Trust Board Meeting ('Part 1') - Formal meeting, which is open to members of the public (to observe)

Thu 27 April 2023, 09:45 - 13:00

Pentecost-South, Academic Centre, Maidstone Hospital

Maidstone and Tunbridge Wells NHS Trust

Agenda

Please note that members of the public will be able to observe the meeting, as it will be broadcast live on the internet, via the Trust's YouTube channel (www.youtube.com/channel/UCBV9L-3FLrluzYSc29211EQ).

04-1
To receive apologies for absence

David Highton

04-2
To declare interests relevant to agenda items

David Highton

04-3
To approve the minutes of the 'Part 1' Trust Board meeting of 30th March 2023

David Highton

Board minutes, 30.03.23 (Part 1).pdf (12 pages)

04-4
To note progress with previous actions

David Highton

Board actions log (Part 1).pdf (2 pages)

Reports from the Chair of the Trust Board and Chief Executive

04-5
Report from the Chair of the Trust Board

David Highton

Report from the Chair of the Trust Board.pdf (1 pages)

04-6
Report from the Chief Executive

Miles Scott

Chief Executive's report April 2023.pdf (3 pages)

Reports from Trust Board sub-committees

04-7
Quality Committee, 12/04/23

Maureen Choong

Summary of Quality C'ttee, 12.04.23.pdf (2 pages)

04-8
Finance and Performance Committee, 25/04/23

Neil Griffiths

Summary of Finance and Performance C'ttee 25.04.23.pdf (1 pages)

04-9
People and Organisational Development Committee, 21/04/23 (incl. quarterly report from the Guardian of Safe Working Hours)

Emma Pettitt-Mitchell

Summary of People and Organisational Development Cttee, 21.04.23 (incl. quarterly update from the Guardian of Safe Working Hours).pdf (5 pages)

04-10
To approve revised Terms of Reference for the Remuneration and Appointments Committee (annual review)

David Highton / Kevin Rowan

RemCom Terms of Reference.pdf (3 pages)

Integrated Performance Report

04-11
Integrated Performance Report (IPR) for March 2023

Miles Scott and colleagues

Integrated Performance Report for March 2023.pdf (38 pages)

04-12
Update on the provision of non-emergency patient transport

Sarah Davis (for Sean Briggs) and Rachel Jones

N.B. This will be a verbal report.

Systems and Place

04-13
Update on the Kent and Medway Integrated Care Board (KM ICB)

Cedi Frederick (Chair of the KM ICB) and Paul Bentley (Chief Executive of KM ICB)

N.B. The item will take place at 11am.

A presentation will be given at the meeting.

04-14
To approve the Joint Forward Plan for the Kent and Medway Integrated Care System (ICS)

Rachel Jones, with Cedi Frederick and Paul Bentley

To approve the Joint Forward Plan for the Kent and Medway Integrated Care System (ICS).pdf (76 pages)

04-15
Update on the West Kent and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)

Rachel Jones

Update on the West Kent and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB).pdf (2 pages)

04-16
Review of the outcome of the Hewitt Review of Integrated Care Systems

Rachel Jones

Review of the outcome of the Hewitt Review of Integrated Care Systems.pdf (100 pages)

Quality items

04-17
Quarterly Maternity Services report

Rachel Thomas

N.B. This item has been scheduled for 12:10pm.

Quarterly Maternity Services Report.pdf (17 pages)

Planning and strategy

04-18
The final planning submissions for 2023/24

Rachel Jones and Steve Orpin

The final planning submissions for 202324.pdf (7 pages)

04-19
Update on the corporate objectives for 2023/24

Rachel Jones

N.B. This will be a verbal report.

Assurance and policy

04-20
Quarterly report from the Freedom to Speak Up Guardian

Christian Lippiatt

N.B. This item has been scheduled for 12:45pm.

Quarterly report from the Freedom to Speak Up Guardian - April 2023.pdf (8 pages)

Other matters

04-21
To consider any other business

David Highton

04-22
To respond to any questions from members of the public

David Highton

04-23
To approve the motion (to enable the Board to convene its ‘Part 2’ meeting) that...

David Highton

in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960,representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 30TH MARCH 2023, 9:45 AM, VIRTUALLY, VIA WEBCONFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board (Chair)	(DH)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Neil Griffiths	Non-Executive Director	(NG)
	Jo Haworth	Chief Nurse	(JH)
	Peter Maskell	Medical Director	(PM)
	Steve Orpin	Deputy Chief Executive / Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Wayne Wright	Non-Executive Director	(WW)
In attendance:	Karen Cox	Associate Non-Executive Director	(KC)
	Rachel Jones	Director of Strategy, Planning and Partnerships	(RJ)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Sue Steen	Chief People Officer	(SS)
	Jo Webber	Associate Non-Executive Director	(JW)
	Alex Yew	Associate Non-Executive Director	(AY)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	The meeting was livestreamed on the Trust's YouTube channel.		

03-6 To receive apologies for absence

Apologies were received from David Morgan (DM), Non-Executive Director; and Miles Scott (MS), Chief Executive. It was also noted that Richard Finn (RF), Associate Non-Executive Director, would not be in attendance. DH then welcomed AY to his first Trust Board meeting since being appointed as an Associate Non-Executive Director.

03-7 To declare interests relevant to agenda items

No interests were declared.

[N.B. AY's role as a non-Board Associate Non-Executive Director at the Kent and Medway Integrated Care Board (ICB) was subsequently declared under item 03-22]

03-8 To approve the minutes of the meeting of 23rd February 2023 and 20th March 2023.

The minutes of the meetings of the 23rd February 2023 and 20th March 2023 were approved as true and accurate records of the meetings.

03-9 To note progress with previous actions

The content of the submitted report was noted and the following actions were discussed in detail:

- **02-10a ("Consider adjusting the target for the "Appraisal Completeness" metric to reflect the fact that performance would likely decline during the appraisal 'window', and the final position would not be known until the 'window' had closed").** SS reported that she was involved in discussions with the Business Intelligence (BI) team about how a trajectory could be applied, to monitor the expected performance on a monthly basis. DH asked whether the first update would be seen at the next Trust Board meeting. SS replied that that would hopefully be the case.
- **03-3 ("Explore what could be developed to show the 'arch' for each of the major income and expenditure categories, to enable Trust Board members to better understand the delivery of the CIP for 2023/24").** SO reported that a planning item had been scheduled for later on the agenda, under item 03-23, so SO would be able to update the position then, as there would be a further planning submission, which would enable the requested information to be presented.

03-10 Report from the Chair of the Trust Board

DH reported the following points:

- Several new consultants had been appointed, although DH had not chaired either of the two Advisory Appointments Committee panels. It was particularly pleasing that the Trust had been able to appoint some new anaesthetists, as such appointments would help with the bariatric service that the Trust wanted to introduce.
- The Trust had been inspected by the Care Quality Commission (CQC) on 28/03/23 and 29/03/23, to review the Well Led domain, and a short feedback meeting had been held with the inspectors on the evening of 29/03/23, during which the inspectors had commended the staff's engagement with the inspection. The draft report would not be issued for a further 10 to 12 weeks, but DH wanted to thank, on behalf of the Trust Board, all staff for their positive attitude towards the inspection.

KC referred to the latter point and echoed DH's thanks to the staff, and to all Trust Board members, for their commitment and support in relation to the inspection.

03-11 Report from the Chief Executive

SO referred to the submitted report and highlighted the following points:

- SO would also like to commend the staff for their approach to the aforementioned CQC inspection.
- The Trust had dealt with the impact of the industrial action by junior doctors, and was preparing for the further action that had been announced, to minimise the impact of that action.
- The Trust's performance remained strong, despite the continued significant pressures faced, and SO wanted to thank all staff for their continued hard work and commitment.
- Over 400 nominations had been received for the forthcoming Staff Star Awards, and SO had been humbled by reading the nominations.

Reports from Trust Board sub-committees

03-12 Quality Committee, 08/03/23

MC referred to the submitted report and highlighted the following points:

- A separate report on the Patient Safety Incident Response Plan (PSIRP) would be considered under item 03-20 later on the agenda.
- As part of the evaluation of the meeting, the Committee had acknowledged the marked improvement in the analysis of the information presented to the Committee.

03-13 Finance and Performance Committee, 28/03/23

NG referred to the submitted report and highlighted the following points:

- Much of the substantial items would feature under separate items on the Trust Board's agenda.
- The Committee had discussed the performance on outpatients and an updated position would be discussed at the April 2023 meeting.
- The Cost Improvement Programme (CIP) for 2023/24 was discussed, and the hard work that lay ahead was acknowledged.
- The summary report from the People and Organisational Development Committee had been received, which reflected the desire for the two Committees to work more closely.

03-14 People and Organisational Development Committee, 24/03/23 (incl. approval of the revised Terms of Reference)

EPM referred to the submitted report and highlighted the following points:

- A useful review had been undertaken on the people-related factors associated with the Kent & Medway Orthopaedic Centre (KMOC), and EPM had discussed with JW, as Chair of the Patient Experience Committee, the patient-related aspects, which would be considered in the future.
- Revised Terms of Reference had been agreed and these were submitted for approval.
- The Freedom to Speak Up Guardian (FTSUG) had attended to discuss the feedback mechanism in place for the staff who had raised concerns.

- The national NHS staff survey had been reviewed and SS had been asked to develop some innovative ideas to respond to the findings, and to also improve the response rate.
- The retention team had attended the meeting, to observe proceedings.

EPM then also noted, following a prompt by WW, that the Wellbeing Committee would submit a report to the People and Organisational Development Committee each quarter, and anything relevant would be highlighted to the Trust Board.

The revised Terms of Reference were approved as submitted.

03-15 Patient Experience Committee, 02/03/23 (incl. approval of the continuation of the current Terms of Reference)

JW referred to the submitted report and highlighted the following points:
- The Divisions had now started to report on their patient experience activity and a report had been considered from the Cancer Services Division.
- The Patient Led Assessment of the Care Environment (PLACE) audits had been discussed, as had the work on outpatient transformation.
- The Committee had also heard about the volunteering work taking place at the Trust and JW would recommend that all Trust Board members read the report that had been submitted to the Patient Experience Committee.

JW then asked the Trust Board to approve an extension of the Trust's existing Patient Experience Strategy ("Making it personal") until the end of 2023/24, to align with the review of the patient experience framework led by NHS England (NHSE), for which the Trust would be a pilot site. The Trust Board duly approved the requested extension to the Trust's current Patient Experience Strategy, to the end of March 2024.

KR then highlighted that the submitted report had also requested the continuation of the Patient Experience Committee's current Terms of Reference for a further 12 months. The Trust Board duly approved the requested continuation of the current Terms of Reference.

03-16 Audit and Governance Committee, 01/03/23 (incl. an update on bribery-related best practice)

MC referred to the submitted report and highlighted the following points:
- Appendix 1 contained an update on bribery-related best practice, for the Trust Board's information.
- There were no significant issues to escalate to the Trust Board, although there had been a lively discussion on red-rated risks.

03-17 Charitable Funds Committee, 22/03/23

In the absence of DM, MC referred to the submitted report and highlighted the following points:
- It had been a positive meeting, and the new Head of Charity and Fundraising was making good progress.
- The Trust's staff had been asked to vote on the design option for the new charity logo.

DH reminded Trust Board members that Maidstone and Tunbridge Wells NHS Trust was the corporate trustee for the charitable fund, and the associated duties for the Trust Board, and Trust Board members, were exercised through the Charitable Funds Committee. The point was acknowledged.

Integrated Performance Report

03-18 Integrated Performance Report (IPR) for February 2023

SO introduced the item by referring to the Executive Summary on page 5 of 38. SS then referred to the "People" Strategic Theme and reported the following points:
- The vacancy rate continued to experience special cause variation of an improving nature, and the overall rate was now just under 9%.

- The “Turnover Rate” had been above the 12% target for more than six months and it was very difficult to bring the rate below the target.
- The sickness rate was subject to common cause variation, and that variance was demonstrated across the months and the seasons.
- A ‘stretch’ target had been set for appraisal completeness, at 95%, and the 90% rate was one of the highest rates achieved by the Trust. Work was however underway to improve the rate further and also focus on hard-to-reach areas for the next appraisal round.
- The focus on staff turnover would shift from numeric aspects to qualitative aspects, such as candidates’ experiences and the ‘time to hire’. Such aspects would then inform the work to improve staff retention.
- In relation to next steps, and the “Action Plan” on page 9 of 38, the Trust was struggling to attract key skills, either because of a general market shortage or difficulty in attracting people to the Trust’s geographical areas. The Trust would therefore explore the use of attraction bonuses, utilise ‘retire and return’, create talent pools and introduce ‘stay interviews’.

JW asked about staff turnover among Allied Health Professionals (AHPs) and healthcare scientists. SS acknowledged the challenges in such areas, and also noted that work was taking place in Administrative & Clerical (A&C) posts. SS then elaborated on the approach being taken, which would take into account the market and the ongoing relationships.

SO congratulated SS and her colleagues for the continued reduction of the vacancy rate, but noted that staff turnover needed continued focus. SO also stated that he had discussed the staff retention data with the BI team, and discovered that the staff who had been transferred to the outsourced laundry service would be included in the staff turnover data, as such staff would be regarded as having left the Trust. The point was acknowledged.

WW echoed SO’s commendation about the vacancy rate, but noted that one of the issues discussed at the People and Organisational Development Committee was the circa 700 staff who had not had an appraisal with their line manager, so asked SS to elaborate on the actions being taken to increase the appraisal rate to as close to as 100% as possible. SS acknowledged that there had been some comments regarding the complexity of the appraisal system, although SS felt such comments may be related to the completion of the process on the MTW Learning system, rather than the completion of the appraisal per se. SS continued that work would however take place with the relevant areas, including the harder-to-reach areas, to improve the position. SS also noted that the staff who had not had an appraisal for two consecutive years would be reviewed. WW therefore asked when the data would be available to target action in the areas described by SS. SS replied that the underlying issues were more general, and across different Agenda for Change (AfC) bandings, and not limited to particular areas, although the action would be targeted to specific areas. DH noted that the aforementioned action 02-10a was relevant to the issues. The point was acknowledged.

AY referred to the “Top Contributors” box on page 9 of 38 and noted that some of the areas seemed to provide an opportunity for ‘quick wins’. AY therefore asked if SS was focusing on such ‘quick wins’. SS acknowledged the point and explained the approach but also noted that some other factors, such as Outer London payments, were not within the Trust’s control, although some response could be made. SS also highlighted that some of the “Top Contributors”, such as “Inadequate break times/poor wellbeing” related to staffing levels, so such aspects would be expected to improve.

PM referred to the “Patient Safety & Clinical Effectiveness” Strategic Theme and reported the following points in relation to the “Incidents resulting in harm”:
- Mortality would be considered under item 03-19.
- There was still common cause variation in the “Reduction in the rate of patient falls…” metric, which was mainly due to the work undertaken by the Deputy Chief Nurse, Quality and Experience. The Patient Safety Incident Response Framework (PSIRF) work that would be discussed under item 03-20 would also assist, in terms of the introduction of After Action Reviews (AARs).

SM then explained the latest position in relation to the and “Infection Control - COVID” metric and reported the following points:
- The Trust was still experiencing common cause variation for hospital-onset COVID-19. There had been a slight increase in February, which was related to an increase in the community. A few

patients with asymptomatic COVID-19 had also been admitted to wards, following the cessation of testing for the non-respiratory admissions stream, which had been done in accordance with national guidance. SM however expected the position to improve.
- There was no *Clostridiodes difficile* graph in the IPR that month, as the number of cases had reduced. The annual trajectory had been breached, with 78 cases compared to the maximum trajectory limit of 62, but the Trust was in a much better position than at this time last year.

DH noted that there had been some norovirus cases on the Trust's wards. SM confirmed that there had been a relatively small number of cases that had affected three wards, but the virus had not extended beyond such wards, and each ward-based incident had been closed quickly, although bed occupancy on those wards had been adversely affected, as norovirus patients could not be cohorted. SM added that all of the incidents had now however been closed and there were no active outbreaks.

WW noted that new strains of COVID-19 had been seen in the US, so asked whether SM was concerned. SM replied that there had been no change in the severity of symptoms experienced by affected patients but the situation was being monitored closely.

SB then referred to the "Patient Access" Strategic Theme and reported the following points:
- SB would like to thank SM and her colleagues for their work in relation to patient flow.
- The Trust had performed well on the Emergency Department (ED) 4-hour waiting time target in February 2023. The Trust had been the best performing Trust in the country for much of February, but March had started to see daily attendance levels of circa 700, and the Trust had not quite solved how to deal with that level of attendances. However, the Trust was still the second or third best performer in the country.
- January had been a difficult month for cancer access target performance, because of the Christmas holidays, but the targets had still been met across all measures for that month. The waiting list backlog was now close to 4%, which was the desired level. SB was grateful for the work that RJ had done with the urology teams to support the sustainability of that service.
- For Referral to Treatment (RTT) waiting times, the Trust was likely to end March 2023 with 300 to 350 patients who had waited over 40 weeks for treatment. That number was higher than the Trust wanted, but some factors had emerged, including large periods of December where the Trust had seen over 800 ED attendances per day; and the junior doctors' strike in March. The strike had adversely affected the 40-week waiting list position by about 150 patients. However, the Trust still had the lowest number of patients waiting 40 weeks in the country. Some of the Trust's capacity in the recent months had also been used to support other local providers with their patients, some of whom had waited over 78 or 85 weeks.
- The Diagnostics Waiting Times and Activity (DM01) standard performance had still been affected by echocardiograms, but a plan was in place and SB was confident the position would recover.
- Outpatient transformation progress been slow, and SB had recognised that the issue had not been a high enough priority for the operational teams. The teams had however developed a strong plan that focused on three key aspects, and that work would be considered in more detail at the Finance and Performance Committee meeting in April 2023. A patient portal Business Case had also been approved.

EPM acknowledged the support the Trust had provided to other local NHS providers, but noted that 150 patients had been affected by the junior doctors' strike, so asked if forward projections had been made in relation to the impact of the forthcoming strike. SB firstly clarified that that the 150 patients to which he had referred was the number of 40-week waiting list patients that had been affected by the strike, not the total number of affected patients, which was far higher. SB then confirmed that forward activity projections for the strike were being finalised.

WW commended SB on the 40-week waiting time position, but asked what would be required to deliver a maximum 20-week waiting time. SB explained that the overall patient tracking list (PTL) contained circa 32,000 patients, and the RTT standard was based on how many patients were, on average, treated within 18 weeks. SB continued that 92% of patients should be seen within 18 weeks, and circa 70% of the Trust's patients were treated within 18 weeks. SB then confirmed that the Trust continued to monitor performance against the 18-week standard, and the aforementioned outpatient transformation work, as well as the plans to increase theatre utilisation, would make a major difference to the RTT waiting time performance. SB however highlighted the need for caution,

to ensure there was an appropriate balance across the Integrated Care System (ICS), to avoid widening the inequalities that would arise from the Trust reducing its waiting times further while patients at other Trusts continued to wait far longer. SB also noted that further work was required to support the other Trusts in the ICS to reduce their own waiting times. DH also emphasised that the target for Trusts was to have no patients waiting 78 weeks for treatment by 31/03/23, and to have no patients waiting 65 weeks for treatment by the following year, so the Trust needed to contribute to the ICS position, although the processes to support other Trusts needed to be efficient, to avoid wasting theatre slots from waiting list transfers. MC asked what level of service improvement commitment had been made by other Trusts, to avoid them having to transfer patients. SB explained the liaison that had occurred with Dartford and Gravesham NHS Trust (DGT), while the Trust's Director of Operations for Patient Flow had been appointed as the Chief Operating Officer at Medway NHS Foundation Trust, which SB hoped would lead to an improved relationship. SB also noted that the KMOC would lead to improvements, while clear pathways were in place with DGT and East Kent Hospitals University NHS Foundation Trust. SB also recognised the need for all system partners to be more proactive. SO then added further details to emphasise the importance of the KMOC, the Business Case for which would be considered under item 03-25.

JH then referred to the "Complaints responded within target" metric and reported the following points:

- The rate had increased slightly, but performance was being maintained, at circa 60%, while the number of overdue complaints continued to be reduced. The position had now been maintained for four months. The plan was to reach the 75% target and then 90% by the end of the year.
- A new Head of Complaints and PALS had started in post on 27/03/23. The individual had lots of experience, so JH was hopeful the position would improve.
- There had been a slight increase in Friends and Family Test (FFT) response performance for February. The Trust had had the highest number of responses since the beginning of 2022/23, and the position for March had improved further.
- The recommendation rate from the responses was 95%.
- The initiatives that had been implemented in the ED included using volunteers to approach patients at the point of their discharge.
- The outpatient FFT was still a problem, but the Trust would contract with a new service provider and a preferred provider had been identified.

RJ then referred to the "Systems" Strategic Theme and reported the following points in relation to the "Discharge before Noon" metric:

- There had been a slight reduction in the discharges before noon in February. That seemed to correlate with reduced pressure in the system. However the pressure had increased over the last two weeks. The correlation may however just be a coincidence.
- The Trust had a known issue with discharges before noon at the weekend. Rostering and other measures had been explored, but weekend discharges were more reliant on criteria-led discharge, so that would be the next area of focus. Pilots for Electronic Discharge Notification (eDN) would commence soon, which would help. However, a step-change in performance was required to achieve the 33% standard.

DH noted that the number of medically optimised for discharge (MOFD) patients had increased, to 147 at that morning, which would make it more difficult to reduce escalation capacity. DH added that he was therefore concerned about entering the Easter period with such a high level of MOFD patients, so asked whether action was planned. RJ acknowledged the point while SB provided some context regarding the increase in MOFD patients. PM added that some analysis had been done in relation to the last junior doctors strike, and that had showed that there had been a statistically significant reduction in admissions across all specialties except orthopaedics. PM also stated that a meeting would be held on 31/03/23 to consider and discuss the forthcoming strike, which was expected to be far more disruptive.

SO then referred to the "Sustainability" Strategic Theme and reported the following points:

- The overall financial position at the end of February was in accordance with the Trust's plan. The Trust had been behind its plan in January but the position had been recovered. The Trust also remained on course to deliver a breakeven position by the end of 31/03/23.

- The junior doctors strike had adversely affected the Trust's cost base by hundreds of thousands of pounds, and a similar adverse impact was expected for the strike announced for April 2023.
- The Trust's cash position was good, and the "concerning variation of a declining nature" status was in accordance with SO's expectations at that point in the year.
- The CIP performance was stable, in that the forecast value would be delivered, although that was not the planned level. Non-recurrent means had therefore had to be deployed to achieve the overall financial position.
- The overall expenditure on agency staffing had reduced for the second month in row, following some good work by the Medicine & Emergency Care Division. The closure of escalation capacity would also have a positive impact, as would the reduction in the vacancy rate.
- 2022/23 was the first year that agency expenditure had remained 'flat' during winter, as an increase was usually seen during that period.
- The control process for agency staff would be increased. The Trust's target for 2023/24 was for expenditure on agency staff to be below 3.7% of the Trust's overall expenditure. If the Trust's plans were delivered, agency expenditure would be at 3% at some points during the year, but the average would be circa 4% because of the expected increased expenditure during winter.

EPM observed that the national target was 3.7% but she understood the Trust's plan was to achieve 4.3%. SO clarified that the average planned position would be 4.3%, but referred to page 19 of 28 of the report submitted under item 03-23 and explained that the position would fluctuate across the year, and at some points the rate would be below 3.7%. EPM welcomed the position being reported in the IPR during 2023/24 and noted that the People and Organisational Development Committee would discuss the issue at its meeting in April 2023.

JW asked what impact the KMOC would have on agency staffing expenditure during 2023/24. SO explained that the desire was to have as many staff as possible recruited permanently to the new facility, and as part of the original financial modelling, an assumption of 25% agency staffing had been made, which would equate to 20 to 30 agency staff from an overall staff cohort of 200, although it was hoped the actual number would be lower.

WW noted the challenges in delivering the CIP for 2022/23, and in relation to elective activity, so asked SO if he was comfortable with the plans to deliver the CIP for 2023/24. SO confirmed that he was not comfortable, but lessons would be learned from previous years' CIPs. SO also commended SB and his operational teams for the leadership they had shown in embracing the challenge. SO then gave his further perspective on the challenges, and the opportunities being explored to improve productivity and efficiency. SO also noted that the ICS's financial position meant that the Trust needed to closely monitor the ICS's ability to fund any additional activity the Trust undertook, as there was a risk that the Trust would bear the costs of such activity. SO also acknowledged the importance of starting 2023/24 with a strong performance, and progress would be reported to, and scrutinised by, the Finance and Performance Committee and Trust Board.

JH then highlighted an emerging risk in the reduced supply of Internally Educated Nurses. The point was acknowledged.

Quality items

03-19 <u>Quarterly mortality data</u>

PM referred to the submitted report and highlighted the following points:
- The report was a 'hybrid', as Telstra Health had taken on the responsibility for writing the main content of the first part of the report, while the other parts included the Mortality Surveillance Group and Medical Examiners' service.
- The Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) were much the same as they had been recently, and were below 100 i.e. "as expected".
- Two new CUmulative SUM (CUSUM) alerts, on congestive heart failure, non-hypertensive; and substance-related mental disorders, although the second alert only related to one patient, and PM had asked for a snapshot audit to be undertaken for the first issue.

- The table on the right hand side of page 6 of 10 showed that improvement was still required in relation to documentation, which was important to ensure the Clinical Coding was correct and comprehensive.
- There had been some issues with the resilience of the Medical Examiners service, but there were plans to increase that reliance.
- There main issue that PM had discussed with the Lead Medical Examiner was that death certificates were not being completed in a timely manner, which adversely affected the issuing of the Medical Examiners' reports, which needed to be issued within three days.
- Data was now presented to the MSG in a more focused way, using Statistical Process Control (SPC), and the first hour of the MSG meetings was a 'golden hour' to discuss individual cases. A regular item on morbidity and mortality would be added to the Directorate's clinical governance meetings.
- Letters would be sent out to the teams who had provided excellent care, to encourage and recognise that excellent care was provided by the vast majority of services.
- A Patient Safety Team representative now attending the MSG, which was important in relation to the Structured Judgment Review (SJR) process.

DH noted that several Medical Examiners had resigned so asked if PM was confident about the resilience of the service. PM replied that he was confident with the number of Medical Examiners, but there were some issues with the speciality coverage, as there need to be expertise across all specialties. PM also clarified that there were no particular issues in relation to the reason for the resignations, as the individuals concerned had left the Trust, and not just resigned from the Medical Examiner role.

03-20 <u>To approve the Trust's Patient Safety Incident Response Plan (PSIRP)</u>

JH referred to the submitted report and highlighted the following points:
- The PSIRP was related to the PSIRF, and the PSIRP outlined the intended approach to incidents, which was based on national guidance that stated the types of incidents that required a patient safety investigation. The proposed Plan would also enable a more agile approach, via the use of AARs.
- The Plan had been considered at the Executive Team Meeting (ETM) and Quality Committee, and the approach had been recommended to the Trust Board, although the process would be dynamic and could be adjusted.

KC commented that she liked the change in approach, and commended the plans to increase the involvement of families and utilise digital methods to contact families, but asked for assurance that families without digital access would still be engaged with. JH explained that a portal would be used, while a lay person would be engaged for the work, and the needs of the families would be identified and responded to, in full recognition that some would not have digital access.

KC also noted that the submitted report contained some typographical errors, so proposed these be corrected prior to its further circulation/publication. JH agreed.

Action: Arrange for the typographical errors in the Patient Safety Incident Response Plan that was considered by the Trust Board on 30/03/23 to be corrected, prior to its further circulation/publication (Chief Nurse, March 2023 onwards)

MC also welcomed the increased level of engagement with families. MC then also stated that numerators had been included against the improvement plan, so it would be helpful to see some trajectories added. JH confirmed she would consider MC's point.

Action: Consider if/how performance trajectories could be applied to the improvement measures within the Patient Safety Incident Response Plan (Chief Nurse, March 2023 onwards)

The Patient Safety Incident Response Plan (PSIRP) was duly approved, subject to the correction of any typographical errors.

Workforce

03-21 <u>The finding of the national NHS staff survey 2022</u>

SS referred to the submitted report and highlighted the following points:

- The national survey had been changed in 2021 to align with the NHS People Promise, which enabled progress against the seven key priorities to be monitored over time.
- The Trust was ranked in the top three Trusts to work at across the South East.
- The Trust had scored above the national average for four of the seven People Promise themes, and were at the average for the other three.
- 58% of staff did not complete the survey, so that would be an area of focus, although the response rate had reduced nationally. Triangulation also occurred with other data sources, such as listening events, FTSUG issues etc.
- The Trust's scores had improved over time for "Recognised, Rewarded"; "Each Have Voice"; "Flexible" and "Team". The scores had however declined for "Compassionate, Inclusive"; "Safe, Healthy"; "Always Learning"; "Engaged" and "Morale", although there were several factors that were believed to have affected such areas.
- Page 15 of 20 showed that the majority of Divisions across the Trust had improved their position, but work was taking place with the leaders for the Estates and Facilities areas.
- Mandatory objectives would introduced for senior leaders in 2023/24, which would link back to the Exceptional Leaders' programme, and focus on increasing visibility; and also going 'back to the floor', to either spend time with their teams or 'walk the floor' further.
- The launch of 'Exceptional leaders for all' would start in April for staff in AfC bands 5 to 7.
- Overall, the survey findings triangulated with other data sources, but the test was now to deliver action, and discussions had been held at the ETM and People and Organisational Development Committee. The next steps involved further engagement with the Divisions.

Systems and Place

03-22 Update on the West Kent and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)

DH firstly declared that AY was a non-Board Associate Non-Executive Director at the Kent and Medway ICB, and would be a member of the ICB's Performance and Investment Committee, which was relevant for all the ICS-related items on the agenda. The point was acknowledged.

RJ then referred to the submitted report and highlighted the following points:

- The Joint Forward View document would be submitted to the Trust Board in April 2023.
- A further planning submission would need to be made.
- The ICB were involved in a public consultation on Improving Section 136 health-based places of safety. Kent and Medway had been allocated £3.7m of government funding to make improvements.
- The submitted report included a letter confirming the outcome of the latest Place Oversight Meeting for West Kent.

DH referred to the latter point and welcomed oversight being at Place level instead of ICS level. RJ however clarified that there were still two separate oversight meetings, but these were held on same day and tried to avoid duplication.

NG remarked that the Finance and Performance Committee had noted that virtual wards were not being as effective as intended. PM explained that the frailty virtual ward was progressing well, but the respiratory virtual ward was not, so work was in progress to address the issues. PM added that there was however some concern regarding the placement of virtual wards within the care architecture.

Planning and strategy

03-23 Update on the Trust's planning submissions for 2023/24

DH firstly noted that Trust was almost certain that a further submission would be required in the near future, and the submitted report was similar to the plans that had been considered at the Trust Board meeting on 20/03/23. RJ then referred to the submitted report and highlighted that the activity plans had not changed but there had been some changes to the financial plan.

SO then referred to the submitted report and highlighted the following points:

- There had been a reduction in the 'planning gap' that had been discussed at the extraordinary Trust Board meeting on 20/03/23, and the planning deficit was now at £12.9m.
- Report included the agency expenditure trajectory that had been discussed under item 03-18.
- The overall financial position was significantly challenged nationally, but the requirement for a further planning submission was related to the need to have credible and deliverable financial plans across all providers and ICSs.
- The national expectation was that there would be no above-inflation increase in costs, including pay costs, but the Trust had seen such increases in A&C staff, Scientific and Technical staff and Nursing staff, so SO would work with SS' and JH's teams to try and address the issues. The 'arches' that had been referred to under action 03-3 would be helpful on such issues.

The Trust Board therefore noted the submission that had been made and also acknowledged that a further submission would be required.

03-24 Update to capital programme funding and expenditure approvals, 2022/23

DH firstly noted that the report had been considered by the Finance and Performance Committee on 28/03/23, and had been recommended for approval by the Trust Board. SO then referred to the submitted report and highlighted the following points:

- The individual Business Cases were below the threshold for approval by either the Finance and Performance Committee or Trust Board, but the overall programme had been submitted, to ensure that the Finance and Performance Committee and Trust Board were aware of the full details of the actual expenditure, given the Trust Board's approval of the programme at the start of 2022/23, as part of the financial plan for that year.
- The two major schemes in the programme were the KMOC and Community Diagnostic Centre (CDC), both of which were progressing.

To Trust Board approved the overall use of capital resource for 2022/23 as described within the submitted report.

03-25 To approve the Full Business Case (FBC) for the additional orthopaedic elective capacity for Kent and Medway

DH firstly pointed out that the FBC had been considered at the Finance and Performance Committee on 28/03/23, and the Committee had recommended that the Trust Board approve the FBC. DH also explained that the Trust Board had previously approved the Outline Business Case (OBC) for the project, but the FBC needed to be developed, approved by the Trust Board and submitted to NHSE, for final approval, so that contracts could be signed and construction commence. DH also pointed out that the submitted report clearly showed the changes between the OBC and FBC.

SB then referred to the submitted report and highlighted that there had been very few changes from when the Trust Board had considered and approved the OBC, and the main change was an increase in outpatient activity, which had improved the financial position of the Case.

DH asked whether the timescale for consideration by NHSE was known. SO confirmed that the FBC was scheduled to be considered at the June 2023 meeting of NHSE's Joint Investment Sub-Committee (JISC), but there was a possibility that it could be considered at the JISC's meeting in May, although that was contingent on some items being completed to NHSE's satisfaction before then. SO however added that when NHSE had approved the OBC, approval had also been given for the associated works, so if the JISC did not consider the FBC until June, there would be no adverse impact on the project timescale. SO also however clarified that even if the FBC was considered by the JISC in May, the timescale would not be accelerated, although there would be overlapping certainty between the funding that had been approved to date and the future approved funding. The point was acknowledged.

The Trust Board approved the Full Business Case (FBC) for the additional orthopaedic elective capacity for Kent and Medway, as submitted.

DH then commended the progress that had been made and thanked all those that had contributed to such progress. SB added his specific thanks to the Associate Director of Finance – Financial Projects and Deputy Chief Operating Officer.

03-26 To approve the Digital Pathology Outline Business Case (Kent and Medway Pathology Network)

DH firstly also noted that the OBC had been considered at the Finance and Performance Committee on 28/03/23, and had been recommended for approval by the Trust Board. RJ then referred to the submitted report and highlighted the following points:

- The Trust Board was just being asked to approve the development of the FBC, and no further commitments would be sought, or made, at that point.
- The OBC had been considered by the ETM and across the ICS.
- MS was the Chair of the Pathology programme, so he was well aware of the project.
- The full details would be within the FBC, as there was a query as to whether the revenue would be provided centrally or need to be provided locally.
- The Trust Board was therefore being asked for permission to develop the FBC, which would then be considered by the Business Case Review Panel, ETM and Trust Board, given the scale of the investment.

The Trust duly approved the Outline Business Case (OBC) for the Digital Pathology Outline Business Case (Kent and Medway Pathology Network), which equated to approval for the development of the FBC.

03-27 To approve a Business Case for Trust Staff Accommodation

DH firstly also noted that the Business Case had been considered at the Finance and Performance Committee on 28/03/23, and had been recommended for approval by the Trust Board. RJ then referred to the submitted report and highlighted the following points:

- The new accommodation facility at Springwood Road had been successful thus far.
- The Trust had a lease on some older buildings in the same area.
- A strategic review had been undertaken which had incorporated all options, including the use of the Mercure Hotel at Tunbridge Wells. Although that option was not currently financially viable, discussions were continuing, supported by MS.
- The older accommodation under the lease comprised four blocks but they needed to be refurbished, with new kitchens, new bathrooms etc. to align with quality of the new accommodation facility.
- The Kent and Medway Medical School (KMMS) accommodation had been significantly delayed, so the Trust had to find alternative accommodation for the students from July 2023.
- Work had been done with the One Public Estate programme to identify demand, and RJ proposed that the Trust continued to work with One Public Estate, to enable the accommodation to be fully utilised, given the financial challenge associated with the proposed option.
- The financial summary was contained on page 14 of 26. RJ acknowledged, as had been raised at the Finance and Performance Committee meeting, the need to improve the management of the accommodation, but there were some opportunities to reduce the financial impact.
- RJ believed that the proposal was a good strategic option that would meet several future needs.
- The utilisation of the properties would be such that the proper refurbishment works would be unable to start until April 2024, when the KMMS accommodation building opened.
- The Trust would be able to abide by the International Financial Reporting Standards (IFRS) rules, provided the documentation was executed by the end of 31/03/23. The Trust's legal advisers had therefore prepared the relevant documents but the execution of the documents would depend on the Trust Board's decision.

DH reiterated that the Trust would carry the risk of void units, so the Finance and Performance Committee had confirmed its support for the Business Case only on the basis that the management of the accommodation improved. RJ acknowledged the point and noted that a further report, on future rental income, would be prepared in the coming weeks.

WW referred to page 14 and asked whether the future affordability for staff had been considered. RJ explained that the accommodation units comprised four or five shared blocks, while the rental values in the submitted report included all bills. RJ continued that the Trust was keen to make the rental affordable, and the market rates had been provided for information and context to enable comparison with the costs that would be incurred for private accommodation. RJ added that the Trust would however need to cover the accommodation costs. The point was acknowledged.

The Business Case for Trust Staff Accommodation was approved as submitted, and it was confirmed that the leases would be able to be executed on 31/03/23.

Annual Report and Accounts

03-28 Confirmation of the outcome of the Trust's 'going concern' assessment

SO referred to the submitted report and highlighted the following points:

- As part of the annual accounts, the Trust had to make a statement about the basis on which the accounts would be prepared.
- The ETM and Finance and Performance Committee had considered the issue and confirmed their support for the Trust's annual accounts for 2022/23 being prepared under the going concern principle.

The Trust Board confirmed that the Trust's annual accounts for 2022/23 should be prepared under the going concern principle.

Other matters

03-29 To consider any other business

There was no other business.

03-30 To respond to questions from members of the public

KR confirmed that no questions had been received.

03-31 To approve the motion (to enable the Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

The motion was approved, which enabled the 'Part 2' Trust Board meeting to be convened.

Trust Board Meeting – April 2023

NHS Maidstone and Tunbridge Wells NHS Trust

Log of outstanding actions from previous meetings **Chair of the Trust Board**

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress[1]
02-10a	Consider adjusting the target for the "Appraisal Completeness" metric to reflect the fact that performance would likely decline during the appraisal 'window', and the final position would not be known until the 'window' had closed.	Chief People Officer	February 2023 onwards	Discussions are ongoing to indicate a trajectory for the three-month window of appraisal completion.
03-20a	Arrange for the typographical errors in the Patient Safety Incident Response Plan that was considered by the Trust Board on 30/03/23 to be corrected, prior to its further circulation/publication.	Chief Nurse	March 2023 onwards	A verbal update will be given at the meeting.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
02-10d	Provide an "Update on the provision of for non-emergency patient transport" at the Trust Board meeting in April 2023.	Chief Operating Officer and Director of Strategy, Planning and Partnerships	April 2023	A verbal update has been scheduled for the Trust Board meeting in April 2023.
03-3	Explore what could be developed to show the 'arch' for each of the major income and expenditure categories, to enable Trust Board members to better understand the delivery of the CIP for 2023/24.	Deputy Chief Executive / Chief Finance Officer	April 2023	This has been included in the planning update item at the April 2023 Trust Board meeting.
03-20b	Consider if/how performance trajectories could be applied to the improvement measures within the Patient Safety Incident Response Plan.	Chief Nurse	April 2023	The application of performance trajectories was duly considered; however, it was agreed that due to the further data being required following the 'go live' of the InPhase Incident Reporting and Risk Management System, that such performance trajectories would be

[1] Not started | On track | Issue / delay | Decision required

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
				developed and implemented in six months, once the Trust's starting position was understood.

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
N/A	N/A	N/A	N/A	N/A
				N/A

NHS Maidstone and Tunbridge Wells NHS Trust

Report from the Chair of the Trust Board **Chair of the Trust Board**

Consultant appointments

I and my Non-Executive colleagues are responsible for chairing Advisory Appointment Committees (AACs) for the appointment of new substantive Consultants. The Trust follows the Good Practice Guidance issued by the Department of Health, in particular delegating the decision to appoint to the AAC, evidenced by the signature of the Chair of the AAC and two other Committee members. The delegated appointments made by the AAC since the previous report are shown below.

Date of AAC	Title	First name/s	Surname	Department	Potential / Actual Start date	New or replacement post?
06/04/23	Consultant Palliative Care	**Beth**	**Mackay**	Oncology	April 2024	New

Which Committees have reviewed the information prior to Board submission?
N/A

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Information

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Report from the Chief Executive **Chief Executive**

I wish to draw the points detailed below to the attention of the Board:

- Our hospitals have been managing the challenge of national industrial action by the British Medical Association (BMA) this month. This involved approximately 320 of our junior doctors and affected our services from 11-15 April. While we worked hard putting plans in place to ensure any impact to patients was kept to a minimum, we did unfortunately have to postpone a number of appointments and procedures. Patients impacted were contacted before their appointment and rescheduled to the nearest possible date. The majority of care did however continue as normal, with urgent and oncology appointments prioritised. We know how challenging this has been for our teams and would like to thank colleagues for their work to continue providing our patients with the best possible care during this time. We welcomed our junior doctors back after the industrial action and continue to work closely with Staff Side colleagues to support staff and our services and reduce the impact of any future action on our patients.

- Royal College of Nursing members working on Agenda for Change contracts will take 48 hours of round-the-clock strike action from 8pm 30 April to 8pm 2 May 2023. This will not impact on this Trust because nurses are not taking action here but could impact on other NHS services run in the local area. Unison announced that their members have voted to accept the pay offer agreed between non-medical unions and government, which they recommended to their membership.

- Our CQC 'Well-Led' inspection took place on 28 and 29 March and we would like to thank everyone involved in this as well as the unannounced visits earlier last month. While we've already had some positive feedback from the inspection team, we look forward to the full report in 10-12 weeks. Initial feedback and comments included:

  - Systems in place to support staff following challenging incidents being reported and how the trust had dealt with difficult situations in a sensitive way
  - A strong clinically-led model in place
  - A compassionate approach to management and a strong stable leadership team
  - Improvements needed to governance and risk management

- Work is progressing with the Kent and Medway Orthopaedic Centre build, with the latest updates on the project as follows:

  - Groundworks are on target and are due to be completed at the end of May.
  - The modular units which will make up the building are being built off-site and are expected to arrive in the summer.
  - The recruitment of the approx. 200 posts required for the centre is underway and on track. A number of appointments have already been made including two leadership roles and nine internationally educated nurses. More interview rounds are taking place soon.
  - The operational readiness group has met for the first time. Their key focus is on equipment, patient engagement and communications, and policy.
  - NHS England will be reviewing the Full Business Case until the end of May. It is due to be submitted to the NHS England and the DHSC Joint Investment Sub-Committee (JISC) in June for approval.

