Classification: Official

Publication approval reference: PAR1378

NHS Oversight Framework

27 June 2022

Contents

1. Introduction

1. Integrated care systems (ICSs) are partnerships of health and care organisations that together plan and deliver joined up services to improve the health of people who live and work in their area. Following several years of locally-led development, the Health and Care Act 2022 has now put ICSs on a statutory footing.

2. From 1 July 2022 integrated care boards (ICBs) will be established with the general statutory function of arranging health services for their population and will be responsible for performance and oversight of NHS services within their ICS. NHS England will work with ICBs as they take on their new responsibilities, the ambition being to empower local health and care leaders to build strong and effective systems for their communities.

3. 2022/23 will be a year of transition as ICBs are formally established and new collaborative arrangements are developed at system level. Over the course of 2022/23 NHS England will consult on a long-term model of proportionate and effective oversight of system-led care.

4. This updated NHS Oversight Framework describes NHS England's approach to NHS oversight for 2022/23. It aligns to the priorities set out in the 2022/23 priorities and operational planning guidance and the legislative changes made by the Health and Care Act 2022, including the formal establishment of ICBs and the merging of NHS Improvement (comprising Monitor and the NHS Trust Development Authority) into NHS England.

5. Building on the approach outlined in the NHS System Oversight Framework 2021/22, the 2022/23 framework reinforces system-led delivery of integrated care in line with the direction of travel set out in the NHS Long Term Plan, Integrating care: Next steps to building strong and effective integrated care systems across England and the Integration White Paper (Joining up care for people, places and populations).

6. The approach for 2021/22 provided a single, consistent NHS monitoring framework with the flexibility to support different system delivery and governance

arrangements, as well as local partnership working. This updated framework continues that approach, but updates it to take account of:

a. the establishment of statutory ICBs with commensurate responsibilities
b. NHS England's duty to undertake an annual performance assessment of these ICBs
c. early learning from the implementation of the System Oversight Framework during 2021/22
d. revised NHS priorities as set out in 2022/23 planning documentation.

7. The framework will support ICBs and NHS England to work together and develop proportionate and locally tailored approaches to oversight that reflect:

a. a shared understanding of the ambitions, accountabilities and roles between NHS England, ICBs, individual trusts and local partnerships, and how performance will be monitored
b. the unique local delivery and governance arrangements specifically tailored to the needs of different communities
c. the importance of delivery against both the shared system priorities agreed between local partners and national NHS priorities.

8. This updated framework will take effect from 1 July 2022 and the existing oversight arrangements as set out in the System Oversight Framework 2021/22 apply until this date.

2. Purpose and principles

9. The overall purpose of and approach to NHS oversight was consulted on prior to publication of the 2021/22 System Oversight Framework. This refreshed framework aligns with these key principles.

10. The purpose of the NHS Oversight Framework is to:

a. ensure the alignment of priorities across the NHS and with wider system partners

b. identify where ICBs and/or NHS providers may benefit from, or require, support

c. provide an objective basis for decisions about when and how NHS England will intervene.

11. The approach to oversight is characterised by the following key principles:

a. working **with and through ICBs**, wherever possible, to tackle problems

b. a greater emphasis on **system performance and quality of care outcomes**, alongside the contributions of individual healthcare providers and commissioners to system goals

c. matching **accountability for results** with improvement support, as appropriate

d. **autonomy** for ICBs and NHS providers as a default position

e. **compassionate leadership behaviours** that underpin all oversight interactions informed by Our Leadership Way (an agreed set of behaviours describing what good leadership should look and feel like), the National Quality Board's (NQB's) Our shared ambition for compassionate, inclusive leadership and the NHS board level competency frameworks.

3. Role of integrated care boards

12. ICBs will become formally established on 1 July 2022 and have legal duties to arrange NHS services for their ICSs. NHS England has issued statutory guidance on the preparation of the ICB constitution,. Along with the 2022/23 priorities and operational planning guidance, this sets out the governance ICBs must have in place.

13. ICBs are responsible for ensuring their delegations to place-based partnerships are discharged effectively, and for leading the oversight of individual providers within their ICSs in line with the principles outlined in this document. ICBs will also co-ordinate NHS support interventions within their system, where appropriate, working in partnership with NHS England.

14. NHS England has statutory accountability for oversight of both ICBs and NHS providers. In general, we will discharge our duties in collaboration with ICBs, asking ICBs to oversee and seek to resolve local issues before escalation. In some exceptional circumstances, such as where enforcement action is required, we will intervene directly with providers. Should such intervention be required this will happen with the full awareness of the relevant ICB.

4. Approach to oversight

15. Ongoing oversight will focus on the delivery of the priorities set out in NHS planning guidance, the overall aims of the NHS Long Term Plan and the NHS People Plan, as well as the shared local ambitions and priorities of individual ICSs.

16. To achieve this, the NHS Oversight Framework is built around:

    a. Five national themes that reflect the ambitions of the NHS Long Term Plan and apply across trusts and ICBs: quality of care, access and outcomes; preventing ill-health and reducing inequalities; people; finance and use of resources; and leadership and capability (Figure 1).

    b. A set of high-level oversight metrics, at ICB and trust level, aligned to these themes.

    c. A sixth theme, local strategic priorities. This reflects the ICB's contribution to the wider ambitions and priorities of its ICS and recognises:

        i. that systems each face a unique set of circumstances and challenges in addressing the priorities for the NHS

        ii. that each integrated care partnership[1] will set out an integrated care strategy that its ICB must have due regard to in planning and allocating NHS resources

        iii. the continuing ambition to support greater collaboration between partners across health and care, to accelerate progress in meeting the most critical

