considering, trusts' feedback on this.

Self-certification

We agree in principle with the suggestion of a three-fold assessment that considers providers' Care Quality Commission (CQC) well-led ratings, their self-certification, and relevant third-party information. It is good practice (as set out in the provider code of governance) for boards to assess their own capability annually, and aligning this self-certification and the rest of the provider capability

assessment with the annual reporting cycle (and annual governance statement) would be sensible to avoid duplication.

However, it is not clear if quarterly self-certification will add value for providers, ICBs or NHSE. Provider capability will only in extremely rare circumstances change meaningfully within a three-month period, and the framework already requires providers to alert the ICB and NHSE of any change of circumstances that could impact their self-certification. Annual self-certification against the provider licence was specifically removed by NHSE in 2023 to reduce duplication and the regulatory burden on boards and on NHSE, reflect subsidiarity, and empower providers and systems. Reintroducing it here on a quarterly basis runs against this logic.

We have additional comments about self-certification statements (annex B) themselves:

- On the first bullet of the strategy box, it would support providers if it was clear that trust strategies will include trust/local priorities, as well as reflecting shared priorities.
- It would be helpful to understand the definition of productivity used in this document, since the list of guidance provided here is not exhaustive.
- The second bullet in the finance box requires boards to confirm that "financial considerations (including efficiency programmes) do not adversely affect patient care and outcomes". Financial considerations inevitably affect patient care and therefore outcomes: boards have finite resources and must choose how to allocate them. It would be preferable to word this in terms of boards taking care to assess and balance any proposed efficiency programmes in terms of their impact on patient care and outcomes.
- We are also concerned that, in the language used, the self-certification statements do not recognise providers working substantively with more than one ICB.

Capability ratings

While ICB capability ratings are expected to determine their level of participation in the oversight of providers, we are unclear about the value of equivalent regular ratings for providers. They are, however, likely to significantly increase regulatory burden.

We are generally supportive of NHSE's intention to bring a symmetry of approach in the assessment and oversight of ICBs and providers. However, the difference in the suggested capability rating terminology creates the opposite impression. For ICBs, there are suggested ratings of "excelling", "achieving", "progressing" and "insufficient progress", all focused on a direction of travel and improvement towards a positive goal.

By contrast, the terminology suggested for provider capability is negative, being framed around 'concerns', and using a three-point scale rather than ICBs' four-point one. It is also unclear whether these ratings would be published with commentary, as otherwise they are likely to have a significant negative impact on public perceptions. "Major concerns" will significantly undermine confidence in all aspects of a provider. "Some concerns – provider under review" could similarly cause public concern, as well as suggesting that any concerns may be unknown to the provider, which will usually not be the case. Finally, even the 'top' rating of "no material concerns" will be opaque to any reader not

familiar with audit terminology, and implies the existence of some, less significant, concerns. The impact of such terminology on staff morale within provider trusts should also not be underestimated.

For these reasons, we recommend that capability assessment ratings for providers and ICBs use the same terminology, to create the desired symmetry of approach and to encourage, and focus on, improvement.

Additionally, as trusts are already segmented under the oversight and assessment framework, as well as being inspected, assessed and rated by CQC, we suggest not publishing provider capability assessment ratings. Doing so would add unnecessary complexity and potential confusion to the publicly available information on trusts' performance.

We are not clear about the purpose of updating provider capability scores quarterly (given that the assessment takes place annually, as set out in 73, p.24). We suggest issuing the rating annually, unless it is revised in-year where circumstances change, in which case a new rating will be issued.

To what extent do you agree or disagree that the 'additional considerations' (comprising aggregated system performance) alongside organisational delivery metrics will encourage greater collaboration between NHS system partners to resolve system-wide issues?

Neither agree nor disagree

It is clear that the achievement of NHS system-wide objectives depends on the contribution of all system partners. However, it is challenging to design a methodology for evaluating system performance that is fair, transparent and able to drive closer partnership working.

Whether moderating one organisation's segmentation based on the performance of others will encourage greater collaboration between partners will depend on the relationships within the system. Where there is strong shared purpose and trust, it could lead to closer working and strengthen the sense that problems are shared between local partners. Where systems are less mature, it could result in animosity or resentment.

