# NHS Oversight and Assessment Framework



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1. Introduction
2. The NHS England [Operating Framework](https://www.england.nhs.uk/wp-content/uploads/2022/10/B2068-NHS-England-Operating-Framework.pdf) published in October 2022 sets out how our ways of working have evolved to reflect the development of integrated care systems (ICSs). It describes how we work with integrated care boards (ICBs), providers, and wider system partners to improve local health and care outcomes, maximise value for taxpayer money and deliver better services for our patients.
3. Detailing our approach to NHS oversight and assessment is critical to the implementation of our Operating Framework, driving a culture of continuous improvement, and building on our commitment to support ICBs to achieve full maturity. Following the coming together of NHS England and NHS Improvement, we published our first System Oversight Framework in September 2021. This was replaced by an updated NHS Oversight Framework published in July 2022 to coincide with the establishment of ICBs.
4. Two years after the last update to the framework, we have worked with ICBs and providers on our oversight and assessment approach and sought feedback. In order to better serve patients, system partners have expressed a desire for greater clarity of roles and responsibilities, use of a broader range of short- and medium-term outcome measures, less subjectivity in measuring success, and adoption of mature relationships in supporting organisations to improve. This NHS Oversight and Assessment Framework responds to that feedback and builds the foundations set out in our Operating Framework.
5. The framework has been developed for consultation following a period of engagement. It highlights the importance of all partners playing their part in mutually successful systems as well as balancing the need to deliver against immediate priorities and longer-term sustainable improvement. Our approach ensures that we:
	* + - 1. have a robust process of oversight, transparency and accountability that rewards improvement and bring all parts of the NHS system together around common goals, realising benefits for patients, staff and wider society
				2. have a clear approach to developing leadership capability in line with the findings of the [Messenger Review](https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future), giving leaders the tools they need and the competency to drive change
				3. can explain how improvement will be delivered through the principles established as part of [NHS IMPACT](https://www.england.nhs.uk/nhsimpact/)[[1]](#footnote-2) and NHS England’s support offer
6. The framework applies to ICBs and providers[[2]](#footnote-3) and it supports the NHS system[[3]](#footnote-4) partners to develop approaches to oversight that reflect:
	* + - 1. a shared understanding of the accountabilities and roles between each member of the NHS system, how performance is monitored, and how support or intervention needs are identified and addressed
				2. the importance of delivery against both individual and shared system priorities
7. Oversight and assessment
8. The NHS Oversight and Assessment Framework. It serves 4 core purposes:
	* + - 1. to align priorities across the NHS and with wider system partners to drive shared ownership of improvement
				2. to enable the sharing of good practices to support mutual improvement
				3. to identify where ICBs and/or providers may benefit from or require support or intervention, and
				4. to provide an objective basis for decisions about when and how NHS England intervenes using our regulatory powers should this be necessary
9. Our approach to oversight is characterised by the following key principles:
	* + - 1. as set out in the Operating Framework, effective leadership behaviours that underpin all interactions
				2. balancing the contributions of individual organisations with shared system performance and outcomes
				3. working in partnership with ICBs to discharge our respective responsibilities
				4. understanding variation and, where appropriate, holding organisations responsible
				5. promoting system-led improvement and mutual accountability
10. For this document, oversight and assessment are defined as:
	* + - 1. **Oversight** is the ongoing monitoring of performance and quality of services being delivered by the NHS, to manage the delivery of the priorities set out in [NHS planning guidance](https://www.england.nhs.uk/operational-planning-and-contracting/), the NHS Long Term Plan, and the [NHS Long Term Workforce Plan.](https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/) Its purpose is to provide assurance of performance and delivery as well as identify areas of challenge and those requiring support or intervention. The oversight framework specifically sets out how ICBs and NHS trusts and foundation trusts are overseen, it does not cover the oversight of primary care providers who are overseen by ICBs in line with their delegated commissioning responsibilities.
				2. **Assessment** is the process by which we judge an organisation’s capability and governance. For ICBs, NHS England has a statutory responsibility to conduct a performance assessment for each financial year. We have no similar statutory duty for providers but we work alongside the Care Quality Commission (CQC) to ensure these organisations are providing safe and effective care and delivering services in line with the conditions of their provider licence.
11. A critical element of oversight is 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 providers are expected to escalate issues where there are significant actual or prospective changes in performance or quality risks in line with our Operating Framework.
12. Roles and responsibilities
13. The NHS England Operating Framework defines each organisation’s roles and responsibilities in oversight. We are responsible for overseeing the performance of ICBs and providers but may choose to ask ICBs to carry out the oversight of providers in their NHS systems in the first instance.
14. The ICB is responsible for arranging for the provision of healthcare services to meet the health needs of its local population, alongside other statutory duties. The ICB is the leader of the NHS system within its ICS and oversees the delivery of joint system plans and strategies requiring mutual accountability. A key element of discharging its responsibilities is to ensure that the service-delivery models in its NHS system are working effectively via place-based partnerships, provider collaboratives, the primary-secondary care interface and integrated neighbourhood teams. It should lead the oversight of individual providers in line with the principles outlined in this document, and co-ordinate support or interventions within its NHS system, where appropriate, working in partnership with us. We also expect all ICBs to have a robust commissioning approach that works with local communities, providers of healthcare services and their local authorities in partnership.
15. Providers are responsible for providing safe, effective, efficient, and high-quality services. The provider must work effectively with its NHS system partners to deliver its contributions to shared objectives, plans and priorities, including financial and operational performance. It must comply with the NHS provider licence and standards set by regulators.
	1. Oversight of providers
16. ICBs and NHS England both have responsibilities to oversee providers under the [NHS Act 2006](https://www.legislation.gov.uk/ukpga/2006/41/contents). ICBs, using their contractual and other powers, ensure the services they commission from providers are high quality, value for money and sustainable. NHS England ensures the timely and proportionate use of its statutory powers to intervene and if necessary, require action from providers that are at risk of underperformance or quality deterioration. In particular, this may involve the use of our statutory powers to take enforcement action against a provider if there is a suspected or actual breach of its licence.
17. In line with our Operating Framework, we aim to discharge our responsibility for overseeing providers through[[4]](#footnote-5) the relevant ICB, asking the ICB to oversee the providers in its NHS system in the first instance. In some circumstances, however, we may need to take a more direct role and oversee providers with the ICB as partners, such as where there are areas of challenge or improvement opportunities or services not being delivered to standards we all aspire to. This will be the case in the areas of key national priorities of urgent care, elective care, cancer care, primary care, mental health care and finance as set out in paragraph 36. In these circumstances, we will work with the ICB and other parts of the NHS system as needed to provide support and otherwise intervene as needed to ensure NHS systems can deliver high-quality care to the desired standard. This builds on our successful approach to elective, cancer and urgent care recovery to ensure intervention is targeted, proportionate and drives rapid improvement.
18. Where we are working with an ICB to oversee the providers in its NHS system, we will set out agreed ways of working in an annex to the ICB annual assessment letter (see section 5.1 for ICB annual assessment). This will ensure our joint oversight approaches are aligned, and streamlined, and duplication is minimised.
19. The oversight responsibilities of ICBs include, but are not limited to:
	* + - 1. overseeing the commissioning and management of contracts, delegation and partnership agreements with providers
				2. leading the day-to-day oversight of providers across their NHS system, including but not limited to provider collaboratives, providers that function across multiple ICBs, independent providers, and primary care providers to ensure effective arrangements are in place to deliver on plans, performance, outcomes, and transformation
				3. advising us on the support or intervention needs of their providers within their NHS system according to the principles of oversight detailed in this framework, and supporting the resolution of these issues per agreed recovery plans
				4. managing NHS system-wide risks and delivery against performance, quality, and financial plans, and acting as liaisons with us for matters relating to providers in their NHS system (except for those services directly commissioned by us), including timely and transparent escalation of issues
				5. working in partnership with providers, alongside other partners, to find local resolutions to risks, concerns and challenges, and co-ordinate and tailor necessary support or intervention
				6. providing assurance and input into regulator assessments of providers and NHS systems, including those led by CQC
20. We determine our level of confidence in an ICB’s capability through an assessment process with an aspiration that all ICBs will reach a rating of ‘Excelling’ or ‘Achieving’ (see section 5.2 for ICB capability). Generally, those ICBs rated ‘Excelling’ or ‘Achieving,’ will lead the oversight of providers that have a segment of 1 or 2 (see section 4.2 for segmentation) in their NHS systems, and work in partnership with us for the oversight of providers that have a segment of 3 or 4.
21. ICBs are at different stages of maturity and for those that have a capability rating of ‘Progressing’ or ‘Insufficient progress’, we will work in partnership with them to jointly oversee the providers in that NHS system.
22. The common principles for both circumstances include:
	* + - 1. provider oversight arrangements for each NHS system are set out in the annual assessment letter from the regional director to each ICB’s chair and chief executive
				2. ICBs recommend support or intervention for a provider to us where required but we make final decisions on segmentation and enforcement action, where necessary
				3. ICBs play an active role in:
		1. proposing the transition criteria providers in receipt of formal support or intervention have to meet to exit intervention
		2. supporting the provider in meeting those criteria
23. The key features of our oversight of providers with or through an ICB are detailed in Table 1.