- The additional funding to support capacity in other places so that we can discharge patients has been extended for another two months**.** This has helped us buy some additional rehabilitation capacity in a local care home, move patients who are waiting for long term care when they live outside Kent, and supported the use of a couple of flats for patients waiting who

have housing issues. In addition we have been able to put in some dedicated care packages for patients in difficult to commission areas.

- Our transition from Datix to InPhase has now gone live which will improve the management of incidents, complaints/PALS, risks and claims. This integration will also introduce LfPSE (Learn from Patient Safety Events Service) reporting which is to replace the current NRLS (National Reporting Learning System) process. Not only will the new platform improve on what is currently recorded but added functionality will also strengthen the quality of data recorded enabling a true reflection of how incidents, complaints/PALS, risks and claims are being managed and mitigated both departmentally and organisationally.

- At the beginning of the year we asked for help in recognising the fantastic work of staff and volunteers at MTW as part of our Exceptional people, outstanding care Star Awards. My thanks to everyone who wrote one of the 450 nominations we received – they were a pleasure to read. The event was cancelled for three years as we responded to the pandemic and we are thrilled the awards are back. This is a wonderful opportunity to celebrate the people and teams who reflect the behaviours, values and outstanding care we see across MTW every day. The judges faced a difficult job We are delighted to announce the shortlisted nominees for each of the categories which you can view on our website. The winners of the awards will be announced on 28 April and will also be published on our website and social media channels.

- As well as our own upcoming awards, our teams and colleagues continue to be recognised externally for their fantastic work. Most recently this includes:

  - The shortlisting of our Care Coordination Centre in the Improvement 'Urgent and Emergency Care through Digital' category in the HSJ Digital Awards 2023. The centre works with a digital bed management system which provides real time information on bed occupancy 24 hours a day, seven days a week. This data shows how many of the 700 beds across its hospitals are empty, may need cleaning or have a patient who is leaving. This has helped significantly improve bed turnaround times and helps provide patients with the right care, in the right place, at the right time.

  - Student Nurse Karla Hamlet has been shortlisted for an Innovation in Practice Award at this year's prestigious Student Nursing Times Awards. Karla was shortlisted for her work on the VOICE BOX project which supports students to share ideas to improve their education and working experience at the Trust while on their placements. From the data collected, teams work to find solutions and take forward new ideas. The VOICE BOX project is intended to offer both nursing staff and nursing students a voice. It empowers students to create change, foster good relationships between teams and deliver outstanding patient care.

  - The Maternity Triage, Maidstone Birth Centre and Antenatal Ward teams have been named joint winners of the National Institute for Health and Care Research (NIHR) awards for their contribution to vital research projects across the region. The judging panel for the awards, made up of NIHR and NHS representatives from around the region, were impressed with the support given to the GBS3 trial by all three teams. The trial involved the routine testing of pregnant women for group B Strep (GBS), the most common cause of life-threatening infection in newborn babies in the UK, comparing two different testing approaches. The teams' dedication to research has led to 80% of eligible women being offered the test for group B Strep.

- As one of the top performing trusts in the country for timely cancer treatment, and one of only a handful of trusts to have met national cancer standards for three years, the work of the Kent Oncology Centre was highlighted in a series of powerful special reports on BBC South East News. Our team of 600 staff see more than 150,000 patients a year, and carried out 35,000 chemotherapy treatments and more than 50,000 radiotherapy sessions last year. Over four days the centre was the focus of a series of powerful daily reports by the regional flagship BBC South East Today news programme, looking at the impact a cancer diagnosis has on patients,

their families and the staff who look after them. As part of the series, the BBC met a number of patients receiving cancer care to talk about their experiences. They also spoke to colleagues about the treatments offered to cancer patients and how these continue to develop, and visited some services that patients may not see. To watch the reports, visit the Trust's YouTube channel.

- Congratulations to the winner of the Trust's Employee of the Month award for March – Nurse, Marie Arnaez. Marie was given the award after receiving a special compliment from a patient following a sensitive conversation over the phone relating to their care. The patient said: "I never thought I'd be smiling through most of that conversation, or, even better, hang up the phone to go about the rest of my day smiling. But I'll tell you, she had that effect on me. Her love of her job and her basic decency and empathy reached out even across the phone." Business Intelligence Business Partner, Gavin Ward was given the Highly Commended award for March after being nominated for his support to our finance colleagues.

Which Committees have reviewed the information prior to Board submission?
N/A

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Summary report from Quality Committee, 12/04/23 Committee Chair (Non-Exec. Director)

The Quality Committee met (virtually, via webconference) on 12th April 2023 (a Quality Committee 'deep dive' meeting).

1. **The key matters considered at the meeting were as follows:**
   - The **actions from previous meetings** were noted.
   - The Clinical Audit and Regulatory Compliance Lead, and Director of Quality Governance attended for a **review of draft quality priorities for 2023/24 (for inclusion in the Quality Accounts 2022/23)** which included an update on implementation of Quality Accounts priorities 2022/23, wherein the Committee noted the intention to implement watch metrics on the InPhase Incident Reporting and Risk Management System to support the monitoring process of the Trust's quality priorities and was informed of the mechanisms to further embed a safety culture at the Trust. The Committee approved the draft quality priorities for 2023/24, for inclusion in the Quality Accounts 2022/23; however, it was agreed that the Director of Quality Governance liaise with the Divisional Director of Operations, Core Clinical Services to obtain further clarification regarding the "achievement update" which had provided for the "improving the waiting times for our patients who are waiting for an operation" quality priority.
   - The Deputy Chief of Service for Surgery; the Deputy Chief of Service for Medicine and Emergency Care; and the Senior Sister, Critical Care Outreach Team presented a **Further review of the management of Sepsis at the Trust** which provided Committee members with details of the challenges associated with embedding the importance of Sepsis at the Trust; the initiatives which had been developed to increase clinical engagement with Sepsis; and the further work which was required to ensure that completion of the Sepsis Electronic Screening Tool was mandated for all clinical staff. A discussion was then held regarding the utilisation of the Strategy Deployment Review (SDR) process to provide robust executive oversight to the management of sepsis and deteriorating patients and it was agreed that the Assistant Trust Secretary should schedule an "Update on the management of Sepsis at the Trust" item at the September 2023 'main' Quality Committee meeting.
   - The Medical Director, Senior Business and Delivery Manager (Medical Directorate), and Business Intelligence Manager attended for an **in-depth review of the Trust's mortality rate** which included a comprehensive overview of the mechanism via which the Trust's mortality rate was calculated; the work to improve mortality governance at the Trust and the associated lessons learned process; and the importance of ensuring a culture of learning at the Trust, and it was agreed that the Medical Director should consider what, if any, actions could be implemented to expedite the Structured Judgement Review (SJR) process for the backlog of outstanding SJRs. It was also agreed that the Medical Director should investigate the development of a mortality dashboard, to improve the accessibility of mortality data for Trust staff.
   - The Committee reviewed the **items scheduled for scrutiny at future Quality Committee 'deep dive' meetings**, and it was confirmed that the June 2023 Quality Committee 'deep dive' meeting would focus on a "Review of Stroke Services"; a "Review of the Trust's medicine management and optimisation"; and a "Further review of the Quality and Clinical Governance issues associated with the implementation of the Electronic Patient Record". It was also agreed that the Assistant Trust Secretary should remove the "Review of the management of falls at the Trust" item from the June 2023 Quality Committee 'deep dive' meeting and schedule a "Closure report for the "Reduction in the rate of patient falls to 6.35 per 1000 occupied bed days by March 2023" breakthrough objective" item at the May 2023 'main' Quality Committee meeting.
   - Under **Any Other Business** the Director of Quality Governance informed Committee members of the potential impact on reporting associated with the 'go live' of the InPhase Incident Reporting and Risk Management System on the 24th April 2023.
   - The Committee conducted an **evaluation of the meeting** wherein Committee members commended the presentations which had been provided.

2. **In addition to the agreements referred to above, the meeting agreed that:** N/A

3. The issues from the meeting that need to be drawn to the Board's attention are: N/A
Which Committees have reviewed the information prior to Board submission? N/A
Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1] 1. Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Summary report from the Finance and Performance Committee, 25/04/23	Committee Chair (Non-Exec. Director)

The Committee met on 25th April 2023, via a webconference.

1. The key matters considered at the meeting were as follows:

- The **actions from previous meeting**s were reviewed and it was agreed that the Trust Secretary should undertake a review of compliance with the Committee's Terms of Reference, as part of the current annual review/update of the Terms of Reference.
- The Chief of Service, Director of Operations and Director of Nursing and Quality from the Cancer Services Division attended for an interesting **deep dive into the outpatients transformation programme.** The Committee heard details of the three workstreams that would focus on the 'basics'; digital transformation; and new outpatient pathway transformation; and asked for further data on the average time taken to answer outpatient telephone calls. The team was also asked to consider how the quality of outpatient telephone call responses could be measured. It was also agreed that a further update should be scheduled in July 2023.
- The **Patient Access strategic theme metrics for month 12** (i.e. March. 2023) were reviewed and the Trust's achievements for what had been a tough 2022/23 were acknowledged.
- The review of **financial performance for month 12** confirmed that the Trust had delivered its financial plan for 2022/23, although much of that delivery had been via non-recurrent means. The recent increase in temporary staffing expenditure was reported to be, in part, related to staff taking their full Annual Leave (A/L) entitlement by the end of March, so the Deputy Chief Executive agreed to liaise with the Chief People Officer to explore whether the Trust could base its staff members' A/L year on the date they started at the Trust.
- The latest **quarterly analysis of consultancy use** was received, which highlighted the significant reduction of such expenditure in 2022/23 when compared to previous recent years.
- An **update on the Trust's final planning submissions for 2023/24** was given, which noted that a further submission was required by 04/05/23. The Committee discussed the further pressures that had arisen recently, including inflationary pressures, as well as the current status of the 2023/24 Cost Improvement Programme (CIP). It was also agreed to schedule a "Confirmation of the Trust's final planning submissions for 2023/24" item in May 2023.
- The latest six-monthly **update on the PFI contract at Tunbridge Wells Hospital** was received, and it was agreed to receive future updates annually.
- The latest **update on the implementation of the Electronic Patient Record (EPR)** was given.
- The Trust Secretary gave details of the latest **annual review of the Standing Financial Instructions, Standing Orders and Scheme of Delegation**.
- The **summary report from the People and Organisational Development Committee in February 2023** and **the reports submitted to that Committee in relation to the "Reduce the amount of money the Trust spends on premium workforce spend" Breakthrough Objective** were noted; as were the latest **uses of the Trust Seal**.

2. **In addition to the agreements referred to above, the Committee agreed that:**

- The Deputy Chief Operating Officer should ensure that the A3 process was completed for the "Patient Access –Activity Levels" section of the Integrated Performance Report
- The Deputy Chief Executive should circulate, to Committee members, the work that had been done to show the 'arch' for each of the major income and expenditure categories.
- The (Deputy Director of Finance (Performance) should provide Committee members with further details of the Trust's income position; and also confirm how much of the £5m of "Divisional Efficiencies" CIP scheme was rated as "High Risk".
- The Trust Secretary should continue to schedule the Committee's consideration of the reports submitted to the People and Organisational Development Committee in relation to the "Reduce the amount of money the Trusts spends on premium workforce spend" Breakthrough Objective.

3. **The issues that need to be drawn to the attention of the Board are as follows:** N/A

Which Committees have reviewed the information prior to Board submission? N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the People and Organisational Development Committee, 21/04/23 (incl. quarterly update from the Guardian of Safe Working Hours (covering January to March 2023))

Committee Chair (Non-Exec. Director)

The People and Organisational Development Committee met (virtually, via webconference) on 21st April 2023 (a 'main' meeting).

The key matters considered at the meeting were as follows:

- The **actions from previous 'main' meetings** were noted and it was agreed that the Deputy Chief People Officer, Organisational Development should liaise with the Assistant Trust Secretary to consider, and confirm, the scheduling of the "Multi-professional Learning and Development Strategy" at a future Committee meeting.
- The Committee noted the **workforce plan for 2023/24**.
- The Programme Director, Premium Staffing Spend and Deputy Chief Executive / Chief Finance Officer presented an **update on the progress with the Sustainability Strategic Theme four key themes** which included a comprehensive overview of the Trust's agency expenditure outturn for 2022/23; the programme of work to improve the e-Rostering and the associated controls at the Trust; and details of the work required to improve medical rostering. The following actions were agreed:
  - The Chair of the Committee, Chief People Officer, and Deputy Chief Executive / Chief Finance Officer should liaise to consider the reporting arrangements in relation to the "Update on the progress with the Sustainability Strategic Theme four key themes" item at the People and Organisational Development Committee and Finance and Performance Committee, to prevent the duplication of workload, whilst ensuring the relevant aspects received the appropriate oversight.
  - The Deputy Chief People Officer, Organisational Development; and Programme Director, Premium Staffing Spend should liaise to ensure an aligned approach to the implementation of operational controls and cultural changes required to reduce agency expenditure.
  - The Programme Director, Premium Staffing Spend should ensure that the work of various forums at the Trust (e.g. the Flexible Working Group) were considered as part of the work to address the Sustainability Strategic Theme four key themes.
  - The Programme Director, Premium Staffing Spend; and Deputy Chief Executive / Chief Finance Officer should ensure that a future "Update on the progress with the Sustainability Strategic Theme four key themes" report to the Committee includes a 'roadmap' and associated timelines for the delivery of the four key themes.
- The Head of Equality Diversity and Inclusion (EDI) & Engagement attended for a **Review of the equal pay annual audit return 2022/23** which included details of the evidence-based actions for employers which had been issued by the Government Equalities Office; and the de-biasing recruitment training which had been scheduled throughout 2023, commissioned by the Kent and Medway Integrated Care Board (ICB) and it was agreed that the Head of EDI & Engagement should develop a set of defined targets for the reduction of the Trust's Gender Pay Gap, to enable accountability and oversight of the performance of the proposed action plan. It was also agreed that the Head of EDI and Engagement should provide Committee members with details of the Trust's Gender Pay Gap by staffing group, to enable consideration as to whether targeted interventions were required in relation to any specific staffing group.
- The **Guardian of Safety Working Hours** attended for the latest **quarterly update** which covered January to March 2023 (the report has been enclosed under Appendix 1).
- The Head of Organisational Development (OD, Leadership, Wellbeing, Engagement & EDI) and Interim Deputy Chief People Officer, People and Systems attended for a **Review of the high vacancy rates within the Trust's lower banded support roles** which included details of the further 'deep dives' which would be conducted into specific areas, the key issues which had been identified such as inadequate management relationships; and the further work which was required to support the development of middle managers. It was agreed that the Deputy Chief

People Officer, Organisational Development should check, and confirm to Committee members, the proportion of NHS Agenda for Change (AfC) pay band 2 - 4 staff which did not receive an appraisal as part of the Trust's appraisal process for 2022.

- The Interim Deputy Chief People Officer, People and Systems presented the latest **review of the "Strategic Theme: People" section of the Integrated Performance Report (IPR)** which included commendation of the significant reduction which had been made in both the Trust's vacancy rate and turnover rate and the importance of celebrating such achievements.
- The Committee received the first **update from the Health and Wellbeing Committee**.
- The **findings from the Committee's evaluation for 2023** were discussed and several recommendations were supported. It was also agreed that the Chief People Officer should explore the inclusion of improvement trajectories and impact assessments as part of reports to the Committee, where appropriate.
- The Committee's **forward programme was noted**.
- Under the **evaluation of the meeting** the Committee commended the discussions which had been held regarding key issues.

In addition to the actions noted above, the Committee agreed that: The Chief People Officer; Deputy Chief Executive / Chief Finance Officer; and Interim Deputy Chief Nurse, Workforce and Education should consider, and confirm to the Committee, the methods by which the Trust's Executive Directors would support the programme of work to achieve a reduction in the Trust's Gender Pay Gap.

The issues from the meeting that need to be drawn to the Board 's attention as follows:

- The quarterly update from the Guardian of Safe Working Hours (covering January to March 2023) is enclosed in Appendix 1, for information and assurance

Reason for receipt at the Board (decision, discussion, information, assurance etc.)[1]
Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

'MAIN' PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE – APRIL 2023

NHS Maidstone and Tunbridge Wells NHS Trust

QUARTERLY UPDATE FROM THE GUARDIAN OF SAFE WORKING HOURS (JANUARY TO MARCH 2023) **GUARDIAN OF SAFE WORKING HOURS**

The enclosed report covers the period January 2023 – March 2023:

- During this period there were a total of 91 Exception Reports (down from 177 in the last quarter)
- Main reduction was in numbers of Exception Reports from General Medicine.
- Inadequate staffing levels were the main reason for excessive hours worked by trainee Doctors.
- 5 Exception Reports were related to missed educational opportunities
- 10 Exception Reports were made due to patient safety – all of these were related to inadequate staffing levels

Reason for circulation to People and Organisational Development Committee
Assurance

Reporting Period: January 2023 to March 2023

Exception Reports-Patient Safety (All related to low staffing levels)

Specialty	Grade	No. Exceptions raised
Medicine	FY1	2
	CT	1
	ST	3
ENT	FY2	1
Gastroenterology	FY1	3
Total		10

Exception Reports-Work Schedule related

Specialty	Grade	No. Exceptions raised
Medicine	FY1	20
	CT	17
	ST	9
ENT	FY2	1
Gastroenterology	FY2	13
Haematology	FY2	2
	ST	5
Ophthalmology	ST5	1
Trauma and Orthopaedics	FY2	3
Obstetrics and Gynaecology	ST5	1
General Surgery	FY1	4
Total		76

Exception Reports-Educational Opportunities missed

Specialty	Grade	No. Exceptions raised
Medicine	ST	1
	CT	2
ENT	FY2	1
Obstetrics and Gynecology	ST	1
Total		5

(Total combined ERs = 91)

Work Schedule Reviews

No new work schedule reviews were undertaken this period.

Fines

No fines were instigated during this period

Report commentary

During the period **January 2023 to March 2023** there were a total of 91 Exception Reports.

5 of these were due to missed educational opportunities.
76 were due to work schedule/staffing levels.
10 of these were due to Patient Safety (all of these were also recorded under work schedule review/ staffing as this was the main concern)

There has been a 60% drop in the number of Exception Reports over the last 3 months. This is largely due to a reduction in the numbers from Medicine. It is to be hoped this reflects the work done by the Chief of Service for Medicine and Emergency Care and colleagues with regards to staffing levels and the rota.

There continues to be long delays in Supervisors responding to Exception Reports . I note that the Medical Staffing team are going to send out more reminders. I have asked if the Medical Staffing team can attach a link regarding how to use Allocate for Exception Reporting and how to obtain or reset passwords to these reminders. This has been successful at several other trusts.

In the last report there were a relatively large number of reports from ophthalmology. This related to problems with an overrunning clinic. This number has reduced to 1 which is pleasing.

There were 7 Exception Reports from Haematology. This relates to non-resident registrars working more hours onsite than their hours contracted. The former Guardian of Safe Working Hours asked for a work schedule review. I have recently contacted the relevant Supervisors for an update.

Dr Tim Bell

NHS Maidstone and Tunbridge Wells NHS Trust

To approve revised Terms of Reference for the Remuneration and Appointments Committee (annual review)	Chair of the Trust Board / Trust Secretary

The review of the Remuneration and Appointments Committee's Terms of Reference is due, as they were last approved by the Trust Board in February 2022.

The Terms of Reference have therefore been reviewed and some changes are proposed. These are shown as 'tracked' on the following pages. They are essentially 'housekeeping' changes and amendments to remove any ambiguity over the Committee's role and scope.

The changes were agreed at the Remuneration and Appointments Committee meeting held on 30/03/23, and the Trust Board is asked to approve the changes.

Which Committees have reviewed the information prior to Trust Board submission?

- Remuneration and Appointments Committee, 30/03/23

Reason for submission to the Trust Board (decision, discussion, information, assurance etc.) [1]

To approve the revised Terms of Reference for the Remuneration and Appointments Committee

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

REMUNERATION AND APPOINTMENTS COMMITTEE

TERMS OF REFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

1. Purpose

In accordance with the Code of Conduct and Code of Accountability[2], a Remuneration and Appointments Committee is constituted by the Trust Board.

2. Membership

- The Chair of the Trust Board (Chair of the Committee)
- All Non-Executive Directors

The Vice Chair of the Committee will be the Vice Chair of the Trust Board.

Members are expected to attend all relevant meetings.

3. Quorum

The Committee shall be quorate when the Chair and two Non-Executive Directors are in attendance.

4. Attendance

The following are invited to attend each main meeting:

- Chief Executive
- Chief People Officer
- Associate Non-Executive Directors

Other staff may be invited to attend, to meet the Committee's purpose and duties.

5. Frequency of Meetings

Meetings will be scheduled according to need, but there will be a minimum of one meeting per year.

6. Duties

6.1 To review, on behalf of the Trust Board, the appointment of members of the Executive Team, to ensure such appointments have been undertaken in accordance with Trust Policies.

6.2 To review, on behalf of the Trust Board as required, the remuneration, allowances and terms of service of ~~members of~~ the Executive Directors~~Team~~[3], to ensure that they are fairly rewarded for their individual contribution to the organisation; and by having proper regard to whether such remuneration is justified as reasonable.

6.3 To review, with the Chief Executive, the performance of ~~members of~~ the Executive Directors~~Team~~.

6.4 To oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments, taking account of the Trust's Standing Financial Instructions and national guidance, as appropriate. Any non-contractual payment to an Executive Director ~~staff member~~ must be first reviewed and approved by the Committee.

6.5 To consider and approve, on behalf of the Trust Board, proposals on issues which represent significant changes to remuneration e.g. "Agenda for Change" implementation, Consultant contract/incentive scheme[4].

---

[2] Department of Health, 1994 (and subsequent revisions)

[3] The Executive Director roles are defined with the Trust's Standing Orders

[4] The Committee will not consider matters relating to individual posts covered under the Agenda for Change national framework, or matters relating to individual medical staff

7. Parent Committee and reporting procedure

The Remuneration and Appointments Committee is a sub-committee of the Trust Board.

The Chair of the Remuneration and Appointments Committee will determine the extent (and format) to which the ~~detailed~~ activities of the Committee are reported to the Trust Board.

8. Sub-committees and reporting procedure

The Remuneration and Appointments Committee has no sub-committees, but may establish fixed-term working groups, as required, to support the Committee in meeting the duties listed in these Terms of Reference

9. Administration

The minutes of the Committee will be formally recorded and presented to the following meeting for approval and review of actions.

The Committee will be serviced by administrative support from the Trust Secretary.

10. Emergency powers and urgent decisions

The powers and authority of the Remuneration and Appointments Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted the Committee's Vice Chair or the Chair of the Audit and Governance Committee. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Committee, for formal ratification.

11. Review of Terms of Reference

These Terms of Reference will be agreed by the Remuneration and Appointments Committee and approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements

History

- Revised Terms of Reference agreed by the Remuneration Committee, 24/06/15
- Revised Terms of Reference approved by the Trust Board, 22/07/15
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 25/01/17
- Revised Terms of Reference approved by the Trust Board, 22/02/17
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 23/01/18
- Revised Terms of Reference approved by the Trust Board, 01/03/18
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 29/03/18 (to list Chief Executive among those invited to attend each meeting, and note the change in secretariat function)
- Revised Terms of Reference approved by the Trust Board, 26/04/18
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 19/12/19
- Revised Terms of Reference approved by the Trust Board, 30/01/20
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 19/11/20
- Revised Terms of Reference approved by the Trust Board, 26/11/20
- Revised Terms of Reference approved by the Trust Board, 24/02/22
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 30/03/23 (annual review)
- Revised Terms of Reference approved by the Trust Board, 27/04/23 (annual review)

Integrated Performance Report (IPR) for March 2023	**Chief Executive / Members of the Executive Team**

The IPR for month 12, 2022/23, is enclosed, along with the monthly finance report and the latest 'planned vs actual' nurse staffing data.

Which Committees have reviewed the information prior to Board submission?
Finance and Performance Committee, 25/04/23

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Review and discussion

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

March 2023

MTW
exceptional people, outstanding care

Contents

Note: Detailed dashboards and a deep dive into each SDR and CQC Domain are available on request - mtw-tr.informationdepartment@nhs.net

Key to KPI Variation and Assurance Icons

Variation			Assurance					
Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or higher pressure due to (H)igher or (L)ower values	Common cause - no significant change	Consistent (P)assing of Target - Upper control limit is below the target line or Lower control limit is above the target line (depending on the nature of the metric)	Metric has (P)assed the target for the last 6 (or more) data points, but the control limits have not moved above/below the target.	Inconsistent passing and failing of the target	Metric has (F)ailed to meet the target for the last 6 (or more) data points, but the control limits have not moved above/below the target.	Consistent (F)ailing of Target - Lower control limit is below the target line or Upper control limit is above the target line (depending on the nature of the metric)	Data Currently Unavailable or insufficient data points to generate an SPC

Maidstone and Tunbridge Wells NHS Trust

Escalation Rules:

Please see the Business Rules for the five areas of Assurance: Consistently Failing, Not achieving target >=6 months, Hit or Miss, Consistently Passing and Achieving target >=6 months (three slides in the last Appendix)

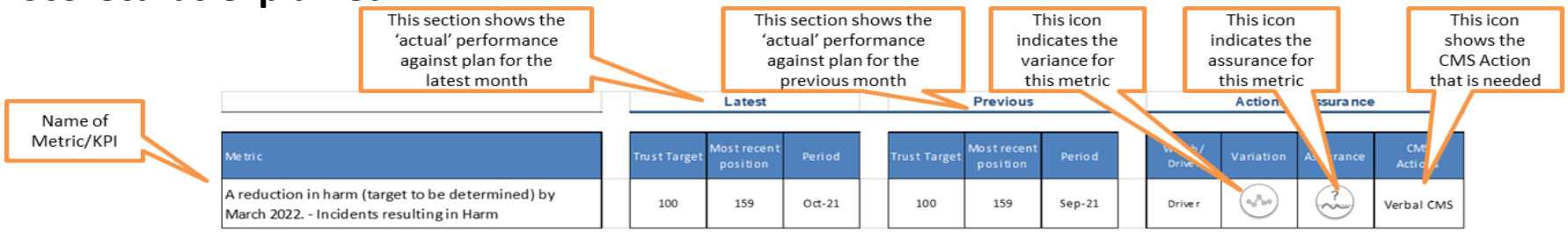
Escalation Pages:

SPC Charts that have been escalated as have triggered the Business Rule for Full Escalation have a Red Border

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. Low (L) special cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is upwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (L) special cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is downwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

Scorecards explained



Further Reading / other resources

The NHS Improvement website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - https://improvement.nhs.uk/resources/making-data-count

MTW exceptional people, outstanding care

Executive Summary

Executive Summary

Vacancy Rate has improved further to 8.73% and continues to experience special cause variation of an improving nature, passing the target for 6+ months. Turnover Rate has failed the target for more than six months and continues to be in special cause variation of a concerning nature. Agency spend has failed the target for >6 months and is now in special cause variation of a concerning nature. Sickness levels are in variable achievement of the target and common cause variation. The Trust Appraisal rate remains in escalation as is not achieving the target but is now experiencing special cause variation of an improving nature. Statutory and Mandatory Training has achieved the target in March 23 at 86.2% but remains in special cause variation and variable achievement of the target. The Trust was £1.4m in surplus in the month which was £0.2m favourable to plan. Year to Date the Trust is surplus to plan by £0.2m.

With the continued improvement in the Nursing Vacancy Rate, the Nursing Safe Staffing Levels have improved further (above target in March). The rate of inpatient falls continues to experience common cause variation and variable achievement of the target. Hospital on-set of COVID remains in escalation and the Trust reported one case of MRSA in March. These indicators also impact the Incidents resulting in harm indicator which continues to experience common cause variation and failing the target for more than six months. Complaints response times have not achieved the target for the year (with a mean of 60%), however the number of overdue complaints has been showing a downward trend and is experiencing special cause variation of an improving nature. Friends and Family Response times remain challenging but have seen some improvements in Maternity and Inpatients.

Diagnostic Waiting Times continues to experience special cause variation of an improving nature, but is consistently failing the target at 94.1%, driven by the low performance for Echocardiography which is starting to recover. RTT performance is experiencing common cause variation and has not achieved the trajectory target for more than six months. Performance was fairly consistent month on month throughout 2022/23. We remain one of the best performing trusts in the country for longer waiters. First outpatient activity levels are experiencing common cause variation and have failed the trajectory target for more than six months, not achieving the target for the year. Diagnostic Activity levels are consistently below target but remain above 1920 levels. Elective activity is now experiencing common cause variation and passing the target as has achieved the plan for more than six consecutive months. Overall Elective Activity levels achieved the target for the year (over 2,000 higher). Both Elective and OP New Activity levels were >8% higher than the 1920 (pre-COVID) levels.

The number of patients leaving our hospitals before noon continues to experience special cause variation of an improving nature. A&E 4hr performance continues to experience common cause variation and variable achievement of the target. However, the Trust's performance has remained one of the highest both Regionally and Nationally throughout the year. Ambulance handovers continue to experience common cause variation and variable achievement of the target and are no longer escalated. The Trust has once again achieved the Cancer Waiting Times 62 Day standard for the month of February and has continued to achieve the national 2 Week Wait (2WW) Standard. Achievement of these standards continues to remain increasingly challenging with the continued high number of 2WW referrals and the number of patients on the 62 day backlog.

Escalations by Strategic Theme:

People:
- Turnover Rate (P.8)
- Sickness Rate (P.9)*
- Appraisal Completeness (P.9)

Patient Safety & Clinical Effectiveness:
- Incidents resulting in Harm (P.11)
- Infection Control - COVID (P.12)

Patient Access:
- RTT Performance (P.14)
- Planned levels of new outpatients activity (P.15)
- Outpatient Calls answered <1 minute (P.17)
- Outpatient Clinic Utilisation (P.17)
- Diagnostic Waiting Times (P.18)
- Planned levels of Diagnostics activity (P.19)

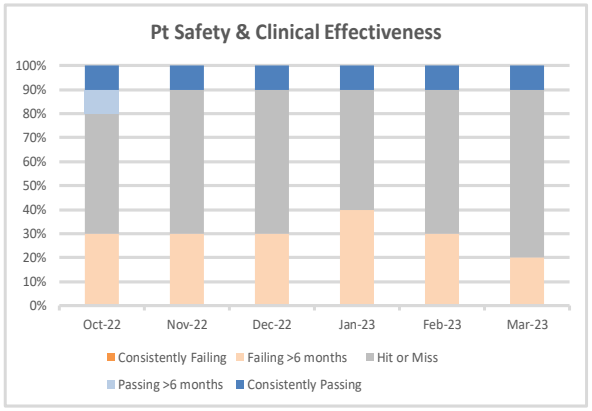
Patient Experience:
- Number of New Complaints received (p.21)*
- Complaints responded within target (P.22)
- FFT Response Rates - Inpatients, A&E, Outpatients and Maternity (P.23)

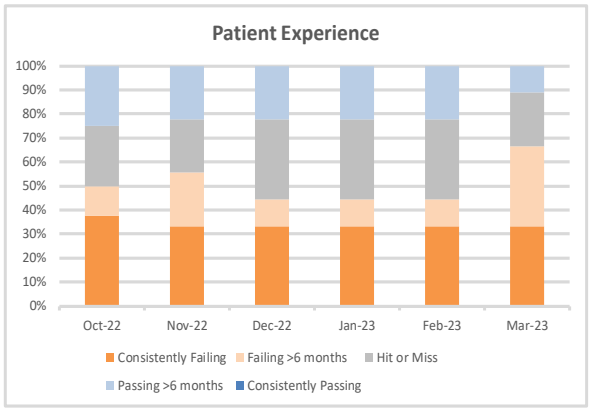
Systems:
- Discharges before Noon (P.25)

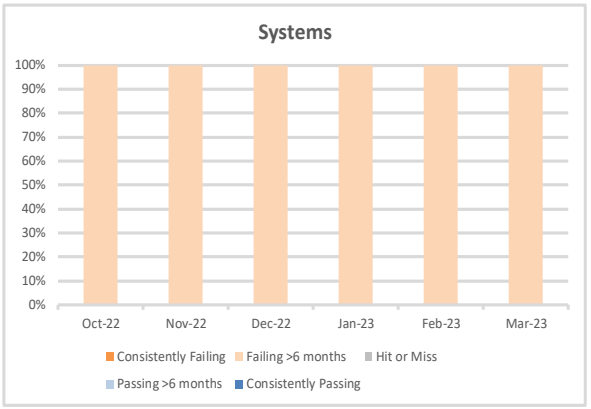
Sustainability
- Agency Spend (P.27)

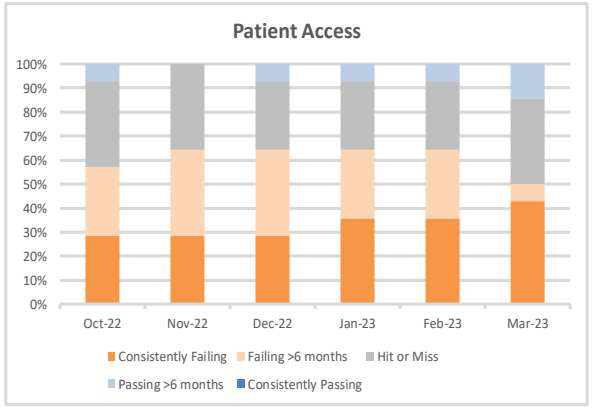
*Escalated due to the rule for being in Hit or Miss for more than six months being applied

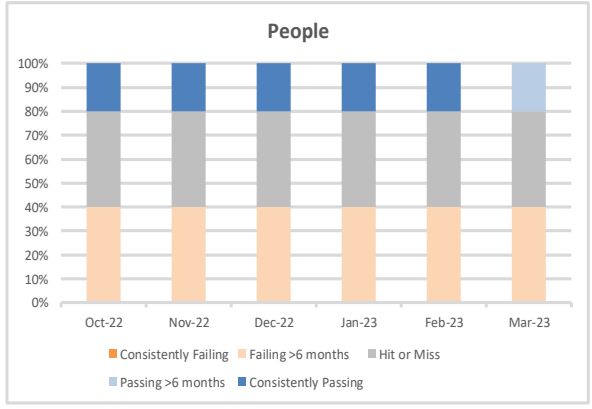
Assurance Stacked Bar Charts by Strategic Theme

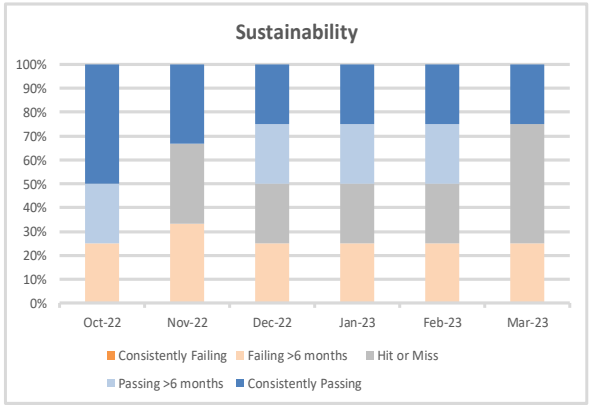












Matrix Summary

March 2023		Assurance				
		Pass★	Pass	Hit and Miss	Fail	Fail -
Variance	Special Cause - Improvement	Flow: % of Emergency Admissions that are zero LOS (SDEC)	Reduce the Trust wide vacancy rate to 12% by the end of the financial year 2022-3 Vacancy Rate		Appraisal Completeness	Ensure activity levels for diagnostics match those pre-Covid - CT To increase the number of patients leaving our hospitals by noon on the day of discharge Transformation: % OP Clinics Utilised (slots) Access to Diagnostics (<6weeks standard) Friends and Family (FFT) % Response Rate: A&E
	Common Cause	Summary Hospital-level Mortality Indicator (SHMI)	Ensure activity levels for theatres match those pre-Covid - Total Elective Cancer - 2 Week Wait Complaints Rate	Delivery of financial plan, including operational delivery of capital investment plan. Reduction in the rate of patient falls to 6.36 per 1000 occupied bed days by March 2023 Ensure activity levels for outpatients match those pre-Covid - Follow Up Outpatients To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience. Number of New SIs in month A&E 4 hr Performance Cancer - 62 Day Never Events Safe Staffing Levels Sickness Absence % VTE Risk Assessment (one month behind) IC - Rate of Hospital CDifficile per 100,000 occupied beddays Flow: Ambulance Handover Delays >30mins Flow: % of Emergency Admissions into Assessment Areas	Reduction in incidents resulting in harm by 8.2% by March 2023 RTT Patients waiting longer than 40 weeks for treatment To reduce the overall number of complaints or concerns each month % complaints responded to within target Flow: Super Stranded Patients Friends and Family (FFT) % Response Rate: Inpatients	To achieve the planned levels of new outpatients activity (shown as a % 19/20) Ensure activity levels for diagnostics match those pre-Covid - MRI Ensure activity levels for diagnostics match those pre-Covid - NOUS Diagnostic Activity (MRI,NOUS,CT Combined) Transformation: CAU Calls answered <1 minute Achieve the Trust RTT Trajectory by March 2023
	Special Cause - Concern	Cash Balance (£k)		Standardised Mortality HSMR Capital Expenditure (£k) Statutory and Mandatory Training IC - Number of Hospital acquired MRSA	Reduce Turnover Rate to 12% by March 2023 Reduce the amount of money the Trusts spends on premium workforce spend Infection Control - Hospital Acquired Covid	

Strategic Theme: People

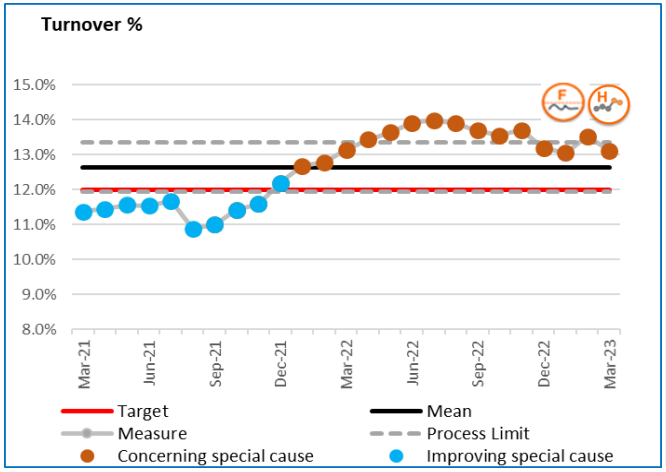
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Well Led	Reduce the Trust wide vacancy rate to 12% by the end of the financial year 2022-3	12%	8.7%	Mar-23	12%	9.4%	Feb-23	Driver			Note Performance
Breakthrough Objectives	Well Led	Reduce Turnover Rate to 12% by March 2023	12%	13.1%	Mar-23	12%	13.5%	Feb-23	Driver			Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Well Led	Sickness Absence	4.5%	4.1%	Feb-23	4.5%	4.3%	Jan-23	Driver			Not Escalated
	Well Led	Appraisal Completeness	95.0%	90.1%	Mar-23	95.0%	90.4%	Feb-23	Driver			Escalation
	Well Led	Statutory and Mandatory Training	85.0%	86.2%	Mar-23	85.0%	84.7%	Feb-23	Driver			Not Escalated

Breakthrough Objective: Counter Measure Summary

Metric Name – Reduce Turnover Rate to 12% by March 2023

Owner: Sue Steen
Metric: Turnover Rate
Desired Trend: 7 consecutive data points below the mean

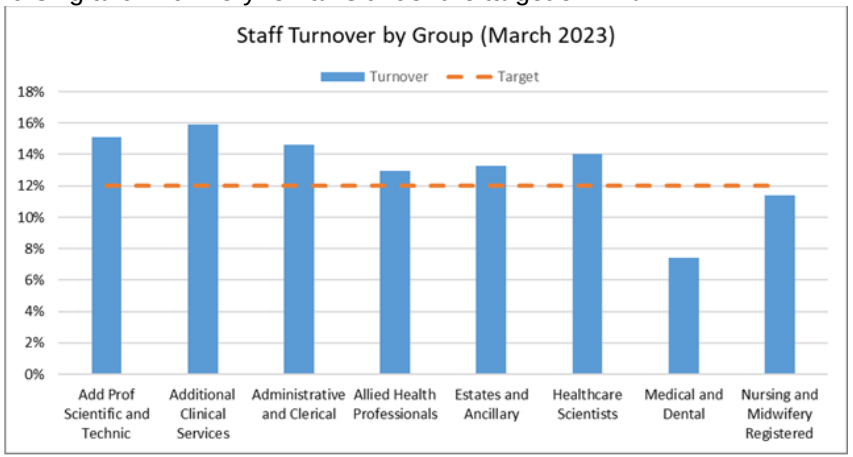
1. Historic Trend Data



Mar-23
13.12%
Variance / Assurance
Metric is currently experiencing special cause variation of a concerning nature and has not achieved the target for more than 6 months
Max Target (Internal)
12%
Business Rule
Full CMS as not achieved target for 6+ months

2. Stratified Data

Nursing and Midwifery remains under the target of 12%



3. Top Contributors

These are some of the main contributors of focus for the working groups

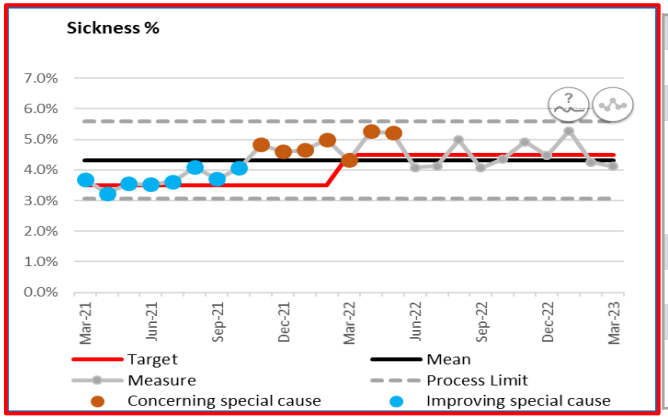
Attraction	Learning & Development
Flexible working can be too rigid / No free food / Increased cost of living at TW site / No USP staff benefits for working at MTW	No clear progression path / Upskilling does not lead to promotion
Inadequate break times / Poor wellbeing	Onboarding slow / Gaps in leadership capability
	Not enough locally trained staff / Lack of staff development
Processes	**Retention**
Retire and return policy out of date, putting people off returning	Not feeling valued, engaged, part of a team / Feedback from listening events taking too long to action
TRAC process takes too long, leading to delays / lack of transparency in recruitment	No outer London waiting, losing staff to Dartford / easier to find better pay elsewhere

4. Action Plan

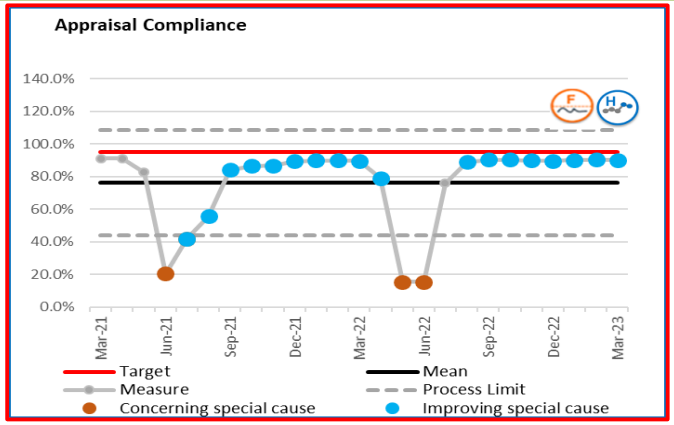
A full action plan by the working groups has been developed; some of the key actions shown:

Action	Status
Agree a formal pathway for approval for all incentives schemes	April
Set up an IG Recruitment based Account	May
Review and amend Retire and return policy to reduce barriers for ex-employees returning to MTW	May
Streamline recruitment processes - (temporarily on hold)	May
Create talent pool/ list of names of people interested in promotion	Ongoing
Introduce virtual onboarding info pack	April
Introduce a clear and consistent Recruitment and Retention Premium approach (for hard to recruit roles)	April
Introduce stay interviews	May

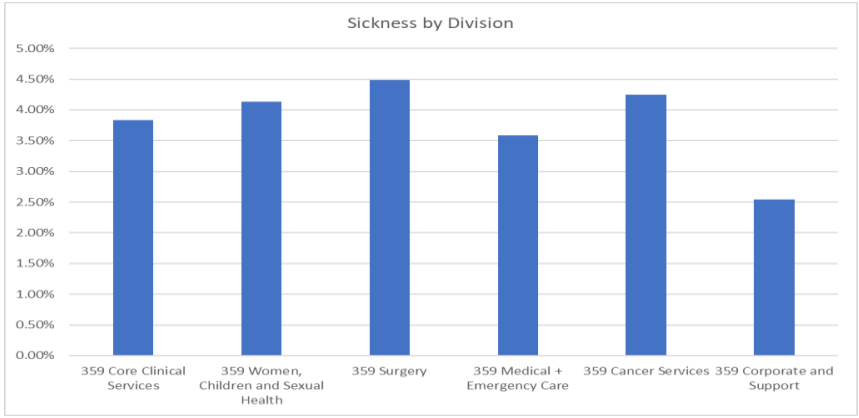
People – Workforce: CQC: Well-Led

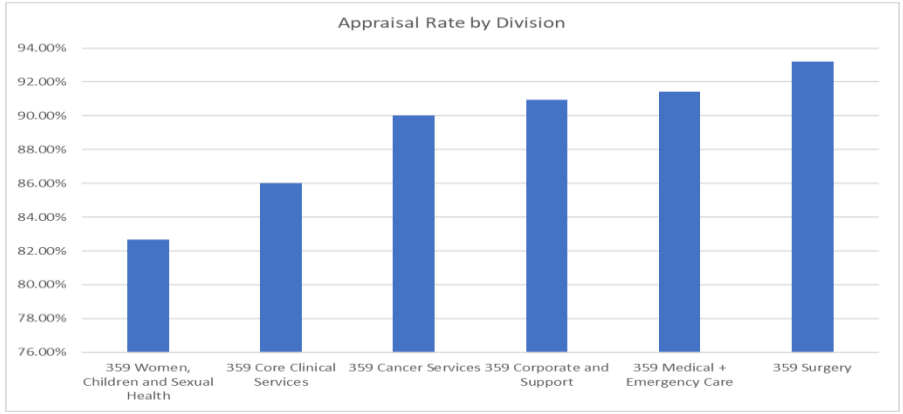


Feb-23
4.12%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Target (Internal)
4.5%
Business Rule
Escalated as in Hit & Miss for >6months



Mar-23
90.14%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and failing the target for 6+ months
Max Target (Internal)
95%
Business Rule
Has failed the Target for 6+ Months





Summary:	Actions:	Assurance & Timescales for Improvement:
Sickness % - This metric is experiencing Common Cause Variation and variable achievement of the Target **Appraisal Completeness - T**his metric is experiencing Special Cause Variation of an improving nature and failing the target for 6+ months	**Sickness**: Further deep dive analysis on reporting on sickness absence will be included in future Integrated Performance Reports **Appraisal Completeness:** A stretch target of 95% was introduced in 2022/23. The previous target of 90% was increased to a stretch target. Ongoing work with Divisions to improve performance is taking place targeted at areas of lower compliance. Appraisal window for 2023 opened on 17th April and is closing on 30th June 2023	**Sickness:** Continued monitoring of any spikes for non-seasonal reasons for absence Undertake a further review of the sickness target to bring this down further. Increased numbers of sickness management cases are brought through to support people on long-term absence or with underlying health conditions.

