HFMA response
May 2021

# The HFMA's response to the system oversight framework 2021/22 consultation

## Who we are

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For over 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The qualifications are delivered through HFMA's Academy which was launched in 2017 and has already established strong learner and alumni networks.

### Question 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'? If not, how could the proposed approach be improved?

**Yes, mostly agree**

An aligned and clear approach to the oversight of ICSs and the NHS organisations within them is essential as ICSs continue to develop in line with the proposals set out in *Integration and innovation working together to improve health and social care for all* (the white paper). The HFMA welcomes the

move to provide clarity and to provide an objective basis to identify which ICSs and/or their constituent organisations may require support or intervention.

The principles set out in the consultation are welcome. However, further detail is needed to understand how the oversight approach will practically work to meet the key principles:

- **With and through an ICS**
  In practice, how will NHS England and NHS Improvement work with and through an ICS? There also needs to be clarity over the lines of communication. Does this mean that any communications with an individual organisation will go through the ICS or will the ICS be informed of direct communications with an NHS organisation? There needs to be an agreed approach to communications which is open and transparent but balances the need for both the system and constituent organisations to be aware of issues without creating information overload and risking key messages getting lost.
- **System performance and quality of care outcomes**
  Additional guidance is needed on what is meant by 'system performance' – both operationally and financially. Although the consultation makes a number of references to performance and monitoring performance, further detail is needed to understand what is the system being measured against and how will that be determined? It would be helpful to set out what good performance looks like.
- **Accountability for results**
  There needs to be some definition and understanding of what the difference is between oversight, management and regulation versus who is doing what and where the accountabilities lie. Further clarity is needed on the meaning of 'matching accountability for results with improvement support'. In order to match accountability to results, there needs to be recognition of those organisations that can impact the results and the levers for influence across the partnership. For example, how does the ICS influence local government actions to address health inequalities and how is it held accountable.

  For 2021/22, the ICS is not a statutory body and each constituent organisation is accountable for its own performance. It would be helpful to provide some examples such as what happens for the system if a constituent organisation fails to meet its target when the system as a whole does meet its target, and vice versa what is the impact on an individual organisation that meets its targets but others in the system do not? There are many pass/ fail permutations, and it would be helpful if the likely consequences for each constituent organisation, and the system as a whole, were outlined.
- **Greater autonomy**
  Greater autonomy for ICSs and organisations with evidence of collective working and a track record of successful delivery of NHS priorities is welcome and reflects well the aim to create a permissive environment to allow systems to do the right thing for their local population. However, there needs to be a consistent and transparent way to apply this to systems that are set up in varying ways, with a clear focus on outcomes.
- **Compassionate leadership**
  A definition of 'compassionate leadership behaviours' is needed, as well as details of how this will be assessed.

The proposed approach to oversight is expected to be published in June 2021, which is already a quarter into the financial year. The approach will need to be clear on transition arrangements from previous oversight arrangements and be mindful of how these arrangements can be used to transition into an updated approach to reflect the expected legislative changes set out in the white paper.

## Question 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’? If not, please give your reasons:

**Yes, partly agree**

The HFMA welcomes the ability to tailor the oversight arrangements to reflect local circumstances and agree this should be developed locally between ICSs and NHS England and NHS Improvement regional teams. This approach recognises the different pace in which ICSs are developing, as well as their different sizes, existing arrangements and challenges. However, to ensure this is done in a transparent and consistent manner, there needs to be clarity in a number of key areas as follows:

- How will ‘place-based system’ be defined? The notion of ‘place-based’ can differ between individuals, organisations and sectors and is likely to vary between systems. There will need to be clarity over how the oversight framework defines them, and it is likely to need to be agreed with individual systems. For example, they may be defined as a group of primary care networks or formalised geographical sub-section within the ICS with area leads, such as integrated care partnerships.
- The system to place dynamic will need to be clear as part of oversight arrangements. For example, it is unclear at the moment how the chief finance officer at an ICS level will be supported by the place level – practically they will not be able to attend all place level boards/committees. The oversight arrangements will need to take into account the local system circumstances as they develop.
- How will ‘failure of an individual provider to collaborate in a system context’ be identified? What does this mean for organisations that operate in several systems and cannot collaborate with everyone or when there are some voices in a system that are louder than others? In order to answer these questions, there needs to be greater clarity on what collaboration means in practice. This could be supported by reference to the system collaboration and financial management agreement. Examples of what good collaboration looks like or what constitutes a failure would be helpful. For example, attending meetings, helping to achieve consensus and signing agreements is evidence of collaboration but only if the actions taken are in accordance with those agreements. How would the actions that the organisation was taking be assessed as collaborative or identified as running contrary to the agreed way forward? If an individual organisation meets its statutory requirements and duty to collaborate but other parts of the ICS are failing to do so, what does that mean for the individual organisation, and ICS?
- When will the assessment of maturity be determined, based on table 1, and by who? As ICS developments are likely to be changing quickly, how often will this be assessed?
- How will an oversight role for the ICS impact on its current partnership approach? Internal challenge and scrutiny is an important part of partnership working. The oversight approach needs to enable the ICS to perform this while guarding against the risk that the ICS is seen as another layer of external oversight. Internal challenge and scrutiny is an important part of partnership working.
- How will potential conflicts of interest be addressed? There will be potential conflicts of interest in terms of oversight of commissioning when that role moves to the statutory NHS ICS body so any arrangements for 2021/22 will need to consider future arrangements too.
- How will new ICS oversight responsibilities be resourced? Will there be any redistribution of resource and/ or workforce from NHS England and NHS Improvement when and/or where oversight arrangements are delegated?
- How will this be made workable for regional providers that work across multiple systems, such as ambulance trusts? Clarity will be needed on how oversight works for these providers and how this links to the oversight arrangements in place for the multiple ICSs they work with.

## Question 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'? If not, how could the proposed approach be improved?

**Yes, partly agree**

The HFMA agrees that the six themes set out in the framework support a balanced approach to oversight. Further detail on how the approach will be used to assess these is needed as follows:

- **Metrics**

How and when will the metrics be developed? Where the metrics are expected to be long-term targets, such as reducing inequalities, it will be important to set baselines against which to measure direction of travel. If oversight is undertaken by the ICS, it will need to consider arrangements to collate and verify data, ideally avoiding the need to collect any new or additional data. Will any national data be provided to the ICS from existing data collections to save time and resources? Also, what is the national role in aligning NHS and local government (adult social care) metrics and targets to support joint decision-making rather than having them in conflict? Local authorities are particularly integral to the performance against 'preventing ill health and reducing inequalities' metric.

- **Local strategic priorities**

It is good to see a locally selected theme. The framework should set out whether this will need to be agreed with NHS England and NHS Improvement, and if so how and when. As with the national themes, metrics will be needed and a baseline set. If the data is not available, then does that restrict the locally selected theme? Also, consideration needs to be given to how this will apply to those working with multiple ICSs, such as ambulance trusts, each of which will have its own local strategic priorities which could lead to competing priorities as well as significant additional workload in supplying data.

- **Working within partners**

Will 'working with partners' explicitly be assessed within any of the themes such as leadership and capability? If so, will this form the duty to collaborate assessment? As set out in response to question 2 above, collaboration and how it will be assessed needs to be clear. For example, organisations within an ICS could meet all the requirements in each theme but have some poor relationships.

## Question 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'? If not, how could the proposed approach be improved?

**Yes, partly agree**

The HFMA welcomes the proposed approach to support NHS England and NHS Improvement regional teams to work together to develop locally appropriate approaches to oversight. We need to recognise systems cover a large population and, if they fail, it will have a significant impact. Capacity and capability needs must be a key element of the proposed approach. The oversight cycle and table 2 provides a framework for this. Further considerations are needed as follows:

- Will the key outcomes in paragraph 20 on page 9 around early identification and management of emerging issues be monitored and how will that be done? When something happens that has a

material impact on the system or performance deteriorates this framework will not have achieved that key outcome – it would be helpful to set out what happens as a result.