Table 1: Oversight of providers with and through ICBs

|  |  |
| --- | --- |
| **Provider oversight led through an ICB rated as ‘Excelling’ or ‘Achieving’ in the first instance** | **Provider oversight led in partnership with an ICB rated as ‘Progressing’ or ‘Insufficient progress’** |
| * In terms of oversight, NHS England typically only has contact with the provider without the ICB in agreed circumstances, for example, to understand best practices and improvement opportunities, direct commissioning relationships, and where there are exceptional challenges including significant underperformance in key national priority areas
* ICB oversees performance, quality, finance and delivery against system plans through robust governance arrangements and review meetings with providers
* ICB and provider have open and mature discussions on issues and challenges, including any early warning signs, and agree on the way forward
* ICB acts as a liaison for the provider with NHS England and escalates issues in a timely and transparently way
* ICB proactively manages system and provider risks, seeking support from us as and when required
* ICB finds local resolutions to issues and challenges in a provider through leadership, peer support, facilitating mutual aid, etc.
* ICB reports to NHS England as necessary on provider-level performance, quality, finance, and progress towards agreed targets
 | * NHS England oversees the provider with the ICB (potentially through a jointly-chaired forum) and shared review meetings are held regularly to discuss quality, performance, finance, and progress against improvement plans
* We may provide direct oversight and support to providers with the awareness of the ICB
* We actively support the ICB in managing risks related to the provider’s issues, and finding resolutions to issues and challenges
* We decide the structure of support or intervention for the provider (having regard for the ICB’s advice) including whether to seek entry into the Recovery Support Programme (RSP) and/or to take enforcement action
* We work with the ICB to agree on an improvement plan for challenged providers, sets the ‘transition criteria’ and planned timelines for any support or intervention, and takes an active role alongside the ICB in monitoring progress and supporting providers to meet those criteria
 |