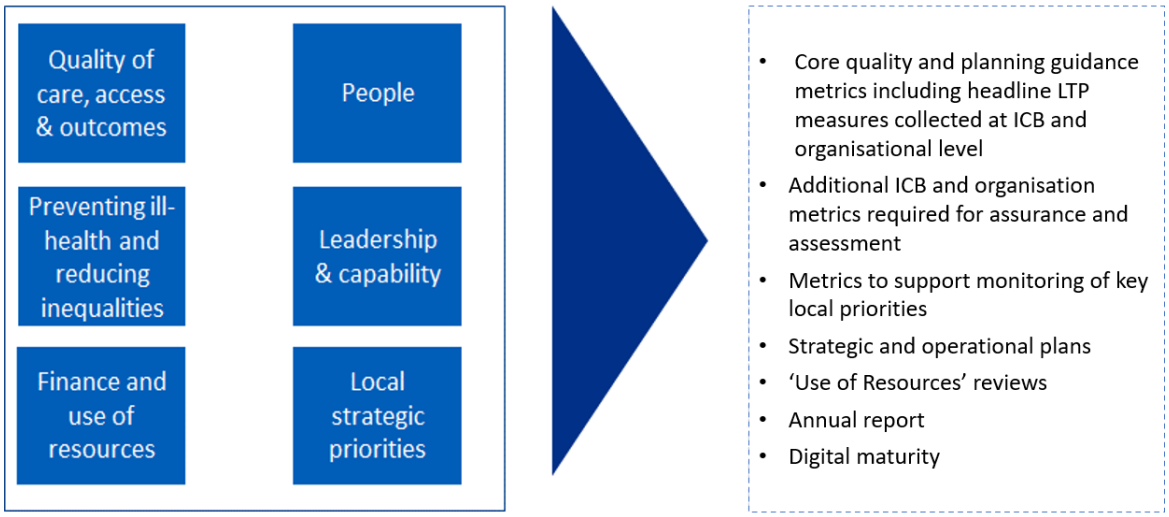
[1] Each ICB and its partner local authorities are required to establish an integrated care partnership, bringing together health, social care, public health and, potentially, representatives from the wider public space where appropriate, such as social care or housing providers.

health and care challenges and support broader social and economic development.

d. A description of how ICBs will work alongside NHS England to provide effective, proportionate oversight for quality and performance across the NHS.

e. A three-step oversight cycle that frames how NHS England teams and ICBs will work together to identify and deploy the right delivery support and intervention to drive improvement and address the most complex and challenging problems, respectively.

Figure 1: Scope of the NHS Oversight Framework for 2022/23



17. NHS England regional teams will lead the oversight of ICBs on delivery against the domains in the NHS Oversight Framework and, through them, gain assurance of place-based systems and individual organisations. Where necessary, regional teams will lead and co-ordinate support requirements identified for the ICB.

18. ICBs will lead the oversight of NHS providers, assessing delivery against these domains, working through provider collaboratives where appropriate. ICBs will consult with their NHS England regional team about any areas of concern identified, specific support requirements and, where necessary, issues requiring formal intervention by NHS England.

19. NHS England and ICBs will together agree the specific arrangements for each system to ensure effective and proportionate oversight, reflecting local delivery and governance arrangements. In 2021/22, NHS England regional teams and

ICSs worked together to establish individual memoranda of understanding (MoU) to reflect their oversight relationship and support ICSs in their journey towards becoming statutory bodies. An outline MoU and supporting guidance have been developed to support ICBs and NHS England regional teams to update individual MoUs to reflect the new statutory arrangements and the updated Oversight Framework.

20. MoUs will set out how NHS England and individual ICBs will work together to:

    a. discharge their respective roles and responsibilities to improve the quality of care and reduce inequalities, taking into consideration system maturity, risks and support needs

    b. improve partnership working at both local and regional level to ensure people across the system have access to high quality health and care services. This includes building an open and learning culture at local and regional level.

21. MoUs will also set out:

    a. The delivery and governance arrangements across the ICB and its partner organisations, including:

        i. The role of place-based partnerships and provider collaboratives in delivering the NHS priorities set out in the 2022/23 priorities and operational planning guidance.

        ii. Quality governance processes that enable the proactive identification, monitoring and escalation of quality issues and concerns. This should include cross-system quality governance as set out in the NQB's A shared commitment to quality and National guidance on system quality groups, which set out specific requirements for governance and intelligence sharing mechanism that ICSs are expected to have in place with system partners.

        iii. Financial governance arrangements in line with the National Health Service Act 2006, as amended by the Health and Care Act 2022, that will support the effective management of resources within the system financial envelope.

    b. The proportionate and robust oversight mechanisms and structures across the ICB and its partner organisations that:

        i. reflect the local delivery and governance arrangements

ii. are aligned to the arrangements set out in this framework, including the respective roles of the ICB and NHS England.

c. The local strategic priorities that the ICS has committed to deliver in 2022/23 as a partnership. These must align to the four fundamental purposes of an ICS.[2]

22. In some cases, bespoke oversight arrangements will be required; for example, where ICBs commission services under a delegated agreement, providers operate across multiple ICBs or a nominated ICB acts as a lead commissioner on behalf of the region. Regional teams will work with ICBs and service providers to ensure there are appropriate oversight arrangements in these situations.

23. There will be a need for flexibility in how the oversight role is carried out within the principles of this framework. In some cases, this may involve adjusting the specifics of the approach, for example:

a. as the NHS continues to rise to the challenge of restoring and transforming services following the COVID-19 pandemic, both tackling backlogs and meeting new care demands

b. where there is a need to respond quickly and proactively to unexpected issues in individual organisations, to national policy changes, the introduction of new service planning or delivery models, or new sector pressures.

[2] The four fundamental purposes of an ICS, set out in *Integrating Care: Next Steps To Building Strong and Effective Integrated Care Systems*, are: improving population health and healthcare, tackling unequal outcomes and access, enhancing productivity and value for money and helping the NHS support broader social and economic development

5. Oversight cycle

24. The oversight process follows an ongoing cycle (Figure 2) of:

    a. monitoring ICB and NHS organisation performance and capability under six themes (Figure 1)

    b. identifying the scale and nature of support needs

    c. co-ordinating support activity (and where necessary formal intervention) so that it is targeted where it is most needed.