The proposal presents additional challenges:

- The moderation process must be clear and transparent – the framework needs to provide further detail as to the views that will be sought by NHSE on provider collaboration.
- It is difficult to objectively judge what constitutes 'good' collaboration. The key point is that collaboration should not be seen as an end in itself: effective or good collaboration is collaboration that supports the delivery of system objectives.
- Board directors retain legal accountability for their organisations' performance – an accountability which is held, sometimes in tension, alongside their duty to cooperate and contribute to the system objectives and financial position. The moderating 'additional considerations' confirm and may even heighten this tension.

- Even where positive collaborative behaviours are well embedded, it is not always possible for NHS system partners to improve others' performance. In particular, it may not be appropriate for NHSE to undertake higher degree of intervention in, or scrutiny of, a high-performing provider which has been downgraded due to problems with their ICB.
- NHS provider organisations will have different roles to play in the delivery of system objectives. System performance against the 'additional criteria' may be impacted by the performance of some providers more than others, depending on the focus of the national priorities used as criteria (e.g. urgent and emergency care targets).
- The role of social care and other non-NHS providers in achieving system objectives may be underplayed and it is possible that the framework could encourage NHS organisations within its scope to engage with one another at the expense of wider partners.
- The national asks on system delivery need to be aligned, avoid duplication, and recognise the principle of subsidiarity and the need for systems to operate in an autonomous way, with a strong provider voice, and with NHSE setting clear direction on the core purposes.

What changes would you make to the framework? Please share details below:

Suggestions for changes and areas of concern have been identified in the sections above, where relevant, but below we have included some specific additional points:

- The framework is still not clear on how the suggested approach will work for providers spanning two or more ICBs. This is significant as most providers treat patients from more than one ICS area and many have core business spanning multiple systems: this issue should therefore be explicitly addressed. For example, where two ICBs differ on their view of a provider's capability, how will that be managed? Will quantitative metrics across several systems be taken separately or amalgamated in some way (there will be cases where performance in one ICB is better than another, for example)? The language throughout should be reviewed to ensure that the process for providers working within two or more systems is clear, so that the entirety of the framework applies effectively to all trusts.
- The link to effective leadership behaviours as per the NHS operating framework, which was included in the earlier draft of the framework, was important and helpful, and we believe it should be reinstated in this document.
- *Table 1: Oversight of providers with and through ICBs*, p. 8, also contains some changes from the earlier draft of the framework which, we believe, are unhelpful. In particular, the column on *Provider oversight led through an ICB rated as 'Excelling' or 'Achieving' in the first instance* excludes the bullet stating that "NHS England makes final decisions on segmentation and enforcement action, where necessary". Given the ultimate statutory responsibility of NHSE in relation to providers, we believe that this point is key to include. The second bullet in the column on *Provider oversight led in partnership with an ICB rated as 'Progressing' or 'Insufficient progress'* now states that NHSE "*may* provide direct oversight and support to

providers with the awareness of the ICB", while our understanding is that this should always be the case for ICBs with lower levels of maturity.