1. The oversight relationship for providers that work across multiple ICBs is primarily with the lead commissioner (the ICB to which the provider is apportioned for financial control purposes per the [NHS Data Service Directory](https://digital.nhs.uk/services/organisation-data-service/export-data-files/csv-downloads/other-nhs-organisations)[[5]](#footnote-6)). The lead ICB will work with other commissioners where duplication needs to be avoided or specific issues addressed. ICBs should follow our [guidance on the commissioning of ambulance services](https://aacesite.s3.eu-west-2.amazonaws.com/wp-content/uploads/2022/12/04104046/ICB-Commissioning-of-Ambulance-Services-FINAL-v1.1.2-_2_.pdf) where applicable.
2. For independent providers, ICBs are expected to oversee quality and performance through contractual levers and escalate quality concerns using appropriate regional forums. We continue to oversee certain independent providers and NHS-controlled providers under [the Independent Provider Risk Assessment Framework (IPRAF)](https://www.england.nhs.uk/long-read/risk-assessment-framework-and-reporting-manual-for-independent-sector-providers-of-nhs-services/) and NHS Oversight and Assessment Framework, working with relevant ICBs as appropriate.
3. For providers of primary care services, ICBs are responsible for contracting and overseeing them for their population including those services for which we have delegated commissioning responsibility. They are not overseen under this framework, and we will work with ICBs to understand and oversee the system's primary care delivery in line with the ambitions of the [delivery plan for recovering access to primary care](https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/) and will be expected to account to NHS England for primary care performance within their system. ICBs must also complete an annual self-certification confirming that they are discharging the primary care commissioning functions NHS England has delegated to them per the expectations set out in the [primary care commissioning assurance framework.](https://www.england.nhs.uk/publication/primary-care-commissioning-assurance-framework/) These self-certifications will also be taken into consideration in ICB capability assessments (see section 5.2 on ICB capability assessments).
4. Regardless of whether oversight of providers is being carried out with or through the relevant ICB, providers remain accountable to NHS England under the terms of the Act and decisions on the use of statutory enforcement powers continue to rest with NHS England. We may work directly with providers regardless of their segment in certain situations including:
	* + - 1. where we directly commission services of the provider such as health and justice, armed forces, and highly specialised healthcare services
				2. where we want to learn from success by working with local leaders to shape best practices in conjunction with expert providers. All leaders across the NHS should expect to work in an agile way to ensure a collective approach to service improvement
5. The standard oversight arrangements apply to those services for which the commissioning has been delegated from NHS England to ICBs but with NHS England retaining accountability (such as primary care and some specialised services). However, there may be additional assurance requirements aligned with delegation agreements and respective assurance frameworks. This will also be taken into account as part of the ICB capability assessment.
6. In circumstances where ICBs are leading the oversight of providers and there are significant disagreements between a provider and its ICB, it is expected that these would be first discussed and resolved at a chief executive and chair level. However, if that is unsuccessful, then providers may escalate issues with their relevant regional director.
7. Oversight model
8. Our oversight model is built around 4 national objectives that reflect the contribution of ICBs and providers to the fundamental purposes of an ICS and a set of high-level metrics at ICB and provider level aligned with these purposes, which are transparent and balanced to reflect both current operating priorities and longer-term strategic ambitions and expectations (see Table 2). These are underpinned by a set principles of how we work with ICBs and providers to identify support needs, deploy support or intervention and drive improvement to address the most complex and challenging problems. Detailed guidance on the composition of each metrics and how these are objectively rated will be published in a separate technical document. We also intend to publish the metric data by organisation.

Table 2: Metrics to assess organisations’ contribution to NHS system objectives as set out in the NHS delivery metrics, updated annually to reflect the latest priorities

|  |  |
| --- | --- |
| **Objectives** | **Sub-Domain** |
| Improve population health and health care | Urgent and emergency care |
| Elective care |
| Cancer care |
| Diagnostics |
| Mental health care |
| Learning disabilities and autism care |
| Primary and community care |
| Children and young people |
| Frailty |
| Tackle inequalities in outcomes, experience and access | Inequalities in access and outcomes |
| Outcomes and prevention |
| Enhancing productivity and value for money | Finance |
| People |
| Support social and economic development | Social value |

We will assign individual types of organisations (ICBs and acute, mental health, community and ambulance providers) the appropriate metrics across the domains to reflect their contribution to the overall NHS priorities in their system and how these are measured.

Figure 1: overall oversight elements



* 1. Monitoring
1. As part of our oversight process, we monitor and gather insights across the oversight domains. The information collected and reviewed includes both quantitative data using the defined delivery metrics as well as qualitative information. Qualitative information may include that derived from ICBs and providers as part of routine conversations, reports from other regulators such as the CQC including ICS assessments, any emerging clinical quality risks in line with the [National Quality Board guidance on risk response and escalation](https://www.england.nhs.uk/publication/national-guidance-on-quality-risk-response-and-escalation-in-integrated-care-systems/), as well as other relevant information provided by third parties such as through 360-degree feedback, peer reviews, or formal publications/assessments.
2. Alongside this, we work with key regulators including the CQC, the Health and Care Professions Council, the General Medical Council (GMC) and the Nursing & Midwifery Council (NMC) through the national and regional Joint Strategic Oversight Group (JSOG) which provides a dedicated space for regulators to share intelligence and develop aligned approaches to support organisations.
3. We hold regular review meetings with ICBs and, where appropriate, providers to discuss emerging issues and track progress against any agreed improvement plans. The expectations for the membership, scope, and frequency of these meetings are set out in Table 3. Ongoing regular meetings may be complemented by focused engagement and escalation where specific challenges emerge, or where an organisation is in the Recovery Support Programme.

|  |
| --- |
| **Scope** |
| **ICB*** ICB’s unique contribution to overall system performance and quality and delivery against the 4 purposes of an ICS
* Effectiveness of current support or intervention arrangements of ICB and its provider partners and the extent to which these may need to be refined
* Extent to which NHS system partners are working effectively together to deliver and improve
* Assurance of commissioning and delivery of delegated services, including but not limited to primary, optometry, dental, and certain specialised services
 | **Provider*** Oversight of and support or intervention to:
* individual organisations, including those that span multiple ICSs, for example ambulance providers and specialist providers
* collaboratives that span multiple places, including for the delivery of specialised services
* place-based partnerships
* Scope is determined by the specific issues identified in discussion between NHS England and ICB leadership
 |
| **Roles and participation** |
| **ICB*** Led by NHS England with:
* ICB leadership team
* relevant national experts
* by exception senior leaders from NHS system/ providers/ organisations where there are specific concerns regarding their organisations
* For organisations in the Recovery Support Programme (RSP), these meetings are led by the National programme team
 | **Provider*** Led by the ICB in line with arrangements set out in the ICB’s governance handbook.
* May involve NHS England in situations where:
* we have concerns regarding a provider being in breach or potential breach of their license conditions
* ICB has requested expert support from us
* provider is in segments 3 or 4
* ICB has a capability rating of Progressing or Insufficient progress
 |
| **Frequency of review meetings** |
| * The meeting frequency will vary according to the governance arrangements agreed between our regional team and ICB, but is expected to be at least quarterly
* We may engage more frequently where there are material concerns or where the RSP is involved
* An annual meeting linked to ICB’s annual performance assessment
 | * The meeting frequency will vary according to the governance arrangements agreed between our regional team, ICB, and provider leadership but is expected to be at least quarterly
* We may engage more frequently where there are material concerns or the RSP is involved
 |