Monitoring

25. As part of the oversight of ICBs and trusts, NHS England will monitor and gather insights about performance across each of the themes of the framework (Figure 1). The information collected and reviewed will include both quantitative data, including, but not limited to, the published Oversight Framework metrics, and qualitative information derived from oversight, quality, improvement and performance conversations with ICBs and their formal reporting documents, as well as other routine information including that from relevant third parties.

26. Depending on the type of information, the collection and review of data may be:

    a. **in year:** using monthly or quarterly collections and forums as appropriate

    b. **annual:** using annual submissions, surveys or other annually published information. In these cases, we expect that systems and regional teams will agree how they monitor progress on a timely basis linked to locally agreed plans and milestones

    c. **by exception:** where material events occur or we receive information that triggers our concern outside the regular monitoring cycle.

27. This information will be used to support ongoing monitoring at ICB and provider level of:

    a. **current performance** and service quality (based on the most recent data and insight available), including onward trajectories where available

b. the **historical performance trend** to identify patterns and changes, including evidence of improvement in reducing clinical variation.

28. A key outcome of the successful implementation of the framework will be the early identification of emerging issues and concerns, so that they can be addressed before they have a material impact or performance deteriorates further. ICBs and trusts are expected to maintain relationships with NHS England so that actual or prospective changes in performance are shared in a timely manner. Where quality risks are material to the delivery of safe and sustainable services, these should be managed and escalated in line with the National Quality Board quality risk response and escalation guidance.

29. NHS England regional teams will work with ICBs to ensure that oversight arrangements at ICB, place (including delegated commissioning arrangements) and organisation level incorporate regular review meetings as appropriate. Meetings will be informed by a shared set of information and regional teams will draw on national and other expertise as necessary (Table 1). Oversight conversations should reflect a balanced approach across the six oversight themes.

30. Ongoing oversight meetings will be complemented by focused engagement with the ICB and the relevant organisations where specific issues emerge.

Table 1: Ongoing monitoring process – review meetings

	ICB	Individual organisations/collaboratives
Scope	• Performance against national requirements including the NHS Long Term Plan deliverables at ICB level across the five national themes of the NHS Oversight Framework • Delivery against key 'local priorities' agreed with system partners • Effectiveness of current support arrangements and the extent to which these may need to be refined • Extent to which system partners are working effectively together to deliver and improve	• Oversight of and support to: – individual organisations, including those that span multiple ICSs, or have significant funding flows from outside an ICS, e.g. ambulance trusts and specialist trusts – collaboratives that span multiple places, including for the delivery of specialised services – place-based partnerships • By exception with scope determined by the specific issues identified in discussion between the NHS England regional team and ICB leadership
Roles and participation	• Led by NHS England regional team with: – ICB leadership team – senior leaders from system providers/ organisations (if not part of the ICB)	• Led by ICB with: – senior leaders from relevant providers/collaboratives – NHS England, where appropriate and by mutual agreement
Frequency of review meetings	• The default frequency for these meetings will vary according to the governance arrangements agreed between the regional team and ICB, but should be at least quarterly • Regional team will engage more frequently where there are material concerns • Annual meeting linked to ICB assessment process	• The default arrangements should be agreed between the ICB and partner organisation, and set out within the MoU

Identifying the scale and nature of support needs

31. To provide an overview of the level and nature of support required across systems, inform oversight arrangements and target support capacity as effectively as possible, regional teams have allocated all ICBs and trusts to one of four 'segments' as described in Table 2. Primary care providers and primary care networks (PCNs) will not be allocated to segments; however, the overall quality of primary care will inform ICB segmentation decisions.

32. Segmentation decisions are determined by assessing the level of support required based on a combination of objective criteria and judgement and are regularly reviewed to ensure they remain an accurate reflection of the level of support required. For individual trusts, NHS England and the relevant ICB will together discuss segmentation and any support required. NHS England will be responsible for making the final segmentation decision and taking any necessary formal enforcement action.

33. Segmentation decisions indicate the scale and nature of support needs, from no specific needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine the specific support requirements. These will be identified as set out in the section 'Identifying specific support needs'

34. The principles and approach to oversight will apply across all segments. These criteria have two components which are set out in detail in Table 3:

    a. objective, measurable eligibility criteria based on performance against the six oversight themes using appropriate oversight metrics

    b. additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

35. Where the objective, measurable eligibility criteria are met this will trigger consideration of the additional factors that will determine the overall segmentation decision.

36. Autonomy will be the default position with the expectation that ICBs and trusts will be allocated to segment 2 unless specific mandated support is required. Those ICBs and trusts allocated to segment 1 will benefit from the lightest oversight arrangements, and may be encouraged to provide peer-to-peer support and spread good practice to other systems and providers.

Table 2: Support segments: description and nature of support needs

	Segment description		Scale and nature of support needs
	ICB	Trust	
1	Consistently high performing across the six oversight themes Capability and capacity required to deliver on the statutory and wider responsibilities of an ICB are well developed	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place based and overall ICB priorities	No specific support needs identified. Trusts encouraged to offer peer support Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations
2	On a development journey, but demonstrate many of the characteristics of an effective ICB Plans that have the support of system partners are in place to address areas of challenge	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Flexible support delivered through peer support, clinical networks, the NHS England universal support offer (e.g. GIRFT, Right Care, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the six oversight themes Significant gaps in the capability and capacity required to deliver on the statutory and wider responsibilities of an ICB	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts)	Bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required (see Annex A)
4	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	In actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme (see Annex A)