Strategic Theme: Patient Safety & Clinical Effectiveness

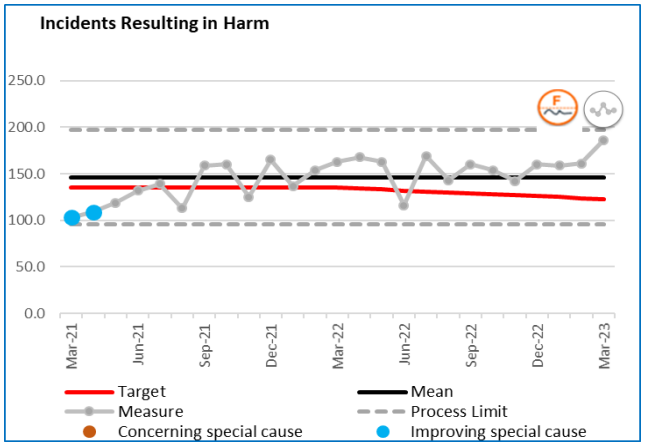
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Safe	Reduction in incidents resulting in harm by 8.2% by March 2023	123	186	Mar-23	124	161	Feb-23	Driver		F	Full CMS
Breakthrough Objectives	Safe	Reduction in the rate of patient falls to 6.36 per 1000 occupied bed days by March 2023	6.36	6.16	Mar-23	6.43	6.20	Feb-23	Driver		?	Verbal CMS
Constitutional Standards and Key Metrics (not in SDR)	Safe	Number of New SIs in month	11	9	Mar-23	11	4	Feb-23	Driver		?	Not Escalated
	Safe	Standardised Mortality HSMR	100.0	100.1	Nov-22	100.0	101.1	Oct-22	Driver	H	?	Not Escalated
	Safe	Summary Hospital-level Mortality Indicator (SHMI)	100.0	91.4	Nov-22	100.0	91.4	Oct-22	Driver		P	Not Escalated
	Safe	Never Events	0	0	Mar-23	0	0	Feb-23	Driver		?	Not Escalated
	Safe	Safe Staffing Levels	93.5%	95.3%	Mar-23	93.5%	93.6%	Feb-23	Driver		?	Not Escalated
	Safe	Infection Control - Hospital Acquired Covid	0	63	Mar-23	0	16	Feb-23	Driver	H	F	Escalation
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays	22.7	19.7	Mar-23	22.7	33.5	Feb-23	Driver		?	Not Escalated
	Safe	IC - Number of Hospital acquired MRSA	0	1	Mar-23	0	0	Feb-23	Driver	H	?	Not Escalated

Vision: Counter Measure Summary

Project/Metric Name – Reduction in harm : Incidents resulting in harm

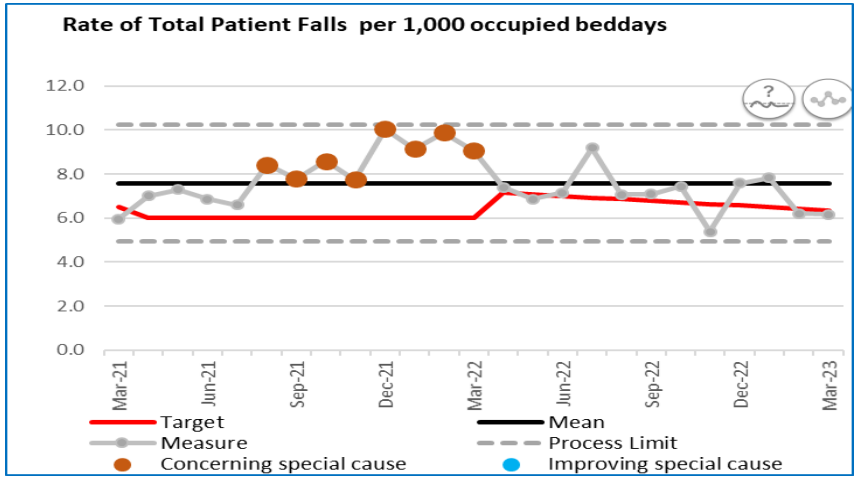
Owner: Peter Maskell
Metric: Incidents resulting in harm
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data

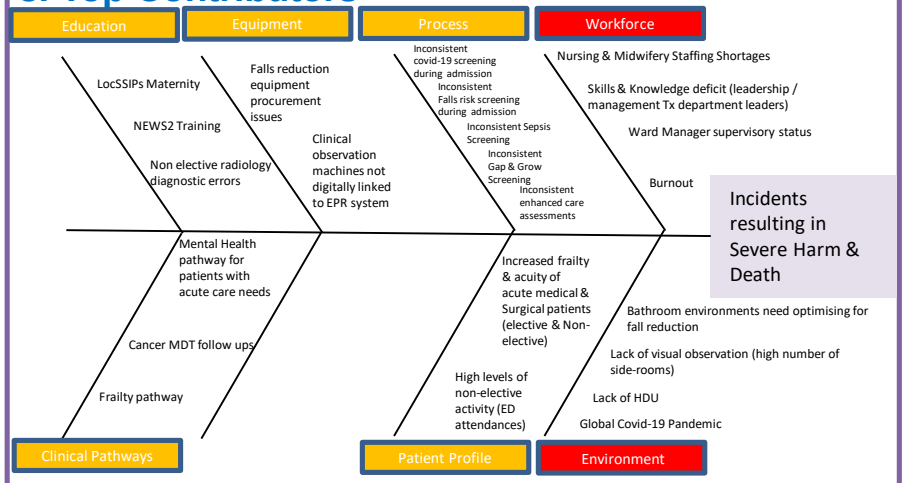


Mar-23
186
Variance / Assurance
Metric is currently experiencing common cause variation and has not achieved the target for more than 6 months
Max Target (Internal)
125
Business Rule
Full Escalation as not achieved target for 6+ months

2. Stratified Data



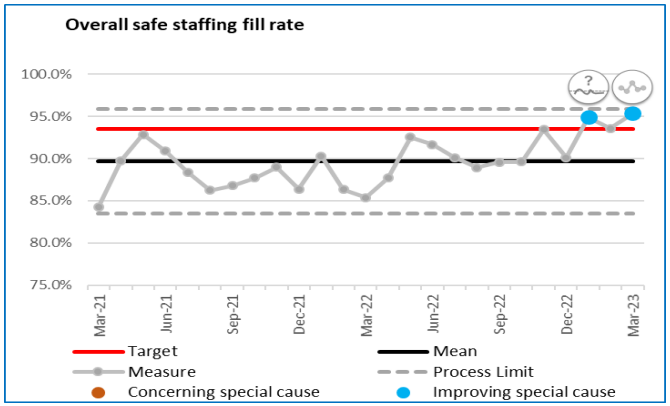
3. Top Contributors



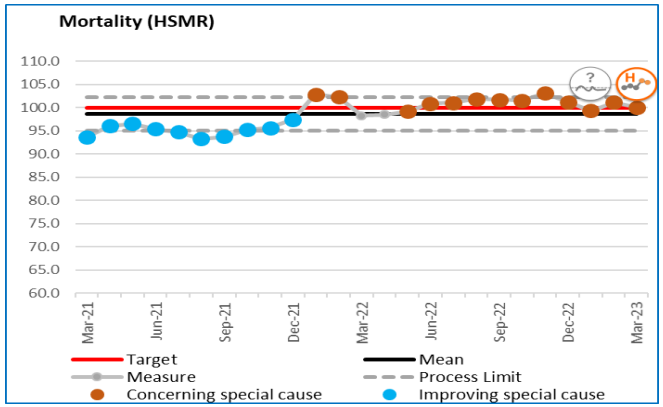
4. Action Plan

Contributor	solution /countermeasure	Owner	Due By
Workforce	Safer staffing fill rate levels	CNO/CPO	Ongoing
Environment/ Equipment/ Process	**Focus on Slips, trips and falls,** as major contributing factor to incidents resulting in severe harm (30%). -The falls rate has remained fairly stable with a slight increase from February 2023 rate of 112 to 127 in March 2023 across the trust . The March falls rate per 1000 bed days against the 6.36 per 1000 bed day target is not yet available but based on the crude numbers is expected to be around the falls target. - A harm A3 event is tentatively scheduled for the 17th of May 2003 with key stakeholders across the trust expected to determine top contributors for harm and root causes. - This will be coupled with data analysed (- SI data and SJR data) around harm to determine a plan to mitigate against the levels of harm across the trust. - Other possible areas of focus may include pressure ulcers and deteriorating patients (including sepsis)	Medical Director	Ongoing - BAU
Workforce	Analyse harm data to determine where other countermeasures to top contributors (outside falls) overlap within other breakthrough objectives (e.g. Staffing levels - patient safety and clinical effectiveness).	Medical Director	Ongoing -

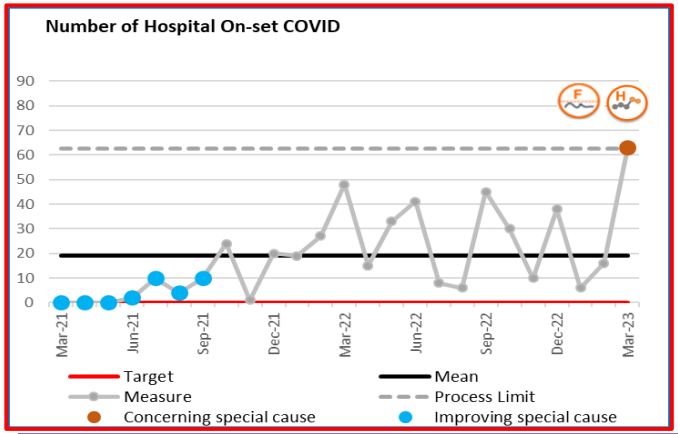
Patient Safety and Clinical Effectiveness: CQC: Safe



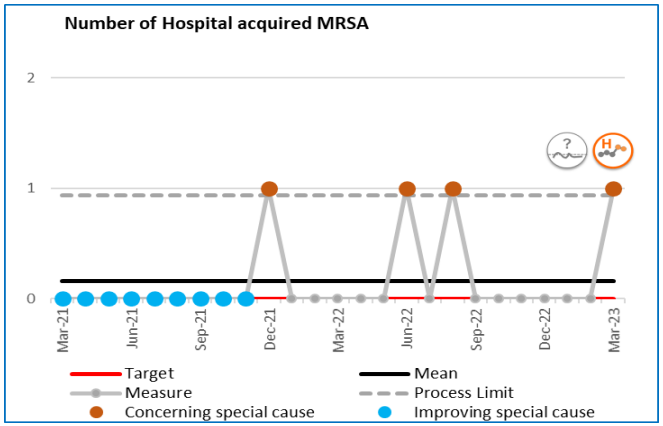
Mar-23
95.3%
Variance / Assurance
Metric is currently Common cause variation and variable achievement of the target
Target (Internal)
93.5%
Business Rule
For information as has moved into hit & miss



Nov-22
101.1
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and variable achievement of the target
Max Target (Internal)
100.0
Business Rule
Returned to variable achievement



Mar-23
63
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and has not achieved the target for >6 months
Max Target (Intern
0
Business Rule
Full Escalation as has not achieved the target for > 6 months



Mar-23
1
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Target
As Expected
Business Rule
Full Escalation as has had a case

Summary:

Safe Staffing Fill Rate: The level reported remains in Common cause variation and variable achievement of the target

Hospital on-set COVID: This indicator is experiencing common cause variation and has failed to achieved the target of zero for more than six months.

Mortality (HSMR): Metric is experiencing special cause variation of a concerning nature but has moved to variable achievement of the target. It should also be highlighted that Trust are still rated 'as expected' by Dr Foster (T-Health). The methodology being used in this calculation is based upon a 12 rolling month period for each data point, so provides a more stable view of performance than individual months. The Mortality Surveillance Group received monthly updates from Dr Foster and in depth analysis. This is then reported onwards into the Quality Committee. A one month lag in our reporting is currently being applied to offset the impact of the uncoded activity in our initial ('flex') submission to SUS. This will be reviewed as our percentage of coded episodes submitted at flex improves.

Actions:

Safe Staffing Fill Rate: The Matrons afternoon staffing huddles are supported by the Bank team to ensure the staffing allocations mitigate any safety risks. The Deputy Chief Nurse and HON for Safe Staffing are now included in the risk assessments for non framework agency requests. Embedding of new staff staffing processes detailed in the Safe Staffing policy is in the planning stage. These new practices will be piloted within the Acute and Geriatric Directorate prior to Trust wide roll out. A deep dive into bank and agency processes is underway in relation to the management of restrictions placed on practice. This will focus initially on bank staff. Retention of Registered Nurses/Midwives and Healthcare Clinical Support Workers (HCSWs) is now a focus with a view to reduce turnover rates. Career roadshows and the Corporate Nursing retention group is ongoing. Student Councils are ongoing with an increase in attendance seen at the last meeting. This forum will continue to expanded and will eventually include students from all professions

Infection Control: With COVID rates stabilising the decision was made on the 29th February to discontinue the need for all staff to wear masks in all areas (with the exception of oncology and outbreak wards). We continued to see sporadic COVID outbreaks that were many associated with asymptomatic patients testing positive on their discharge swab to care homes and symptomatic visitors. A hospital attributed MRSA bacteraemia was identified at TW ICU which is under investigation. The IPC team continues to closely monitor and advise on all patients with healthcare associated infections.

Assurance & Timescales for Improvement:

Safe Staffing Fill Rate: Real time daily staffing data has been developed by the Senior Corporate Nursing and ICC team. The Safe Staffing policy is now live on Qpulse. Reports following the first Safer Nursing Care Tool Audit at MTW are currently being compiled by BI. These will be produced for all clinical areas who participated in the audit. Recruitment activity continues to move at pace. A decrease in HCSW vacancies has been seen. The HCSW recruitment process has been assessed and amended to support both candidates and Clinical Teams. International recruitment activity is ongoing, and a broadening of the number of recruitment agencies has been actioned to support this activity.

Infection Control: We have exceeded our limit for CDI with an end of year total of 79 cases to date against a year end limit of 62. This increased rate correlates with a similar picture regionally and nationally. The monthly rates of C diff have stabilised to within expected rates. IPC team continue to work with the site teams, departments and clinical operations to review patient pathways to support flow and patient safety. The IPC team continue to promote IPC best practice principles through ward and department-based training.

Strategic Theme: Patient Access

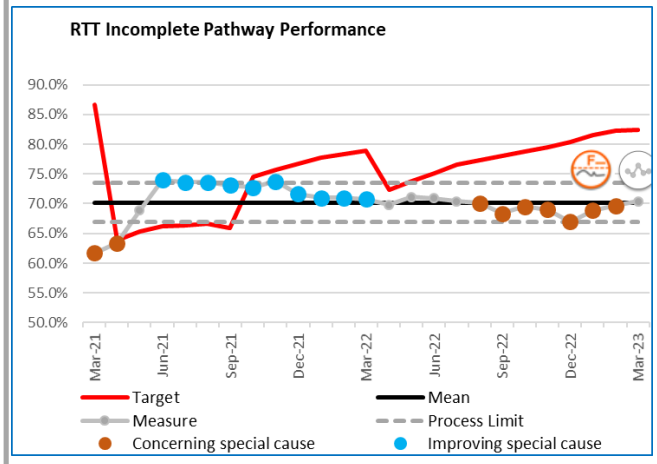
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Responsive	Achieve the Trust RTT Trajectory by March 2023	82.4%	70.4%	Mar-23	82.2%	69.6%	Feb-23	Driver		F	Full CMS
Breakthrough Objectives	Responsive	To achieve the planned levels of new outpatients activity (shown as a % 19/20)	159.4%	139.9%	Mar-23	114.9%	105.7%	Feb-23	Driver		F	Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Responsive	RTT Patients waiting longer than 40 weeks for treatment	422	571	Mar-23	436	661	Feb-23	Driver		F	Escalation
	Responsive	Access to Diagnostics (<6weeks standard)	99.1%	91.1%	Mar-23	98.9%	91.4%	Feb-23	Driver	H	F	Escalation
	Responsive	A&E 4 hr Performance	87.0%	85.3%	Mar-23	87.0%	88.6%	Feb-23	Driver		?	Not Escalated
	Responsive	Cancer - 2 Week Wait	93.0%	95.2%	Feb-23	93.0%	94.7%	Jan-23	Driver		P	Not Escalated
	Responsive	Cancer - 62 Day	85.0%	85.5%	Feb-23	85.0%	85.1%	Jan-23	Driver		?	Not Escalated
	Effective	Transformation: % OP Clinics Utilised (slots)	85.0%	64.6%	Mar-23	85.0%	65.4%	Feb-23	Driver	H	F	Escalation
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways	1.5%	3.6%	Mar-23	1.5%	3.3%	Feb-23	Driver	No SPC	No SPC	Not Escalated
	Effective	Transformation: CAU Calls answered <1 minute	90.0%	57.1%	Mar-23	90.0%	57.8%	Feb-23	Driver		F	Escalation
	Effective	Flow: Ambulance Handover Delays >30mins	5.0%	5.3%	Mar-23	5.0%	4.4%	Feb-23	Driver		?	Not Escalated
	Effective	Flow: % of Emergency Admissions into Assessment Areas	65.0%	62.9%	Mar-23	65.0%	65.3%	Feb-23	Driver		?	Not Escalated
	Responsive	To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20)	149.6%	160.1%	Mar-23	97.4%	104.4%	Feb-23	Driver		P	Not Escalated
	Responsive	To achieve the planned levels of outpatients follow up activity (shown as a % 19/20)	128.5%	133.5%	Mar-23	96.6%	112.5%	Feb-23	Driver		?	Not Escalated
	Responsive	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20)	248.7%	149.5%	Mar-23	219.3%	111.3%	Feb-23	Driver		F	Escalation

Vision: Counter Measure Summary

Project/Metric Name – Achieve the Trust RTT Trajectory by March 2023

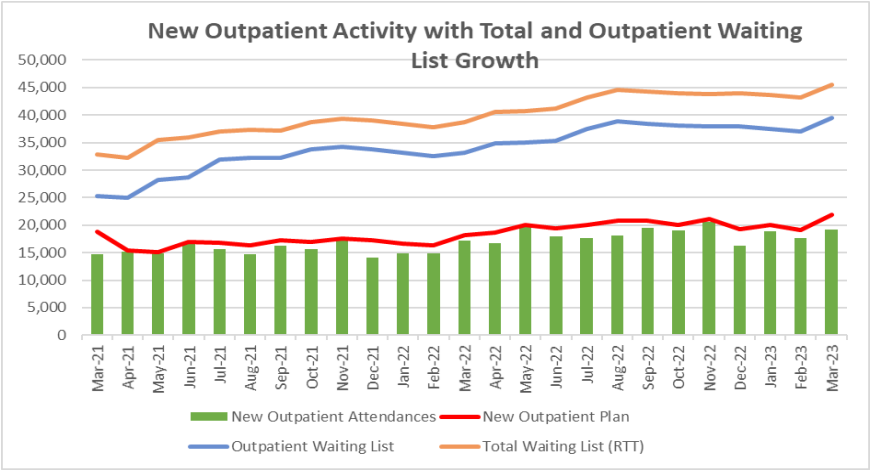
Owner: Sean Briggs
Metric: Referral to Treatment time Standard
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Apr-23
70.4%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
82.4%
Target Achievement
Metric is consistently failing the target

2. Stratified Data



3. Top Contributors

The following are all affecting the RTT position -

- Overall Waiting List growth
- Outpatient Waiting List growth - Gen. Medicine (69%), Haematology (44%), Vascular (29%), Endo (27%) and Audiology (26%) are the specialities with the largest growth in percentage terms.
- Long waits for first outpatient appointments
- Underperformance against plan for New Outpatient activity (year to date)
- Gynae (51.9%), Neurology (40.1%) and Gastro (52.9%) and ENT (53.8%) are the specialities with the lowest performance against the 18 week standard

4. Action Plan

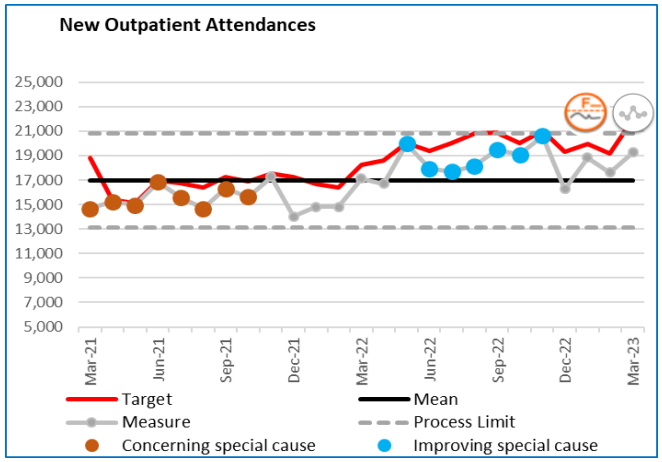
Countermeasures	Action	Who / By when	Complete
Improved New Outpatient Activity	Focussed work on the Breakthrough Objective to Increase New Outpatient Activity	SP	Ongoing
Validation	Recovery plan agreed – Operational team commenced validation from Jan	CAU & PAT team	Ongoing
Daily PTL	Gynae team – focus on patients from 28 weeks to longest waiter Additional PTL for Gastro, General Surgery and T&O.	Specialty GM, Patient Access and Deputy COO	Daily and in progress
Close monitoring of all patients over 40 weeks	Tuesday PTL and Trust Access Performance meeting	RTT Lead and PAT team	Weekly and in progress
40 week trajectory	RTT recovery plan –agreed . Rereviewed trajectory in Jan and shared with specialties	RTT Lead, BI Team	Complete
	Implementation of RTT recovery plan	RTT Lead/GM's	Ongoing

Breakthrough Objective: Counter Measure Summary

Project/Metric Name – To achieve the planned levels of New Outpatient Activity

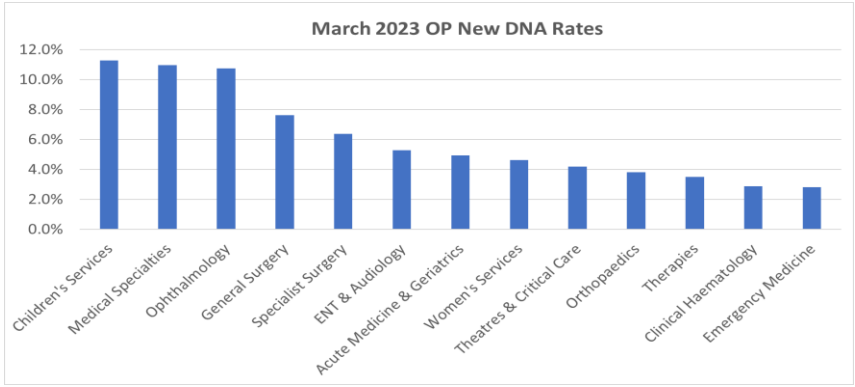
Owner: Sean Briggs
Metric: Elective Activity: New Outpatients
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



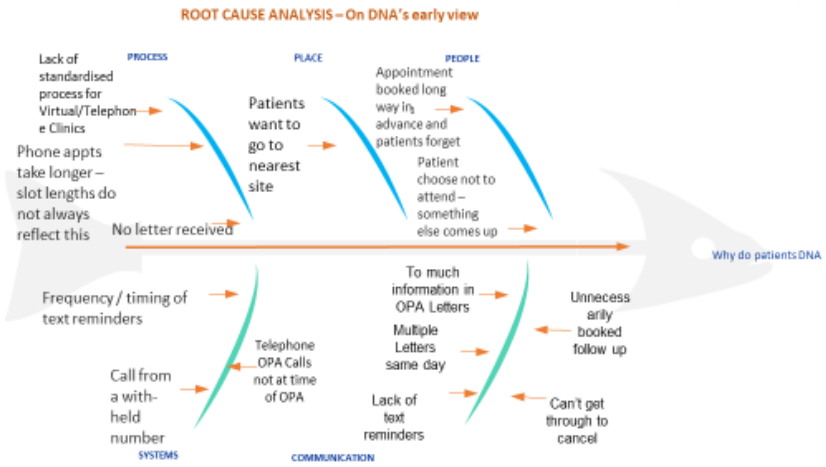
Mar-23
19,246
Variance Type
Metric is currently experiencing Common Cause Variation
Target
21,932
Target Achievement
Metric has failed the target >6months

2. Stratified Data



Although the Trust is near its 5% target the specialties that are not achieving activity levels have a DNA rate of 9% or above

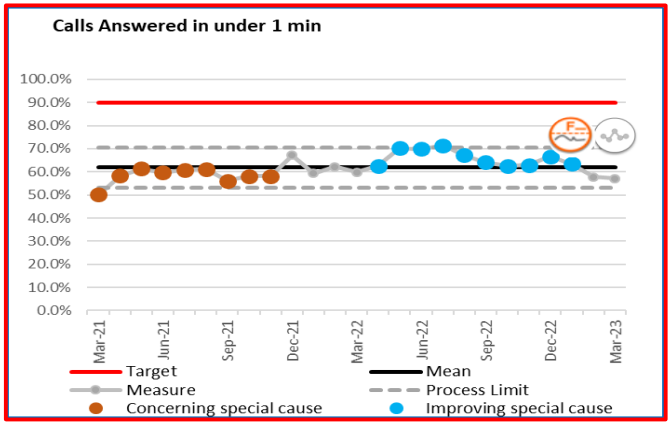
3. Top Contributors



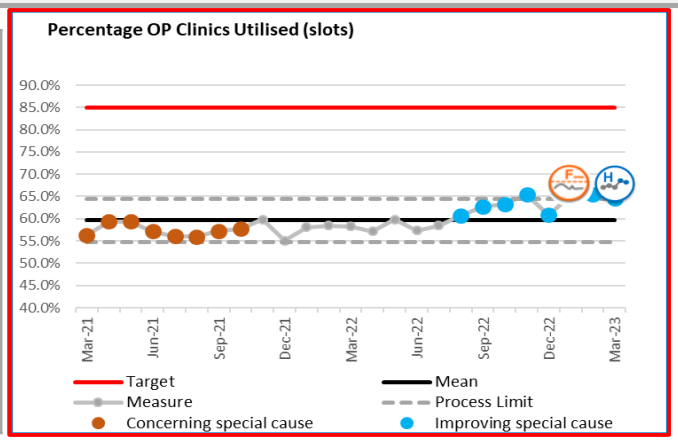
4. Action Plan

Countermeasures	Action	Who / By when	Complete (Y/N)
Two way text	Implementation plan developed	Project Team	Complete
	Operational process flows for CAU to be agreed	Project team	Feb-23
	IT Load balancers installed	IT	Delayed TBC
	Go live	Project Team	TBC- IT work dependant
Switch on Paediatric Text under 13's reminders (agreed for Ophth)	Awaiting agreement from IG and Safeguarding teams. SOP & Policy Document sign off 22.3.23	SP	Apr-23
Telephone Clinics – review of letters & OPA flow	Monitor Telephone Clinic DNA's to see improvement	Project Team/ SP Parrick/ OB	Apr-23
Best Practice	Research and link in with National missed appointment groups	SP/AM	Apr-23

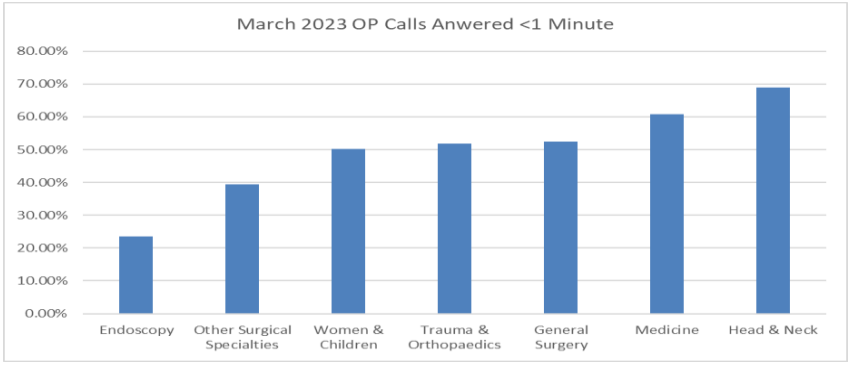
Patient Access – Transformation: Outpatients: CQC: Responsive

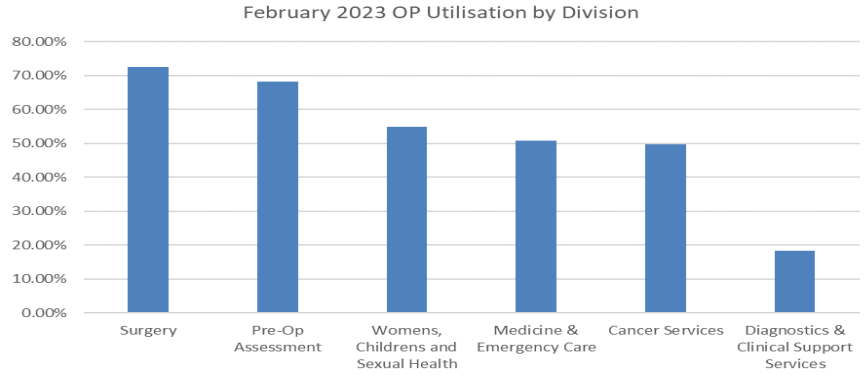


Mar-23
57.1%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and consistently failing the target
Target (Internal)
90%
Business Rule
Full Escalation



Mar-23
64.6%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
85%
Business Rule
Full Escalation





Summary:

Calls Answered: The number of calls answered in less than 1 minute is experiencing common cause variation and remains consistently failing the target. The areas with the lowest response rate is Endoscopy followed by Surgical Specialties,

Outpatient Utilisation: This indicator is experiencing special cause variation of an improving nature and consistently failing the target.

Actions:

Calls Answered: Medicine CAU had the most challenged performance with 248 missed calls, followed by T&O CAU with 226 missed calls. Month on Month there was a reduction in missed calls volumes.

Performance against the under 1 minute KPI: no speciality achieved the target, Haematology had the strongest performance >80%, with Head & Neck second highest, Endoscopy remained low at <30%.

Specialities experienced increased call volumes due to the strike action. CAU feedback included: reduced capacity due to sick absence and vacancies being recruited to.

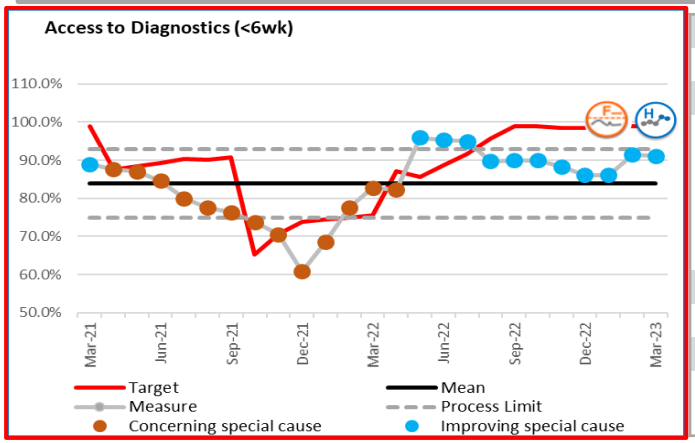
Outpatient Clinic Slot Utilisation: the OPD team will continue to work with the CAU's on their clinic templates and the utilisation of clinic slots. Slot utilisation is discussed at the RTT meeting.

Assurance & Timescales for Improvement:

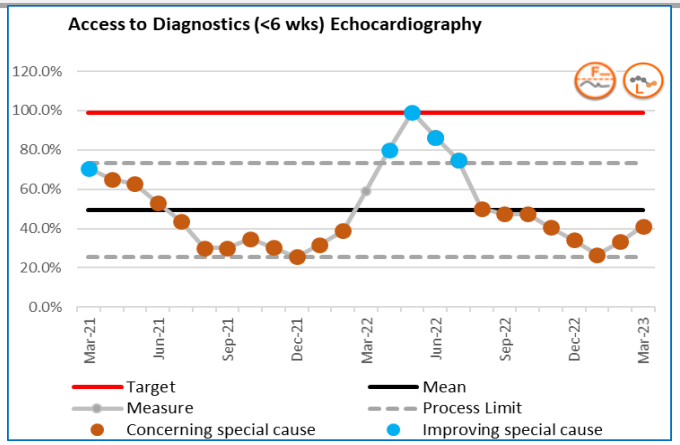
Calls Answered: CAUs continue with their local plans. The OPD Contact Centre is supporting the 2WW office; 77.1% of calls answered in >1min. An additional bank member of staff started in March supporting General Surgery. The 3 vacancies will now start the recruitment process in April 2023 (call centre space issues).

Outpatient Slot Utilisation: audits were conducted in March at Tunbridge Wells (>200 clinics). Key findings are clinics start late and under run, B5 OPD team to start working with CAU's on this. OPD team are still working on creating a 6-4-2 clinic forward look report (room & slot utilisation) this is still delayed due to functionality issues with the Room Manager software.

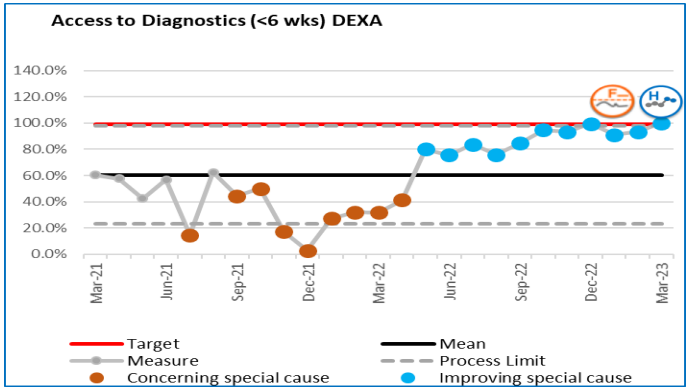
Patient Access – Diagnostics Waiting Times: CQC Responsive



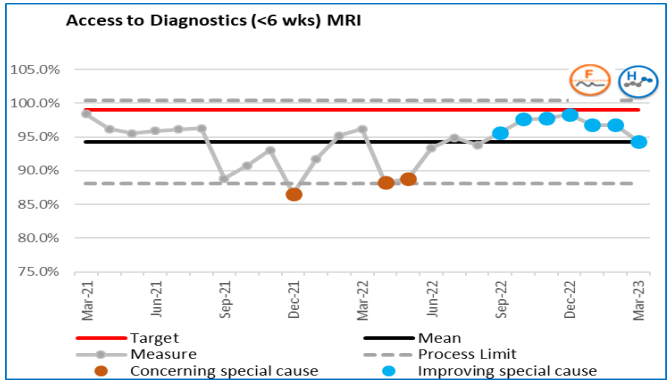
Mar-23
91.1%
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and is consistently failing the target
Target (Internal)
99.1%
Business Rule
Full Escalation



Mar-23
41.2%
Variance / Assurance
Metric is currently experiencing special cause variation of a worsening nature and consistently failing the target
Max Limit (Internal)
99%
Business Rule
For Information as Contributor to Overall



Mar-23
100%
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and consistently failing the target
Max Limit (Internal)
99%
Business Rule
For Information as Contributor to Overall



Mar-23
99.4%
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and has failed the target for more than six months
Max Limit (Internal)
99%
Business Rule
For Information as Contributor to Overall

Summary:

Diagnostic Waiting Times: Performance (measured via DM01) is experiencing special cause variation of an improving nature and consistently failing the target. The main contributor to this underperformance remains Echocardiography.

Echocardiography: is experiencing special cause variation of a concerning nature and consistently failing the target.

DEXA: is experiencing special cause variation of an improving nature and consistently failing the target but this is now showing an improving trend.

MRI: is experiencing special cause variation of an improving nature and has failed the target for more than six months.

Actions:

Echocardiography: Recruitment of staff & trainees live to assist with opening of CDC. Admin work streams being reviewed to streamline booking process.

DEXA: New DEXA in place at TWH and activity commenced.
Additional outsourcing agreement is agreed.
Additional staff training to ensure a more robust service

MRI: Issue with broken coil and lead times for replacement.

Assurance & Timescales for Improvement:

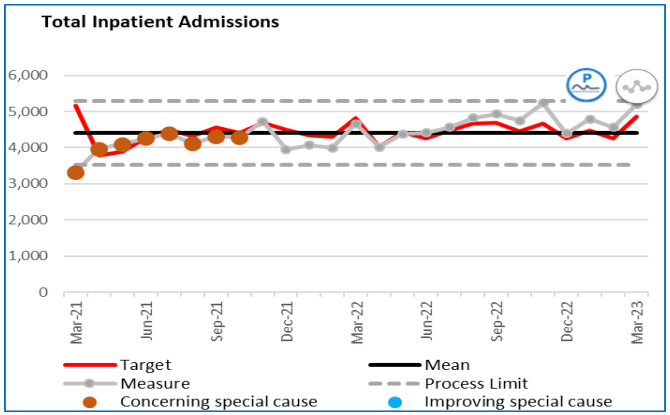
Echocardiography: Department back to full complement of machines. Activity still reduced due to staff in training. The recovery plan has been updated and recovery trajectory is being updated.