Table 3: Ongoing monitoring process – review meetings

* 1. Identifying the scale and nature of support or intervention needs
1. Each ICB and provider is assigned a segment between 1 and 4 indicating their respective level of delivery and support or intervention needs. We make decisions on segments by considering the following elements:
	* + - 1. a set of objective, measurable criteria based on metrics associated with the 6 domains of the oversight framework
				2. a set of ‘additional considerations’, that is, the aggregated NHS system performance on key national priorities such as urgent and emergency care, elective care, mental health care, primary care, and finance
				3. the capability of the organisation to improve without additional support or intervention
				4. the organisation’s improvement trajectory along with the role it is playing in supporting its NHS system partners in meeting shared priorities. We also consider whether challenges are long-standing and how the organisation is working to address them
2. Primary care providers, primary care networks (PCNs), and other non-trust providers or partnerships such as provider collaboratives are not allocated their own segments. These partnerships do, however, influence the ICB’s segment and the overall system performance.
3. Indicative delivery scores are determined through a metric-driven process based on a range of measures linked to the unique contribution of the ICB or provider to the specified oversight domains detailed in Table 2. The metrics that are used to determine this initial score are reviewed on an annual basis and reflect a balance between the major operating priorities of the NHS and longer-term strategic and cultural improvement measures. The list of metrics being used to guide segmentation is published on our website and is derived with consideration of any assessments by the CQC.
4. Each metric is individually scored and contributes to a specific ‘domain’ score. Domain scores are then brought together to form the indicative delivery score. Metric and domain scores may also be used in their own right to support the diagnosis of issues that could benefit from targeted support or interventions on specific pathways. The scoring model for each individual metric is detailed in a separate technical document but will generally be based on:
	1. a quartiled approach where there is no defined benchmark or standard
	2. where a defined standard to be achieved exists those meeting the standard will receive a score of 1. The remaining organisations will be scored 2 – 4 based on tertiles
	3. where there is not a defined standard but there is an expectation to progress or improve those not delivering an improved position will receive a score of 4, this includes organisations who fail to supply data. The remaining organisations will be scored 1 – 3 based on tertiles
5. We are adopting a quartiling/tertiling approach as we looking to assess variation while the NHS recovers toward national standards. As recovery occurs, we will consider how and where to introduce thresholds.
6. As well as demonstrating relative delivery performance through the 1 – 4 scoring, we will also provide details on overall trajectory to recognise those organisations that are improving, maintaining or declining in delivery terms.
7. The indicative delivery score of an individual ICB or provider is then moderated to consider ‘additional considerations’ taking into account the wider performance and delivery of the NHS system focusing on key national priorities. We will consider whole system perspectives of urgent care, elective care, cancer care, primary care, mental health care and finance. This is to ensure that consideration is given to shared priorities for which both ICBs and providers have a role in delivering. 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 (see Annex D). Once this consideration has been completed this will result in a provisional delivery score for each organisation.
8. If only one additional consideration area is challenged, then targeted intervention will be applied in that area and the provisional delivery score cannot be 1.
9. The provisional delivery score will then be translated into a ‘segment’. This segment is determined by taking the provisional delivery score and considering:
	* + - 1. the capability of the provider or ICB to address delivery performance issues
				2. its improvement trajectory
				3. the role it is playing in supporting its broader NHS system partners
				4. whether challenges are complex and long-standing
10. The capability for ICBs and providers includes consideration of their capability ratings (see sections 5.2 and 5.3). Where an organisation has high capability, its segment may be improved by one level from its provisional delivery score recognising the confidence in the organisation’s capability to address the issues identified and the level of support requirements. Equally, where an organisation’s capability is low, the segment may deteriorate by one level from the provisional delivery score.
11. The provisional segment undergoes a moderation process to ensure that the segmentation decision is robust, proportionate and defensible. If the moderation concludes that the final segmentation decision should differ from the provisional segment, this will go through a process of calibration to ensure consistency in decision-making. Once we have approved the final segmentation decision, this is officially conveyed to the organisation and published on our website.
12. Segments are reviewed at least quarterly as part of a review meeting but may be updated at any time based on emerging information. For individual providers, their ICB may make recommendations on segments based on provider capability and an evaluation of support or intervention needs as well as confidence in plans to deliver improvement.

We will consider the advice from the ICB but we are responsible for making the final decision on the segment and taking enforcement action if this is required.