Table 3: Support segments: segmentation approach

	Eligibility criteria	Additional considerations
1	• Performance against the oversight themes typically in the top quartile nationally based on the relevant oversight metrics and • Balanced plan, actual/forecast breakeven or better and • CQC 'Good' or 'Outstanding' overall and for well-led (trusts)	**For ICBs:** • Success in tackling variation across the system and reducing health inequalities • Whether the ICB consistently demonstrates that it has built the capability and capacity required to deliver on its statutory and wider responsibilities **For trusts:** • Evidence of established improvement capability and capacity • The degree to which the trust plays a strong, active leadership role in supporting and driving place-based priorities, provider collaboration and overall ICB priorities
2	This is the default segment that all ICBs and trusts will be allocated to unless the criteria for moving into another segment are met	
3	• Performance against multiple oversight themes in the bottom quartile nationally based on the relevant oversight metrics or • A dramatic drop in performance, or sustained very poor (bottom decile) performance against one or more areas or • Plan not balanced and/or a material actual/forecast deficit or • A CQC rating of 'Requires Improvement' overall and for well-led (trusts)	**For all:** • Existence of other material concerns about a system's and/or organisation's governance, leadership, performance and improvement capability arising from intelligence gathered by or provided to NHS England (e.g. delivery against the national and local transformation agenda) • A material concern with regard to the quality or safety of services being provided or a failure to escalate such risks • Evidence of capability and capacity to address the issues without additional support, e.g. where there is clarity on key issues with

	Eligibility criteria	Additional considerations
		an existing improvement plan and a recent track record of delivery against plan and/or of agreed recovery actions • There are other exceptional mitigating circumstances **For ICBs:** • Evidence of collaborative and inclusive system leadership across the ICB, e.g. where the system is not in financial balance, whether it has been able to collectively agree credible plans for meeting the system envelope • Clarity and coherence of system ways of working and governance arrangements **For trusts:** • Whether the trust is working effectively with system partners to address the problems
4	In addition to the segment 3 criteria: • Longstanding and/or complex issues that are preventing agreed levels of improvement for ICBs or trusts or • A catastrophic safety failure or • A catastrophic failure in leadership or governance that risks damaging the reputation of the NHS or • A significant underlying deficit and/or significant actual or forecast gap to the financial plan or • CQC recommendation (trust)	

37. Where ICBs and trusts have significant support needs that may require formal intervention and mandated support, they will be placed into segment 3 or 4. They will be subject to enhanced direct oversight by NHS England (in the case of individual trusts this will happen in partnership with the ICB) and, depending on the nature of the problem(s) identified, additional reporting requirements and financial controls. Full details are set out in Annex A.

    a. Mandated support consists of a set of interventions designed to remedy the identified problems within a reasonable timeframe. There are two levels of support depending on the severity and complexity of the issues:

        i. Mandated support that is led and co-ordinated by NHS England regional teams with input from the national intensive support team where requested. This level of support means automatic entry to segment 3.

        ii. Mandated intensive support that is agreed with NHS England regional teams and delivered through the nationally co-ordinated Recovery Support Programme (see Section 6: Recovery Support Programme). This level of support means automatic entry to segment 4.

    b. While the eligibility criteria for mandated support will be assessed at ICB and individual trust level, mandated support packages will always be designed and delivered within the relevant system context (e.g. place-based or provider collaboratives). Where the support need is triggered by an individual organisation, this means that local system partners will be expected to play their role in addressing system-related causes or supporting system solutions to the problem(s).

38. For ICBs and trusts in segments 1 and 2, overall support needs will be formally reviewed on a quarterly basis, likely as part of the routine meeting detailed in Table 1 (in the case of individual trusts this will happen in partnership with the ICB). Where ongoing monitoring suggests that the support needs may have changed, this will trigger a review of the segment allocation (see 'Identifying specific support needs' below).

39. For ICBs and trusts in segments 3 and 4, the agreed exit criteria will need to be met to exit mandated support and move to a lower segment (see Annex A).

Identifying specific support needs

40. Where an ICB or trust is triggering a specific concern, the NHS England regional team will work with the ICB to understand why the trigger has arisen and if a support need exists. The regional team will, as appropriate, involve system leaders and appropriate subject matter experts in this process – both to identify the factors behind the issues and determine whether local support is available and appropriate.

41. Regional teams will assess the seriousness, scale and complexity of the issues that the ICB, or trust where a need for support or intervention is evident, is facing. This will be done using information gathered through quality oversight, existing relationship knowledge and discussions with system members, and information from partners and evidence from formal or informal investigations. As part of this, regional teams will draw on the expertise and advice of national colleagues as required.

42. Regional teams, working with the ICB and system leaders (as appropriate), will consider the:

    a. degree of risk and potential impact
    b. degree to which the driver of the issue is understood
    c. views of leadership, governance and maturity of improvement approach
    d. inherent capability and credibility of plans to address the issue
    e. previous steps taken to support the resolution of the issue
    f. extent to which delivery against a recovery trajectory is being achieved.

43. Based on this assessment, regional teams will identify whether an ICB or trust has a specific support need and the subsequent level of support that is required. Support decisions will be taken having regard to the views of the system leadership.

44. This assessment may lead to a re-evaluation of the current allocated support needs segment, although this will not necessarily precipitate a change of segment.

45. Specific support needs will be reviewed through regular ICB oversight meetings, detailed in Table 1, or enhanced oversight arrangements, where these are required to:

a. track improvement and understand the effectiveness of the various support measures
b. ensure support is targeted where it has the greatest impact.