- There is a risk of duplication between the ICS and the regional team. It is an important area requiring further work to avoid the risk of the ICS board taking on the role of NHS England regional leads. Also, there is a resourcing issue for the ICS – can the ICS do all of this and how will it be funded?
- As part of avoiding that duplication, it is important that the different accountabilities of the regional teams and the ICS are defined and understood.
- Robust quality governance arrangements are included as a key element. Further detail is needed to support systems develop these arrangements.
- How will the role of local government services in public health, adult social care and community services be built into the regulatory regime to ensure that the new system has integrated working at its core?
- It is important to recognise that significant cultural change is required as ICSs develop – this should be explicitly recognised and supported through the proposed approach.

It is pleasing to note the paper recognises the oversight arrangements spanning more than one ICS will be required for some. This is particularly an issue for ambulance trusts, specialised providers and some mental health providers. These arrangements will need to be in place before the oversight framework is operational and need to ensure that the oversight arrangements are consistent between ICSs so that multi-ICS organisations are not over-burdened or penalised for issues that are outside of their control. This will need to include consistency with the approach for commissioning and funding of regional providers to ensure that there is alignment across commissioning, investment decisions and performance monitoring across the region.

## Question 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'? How could the proposed approach be improved to better inform oversight arrangements and effectively target support capacity?

**Yes, mostly agree**

The HFMA welcomes the phased implementation of the four 'segments' approach to identify the scale and nature of support needs. The way that the segment for the ICS is determined and the impact of the segments on the organisations that are part of the ICS needs to be clear and understood. This will also need to be further developed in 2022 when the NHS ICS body will presumably have its own assessment and segment and the ICS health and care partnership will be segmented based on the sum of its parts.

Having the default position as segment 2 seems sensible. However, does this mean that all previous assessments will be ignored? There also needs to be clarity over whether there is the ability to move between segments at any time or whether this will be based on a set review period.

The streamlined business case approval for segment 1 bodies risks creating a two-tier system that potentially gives those less in need of additional resources a better chance of getting them or those more in need of transformation and support less likely to get it. Streamlined implies that securing approval will be less onerous and quicker and there will be fewer barriers to work through – this may not be what was intended.

Paragraph 30 on page 12 refers to 'removing the requirement to account for resource deployment in exchange for agreed outcomes.' The meaning of this needs to be clarified – what is the requirement to account for resource deployment that presumably all organisations in segments 2 to 4 will need to do?

For those providers where there are a small number overall, such as ambulance trusts, there is also the issue that using quartile performance to assess segmentation, particularly where there are generally similar levels of performance, is not an appropriate way to identify those that need most support.

## Question 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'? Do you have any additional suggestions that could improve on the proposed approach to oversight, support and intervention?

In addition to the comments included in response to question 5 above, it would be helpful to understand how the proposed oversight approach aligns to the work of other regulators such as the Care Quality Commission – in terms of coverage, timing and success/ failure to meet targets.

## Question 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'? If not, please give your reasons:

**Yes, mostly agree**

The HFMA welcomes the move to a more system-focused support programme. It is likely that this will lead to an increase in resources needed to work with the programme for those historically not in needs of support but within a system of partners that do.

## Question 8: Do you support the proposed approach to the recovery support programme, as set out in section 6: 'Recovery support programme'? How could the proposed approach be improved to better support systems, trusts and/or CCGs to address complex and/or longstanding challenges?

**Yes, partly agree**

The HFMA does support the proposed approach to the recovery support programme. However, clarity is needed as follows:

- details on what support will be provided from the system improvement director (SID) and NHS England and NHS Improvement team. For example, will this be asking for information, providing challenge, providing more money, providing advice on how to use data to make improvements etc? It would be helpful to clarify what 'intensive support for emergency and elective care' means.
- details on the SID appointment. For example, as a joint appointment: who will pay for the SID; who will employ the SID; and how does the SID fit with the organisational board and the ICS board?
- details of where the multi-disciplinary team comes from and how it is resourced.

## Question 9: Do you support the proposed approach to CCG assessment, as set out in section 7: 'CCG assessment'? If not, how could the proposed approach be improved?

**Yes, partly agree**

A simplified approach that supports plans for oversight of ICSs going forward is welcome. However, the impact for CCGs that have merged needs to be set out – is the assessment done at the end of the first year?

We also note that paragraph 64 refers to 2020/21 approach – should this read 2021/22 or has the annual assessment not yet been done?

## Contact

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