Table 4: Segment definitions and expectations

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Segment** | **Description** | **How we will support** | **How we will drive improvement** | **How we will intervene** |
| 1 | Consistently high-performing across domains, delivering against plans and operating in a high-functioning NHS system. Has a track record of successful delivery or effective recovery. | No specific support or intervention needs are identified. Expected to offer peer support to others or support the development of best practice tools. | Will work alongside us to develop best practices and improvement initiatives in areas in which the organisation excels. May be asked to work with us to provide an expert challenge to other organisations. | The use of our enforcement powers is not compatible with this segment. Where enforcement action is required, the organisation will be assigned a delivery segment of 2 or more. |
| 2 | Developing with confidence in the ability to improve further and operate in a high-functioning NHS system. Specific issues exist with plans in place that have the support of system partners. | The organisation can diagnose and clearly explain its support needs which will be predominantly supplied locally. Our support on specific issues is provided where appropriate. | Will work with us to support the development of best practices in areas of high performance. Targeted support aimed at improving specific pathways where issues have been diagnosed. | Due to the relatively high-performing nature of the organisation and its level of maturity, the use of enforcement powers will not be common but may be used where specific issues call for this approach. |
| 3 | ICB or provider and/or wider system are significantly off-track in a range of areas. We lack confidence in the capability to respond to challenges without support. | Support needs are diagnosed together and delivered through local support offers, defined national support programmes and bespoke regional interventions. | Receives enhanced scrutiny targeted at delivering improvement in the most challenged performance areas. Recovery KPIs and trajectories are agreed upon and proactively monitored. | We may apply interventions and/or direct an organisation to take specific actions related to diagnosed issues. Enforcement action may be taken where required.  |
| 4 | There have been multiple serious failures of patient safety, quality, finance, leadership, or governance or the ICB or provider and NHS system face serious, long-standing and complex issues requiring an intensive co-ordinated response  | The Recovery Support Programme (RSP) supports the ICB or provider in undertaking a full diagnostic to identify support needs and develop a full recovery plan in collaboration with system partners | We appoint an improvement director to intensively support the organisation to meet improvement goals. Increased scrutiny to ensure delivery of the agreed recovery plan and meet transition criteria to transition to segment 3. | Entry into the Recovery Support Programme (RSP) and subsequent enforcement action are agreed through relevant executive governance group. Transition out of RSP into segment 3 requires transition criteria to be met.  |

* 1. Implementing support or intervention activity
1. We provide direct support or intervention in circumstances such as the following:
	* + - 1. an ICB or provider has been assigned a delivery segment of 3 or 4, or there is significant underperformance of a key national priority
				2. an ICB or provider does not have the necessary capability to lead the requisite improvement
				3. improvement is not being seen at the pace or scale required
				4. there has been a serious failure of governance, leadership, finance, quality, or patient safety, or there are long-standing challenges
2. While it is not expected that our support offers will cover all support needs for challenged organisations as some support will come via NHS system partners and peers, we will continue to keep support needs of ICBs and providers under review to inform future offers.
3. All organisations may benefit from the universal support offered under our [NHS IMPACT Programme](https://www.england.nhs.uk/nhsimpact/). NHS IMPACT supports the delivery of clinical and operational excellence, both by helping to develop the leadership and organisational capacity, capability and infrastructure to create the conditions for improvement and delivering a small number of programmes to drive adoption and local adaptation of operational processes and clinical pathways that are proven to improve quality and productivity.
4. ICBs and providers assigned a segment of 2 may receive targeted support aimed at improving specific pathways where issues have been diagnosed, such as our offers of support on elective, cancer, and urgent and emergency care recovery.
5. Where an ICB or provider is assigned a segment of 3, NHS England regional teams work with the ICB or provider (for providers this also includes their relevant ICB) and agree the support or intervention needed to transition to segment 2. The agreed support or interventions are recorded and form part of the regular review discussions.
6. Our most intensive support intervention is the Recovery Support Programme (RSP) which is reserved for ICBs and providers assigned a segment of 4. For these organisations, the transition criteria to move to segment 3 are agreed between the region and the programme team, approved through the relevant NHS England governance group, and organisations receive direct support from an improvement director to meet those criteria. These organisations may be subject to enforcement action and leave the programme when the transition criteria have been met in a manner deemed sustainable by the relevant regional and RSP teams and approved by the relevant NHS England governance group. The NHS system partners of these organisations will be expected to provide support where improvements require system-wide action and may also be considered for formal intervention where required. An overview of the RSP is set out in Annex B.
7. Any support or intervention an ICB or provider is receiving is examined as part of regular review meetings to determine whether it is having the desired impact or whether the approach requires adaptation. For organisations in the RSP, this review of support or interventions takes place at escalation meetings and any change in transition criteria, planned timelines, or support has to be agreed through the relevant NHS England executive governance.
8. In some circumstances we may determine that it is necessary to invoke our formal powers of enforcement in response to an identified issue. The [NHS enforcement guidance](https://www.england.nhs.uk/publication/nhs-enforcement-guidance/#:~:text=This%20guidance%20outlines%20how%20NHS,licensed%20independent%20providers%20of%20NHS) contains further details on the circumstances and procedures for taking any such action.
	1. High-performing organisations
9. For organisations that are allocated to segment 1 for at least 1 year, we may consider undertaking the formal oversight meetings on a bi-annual basis, with quarterly informal touchpoints to discuss any emerging issues, opportunities, and hot topics.
10. They may also have access to flexible improvement resources and national leadership opportunities, including taking a role in policy formation with NHS England.
11. Assessment
	1. ICB annual performance assessment
12. NHS England has a legal duty[[6]](#footnote-7) to annually assess the performance of each ICB in respect of each financial year and to publish a summary of its findings.
13. The assessment must consider how well the ICB has discharged its functions and include, but not be limited to, how effectively it has discharged the following specific duties, required under the terms of the Act:
	* + the duty as to improving the quality of services
		+ the duty as to reducing inequality of access and outcome
		+ the duty to obtain appropriate advice
		+ the duty to facilitate, promote and use research
		+ the duty to have regard to the effect of decisions (the ‘triple aim’)
		+ the duty to make arrangements to involve patients, carers and the public in commissioning plans and decisions that affect them
		+ the ICB’s financial duties
		+ the duty to have regard to certain wider local needs assessments and strategies
14. As of 2024/25, our annual performance assessment of ICBs in respect of the preceding year will include consideration of the following:
	* + - 1. an annualised delivery score resulting in a segment of 1-4 (see section 4.2)
				2. a capability assessment, which includes looking at how the ICB has performed its functions during the year, by reference to 6 core functional areas over the year (see section 5.2), the outcome of which will include a capability rating
15. In quarter 2 of each financial year, NHS England will hold a meeting with each ICB dedicated to discussing its annual performance assessment for the preceding year. As part of this meeting, we will discuss the outcome of our capability assessment in respect of the previous year, reflect on existing and emerging issues, and invite the ICB to make any representations that it feels are appropriate.
16. Alongside the capability assessment we will also summarise our views of the ICB’s overall delivery taking into consideration the segment for quarter 1 and performance over the previous year, as well as reflecting on overall delivery against local and national objectives.
17. The ICB’s capability rating and delivery segment for the previous year will then be agreed by the relevant NHS England governance group and formally communicated to the ICB’s chair and chief executive in a letter from the relevant regional director. This letter will, in addition to the headline findings, contain a summary report that outlines the areas in which the ICB has performed strongly and could support others as well as any identified areas for development and any subsequent support we will provide in the year ahead, including signposting to any relevant development support offers. The letter will also include an annex detailing the agreed ways of working between us and the ICB[[7]](#footnote-8). This will include, but may not be limited to:
	* + - 1. how we will work with the ICB to oversee providers in that NHS system
				2. how we will oversee the commissioning of delegated services including primary care services and some specialised services
				3. how we will support the ICB to oversee the delivery of key operational and forward plans
18. If an ICB or provider is entering the Recovery Support Programme (RSP), it will receive a letter from the relevant NHS England national executive.
19. ICB boards will be asked to present and publish their annual assessments alongside their annual report and accounts as part of a public meeting while NHS England will publish a summary of each annual assessment as required by the Act.
	1. ICB capability assessment
20. The ICB capability assessment forms part of our annual performance assessment for each ICB. Our capability assessment of ICBs is based on 6 functional areas listed in Table 5 alongside the criteria ICBs need to meet to assure us that they are delivering their contribution to the 4 purposes of ICSs and have effectively discharged, and will continue to discharge, their statutory duties and powers. The supporting activities that ICBs should undertake for each of these functional areas are outlined in Annex A. Each functional area requires a high level of expertise within the ICB and a collaborative approach to working with local partner organisations.