Co-ordinating support activity

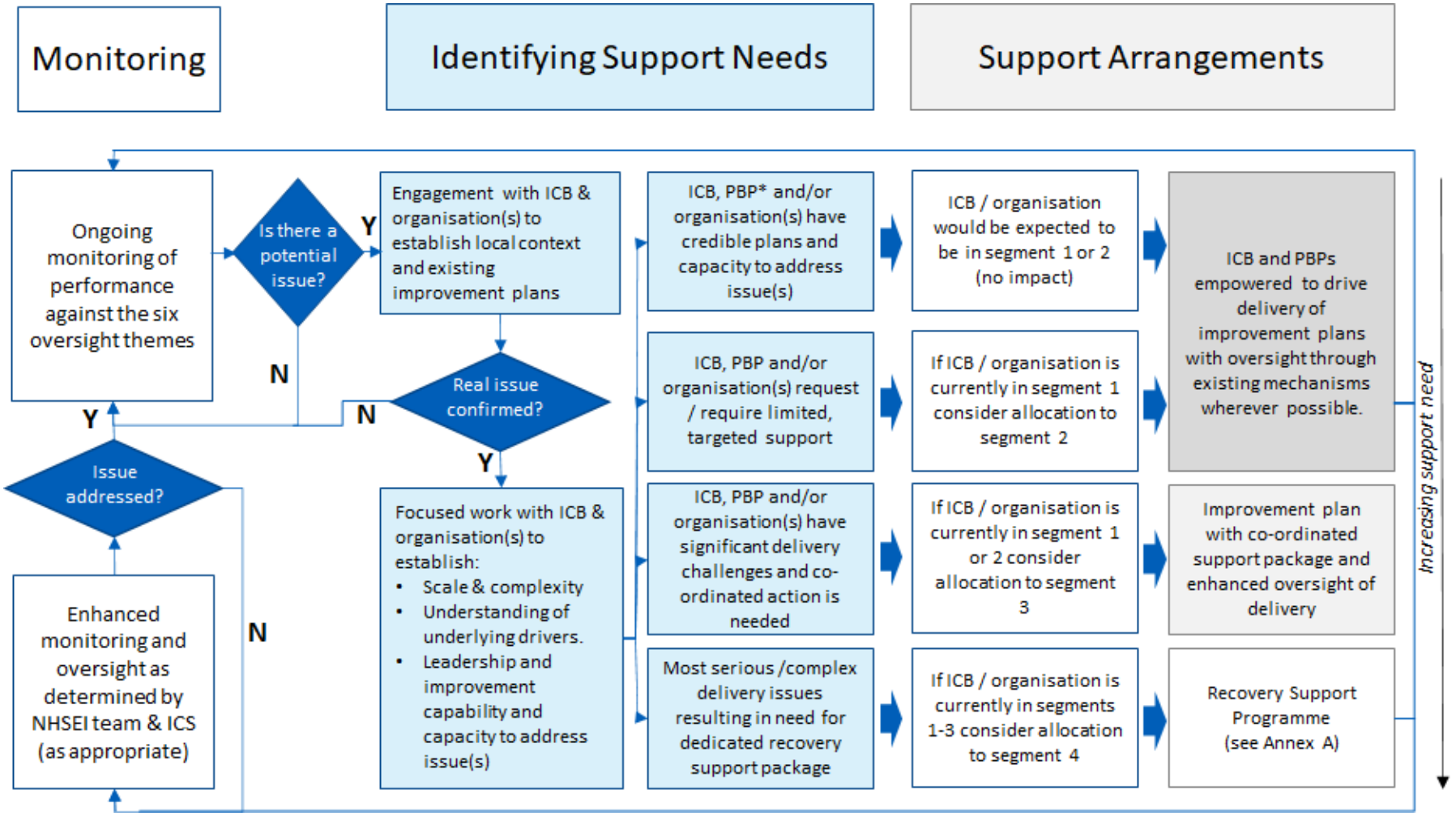
46. NHS England will work flexibly with ICBs to deploy the right support through this ongoing cycle, drawing on the expertise and advice of national colleagues as appropriate. During 2022/23 we will explore with ICBs the role peer review could play in the oversight model in future.

47. In line with the principles governing the framework, NHS England will work with and through ICB leaders, wherever possible, to tackle problems and ensure that the oversight process is both proportionate and co-ordinated across ICBs.

48. Expertise, advice and support from wider NHS England colleagues will be drawn on as appropriate, including clinical quality teams. NHS England colleagues will work to ensure that a co-ordinated support offer is provided and reflected in a co-ordinated action plan. Support requirements will be considered in parallel so that any support activities (and where necessary interventions) are mutually reinforcing and can be deployed at the right level, e.g. where concerns affect multiple organisations a system-wide approach may be needed.

49. Where the operation of the ICB itself is deemed to be a causal part of the identified issue(s), this could result in a change to the oversight approach normally associated with that system's previously assessed maturity level.

Figure 2: Oversight, diagnosis and support and intervention process



6. Recovery Support Programme

50. For ICBs and trusts allocated to segment 4, the national Recovery Support Programme (RSP) provides focused and integrated support, working in a co-ordinated way with the ICB, regional and national NHS England teams.

51. The RSP has replaced the separate quality and finance special measures programmes that were in place between 2013 and 2021 and is:

    a. available to support ICBs and trusts with increasing, complex challenges, helping to embed improvement upstream to prevent further deterioration and enable stabilisation

    b. focused at system level, while still providing tailored, intensive support to individual organisations

    c. focused on the underlying drivers of the problems that need to be addressed and those parts of the system that hold the key to improvement

    d. in the case of ICBs, nationally led by a credible, experienced system improvement director (SID) jointly appointed by the system, region and national intensive support team

    e. able to draw in support from an expert multidisciplinary team co-ordinated by the SID, or improvement director (ID) in the case of trusts

    f. time limited with clear exit criteria

    g. focused on building resilience within trusts and systems with knowledge and skills transfer providing sustainable capability within the system, such that they exit the programme with the knowledge and skills they need to achieve sustainable improvement

    h. designed to place an expectation on systems to build the capacity required to maintain improvement.

52. Where entry to segment 4 and the RSP is triggered by an individual organisation, local system partners will be expected to play their role in addressing system-related causes or supporting system solutions to the problem(s).

53. On entering the RSP a diagnostic stocktake, involving all relevant trust, system, regional and national partners, will:

    a. identify the root cause(s) of the problem(s) and the structural and strategic issues that must be addressed

    b. recommend the criteria that must be met for the system or organisation to exit mandated intensive support (exit criteria)

    c. review the capability of the ICB's or trust's leadership.

