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Friday 14th May 2021

Dear Ms Hardcastle,

BMA response to 'NHS System Oversight Framework 2021/22'

Please find attached the BMA's response to the NHS England and NHS Improvement consultation on its new System Oversight Framework for 2021/22.

We welcome the opportunity to share our views on the proposals and hope that our response is constructive.

Yours sincerely,

Lena Levy
Head of Public Health and Health Care, British Medical Association

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BMA Response: Consultation on a new NHS System Oversight Framework 2021/22

The BMA supports the principle of integration and has campaigned strongly for a collaborative NHS. We therefore welcome the opportunity to respond to this consultation on the SOF (System Oversight Framework) which we recognise has a role in supporting the practical delivery of this collaboration. However, as detailed below, we believe there are significant outstanding questions regarding the terms and application of the SOF as proposed, which must be addressed before it is put into practice.

Our response has been structured in line with the questions posed within the consultation document, though highlights key broader aspects where appropriate.

1. Do you agree that the proposed approach to oversight in the consultation document meets the purposes and principles set out in section 2: 'Purpose and Principles'?

We agree that the key principles all appear appropriate. We welcome the specific inclusion of compassionate leadership in particular. As the BMA has argued in our Caring, Supportive, Collaborative report, it is important that there is a culture shift in NHS leadership towards a model that promotes learning, encourages the development of systems that improve safety and quality of care, and where diversity is celebrated and there is equal opportunity and reward. We hope this principle will support that shift.

2. 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, as set out in section 3: 'Role of integrated care systems'?

We agree that the oversight of ICSs should reflect both the performance and development of the ICS. We have consistently warned of the potential ramifications of variable development of ICSs and the effective 'post-code lottery' that may result. Therefore, we believe this arrangement could provide an important means not only of tracking that development but also supporting less mature systems to progress.

We do, though, feel that an additional and more explicit focus on clinical leadership, representation, and engagement is needed in respect of the oversight of ICSs. We believe that if ICSs are to be successful it is essential that they embed the active involvement of clinicians and frontline staff at all levels. Clear recognition of the importance of the role of clinical leadership, representation, and engagement within the proposed assessment of ICS performance and development is needed.

Equally, it is essential that patient involvement is also embedded throughout ICSs, and that their experiences of care shape the plans and activities of systems. This should also be incorporated into the proposed assessment of ICS performance and development.

3. 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, as set out in section 4: 'Approach to oversight'?

The five national themes are all appropriate and we particularly welcome the inclusion of quality of care; access and outcomes; people – including staff wellbeing; and preventing ill health and reducing inequalities. Equally, the addition of local priorities as a sixth theme is important and, we hope, reflects an intention to avoid an overly top-down or check-list approach to oversight.

We welcome the emphasis on the importance of collaboration and partnership working in delivering for local populations. We strongly believe that collaboration is essential to the future of the NHS, particularly as ICSs develop, so agree that this should be reflected in system regulation and oversight.

It is important that the framework includes the proposed flexibility around the response to the Covid-19 pandemic. The pandemic – as well as the response to it – has disrupted the plans and performance of all NHS organisations and in such a way that their given targets around finances and timeliness for delivering care will be impacted for some time. We agree it is appropriate that some leeway is built into the oversight framework to account for this and to avoid punitive responses to circumstances that have largely been out of the control of individual bodies or systems. We would welcome greater clarity on how this flexibility would operate in practice, as the proposal thus far is very broad.

It is essential that the national theme centred on finance and use of resources also includes flexibility and a recognition of the wider fiscal environment Trusts and ICSs operate in. If overall funding is insufficient, as it has been for some time throughout the NHS, many ICSs, Trusts, and primary care services will inherently struggle to achieve ambitious financial targets and, as a consequence, risk being confined to segments 3 or 4 despite their lack of control over funding levels. Therefore, we believe this theme, as well as the wider SOF, should include a consideration of the impact working in a resource deprived system has on Trust, primary care, and ICS finances. The GMC includes a similar approach in its professional regulation of doctors, which rightly recognises that working in an underfunded environment can have a significant impact on their working lives

Without sight of the metrics cited in this section (15.b.) it is difficult to make a definitive judgement on the proposals. We agree that, alongside local flexibility (15.c.), it is important that there are defined metrics in place, but we believe these must also be subject to scrutiny and be published publicly.

4. 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, as set out in section 5: 'Oversight cycle'?

We broadly agree that the approach set out in section 5 should be effective in supporting regional teams to co-operate and ensure that local approaches to oversight are developed appropriately. Holding regular oversight meetings should, in our view, ensure continuous monitoring of ICS performance and development in a way that recognises the differences between the 42 systems across England. Likewise, collecting data on the schedule set out also appears appropriate and in line with the existing model.

However, there are vital aspects missing from the proposed approach – namely, the transparency of those oversight meetings and associated data, and the role of clinicians and the public in this process.

The development of ICSs, and STPs before them, has been marked by its opacity and lack of direct, meaningful engagement with doctors, staff, and the public. Therefore, as ICSs and the system oversight framework develop, we believe this needs to be addressed. Specifically, and firstly, details and minutes of oversight meetings should be published publicly, to ensure proper transparency and allow the public to have a greater understanding of the development of their local system. Secondly, we believe that clinicians, frontline staff, and patient representatives should be automatically involved in said oversight meetings, to ensure that the ongoing assessment of any given system is informed by both managerial staff, those providing frontline services, and patients.

The set of oversight metrics that NHS England and ICSs will use to flag potential issues and prompt further investigation of support needs (19) should also be made public, to ensure confidence in the approach and allow clinicians and the public to understand how their local organisations are being assessed.