DEXA: The Recovery plan has been completed and the service is now DM01 compliant.

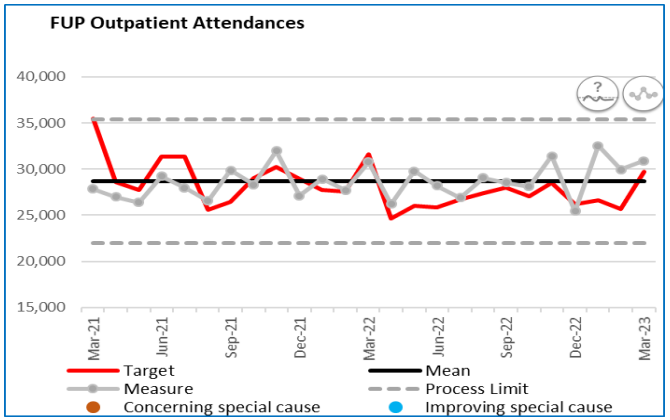
MRI: Managed service has encountered some teething issues, largely linked to equipment and IT but is on a trajectory of recovery. Overall imaging modalities are consistently showing positive improvement.

Overall DM01 Recovery Plan in progress.

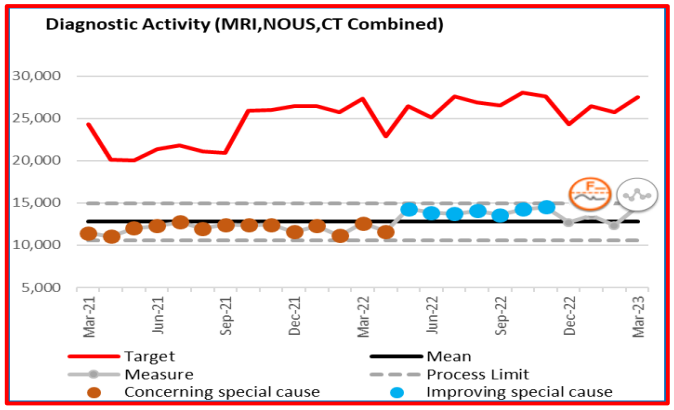
Patient Access –Activity Levels: CQC Responsive



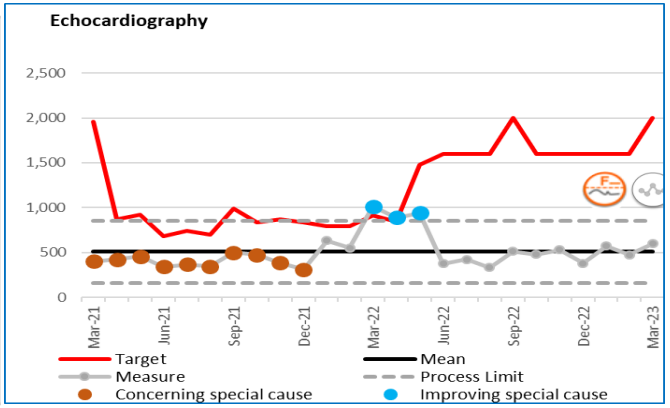
Mar-23
5201
Variance / Assurance
Metric is currently experiencing Common cause Variation and has passed the target for >6 consecutive months
Target
4,861
Business Rule
Not Escalated



Mar-23
30,921
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Target
29,759
Business Rule
Not Escalated



Mar-23
14,602
Variance / Assurance
Metric is currently experiencing common cause variation and consistently failing the target
Target
25,549
Business Rule
Full Escalation as consistently failing the target



Mar-23
599
Variance / Assurance
Metric is currently experiencing common cause variation and is consistently failing the target
Target
2000
Business Rule
For Information as Contributor to Overall

Summary:

Elective Activity (DC/EL): This indicator is now experiencing common cause variation and has passed the target for >6 consecutive months. Performance has been above the plan each month since June 22 and this indicator has therefore achieved the Plan (and was above 1920 levels) for the year.

OP Follow Up Activity: The activity is experiencing common cause variation and has failed the target for >6 months. Activity levels for March 2023 were higher than plan.

Diagnostic Activity: Activity levels are currently above 1920 levels for MRI, CT and NOUS but are experiencing common cause variation and consistently failing the target.

Echocardiography: is experiencing common cause variation and consistently failing the target.

Actions:

Elective Activity (DC/EL): Activity continues to be monitored weekly which has assisted in developing a more robust forecasting plan.

Detailed work undertaken to develop robust and challenging activity plans for all points of delivery for 2023/24

A3s in progress.

Echocardiography: Activity being monitored weekly.

Diagnostic : Work underway with Temporary staffing team and recruitment to support NOUS team.

Assurance & Timescales for Improvement:

Elective Activity (DC/EL): Weekly focus on submitted activity plans with the speciality and directorate teams.
6-4-2 scheduling meetings in place and any capacity identified continues to be offered to speciality teams.
Weekly focus on theatre utilisation and productivity continues via trust performance meetings.
Cancellation SOP in progress.
Action plan to be devised once A3s completed

Diagnostic Activity: Community Diagnostics Centre (CDC) business case has been approved and outputs of the business case are in progress. Recovery plan for Echocardiograms has been revisited and updated with a revised recovery trajectory.

Echocardiography: aim to book up to 6 weeks in advance and call patients prior to appts to reduce DNAs

Strategic Theme: Patient Experience

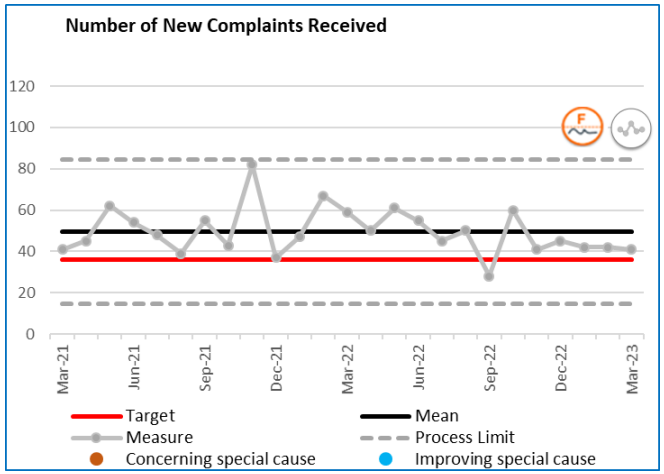
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Caring	To reduce the overall number of complaints or concerns each month	36	41	Mar-23	36	42	Feb-23	Driver		F	Full CMS
Breakthrough Objectives	Caring	To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience.	24	15	Mar-23	24	8	Feb-23	Driver		?	Verbal CMS
Constitutional Standards and Key Metrics (not in SDR)	Caring	Complaints Rate	3.9	2.0	Mar-23	3.9	2	Feb-23	Driver		P	Not Escalated
	Caring	% complaints responded to within target	75.0%	61.9%	Mar-23	75.0%	58.1%	Feb-23	Driver		F	Escalation
	Caring	% VTE Risk Assessment (one month behind)	95.0%	94.9%	Feb-23	95.0%	95.2%	Jan-23	Driver		?	Not Escalated
	Caring	Friends and Family (FFT) % Response Rate: Inpatients	25.0%	18.4%	Mar-23	25.0%	22.6%	Feb-23	Driver		F	Escalation
	Caring	Friends and Family (FFT) % Response Rate: A&E	15.0%	5.3%	Mar-23	15.0%	4.2%	Feb-23	Driver	H	F	Escalation
	Caring	Friends and Family (FFT) % Response Rate: Maternity	25.0%	28.9%	Mar-23	25.0%	20.6%	Feb-23	Driver	H	F	Escalation
	Caring	Friends and Family (FFT) % Response Rate: Outpatients	20.0%	7.6%	Mar-23	20.0%	5.4%	Feb-23	Driver	L	F	Escalation

Vision: Counter Measure Summary

Project/Metric Name – To reduce the overall number of complaints or concerns each month

Owner: Joanna Haworth
Metric: Number of Complaints Received Monthly
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Mar-23
41
Variance Type
Metric is currently experiencing Common Cause Variation
Max Limit (Internal)
36
Target Achievement
Metric has failed the target for >6months

2. Stratified Data

To be developed and provided with an updated Counter Measure Summary (CMS) following the A3 Thinking work that is being undertaken

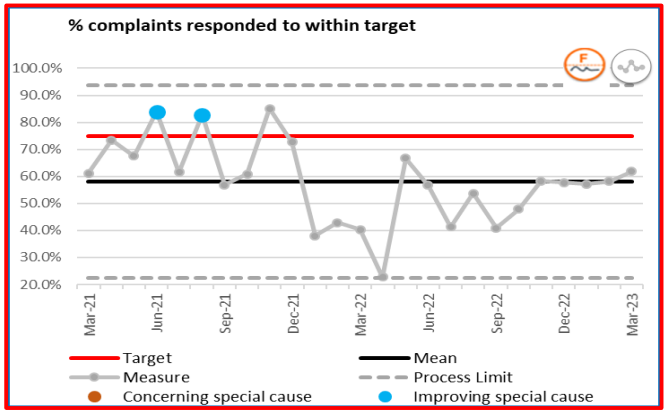
3. Top Contributors

A3 Thinking currently underway to understand the themes of complaints and concerns where poor communication is the main issue affecting patient experience

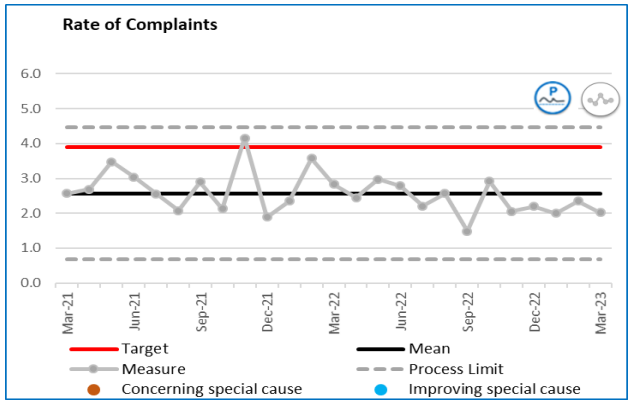
4. Action Plan

Action for A3	Timeline	Progress
Further analysis into number of complaints as well as distribution and Themes to be undertaken	June 2023	In Progress
Review metrics on complaints in preparation for 2324 reporting	April 2023	In Progress
Review any targets associated with the metrics retained for 2324 reporting	April 2023	In Progress
Work in relation to reducing complaints related to Communication continues	Ongoing	In Progress

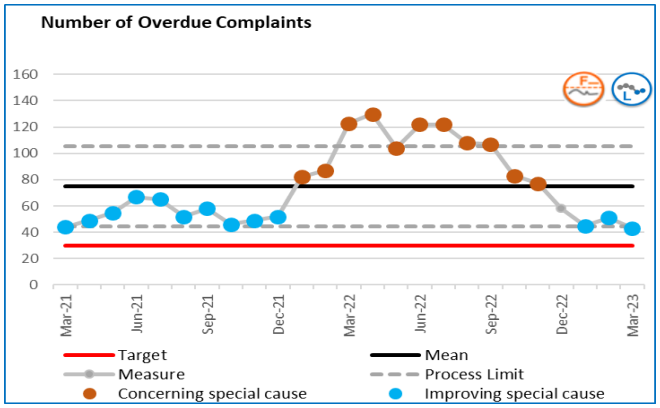
Patient Experience: CQC: Caring (Hit or Miss >6 months)



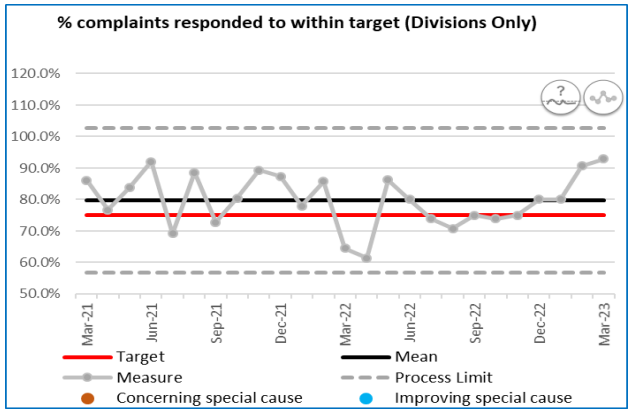
Mar-23
61.9%
Variance / Assurance
Metric is in common cause variation and failing the target for 6+ months
Target (Internal)
75%
Business Rule
Full Escalation failed the target 6+ months



Mar-23
2.2
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has achieved the target for 6+ months
Max Limit (Internal)
3.9
Business Rule
For Information as linked to % Complaint Responded



Mar-23
43
Variance / Assurance
Metric is currently experiencing special cause variation of a concerning nature and consistently failing the target
Max Limit (Internal)
30
Business Rule
For Information as linked to % Complaint Responded



Mar-23
92.9%
Variance / Assurance
Metric is currently experiencing common cause variation and variable achievement of the target
Max Limit (Internal)
75%
Business Rule
For Information as linked to % Complaint Responded

Summary:

% Complaints responded to within target: this indicator is experiencing common cause variation and has failed the target for >6months, noting the target has not been met since November 2021

Actions:

% Complaints responded to within Target:
Complaints performance recovery and stabilisation actions include;

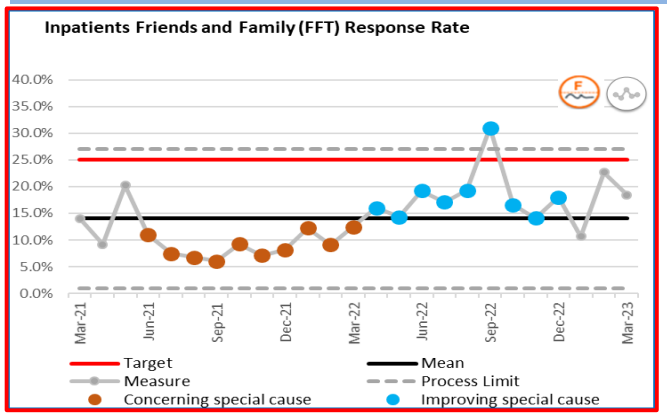
- Interim performance monitoring reported weekly to CN
- Weekly oversight meetings led by CN and DQG
- Successful recruitment to x2 12 month Complaint Lead posts
- Business case for revised complaints model (meeting new 2022 National framework) submitted
- Complaints QA now handed back to divisional leads
- Complaints staff supporting A3 projects in Surgery and Women's to improve complaint response times
- Introduction of new 40 day target to support more complex cases
- New head of complaints & PALS commenced in post 27 March '23

Assurance & Timescales for Improvement:

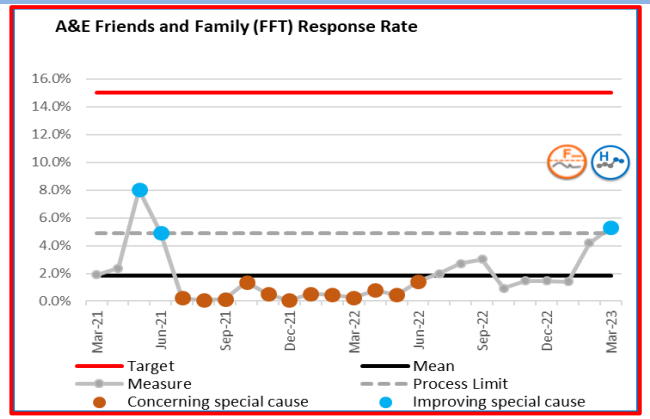
% Complaints responded to within Target:

- We expected to see an improvement in % compliance from November 2022 as a result of the introduction of a new 40-day timeframe for amber complaints and the recovery actions in place
- We are aiming to hit sustained delivery of the target response (75%) by September 2023
- We are aiming to increase our target response time % measure from 75% to 90% by December 2023

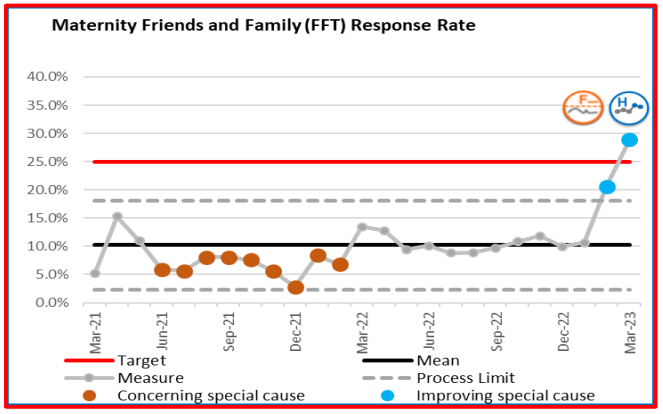
Patient Experience: CQC: Caring



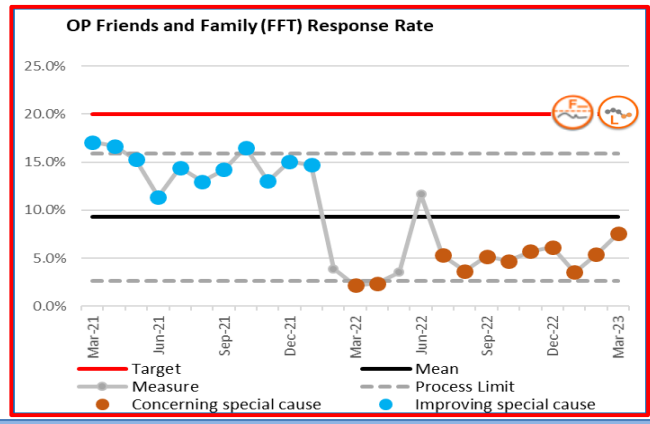
Mar-23
18.4%
Variance / Assurance
Metric is currently experiencing Common cause variation and is failing the target for 6+ months
Target (Internal)
25%
Business Rule
Full Escalation as not achieved target for >6months



Mar-23
5.3%
Variance / Assurance
special cause variation of an improving nature and is consistently failing the target
Target (Internal)
15%
Business Rule
Full Escalation as consistently failing the target



Mar-23
29.0%
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and is consistently failing the target
Target (Internal)
25%
Business Rule
Full Escalation as not achieved target for >6months



Mar-23
7.6%
Variance / Assurance
Metric is currently Special Cause Variation of a concerning nature and is consistently failing the target
Target (Internal)
20%
Business Rule
Full escalation as is consistently failing the target

Summary:

Inpatients (Daycase and IP): Is experiencing common cause variation and has failed the target for 6+ months.
Recommended Rate is 98.3%

A&E: Is experiencing Special Cause Variation of an improving nature, but is consistently failing the target.
Recommended Rate is 89.9%

Maternity: Is experiencing Special Cause Variation of an improving nature, but is consistently failing the target.
Recommended Rate is 98.6%

Outpatients: Is experiencing special cause variation of a concerning nature and is consistently failing the target
Recommended Rate is 95.9%

Actions:

Inpatients: Figures for March showed a slight decrease this month but overall this is an improving picture - to continue with current methodology. Paper card uploads with the facility to use QR code and online. Volunteers are supporting with FFT collection.
A&E: This an improving picture – to continue with current methodology. Hybrid method using text, QR code and online. Meeting with Netcall and ED on 14 March to review progress and to continue to monitor and support.
Maternity: This is an improving picture. Meeting held with the directorate to support improvements to FFT response rate. Volunteers are supporting with FFT collection.
Outpatients: SMS text messaging - initial review indicated poor patient response rate. Potential problem identified with mapping and text messaging. Further meeting in April to work through improvements.
FFT Response All: Overall response rate for March was >6500, our highest ever monthly return.
Scoping in progress for new provider to provide FFT responses and surveys.

Assurance & Timescales for Improvement:

Inpatients: Continue monthly review and support for inpatient areas
A&E: Continue monthly review
Maternity: Assurance they will continue to promote FFT in clinical areas. Continue monthly review.
Outpatients: Continue monthly review.
All: Meetings with Netcall and ED in March and April to monitor and review.
Ward auto remove out of date cards, promote FFT and increase response rate.
Meetings held with ED and Maternity to review FFT and actions put in place including updating IQVIA hierarchy, printing and supplying FFT posters, using iPads and volunteers supporting with FFT collection.
Updated FFT reports circulated to staff.
Imperial Research project
Comms put out reminding staff about FFT. Internet page updated to include more information about FFT and an accessibility information.
We will continue to monitor all aspects of FFT.

Strategic Theme: Systems

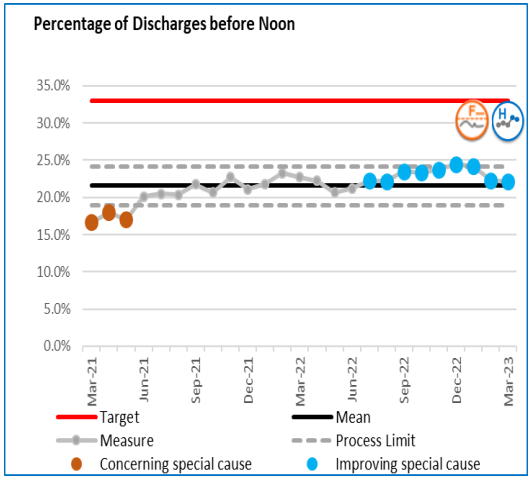
	CQC Domain	Metric	Latest: Trust Target	Latest: Most recent position	Latest: Period	Previous: Trust Target	Previous: Most recent position	Previous: Period	Actions & Assurance: Watch / Driver	Actions & Assurance: Variation	Actions & Assurance: Assurance	Actions & Assurance: CMS Actions
Vision Goals / Targets	Effective	Decrease the number of occupied bed days for patients identified as medically fit for discharge (shown as rate per 100 occupied beddays)	3.5	8.9	Mar-23	3.5	6.7	Feb-23	Driver	No SPC	No SPC	-
Breakthrough Objectives	Effective	To increase the number of patients leaving our hospitals by noon on the day of discharge	33.0%	22.1%	Mar-23	33.0%	22.3%	Feb-23	Driver			Full CMS

Breakthrough: Counter Measure Summary

Project/Metric Name – To increase the number of patients leaving our hospitals by noon on the day of discharge to 33%

Owner: Rachel Jones
Metric: discharges before noon
Desired Trend: 7 consecutive data points above the mean

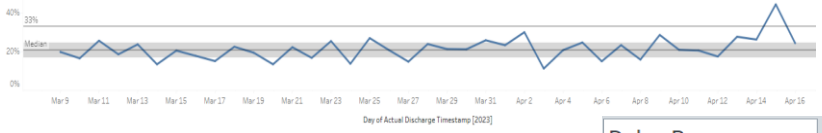
1. Historic Trend Data



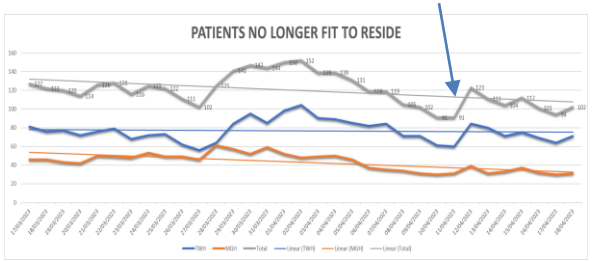
Current Data Source: Teletracking
Mar-23
22.1%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
33%
Target Achievement
Metric is consistently failing the target

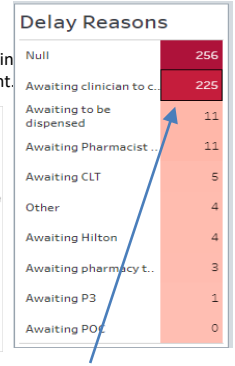
2. Stratified Data

TT DBN Data: For context, the junior doctors strikes occurred on 11th to 15th April. The DBN performance was higher than average at this time with 15th April (Saturday) being 44% DBN.



The NLFTR data shows a decrease overall in April with an overall trending decrease at TWH and MGH between 17/3 to 18/4. There is a step up increase in NLFTR (91 to 123) on 11-12th due to doctors strike and senior clinician oversight.





13.04.23-19.04.23 Analyses by the surgery DBN team has shown the top contributors for delayed discharge being 'NULL' and 'EDN completion'. Further deep dives to be undertaken on 'NULL'.

Week Day	Date	%DBN
M	13/03/2023	24
T	14/03/2023	13
W	15/03/2023	20
T	16/03/2023	18
F	17/03/2023	15
S	18/03/2023	22
S	19/03/2023	19
M	20/03/2023	13
T	21/03/2023	22
W	22/03/2023	17
T	23/03/2023	25
F	24/03/2023	14
S	25/03/2023	27
S	26/03/2023	21
M	27/03/2023	15
T	28/03/2023	24
W	29/03/2023	21
T	30/03/2023	21
F	31/03/2023	26
S	01/04/2023	23
S	02/04/2023	30
M	03/04/2023	11
T	04/04/2023	21
W	05/04/2023	25
T	06/04/2023	15
F	07/04/2023	23
S	08/04/2023	16
S	09/04/2023	29
M	10/04/2023	21
T	11/04/2023	21
W	12/04/2023	17
T	13/04/2023	28
F	14/04/2023	26
S	15/04/2023	44
S	16/04/2023	24
Average		21

3. Top Contributors

Area of Analysis	Considered a Top Contributor?
EDN Completion Times	EDNS are a top contributor in delays in discharge time. There is a clinically led EDN project group focussing on this including utilising Sunrise for a more integrated EDN: EPMA process.
Criteria Led Discharge	The data in Aug 2022 showed that Criteria Led Discharge was only utilised in 1.3% of all discharges, therefore there is an opportunity to increase DBN using this process.

4. Action Plan

CM	Action	Who	When	Complete
Revisit Contributors	• Revisit data to assess top contributors to determine if context has changed. i.e. EDN / patients identified as NLFTR when not.	SAS/ NP	15.05.23	In Progress
Hilton Pathway	• Hilton Stroke pathway improvements commenced: waiting list communications improved, generic email utilised for escalations. Portable key safes purchased.	Hilton/NP/ AG/ FR / OT	31.05.23	In Progress
Criteria Led Discharge	• CLD to be commenced for pathway 0 and pathway 1 patients. Competencies training and signoff for implementation w/c 24.4.	KC/ FR / NP	31.05.23	In Progress
EDN	• Pilot utilising sunrise for EDN starts 19th April on TWH wards 21 and 30.	RG / SF / JS	31.05.23	In Progress
NCTR	• Focus work being undertaken on data quality to deduce impact on BTO projects.	RS/ RG	31.05.23	In Progress

Strategic Theme: Sustainability

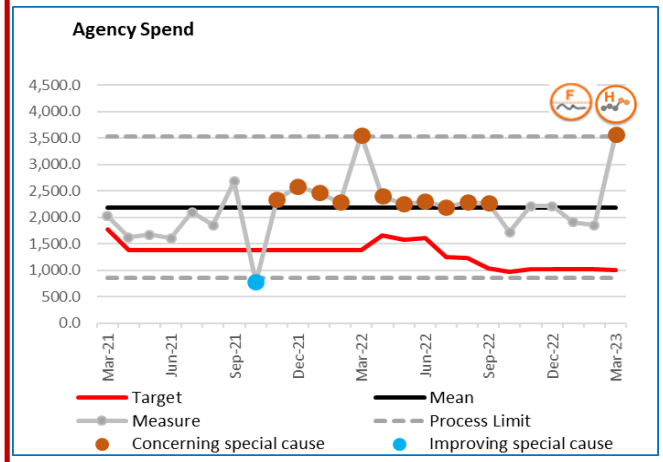
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Well Led	Delivery of financial plan, including operational delivery of capital investment plan (net surplus(+)/net deficit (-) £000)	1,247	1,404	Mar-23	1,211	2383	Feb-23	Driver			Verbal CMS
Breakthrough Objectives	Well Led	Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000	1005	3562	Mar-23	1022	1847	Feb-23	Driver			Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Well Led	CIP	4097	2120	Mar-23	4097	2396	Feb-23	Driver	No SPC	No SPC	Not Escalated
	Well Led	Cash Balance (£k)	5000	7984	Mar-23	8429	31811	Feb-23	Driver			Not Escalated
	Well Led	Capital Expenditure (£k)	3854	13275	Mar-23	3734	6238	Feb-23	Driver			Not Escalated

Breakthrough: Counter Measure Summary

Project/Metric Name – Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000

Owner: Steve Orpin
Metric: Premium Workforce Spend
Desired Trend: 7 consecutive data points below the mean

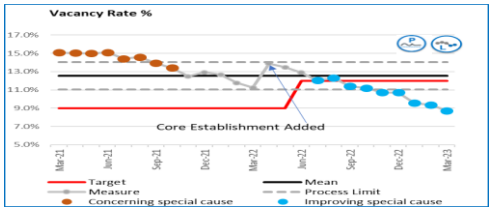
1. Historic Trend Data



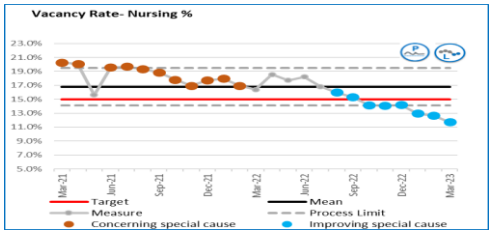
Mar-23
3562
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
1,005
Target Achievement
Metric has not achieved the target for >6 months

Note the Oct 22 value is low due to a release of accruals from previous months

2. Stratified Data



Vacancy Rate: Metric is experiencing special cause variation of an improving nature and has passed the target for six months or more.



Nursing Vacancy Rate: Metric is experiencing special cause variation of an improving nature and has passed the target for six months or more.

3. Top Contributors

Contributing factors to premium workforce spend have been narrowed down to:

- Healthroster Performance
- Unfunded Escalation areas
- Reduction of vacancies
- Enhanced control environment

4. Action Plan

Action	Status
Identify target dates for closure of escalation wards	April
Complete eRostering guidelines for Nursing	April
Recruitment pipeline numbers info from TRAC, to be included into Recruitment Dashboard, to provide workforce forecast	Ongoing
Amend membership to Terms of Reference	Ongoing
Additional drivers to be quantified / worked up	Ongoing
Ensure Rostering is the main focus of future meetings	April

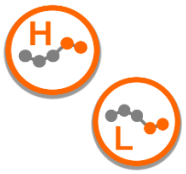
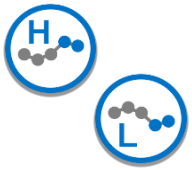
NHS
Maidstone and Tunbridge Wells NHS Trust

Appendices

MTW
exceptional people, outstanding care

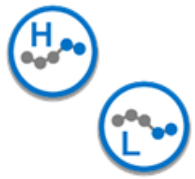
SDR Business Rules Driven by the SPC Icons

Assurance: Failing

Variation	Assurance	Understanding the Icons	Business Rule – DRIVER	Business Rule - WATCH
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.	Metric is Failing the Target (which is likely if it is a Driver Metric). A full CMS is required to support actions and delivery of a performance improvement	Metric is Failing the Target and is showing a Special Cause for Concern. A full CMS is required to support actions and delivery of a performance improvement. Consider escalating to a driver metric
		Common Cause - no significant change. Assurance indicates consistently (F)ailing the target.	Metric is Failing the Target (which is likely if it is a Driver Metric). A full CMS is required to support actions and delivery of a performance improvement	Metric is Failing the Target and is in Common Cause variation. A verbal CMS is required, but do not consider escalating to a driver metric
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.	Metric is Failing the Target (which is likely if it is a Driver Metric). A full CMS is required to support actions and delivery of a performance improvement	Metric is Failing the Target, but is showing a Special Cause of Improvement. Note performance, but do not consider escalating to a driver metric

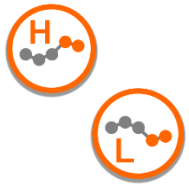
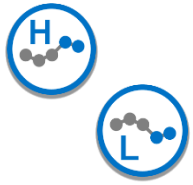
SDR Business Rules Driven by the SPC Icons

Assurance: Hit & Miss

Variation	Assurance	Understanding the Icons	Business Rule – DRIVER	Business Rule - WATCH
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates inconsistently hitting or missing the target.	Metric is Hitting & Missing the Target and is showing a Special Cause for Concern. A **verbal CMS** is required to support ongoing actions and delivery of a continued / permanent performance	Metric is in Common Cause, but is showing a Special Cause for Concern. **Note performance**, but do not consider escalating to a driver metric
		Common Cause - no significant change. Assurance indicates inconsistently hitting or missing the target.	Metric is Hitting & Missing the Target and is in Common Cause variation. A **verbal CMS** is required to support ongoing actions and delivery of a continued / permanent performance	Metric is Hitting & Missing the Target and is in Common Cause variation. **Note performance**, but do not consider escalating to a driver metric
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates inconsistently hitting or missing the target and blue outline indicates this has continued for 6 months or more.	Metric is Hitting and Missing the Target, but is showing a Special Cause of Improvement. **Note performance**	Metric is Hitting and Missing the Target, but is showing a Special Cause of Improvement. **Note performance**

SDR Business Rules Driven by the SPC Icons

Assurance: Passing

Variation	Assurance	Understanding the Icons	Business Rule – DRIVER	Business Rule - WATCH
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates consistently (P)assing the target.	Metric is Passing the Target, but is showing a Special Cause for Concern. A verbal CMS is required to support continued delivery of the target	Metric is Passing the Target, but is showing a Special Cause for Concern. Note performance, but do not consider escalating to a driver metric
		Common Cause - no significant change. Assurance indicates consistently (P)assing the target.	Metric is Passing the Target and is in Common Cause variation. Note performance, consider revising the target / downgrading the metric to a 'Watch' metric	Metric is Passing the Target and is in Common Cause variation. Note performance
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates consistently (P)assing the target.	Metric is Passing the Target and is showing a Special Cause of Improvement. Note performance, consider revising the target / downgrading the metric to a 'Watch' metric	Metric is Passing the Target and is showing a Special Cause of Improvement. Note performance

Passing, Failing and Hit & Miss Examples

Metrics that consistently **pass** have:

The **upper** control limit **below** the target line for metrics that need to be **below the target**

The **lower** control limit **above** the target line for metrics that need to be **above the target**

A metric achieving the target for 6 months or more will be flagged as passing

Metrics that are **hit and miss** have:

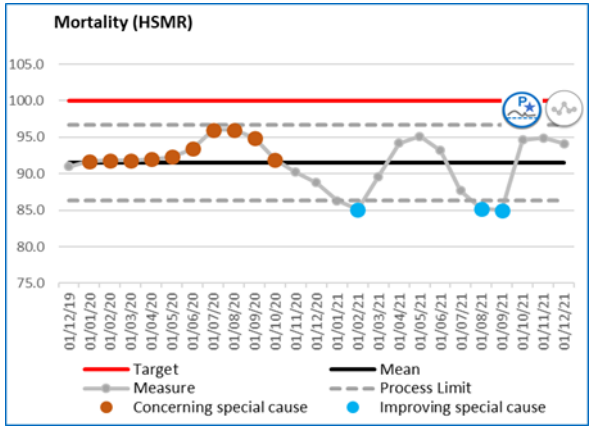
The **target** line **between** the **upper** and **lower** control limit for all metric types

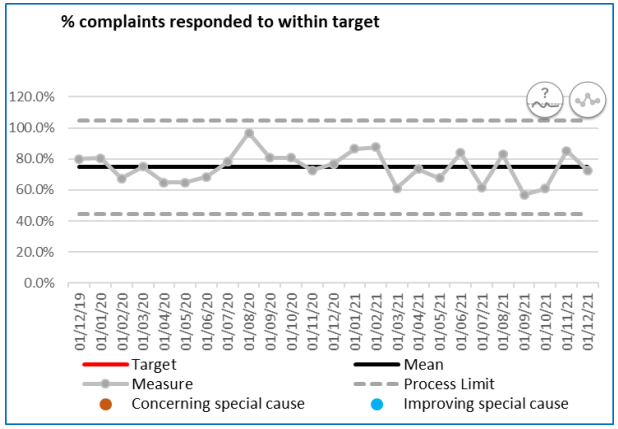
Metrics that consistently **fail** have:

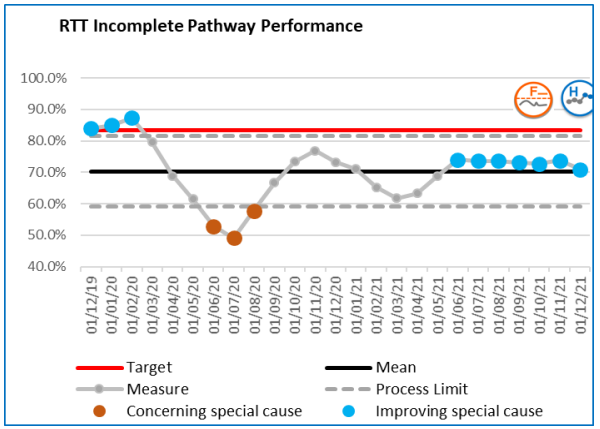
The **lower** control limit **above** the target line for metrics that need to be **below the target**

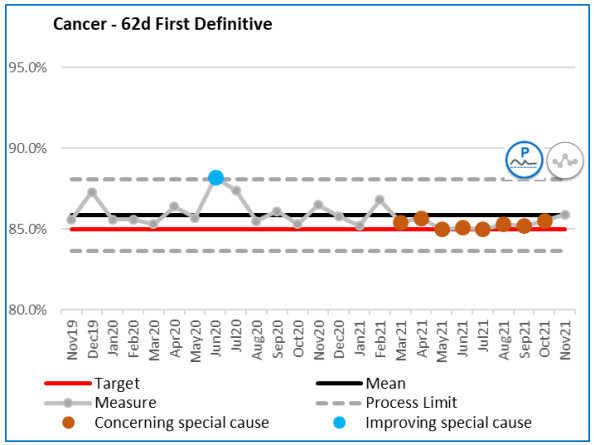
The **upper** control limit **below** the target line for metrics that need to be **above the target**

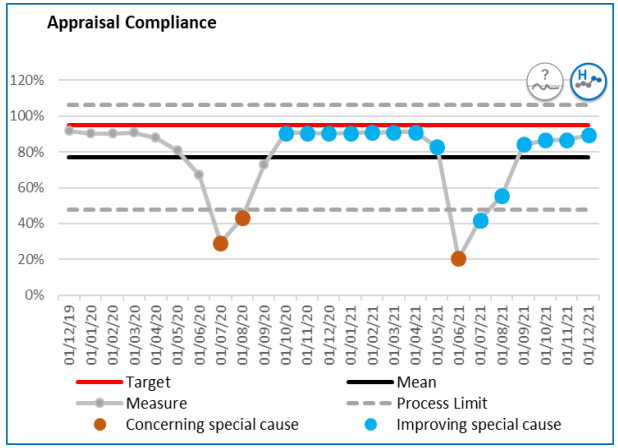
A metric not achieving the target for 6 months or more will be flagged as failing

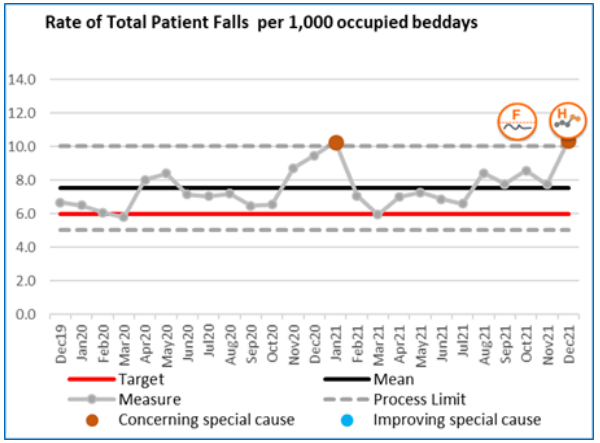












Executive Summary

- The Trust was £1.4m in surplus in the month which was £0.2m favourable to plan. Year to Date the Trust delivered a £0.2m surplus.
- The key pressure is within pay budgets which are £5.9m adverse to plan (net of specific national funding offsetting pay increase and reduction in annual leave carry over accrual). The main pressures continue to be within Emergency Medicine medical staffing spend (£5.5m) and facilities staffing (£1.9m). These pressures were partly offset by underspends within Nursing (£1.7m).
- Cost Improvement Plans (CIP) adverse to plan by £15.1m.
- The closing cash balance at the end of March 2023 was £7.9m which is higher by £2.9m compared with the revised plan resubmitted in June 2022.

Current Month Financial Position

- The Trust was £1.4m in surplus in the month which was £0.2m favourable to plan
- The key current month variances are as follows:
    - Income overperformed by £31.2m in March.
        - The key variances to plan in the month were: Income relating to 6.3% pension contribution adjustment (£15.3m), potential AFC consolidated pay award (£12.5m) as notified by NHSE and PPE push stock funding (£1.2m) which are offset by additional expenditure. Additional income for education training (£1.4m) and income from WGA bodies (£0.8m) mainly associated with income for overseas nurse recruitment.
    - Expenditure budgets overspent by £31.6m in the month, £29m relating to additional central funding therefore a net overspend of £2.6m.
        - The key variances were: Pay budgets £0.9m favourable which includes £3.8m reduction in annual leave accrual which was partly offset by increase in temporary staffing and £0.4m pressure associated with the potential cost for back dated pay award being higher than notified income value. Non Pay budgets were £3.5m adverse to plan which is mainly due £2.3m unidentified CIP and drugs overspend.

Year to Date Financial Position

- The Trust generated £0.2m surplus
- The key year to date variances is as follows:
    - **Adverse Variances**
        - CIP Slippage (£15.1m)
        - Pay budgets net of 6.3% pension and AFC backdated consolidated pay award funding overspent by £2.1m. The Trust reduced the annual leave carry over accrual by £3.8m (to match agreed carry over leave claims) therefore the underlying pay overspend was £5.9m. The main pressures continue to be within Emergency Medicine medical staffing spend (£5.5m) and facilities staffing (£1.9m), these pressures were partly offset by underspends within Nursing (£1.7m).
    - **Favourable Variances**
        - Release of £7.5m from reserves. The following reserves have been released: £2.9m from growth reserve to offset unfunded waiting list initiatives incurred, £2.4m from service developments and £2.2m from contingency to part offset some of the YTD pay pressures and CIP slippage.
        - Reduction in provisions to reflect latest assessment (£2.6m), release of laundry dilapidations (£1.5m) and release of £1.9m of deferred income to match commissioner guidance.
        - Underspends within depreciation (£1.7m), additional funding to support mental health patients (£1.4m), additional clinical income to fund additional service developments and

non elective growth support (£1.2m), overperformance in interest receivable and reduction in interest payable (£0.9m), reduction in PDC (£0.6m), Elective outsourcing due to Elective activity below budget (£0.5m), overperformance on trade income (£0.4m), overperformance associated with overseas visitor income (£0.3m) and reduction in doubtful debt (£0.2m)

Cashflow

- The closing cash balance at the end of March 2023 was £7.9m which is higher by £2.9m compared with the revised plan resubmitted in June 2022.
- Within March the Trust paid £11.8m related to capital invoices, March's Pension £4.5m and Unitary Payment £2.8m (due April), PDC (Public Dividend Capital) £2.9m, Capital loan repayments and interest £0.6m.
- The Trust also paid within March other NHS organisations £3.9m primarily to KCHFT as the Trust received a number of invoices which related to the full 2022-23 year this totalled £2.3m.
- The Trust continues to work with its NHS colleagues to reduce all debtor/creditor balances. This also ensures the Trust is achieving the BPPC target of 95% that NHSE are reviewing regularly, the Trusts BPPC at the end of January is - Trade in value 95.5% and by quantity is 96.2; for NHS by value is 98.8% and by quantity is 84.1%.