54. At the same time as helping to address the specific issues that have triggered mandated intensive support, NHS England will also consider whether long-term solutions are needed to any structural issues affecting the ICB's or trust's ability to ensure high quality, sustainable services for the public.

55. The SID will be jointly appointed by the ICB and NHS England's national and regional intensive support teams and will normally report to the chief executive of the ICB with a reporting line to the Director of National Intensive Support to ensure sufficient independence. Specific arrangements will need to be agreed in each situation to ensure appropriate governance and independence.

56. The SID will support the ICB or relevant organisations to develop the improvement plan, which will include a target timeline for exit from the RSP and segment 4.

57. Where a trust is in the RSP, an ID, reporting to the Director of National Intensive Support, will support the trust and its system partners to develop an improvement plan which will include a target timeline for exit from the RSP and segment 4.

58. NHS England must sign off the improvement plan for both ICBs and trusts placed in segment 4.

59. The SID or ID will work with the ICB, and trust if appropriate, to co-ordinate the necessary support from the system, NHS England teams, the broader NHS or, where appropriate, an external third party. This support could include:

    - intensive support for emergency and elective care
    - intensive support to deliver the national programmes focused on reducing clinical variation across clinical pathways
    - intensive support for workforce and people practices

- financial recovery support including specialist support, eg to reduce agency use, implement cost controls
- drivers of deficit review
- governance review
- governance and leadership programme for improvement in challenged organisations and systems
- tailored delivery of a range of improvement programmes such as 'well led', 'better tomorrow' and 'making data count'.

60. NHS England will make a decision on exit from the RSP on the basis that the agreed exit criteria have been met in a sustainable way and any required transitional intensive support is in place as an ICB or trust moves to segment 3. As support is also mandated in segment 3, the improvement plan should remain in place and will continue to be reviewed at a regional level to ensure improvement is being achieved. Where the objective eligibility criteria for entry into the RSP included a recommendation from the CQC, the decision to exit segment 4 will consider the evidence underpinning the CQC recommendation.

61. In addition to the process described above, further RSP review meetings may be held between the NHS England Board and the trust and its system or the ICB. These meetings can take place:

- on entry to segment 4 and the RSP, to gain assurance that the improvement plan is robust to achieve exit in a sustainable way to the agreed timescale
- on exit to segment 3 from the RSP, to gain assurance that, with an agreed package of support, improvement can be sustained, and any lessons learnt are shared as appropriate
- where there has been a national escalation of concerns regarding a lack of progress either by regional or national executives.

62. Further details on the operation of mandated support, including how decisions are made and how support is applied, is included as Annex A.

7. ICB assessment

63. NHS England has a legal duty to annually assess the performance of each ICB in each financial year and publish a summary of its findings.

64. In conducting this performance assessment, NHS England will consult each relevant health and wellbeing board as to its views on the ICB's implementation of any joint local health and wellbeing strategy.

65. The NHS England regional team will conduct the annual assessment, drawing on national expertise as required and having regard to relevant guidance. We will, in particular, consider how successfully the ICB has:

    a. contributed to the wider local strategic priorities of the ICS

    b. performed its statutory functions, including in particular how it has discharged its legal duties under the National Health Service Act 2006 (as amended by the Health and Care Act 2022) and the Local Government and Public Involvement in Health Act 2007, in relation to:

        i. improving the quality of services

        ii. reducing inequalities

        iii. obtaining appropriate advice

        iv. the effect of decisions (The "triple aim")

        v. public involvement and consultation

        vi. financial duties

        vii. having regard to local assessments and strategies

        viii. promoting and using evidence from research.

    c. delivered on any guidance set out by NHS England or the Secretary of State regarding the functions of the ICB

66. For 2022/23 the assessment will be in narrative form and will identify areas of good and/or outstanding performance, areas for improvement and any areas that are particularly challenged.

67. As this will be the first year in which ICBs operate, NHS England will work with them during the first half of the year to develop further detailed guidance to support annual assessments for 2022/23. We expect to review and develop this approach for future years.

8. Alignment with partner organisations

68. The National Health Service Act 2006, as amended by the Health and Care Act 2022, places a duty on NHS bodies to co-operate with each other in the exercise of their functions. NHS bodies including, but not limited to, NHS England, ICBs and NHS providers must, therefore, work in close partnership to deliver their duties. The Secretary of State may also publish guidance on the duty to co-operate between NHS bodies and between NHS bodies and local authorities, which must be taken into account. A failure to collaborate may lead to formal enforcement action being considered.

69. Alongside the duty of NHS bodies to co-operate with one another, it is essential that all members within ICSs, whether NHS bodies or not, also work together across boundaries to deliver services and outcomes for their population. To achieve this, each integrated care partnership must prepare an integrated care strategy setting out how the assessed needs of its area are to be met by the exercise of functions of:

    a. the ICB
    b. NHS England or
    c. responsible local authorities.

70. The integrated care strategy will have regard for best practice and the need for a joined-up approach and increased partnership with other organisations. The NQB's A shared commitment to quality and National guidance on system quality groups emphasise the importance of prioritising quality in decision-making, having a shared understanding of quality across partner organisations, a set of agreed quality improvement priorities for the system and common quality structures in

place to support intelligence-sharing, improvement and assurance (Including system quality groups).

71. Systems will also continue to benefit from the health and wellbeing boards and local authority health overview and scrutiny committees reviewing and scrutinising their work.

72. At a regional and national level, NHS England will continue to work alongside key regulators, CQC, Health and Care Professions Council, General Medical Council and the Nursing & Midwifery Council through the Joint Strategic Oversight Group (JSOG) function to provide a dedicated space for regulators to share intelligence and develop aligned approaches to support organisations.

73. The Health and Care Act 2022 places new duties on CQC to conduct reviews of the provision of health and adult social care in each ICS and assess the functioning of the ICS, including how its ICB, local authorities and registered service providers work together. NHS England and CQC will continue to work together to ensure synergy between the ICS reviews undertaken by CQC and the ICB assessments undertaken by NHS England.