Table 5: Functional areas for ICB capability assessment

|  |  |
| --- | --- |
| **Area** | **Criteria** |
| **Strategy and planning** | Developing strategies with the integrated care partnership (ICP), and corresponding delivery with providers and partners, that are based on an assessment of population health needs and community insight and will improve health outcomes. |
| **Leadership of the NHS and partnership working** | Building strong partnerships and effective governance and decision-making arrangements between partner organisations and stakeholders, including the voluntary, community, and social enterprise sector, in the ICS that enable organisations to work together to deliver agreed plans. |
| **Arranging for the provision of care services (commissioning)** | Working in collaboration to shape the design of services and plan and allocate resources for healthcare service provision (including delegated commissioning functions based on population health needs. |
| **Assuring performance, quality and delivery** | There are clear arrangements for assuring quality, performance, delivery, and financial accountability against agreed ambitions and spending limits. Ensuring that an appropriate response is in place to address risks to delivery and drive improvement. |
| **Securing transformation and learning** | Driving the system-wide transformation of services, workforce, data, digital and estates and an embedded approach to learning, which supports innovation and research, enabling service quality improvement. |
| **Effective governance and people** | Ensuring that the ICB is an effective and well-run organisation with a high-performing board, robust governance and a healthy workforce and culture. |

1. We will undertake an annual capability assessment of each ICB as part of the annual assessment process (see section 5.1). This may be reviewed and updated in-year if there is a significant change in circumstance.
2. The capability assessment will result in a descriptive capability rating as outlined in Table 6. The final rating will be determined by the individual ratings given to each functional area. Once finalised, both the functional level ratings and overall rating will be published alongside a narrative description of how the rating decision was reached, including highlighting areas of good practice and areas where further improvement may be required, as well as signposting to any relevant development support offers. This narrative will also support leadership teams in appraising and self-assessing in line with the expectations of the NHS Leadership Competency Framework.
3. We will use the ICB’s capability rating to inform our subsequent decisions on an ICB’s segment and associated support or intervention needs.

Table 6: ICB capability ratings

|  |  |  |
| --- | --- | --- |
| **Rating** | **Rating description** | **Potential support or interventions** |
| Excelling | The ICB can demonstrate it fully delivers/excels against all key lines of enquiry outlined under each activity | No Specific support or intervention needs are identified. Expected to offer peer support to others or support the development of best practice tools. |
| Achieving  | The ICB can demonstrate it fully delivers against most of the key lines of enquiry under each activity (with partial delivery against some) | Limited support or intervention is required. Support on specific issues may be provided where appropriate. |
| Progressing | The ICB can demonstrate partial delivery of all key lines of enquiry under each activity or full delivery of a small number | We work in partnership with the ICB to oversee the providers in the ICS. Bespoke regional support may be provided to develop capability.  |
| Insufficient progress | The ICB has not demonstrated, or cannot currently demonstrate, delivery against the key lines of enquiry / can only demonstrate partial delivery of some key lines of enquiry under the activities | We work in partnership with the ICB to oversee the providers in the ICS. We may consider entry of the ICB into the Recovery Support Programme if we are sufficiently concerned and if approved at the relevant NHS England governance group. |