Capital Position

- The Trust's initial capital plan, excluding IFRS 16 items, agreed with the ICB for 2022/23 was £41.3m comprising:
    - **Estates £2.9m:** Estates Enabling and Backlog schemes included contractual commitments from 2021/22 relating to enabling works for Linacs and SPECT CT equipment, as well as MRI enabling/build works at MGH and TWH (relating to In-Health proposed contract). They also included carry forward spend from projects that were planned for completion in 2021/22 but overran e.g. Annexe and Oncology OPD.
    - **ICT £2.8m:** ICT schemes include EPMA costs relate to contractual commitments, IT for KMMS, iPro Anaesthetics, EPR infrastructure upgrade, eChemo prescribing and devices replacement.
    - **Equipment £2.5m:** Included contractual commitments from 2021/22 relating to schemes that could not be delivered by 31st March due to supplier issues, along with emergency schemes approved by ETM. All schemes were approved through the business case or emergency approval process. Major schemes included £567k of Trustwide Patient Monitoring equipment; £214k for replacement OCT machines; £426k for replacement Fluoroscopy equipment at Maidstone.
    - **Externally Funded schemes:** Includes £1.9m for the HASU (approved by ICB from system funding). The West Kent Orthopaedic Centre [Barn] was initially funded at £29m in the plan, but delays on the approvals meant that the OBC has been approved with a reduced figure of £6.5m in 2022/23 and some further early works funding agreed for 2023/24 prior to the FBC review (June 2023).
- Additional funds agreed during the year included Digital Diagnostics (PACS, Home Reporting, iRefer & Digital Pathology) of £546k in total, Endoscopy Decontamination of £58k, Cyber Security £48k, EPR Optimisation (£500k), Patient Portals - Wayfinder (£352k) and Digital Pathology (Fish) £186k, and £9.9m for the CDC programme. The Trust submitted bids to the ICB against available system slippage: £592k, primarily for medical equipment, was approved in M11; of this the Trust spent £590k by year end. This will be subject to a CRL/CDEL adjustment but without additional cash.

Year end outturn.

- The Trust reported £25.2m of capital spend at year end, in line with its forecasts during the last quarter. M12 saw a significant value of £13.2m being spent or accrued as equipment, ICT or building projects were completed. Some items are being held on the Trust's behalf offsite; the Trust has major projects in progress as assets under construction e.g. Barn theatre at Maidstone.
- The CDC development outturned at £4.15m – the national funding agreed in the summer of 2022/23 was £9.87m, but the scheme took longer to procure than expected. The ICB is working with the Trust to identify and secure the £5.7m of capital funding required for 2023/24.

IFRS 16 Capital

- The Trust reported IFRS 16 capitalisations and remeasurements of £10.8m at year end. The most significant elements were:
  - Springwood Block A (The "Trees" blocks) – new lease for just over 20 years taken out on 31st March: initial capitalised cost £5.1m
  - Springwood Block B (Kirkland, Barming blocks) – remeasurements for rental price increases from transition to new blocks and RPI, over 40 year lease: capitalised cost £3.6m
  - Unit A CDC additional works rent – capitalised value £0.9m; CDC land lease for new modular build – capitalised value £0.9m

This capitalised cost was still c. £17m outturn underspend the IFRS 16 resource planned for 2022/23. The main slippage relates to the Kent & Medway Medical school student accommodation project at TWH which was originally planned for completion in March 2023 but has slipped to February 2024. The resource of c. £15m has been re-planned in our 2023/24 submissions, but there is no confirmation as yet of agreed IFRS 16 resource for 2023/24.

Maidstone and Tunbridge Wells NHS Trust

Finance Report

Month 12
2022/23

Maidstone and Tunbridge Wells NHS Trust

Dashboard

March 2022/23

	Current Month					Year to Date				
	Actual	*Plan*	*Variance*	Pass-throug	*Revised Variance*	*Actual*	*Plan*	*Variance*	Pass-throug	*Revised Varianc*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	85.0	53.5	31.5	0.3	31.2	680.5	636.7	43.8	0.4	43.4
Expenditure	(80.0)	(48.1)	(31.9)	(0.3)	(31.6)	(636.1)	(589.3)	(46.9)	(0.4)	(46.5)
EBITDA (Income less Expenditure)	5.0	5.4	(0.4)	0.0	(0.4)	44.4	47.5	(3.1)	0.0	(3.1)
Financing Costs	(3.6)	(5.1)	1.5	0.0	1.5	(44.8)	(48.7)	3.9	0.0	3.9
Technical Adjustments	0.0	1.0	(0.9)	0.0	(0.9)	0.6	1.2	(0.7)	0.0	(0.7)
Net Surplus / Deficit (Incl Top Up funding support)	**1.4**	**1.2**	**0.2**	**0.0**	**0.2**	**0.2**	**0.0**	**0.2**	**0.0**	**0.2**
Cash Balance	8.0	5.0	3.0		3.0	8.0	5.0	3.0		3.0
Capital Expenditure (Incl Donated Assets)	13.3	3.9	(9.4)		(9.4)	25.2	41.3	(16.1)		(16.1)
Cost Improvement Plan (Internal £30m target)	2.1	4.1	(2.0)		(2.0)	14.9	30.0	(15.1)		(15.1)

Note these figures are draft accounts and subject to audit approval

Summary Current Month:

- The Trust was £1.4m in surplus in the month which was £0.2m favourable to plan.
- Income overperformed by £31.2m in March. The key variances to plan in the month were: Income relating to 6.3% pension contribution adjustment (£15.3m), potential AFC consolidated pay award (£12.5m) as notified by NHSE and PPE push stock funding (£1.2m) which are offset by additional expenditure. Additional income for education training (£1.4m) and income from WGA bodies (£0.8m) mainly associated with income for overseas nurse recruitment.
- Expenditure budgets overspent by £31.6m in the month, £29m relating to additional central funding therefore a net overspend of £2.6m. The key variances were: Pay budgets £0.9m favourable which includes £3.8m reduction in annual leave accrual which was partly offset by increase in temporary staffing and £0.4m pressure associated with the potential cost for back dated pay award being higher than notified income value. Non Pay budgets were £3.5m adverse to plan which is mainly due £2.3m unidentified CIP and drugs overspend.

Year to date overview:

- The Trust is on favourable to plan generating a £0.2m surplus year to date.
- The Trusts key variances to the plan are:

Adverse Variances:

- CIP Slippage (£15.1m)
- Pay budgets net of 6.3% pension and AFC backdated consolidated pay award funding overspent by £2.1m. The Trust reduced the annual leave carry over accrual by £3.8m (to match agreed carry over leave claims) therefore the underlying pay overspend was £5.9m. The main pressures continue to be within Emergency Medicine medical staffing spend (£5.5m) and facilities staffing (£1.9m), these pressures were partly offset by underspends within Nursing (£1.7m).

- **Favourable Variances:**

- Release of £7.5m from reserves. The following reserves have been released: £2.9m from growth reserve to offset unfunded waiting list initiatives incurred, £2.4m from service developments and £2.2m from contingency to part offset some of the YTD pay pressures and CIP slippage.
- Reduction in provisions to reflect latest assessment (£2.6m), release of laundry dilapidations (£1.5m) and release of £1.9m of deferred income to match commissioner guidance.
- Underspends within depreciation (£1.7m), additional funding to support mental health patients (£1.4m), additional clinical income to fund additional service developments and non elective growth support (£1.2m), overperformance in interest receivable and reduction in interest payable (£0.9m), reduction in PDC (£0.6m), Elective outsourcing due to Elective activity below budget (£0.5m), overperformance on trade income (£0.4m), overperformance associated with overseas visitor income (£0.3m) and reduction in doubtful debt (£0.2m)

CIP (Savings)

- The Trust has a external (NHSE/I) savings target for 2022/23 of £20m but a internal savings requirement of £30m. Against the £30m internal target the Trust has delivered £14.9m savings which is £15.1m adverse to plan.

Mar-23		DAY				NIGHT				TEMPORARY STAFFING		Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled - RM/N (number of shifts)	Overall Care Hours per pt day	Nurse Sensitive Indicators					Financial review		
Hospital Site name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/ Agency Usage	Agency as a % of Temporary Staffing					FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Medical Unit (M) - NG551	95.3%	101.8%	-	-	134.4%	165.2%	-	-	38.1%	38.8%	118	8.16	35	9.1	15.4%	100.0%	5	0		167,876	205,807	(37,931)
MAIDSTONE	Stroke Unit (M) - NK551	84.0%	97.3%	-	100.0%	212.3%	107.5%	-	-	57.7%	25.4%	460	29.17	131	7.9	17.0%	100.0%	8	0		313,463	425,776	(112,313)
MAIDSTONE	Cornwallis (M) - NS959	97.2%	96.4%	-	-	111.0%	230.6%	-	-	55.7%	32.3%	123	8.88	28	8.1	40.7%	100.0%	3	1		105,868	77,094	28,774
MAIDSTONE	Culpepper Ward (M) - NS551	102.1%	71.6%	-	-	111.2%	125.7%	-	-	29.1%	15.5%	51	3.61	14	5.2	10.9%	100.0%	1	0		157,012	137,727	19,285
MAIDSTONE	Edith Cavell - NS459	107.7%	99.9%	-	100.0%	103.3%	106.5%	-	-	40.5%	25.7%	102	7.21	20	6.3	21.2%	100.0%	5	2		115,314	136,986	(21,672)
MAIDSTONE	Foster Clark - NS251	76.5%	93.0%	-	-	99.9%	94.9%	-	-	25.4%	22.7%	101	6.86	40	7.6	10.5%	93.3%	3	0		155,392	167,607	(12,215)
MAIDSTONE	John Day Respiratory Ward (M) - NT151	96.2%	107.0%	-	-	111.7%	114.4%	-	-	43.3%	40.7%	197	13.95	38	7.2	3.4%	100.0%	4	2		148,686	207,564	(58,878)
MAIDSTONE	Intensive Care (M) - NA251	95.4%	58.1%	-	-	96.9%	83.1%	-	-	13.8%	7.6%	74	4.94	11	43.5	1300.0%	100.0%	0	3		228,073	241,592	(13,519)
MAIDSTONE	Lord North Ward (M) - NF651	95.6%	89.5%	-	100.0%	100.0%	96.8%	-	-	14.7%	6.6%	41	3.06	9	7.0	18.2%	100.0%	1	0		113,978	117,914	(3,936)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	83.9%	70.9%	-	100.0%	80.7%	-	-	-	21.3%	4.7%	21	1.46	3	19.0	52.9%	100.0%	0	0		57,536	56,620	916
MAIDSTONE	Mercer Ward (M) - NJ251	95.9%	107.9%	-	100.0%	101.0%	162.9%	-	-	41.6%	49.1%	79	5.61	11	6.8	42.1%	100.0%	2	4		111,630	173,584	(61,954)
MAIDSTONE	Peale Ward COVID - ND451	90.0%	110.9%	-	100.0%	98.9%	142.7%	-	-	37.8%	33.7%	73	5.13	14	8.7	60.9%	100.0%	3	0		122,523	119,205	3,318
MAIDSTONE	Pye Oliver (Medical) - NK259	92.2%	129.6%	-	-	101.1%	159.3%	-	-	48.6%	57.3%	101	7.02	19	7.1	27.0%	100.0%	3	1		129,560	193,120	(63,560)
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	94.3%	101.5%	-	-	78.6%	-	-	-	30.4%	7.9%	42	2.71	7	36.4	-	-	0	0		55,664	62,047	(6,383)
MAIDSTONE	Whatman Ward - NK959	97.6%	86.2%	-	100.0%	118.1%	161.0%	-	100.0%	82.1%	41.1%	160	11.39	21	7.3	40.9%	100.0%	8	0		100,051	203,837	(103,786)
MAIDSTONE	Maidstone Birth Centre - NP751	119.3%	93.4%	-	-	102.4%	97.1%	-	-	17.7%	0.0%	38	2.01	1	41.1	126.5%	100.0%	0	0		73,878	90,154	(16,276)
TWH	Acute Medical Unit (TW) - NA901	83.3%	80.2%	-	100.0%	103.5%	89.3%	-	100.0%	41.1%	31.0%	243	17.63	85	8.4	19.1%	96.3%	4	0		240,445	255,907	(15,462)
TWH	Coronary Care Unit (TW) - NP301	85.8%	80.6%	-	-	93.7%	-	-	-	19.9%	26.1%	44	3.12	18	11.1	81.5%	100.0%	0	0		72,344	70,688	1,656
TWH	Hedgehog Ward (TW) - ND702	92.3%	81.7%	-	-	113.3%	91.2%	-	-	49.2%	38.2%	263	18.06	69	9.1	13.4%	97.4%	0	0		157,274	124,323	32,951
TWH	Intensive Care (TW) - NA201	100.3%	101.3%	-	-	100.0%	69.9%	-	-	15.6%	0.0%	207	13.94	27	43.3	0.0%	100.0%	0	0		363,637	410,086	(46,449)
TWH	Private Patient Unit (TW) - NR702	108.3%	92.6%	-	100.0%	79.1%	141.8%	-	-	30.5%	2.6%	54	3.58	24	10.0	44.4%	100.0%	4	0		13,733	79,453	(65,720)
TWH	Ward 2 (TW) - NG442	79.2%	121.0%	-	100.0%	102.2%	208.5%	-	100.0%	63.1%	51.9%	144	10.10	57	7.6	39.5%	100.0%	13	0		177,009	228,211	(51,202)
TWH	Ward 10 (TW) - NG131	98.6%	107.5%	-	-	114.3%	151.6%	-	-	54.0%	29.9%	205	14.48	60	6.7	-	-	2	0		142,984	182,564	(39,580)
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	94.9%	140.7%	-	-	131.5%	93.7%	-	-	90.2%	47.7%	345.00	24.08	89.00	7.6	23.7%	100.0%	11	1		159,516	253,142	(93,626)
TWH	Ward 12 (TW) - NG132	83.7%	102.5%	-	100.0%	123.8%	88.4%	-	-	44.1%	36.1%	195	12.66		6.0	33.3%	100.0%	10	1		142,848	175,519	(32,671)
TWH	Ward 20 (TW) - NG230	71.9%	132.9%	-	100.0%	146.3%	108.8%	-	-	53.0%	49.0%	238	16.54	97	7.0	29.4%	100.0%	5	0		168,317	203,949	(35,632)
TWH	Ward 21 (TW) - NG231	88.0%	106.3%	-	-	107.1%	106.3%	-	-	37.7%	44.6%	193	13.01	52	6.3	17.8%	100.0%	8	1		145,279	215,605	(70,326)
TWH	Ward 22 (TW) - NG332	77.9%	129.3%	-	100.0%	91.1%	135.4%	-	-	46.2%	57.4%	160	10.91	61	7.0	13.3%	100.0%	7	1		143,120	217,125	(74,005)
TWH	Ward 30 (TW) - NG330	89.3%	97.6%	-	-	93.6%	130.1%	-	-	40.6%	24.0%	167	10.62	30	6.3	12.1%	100.0%	6	5		122,390	197,609	(75,219)
TWH	Ward 31 (TW) - NG331	103.2%	113.8%	-	-	96.0%	120.7%	-	-	43.7%	24.2%	142	9.32	37	7.0	30.6%	100.0%	8	4		136,506	214,145	(77,639)
TWH	Ward 32 (TW) - NG130	74.3%	95.0%	-	100.0%	84.7%	83.1%	-	100.0%	21.9%	34.1%	137	9.08	47	7.9	-	-	0	0		144,071	152,347	(8,276)
TWH	Ward 33 (Gynae) (TW) - ND302	95.8%	97.8%	-	-	98.4%	93.5%	-	-	40.6%	5.2%	72	4.47	11	7.1	4.6%	100.0%	0	0		98,025	100,076	(2,051)
TWH	SCBU (TW) - NA102	96.1%	134.0%	-	-	111.7%	41.5%	-	-	28.9%	4.9%	139	8.77	8	10.8	53.8%	100.0%	-	0		202,620	216,496	(13,876)
TWH	Short Stay Surgical Unit (TW) - NE901	94.3%	72.4%	-	100.0%	99.9%	103.2%	-	-	19.9%	6.9%	45	3.03	2	12.7	-	-	1	0		79,831	100,036	(20,205)
TWH	Surgical Assessment Unit (TW) - NE701	98.8%	154.8%	-	-	98.3%	100.0%	-	-	35.6%	1.2%	49	3.28	2	23.4	-	-	0	0		75,005	76,027	(1,022)
TWH	Midwifery (multiple rosters)	77.9%	56.4%	-	-	90.0%	89.8%	-	-	18.8%	5.2%	815	46.28	144	**11.1**	69.9%	98.9%		**0**		**779,576**	**901,968**	**(122,392)**
Crowborough	Crowborough Birth Centre (CBC) - NP775	77.1%	94.8%	-	-	54.8%	100.0%	-	-	13.9%	0.0%	39	2.35	3	113.8	69.4%	97.7%		0		142,044	88,960	53,084
MAIDSTONE	Accident & Emergency (M) - NA351	100.3%	104.1%	-	100.0%	98.9%	99.0%	-	-	36.0%	41.8%	404	28.22	42	-	4.9%	89.4%	4	0		374,574	511,009	(136,435)
TWH	Accident & Emergency (TW) - NA301	99.5%	102.4%	-	100.0%	101.0%	89.2%	-	100.0%	44.9%	49.6%	534	37.26	60	-	5.7%	90.4%	6	0		403,226	655,360	(252,134)

Total Established Wards		**8,247,237**	**(1,606,359)**
Additional Capacity bed Cath Labs		42,100	13,052
Crowborough Birth Centre (CBC)			
Other associated nursing costs		9,747,959	-4,454,213
Total		18,037,296	(6,047,520)

Under fill

Overfill

Green: equal to or greater than 90% but less than 110%

Amber Less than 90% OR equal to or greater than 110%

Red equal to or less than 80% OR equal to or greater than 130%

To approve the Joint Forward Plan for the Kent and Medway Integrated Care System (ICS)	**Director of Strategy, Planning and Partnerships / Chair of the Kent and Medway Integrated Care Board (KM ICB) / Chief Executive of the KM ICB**

This enclosed report outlines the requirement for the development of an NHS Joint Forward Plan (JFP) in response to the Kent and Medway Interim Integrated Care Strategy. The JFP has been developed in partnership between NHS Kent and Medway Integrated Care Board and its partner NHS trusts and foundation trusts, as required by national guidance. In future years NHSE suggests that the JFP should be a shared system delivery plan for the Integrated Care Strategy. However, in this initial year it will form the NHS delivery plan for the Integrated Care Strategy in Kent and Medway.

The Kent and Medway Interim Integrated Care Strategy was developed in partnership between the NHS and lead local authorities and was published in December 2022, with the short deadline required to ensure it would influence the development of the JFP.

It is intended that the plan be published before the beginning of the financial year however, the date for publishing the 1st year is 30 June 2023.

It is recommended that the Board approves the Joint Forward Plan for the Kent and Medway ICS.

Which Committees have reviewed the information prior to Trust Board submission?

- Executive Team Meeting, 18/04/23

Reason for submission to the Trust Board (decision, discussion, information, assurance etc.) [1]

Discussion and Approval

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

NHS
Kent and Medway

Kent and Medway Draft Joint Forward Plan

Draft Five Year Forward Plan 2023-2027

NHS
Kent and Medway

Version Control

Version No	Purpose	Date
1	Issued to steering group and content leads for editing by this group only	09/02/2023
2	Issued to steering and project group for development workshop	02/03/2023
3	Issued to steering group for approval to share with system partners	24/03/2023

NHS
Kent and Medway

Contents

NHS
Kent and Medway

Introduction

Welcome to Kent and Medway's Draft Joint Forward Plan. The Kent and Medway Interim Integrated Care Strategy, published in December 2022, sets out a shared purpose and common aspiration for partners of the Kent and Medway Integrated Care System to work in increasingly joined up ways. It is rooted in the needs of people, communities and places and is intended to help us drive forward the agreed priorities for action in health and social care across Kent and Medway.

This Draft Joint Forward Plan is the NHS delivery plan for the Integrated Care Strategy, and is therefore structured to align to the shared outcomes and enablers in the strategy. It is owned by NHS Kent and Medway, the Integrated Care Board, and its partner NHS trusts and foundation trusts, namely Dartford and Gravesham NHS Trust, East Kent Hospitals University NHS Foundation Trust, Kent Community NHS Foundation Trust, Kent and Medway NHS and Social Care Partnership Trust, Maidstone and Tunbridge Wells NHS Trust, Medway NHS Foundation Trust and South East Coast Ambulance NHS Foundation Trust.

In developing the Joint Forward Plan we have adopted the Operational Plan as year one of our five year view. In this way we have clear actions outlined for the first year with aims and ambitions stated for future years. Actions are categorised according to the following planning horizons: short term (<1 year), medium term (1-2 years) and long term (3-5 years+).

Our Interim Integrated Care Strategy is due to be refreshed in the autumn 2023, therefore we will update the Joint Forward Plan on an annual basis to report on progress and ensure we deliver the aims of our strategy. It is hoped that in future years the Joint Forward Plan will develop into a shared system delivery plan.

NHS
Kent and Medway

Integrated Care Strategy

We will work together to make health and wellbeing better than any partner can do alone

Shared Outcome 1

Give children the best start in life and work to make sure they are not disadvantaged by where they live or their background, and are free from fear or discrimination.

Shared Outcome 2

Help the most vulnerable and disadvantaged in society to improve their physical and mental health; with a focus on the social determinants of health and preventing people becoming ill in the first place.

Shared Outcome 3

Help people to manage their own health and wellbeing and be proactive partners in their care so they can live happy, independent and fulfilling lives; adding years to life and life to years.

Shared Outcome 4

Support people with multiple health conditions to be part of a team with health and care professionals working compassionately to improve their health and wellbeing.

Shared Outcome 5

Ensure that when people need hospital services, most are available from people's nearest hospital; whilst providing centres of excellence for specialist care where that improves quality, safety and sustainability.

Shared Outcome 6

Make Kent and Medway a great place for our colleagues to live, work and learn.

Enabler: We will drive research, innovation and improvement across the system

Enabler: We will provide system leadership, and make the most of our collective resources

Enabler: We will engage our communities on this Strategy and in co-designing services

NHS
Kent and Medway

Overview of NHS services in Kent and Medway

NHS Kent and Medway, our Integrated Care Board, holds responsibility for NHS strategic planning and allocation decisions as well as bringing together partner organisations at a system and place level in a collaborative way to improve health and care outcomes. The breadth of responsibilities that our ICB is required to fulfil is wide and there are a range of statutory duties as outlined in our constitution. We are required to arrange for the provision of certain health services to such extent as we consider necessary to meet the reasonable requirements of our population. This includes the following services:

- Community health services (except where part of the public health service)
- Elective hospital care
- Healthcare services for children including those with complex healthcare needs
- Healthcare services for people with learning disabilities
- Healthcare services for people with mental health conditions
- Maternity services
- NHS continuing healthcare.
- Older people's healthcare services
- Rehabilitation services
- Urgent and emergency care including Accident and Emergency, ambulance and out-of-hours services
- Wheelchair services

We have delegated responsibility, from NHS England, for the commissioning of primary medical services (also known as general practice). Under the delegated arrangements, NHS England continues to hold GP contracts, but we are responsible for the day-to-day management of these. We also have delegated responsibility for the commissioning of dental services and community pharmacies.

Specialised healthcare such as heart and brain surgery; neonatal services; secure psychiatric services; public health and health promotion services; prison health; or healthcare for serving members of the Armed Forces (except emergency care) are commissioned directly by NHS England.

In ensuring the provision of services we are also required to ensure services are in place to respond to the Integrated Care Strategy. The Integrated Care Strategy is underpinned by the Joint Strategic Needs Assessments across Kent and Medway and in responding to this strategy the Joint Forward Plan also responds to those needs assessments. Medway Council has begun the process of refreshing its Joint Local Health and Wellbeing Strategy, which will include consideration of other priorities across the system and will explicitly include consideration of the Integrated Care Strategy. In Kent the draft Joint Local Health and Wellbeing Strategy that had been in development was included in the Integrated Care Strategy. There is therefore no separate and discrete JLHWS for Kent with the planned priorities fully subsumed within the Integrated Care Strategy.

The Kent and Medway Integrated Care System structure and the partnerships that are being developed to deliver our ambitious strategy are outlined on the following page.

NHS
Kent and Medway

Kent and Medway Integrated Care System

Kent and Medway Integrated Care Partnership

Members include: Kent and Medway ICB, Kent County Council, Medway Council, Health and Care Partnerships, District Councils, VCSE representative

Owns the Integrated Care Strategy

NHS Kent and Medway Integrated Care Board
Responsible for the Joint Forward Plan

Kent County Council and Medway Council

4 Place-based Health and Care Partnerships

12 District and Borough Councils

Provider Collaboratives

41 Primary Care Networks

Individual Providers
including voluntary and community services, independent sector,
NHS Trusts and NHS Foundation Trusts

System
1.9m people

- At system level we come together at scale to set overall system strategy, manage resources and performance, share research and good practice, plan specialist services, and drive strategic improvements whilst protecting our natural resources and reducing our emissions. **All** partners constitute the system. System-wide partners include NHS Kent and Medway, Kent County Council and Medway Council.

Places
260,000 – 720,000 people

- Alliances of health and care partners working together to design and deliver services to improve outcomes for the population of Kent and Medway, within delegated responsibilities and budgets. We have 4 Place Based Health and Care Partnerships in Kent: Dartford, Gravesham and Swanley; East Kent; Medway and Swale; and West Kent.

Neighbour-hoods
Typically 30,000-50,000 people

- Local decision making and integrated teams to meet the unique needs of their populations – including local health and care organisations and the VCSE, primary care networks, community groups and community assets.

NHS
Kent and Medway

Chapter 1

How we will give children the best start in life

Shared Outcome 1: We will give children the best start in life and work to make sure they are not disadvantaged by where they live or their background, and are free from fear or discrimination.

Integrated Care Strategy Summary

NHS Kent and Medway

Delivering effective maternity services; We are committed to improving outcomes and experience for families using our maternity and neonatal services. We will continue to implement the ambitions of the NHS Long Term Plan and use the learning from the Independent Inquiry into East Kent maternity services (Reading the Signals Report) to help us hear the voices of families who use services and involve them in helping us make positive changes.

Supporting families to start well; Health inequalities begin early in life. These differences include smoking in pregnancy, breastfeeding and childhood obesity, which can affect health and wellbeing outcomes in later life. The wider socio-economic context of the family and community, and access to environmentally sustainable open spaces also contributes families to start well, for example if fewer children experience child poverty, adult health outcomes and healthy life expectancy will improve. Services need to evolve to meet the needs of the population, be evidence based and co-produced with our partners and users that have lived experiences. Integrated support for families must include a wide offer that spans housing, communities, health, education, social care and the voluntary sector. We will also work as a system to improve the support we provide to children with special educational needs and disabilities (SEND) in Kent and Medway, including those who are neurodiverse.

Adopting a whole family approach. A whole-family approach, with early help and a focus on preventing rather than responding to crises, is an essential component to reducing inequalities. Taking an approach like this across Kent and Medway ICS will better enable families to have the confidence to take ownership of their health and care journey. It will ensure improved outcomes by addressing issues such as generational trauma, housing challenges and other components that inhibit families from thriving. We are committed to developing a Family Hub model, including access to Start for Life Universal Services; midwifery, health visiting, mental health, infant feeding, safeguarding and Special Educational Needs and Disabilities services.

Shared Outcome 1: We will give children the best start in life and work to make sure they are not disadvantaged by where they live or their background, and are free from fear or discrimination.

Safeguarding children. Protecting children and young people is one of our most important responsibilities. As partners, we need to bring together our collective information, skills and resources to provide fully joined up support for children and families. The ICS presents opportunities to strengthen our multiagency safeguarding arrangements so we can ensure children and young people grow up in safe, strong communities free from adverse situations that could harm them. We will ensure children and young people's voices are listened to. We will safeguard and promote the welfare of looked after children and care leavers, supporting them to live a positive and fulfilled life and transition into independence with confidence and ambition for the future. We will continue to work closely with Government to support the National Transfer System and ensure unaccompanied asylum-seeking children are cared for fairly and safely without disproportionate impact on our area.

Key to timescales

- ● Short term < 1 year
- ●● Medium term 1-2 years
- ●●● Long term 3-5 years+

NHS
Kent and Medway

Goal	Actions	Timescale	Owner(s)
Deliver effective maternity services **Metrics** National ambition - To halve the rates of stillbirths, neonatal deaths, maternal death and brain injuries by 2025. Local metrics: • Kent and Medway stillbirth rate • Kent and Medway neonatal death rate • Kent and Medway HIE rate Ensure all women have personalised and safe care through every woman receiving a personalised care plan and being supported to make informed choices. Metrics: • Number of women with a personalised care and support plan	Provide targeted support to East Kent Hospitals University Foundation Trust to implement and gain assurance on the recommendations of the Reading the Signals Report and other specific local quality improvement requirements	●●	NHS Kent and Medway Improving Outcomes Board Local Maternity and Neonatal Systems Board
	Ensure continuous improvement of services through utilising the perinatal quality surveillance model across the system to identify quality concerns and support shared learning and proactive actions to improve patient safety.	Ongoing	
	Continue to develop local Maternity Voices Partnerships as our main way of hearing service user feedback and involving people who have used services in making improvements, incl. ensuring diversity in MVP membership/participation.	●●	
	Embed personalised care and support planning to increase choice and control for women throughout their pregnancy and postnatal period, contributing to families achieving the best start in life.	●●	
	Take targeted action on workforce recruitment, retention and training to ensure that all maternity and neonatal services achieve sustainable, safe and effective staffing levels.	●●	
	Support all of our trusts to fully implement maternity continuity of carer, initially focusing on black, Asian and mixed ethic groups and those living in our most deprived communities.	●●●	
	Procure a new shared maternity information system across all of our trusts to give families improved access to their records and enable better information sharing across services	●●	
	Ensure community maternity services work in close partnership with health visiting and other community services for families, particularly in the development of Family Hubs.	●●	

Goal	Actions	Timescale	Owner(s)
Deliver effective maternity services (continued) **Metrics** Reduce inequalities in access and outcomes: • Number of women in deprived and BAME groups with a personalised care and support plan • Number of women in deprived and BAME groups in a maternity continuity of carer pathway • Smoking at time of delivery (SATOD)	Continue to develop our specialist perinatal mental health community services, enabling more people to access them, including assessment and signposting for partners.	●●	NHS Kent and Medway Improving Outcomes Board Local Maternity and Neonatal Systems Board
	Complete the implementation of Thrive, our new maternal mental health service offering psychological support for birth trauma and perinatal loss.	●	
	Complete the co-production and implementation of new services and pathways in the NHS Long Term Plan that support families who need additional support during their maternity journey, including smoking cessation, pelvic health, and specialist maternal medicine.	●	
	Continue the implementation of targeted actions to address inequalities of outcomes in maternity and neonatal services, as set out in our perinatal equity action plan.	●●	
	Continually improve our neonatal services through partnership working with the KSS neonatal Operational Delivery Network to deliver the recommendations of the Neonatal Critical Care Review (NCCR) and take on local commissioning of these services.	●●	
	Reduce the risk for those with military connected pregnancies by implementing recommendations from the Maternity Military Matters Project, ensuring a military family approach and supporting maternity services to understand military life and culture.	●	Local Maternity and Neonatal Systems Board Armed Forces Network.
	Deliver the actions from the Ockenden report as set out in the April 2022 letter, the East Kent Reading the Signals Report (2022) as well as those that will be set out in the new NHSE national single delivery plan for maternity and neonatal services.	Ongoing	East Kent Hospitals University NHS FT Board Local Maternity and Neonatal Systems Board

NHS
Kent and Medway

Goal	Actions	Timescale	Owner(s)
Support families to start well **Metrics** • Number of children on the waiting list for ADHD and autism diagnostic assessments • Number of children waiting over 18 weeks for treatment • Core20PLUS5 metrics for children and young people, for example number of asthma attacks, waiting list for tooth extractions due to decay for children admitted as inpatients, number of children and young people accessing mental health services	Evolve our services to meet population need, taking a holistic, family centred approach. Actively reduce barriers to supporting families in the widest-sense working with partners in housing, health, education, social care and voluntary sector.	●●●	NHS Kent and Medway Integrated Care Board Kent & Medway Children's Programme Board
	Grow our workforce to work together to deliver care closer to home within a network of local support.	●●●	
	Redesign pathways to reduce elective surgical and outpatient appointment wait times for secondary and tertiary care, including Paediatric Surgery as detailed in our operational plan. Dartford, Gravesham and Swanley Health and Care Partnership has also identified this as a priority.	●●	
	Pilot integrated models of care with a focus on long term conditions, emotional wellbeing, (special educational needs and disabilities) SEND and other risk factors. This will support: - strengthening relationships and joint working practices across health, social care and education - sharing of specialist skills and knowledge between professionals/clinicians and children/families - clearer Information, advice and guidance, including for families - joined up decision making, systems and plans - better experience and outcomes for children, young people and families - a reduction in emergency department attendances	●	

Goal	Actions	Timescale	Owner(s)
Support families to start well (continued)	Improve support to children with special educational needs and disabilities (SEND) with better, faster clinical assessment of SEND needs and improving experience that parents have when they contact us. Explore arrangements to bring services for children with SEND together to maximise resources and deliver better outcomes, and other measures as set out in the Kent and Medway Integrated Children's Delivery Board Plan.	●	NHS Kent and Medway Integrated Care Board SEND Improvement and Assurance Board
	Support armed forces children to thrive at school by identifying need and using the Thriving Lives toolkit.	●	Kent Community Health NHS Foundation Trust Board School Health Services supported by the Armed Forces Network
Adopt a whole family approach with early help and a focus on preventing rather than responding to crises	Work in partnership with local authorities to develop the Family Hub Model - Start for Life Universal Services; midwifery, health visiting, mental health, infant feeding, safeguarding and SEND	●●	NHS Kent and Medway Integrated Care Board Kent & Medway Children's Programme Board,
	Change our commissioning approach from activity based commissioning (for example number of clinical sessions) to outcome-based commissioning.	●●●	
	Develop an approach to better support the child, young person, young adult (0-25) and their families at key transition points in order to improve outcomes and ensure continuity of care. This includes looked after children.	●●	Kent and Medway NHS and Social Care Partnership Trust Board, Kent & Medway Children's Programme Board
	Implementation of the Armed Forces Act 2021 to ensure the removal of disadvantage in accessing services for Armed Forces Children and families. Increase awareness training, identification of the armed forces community and reduce delayed or interrupted treatment/care of service children	●	Provider trust boards Armed Forces Network

Goal	Actions	Timescale	Owner(s)
Safeguard children	Deliver the NHS Kent and Medway Safeguarding Strategy. The key aims are: - to prevent violence and violence related trauma, injuries and deaths in the communities across Kent and Medway. - to work with partners in providing strategic leadership to improve outcomes for vulnerable children and adults at risk of violence or aggression. The objectives address domestic abuse, violence reduction, contextual safeguarding and PREVENT. - to create a safeguarding culture for the future health system - to promote health equality and access to early help, signposting and support to promote positive safeguarding outcomes. - to strengthen system assurance and a continuous improvement approach. - to ensure that no person is deprived of their liberty without the appropriate legal framework being in place. This strategy ensures we meet all statutory reporting requirements, is focused on working with key stakeholders and partners and includes ensuring the voice of these children and young people are used to inform service development.	●●●	NHS Kent and Medway Improving Outcomes Board

Chapter 2

How we will help the most vulnerable and disadvantaged

Shared Outcome 2:
We will help the most vulnerable and disadvantaged in society to improve their physical and mental health; with a focus on the social determinants of health and preventing people becoming ill in the first place.

Integrated Care Strategy Summary

NHS Kent and Medway

Tackling inequalities and preventing ill health, targeting those most in need; Everyone deserves the same opportunities to lead a healthy life, no matter where they live or who they are. Our key goal will be to ensure a whole system collaborative approach to Population Health Management, reducing avoidable unfairness in people's health and well-being outcomes. Our health and social care provision needs to be made available to all, with increasing attention needed for those who are more disadvantaged. We will empower our local neighbourhood and place-based partners to tailor services and interventions to meet the needs of their communities. We aim to make promotion of healthy choices part of every encounter with individuals - Making Every Contact Count (MECC). Our NHS organisations will also continue to adopt the Core20PLUS5 model, a national NHS approach to support the reduction of health inequalities at both national and system level.

Tackling mental health issues with the same energy and priority as physical illness; The Kent and Medway Mental Health Learning Disability and Autism Provider Collaborative Board brings together all the mental health and wellbeing partners with those with lived experience to integrate service models and develop a shared accountability for improving the mental wellbeing of our communities. Through our community mental health framework, Mental Health Together, we are implementing an entirely new service model to support people with complex mental health difficulties. Our Local Transformation Plan for Children, Young People, and Young Adults' Emotional Wellbeing and Mental Health outlines how we will widen access to services closer to home, reduce unnecessary delays and deliver specialist mental healthcare.

Shared Outcome 2: We will help the most vulnerable and disadvantaged in society to improve their physical and mental health; with a focus on the social determinants of health and preventing people becoming ill in the first place.

Addressing the social determinants of health, such as community support and employment and skills. Our approach to social prescribing will help to connect people to community services and groups local to them that can help to support their mental and physical health. Our ambition is to grow the Kent and Medway economy and ensure that everyone can benefit from increased prosperity. This includes supporting people who are finding it hard to access or remain in work due to mental or physical health issues.

Supporting people deal with the current cost of living crisis; This is an issue of high importance for the system and an early opportunity to work together better. Alongside national interventions, partners across the Kent and Medway ICS are putting in place support for local people. The ICP has agreed to coordinate activity where this will add value and agree collectively how best to focus resources to have the greatest positive impact on health and wellbeing.

Developing the Kent and Medway physical environment as a place where people thrive. We will work with housing providers, voluntary, community and social enterprise partners and others to continue to improve the quality of housing of all tenures. Partners will work together to plan housing development and regeneration in a way that improves quality of life for new and existing communities. Reaching our challenging environmental targets and adapting to climate change will require all partners to play their part.