5. Do you support the proposed approach to segmentation across ICSs, trusts and CCGs, as set out in section 5 page 12 - 18: 'Identifying the scale and nature of support needs'?

The proposed approach to segmentation appears appropriate and we recognise that this largely replicates and/or extends existing regulatory mechanisms, which should provide clarity and continuity. We also welcome the expectation for systems and system partners to support each other, as well as the recognition that some systems or organisations will be able to resolve financial and performance issues without mandated support.

However, we do feel that there are outstanding issues in this section that should be resolved. Firstly, how will changes in segmentation be related to and explained to staff and the public? Will details of a given body's segmentation be published publicly alongside its recovery plans? Secondly, oversight metrics are again cited here but without detail of what these metrics will be – this information should be published publicly.

In line with the inclusion of the degree to which trusts play a strong, active leadership role in their local ICS as a criterion for entry to segment 1, we would welcome clarity on if and how this will interact with the proposals for a Duty to Collaborate set out in the Government's White Paper.

Moreover, while the scope of the SOF does not include General Practice specifically, we believe that the extent to which GPs play a strong, active leadership role within ICSs should also be included as a criterion for ICS segmentation. General Practice has a vital role to play in the development and potential success of ICSs and it is essential that this is embedded within the SOF.

6. Do you have any additional suggestions that could improve the proposed overall approach to oversight, support and intervention, section 5 page 12 - 18: 'Identifying the scale and nature of support needs'?

As outlined above, we strongly believe that clinical and public engagement are vital to the development of ICS and should be included within their oversight. This should be both as a metric of performance and as an important step in the oversight process itself, with staff and the public informed of and involved in any recovery plan.

Likewise, as above, we believe that assessments of a Trust or ICS's financial performance and subsequent decisions on their segmentation under the SOF should take into account the wider fiscal environment in which they operate. This should include considerations of both current and historic shortfalls in NHS funding for systems, Trusts, and services in question - the best possible support package will be ineffective if there is insufficient funding to properly support either their improvement or sustainability.

We believe oversight of performance should also include an assessment of the extent to which a CCG, ICS, or given body has facilitated education and research. This is particularly important given the significant impact we know the Covid-19 pandemic has had on continuity of training and education for trainee doctors and other clinical staff.

Additionally, significant questions remain regarding the relationship between the SOF and other existing regulators within the NHS, as well as wider non-NHS services linked to ICSs. These include how the SOF will relate to the work of the CQC and, in particular, its regulation of General Practice. While the BMA's understanding is that the proposed SOF will not cover the regulation of General Practice or GP practices, the reference to PCNs (Primary Care Networks) within the consultation document raises questions about whether the SOF will create a further layer of regulation for GPs which need to be addressed.

7. Do you agree that the current model of special measures for individual organisations should be replaced by a more system-focused support programme, as set out in section 6: 'Recovery Support Programme'?

The proposal for the unified 'Recovery Support Programme' is in-keeping with the wider reforms taking place and should, if done right, ensure a more holistic approach to improvement support than the current separate models provide.

It is essential, however, that this support includes a recognition that Trusts – as well as community services, GP practices and PCNs, and other NHS bodies – do not exist in a vacuum and that their financial position will often be the result of, and contingent on, decisions outside their immediate responsibilities such as the overall funding allocated to the NHS or commissioning decisions.

We agree that it is important that systems play a key role in the recovery of their constituent organisations, in line with the long term development of ICSs.

8. Do you support the proposed approach to the Recovery Support Programme, as set out in section 6: 'Recovery Support Programme'?

The existing separate programmes of special measures and financial special measures are complex and frequently overlap. Therefore, combining the two into a single approach appears to be an appropriate step.

But clarity is needed on what 'long term' actions could mean in practice and what kind of changes could be made as part of the recovery process, beyond the removal of senior leaders. Particularly in the case of ICSs, it is essential that any such change is carried out carefully and with significant and sincere and early engagement with local leaders, staff, and patients, to ensure that any new leadership has their trust and confidence.

9. Do you support the proposed approach to CCG assessment, as set out in section 7: 'CCG assessment'?

We consider the proposed approach to be appropriate and particularly welcome the inclusion of specific references to addressing inequalities, implementation of the People Plan, multi-professional leadership, and adherence to the Mental Health Investment Standard.

However, clarity is needed regarding how commissioning, commissioners, and commissioning decisions will be subject to oversight via the framework as and when CCGs merge into ICSs – a process we expect will take place from Autumn 2021. Will those ICSs then be responsible for the immediate oversight of their own commissioning decisions? Will this be addressed by the wider oversight of ICSs, or will a new system need to be introduced?

We believe oversight of CCG performance should also include an assessment of the extent to which they have facilitated education and research. This is particularly important given the significant impact we know the Covid-19 pandemic has had on continuity of training and education for trainee doctors and other clinical staff.

While we note the focus on health inequalities within the proposed approach to CCG assessment, as well as the wider SOF, we are conscious that there is no reference to public health in the consultation document. Public health doctors and teams will have a vital role in the tackling of health inequalities both now and even more so as ICSs mature. Therefore, we would welcome a recognition of the role of public health and the importance of CCG and ICS relationships with public health teams within the framework.

Clarity is also needed on how the SOF and regulation of ICSs will interact with other regulators and organisations with oversight of elements of an ICS's work – such as Local Authorities and their responsibility for public health services. As raised above, this same question also applies to the SOF's relationship to other regulators operating within the NHS – namely the CQC – and to the regulation of other services, such as General Practice.