5.3 Provider capability assessment

1. The NHS provider licence sets specific requirements on trust governance, including the ability to deliver national priorities, maintain standards of organisational and quality governance, and collaborate effectively with system partners.
2. To reflect this, we will consider the provider's capability when allocating it to a segment. This will incorporate, for a given provider:
	* + - 1. its CQC well-led rating
				2. issues uncovered following any relevant third-party information
				3. the provider boards’ organisational awareness and track record of delivery
3. We will also consider the extent to which the provider is collaborating with partners to improve system performance.
4. Provider issues in recent years demonstrate the importance of capturing and responding to third-party information that may highlight these. We will consider the results of any investigations arising from information received from sources including:
	* + - 1. other regulators, such as the Health & Safety Executive, the Information Commissioner and the Human Tissue Authority
				2. professional medical and clinical bodies, such as the GMC, NMC and Royal Colleges
				3. information from the ICB and CQC ICS reviews which may flag any collaboration issues
				4. clinical and cultural issues, for example, coroner reports, whistleblowing and Freedom To Speak Up (FTSU) information or adverse staff survey results
5. Provider boards represent the first line of oversight and assurance. To reflect this, and endorse a level of organisational responsibility, collaboration with system partners, and commitment to continuous improvement, we will require boards to quarterly self-assess against specific operational areas on behalf of their organisation. These areas will include strategy, quality, people, access, productivity and finance. A full list of the proposed criteria by area can be found in Annex B.
6. We will use the self-certification both prospectively and retrospectively in 2 ways:
	* + - 1. where providers cannot certify against these requirements, we will seek to understand the reasons why and to identify planned actions to address this
				2. subsequent delivery (or not) against these self-certified requirements will inform our and the relevant ICB’s views of management teams and any support or development needs[[8]](#footnote-9)
7. Where an issue arises, NHS England and/or the ICB will engage with providers to consider:
	* + - 1. the extent to which the provider was aware of the issue
				2. robustness of plans to address it and management’s ability to do so
				3. subsequent delivery of plans to address the issue
8. Where circumstances change and a provider can no longer meet its self-certification, boards will by exception be expected to inform both us and their ICB immediately. For example, where a board becomes aware of serious whistleblowing or speaking up concerns which, if verified, could impact its certification, or there is a sudden and unexpected change in the trust’s costs or income.
9. Provider capability is assessed annually by the ICB with input from us where oversight is being discharged through the ICB in the first instance. Where we are overseeing a provider with the ICB, we will lead the provider capability assessment with input from the ICB. ICBs will be expected to manage any conflicts of interest while undertaking this exercise. Provider capability is kept under review and may be changed in-year if there are significant changes in circumstance such as new third-party information. Provider capability will be rated as either ‘**No material concerns**’, ‘**Some concerns – provider under review**’ or ‘**Major concerns**’. See Annex C for more information.
10. We will use the information above to inform our final decision on the delivery segment we allocate to a provider and the associated support or intervention needs. For example, where there is evidence that supports the provider’s strong capability to address concerns, such as its CQC well-led rating, self-certification and track record, this may improve the delivery segment. Conversely, where the evidence suggests weaker capability, this process could deteriorate the delivery segment as it indicates the need for support or intervention to address the challenges.
11. Publication of information
12. To support transparency NHS England will publish ICB & Provider capability scores, segmentation and underlying metrics on a quarterly basis

##

## Annex A: Recovery Support Programme

* + - * 1. NHS England launched the Recovery Support Programme (RSP) in 2021 to provide focused integrated support to the most challenged ICBs and providers (NHS trusts and foundation trusts). It has been developed to provide intensive support at either the organisational level, working with the relevant ICB as appropriate, or across the whole health and social care system, working with non-NHS partners where necessary and coordinating support through the ICB.

**Referring organisations to the RSP**

* + - * 1. NHS England may consider an ICB or provider for entry into the RSP in any of the following circumstances:

where we have assigned it a provisional segment of 4

where we have sufficiently high levels of concern, arising recently or otherwise not covered by the metrics, for example, there have been major failures of governance, leadership, finance, quality, or patient safety

where it is deemed necessary as part of a whole-system response to complex system-wide challenges regardless of its own performance and capability levels

* + - * 1. Where we consider a referral to the RSP is appropriate, our relevant governance group will be asked to approve this decision based on a broad range of information. Where entry into the RSP is agreed, the organisation’s final segment is confirmed to be 4.
				2. Once we have made a decision to enter an organisation into the RSP, this is communicated to the organisation by our Chief Operating Officer and shared publicly on the NHS England website.

**Activities undertaken in the RSP**

* + - * 1. Following entry into the RSP, a diagnostic stocktake involving all relevant NHS system partners is undertaken to:

identify the root cause(s) of the problem(s) and the structural and strategic issues that must be addressed, as well as the role of different parts of the system in helping to address the challenges

recommend the transition criteria that must be met for the ICB or provider to transition from the RSP to segment 3 and an indicative timeline to achieve this

recommend, in some instances, that the ICB and/or the wider NHS system should be in the RSP alongside the provider that is being supported. This is likely to be in the cases where there is evidence the provider is being serially challenged and/or other NHS system partners need to be involved to implement the requisite solutions as determined by the diagnostic

* + - * 1. The RSP undertakes a supplementary evaluation of the organisation’s leadership capability. This evaluation will take into consideration the organisation’s current capability score and may lead, if necessary, to changes to the leadership of the ICB or provider to ensure the board and executive team can make the required improvements. Where changes are required, these will happen as soon as is practical and the necessary support will be provided to facilitate this.
				2. At the same time as developing plans to address the specific issues that triggered entry into the RSP, we will consider whether long-term solutions are needed to address any structural issues affecting the organisation’s ability to ensure high-quality, sustainable services for the public.
				3. We will appoint an improvement director (ID) who acts on our behalf to support the development of the improvement plan to meet the agreed criteria and provide assurance of the ICB or provider’s approach to improving performance.
				4. The ID works with the provider or ICB to coordinate necessary support from its NHS system, ourselves, the broader NHS or, where appropriate, external third parties. 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, for example, to reduce agency use, implement cost controls

facilitating reviews such as a drivers of deficit review or a governance review

participation in governance and leadership programmes 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’

* + - * 1. In addition, we will typically put the following additional interventions in place:

regular formal progress and challenge meetings with our executives

board vacancies filled at our direction (providers only)

* + - * 1. For particularly challenged systems, further interventions may include:

NHS England appointing a board adviser

enhanced reporting requirements
or

enhanced financial controls including:

rapid roll out of core controls over expenditure and core drivers of expenditure, includes both pay and non-pay, as well as all commissioning decisions including relating to CHC and primary care, along with other measures to immediately strengthen financial control, in line with those set out in NHS England guidance, including the ‘Grip and Control’ checklist

the expectation of these controls is that expenditure is reduced as a result, not just a rubber stamping exercise – so falling numbers of requests should be a routine outcome of the process, which NHS England will expect to see evidence of

NHS England control of applications for Department of Health and Social Care financing (trusts)

‘triple lock’ mechanism, requiring ICB and NHS England approval of spend over an agreed limit

reduced capital approval limits (trusts), reduction in capital envelope, and also a suspension of any capital investments that have a negative revenue impact

enhanced reporting of financial and operational position including additional detail on staffing, evidence of operation of controls, and progress with efficiency and financial recovery plans

independent review of expenditure controls to ensure that they are comprehensive, well designed, effective and have appropriate board-level oversight

* + - * 1. We may support the interventions listed above using formal enforcement action.
				2. Any change in transition criteria, planned timelines, or major support resets would need to be agreed through the relevant governance group.
				3. For providers, we will ensure they address any identified urgent patient safety and quality issues as a priority. The CQC will continue to monitor quality at the provider and if at any time patients are at immediate serious risk of harm, the CQC can use its urgent powers to safeguard them.