Annex A: Intervention and mandated support

Introduction

1. Mandated support applies when integrated care boards (ICBs), NHS trusts and foundation trusts ('trusts'), have serious problems and where there are concerns that the existing leadership cannot make the necessary improvements without support.

2. Mandated support consists of a set of interventions designed to remedy the problems within a reasonable timeframe. There are two levels depending on the severity and complexity of the issues:

    - Mandated support that is led and co-ordinated by NHS England regional teams with input from the national intensive support team where requested. This level of support means automatic entry to segment 3 of the NHS Oversight Framework.
    - Mandated intensive support that is agreed with NHS England regional teams and delivered through the nationally co-ordinated Recovery Support Programme (RSP). This level of support means automatic entry to segment 4 of the NHS Oversight Framework.

3. While the eligibility criteria for mandated support will be assessed at ICB and trust level, mandated support packages will always be designed and delivered within the relevant system context (e.g. place-based or provider collaboratives). Where the support need is triggered by an individual organisation, this means that local system partners will be expected to play their role in addressing system-related causes or supporting system solutions to the problem(s).

4. Mandated support may involve the use of NHS England's statutory enforcement powers. A decision by NHS England to take such action must comply with the relevant statutory threshold and conditions. A trust considered to be in need of mandated support may be subject to enforcement action that requires it to carry out specific actions as part of the intervention.

5. This annex explains:

- how NHS England determines the requirement for mandated support and the level of support
- what happens to an ICB or organisation when mandated support applies
- the roles and responsibilities of other key organisations involved, specifically the Care Quality Commission (CQC)
- how an ICB or trust exits from mandated support
- what Recovery Support Programme (RSP) review meetings are.

6. This annex supersedes the previously published policy described as 'special measures' and should be read in conjunction with the 2022/23 NHS Oversight Framework.

7. While regulatory action arising from this framework at NHS foundation trusts will utilise the NHS provider licence, NHS England will, from July 1, use the legacy NHS Trust Development Authority powers it will inherit on that date to underpin any enforcement/mandated actions at NHS trusts until they receive a licence as per section 49 of the Health and Care Act 2022.

How NHS England determines the need for mandated support

8. NHS England determines which ICBs and trusts require mandated support with reference to a set of objective criteria, but also by considering other appropriate considerations. Any ICB or trust meeting the objective criteria set out below is eligible to be considered for the relevant level of mandated support but may also be excluded from this in light of other relevant considerations.

Mandated support (segment 3)

9. An ICB or trust is eligible to be considered for mandated support and entry to segment 3 if:

- performance against multiple oversight themes is in the bottom quartile nationally based on the relevant oversight metrics

  or

- there has been a dramatic drop in performance, or sustained very poor (bottom decile) performance against one or more areas

  or

- it has an underlying deficit that is in the bottom quartile nationally and/or is reporting a negative variance against the delivery of the agreed financial plan and/or it is not forecasting to meet plan at year end

  or

- for trusts, there is a CQC rating of 'Requires Improvement' overall and for well-led.

10. Where there are material concerns about an ICB's and/or trust's governance, leadership, performance and improvement capability arising from intelligence gathered by or provided to NHS England (eg delivery against the national and local transformation agenda), this may also trigger consideration of mandated support. In these circumstances regional teams will also consider the extent to which the above objective eligibility criteria are met.

11. Meeting one of the objective eligibility criteria does not automatically lead to entry to segment 3. In considering whether an ICB or trust that has met the eligibility criteria would benefit from mandated support, regional teams will consider whether:

    For all:

    - there is the capability and capacity to address the issues without additional support, eg where there is clarity on key issues with an existing improvement plan and a recent track record of delivery against plan and/or of agreed recovery actions
    - there are other exceptional mitigating circumstances.

    For ICBs:

    - there is evidence of collaborative and inclusive system leadership across the ICS, e.g. where the system is not in financial balance, whether it has been able to collectively agree credible plans for meeting the system envelope
    - there is clarity and coherence in ways of working and governance arrangements across the system.

For trusts:

- whether the trust is working effectively with other system partners to address the problems.

12. NHS foundation trusts will only be placed in segment 3 where there is evidence that they are in actual/suspected breach of their NHS provider licence conditions (or equivalent for NHS trusts).

Mandated intensive support (segment 4)

13. An ICB or trust is eligible to be considered for mandated intensive support and entry to segment 4 if, in addition to the considerations for mandated support above, any of the following criteria are met:

- longstanding and/or complex issues that are preventing agreed levels of improvement for ICBs or trusts

  or

- a significant underlying deficit and/or a significant actual or forecast gap to the agreed financial plan

  or

- a catastrophic failure in leadership or governance that risks damaging the reputation of the NHS

  or for trusts only:

- a recommendation is made by the CQC.

14. The CQC, through the Chief Inspector of Hospitals, will normally recommend to NHS England that a trust is mandated to receive intensive support when it is rated 'Inadequate' at the single trust rating level.

15. The evidence provided by the CQC will include the reasons why it is recommending the trust is mandated to receive intensive support, the specific areas of improvement where actions need to be taken and what improvements in quality need to be achieved.

16. Based on the full range of information and judgement, NHS England will decide, following national moderation, whether the trust will be placed in segment 4 and receive intensive support through the RSP.

What happens when NHS England mandates support for an ICB or trust

Mandated support (segment 3)

17. NHS England will communicate its decision to the ICB or trust, and work with it to develop and deliver a bespoke mandatory support package through the relevant regional improvement hub, drawing on system and national expertise as required.

18. The relevant NHS England regional leadership will sign off the criteria that the ICB or trust must meet to exit mandated support (exit criteria) and the ICB or trust will develop an improvement plan with a target timeline for meeting the exit criteria.

19. Typically, the following additional interventions will be put in place:

    - enhanced monitoring and oversight of the ICB or trust by the NHS England regional team
    - NHS England advisory role for senior appointments, including shortlisting and as external assessor on interview panels.