Key to timescales

- ● Short term < 1 year
- ●● Medium term 1-2 years
- ●●● Long term 3-5 years+

NHS
Kent and Medway

Goal	Actions	Timescale	Owner(s)
Tackle inequalities and prevent ill health, targeting those most in need	Embed Population Health Management (PHM) across the system through a comprehensive Population Health Roadmap structured around the core PHM framework capabilities of infrastructure, intelligence, intervention and incentives. Local services will design new proactive models of care which will improve health and wellbeing today as well as in future years Population Health. The roadmap includes ensuring a sustainable footing for the segmentation dataset and outcomes platform.	●●	NHS Kent and Medway Inequalities, Prevention and Public Health (IPPH) Committee
	Develop local place prevention plans. Targeting individuals from more deprived and disadvantaged communities who are less likely to engage in or have access to preventative programmes, e.g. immunisations, screening, dental checks and eye tests	●	NHS Kent and Medway IPPH Committee Prevention Subcommittee
	Embed Making Every Contact Count to make promotion of healthy choices part of every health service encounter with individuals	●	
	Define the approach, process of allocation and aims for using health inequalities funding and additional funding, to include an evaluation approach	●	
Metrics • Core20PLUS5 • Decrease in the number of asthma attacks • Oral health – tooth extractions due to decay for children admitted as inpatients	Apply the Core20PLUS5 model to drive targeted action in improving healthcare inequalities, aligned to our Population Health Management approach and engaging local communities in design and delivery. This will include the PLUS Groups being identified at place and the CORE20PLUS Connectors programme. The Core 20 Plus connectors programme is currently focused on early cancer diagnosis through bowel cancer screening and understanding the perinatal needs of Black, Asian and Minority Ethnic communities.	●●	NHS Kent and Medway IPPH Committee Inequalities Subcommittee

Goal	Actions	Timescale	Owner(s)
Tackle inequalities and prevent ill health, targeting those most in need (continued) **Metrics** • Covid Immunisation - % of eligible adults vaccinated • COVID-19 vaccination uptake for black and minority ethnic groups and the most deprived quintile compared to the national average	Providers of health care services will work to understand the health inequalities within waiting lists and take action to level up access and outcomes across the population. Also to make changes in their approach or provision to ensure services are accessible.	●	Provider Trust Boards
	Turning the Tide Oversight Board will act in a leadership role with a focus on reducing ethnicity related health inequalities across Kent and Medway. To complete a social marketing insight project and mobilise the hypertension pathway with an ethnicity focus. Matrix working within the NHS and across local authorities.	●	NHS Kent and Medway IPPH Committee Oversight Board Turning the Tide
	The Covid Vaccination Programme includes a specific focus on ensuring covid vaccinations are easily accessible to all eligible members of the population. Data will be used to identify low areas of uptake and target additional support. Learning will support the development of the an action plan in response to the integrated national vaccination strategy.	●●	NHS Kent and Medway Improving Outcomes Board Subcommittee
	Codesign a fluid engagement strategy – Continue to attend community organisations and understand ways we can work with them that would be mutually beneficial. Progress data linkage, analytical support and outcome measures to evidence VCSE benefit, developing principles for the transfer of budget to preventative measures.	●	Medway and Swale Health and Care Partnership (HCP) Health Inequalities Board
Support people deal with the current cost of living crisis	Work together to address the cost-of-living crisis and its likely detrimental effect on people's health and widening health inequalities. It is an issue of high importance for the system and an early opportunity to work together better. The integrated care partnership (ICP) has agreed to coordinate activity where this will add value and agree collectively how best to focus resources to have the greatest positive impact on health and wellbeing. This is also a priority area for Medway and Swale Health and Care Partnership (HCP).	●	Medway and Swale HCP Health Inequalities Board KCC Financial Hardship Task and Finish Group,

Goal	Actions	Timescale	Owner(s)
Tackle mental health needs with the same energy and priority as physical illness **Metrics** • For 2023/24 27,937 people with a serious mental illness will receive 2 or more contacts with a transformed model of care • Achieve 5% year on year increase in the number of people supported by community mental health services	Deliver an entirely new service model to support people with complex mental health difficulties through our community mental health framework, Mental Health Together. Set up the implementation group, recruit to new roles, Kent and Medway NHS and Social Care Partnership Trust as lead provider to set up commissioning arm Trailblazer of the core model in Medway. Evaluate and monitor Mental Health Together with a particular focus on marginalised groups. Roll out to Swale. Roll out to East Kent, West Kent, DGS Service User Network (SUN) model to be rolled out for peer support for community eating disorders Pilot transformed Community Rehabilitation pathway to include VCSE, local authority and secondary care in west Kent . Procurement of the VCSE element for eating disorders	●● ● ● ●● ● ● ●●	NHS Kent and Medway Improving Outcomes Board Mental Health, Learning Disability and Autism Operational Delivery Group
	Implement our Local Transformation Plan for Children, Young People, and Young Adults' Emotional Wellbeing and Mental Health, which outlines how we will widen access to services closer to home, reduce unnecessary delays and deliver specialist mental healthcare.	●●●	NHS Kent and Medway Improving Outcomes Board. Kent and Medway NHS and Social Care Partnership Trust Board Mental Health, Learning Disability and Autism Operational Delivery Groups
	Implement our local transformation plan for people with learning disabilities and autistic people which outlines how we will widen access to services closer to home, reduce unnecessary delays and secure equitable access to early intervention and prevention services to prevent escalation of people's needs and premature deaths	●●●	

Goal	Actions	Timescale	Owner(s)
Address the social determinants of health, such as community support and employment and skills.	Work in partnership to promote community safety. We will work together in tackling issues such as crime, antisocial behaviour and discrimination that can make people feel unsafe or unwelcome	●●	INHS Kent and Medway IPPH Committee Prevention Sub Committee
	Create a range of opportunities and systemic support in the community, including housing, community infrastructure, carer / family support and workforce, employment and life opportunities, to enable people with learning disability, autism or both to live as safely and autonomously as possible, in their local neighbourhood (preventing the use of large institutional settings).	●●●	NHS Kent and Medway Improving Outcomes Board Learning Disability and Autism Operational Delivery Group
	Promote positive mental wellbeing in all communities Work through communities to tackle the wider drivers of mental ill health in all age groups including loneliness, financial distress, abuse, addiction, housing and relationships.	●●	NHS Kent and Medway IPPH Committee Inequalities Subcommittee Kent Housing Group
	Develop a social prescribing and community navigation strategy that sets the framework for social prescribing and community navigation across the Kent and Medway system.	●	INHS Kent and Medway IPPH Committee Inequalities Subcommittee
	Pilot work to support a wide range of initiatives for young people including volunteering opportunities, co-design of PSHE curricular to support healthy choices (with clinical support), offering opportunity to entry level roles in health and care as well as apprenticeship.	●	Medway and Swale H&CP Health Inequalities Board

Goal	Actions	Timescale	Owner(s)
Develop the Kent and Medway physical environment as a place where people thrive	Aim to ensure high quality homes are available to all, including the most vulnerable, and tackle homelessness. Work across the ICS to prevent and respond to homelessness, addressing the root causes.	●●	NHS Kent and Medway IPPH Committee Inequalities Subcommittee IPPH Subcommittee: Inequalities, Kent Housing Group
Help and protect adults with care and support needs in the Kent and Medway area who may be experiencing, or are at risk of, abuse or neglect, and unable to protect themselves.	Support the delivery of the Kent and Medway Safeguarding Adults Board Strategic Plan 2022-2025 through partnership working as a member of the Kent and Medway Safeguarding Adults Board. The key priorities are promoting person centre safeguarding, strengthening system assurance and embedding improvement and shaping future practice.	●●●	Kent and Medway Safeguarding Adults Board
	Deliver the NHS Kent and Medway Safeguarding Strategy. The key aims are: - to prevent violence and violence related trauma, injuries and deaths in the communities across Kent and Medway. - to work with partners in providing strategic leadership to improve outcomes for vulnerable children and adults at risk of violence or aggression. The objectives address domestic abuse, violence reduction, contextual safeguarding and PREVENT. - to create a safeguarding culture for the future health system - to promote health equality and access to early help, signposting and support to promote positive safeguarding outcomes. - to strengthen system assurance and a continuous improvement approach. - to ensure that no person is deprived of their liberty without the appropriate legal framework being in place. This strategy ensures we meet all statutory reporting requirements and is focused on working with key stakeholders and partners across the system.	●●●	Kent and Medway Safeguarding Adults Board

NHS
Kent and Medway

Chapter 3

How we will help people to manage their own health and wellbeing

Shared outcome 3:
We will help people to manage their own health and wellbeing and be proactive partners in their care so they can live happy, independent and fulfilling lives; adding years to life and life to years.

Integrated Care Strategy Summary

NHS Kent and Medway

Supporting people to age well - championing resilience and independence; Our adult social care services support people of all ages to live as full and safe a life as possible. They will continue to promote people's wellbeing prevent, reduce or delay the need for care and support and safeguard vulnerable adults. We will do this by focusing on the individual strengths of people with care needs, their families and carers. Accessible and integrated health and social care services where partners work together will enable people to live independently and safely within their local community.

Supporting our population to adopt positive health behaviours; As part of our Population Health Management approach, we will deliver evidenced based support, including emotional and mental health support, at an appropriate scale to help people maintain a healthy weight, eat a healthy diet, participate in physical activity – including in environmentally sustainable green spaces, maintain good sexual health, and minimise alcohol, substance and tobacco use. We will engage with and raise awareness of National programmes - such as the NHS Digital Weight Management Programme and the Diabetes Prevention Programme - and incorporate these into existing pathways in a coherent way to ensure that we optimise their impact within Kent and Medway.

Shared outcome 3: We will help people to manage their own health and wellbeing and be proactive partners in their care so they can live happy, independent and fulfilling lives; adding years to life and life to years.

Delivering personalised care so people have choice and control over their care; Kent and Medway's personalised care approach is underpinned by the ESTHER philosophy, this emphasises the "*what matters to me*" methodology. Both Kent and Medway Councils work with 'Think Local, Act Personal' to make personalised care real. Dementia care is a priority. We are committed to ensuring that every person living with dementia is supported to live as well and as independently as possible. The means receiving high quality, compassionate care from diagnosis through to end of life. This applies to all care settings, whether home, hospital or care home.

Protecting the public from diseases such as Covid-19; Health protection is multi-faceted and there are many agencies involved in protecting the public from communicable diseases, non-infectious environmental hazards and the risks of a future in which antimicrobials are no longer effective. The Kent and Medway Health Protection Board is a multi-agency board on health protection across Kent and Medway with a focus on protecting the public.

Providing palliative and end of life care to those in the last stages of their life. Since July 2022, the Integrated Care Board also has become responsible for PEOLC as part of the Health and Care Bill with both statutory guidance and a handbook for implementation published in late September 2022. Our Strategy aims to make sure that individuals who are in the last stages of their lives and dying receive the care they need to preserve their dignity and wellbeing, to keep them independent for as long as possible and to be comfortable, dying in a place of their choosing.

Key to timescales

- ● Short term < 1 year
- ●● Medium term 1-2 years
- ●●● Long term 3-5 years+

NHS
Kent and Medway

Goal	Actions	Timescale	Owner(s)
Support our population to adopt positive health behaviours **Metrics** • Screening rates e.g. learning disability cervical screening, bowel screening, breast screening • Percentage of patients aged 18 or over with GP recorded hypertension in who the last blood pressure reading is below the age-appropriate treatment threshold	As part of our Population Health Management approach, we will deliver evidenced based support, including emotional and mental health support, at an appropriate scale to help people maintain a healthy weight, eat a healthy diet, participate in physical activity, maintain good sexual health, and minimise alcohol, substance and tobacco use.	●●●	NHS Kent and Medway IPPH Committee Prevention Subcommittee
	Work with Health Care Partnerships to implement evidence-based support for increasing activity and preventing diabetes. Partners across the ICS will work together to promote referrals to the NHS Digital Weight Management Programme and incorporate the programme in a coherent way into existing pathways. Existing incentivisation measures will be utilised to encourage referrals taking into account good models of behaviour change.	●●	
	Continue to conduct system-wide health needs assessments to help us to target where we need to mitigate against health and social inequalities, and test and learn from new approaches to promoting positive health behaviours.	●●	
	Build on current Health Inequalities pilots to provide targeted, improved access to proactive reviews and screening, including dental checks, supported by patient focussed support services that understand and address barriers and behaviours which prevent people from engaging in their wellbeing and long-term health.	●●	
	The NHS LTP Tobacco Dependence Treatment Service Programme will continue to be driven forward ensuring support to quit smoking for eligible members of the population. This will sit alongside the existing strong offer of LA community stop smoking services provided across Kent and Medway. The established Smoking in Pregnancy specialist midwives in each acute trust will continue to work to support those who are pregnant to quit smoking. Provide access to services for those most at risk of health inequality will continue with, for example programmes to increase treatment to target for hypertension, increase engagement in NHS Health Checks and in diabetes management programmes. Development of the CVD Prevention Group will further address cardiovascular health including the wider determinants of health.	●●	INHS Kent and Medway IPPH Committee Prevention Subcommittee PPH

Goal	Actions	Timescale	Owner(s)
Support our population to adopt positive health behaviours (continued)	We will Make Every Contact Count to signpost support to reduce the smoking rates in higher prevalence groups.	●●	NHS Kent and Medway IPPH Committee Prevention Subcommittee
	Contraceptive services providers will work together to ensure a seamless service for the public and will also consider the wider health and sexual health needs of the patients.	●●	
	Promote active travel through working with local councils to identify access to public transport and safe cycle routes and promote access to Green Social Prescribing to support self-management of health and wellbeing	●●	NHS Kent and Medway IPPH Committee Kent and Medway Executive Sustainability Group
Protect the public from infectious diseases, chemical, biological, radiological, and nuclear incidents, and other health threats	The Kent and Medway Health Protection Board (KMHPB) is a multi-agency board on Health Protection across Kent and Medway with a focus on protecting the public. It provides oversight of existing health protection issues as well as horizon scanning for any emerging situations and threats to support a joined up and coherent system. The Board provides assurance and system leadership and assurance to Directors of Public Health in Kent and Medway in relation to their statutory functions around health protection. It receives updates on areas of health protection and recommends steps for system-wide improvement, system alignment and the commissioning of services with a focus on reducing health inequalities in our populations. We will work with the board, consider their recommendations and oversee the appropriateness of strategies and plans in place on health protection and emergency prevention, planning and response matters.	●●●	NHS Kent and Medway IPPH Committee Kent and Medway Health Protection Board (KMHPB)

Goal	Actions	Timescale	Owner(s)
Support people to age well, championing independence and resilience	Proactive identification of those that are frail or at greater risk of future hospitalisation, care home admission or death to target prevention strategies and support people to manage their health and wellbeing. This includes acute frailty response and frailty hubs e.g. Home Treatment Service and Medway frailty unit at Sheppey Hospital	●●	Kent and Medway Improving Outcomes Board Subcommittee Urgent and Emergency Care Board Community service provider boards
	Promote a multidisciplinary approach where professionals work together in an integrated way to provide tailored support that helps people live well and independently at home for longer. Development of neighbourhood models of care in alignment with Fuller Stocktake.	●●	
	Make the system more coordinated so it is easier to navigate and get the right care to maintain independence for patients, loved ones and health/care staff.	●●	
	Increase support offer to care homes with strong relationships between care homes, local general practices, community services, hospices and other health/care teams as part of the Enhance Health in Care Home (EHCH) national requirements.	●	
	Embed technology-enabled care such as wearable devices and home monitors as core tools to support long term health problems in new ways, and support people to remain at home safely where possible. Also support the role out of digital social care records across care homes and domiciliary care. Explore further opportunities between health and care to further this relationship as well as considering the role of remote monitoring in care homes.	●	

Goal	Actions	Timescale	Owner(s)
Deliver personalised care so people have choice and control over their care – Dementia **Metrics** • Dementia Diagnosis Rate maintained at 66.7% • 75% people wait 6 weeks from referral to memory assessment (service) • % people waiting 6 weeks from diagnosis to treatment – metric in development	Recover waiting lists and ensure sufficient capacity to achieve and maintain a dementia diagnosis rate of 66.7%. Reduce the waiting list to enable people to start treatment in closer to six weeks from referral.	●●	NHS Kent and Medway Improving Outcomes Board Subcommittee Mental Health, Learning Disability and Autism Operational Delivery Group
	Increase the number of Dementia Coordinators in each PCN to enable people living with dementia and their carers to access better information and support	●	
	Increase the use of DiADem, the tool to support GPs in diagnosing people living with advanced dementia and pilot in a care home setting. Consider its use for people with dementia who are housebound. Introduce A GP with Extended Role (GPwER) in Dementia and later in local care.	● ●●	
	Review the services provided to Carers with Health and Care Partnerships and Local Authorities and ensure that the needs of those families affected by Dementia can access community resources.	●	
	Embed Admiral Nurses into the wider pathway to provide expert practical, clinical and emotional support to families/carers living with dementia, as part of a tiered model working with VCSE, so Admiral Nurses can focus on those with higher level complex needs.	●	
	Refine the current Dementia pathway, recognizing the impact of an ageing population.	●	

Goal	Actions	Timescale	Owner(s)
Deliver personalised care so people have choice and control over their care **Metrics** • Number of personalised care interventions	Roll out across the system the ESTHER Ambassador training for all staff underpinning the Personalised Care approach and culture.	●	NHS Kent and Medway IPPH Committee Inequalities Sub Committee
	Encouraging take up of the free Personalised Care Institute (PCI) Personalised Care Accredited Training offer across Local Maternity System, PCNs and all Delivery Partners.	●●	
	Encourage regular care plan reviews in line with the SOF and ensure they are consistently coded accordingly.	●	
	Develop one off Personal Health Budgets (PHB's) to other identified cohorts linked to population health needs. Develop robust financial governance framework and clinical governance framework to support this. Provide a clear, published local offer of what is available through a one off PHB with local examples of PHB use. Pilot integrated health and care budgets pooling resources by use of Better Care Fund.	●●	
	Co-Produce across the system a Social Prescribing and Community Navigation Strategy, to include links with green social prescribing – due for completion in summer 2023.	●	
	Set up a Social Prescribing and Community Navigation Support Group, The programme includes: the development of peer support, induction and continuing professional development, managerial supervision, access to information and resources and will aim to create a progressive learning culture within the community of social prescribing link workers across the Kent and Medway area.	●●	
	Social Prescribing mapping across Kent & Medway to enable easy access/location of appropriate services across the System.	●	

Goal	Actions	Timescale	Owner(s)
Provide palliative and end of life care to those in the last stages of their life **Metrics** • Expected deaths known to palliative care • Time spent at home (not in hospital) during the last 60 days of life	Improve the identification of those who are likely to be within the last year of life with targeted support to manage their changing health needs over time.	●●	NHS Kent and Medway Improving Outcomes Board Urgent and Emergency Care Board, reporting to Subcommittee
	Support people to die in their place of choice by ensuring models of care and services evolve over time, always keeping the individual's wishes at the heart of decision making.	●●	
	Raise community awareness of death and dying to enable "Compassionate Communities" to grow and providing robust bereavement services for all.	●	
	Provide a single point of access, available 24-hours-a-day, seven-days-a week to provide an alternative to 111/999 in times of crisis and to enable more people, where appropriate, to live well and die well, at home or the place of their choosing such as a hospice.	●	
	Develop advance care plans for every individual enabling joined up care through the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) roll out across Kent and Medway.	●	
	Prescriptions for medicines that support comfort at the end of life will be the norm and readily available in pharmacies and we will aim to broaden training for informal carers on how to administer these 'just in case' medications.	●●	
	Take learning from deaths by reviewing outcomes for individuals and families to improve comfort, dignity and ensure wishes are being met.	●	
	Provide a comprehensive end of life care training programme across all in Health and Social Care in Kent and Medway.	●	

NHS
Kent and Medway

Chapter 4

How we will support people with multiple health conditions

Integrated Care Strategy Summary

NHS Kent and Medway

Patient Empowerment and Multidisciplinary Teams. People with multiple health conditions are best served by teams made up of multiple disciplines. This ensures a holistic approach to common conditions such as cancer, cardiovascular disease, dementia, respiratory disease, and frailty. Complex Care Teams and Multi-Disciplinary Teams working with Primary Care and Social Care will co-ordinate identified groups of people and respond to needs and opportunities at a local level. A model of shared decision-making will empower the people of Kent and Medway to make informed choices about how, when and where they receive care. This will utilise personal health budgets and social prescribing where appropriate, alongside patient centred services such as complex care teams encompassing physical, mental health and social care disciplines, enabled by the Better Care Fund.

High quality Primary Care. Primary care is, and will remain, the bedrock of the NHS. We know that it is still too difficult for people to get an appointment to see their GP and primary care team, and we must do all we can to support people and general practices. We want general practice to offer a consistently high-quality service to everyone in Kent and Medway, delivered by a skilled multidisciplinary team working in partnership with other health and care services to maximise benefits for our population. Kent and Medway ICB has recently taken over delegated authority for commissioning Pharmacy, Optometry and Dentist services. We will ensure all pharmacies are supporting people with health care, self care, signposting and healthy living advice. We will improve and increase access to dentist services. We will also improve people's access to NHS sight tests and other locally commissioned eye health services, focussing on improving equality of access for everyone.

Shared outcome 4: We will support people with multiple health conditions to be part of a team with health and care professionals working compassionately to improve their health and wellbeing.

Support for Carers. We recognise the important role of formal and informal carers in a person's care team. There are many different types of carer and they come from all walks of life, ages, ethnicities, and backgrounds. However, they have one thing in common; their role directly benefits the people they look after and society as a whole, so we must recognise their needs and support them too. Young carers have particular needs. We will continue to work together to ensure there is good understanding across all services that work with children about the impacts of being a young carer, how to identify 'hidden carers' and how to put support in place for them, including working with VCSE organisations who provide vital support for carers of all ages.

Key to timescales

- ● Short term < 1 year
- ●● Medium term 1-2 years
- ●●● Long term 3-5 years+

NHS
Kent and Medway

Goal	Actions	Timescale	Owner(s)
High quality Primary Care – General Practice Through the NHS Kent and Medway ICB GP Development plan, there is a commitment to address the demand placed on primary care services. **Metrics** • Number of general practice appointments per 10,000 weighted patients • FTE doctors in general practice per 10,000 weighted patients	Support GP practices and Primary Care Network's (PCN) to engage with their local communities, and increase the number of people referred to the community pharmacy consultation services.	●	NHS Kent and Medway Improving Outcomes Board Primary Care Strategic Oversight Committee
	All GP practices will be supported to install digital telephone systems to make it easier for patients to call their GP practice, and to utilise the functionality and reporting available to drive efficiency.		
	Develop an attraction offer for GPs to work in general practice in the areas where we know we have higher deprivation i.e. Medway, Swale and Thanet in 2022 to 2024	●	
	Support practices and PCNs to continue to develop their response to the estates strategy to further inform commissioning decisions.	●●	
	A pilot of eConsultations into a Health Hub is complete. This will be developed into a sustainable eHub model, including, the blueprint, evaluation of the health hub model and business case for scaling across Kent and Medway		
	Scope a research project to pilot different approaches to modelling demand and capacity in general practice across Kent and Medway	●●	
	Increase the number of people using online primary care services. This will be supported by introduction of a programme of interventions with our stakeholders that address digital exclusions. We will also support digital remote monitoring technologies to create clinical capacity.	●●	
	Increase the number of additional roles staff working in general practice.	●●	

Goal	Actions	Timescale	Owner(s)
High quality Primary Care – General Practice (continued)	Deliver 3 distinctive areas of intervention in relation to GP practice support, to improve care for our patients: • Proactive: risk stratification of a range of information and data to proactively understand variations in quality and outcomes and support the improvements to address these • Supportive: working with practices to continuously learn and improve their services for better outcomes for their population • Reactive: using information gathered from proactive and supportive interventions to identify and escalate concerns, providing reactive support when needed to ensure safety and effectiveness	●●	NHS Kent and Medway Improving Outcomes Board Subcommittee Primary Care Strategic Oversight Committee
High quality Primary Care – Pharmacy Services **Metrics** • Number of completed referrals to community pharmacist consultation service from general practice	We will implement a collaborative provider approach to Medicines Optimisation Strategy and deliver 3 main work programmes: **Medicines Value** including aseptics and sustainability: • to ensure medicines are used cost effectively to achieve optimal patient outcomes • to ensure access to adequate resilient high quality aseptic services that supports healthcare staff • to identify and implement medicines related initiatives that support sustainability goals **Medicine Safety** including overprescribing and mental health to ensure that patients are not prescribed medicines that are inappropriate or no longer necessary, or where harms outweigh benefits. **Assurance and outcome monitoring** including community pharmacy • establish programme and lead the roll-out of community pharmacy clinical services The main work programmes will be supported by 3 enablers: **Workforce** -to improve the recruitment and retention of Pharmacy workforce and ensure appropriate access to training and development opportunities Creation of a dynamic and flexible workforce that can work across systems built around the needs of people who use our services.	●	NHS Kent and Medway Improving Outcomes Board Integrated Medicines Optimisation Committee

Goal	Actions	Timescale	Owner(s)
High quality Primary Care – Pharmacy Services (continued)	**Digital-** to embed digital technology to improve patient experience, improve safety and support cost effectiveness **Medicines optimisation in primary care**	●	As above
High quality Primary Care – Optometry and Ophthalmology	We will adopt an integrated Tiers of Care approach to Optometry and Ophthalmology in the community, to ensure as much capacity as possible is available to deliver appropriate care in a community setting.	●	Medway Improving Outcomes Board NHS Kent and Medway ICB Elective Care Board
	We will integrate Optometry, Community & acute Ophthalmology care by digitalisation of the referral (EeRS) and electronic patient record systems (EPR) to promote shared care approach and reduce the requirement for hospitals visits where possible.	●	
	As many patients as possible will be repatriated from acute care setting to primary/community setting to improve access and waiting times. Currently In Progress for Glaucoma, Minor Eye Conditions & Hydroxychloroquine Monitoring.	●	
Patient Empowerment and Multidisciplinary Teams	Ensure that patients have timely, appropriate access to effective Primary Care, achieved through strategies aligned to the 3 key Fuller Report recommendations, including providing more proactive, personalised care with support from a multidisciplinary team. • Continued development of Complex Care Nursing services, aligned to structured MDT approaches, leading to greater integration of Primary Care and community services • Further integration of system wide care record (KMCR) to support continuity of care and a holistic approach • Continuing the increased use of personalised health budgets and social prescribing, manged by complex care support to reduce the burden on Primary Care	●	NHS Kent and Medway Improving Outcomes Board Primary Care Strategic Oversight Committee Kent Community Health NHS Foundation Trust Board

NHS
Kent and Medway

The following four pages are focused on actions relating to major or common conditions, including those identified in the NHS Long Term Plan

	Actions	Timescale	Owner(s)
Maternity	See shared outcome 1 – delivering effective maternity services, page 11.		
Serious Mental Illness (SMI) **Metrics** The number of people on the SMI register in receipt of all 6 core physical health checks Q1 - 9,922 Q2 - 10,228 Q3 - 10,533 Q4 - 10,839 Progress towards the 60% target has been made with more than 40.6% of people with SMI across Kent & Medway have received a physical health check, at the end of Q1 22/23.	The Kent and Medway Provider Collaborative Board has made a commitment to deliver compliance against the Long Term Plan (LTP) for Mental Health. Providers and Health and Care Partnerships (HCP) are represented on this Board. The Mental Health Operational Delivery Group (ODG) is the operational vehicle for the delivery of the system priorities and currently oversees 8 workstreams aligned to the strategic objectives of the LTP. Internal assurance and performance meetings have been established within the ICB Mental Health Team to monitor progress at a system level in delivering the LTP. These meetings include a monthly Quality and Outcomes Assurance Meeting to systematically bring together, review, share and triangulate the quality intelligence and outcomes of the adult mental health and dementia programmes. Physical Health Checks: Work is ongoing to increase outreach/engagement of service users to improve the uptake of the physical health checks among people with serious mental illness, focussing on hard-to-reach groups. Part of this project enables our providers to carry out the checks in a much wider remit than GP surgeries, i.e., people's homes, community centres etc. Progress towards the 60% target has been made with more than 40.6% of people with SMI across Kent & Medway have received a physical health check, at the end of Q1 22/23.		NHS Kent and Medway Improving Outcomes Board Subcommittee Mental Health Operational Delivery Group

	Actions	Timescale	Owner(s)
Cardiovascular disease and Hypertension **Metrics** • Percentage of hypertension patients who are treated to target as per NICE guidance • % of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins • CVD high risk patients on lipid lowering therapy	Provision of specialist cardiology pharmacy resources to primary care across Kent and Medway through the Hypertension Support Package (HSP). The HSP menu of support offered to practices includes direct interventions with patients by undertaking clinical consultations, running hypertension clinics, and mentoring of local healthcare professionals, either virtually or in person depending upon specific needs.	●	NHS Kent and Medway Improving Outcomes Board Subcommittee Integrated Cardiac Delivery Network, Primary Care Strategic Oversight Committee
	Target 30 initiative is underway to provide additional support to the lowest performing practices treatment to target for hypertension. This includes a free pilot to all Kent and Medway practices of Accurx batch messaging and floreys.		
	Continue Hypertension Heroes (HTH) project working with VCSE organisations recruiting volunteers to be trained to support local, targeted communities in understanding the importance of managing their blood pressure, supporting them to use a home monitor and report the results into their GP practice. Designed to reach people and communities who may not be engaging with health services and GPs.	●●	
	Increase detection and optimise the management of hypertension, atrial fibrillation, high cholesterol, and 10-year cardiovascular disease risk by: • case finding including through community pharmacies and the Primary Care Network investment and impact fund and management through the Quality Outcomes Framework • work with local government to support restoration and improvement of the NHS Health Check programme This is also a priority for Dartford, Gravesham and Swanley Health and Care Partnership.	●●	
	Develop the maturity of the clinical network to support specialised commissioning delegation requirements.	●	

	Actions	Timescale	Owner(s)
Cancer **Metrics** • Cancer constitutional targets met at system and provider level • Number of patients diagnosed at stage 1 or 2	Support initiatives which will deliver earlier cancer diagnosis so that 75% of newly diagnosed patients are diagnosed at stage 1 or 2.	●●●	NHS Kent and Medway Improving Outcomes Board Cancer Alliance Delivery Board
	Streamline pathways to ensure that all patients receive a diagnosis or 'rule out' of cancer within 28 days.	●●	
	Roll out a Targeted Lung Health Check Programme for all patients across Kent and Medway.	●●	
	Ensure that all cancer constitutional targets are consistently met at system and individual provider level.	●	
	Every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.	●	
	Make sure that people can access more effective tests and treatments, from genomic testing to the latest diagnostic technologies to help find more cancers before symptoms appear.	●●●	
	Support projects and initiatives which mean that after treatment, patients will move to a follow-up pathway that suits their needs and ensures they can get rapid access to clinical support where required.	●●	
Long Covid **Metric** • Proportion of people referred to a post COVID service who are not assessed by a registered health care assessment within 15 weeks of referral	Implement the enhanced specification for the Long Covid Service including care pathways and services in line with national requirements and local need.	●	NHS Kent and Medway Improving Outcomes Board
	Identify and reduce inequalities of access to Long Covid Services and outcome variation through local and regional peer reviews.	●	

Goal	Actions	Timescale	Owner(s)
Long covid (continued)	Work with London Paediatric Hub to determine local provision required to support Children and young people with Long Covid	●	NHS Kent and Medway Improving Outcomes Board
	Improve care pathway for those requiring fatigue management	●	
	Enhance capacity in Pulmonary Rehabilitation provision to enable access to those with Long Covid	●	
Diabetes **Metric** • Proportion of those with type 2 diabetes receiving recommended care processes	Increase the number of patients with diabetes receiving all 8 care process with the aim of at least meeting national average achievement by increasing education and workforce capacity, reconfiguring the multidisciplinary diabetic foot care pathway and additional advanced practitioner roles.	●	NHS Kent and Medway Improving Outcomes Board Integrated Diabetes Delivery Network
	Increase the number of people supported through the NHS Diabetes Prevention Programme as a proportion of patients profiled.	●	
Chronic respiratory disease **Metric** • Percentage of people aged 65 and over who received a flu vaccination	Restart of Spirometry in primary care and community services, aim to get 100% coverage of spirometry for all patients across Kent and Medway.	●	NHS Kent and Medway Improving Outcomes Board Primary Care Strategic Oversight Committee
	To get 100% coverage of FENO (fractional exhaled nitric oxide) for all patients across Kent and Medway.	●	
	Expansion of pulmonary rehab services to prevent exacerbations and admissions. Increase referral rate to 60% of eligible patients.	●	
	Collaborate across the system to optimise the use of respiratory medicines and pilot the 'asthma friendly schools' initiative in Medway and Swale.	●	

NHS
Kent and Medway

Chapter 5

How we will ensure access to hospital services and centres of excellence for specialist care

Shared Outcome 5: We will ensure that when people need hospital services, most are available from people's nearest hospital; whilst providing centres of excellence for specialist care where that improves quality, safety and sustainability.

Integrated Care Strategy Summary

NHS Kent and Medway

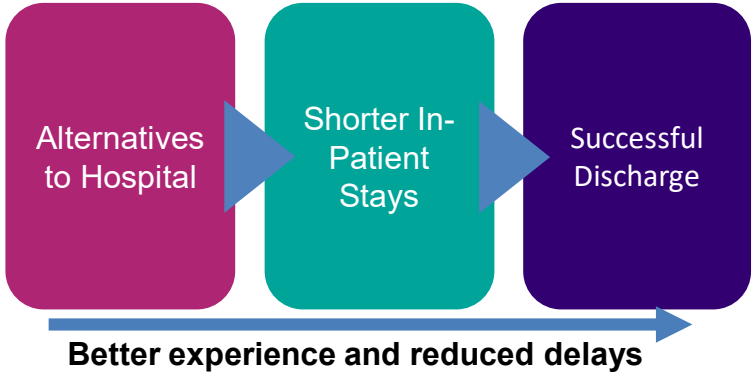
Improving flow through the system. Demand on our emergency departments is at an all-time high nationally. In turn, this leads to full hospital wards, made worse by the challenges of discharging patients from the acute hospital setting. Embedding new models and services will allow us to not only reduce pressure on Emergency Departments but also deliver more appropriate care faster and closer to the patient's home. In peak times, we want to improve the communication channels of our services throughout the system so they can escalate and de-escalate to support the wider system and take proactive decisions to balance demand. We will continue to develop relationships with our partners and get better at using data and evidence to inform commissioning decisions.

Providing quality healthcare as close to home as possible; We recognise the importance of providing quality healthcare as close to our populations as possible and we will continue to plan our services in to enable this to happen. Partners within the ICS must join up health and care around individuals so that they can access the service and receive the requisite quality. Some hospital services will continue to move to community-based settings. For example, during the COVID-19 pandemic, virtual wards and consultations helped ease pressure on hospitals and enabled primary care and other parts of the system to provide essential services.

Shared Outcome 5: We will ensure that when people need hospital services, most are available from people's nearest hospital; whilst providing centres of excellence for specialist care where that improves quality, safety and sustainability.

By improving our commissioning relationships with providers of adult social care (including private sector and VCSE) we will ensure sufficiency of the adult social care market and aid discharge from the acute setting. Our ambition is that the Kent system jointly plans, commissions, and delivers discharge services that maintain flow and are affordable within existing budgets available to NHS commissioners and local authorities, pooling resources where appropriate and responding to seasonal pressures.

Continuing to develop centres of excellence for specialised services. There is compelling evidence that creating centres of clinical excellence provides improved outcomes for patients. Increasing the volume and variety of cases within a specialism in centres of excellence that have all the necessary supporting clinical adjacencies, helps to address major geographical inequalities in life expectancy, infant mortality and cancer mortality. These centres of clinical excellence are also proven to attract and retain quality staff, and enhance clinical research and innovation.



Key to timescales

- ● Short term < 1 year
- ●● Medium term 1-2 years
- ●●● Long term 3-5 years+

NHS
Kent and Medway

Goal	Actions	Timescale	Owner(s)
Provide quality healthcare as close to home as possible – mental health **Metrics:** • Out of area placement occupied bed days - 570 will be set as an average for Q1- Q4 2023/24. • Length of Stay against a target of 32 days for younger adults and 77 days for older adult wards • 80% patients discharged from acute admission are followed up with a face to face or phone contact within 72 hours	Eliminate the use of inappropriate out of area mental health placements (OAPS) used for adult acute admission so that more people can be admitted closer to home.	●●●	NHS Kent and Medway Improving Outcomes Board Mental Health, Learning Disability and Autism Operational Delivery Group
	Improve the mental health system/bed capacity and management to ensure acute mental health care remains therapeutic and purposeful and that effectiveness and experience of care is improved. Actions include: Revise acute admission inpatient skill mix and workforce plan developed	●●	
	Improve collaboration between Health and Social Care Partners via a co-produced Patient Flow Pathway	●	
	24/7 Urgent Crisis Line from March 2023 will be accessed by the public via NHS 111	●	
	2 Crisis Houses in Medway and east Kent and then roll out to west and north Kent	● ●●	
	West Kent Urgent Care Hub 23/24 and roll out to east and north Kent.	●●	
	Pilot alternative to Emergency Departments Model	●	Kent and Medway NHS and Social Care Partnership Trust Mental Health, Learning Disability and Autism Operational Delivery Group

Goal	Actions	Timescale	Owner(s)
Provide quality healthcare as close to home as possible – East Kent hospitals programme	East Kent hospitals programme – East Kent Hospitals University NHS Foundation Trust submitted an expression of interest to the government's new hospitals programme, seeking vital and long overdue investment of £460m in our hospitals for the long term. A decision on the long-listed schemes is expected in the near future. A successful bid is essential before the NHS can consult on options to transform how our services are delivered in future. In the meantime, we are undertaking due diligence with the construction industry to further test the viability and deliverability of both options. This exploratory process is an important piece of work that will provide an additional assurance test before consultation gets underway	●●●	East Kent Hospitals University NHS Foundation Trust Board
Provide quality healthcare as close to home as possible and Improve flow through the system - Community Diagnostics Centres	Diagnostic imaging services flow improvement will be established through expansion of the Community Diagnostic Centres (CDCs) in East and West Kent together with the development/establishment of a new CDC at Sheppey Community Hospital and its associated spoke site at Rochester Healthy Living Centre which are scheduled for operational delivery in 2023/24. In addition, Dartford & Gravesham NHS Trust has submitted a plan for £19.5m standard CDC hub which is pending national approval. The Kent & Medway CDCs provide diagnostic imaging, pathology and physiological measurement services nearer to home, in community settings, separate from acute hospital sites. The CDCs contribute to improved patient flow through:- • Redesign of patient pathways with a system led approach to improve access and alignment of elective pathways to CDC activity • Establishment of system wide polices/procedures to standardise systems and processes thereby reducing delays in diagnosis and supporting delivery of diagnostic/cancer/elective backlog reduction	West Kent CDC (Hermitage Court) ● East Kent CDC (Buckland Community Hospital Hub) ●●	NHS Kent and Medway Improving Outcomes Board Kent and Medway Imaging Network Board

Goal	Actions	Timescale	Owner(s)
Provide quality healthcare as close to home as possible and Improve flow through the system - Community Diagnostics Centres (continued) **Metrics:** • 95% patients will receive a diagnostic test within six weeks of referral, with a stretch target to achieve 99% DM01 compliance by March 2025. • Increase activity from the 2019/2020 activity baseline by 15% in imaging and 26% in endoscopy • Reducing carbon emissions associated with patient/staff travel – 3.5% (9.5 billion miles) of all road travel in England is linked to NHS	Continued… • Collaboration with the Cancer Alliance to review cancer pathways and ensure optimisation of CDC capacity by prioritising a 25% increase of capacity for suspected cancer referrals to (a) increase the percentage of patients receiving tests within 6 weeks of referral (b) increase the percentage of cancers diagnosed at stage 1 and 2 and (c) contribute to achievement of the faster diagnosis standard by March 2024 • Expansion of GP Direct Access to improve patient flow from point of referral • Establishment of 7 day 12 hour services • Introduction of Digital Pathways reducing processing delays • Introduction of Picture Archiving and Communications Systems (PAC) across each CDC enabling PACs based reporting • Faster access to diagnostic imaging services The ICB and Kent & Medway Imaging Network work in partnership ensure compliance with national standards and improve patient pathways/flows and resource optimisation.	Continued… Medway and Swale CDC (Sheppey Community Hospital Hub, Rochester Healthy Living Centre Spoke) ● Dartford, Gravesham and Swanley ●●	NHS Kent and Medway Improving Outcomes Board Kent and Medway Imaging Network Board

Goal	Actions	Timescale	Owner(s)
Provide quality healthcare as close to home as possible and Improve flow through the system **Metric:** • Number of patients that the virtual ward is able to simultaneously manage	Continue to develop the use of virtual ward pathways to plan for safe and timely discharge, ensure safe and effective home-based follow-up support and enhance flow through the system.	●	NHS Kent and Medway Improving Outcomes Board Urgent and Emergency Care Board Provider Trust Boards
	Increase in number of rehabilitation beds to meet required demand. Including greater utilisation of ambulatory and community bed-based alternatives to acute hospital admission which are a more effective settings of rehabilitation care, where patients can be safely managed with effective coordination.	●	
	More intensive step-down services with enhanced nursing and therapies cover will help patients achieve care outcomes with a shorter length of stay, allow more acute needs to be safely managed.	●	
Improve flow through the system – Urgent and Emergency Care **Metrics:** We are currently achieving the 76% A&E 4-hour standard. The first draft operational activity plan shows achievement of 81% by March 2024. Our ambition is to achieve 88% and to have all of our acute trusts achieving 76% by the end of 2024.	The Urgent and Emergency Care Recovery programme will focus on general practice, high intensity users, single point of access, urgent community response and step-up virtual wards. Actions are also included in the programme in relation to mental health support, urgent treatment centres, 111 and 999 activity, same day emergency care (SDEC), intermediate care and discharge. There are a number of actions in relation to the enablers – estates, communications, system coordination and workforce.	●●●	NHS Kent and Medway Improving Outcomes Board Urgent and Emergency Care Board
	Continue to meet and exceed the target 70% two hour urgent community response standard	●	Community service provider boards

Goal	Actions	Timescale	Owner(s)
Improve flow through the system – Urgent and Emergency Care (continued)	Implement a single ICS wide referral optimisation system with pre-programmed patient pathways and decision making that has been agreed by both primary and secondary care to ensure that patients are directed first time to the most appropriate point of care following presentation of a health concern.	●	NHS Kent and Medway Improving Outcomes Board Urgent and Emergency Care Board
Improve flow through the system – Elective Care **Metrics**: • Increase elective activity to 115% of pre-pandemic levels and reduce long waits to deliver the 109% Elective Recovery Fund target • Ambitious goal to deliver elective activity to around 130% of pre-pandemic levels by 2024/25.	Deliver more elective care to address backlogs	●●	Provider Trust Boards, NHS Kent and Medway Improving Outcomes Board NHS Kent and Medway ICB Elective Care Board
	Eliminate waiting times over 65 weeks by March 2024	●	

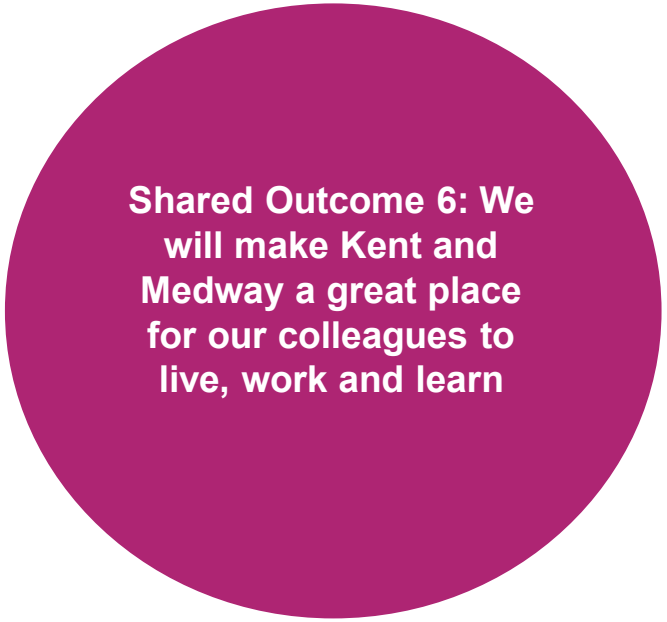
Goal	Actions	Timescale	Owner(s)
Improve flow through the system – Winter Planning	Maintain flow during winter alongside continuing to improve services. Produce a joint plan with health and social care partners. Use data and analysis of previous winter trends to determine how best to meet the increased demand. Produce surge plans for critical care, acute beds, paediatric care, maternity, primary care, social care and community services using escalation frameworks (OPELs) to determine the surge demand. Coordinate the response through the Operational Control Centre (OCC).	●	NHS Kent and Medway Improving Outcomes Board Urgent and Emergency Care Board
Continue to develop centres of excellence for specialised services	Finalise Joint Working Agreement between NHS England and ICB and continue preparation for the delegation of specialised commissioning.	●	NHS Kent and Medway Productivity and Investment Board Delegation reference group
Continue to develop centres of excellence for specialised services – Vascular Services	Vascular services reconstruct, unblock or bypass arteries and are often one-off specialist procedures to reduce the risk of sudden death or amputation and prevent stroke. Evidence shows that patients who need vascular treatment receive better care and have a better chance of survival when they are treated by a team of vascular surgeons, interventional radiologists, nurses and therapists, who treat large number of these patients. Kent and Canterbury Hospital will become the county's specialist centre for inpatient vascular surgery in April 2023. Outpatient appointments and diagnostic tests will continue at patients' local hospitals in Ashford, Canterbury, Margate, Maidstone, and Medway. Day surgery will continue at Canterbury and Medway hospitals. Vascular patients will also benefit from the new interventional radiology suite that opened at Kent and Canterbury Hospital in May 2022, with a second suite opening April 2023, which provide minimally invasive image-guided procedures to treat patients with vascular and other diseases.	●	NHS Kent and Medway ICB and all Provider trusts represented on NHS England Programme Oversight Group

Goal	Actions	Timescale	Owner(s)
Continue to develop centres of excellence for specialised services – Stroke **Metrics** • Percentage of patients receiving thrombectomy	We will reconfigure acute stroke services. The Kent and Medway Stroke Review was instigated in 2014 by local healthcare professionals, including senior doctors, nurses and care professionals. National guidance states that the quality of a stroke unit is the single biggest factor that can improve a person's outcome following a stroke. Successful stroke units, both hyper-acute stroke units (HASUs) and acute stroke units (ASUs), are built around a multi-disciplinary team that is able to meet the collective needs of the patient. The plan is to establish HASUs and ASUs operating 24 hours a day, 7 days a week, to care for all stroke patients across Kent and Medway. This will deliver many benefits for patients, most notably improved survival rates and have improved quality of life and independence. Following the development of options, options appraisal and public consultation, the Joint Committee for stroke agreed that three HASU/ASUs would be established at Darent Valley Hospital, Maidstone Hospital and William Harvey Hospital. The programme is to be delivered in two phases, with MTW and DGT going live in phase 1 and EKHUFT in phase 2. Works on phase 1 are due to start by July 2023 for completion in 2024. Thrombectomy is a procedure which can significantly reduce the severity of disability caused by an ischaemic stroke. Modelling suggests that up to 10% of patients with stroke may be appropriate for treatment with thrombectomy and current levels across the NHS are low – around 2.2%. The Getting it Right First Time (GIRFT, 2022) aims for 8% of all patients with a stroke accessing thrombectomy by 2025. Currently all Kent and Medway patients are transferred to the Royal London Hospital (RLH) to receive their thrombectomy. EKHUFT will provide the thrombectomy service for stroke patients within east and west Kent. Patients at DGT will continue to be transferred to the RLH, due to shorter transit times but will access the Kent and Medway service at Canterbury when the RLH is not accepting patients. Preparation and enabling works for the development have started. The main building works for the thrombectomy suite are due to start in April 2023 and be completed by March 2024.	Phase 1: Maidstone Hospital and Darent Valley. ● Phase 2: William Harvey. ●● ● ●	Provider trust boards

NHS
Kent and Medway

Chapter 6

How we will make Kent and Medway a great place for our colleagues



Integrated Care Strategy Summary

NHS
Kent and Medway

Growing our workforce and skills The demand for staff is outstripping supply and, along with an ageing workforce, this is putting increased pressure on our teams. We will create an attractive employment proposition for health and care. One that develops and retains our exceptional local workforce and attracts people into careers in health and care from within and beyond Kent and Medway, reducing the need for expensive agency workers. To do this, organisations within the ICS will work together to attract and retain professionals, work with education and training providers to develop exciting and diverse careers and training opportunities, provide talented and capable leadership and offer flexible and interesting careers.