**Transition from the RSP**

* + - * 1. Transition from the RSP will ordinarily occur when it can be demonstrated that the transition criteria have been met sustainably. Over time, it may be necessary to review or revise these criteria – any change to transition criteria or planned timeline must be approved through the relevant governance group.
				2. When making a decision to approve the transition to segment 3, we will consider the proposed transitional support package that may be needed when an ICB or provider enters segment 3 to ensure improvement is sustained.
				3. Until we are satisfied that the transition criteria have been met (or are not on track to be met sustainably), the organisation will remain in the RSP to allow the necessary improvements to be made. This might occur, for example, when 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 to the planned timeline, the ICB or provider will prepare a revised planned timeline and improvement plan with their ID that lists actions to address any outstanding or new concerns.
				4. We will inform the organisation of our decision to approve the transition to segment 3, and with this exit from the RSP, once it has completed its formal decision-making processes. We will then share our decision publicly on our website.

## Annex B: Proposed quarterly self-certifications for providers

|  |
| --- |
| **The board confirms that:** |
| **Strategy** |
| * The organisation's strategy reflects shared priorities across the system and has an agreed contribution to the joint forward plan and capital plan with ICB and system partners.
* The organisation is meeting, and will continue to meet, any regulatory directions placed on it or undertakings.
* The trust is working effectively and collaboratively with system partners and its provider collaborative for the overall good of the system and population served.
 |
| **Quality of care** |
| * Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.
* Systems are in place to monitor patient experience, and there are clear paths to relay safety concerns to the Board.
 |
| **People** |
| * Staff feedback is used to improve quality of care provided by the trust.
* Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels.
* Staff are able to express concerns in an open and constructive environment.
 |
| **Access** |
| * Plans are in place to improve performance against the relevant access and waiting times standards.
* The trust is able to identify and address inequalities in access/waiting times to NHS services across its patients.
* Appropriate population health targets have been agreed with the ICB.
 |
| **Productivity** |
| Plans are in place to deliver productivity improvements as referenced in, for example, the NHS model system guidance, The Insightful Board and other guidance as relevant. |
| **Finance** |
| * The trust has a robust financial governance framework and appropriate contract management arrangements.
* Financial risk is managed effectively and financial considerations (for example, efficiency programs) do not adversely affect patient care and outcomes.
* The trust actively engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial out-turn.
 |
| **The board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.** |

Annex C: Provider capability assessment – criteria and ratings

|  |  |
| --- | --- |
| **Provider capability rating** | **Indicative expectations/criteria** |
| **No material concerns** | * CQC well-led rating of at least ‘Good’ and no site or service is rated inadequate by the CQC
* Board has historically delivered on self-certification requirements and can give a positive self-certification; no contradictory exception reports
* No material concerns arising from third parties
* Board working with system partners highly effectively and proactively – if this is impacting the delivery score (ie Provider is taking action to support overall system performance which is impacting their delivery) we will consider using the capability assessment to improve the provisional score
 |
| **Some concerns – provider under review** | * CQC Well-led ‘requires improvement’ in past 12 months, and limited number of sites/ services rated inadequate
* Board unable to prospectively self-certify or retrospectively meet self-certifications; Material exception report highlighting a concern
* investigations underway following a third party issue, or minor concerns revealed which management have a plan to address or are addressing
* Board meeting some expectations regarding collaboration with system partners
 |
| **Major concerns** | * CQC well-led rating of at best ‘requires improvement’ in last 12 months or ‘Inadequate’ if older, significant numbers of quality concerns at site and service level
* Board has historically failed to deliver on self-certification requirements or cannot give a positive self-certification
* Serious governance or quality concerns arising from third party information
* Failure to meet collaboration and cooperation expectations as per NHS England Guidance and Provider licence
 |

## Annex D: Segmentation flowchart



1. NHS IMPACT (Improving Patient Care Together) is the new, single, shared NHS improvement approach. [↑](#footnote-ref-2)
2. For the purposes of this document, ‘providers’ refers to NHS trusts and foundation trusts only and does not include primary care or independent providers. [↑](#footnote-ref-3)
3. The ICB and its NHS partners, including NHS England, make up the ‘NHS system’ within each ICS. [↑](#footnote-ref-4)
4. For this document, oversight of providers ‘through’ its relevant ICB refers to an arrangement whereby NHS England asks the ICB to carry out the oversight of providers in the first instance. It does not imply that NHS England delegates its oversight responsibilities in relation to providers to the ICB. [↑](#footnote-ref-5)
5. To refer to the full list of ICB financial apportionment relationships, access the ‘ICB financial apportionment’

tab within the file titled “ICB partner organisations” on the Organisation Data Service (ODS) webpage using the hyperlink provided. [↑](#footnote-ref-6)
6. Section 14Z59 of the National Health Service Act 2006 as amended by the Health and Care Act 2022 [↑](#footnote-ref-7)
7. As of 2024/25, this letter will replace the Memoranda of Understanding previously agreed between NHS England regional teams and ICBs. [↑](#footnote-ref-8)
8. For 2024/25, the first self-certification will be expected at the end of quarter 2. [↑](#footnote-ref-9)