20. The interventions listed above may be supported or implemented using formal statutory enforcement action

21. Depending on the nature of the problem(s) identified and the support need, further interventions may include enhanced:

    - scrutiny/assurance of plans
    - reporting requirements
    - financial controls including lower capital approval limits.

Mandated intensive support (segment 4)

22. NHS England will communicate its decision to the ICB or trust and then make a formal public announcement.

23. Mandated intensive support will be agreed with the region and delivered through the nationally co-ordinated RSP. The RSP has been developed to provide intensive support either at organisation level (with system support) or across a whole health and social care system.

24. A diagnostic stocktake involving all relevant system partners will:

- identify the root cause(s) of the problem(s) and the structural and strategic issues that must be addressed
- recommend the criteria that must be met for the ICB or trust to exit mandated intensive support (exit criteria) and an indicative exit timeline. These must be agreed by NHS England.

25. NHS England will review the capability of the ICB's or trust's leadership. This may lead, if necessary, to changes to the management of the ICB/trust to make sure the board and executive team can make the required improvements. Where changes are required, this will happen as soon as is practical and the necessary support will be provided to facilitate this.

26. At the same time as helping to address the specific issues that triggered mandated intensive support, NHS England will consider whether long-term solutions are needed to address any structural issues affecting the ICB's or trust's ability to ensure high quality, sustainable services for the public.

27. NHS England will appoint a system improvement director (SID) or an improvement director (ID) who will act on its behalf to provide assurance of the ICB's or trust's approach to improving performance. The SID or ID will support the ICB or trust to develop an improvement plan with an indicative timescale for meeting the exit criteria (typically within 12 months).

28. The ID will work with the trust and/or ICB to co-ordinate the necessary support from the system, NHS England teams, the broader NHS or, where appropriate, an external third party. This could include:

- intensive support for emergency and elective care
- intensive support to deliver the national programmes focused on reducing clinical variation across clinical pathways
- intensive support for workforce and people practices
- financial turnaround/recovery support including specialist support, eg to reduce agency use, implement cost controls
- drivers of deficit review

- governance review
- governance and leadership programme for improvement in challenged organisations and systems
- tailored delivery of a range of improvement programmes such as 'well led', 'better tomorrow' and 'making data count'.

29. Typically, the following additional interventions will be put in place:

    - regular formal progress and challenge meetings with national-level NHS England oversight
    - board vacancies filled on the direction of NHS England (trusts).

30. Depending on the nature of the problem(s) identified and the support need, further interventions may include:

    - NHS England-appointed board adviser
    - enhanced reporting requirements
    - enhanced financial controls including:
        - NHS England control of applications for Department of Health and Social Care financing (trusts)
        - peer review of expenditure controls
        - reduced capital approval limits (trusts)
        - rapid roll out of extra controls and other measures to immediately strengthen financial control, including those set out in NHS England guidance (including the 'Grip and Control' checklist).

31. The interventions listed above may be supported or implemented using formal statutory enforcement action

32. Where a trust is deemed to require mandated intensive support on the recommendation of the CQC, there will be close dialogue between the CQC, NHS England, the trust and ICB, which will include what improvements in quality would give assurance of progress being made. These improvements form the basis of joint reviews of progress during the mandated intensive support period, as well as the existing regular information exchange between the CQC and NHS England regional leads.

33. This process of information exchange and review will enable extra support or intervention to be considered as needed. These decisions need not wait until the next re-inspection.

34. NHS England will ensure that the trust addresses any urgent patient safety and quality issues identified as a priority. The CQC will continue to monitor quality at the trust. If at any time patients are at immediate serious risk of harm, the CQC can use its urgent powers to safeguard them.

35. The expectation is that the CQC will re-inspect the trust within 12 months of the start of mandated intensive support. It will judge if the quality of patient care and the trust's leadership have improved.

How ICBs and trusts exit from mandated support

36. Exit from mandated support will ordinarily occur when it can be demonstrated that exit criteria have been met in a way that is sustainable. Over time it may be necessary to review or revise these exit criteria. Any change to exit criteria must be approved by NHS England.

Mandated support (segment 3)

37. To be considered for removal from mandated support, an ICB or trust must demonstrate that the exit criteria have been met in a sustainable way. When deciding on a recommendation to exit, the NHS England regional team will also consider whether a targeted and time-limited post-exit support package is needed to ensure the improvement is sustained.

Mandated intensive support (segment 4)

38. To be considered for removal from mandated intensive support, an ICB or trust must demonstrate that the exit criteria have been met in a sustainable way. When making a decision on a recommendation to approve exit, NHS England will also consider the proposed transitional support package that will be needed when an ICB or trust enters segment 3 to ensure the improvement is sustained.

39. Where a trust is in segment 4 and so in receipt of mandated intensive support as a result of a recommendation of the CQC, NHS England will take account of any recommendation by the Chief Inspector of Hospitals before deciding the trust should exit that segment. The Chief Inspector will usually recommend this where

there is no reason on grounds of quality why a trust should remain in receipt of mandated intensive support – that is, if the quality of care is showing sufficient signs of improvement, even if it is not yet 'good', and if the trust leadership is robust enough to ensure that the trust will sustain current improvements and make further improvements. NHS England must also be confident that improvements will be sustained.

40. Where NHS England is not satisfied that the exit criteria have been met, mandated intensive support will be extended for a short period to allow the ICB or trust to make the improvements needed. This might occur, for example, where there have been changes to the leadership team and more time is needed for the new team to bring about change. In the case of an extension, the ICB or trust will prepare a revised improvement plan that lists actions to address any outstanding or new concerns.

41. NHS England will inform the ICB or trust in question of its exit decision once it has completed its formal decision-making processes. NHS England will then make a formal public announcement

Contact us:
enquiries@england.nhs.uk

NHS England
Wellington House
133-155 Waterloo Rd
London
SE1 8UG

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

Publication approval reference: PAR1378