- In this sentence: "ICBs, using their contractual and other powers, ensure the services they commission from providers are high quality, value for money and sustainable." (13, p. 6), it would be helpful to define which "other powers" are being referred to.
- In relation to NHSE's role, the framework says that it may "require action from providers that are at risk of underperformance or quality deterioration" (13, p. 6). The term "quality deterioration" is an addition to the pre-consultation draft, which implies that even where a provider is delivering to the required quality, any deterioration can lead to NHSE 'requiring action'. This makes sense in terms of taking action to pre-empt issues before they lead to underperformance. However, it will be important that this does not apply to seasonal fluctuations or well-understood deteriorations (for example as a result of reconfiguring pathways), and so perhaps the addition of a qualifier phrase, such as "sustained or unexpected deterioration", or similar, would help.
- An explicit approach to joint oversight, agreed and set out in an annex to the ICB annual assessment letter (15, p.6), is welcome to avoid duplication and ensure alignment between NHSE and ICBs. However, for the sake of transparency, providers subject to such approaches should also have sight of this agreement, to understand how their oversight will be carried out. Moreover, it would make sense for providers subject to joint oversight to be involved in agreeing with the ICB and NHSE how that will work, and therefore be party to the agreement set out in the letter.
- In line with the point above, when ICBs recommend support or intervention for a provider to NHSE (19(b), p.7), this should be done with the full knowledge of the provider concerned.
- We note the change of language from "improvement criteria" to "transition criteria" in 19(c), p.7, and throughout the document. While the terminology of "improvement" is well-understood and implies a focus on improving care, "transition" unhelpfully puts the focus on improving segmentation for the provider/ICB. We suggest reverting to "improvement".
- Specific attention to ICBs' responsibilities for primary care services is welcome. We note that the performance of primary care in a system will have an impact on the performance of all providers in that system, and given primary care is regulated separately, the framework cannot fully capture all the factors influencing system performance (23, p.9).
- The wording used in relation to leaders working to ensure a collective approach to service improvement is unchanged from the earlier draft, stating that they are expected to "work in an agile way" (24(b), p.10). However, it is not clear what this should mean in practice, or what good looks like.
- We are pleased to see the addition of a specific reference to an escalation route for providers with their regional director should there be significant disagreements between providers and ICBs that cannot be resolved locally (26, p.10), which reflects our earlier suggestion. We also believe that NHSE should take any such disagreements into account when receiving the ICB perspective on provider capability.

- In relation to self-certification, the requirement to inform NHSE, as well as the ICB in the first instance if the self-certification cannot be met (72, p. 24), potentially contradicts the overall approach to oversight through ICBs for providers in segments 1 and 2. ICBs and providers have told us that they struggle to understand when NHSE should and should not be involved, and the framework should be consistent to aid clarity about this.
- In 73 (p. 24), it would be helpful to reword the first sentence for clarity. We suggest: "Where oversight is being discharged through the ICB in the first instance, provider capability is assessed annually by the ICB with input from NHSE."
- We have consistently raised the issue of potential conflicts of interest associated with the dual role of ICBs as partners and overseers. While we appreciate the addition of a sentence on ICBs needing to manage any conflicts of interest in the section on provider capability (73, p.25), the contentious nature of ICBs' perspectives on provider capability significantly informing provider capability ratings should not be underestimated. This may undermine the success of the new approach, particularly where ICBs' and providers' views diverge.

Conclusion

We welcome the opportunity to respond to this important consultation on an updated NHS oversight and assessment framework for 2024/25, and look forward to continue working with NHSE and trusts as the new framework is implemented and evaluated.

Trust leaders have asked for NHSE oversight, and the NHS regulatory system as a whole, to be aligned to the aims of system working, to have regard to the wider context and systems trusts are operating in, and to enable collaboration. We welcome the clear intention from NHSE to adapt the oversight framework to support this way of working.

We are concerned that this framework may not provide a right-touch, ongoing assessment approach, which recognises the principle of subsidiarity and empowers systems to deliver for patients and populations. The framework, as currently articulated, would likely increase the regulatory burden, particularly due to the emphasis on ongoing quarterly updates.

The assessment framework rightly aims to be nuanced enough to be fair, and dynamic enough to be responsive. Perhaps inevitably in such a complex environment, and when seeking to moderate the assessment of one organisation via that of others, what is presented here risks being overly complex, burdensome to NHSE, ICBs and trusts, and potentially highly subjective.

We have made the point repeatedly that asking ICBs to be both partners and quasi-regulatory overseers of providers is not conducive to genuine partnership, and mitigation is highly dependent on relationships and personalities, which will change over time. The single sentence on conflicts of interest included in the updated framework is not enough on its own to address these issues.

We are concerned about the short timeframe for this formal consultation, the limited word count of the online questionnaire, and the restrictive scope of the consultation questions. We are also concerned about the absence of the metrics from the consultation.

We strongly believe that the terminology, framing and publication of the suggested provider capability ratings will be particularly unhelpful for providers and potentially worrying for patients and service users, and recommend NHSE reconsiders this proposal.

In summary, while supportive of the intentions behind this framework review, we believe that the suggested purpose and principles of oversight may fall victim to the complexity of the proposals. There are areas, including the metrics, that require further input from providers, and there is more work to be done to ensure that the framework adheres to the principles of good regulation.