Championing inclusive teams There are over 80,000 health and care colleagues across a range of services based in Kent and Medway. We will work with all our partner organisations to embed cultures that promotive civility, respect and inclusion, providing shared talent and development opportunities and education for leaders and teams, with shared action to grow and celebrate our diversity and be representative of our communities including systematically addressing bias, empowering and developing colleagues from underrepresented groups and celebrating diversity at all times.

Looking after our people Wherever you work in health and care in Kent and Medway, we want it to be a great place to work and learn. We will develop wrap-around wellbeing services for our workforce. These will support those with illnesses as well as empowering colleagues to proactively manage their wellbeing. We will identify specific interventions that align with our population health priorities, particularly with colleagues who are experiencing health inequalities.

Shared Outcome 6: We will make Kent and Medway a great place for our colleagues to live, work and learn

We will build on our Kent and Medway health and care academy by working in partnership with local employers, schools, careers services and education partners to create a robust pipeline of local workforce for future years, developing new roles such as apprenticeships, new ways of working such as cross-organisational portfolio roles with the skills and digital capability to be ready for the modern workplace.

We want to develop programmes that help to reduce long term and youth unemployment, bring young people into work and support carers as part of our wider workforce.

Building 'one' workforce at place Working across health and care partnerships, we will use our anchor institutions to develop one workforce at place, create integrated neighbourhood teams with embedded flexible working, mobility and enabled through digital technology and capabilities. Through this, we hope to reduce unnecessary commuting and reduce our carbon footprint. We also have a vital and valued volunteer workforce - we will ensure that that we celebrate their invaluable work but also seek their input to shape, improve and deliver services.

The Kent and Medway People Strategy is being developed alongside the Integrated Care Strategy and Five Year Joint Forward Plan and is being led by the Chief People Officers across Kent and Medway with engagement of a range of partners. The strategy development will be overseen by the Integrated Care Board's People Committee.

NHS
Kent and Medway

How we're working with partners across the system

To realise our ambition of Kent and Medway being a great place to work, live and learn we are working on a Kent and Medway People Strategy. This strategy is being developed alongside the Interim Integrated Care Strategy and Joint Forward Plan and led by the Chief People Officers across Kent and Medway with engagement of a range of partners. The strategy development has been overseen by the Integrated Care Board's People Committee.

We will deliver this strategy and delivery plan through collaboration with our Health and Care Partnerships, through Provider Collaboratives and through shared workforce programmes.

Workforce is often recognised as a key challenge to the delivery of our ambitions. Our short term workforce priorities include:

- Developing our Health and Care Academy hub and spoke model with a range of activities to grow workforce skills, partnership working with colleges, schools, voluntary organisations and providers to promote careers, hold joint recruitment events and attract to hard to recruit roles
- A range of developmental opportunities that support inclusive cultures and compassionate, inclusive leadership including shared talent and mentoring programmes, debiasing recruitment, cultural intelligence and leadership development programmes across Kent and Medway
- Maximising our health and wellbeing offers including a range of offers to health and care colleagues and shared programmes to improve retention, such as a menopause programme, flexible working programme, new starter champions, legacy nurse programme, talking wellness hub and an increase in TRiM (trauma risk management) practitioners and mental health first aiders to support workforce wellbeing
- Programmes to support integrated care workforce models including planning and organisational development and a workforce efficiency programme to maximise existing resources and reduce temporary staffing cost

Key to timescales

- ● Short term < 1 year
- ●● Medium term 1-2 years
- ●●● Long term 3-5 years+

NHS
Kent and Medway

Goal	Actions	Timescale	Owner(s)
Make Kent and Medway a great place to live, work and learn	Develop the Kent and Medway People Strategy.	●	NHS Kent and Medway Integrated Care Board NHS Kent and Medway People Committee
	Academy Hub and Spoke Pilot - To create a greater presence and influence with the Academy, we are planning that each Health and Care Partnership (HCP) will "host" a skills and employability coordinator placed within their workforce to influence the HCP to ensure they are working towards the outcomes of the Academy. The Academy will be piloting the initial "Hub & Spoke" model with East Kent initially until March 2023 with a view to create equivalent arrangements in all of the H&CP's across Kent & Medway.	●	NHS Kent and Medway Integrated Care Board NHS Kent and Medway People Committee
Champion inclusive teams	Deliver a Kent and Medway talent development programme, focused on staff groups where intervention is needed to assist colleagues to progress, starting with Band 5 nurses pilot.	●	NHS Kent and Medway Integrated Care Board NHS Kent and Medway People Committee
	Deliver a Kent and Medway mentoring programme to support colleagues with protected characteristics (reciprocal and reverse mentoring).	●	
	Develop a debiasing recruitment programme to systematically de bias recruitment processes as part of the Overhauling recruitment programme. Commenced across health, opportunities in social care are being explored.	●	NHS Kent and Medway Integrated Care Board NHS Kent and Medway People Committee
	Develop a culture and inclusion plan and Kent and Medway commitment to levelling up staff experience across health, including cultural dashboard and metrics for the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) and gender pay.	●	
	Develop cultural intelligence through the pilot and rollout of the Cultural intelligence development programme to improve leadership, culture and behaviours	●	

Goal	Actions	Timescale	Owner(s)
Champion inclusive teams (continued)	Deliver Kent and Medway leadership and management development programmes built to deliver consistency and high quality development as part of our response to the Messenger review (including our international colleagues)	●	NHS Kent and Medway Integrated Care Board NHS Kent and Medway People Committee
	Scoping of how just learning restorative justice practice can be embedded in all organisations, following development programme	●	
	Shared calendar of cultural events, with Equality, Diversity and Inclusion (EDI) networks working together on key events such as PRIDE, Black History Month, Disability Month etc	●	NHS Kent and Medway Integrated Care Board NHS Kent and Medway People Committee
Look after our people **Metrics:** • Sickness rate 4.32% • Turnover: 12.4%	Review all health and wellbeing services, including growing occupational health review, to develop one wellbeing approach across health and care	●	
	Identify and develop interventions that align with population health priorities	●	
	Kent and Medway commitment to zero tolerance to violence, aggression, discrimination and abuse. This is also a priority for Medway and Swale Health and Care Partnership Workforce Group.	●	Health and Care Partnership Workforce Groups
	Shared support approach for cost of living including some benefits and building relationships with partners in Kent and Medway for the benefit of Kent and Medway health and care colleagues	●	
	Implement the Kent and Medway Retention plan focused on key system themes for retention including flexible working, generational needs and key interventions evidenced from staff feedback and workforce metrics	●	NHS Kent and Medway Integrated Care Board NHS Kent and Medway People Committee

Goal	Actions	Timescale	Owner(s)
Grow our workforce and skills **Metrics:** • Substantive workforce growth: 1683 WTE, 5.31% • Vacancy: 7.22%	Develop the Kent and Medway health and care academy workforce plan to create pipeline of local workforce, develop high quality education and skills as part of the People Strategy. This is also a priority for Medway and Swale Health and Care Partnership Workforce Group.	●	Health and Care Partnership Workforce Groups
	Launch the Kent and Medway Academy website which will be the central repository for Kent and Medway education, development and skills. Access to quality training is also a priority for Medway and Swale Health and Care Partnership Workforce Group.	●	NHS Kent and Medway Integrated Care Board NHS Kent and Medway People Committee
	Focus on Kent and Medway hard to attract areas to deliver wider recruitment campaigns with programme in place for 23/24 and rotations i.e. GP attraction campaign, system International Recruitment	●	NHS Kent and Medway Integrated Care Board NHS Kent and Medway People Committee
	Develop Kent and Medway attraction platform and employee proposition including exploring options with housing	●	
	Commence Kent and Medway programmes for long term unemployment, increasing employment for people with learning disabilities, autism and neurodiversity and carers	●	Programme Board (education and careers)
	Kent and Medway focus on new role development and placement expansion for transformation priorities and hard to recruit areas needing redesign i.e. Kent and Medway entry health and care roles, voluntary sector inclusion	●	Programme board (integrated care)
	Kent and Medway careers framework developed for professional groups. This is also a priority for Medway and Swale Health and Care Partnership Workforce Group.	●	NHS Kent and Medway Integrated Care Board NHS Kent and Medway People Committee
	Work collaboratively to develop digital leadership (clinical and technical) and support professionalism and career development (for example engaging with the Skills Development Network). Priorities will include cyber, information governance and clinical safety, where there are limited skills available and opportunities to create shared functions	●●	Provider Trust Boards, System oversight by the Digital and Data Board, NHS Kent and Medway

NHS
Kent and Medway

Goal	Actions	Timescale	Owner(s)
Build one workforce at place	Create integrated neighbourhood teams with embedded flexible working enabled through digital capability. Planning work is underway for pilots in West Kent and East Kent.	●	Health and Care Partnership Boards, Programme board (integrated care), reporting to People Committee and NHS Kent and Medway ICB
	Engage volunteer workforces in shaping, improving and delivering services. Pilot underway in East Kent HCP	●	
	Refresh the workforce sharing agreement to be inclusive of social care, primary care and voluntary sector	●	NHS Kent and Medway Integrated Care Board NHS Kent and Medway People Committee
	Place level workforce plans in place	●	Health and Care Partnership Boards
	Flexible workforce model at place level (building on the bank models for primary care, trusts and social care)	●	
Workforce efficiencies and temporary workforce **Metrics:** • Bank reduction: -862 WTE, -31/28% • Agency reduction: -442 WTE, -45.34%	Temporary staffing and workforce efficiency plan in place to deliver workforce productivity and attractive ways of working for our flexible workforce	●	Provider Trust Boards, NHS Kent and Medway ICB
	Advance levels of attainment programme to review e-rostering and e-job planning for expansion to support reduction in temporary staffing and enhance clinical productivity (working with digital, finance and operational colleagues). Diagnostic to be undertaken in Q1 23 to inform scoping and plan for 23/24	●●	NHS Kent and Medway Integrated Care Board NHS Kent and Medway People Committee

NHS
Kent and Medway

Chapter 7

How we will drive research, innovation and improvement across the system

Integrated Care Strategy Enabler: We will drive research, innovation and improvement across the system

We will achieve this through:

- Establishing ways to better collaborate on research across our system;
- Unlocking additional capacity by empowering our workforce to take part in research and improvement in their everyday work;
- Championing innovation and being open to trying new ideas;
- Sharing and using data safely and effectively to achieve better outcomes, and;
- Embracing digital transformation as a system.

Key to timescales

- ● Short term < 1 year
- ●● Medium term 1-2 years
- ●●● Long term 3-5 years+

NHS
Kent and Medway

Goal	Actions	Timescale	Owner(s)
Promote and facilitate research, and improve research collaboration across the system	To embed research collaboration through the Joint Research Collaborative (JRC), and utilise the JRC to engage with its membership to design and implement appropriate prioritisation activities	●	NHS partners, Local Authority and VCSE Supported by National Institute for Health and Care Research/ Kent Surrey and Sussex Clinical Research Network Academic Health Science Network collaborative
	We will increase research and innovation leadership capacity within NHS, local government (particularly district councils) and Primary Care (particularly General Practice). Integrated Care Boards leads to collaborate and inform National Institute for Health and Care Research Kent Surrey and Sussex Infrastructure partners and Universities of system investment priorities to build capacity.	●	
	We will ensure citizens are well informed and understand it's their right and choice to participate in research by: • Integrating research messaging into everyday public and professional communication including patient emails, clinic letters, organisational websites (NHS and local authority) • Engaging the Integrated Care Partnership in a Social Movement Pilot around research awareness, and a priority • Promoting https://bepartofresearch.nihr.ac.uk/ through all channels in order to facilitate awareness and direct (digital) access to opportunities.	●	NHS Kent and Medway NHS partners, Local Authority

Goal	Actions	Timescale	Owner(s)
Promote and facilitate research, and improve research collaboration across the system (continued)	Engage with the research community on appropriate methods when commissioning new evidence-based interventions. Enable system wide capability to access and synthesise evidence, and create/utilise existing communication systems to alert the workforce to new evidence, including integrating, signposting messages from different agencies.	●	NHS partners, Local Authority and VCSE Supported byNational Institute for Health and Care Research (NIHR) / Kent Surrey and Sussex (KSS) Clinical Research Network (CRN) Academic Health Science Network (AHSN) collaborative
	We will also: • Map and prioritise evidence gaps, and match need against local Research and Innovation Leadership strengths in Kent and Medway • Co-develop new research and innovation studies/trials to address local evidence gaps and in line with local strengths, and • Accelerate evaluations and implementation with the NIHR Applied Research Collaborations to tackle specialist themes and topics linked to local priorities	●	
	We will reduce disparities in citizens' research opportunities and benefit from proven innovation. The Integrated Care Partnership and Regional NIHR partners will identify a community with whom all partners can systematically and collectively engage in health and research promotion. We will develop a pilot programme to engage under-served communities to better understand their needs and to support equitable access to research opportunities	●	NHS partners, supported by NIHR / KSS CRN AHSN collaborative

Goal	Actions	Timescale	Owner(s)
Empower our workforce to take part in research and improvement in their everyday work	Educate and support the health and care workforce to be confident, competent, and afforded the time to talk about research and innovation opportunities as an integral part of the delivery of care.	●	NHS Research and Development Leads, reporting to NHS Boards and NIHR/ KSS CRN AHSN collaborative
	Promote Research as a career option for all disciplines, enabled through integrated care and research workforce planning and development.	●	
	Empower the workforce to contribute to research and innovation every day and in diverse ways including: leading research programmes, delivering research, providing opportunities to articulate challenges that can be addressed through innovative solutions.	●	
	Build protected time within job plans/roles to lead research and innovation activities, for example as a site base principal investigator, chief investigators and Innovation Fellows leading studies nationally, regionally and locally.	●	
	Where capability building programmes exist e.g. Kent Community Health NHS FT Innovation Fellowship we will evaluate their impact and support spread across the system.	●	
	Develop a mentorship and coaching network on the application of innovation principles and approaches in the 'real world'.	●	
	Provide opportunities to learn, develop skills, capability and confidence in the adoption and spread of innovation e.g. scale and spread of KSS AHSN Digital and Innovation Fellowship programmes.	●	
	Build a diverse and inclusive research and innovation workforce in terms of all health and care disciplines. NIHR/AHSN and system partners to implement organisational EDIB (Equality Diversity Inclusion and Belonging) plans, across all business functions to support increased diversity in research and innovation workforce.	●	

Goal	Actions	Timescale	Owner(s)
Empower our workforce to take part in research and improvement in their everyday work (continued)	Promote research and innovation activities across boundaries, within the system, to enable flexibility and choice as well as making the most of connections to regional and national networks with innovation, insights and expertise. We will create a multi-disciplinary peer support network across Kent and Medway.	●	NHS Research and Development Leads, reporting to NHS Boards and NIHR/ KSS CRN AHSN collaborative
Champion innovation and be open to trying new ideas	We will generate a rich pipeline of demonstrably useful, evidence-based innovations by connecting commercial and clinical innovators to health and care organisations, providing advice and bespoke support at every stage of the innovation pathway and matching proven technologies to NHS challenges. KSS NIHR AHSN will collaborate to horizon scan for innovations that can provide solutions to local challenges and list of technologies that the ICS is seeking to scale	●	NIHR/ KSS CRN AHSN collaborative
	We will promote a culture and design activities and processes so people are encouraged and empowered to try, test and learn from new ways of doing things, including: • Learning from and spreading local excellence in innovation • Understanding the needs of the person, or the care provider or commissioner and prioritising the most important challenges; • Searching for relevant innovation and enabling testing innovation within the ICS; and • Supporting and facilitating the spread of innovation where it is successful Kent and Medway will become a Learning Health System by partnering with research stakeholders that can help with clinical evaluation and the establishment of evidence bases to ensure interventions are effective	●	NHS Research and Development Leads, reporting to NHS Boards and NIHR/ KSS CRN AHSN collaborative

Goal	Actions	Timescale	Owner(s)
Share and use data safely and effectively to achieve better outcomes	Build a 'Trusted Research Environment' based on national guidance. This will allow a safe secure computing environment for linked data research and other complex analytics locally.	●●●	NHS Kent and Medway ICB
	Develop and agree a communications and engagement plan to promote use of linked data for secondary uses to the wider public.	●	NHS Kent and Medway ICB
	Discuss with councils signing up to the Shared Health and Care Analytics Board (SHcAB) Joint Controller Agreement and single operating model for approving data access and data integration, where appropriate.	●	NHS Kent and Medway ICB
	Simplify governance and decision making arrangements for Kent and Medway Care Record (KMCR) to be made available for linked data access requests for secondary uses by aligning with existing SHcAB arrangements.	●	NHS Kent and Medway ICB
	We will create a Data Ethics Board to review data requests for pure research, building on our vision to become a 'Trusted Research Environment' and complementing SHcAB.	●	NHS Kent and Medway ICB
	The ICB will agree and implement a funding model for the new linked dataset called Kent Research Network for Education and Learning (KERNEL) being developed by the Kent & Medway Data warehouse. KERNEL development is expected to last next 4 years.	●●●	NHS Kent and Medway ICB

Goal	Actions	Timescale	Owner(s)
Share and use data safely and effectively to achieve better outcomes (continued)	Incentivise and promote GP engagement and training in SHcAB related and analytical activities e.g. GP Fellowship programme in Public Health and Population Health Management.	●	NHS Kent and Medway Improving Outcomes Board Primary Care Strategic Oversight Committee
	Review how to participate in other data integration activities such as Financial Hardship programme by KCC and Kent districts where integrated council data is used for case finding to support work around homelessness and falls prevention.	●	NHS Kent and Medway ICB
	Transfer hosting arrangements and historical data for Optum / Mede analytics tool to the Kent & Medway Data warehouse in 2024 for advanced analytical projects similar to the Kent Integrated Dataset (KID).	●●	NHS Kent and Medway ICB
Embrace digital transformation as a system	Establish a Digital and Data Board to deliver the ICS Digital and Data Strategy. A number of the actions included in this strategic plan are referenced over the following slides.	●	NHS Kent and Medway ICB Digital and Data Board
	Electronic Patient Record Optimisation to ensure that all organisations across Kent and Medway ICS have an EPR in line with National Standards	●●	Provider Trust Boards, System Digital and Data Board
	Convergence Programme that works with EPR to the next stage of being a fully digitally integrated health and care system	●●●	
	A Digital First programme to enable multidisciplinary and extended practice teams to work collaboratively	●●	NHS Kent and Medway ICB Digital and Data Board
	Continue to build share care records and care plans with the contribution of multi-disciplinary teams and patients	●●●	Provider Trust Boards, KMCR Project Board Digital and Data Board

Goal	Actions	Timescale	Owner(s)
Embrace digital transformation as a system (continued)	Convergence of Diagnostics across ICS through development of single Pathology, Radiology and imaging systems.	●●●	NHS Kent and Medway Improving Outcomes Board Kent and Medway Pathology and Imaging Networks
	Develop an ICS shared systems, data and technical architecture that delivers What Good Looks Like and enables cross organisational patient pathways, high quality information for direct care, planning and research, integrated working, reduces costs and increase operational and cyber resilience.	●	Provider Trust Boards, System Digital and Data Board
	Work in partnership with Kent County Council and Medway Council to deliver a provide access to basic technologies and promote digital literacy to allow citizens to successfully use digital tools to access health and care services. This includes digital hardware loan scheme, a WiFi voucher scheme and citizen digital champions scheme to improve digital literacy, patients' confidence and skills to access digital services.	●	NHS Kent and Medway ICB Digital First Programme Board
	Support the General Practice workforce, as the first point of contact with the NHS, to adopt digital technologies to support citizens navigate digitally enabled health and care pathways.	●	NHS Kent and Medway ICB Digital First Programme Board
	Support practices to accelerate patient prospective access to their GP records	●	Medway Improving Outcomes Board Primary Care Strategic Oversight Committee

Goal	Actions	Timescale	Owner(s)
Embrace digital transformation as a system (continued)	Work with CQC registered adult social care providers to promote the implementation of Digital Social Care Records (DSCR) to meet the adoption target of 80% by March 2024	●	NHS Kent and Medway ICB Kent and Medway Adult Social Care Digital Transformation Programme Board
	Sensor based falls prevention and detection technologies, such as acoustic monitoring, will be in use in Care Homes for the residents identified as most at risk of falls, reaching at least 10% of residents by March 2023; 20% by 2024	●	
	Improve NHS App functionality by linking local patient engagement portals (PEPs) with the NHS App under the Wayfinder programme.	●●	Provider Trust Boards
	Support General Practice in Kent and Medway adopt online registration processes.	●	Medway Improving Outcomes Board Primary Care Strategic Oversight Committee reporting to NHS Kent
	Support General Practice in Kent and Medway optimise routine administrative and clinical workflows through the use of automated tools.	●●●	
	Meet the objectives set out in Sustainable ICT and Digital Services Strategy (2020 to 2025).	●●	Provider Trust Boards, System Digital and Data Board
	Implement an electronic referral optimisation system (EROS). Deploy a digital solution which will enhance and optimise referral processes. Enable timely decision making, support, care, and access to treatment for patients throughout the healthcare system in Kent and Medway. Ensures that the right patients are seen in the most appropriate service with appropriate clinical workup and information.	●●	NHS Kent and Medway ICB Digital and Data Board

NHS
Kent and Medway

Chapter 8

How we will provide system leadership and make the most of our resources

Integrated Care Strategy Enabler: We will provide system leadership, and make the most of our collective resources

We will achieve this through:

- Playing our part as 'anchor institutions', using our assets and resources to benefit the communities around us, including embedding sustainability in everything we do through our Green Plan
- Championing our values. We will continue to build partner leadership and commit to tackling the wider determinants of health
- Monitoring quality and providing governance; for example holding each other to account and developing core metrics that encompass health and social care
- Guiding resource allocation; By understanding each other better we can reduce duplication and make the most of our collective resources, pooling resources where appropriate, and removing obstacles to operational teams working together
- Interfacing with national bodies; The ICS will act as the voice of Kent and Medway, advocating on behalf of our population to influence policy
- Building resilience and preparing for emergencies; Continuing to coordinate our Covid-19 response at ICS level, and being prepared for other emergencies
- Working with our Places and Neighbourhoods to align priorities and develop implementation plans.

NHS
Kent and Medway

Our financial duties

The current financial climate for the NHS is challenging, with ever increasing demand and limited financial resources, both revenue and capital. This has made achieving the revenue breakeven duty challenging across the NHS in 2022/23. The Kent and Medway system is forecasting achieving a deficit at the end of 2022/23 of £25.3m.

Looking forward, each system partner has focused on balancing delivery across the national recovery objectives for 2023/24 with a focus on recovering our core services and productivity. It is in this context that the 2023/24 financial plan has been developed. The initial system financial plan for 2023/24 is an unbalanced plan and whilst the system is working hard to balance this for final plan submission it is highly likely that there will be a planning deficit within some organisations in the system.

The system is committed to achieving financial sustainability but also recognises that this may be over a longer time period than one year. There are two Trusts, Medway Foundation Trust (MFT) and East Kent Hospitals University Hospital Foundation Trust (EKHUFT) which are in the NHS England, Recovery Support Programme. They are also in Single Oversight Framework (SOF) 4 which has a requirement for mandated intensive support as these Trusts face very difficult challenges. The Integrated Care Board (ICB) is in SOF 3. This means that NHSE work collaboratively with the ICB to provide support to understand the needs and agree improvement actions.

There are key factors that have in, 2022/23, impacted upon the system's financial performance. These factors will continue, to some degree, to influence the system's productivity and financial performance in 2023/24 and are all evidenced and addressed in this, our Draft Joint Forward Plan.

The system recognises that it will be challenging to deliver a fully recurrent CIP programme. There will be an element of non-recurrent delivery as in previous years. The CIP percentage is between 8% to 10% across the system. This is a challenging ask but the system is working towards strengthening its CIP programme which will support the system's ambition to become financial sustainable.

Whilst capital is constrained nationally, the system, as a whole, invests c.£73m annually, in Board approved capital plans, on maintenance and additional improvements to the estate infrastructure, replacement of medical and IT equipment. We spend c.£14m of our system capital allocation on digitalisation to improve how we deliver patient care and supporting the transformation of services which is improving patient outcomes.

Key to timescales

- ● Short term < 1 year
- ●● Medium term 1-2 years
- ●●● Long term 3-5 years+

NHS
Kent and Medway

Goal	Actions	Timescale	Owner(s)
Play our part as 'anchor institutions', including embedding sustainability in everything we do through our Green Plan	Implement the Kent and Medway Integrated Care System Green Plan to embed sustainability in everything we do and meet our statutory duties. In the medium term we will: • Calculate ICB staffs' commuting footprint and promote lower carbon alternatives such as active transport or greener transport methods. • Measure system partners' annual footprints, both for travel to and from work and when travelling for work, to promote lower carbon alternatives. • Promote vehicle sharing schemes (when safe to do so post Covid) amongst system partners, reducing the number of vehicles on the road.	● ●●	NHS Kent and Medway IPPH Committee Medway Executive Sustainability Group NHS Provider Boards
Metrics • Included in Green Plan • Reach net zero on our emissions by 2038-40.	In the longer term we will: • Ensure that all new cars leased by staff through NHS Kent and Medway are either Ultra Low Emissions vehicles or Zero Emission Vehicles, and we will vigorously promote active and greener forms of transport to all staff. • Engage with public transport providers to identify options for subsidised or free access to public transport for ICS staff when travelling to and from work. • Develop a program that supports the establishment of anti-idling zones in and around all system partner's infrastructure to improve local air quality. • Engage with suppliers to identify economies of scale and shared specifications in the phased replacement of existing system partner fleet vehicles with electric alternatives. • Establish a campaign with all system partners to implement the clean air framework methodology for measuring and planning to reduce the impacts of air pollution in their sites.	●●●	INHS Kent and Medway IPPH Committee Medway Executive Sustainability Group NHS Provider Boards

NHS
Kent and Medway

Goal	Actions	Timescale	Owner(s)
Champion our values, continue to build partner leadership and commit to tackling the wider determinants of health	Repeat the Symposium event first held in October 2022 which brought together over 100 leaders from across the system as an opportunity to create space to continue to build a culture of collaboration and trust and to develop our interim Integrated Care Strategy.	●	NHS Kent and Medway ICB
	Continue to develop single specialty or clinical support service networks to ensure dedicated commitment to and transformation of services in line with the NHS Long Term Plan and relevant national or local strategies.	●	NHS Kent and Medway ICB
Monitor quality **Metrics** • Integrated Quality and Performance Report • Get It Right First Time reports	Deliver the National Quality Board's shared commitment to quality which focuses on ensuring care is: safe, effective, response and personalise, caring, well-led, sustainably resourced and equitable.	●	NHS Kent and Medway Improving Outcomes Board
	Share data and intelligence through the System Quality Group, following National Quality Board guidance on metrics. Also to develop quality monitoring using a standardised set of quality metrics.	●	
	Reduce variation across the system as defined by the Get It Right First Time Programme	●	
	Reduce the number of providers rated as Requires Improvement of Inadequate by the CQC	●	NHS Kent and Medway ICB NHS provider trust boards,
	Establish cross system learning and quality improvement programmes focusing on key quality priorities set by the system	●	

Goal	Actions	Timescale	Owner(s)
Guide resource allocation, make the most of collective resources, pool resources where appropriate and remove obstacles to operational teams working together **Metrics** • Patients with LoS 21+ days who no longer meet the criteria to reside • A reduction in super stranded patients (LoS 21+ days) of 2% of bed base • Increase patient initiated follow up take-up to 5% of OPA activity • Number of requests for pre referral specialist advice (including Advice & Guidance models)	Meet our statutory requirement to remain financially viable and commit to achieve financial sustainability and a break even position.	●●●	NHS Kent and Medway ICB Provider Trust Boards
	Deliver our cost improvement plan. This includes actions around workforce, outpatient transformation, theatre utilisation, procurement, length of stay, corporate, Getting it Right First Time (GIRFT), and medicines optimisation. This work supports the financial performance and the efficiency and productivity of the system. Some of the CIP schemes are cross-cutting programmes of work and multi-year.	● ●●	
	Through the work of the System Productivity and Efficiency Team identify, evidence and implement programmes of work that contribute to financial and operational recovery across the system, for example focusing on areas such as estates, medicines optimisation and transportation.	●●●	NHS Kent and Medway Productivity and Investment Committee
	Continue to use value for money audits and benchmarking tools such as Model System Hospital, NHS England benchmarking (including corporate services), GIRFT, service line reporting and patient level information costing to review opportunities for focus, efficiencies and productivity improvements.		NHS Kent and Medway Productivity and Investment Committee Provider Trust Boards and
	Deliver key system capital transformation priorities referenced earlier in this plan to support the delivery of improved patient outcomes, including: • Stroke units to support the Hyper and Acute Stroke Service • Electronic Health Records • Invest in the eradication of mental health dormitories • Edenbridge Memorial Health Centre • Community Diagnostic Centres	●●●	Provider Trust Boards NHS Kent and Medway ICB

Goal	Actions	Timescale	Owner(s)
Guide resource allocation, make the most of collective resources, pool resources where appropriate and remove obstacles to operational teams working together (continued) **Metrics** (continued) • Financial stability : variance from break :even • Financial efficiency : variance from efficiency plan	Produce a full business case for the Kent and Medway Elective Orthopaedic Centre	●	NHS Kent and Medway ICB Provider Trust Boards,
	Implement the Procurement Transformation Operating Model, which includes establishment of system lead and oversight board, an agreed MOU for collaborative working, review of key data sets, ongoing use of tools to review variation in contracts, and confirmation of the future structure of procurement services.	●●	NHS Kent and Medway Productivity and Investment Committee
	Build on the informal and formal joint working arrangements to deliver more joined up care by establishing three provider collaboratives and agreeing priorities for 2023/24: • Mental Health, Learning Disabilities & Autism - building on the current collaborative and it's work programme (this includes work on commissioning specialised services, quality improvement and sharing best practice) • Acute Services - a new Collaborative focusing on diagnostics and pathology. • Primary, Community and Social Care (predominantly dealing with out of hospital pathway of care) - a new collaborative.	●	NHS Kent and Medway Improving Outcomes Board Mental Health, Learning Disability and Autism Operational Delivery Group,

NHS
Kent and Medway

Goal	Actions	Timescale	Owner(s)
Guide resource allocation, make the most of collective resources, pool resources where appropriate and remove obstacles to operational teams working together (continued)	In 2023/24 we will invest £22.8m with Medway Council and £125.7m with Kent County Council through the Better Care Fund. The services in the BCF are mainly focused on discharge support, admittance avoidance and carers support, such as community equipment, carers breaks and reablement services. These are areas where the ICB and social care are pushing for greater integration and have worked well together in the past. This greater integration will free up beds in our hospitals and supports us, as an integrated system, to provide the right care in the right location at the right time.	●	NHS Kent and Medway Productivity and Investment Committee Joint Commissioning Management Group
	Establish Kent and Medway system Estates strategy. The Estates and Infrastructure Strategy for the ICS will set out the ICS's shared estates and infrastructure commitments and will provide a roadmap to support integrated working between teams across partner organisations. The strategy will also include information about the ICS's Sustainability programme and how this will support the estates and infrastructure priorities (such as the public sector decarbonisation schemes (PSDS) and future intentions). It will also need to link closely with the ICS's Digital Strategy, identifying how estate may be better utilised and supported by improved digital utilisation. .	●	NHS Kent and Medway ICB
Build resilience and prepare for emergencies; Continuing to coordinate our Covid-19 response at ICS level, and being prepared for other emergencies	Work closely with our partners cross the ICS to develop a system-wide Adaptation Strategy to address the effects of climate change that are already being observed and to respond to anticipated climate change impacts in the future. This may include improving our infrastructure to ensure it is stronger and safer, replanting trees, developing green spaces and supporting ecosystems, and working with partners to develop innovative solutions to prevent and manage natural catastrophes.	●	NHS Kent and Medway ICB, Provider Trust Boards

Goal	Actions	Timescale	Owner(s)
Work with our Places and Neighbourhoods to align priorities and develop implementation plans	Support the principle of subsidiarity, delegating decisions from NHS Kent and Medway to Health and Care Partnerships to ensure services are co-designed, commissioned and delivered in partnership with local communities, as close to the service user as possible. Operating models and Memorandums of Understanding to be developed and agreed.	●●●	NHS Kent and Medway ICB Provider Trust Boards

NHS
Kent and Medway

Chapter 9

How we will engage our communities

Integrated Care Strategy Enabler: We will engage our communities on this Forward Plan and in co-designing services

We will actively engage our communities on the Interim Integrated Care Strategy and our Joint Forward Plan through:

- Involving people from all walks of life to have their voice heard;
- Utilising multiple channels to ensure accessibility, and;
- Refreshing our Strategy, Joint Forward Plan and developing supporting documents.

NHS
Kent and Medway

Goal	Actions	Timescale	Owner(s)
Involve people from all walks of life and through multiple channels	Continue to listen to the voice of those with lived experience of our services, including those unable to access what they perceive they need through a mixture of engagement tools and activities. Ensure accessibility is key to what we do.	●●●	NHS Kent and Medway IPPH Committee
	Further develop the Communications and Engagement Oversight Group to lead joint working across the Integrated Care System using the strategy and forward plan as the starting point in partnership working.	●	
Refresh the Interim Integrated Care Strategy and Joint Forward Plan	Deliver the communications and engagement strategy for the Interim Integrated Care Strategy by attending in-person and virtual events across Kent and Medway to engage on the content of the Strategy and Joint Forward Plan. Arrange strategy and forward plan-specific events and roadshows to engage across all our communities. Use digital and print material developed for this purpose. Campaign to also include use of social media, stories in digital e-bulletins, stores in printed materials – with all partners across the system. Potential interviews and short videos. Provide feedback to the strategic oversight group to inform changes.	●	
	Deliver online survey on 'Have Your Say' platform to support engagement listed above. Opportunities provided for paper-based response via dedicated print materials.	●	
	Support communication and engagement for large-scale change, projects and activities within the Strategy and Joint Forward Plan to ensure visibility of activities under way, achieved and completed.	●	
	Plan and deliver a second symposium event in October 2023 to hear from all stakeholders on the development of the strategy.	●	NHS Kent and Medway ICB

NHS
Kent and Medway

Have your say

We need everyone to help us do things differently; it's time to make positive, long-term change to the way we plan and deliver services so that we can make meaningful changes to the health and wellbeing of Kent residents.

We want to prevent ill-health wherever possible. This Forward Plan outlines some of the work we are planning – we want to know what you think and your ideas.

There are lots of ways for you to have your say to help us plan for the future.

Your views will be listened to and will help shape our plans and strategies for the future.

You can share your thoughts on our Interim Integrated Care Strategy and our Forward Plan or on wider issues relating to health and wellbeing by registering for our online platform:

Have Your Say in Kent and Medway

https://www.haveyoursayinkentandmedway.co.uk/

Here you will also find out more about some of the exciting projects underway and examples of how we are demonstrating our new future.

- Alternatively, you can write to us at:

  Kmicb.engage@nhs.net or

  The Engagement Team

  Kent and Medway ICS

  Kent House

  81 Station Road

  Ashford

  TN23 1PP

NHS
Maidstone and Tunbridge Wells NHS Trust

Update on the West Kent and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)	**Director of Strategy, Planning and Partnerships**

The enclosed report provides information and updates on the establishment of the Kent & Medway Integrated Care Board (ICB) and the West Kent Health Care Partnership (WKHCP) and includes details of the teams which have been developed to support the programme of work and referenced the discussions in relation to Primary Care Senior Leadership.

Which Committees have reviewed the information prior to Trust Board submission?

- Executive Team Meeting, 25/04/23

Reason for submission to the Trust Board (decision, discussion, information, assurance etc.) [1]

The report is for information and discussion to facilitate feedback between MTW, the HCP and the wider system.

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

West Kent HCP and K&M ICB update March 2023

Kent & Medway Integrated Care Board

Work continues on the Joint Forward View document. A draft has been circulated for comment and any additional updates with a view to producing a final version for the next Steering Group on 28th March. It is on the ETM agenda and will be discussed at the April Board.

The operational plan was submitted on 22nd March following an extra ordinary Board on 20th March. It has now been confirmed that a further iteration will be required by NHSE on 4th May. K&M ICB have a meeting with the regional team on 20th April for which we may need to provide an updated position.

West Kent Health & Care Partnership Highlights

The partnership continues to develop our integrated neighbourhood team (INT) model in our 9 PCNs. Implementation will commence with 2 PCNs with higher levels of deprivation and health inequalities. We continue to work with the ICB to consider resourcing the development of the INTs alongside the primary care Medical Director post for WK HCP which will shortly be advertised. On 8th March the HCP had Board away day which was well attended and focussed on the development of INTs.

We have established an HPC Discharge Capacity Programme Board which includes all partners and will inform the work that Mairead McCormick (CEO of KCHFT) is leading on discharge pathways across K&M.

We have had confirmation that we will be receiving an allocation of £3.59m for discharge capacity schemes for 23/24 against a long list total of £10.6m. With the funding available we can continue with the schemes we have in place (£3.62m) but there would not be capacity for any additional schemes. An urgent discussion is being arranged and an extension until 18th April has been requested.

WKHCP Risks and Challenges

The 2 top rated red risks are:

Workforce - All providers are identifying capacity issues with staffing core services and 2022/23 planning. Of particular note are ongoing shortages of domiciliary care staff in social care. primary care staffing capacity to meet increasing demands presenting at practices also raised as an issue and nursing capacity pressures in secondary care.

Demand pressures - Pressures across WK system arising from range of sources including: planned care backlog; Covid/Post Covid related demand; new ways of working i.e. VCA/remote consultations, vaccination/booster programme and urgent care demand.

Review of the outcome of the Hewitt Review of Integrated Care Systems	**Director of Strategy, Planning and Partnerships**

The Hewitt review considered the role and power of ICSs. We discussed at Board and made a submission. The attached is the outcome of the review in the form of a provider briefing.

- The report recognises that without investment, workforce and leadership development, recurrent and multi-year funding, reduction of duplicative or unnecessary data requests, and effective planning (centrally and locally), systems will be unable to achieve their potential.
- It makes the case for reducing the number of national targets to give local leaders the 'time and space' to lead with a suggestion of 10.
- It highlights social care and says it should be a strategic priority for government.
- It recommends establishing an initial cohort of 10 "high accountability and responsibility partnerships".
- ICBs are positioned as system overseers, rather than equal partners of Trusts.
- It recommends reviewing the entire NHS capital regime, reducing the use of short-term funding pots, and learn from good practice (including internationally) around payment models.
- NHS England and DHSC should convene a national partnership group to develop a new framework for GP primary care contracts.

The political appetite for such significant change (and necessary investment over the longer term) has yet to be seen: the Department of Health and Social Care (DHSC) has so far only committed to "review in due course."

Which Committees have reviewed the information prior to Trust Board submission?
- Executive Team Meeting, 25/04/23

Reason for submission to the Trust Board (decision, discussion, information, assurance etc.) [1]
Discussion and Information.

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

The Hewitt Review

Introduction

In November, the Rt Hon Patricia Hewitt, chair of NHS Norfolk and Waveney integrated care board (ICB) and deputy chair of the integrated care partnership (ICP), was commissioned by the chancellor, the Rt Hon Jeremy Hunt, to lead a review into the role and powers of integrated care systems (ICSs).

The terms of reference of the review were:

- How to empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending.
- The scope and options for a significantly smaller number of national targets for which ICBs should be both held accountable for and supported to improve by NHS England (NHSE) and other national bodies, alongside local priorities reflecting the particular needs of communities.
- How the role of the Care Quality Commission (CQC) can be enhanced in system oversight.

The review was conducted with significant engagement with leaders from across health and social care and we had a welcome and constructive relationship with the review team on behalf of our members. NHS Providers has contributed throughout the review including: a submission during the formal call for evidence, discussion sessions with workstream leads, several meetings with Patricia Hewitt, and written feedback on various drafts of the report. Members' views were sought throughout and we are grateful to all who contributed their perspectives either through NHS Providers or directly to the review team.

Overview

- The Hewitt Review is an ambitious and extensive review which seeks to maximise the opportunities ICSs bring to improve population health and wellbeing.
- There is welcome recognition throughout of the issues hindering progress and placing unhelpful burdens on system players. The report recognises that without investment, workforce and leadership development, recurrent and multi-year funding, reduction of duplicative or unnecessary data requests, and effective planning (centrally and locally), systems will be unable to achieve their potential.

- The report makes the case for reducing the number of national targets to give local leaders the 'time and space' to lead. Hewitt suggests that there should be no more than ten national priorities, and that local priorities should be treated with equal weight.
- The report suggests high performing ICSs should have fewer national targets – it recommends establishing an initial cohort of 10 "high accountability and responsibility partnerships" (HARPs).
- The report clearly explains the fundamental need to join up heath and social care in numerous ways, and the challenges of doing so. It also emphasises the need to shift the focus to prevention and health improvement, including through more joined up central government, an increase in prevention spending, and a focus on inequalities and discrimination.
- The review recognises the importance of collaboration and co-design as drivers of improvement. It emphasises the need for improvement support to be the focus of most intervention, espousing a 'one team' approach to system development and oversight.
- The report aims to set out clearly the responsibilities and accountabilities of the different players in systems locally, regionally and nationally. We are concerned that it falls short of providing the clarity we believe is necessary to enable more effective collaboration (see NHS Providers View below). We are also concerned that ICBs are positioned as system overseers, rather than equal partners of trusts.
- On finance and capital, Hewitt recommends reviewing the entire NHS capital regime, reducing the use of short-term funding pots, and learn from good practice (including internationally) around payment models.
- The political appetite for such significant change (and necessary investment over the longer term) has yet to be seen: the Department of Health and Social Care (DHSC) has so far only committed to "review [the report's recommendations] in due course."

The Hewitt Review report has four main chapters. This briefing sets out the main findings and recommendations for each, and gives NHS Providers' view.

From focusing on illness to promoting health

This chapter describes the main health challenges facing the nation. It highlights the impact of health inequalities and promotes the importance of addressing the wider determinants of health, including education and housing, to enable people to live longer and healthier lives.

It also discusses about the role of ICSs in delivering a more holistic approach to improving populations' health, and the need for local leaders to be empowered to do this, while ensuring they

remain accountable for performance and spending. Data and digital is framed as a key enabler to driving this shift forward.

Key recommendations

- An increase in the public health grant to local authorities.
- A framework on what constitutes spending on prevention, decided by a working group of local government, public health leaders, Office for Health Improvement and Disparities, NHSE and the Department of Health and Social Care, and a cross section of ICS leaders.
- The government, NHSE and ICS partners, through their ICP, should commit to increasing resources going to prevention. In particular, the share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next five years.
- A "national mission for health improvement" led by the government.
- A health, wellbeing and care assembly should be established to complement the activity of the NHS assembly, reflecting the need to bring in other systems partners.
- Population health, prevention and health inequalities should be part of the training and continuing development for all professions and embedded in the national workforce plan to help develop the skills needed to improve health equity.
- ICSs should be supported to establish an integrated view of population and personal health and wellbeing.

NHS Providers view

We welcome many of the proposals outlined in this chapter. It offers clear messages on the impact of inequality, racism and discrimination, and we welcome the focus on the wider determinants of health.

We agree that health improvement must be a key focus for central government, and welcome the recommendations around cross-departmental working to drive these ambitions forward. This mirrors the local collaboration that ICSs have been established to promote.

We welcome the focus on improved data and use of digital as enablers to addressing health inequalities. While recommendations around building on good practice and improving joined up working are important, we believe the report could go further in highlighting innovative, practical ways ICSs can progress this agenda.

We strongly support the call to increase the public health grant. NHS Providers has, over several years, called for this. Furthermore, we would argue that any increase in the allocation should reflect

and address the current inflationary pressures and years of underfunding that has effectively acted as a cut to the grant over the last decade.

While we welcome the proposed shift towards spending on prevention, we would welcome further clarity on the target to increase funding for prevention by 1%, including the evidence and baseline for this proposed increase. Upfront funding, including through an increase to the public health grant allocation, is key to delivering an increase in funding for prevention without diverting resources from elsewhere in the system.

Delivering on the promise of systems

Here, Hewitt addresses the need for substantial culture and behavioural change from all involved in health and social care if ICSs are to achieve the ambitions set out for them in the Health and Care Act 2022.

This section considers the roles and responsibilities of government departments, NHSE, the CQC, and the partners in ICSs, including the approach to oversight, assessment and performance management across health and social care. Acknowledging the different regulatory, financial and accountability frameworks that various ICS partners sit within, the focus here is on the NHS's framework of regulation and accountability, which NHSE and the CQC are already taking steps to change in light of the Act.

Stressing the need for strong ICS accountabilities, given the public funds at their disposal, Hewitt's starting point is that ICBs must be 'great partners' within both their ICS and within the overarching NHS structure – although it also positions ICBs as the bodies "with and through" which most regulatory activity is carried out.

Key recommendations

- The number of national targets should be significantly reduced, and total no more than 10.
- ICSs should set a limited number of locally co-developed targets which should be treated with equal weight to national targets and local outcomes.
- National Planning Guidance should be developed collaboratively with system leaders, and should focus on a small number of key priorities. This should be reflected in a streamlined Mandate for the NHS. To achieve this collaboration, NHSE and ICBs should agree a common approach to co-production, including working with organisations such as NHS Confederation and NHS Providers.

- Each ICS should define places and place-level leadership, transparently and accessibly for their communities.
- ICSs should be supported to become 'self-improving systems' and ministers, NHSE and ICSs should confirm the principles of subsidiarity, collaboration and flexibility to underpin this.
- Support and intervention in relation to providers should be exercised 'with and through' ICBs by default as per NHSE's Operating Framework. ICBs should lead in working with providers facing difficulties, supporting trusts to agree improvement plans, and calling on support from NHSE regions as required and depending on ICS maturity.
- An appropriate group of ICS leaders (including local government and other partners from outside the NHS) should work with DHSC, Department for Housing, Levelling Up and Communities (DHLUC) and NHSE to create new higher autonomy and responsibility partnerships (HARPs) - more mature ICSs able to take on advanced levels of autonomy and responsibility. Hewitt estimates around 10 systems will be able to work in this way from April 2024.
- 2023/24 should be a transitional year for the CQC as it works with NHSE and ICSs to co-design an effective long-term approach to their reviews of ICSs, and to develop the capabilities and skill sets to support the successful development of ICSs.
- The balance of resourcing between national, regional and system should be further considered in 2023/24, with a larger shift of resource towards systems.
- The required 10% cut in the ICB Running Cost Allowance for 2025-26, which will come on top of a 20% cut in 2024-25, should be reconsidered before the Budget 2024.
- NHSE should work with the Local Government Association (LGA), NHS Confederation and NHS Providers to develop a leadership support offer for systems, and a national peer review offer for systems should be developed, building on the LGA approach.
- NHSE regions should prioritise support for improvement over 'performance management'. Regional teams should support systems in translating national expectations to local circumstances, and ICBs should be involved in the work currently underway to design new regional teams.
- The role of data and its collection should be reviewed by DHSC and NHSE, working with ICS colleagues, to reset baselines, remove duplicative or unnecessary requests. This work should be completed within three months. In addition, data collection should be automated from the Federated Data Platform, replacing both SITREPS and additional data requests.

NHS Providers view

This section sets out to tackle some of the thorny issues our members are raising with us as ICSs evolve, and seeks to resolve issues at the heart of the remit of the Review: clarifying the responsibilities and associated accountabilities of the partners in ICSs (including ICBs), NHSE regional

teams, NHSE centrally and the DHSC. This is no easy task, and there are welcome steps taken here to make real the ethos of partnership and collaboration.

The report strongly recognises the value of subsidiarity and effectiveness of co-design, and the counter-productive impact of numerous and unfocused national targets, ad hoc and duplicative data requests and invasive oversight. We agree with Hewitt's assessment of the burden created by excessive national targets, and support a shift towards more streamlined priority setting from the centre. We will be keen to ensure these fewer targets retain, and in some cases strengthen, a focus on community services and mental health.

Hewitt relies heavily on the existing NHSE Operating Framework and NHS Oversight Framework to describe the relationship between ICBs and providers. The review reinforces the role of ICBs in day to day oversight of providers, with NHSE working 'with and through' ICBs to support improvement and remedy issues. There is welcome recognition that not all ICBs will immediately have the capability to undertake this role and that support for their development from NHSE in these cases will be required.

However, the fundamental tension remains that ICBs are asked to be both system partners and overseers (in some cases performance managers) of trusts. This puts both ICBs and providers in a challenging position; one that may reinforce instead of moving away from a culture of command and control, and undermine the 'one team' approach that is well expressed elsewhere in the review. In this section, Hewitt also recommends that ICBs coordinate collaboratives' priorities and should be involved in appointing trust leaders. Increased autonomy of ICBs should not be achieved at the expense of the proper autonomy of trusts and collaboratives.

We fed back strongly during the review's development that clarity about accountabilities was required. The section on accountability relationships sometimes uses the term unhelpfully – for example without a statutory basis. The section ultimately does not add clarity who is accountable to whom within systems.

The inclusion of provider collaboratives as key drivers of improvements for the population is welcome, but the potential of provider collaboratives feels under-developed, and there is little recognition of the specific challenges for providers which straddle more than one ICS.

There is a logic to the evolution of health overview and scrutiny committees (HOSCs) to system oversight committees, but we are concerned that this (along with the proposed ICP Forum) adds

another layer of scrutiny and potentially bureaucracy in systems when the aim was the opposite. We also query whether the proposed Joint HOSCs might cut across the responsibilities of ICPs.

We would be pleased to work with the NHS Confederation and LGA on leadership support scoping and provision, and on developing co-design principles to improve National Planning Guidance.

Hewitt suggests "HARP" systems should be given greater financial freedoms and a radical reduction in the number of shared national priorities. We agree with these ambitions, which will afford more mature ICSs the bandwidth to drive forward local priorities. We will be interested to see whether and how these recommendations are taken forward by DHSC and NHSE.

We also share Hewitt's concerns about the impact of cutting the ICB running cost allowance in the context of the shift of resources from national to local. Systems will need adequate resourcing to deliver on the core ambitions of system working – especially as more is being asked of them than their predecessor organisations in overseeing trusts, for example.

Resetting our approach to finance to embed change

This chapter discusses the creation of value through the NHS, the need to focus on prevention and upstream funding to cut avoidable spending, and the importance of financial accountability.

It also calls for work to better understand ICS level prevention spending, greater financial alignment between the NHS and local authority partners, and greater flexibility for systems to determine allocations for different services.

Key recommendations

- NHSE, DHSC and HM Treasury should work with ICSs collectively, and with other key partners including the office for local government and the Chartered Institute for Public Finance and Accountancy to develop a consistent method of financial reporting.
- As far as possible, ending use of small in-year funding pots with extensive reporting requirements.
- More flexibility for systems to determine allocations for services and appropriate payment mechanisms within system boundaries, and updated NHS payment scheme to reflect this.
- National guidance should be further developed providing a default position for payment mechanisms for inter-system allocations.

- DHSC, DLUHC and NHSE should align budget and grant allocations for local government (including social care and public health which are currently allocated at different points) and the NHS so systems can more cohesively plan their local priorities over a longer time period.
- Government should accelerate the work to widen the scope of section 75 transfers, to include previously excluded functions (such as the full range of primary care services) and review the regulations with a view to simplifying them.
- Review of legislation with a view to expanding the scope of the organisations that can be part of s.75 arrangements to include social care providers, VSCE providers and wider providers such as housing providers.
- NHSE should work with DHSC, HM Treasury and the most innovative and mature ICBs and ICSs, drawing upon international examples as well as local best practice, to identify most effective payment models to incentivise and enable better outcomes and significantly improve productivity.
- Government to commission a review of the entire NHS capital regime, working with systems, with a view to implementing its recommendations from 2024.

NHS Providers view

We welcome the framing of this chapter, which clearly articulates the value the NHS creates in the wider economy. It also provides an important focus on lifting the financial barriers to prevention spending, and better understanding current spending by systems. These are important components in driving forward a successful prevention-based models. However, it is important to recognise that adding up, and effectively comparing, spending within and between systems, is a very complex task. This is particularly the case as much of this spending will be outside of the NHS, for example via local authority budgets.

We are pleased to see recommendations around the alignment of NHS and local government funding allocations and the removal of non-recurrent funding pots. These proposals will help to reduce burden on members and support a more effective approach to financial planning within system working.

We agree with the recommendation to remove hypothecation where possible, and afford systems greater flexibility to determine local allocations for services. However, the acknowledgement that we are not at the stage where we can remove all hypothecation is an important one and reflects the ongoing development of ICSs. We therefore strongly agree with the recommendation to retain the mental health investment standard, and to build on it to introduce a focus on delivering outcomes for populations within it. We also welcome the recommendation of a review of capital spending, which supports our ongoing campaigning on the importance of capital funding for providers.

Unlocking the potential of primary and social care and their workforce

This chapter focuses on both primary care and social care. It refers to the 2022 Fuller stocktake of primary care, and builds on its vision for integrated working, making recommendations around the contracting and commissioning of primary care services.

The report draws out the vital role of the social care sector. It suggests that in the longer term there must be a conversation about the funding and value of social care. In the meantime, it says social care must be a priority for investment and workforce development, and that ICSs can play a key role in supporting a more sustainable sector.

Key recommendations

- NHS England and DHSC should convene a national partnership group to develop a new framework for GP primary care contracts.
- Publication of a complementary strategy for the social care workforce as soon as possible.
- Investment in workforce development in social care should be longer term, as a minimum based on a three-year rolling planning cycle to support multi-year investment programmes.
- There should be a clear expectation that part of the training and development budgets within each NHS entity (i.e. primary care practices as well as trusts and foundation trusts) and within social care (at least commissioning and, ideally, provision) should be used for shared training and development of staff with other parts of the NHS and social care.

NHS Providers view

The report offers a clear vision for social care, and we support the view that social care should be a strategic priority for government. Many of the proposals support our view that social care plays an essential role in addressing key challenges facing the health and care system.

In particular, we welcome recommendations around a complementary strategy for the social care workforce, and long-term investment in the social care workforce. These proposals reflect our concerns about workforce pressures in social care, and our view that, where possible, joined up training and recruitment of NHS and social care staff is beneficial.

The recommendation that NHSE co-develops a framework for GP contracting, and that the national partnership group should discuss how primary care can be better supported and incentivised to work at scale, is also welcome. This is particularly important given the increased emphasis on this kind of working, including through vertical integration of primary and secondary care.

The Hewitt Review

An independent review of integrated care systems

Rt Hon Patricia Hewitt

Published 4 April 2023

Contents

Foreword

It has been a privilege to carry out this review. Although the invitation to do so came as a complete surprise, it was an opportunity I could not turn down. As chair of the Norfolk and Waveney NHS integrated care board and deputy chair of its integrated care partnership, and previously one of the first independent chairs of a sustainability and transformation partnership, I have no doubt that the decision to put integrated care systems onto a statutory footing was the right one, widely supported across the political spectrum.

I stepped down as Secretary of State for Health over fifteen years ago. The biggest contribution I helped make to the health of the nation was the smoke-free legislation: an important reminder in the context of this review that we should never mistake NHS policy for health policy. And one of the most creative was the nation-wide public engagement through 'Our health, our care, our say' that confirmed public support for a health and care system that would enable them to be as healthy and independent as possible.[1]

ICSs have been born in difficult times. The answer is not simply more money, although of course that is needed, particularly in social care. Unless we transform our model of health and care, as a nation we will not achieve the health and wellbeing we want for all our communities - or have the right care and treatment available when it is needed.

ICSs bring together all the main partners - local government, the voluntary, community, faith and social enterprise sector, social care providers and the NHS - in a common purpose expressed in 4 main aims: to improve outcomes in population health and healthcare; to tackle inequalities in outcomes, experience and access; to enhance productivity and value for money; and to help the NHS support broader social and economic development.

This report shows how they are already making a difference and explains what needs to happen next to accelerate that progress.

As Secretary of State myself, I was a ‘window-breaker’ rather than a ‘glazier’.[2] Like today’s ministers, I was impatient for change - and rightly so. But my preferred style as a leader remains collaborative: bringing people together to understand each other’s perspective, learning from and challenging each other, and working through disagreements or conflict as honestly and openly as possible to agree the best way forward. That is how I have carried out this review, and as a result I believe that most of my recommendations will command widespread support. But there is a wide range of passionately held views and it would be surprising if there was unanimity on all points. Indeed, an independent review with which everybody agreed would be pointless.

Given the scope of my terms of reference, and the tight timescale, it is hardly surprising that the review has been an intense and sometimes challenging process. I am hugely grateful to the many hundreds of people who have been involved through engagement events, town hall meetings and the 5 review work streams as well as in preparing over 400 submissions in response to the call for evidence. I have also drawn upon the many preceding important reviews and papers, including the work of the King’s Fund, Professor

[1] Our health, our care, our say: a new direction for community services.
[2] Nicholas Timmins, Glaziers and Window Breakers: Former Health Secretaries in their own words, Health Foundation, May 2015

Sir Chris Ham, the Fuller Stocktake and the Messenger Review to name but a few. It has been a privilege to work with so many inspiring colleagues: every conversation has taught me something more. To all of you who have contributed to these rich discussions, thank you.

The time comes, however, when the drafting has to stop. I am painfully aware that it has not been possible to do justice to every insight and recommendation, or work through every issue raised in our discussions. Nonetheless, I hope everyone will feel that their efforts have been worthwhile, and that this report provides all of us committed to the success of ICSs with a platform for the next stage.

Many of my recommendations are designed to shape how we work together in the coming months and years, not only strengthening collaboration at local level but ensuring the breadth of partnership within ICSs is mirrored nationally. Real partnership starts with real work and I have made a number of recommendations for how the way we are learning and creating together within systems, should be embraced and embedded nationally: for instance, with DHSC, DHULC, NHS England, HM Treasury, ICSs and others working in concert on important areas of change including much-needed reform to the financial framework.

This review could never have happened without many people's exceptionally hard work. I am grateful to the Secretary of State for commissioning this review and his ministers, advisers and departmental officials for their support throughout. I am equally grateful for the active engagement of Amanda Pritchard and many senior colleagues at NHS England. Without them all, the review would not have been possible.

I am particularly grateful to the co-chairs of the 5 work streams: Sam Allen, Rt Hon Paul Burstow, Felicity Cox, Dr Penny Dash, Adam Doyle, Sir Richard Leese, Dr Kathy McLean, Patricia Miller, Cllr Tim Oliver and Joe Rafferty.

I want to thank Matthew Taylor, Annie Bliss, Ed Jones and others at the NHS Confederation whose ICS, primary care, mental health and other networks were invaluable and who provided additional policy and engagement support throughout. My thanks go equally to the Care Providers Alliance, the County Councils Network, the Health and Wellbeing Alliance of VCFSE sector representatives, Healthwatch, the Local Government Association, National Voices, NHS Providers, the Patients Association, the Social Partnership Forum, and the many others who have contributed and facilitated this work. I was also exceptionally fortunate in my DHSC Secretariat: Jason Yiannikkou, Jonathan Walden, Georgina Connah, Laura Bates, Alexandra Kirsima, Haleema Nazir and Thomas Savage, all of whom deserve immense praise.

As the review concludes, and despite the very real challenges that lie ahead, I am even more optimistic about what we can achieve together than I was when this process started. I look forward to working with you all on the next stage of our exciting journey together.

Rt Hon Patricia Hewitt

April 2023

Terms of reference

The review's terms of reference were published on 6 December 2022 and are set out below.

Objectives and scope

The review will consider how the oversight and governance of integrated care systems (ICSs) can best enable them to succeed, balancing greater autonomy and robust accountability with a particular focus on real time data shared digitally with the Department of Health and Social Care, and on the availability and use of data across the health and care system for transparency and improvement. It will cover ICSs in England and the NHS targets and priorities for which integrated care boards (ICBs) are accountable, including those set out in the government's mandate to NHS England.

In particular it will consider and make recommendations on:

- how to empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending
- the scope and options for a significantly smaller number of national targets for which NHS ICBs should be both held accountable for and supported to improve by NHS England and other national bodies, alongside local priorities reflecting the particular needs of communities
- how the role of the Care Quality Commission (CQC) can be enhanced in system oversight

Engagement

The review will draw upon the expertise of ICSs, local government, the NHS, the voluntary sector, patient and service user representatives and other subject experts including in academia, government departments and relevant thinktanks.

Governance and timing

The review will be led by Rt Hon Patricia Hewitt and will be independent of government.

Secretariat support will be provided by the Department of Health and Social Care.

The review will report to the Secretary of State for Health and Social Care, with interim findings by 16 December 2022, a first draft by 31 January 2023 and a final report by no later than 15 March 2023.

Executive summary

Integrated care systems (ICSs) represent the best opportunity in a generation for a transformation in our health and care system. Effective change will require the combination of new structures with changed cultures. Everyone needs to change, and everyone needs to play their part.

The review has identified 6 key principles, that will enable us to create the context in which ICSs can thrive and deliver. These are: collaboration within and between systems and national bodies; a limited number of shared priorities; allowing local leaders the space and time to lead; the right support, balancing freedom with accountability and enabling access to timely, transparent and high-quality data.

From focusing on illness to promoting health

Delivering these principles will require genuine change in how the health and care system operates. While there will always be immediate pressures on our health care system, shifting the focus upstream is essential for improving population health and reducing pressure on our health and care system.

This will require a shift in resources - the share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years. It will also require cross-governmental collaboration to embed a national mission for health improvement and the establishment of a new Health, Wellbeing and Care Assembly.

Our use of data must also support this mission, with improved data interoperability and more effective use of high-quality data. Alongside this we need to empower the public through greater use of the NHS App and further long-term commitment for the development of citizen health accounts.

Delivering on the promise of systems

ICSs hold enormous promise, bringing together all those involved in health, wellbeing and care to tackle both immediate and long-term challenges. To do this effectively, national and regional organisations should support ICSs in becoming ‘self improving systems’, given the time and space to lead - with national government and NHS England significantly reducing the number of national targets, with certainly no more than 10 national priorities.

We should encourage and deliver subsidiarity at place, system, regional and national levels. We are currently one of the most centralised health systems in the world, and ICSs give us an opportunity to rebalance this.

The most effective ICSs should also be encouraged to go further, working with NHS England to develop a new model with a far greater degree of autonomy, combined with robust and effective accountability.

For every ICS, increased transparency is vital to enabling local autonomy. The availability of timely, transparent and high-quality data must be a priority, and NHS England and the Department of Health and Social Care (DHSC) should incentivise the flow and quality of data between providers and systems. The Federated Data Platform can provide the basis for a radical change in oversight, to replace situation reports (SITREPS), unnecessary and duplicative data requests.

Both the Care Quality Commission (CQC) and NHS England will continue to have a vital role to play in oversight and accountability, but they should ensure that their improvement approaches are as complementary as possible, and complementary to peer review arrangements between systems.

Finally, it will be vital to ensure the right skills and capabilities are available to ICSs as both systems and national organisations manage through a period of challenge for the nation's finances. There needs to be consideration given to the balance between national, regional and system resource with a larger shift of resource towards systems.

Unlocking the potential of primary and social care and their workforce

In order to make the promise of ICSs a reality, we also need to pull down some of the barriers that currently exist for primary care, social care and the way we train health and care workforce.

Given the interdependence of health and social care, the government should produce a complementary strategy for the social care workforce. More should also be done to enable flexibility for health and care staff, both in moving between roles and in the delegation of some healthcare tasks.

National contracts present a significant barrier to local leaders wanting to work in innovative and transformational ways. I have recommended that work should be undertaken to design a new framework for General Practice (GP) primary care contracts, as well as a review into other primary care contracts.

Work also needs to be done to ensure that there is the flexibility to competitively recruit and train more specialists in fields such as data science, risk management, actuarial modelling, system engineering, general and specialised analytical and intelligence.

Resetting our approach to finance to embed change

We are currently not creating the best health value that we could from the current investment in the NHS. Instead of viewing health and care as a cost, we need to align all partners, locally and nationally, around the creation of health value.

NHS funding remains over-focused on treatment of illness or injury rather than prevention of them and ICS partners struggle to work around over-complex, uncoordinated funding systems and rules in order to shift resource to where it is most needed.

Instead, it is important to identify the most effective payment models, nationally and internationally, with an aim to implement a new model with population-based budgets, which will incentivise and enable better outcomes and significantly improve productivity. There should also be a review into the NHS capital regime to address the inflexibility in use of capital and the layering of different capital allocations and approvals processes.

NHS England should also ensure that systems are able to draw upon a full range of improvement resources to support them to understand their productivity, finance and quality challenges and opportunities.

1. Introduction

1.1 Across the developed world, healthcare systems are facing the challenge of increasing pressures, public expectations and opportunities (including those opened up by new digital and data technologies). As other healthcare systems are finding, no matter how much money is invested in treating illness, unless we transform how we deliver health and care, we will not achieve the health and wellbeing we want for all our communities - or have the right care and treatment available when we need it.

1.2 In England, integrated care systems (ICSs) represent the best opportunity in a generation for that urgently needed transformation of our health and social care system. They provide the opportunity to break out of organisational siloes, enabling all partners to work together to tackle deeply rooted challenges, drawing together their collective skills, resources and capabilities around their 4 core purposes, to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- support broader social and economic development

1.3 If we allow the development of ICSs to become “just another NHS reorganisation”, we will let down patients, the public and everyone working in the health and care system.

Integrated care systems (ICSs) are partnerships that bring together local government, the NHS, social care providers, voluntary, community, faith and social enterprise (VCSFE) organisations and other partners to improve the lives of people who live and work in their area, in line with their 4 core purposes. Each ICS includes a statutory integrated care partnership (ICP) and integrated care board (ICB).

The ICP is a statutory committee jointly formed between the ICB and the relevant local authorities within the ICS area. The ICP brings together the broad alliance of partners and is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.

The ICB is the statutory NHS organisation responsible for bringing NHS and other partners together to plan and deliver integrated health and care services and accountable for the finances and performance of the local NHS as a whole.

Why we need a new approach

1.4 There are 3 main reasons why we need a new approach for the health and care system. First and foremost are the immediate pressures upon the NHS and social care, already visible before the pandemic, but greatly exacerbated as a result of it. The public's immediate priorities for the NHS - access to primary care, urgent and emergency care, cancer, other 'elective' care, and mental health services - are just as important to ICSs as they are to ministers and NHS England.

1.5 Second, there is a growing number of people living with complex, long-term physical and mental health conditions, often associated with serious disabilities or ageing.

1.6 Third, as a nation, we are becoming less, rather than more healthy, both physically and mentally. More people spend longer in ill-health and die too young, particularly the least economically advantaged and those most affected by racism, discrimination and prejudice.

> "Against the backdrop of those health challenges, we cannot just keep doing more of the same. The traditional way of operating a health system, where you have your hospitals and your primary care and you have your social care separate, and you have those things relatively siloed, is not a system that works in a world where people are living a long time with multiple health conditions. We know that the determinants of health are much broader than just what happens in a hospital. They include housing, wider care and education. Joining up is an imperative, both for improving health outcomes and for having a sustainable, affordable health system to get what we want."
>
> Helen Whately, MP, Minister of State for Social Care

1.7 ICSs are designed to tackle all 3 problems. As the examples throughout this report illustrate, many are already succeeding in doing so.

1.8 They are already starting to tackle immediate and often intractable problems - including ambulance queues and delayed discharges - which cannot be solved by any one organisation alone or by continuing to work in the same old ways. These problems require close partnerships between many parts of the health and care system - primary care, community health, mental health, acute hospital trusts, local government and social care providers - working together in different ways.

> Dorset ICS has halved the number of A&E and emergency admissions among elderly people through its Ageing Well programme, improving anticipatory, preventative care by integrating community, primary and social care teams at neighbourhood level. ICB investment enabled the anticipatory care programme to undertake upstream interventions for patients with long term conditions. Interventions were developed for specific risk groups

by a multi-agency partnership. The ICS is now using data to predict who might be a frail patient at risk of falling, and intervene to help prevent falls and promote self-care. A digital programme supports an out of hours clinical team to respond to care homes and prevent admissions. The ICS is also expanding the use of virtual wards and is piloting the use of Age Care Technologies which support independence in the home. This is saving approximately £33,000 per person per year in care costs.

1.9 Despite many impressive examples of innovative working, the NHS in general is not yet currently configured to optimise the management of complex, long-term conditions. The result is a system that is fragmented rather than integrated, making it frustrating, inefficient and often challenging for patients and families as well as staff. ICSs, by integrating health and social care services, and working more closely with VCFSE providers, should aim to ensure that services are joined up, pressures are actively managed, and the interests of patients and the public are prioritized.

1.10 It has also long been recognised that the NHS is, in practice, more of a National Illness Service than a National Health Service. Despite important and continuing efforts by NHS England, the reality is that we are a very long way from devoting anything like the same amount of time, energy and money to the causes of poor health as to its treatment. That cannot be done by the NHS alone and ICSs - established as equal partnerships between local government, the NHS, the voluntary, community, faith and social enterprise sector, social care providers and others - are the right vehicle to build on and reinforce existing work.

1.11 Faced with these challenges, but also with many inspiring examples of success, it is not surprising that throughout this review I heard such strong commitment from leaders in ICBs and ICPs, local authorities, providers and national bodies, to the core purposes of ICSs. As so many ICS leaders - both non-executive and executive - said: “This is why I applied for this job.”

1.12 At the same time, however, I heard real concern that the transformational work of ICSs and specifically the opportunity to focus on prevention, population health and health inequalities might be treated as a ‘nice to have’ that must wait until the immediate pressures upon the NHS had been addressed and NHS performance recovers. That is what has always happened before, and must not happen this time.

1.13 Prevention, population health management and tackling health inequalities are not a distraction from the immediate priorities: indeed, they are the key to sustainable solutions to those immediate performance challenges.

1.14 For too long, we have talked about the challenge of moving resources upstream to enable people to live independently for as long as possible, build more resilient communities and reduce health inequalities. This is how we can sustainably tackle

the causes and not just the symptoms of an over-burdened NHS, moving away from the constant cycle of 'winter crisis' management. Furthermore, the partnership working that is at the heart of ICSs is, itself, an essential means to tackle those symptoms of 'winter crisis', including delayed ambulance arrivals, handovers and delayed discharges. These and many other challenges do not just affect one organisation; they can only be effectively tackled by many organisations working together, integrating care across the entire pathway and making the best use of available resources to achieve better, safer outcomes.

Why it can be different this time

1.15 Many of us have talked over many decades about the need to focus on prevention, population health and health inequalities. We have called for a shift from a top-down, centralised system of managing the NHS to a bottom-up system responsive and responsible to local communities and engaging the enthusiasm, knowledge and creativity of staff along with patients, carers and volunteers. The creation of primary care trusts (PCTs) and then clinical commissioning groups (CCGs) were attempts to do exactly that, but each was reorganised and swept away in their turn.

1.16 There are many reasons, however, for believing it can be different this time. There is a welcome, and almost unprecedented, degree of cross-party support for ICSs, both nationally and locally. Although we often hear the plea to "take the NHS out of politics", that is neither possible nor desirable: in any democracy, different political parties will have different views on priorities for public spending as well as how best to fund public services. However, the extent of policy alignment now provides the basis for changes that will last well beyond one parliament, government or minister, giving ICSs the time and space to embed the new model.

"Local leaders are best placed to make decisions about their local populations… with fewer top-down national targets, missives and directives and greater transparency to help us hold the system to account."

Rt Hon Steve Barclay, Secretary of State for Health and Social Care

"There is no alternative to health and social care integration. Stakeholders and leaders across health, social care and wider public services know that pressing forward with broad-based integrated care systems and local partnerships in 2023 is the only long-term solution to creating a financially sustainable and successful NHS and social care system; improving the population's health and reducing health inequalities."

Annual report of the Health Devolution Commission, an independent cross-party and cross-sector body.[3]

1.17 By establishing ICSs in statute as broad local partnerships we now have the right structures for change. But there is also a growing understanding that while structures matter, culture, leadership and behaviours matter far more. The failure to recognise that in the past is one of the main reasons why previous attempts have not worked.

"Collaborative behaviours, which are the bedrock of effective system outcomes, are not always encouraged or rewarded in a system which still relies heavily on siloed personal and organisational accountability...the current cultural environment tends to be unfriendly to the collaborative leadership needed to deliver health and social care in a changing and diverse environment...a re-balancing towards collaborative, cross-boundary accountability is a pre-requisite to better outcomes."[4]

Messenger Review

1.18 NHS England has itself recognised the need for change and embarked on an important and welcome transformation in its size, focus and ways of working. The insightful review of NHS leadership by General Sir Gordon Messenger and Dame Linda Pollard, and the follow-up work, will help to accelerate that change. The Messenger Review stressed that although 'command and control' is occasionally essential, the most successful organisations need collaborative leadership, good management at every level and clear accountability for defined outcomes. In a similar spirit, when establishing this review, the Secretary of State for Health and Social Care himself stressed the need to reduce 'top-down national targets, missives and directives'.

"This requires a cultural and behavioural shift towards partnership-based working; creating NHS policy, strategy, priorities and delivery solutions with national partners and with system stakeholders; and giving system leaders the agency and autonomy to identify the best way to deliver agreed priorities in their local context."

NHS England, new operating framework, October 2022

1.19 The Health and Care Act (2022) has decisively changed the framework of policy and structures. Previous government policies over several decades have encouraged strong sovereign organisations, using competition to drive quality and

[3] Annual Report 'ICSs: a great deal done - a great deal more to do'
[4] Independent report by Sir Gordon Messenger and Dame Linda Pollard "Health and social care review: leadership for a collaborative and inclusive future"

outcomes - most keenly seen in the establishment of foundation trusts. There is no doubt that this has brought benefits: new models of care, greater clinical innovation and the creation of strong boards.

1.20 In many cases, incentives have encouraged leaders to think about their organisation's interests without regard for the wider system. The new, partnership-based structures for statutory ICSs, including the statutory duty to co-operate, recognises that problem and reinforces the need to place the interests of patients and the public first. The 2022 Act also includes significant changes in the procurement framework for healthcare services, giving commissioners more flexibility when selecting providers but retaining the freedom to use competitive processes in the best interests of patients and the public.

1.21 Finally, millions of people are becoming increasingly active in managing and improving their own health and wellbeing, often using ever more sophisticated digital monitoring tools and apps to assist them. This can provide the basis for a very different conversation with the public - including those who are disadvantaged or discriminated against - about what we need to do for ourselves and within our families and communities, and what health and care services can be expected to do for us.

How this review can help

1.22 The creation of ICSs, and the new approach they represent, is the right reform at the right time. But more is needed to enable them to succeed.

1.23 We have created ICSs but not yet the context in which they can thrive and deliver. We have a clear choice - either do what we have done before and create something only to almost immediately undermine its purpose, or back ICSs as part of a commitment to a different model of health policy and delivery.

1.24 This review has given all of us working within and with ICSs the opportunity to consider what needs to be done locally and nationally to create the conditions in which ICSs can succeed.

1.25 Critically, all of us need to change. Local partners within every ICS need to put collaboration and cooperation at the heart of their organisations. NHS England, DHSC and CQC need to support and reflect this new model in the crucial work they do; and central government needs to change, mirroring integration within local systems with much closer collaboration between central government departments and other national bodies.

1.26 In the first stage of this review, we agreed that specific recommendations needed to be based upon clear principles that would command widespread support and form a touchstone for all of us to use in considering how we behave within

systems, within national organisations and in the relationships between them. Six principles emerged clearly from our discussions:

- Collaboration: within each system as well as between systems and national bodies. Rather than thinking about national organisations, regions, systems, places and neighbourhoods as a hierarchy, we should view each other as real partners with complementary and interdependent roles and work accordingly. Subsidiarity within each ICS is therefore vital, recognising that particularly in larger systems, much of the work will be driven by Place Partnerships, building on the work of each Health and Wellbeing Board (HWB) within the wider system, as well as by Provider Collaboratives. Different local partners - notably local government itself, as well as the VCFSE sector - have different accountability and funding arrangements. Only ICSs can create mutual accountability between all partners around jointly agreed outcomes and targets for both the long-term health of the population and for immediate issues such as discharge and tackling the backlog. On the other hand, it is also essential to recognise that, while the role of national organisations should change, some things can only be done effectively and efficiently by them. NHS England's new operating framework and its emphasis on aligned support and collaboration managed by or with the ICS rather than direct to provider organisations is therefore extremely helpful.

- A limited number of shared priorities: the public's immediate priorities - access to primary care, urgent and emergency care, community, mental health and social care services and elective diagnostics and treatment - are priorities for all of us including ministers, NHS England and ICBs. The level of interest in these matters rightly makes them a central part of accountability for all ICBs and their partners in the wider ICS. Evidence-based guidance and best practice examples are, of course, invaluable to local leaders; but it is essential that those local leaders have flexibility about how they apply those lessons to their particular local circumstances.

- Give local leaders space and time to lead: effective change in any system - particularly one as complex as health and care - needs consistent policy, finances, support and regulation over several years. Adding new targets and initiatives, providing small funding pots (often with complex rules and reporting requirements), or non-recurrent funding makes it impossible to plan or even recruit, wastes money and time, and weakens impact and accountability. Multi-year funding horizons, with proportionate reporting requirements, are essential, as is recognising that statutory ICSs are less than a year old.

- Systems need the right support: ICSs require bespoke support geared to the whole system and the partners within it, rather than simply to individual providers or sectors. But there is considerable variety between systems, in maturity as well as size, geography, demographics, NHS configuration and

local government structures, relationships between partners and so on. Support and intervention from NHS England to ICSs, through ICBs, needs to be proportionate: less for mature systems delivering improving results within budget; more for systems facing greater challenges or with weaker relationships and leadership.

- Balancing freedom with accountability: with greater freedom comes robust accountability, including for financial spending and ensuring value for money. That accountability includes the local accountability that is hard-wired into ICSs - through Health Overview and Scrutiny Committees (HOSCs), local government, ICPs, Healthwatch, foundation trust governors and many other forms of patient and public involvement. Peer review, widely used in local government, should also have a much greater role for ICSs as a whole. Within the 2022 Act, accountability for NHS performance and finances within each ICS also involves the accountability of ICBs to NHS England. But the Act also includes a new role for CQC as the independent reviewer of ICSs as a system, as well as their existing functions in relation to social care, NHS and other healthcare providers. CQC is transforming its own working methods to meet these new responsibilities. This will need to be done hand in hand with NHS England's role in overseeing systems. It will also be essential to consider the vital, but different, role of supporting ICSs, ICBs and providers with great challenges to improve, particularly where there are major failings in care.

- Enabling timely, relevant, high-quality and transparent data: we recognize that timely, relevant, high-quality and transparent data is essential for integration, improvement, innovation and accountability. As high performing ICSs are already showing, high quality, integrated data collection and interoperable digital systems can initiate real change. NHS England, working in collaboration with DHSC and local government (including through the Department for Levelling Up, Housing and Communities (DLUHC), the Local Government Association (LGA) and other local government representative bodies or stakeholders) has a key role to play. By defining standards on data taxonomy and interoperability, and coordinating data requests to the system, they can create the conditions for wider transformation.

1.27 In the rest of this report, I set out how these principles can be translated into action.

2. From focusing on illness to promoting health

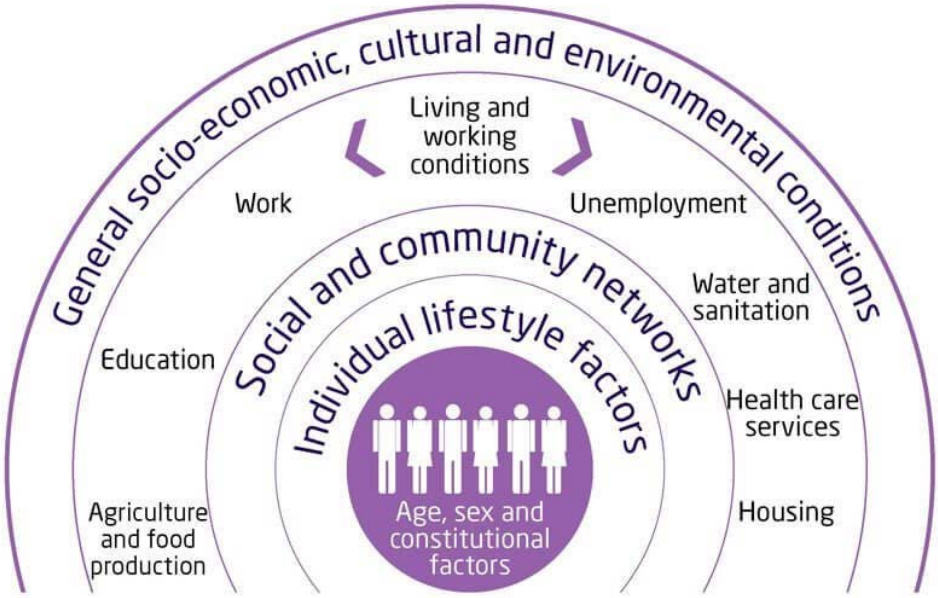
2.1 The review was specifically asked to look at how to empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending, supported by high quality and transparent data.

2.2 The ultimate objective of health policy is that more people live longer, healthier and happier lives. But too many of our nation's population do not live as long or as healthily as they could, with improvements in life expectancy stalled or even declining amongst some groups, and unhealthy life expectancy increasing, particularly amongst disadvantaged communities. The COVID-19 pandemic starkly highlighted the human cost of health inequalities, with the mortality rates from COVID-19 in the most deprived areas being more than double those in the least deprived areas and death rates being highest among people of Black and Asian ethnic groups.[5]

2.3 In England today, there is a 19-year gap in healthy life expectancy between people in the most and least deprived areas of the country.[6] Those health inequalities, so damaging to the lives of individuals and their families, also impact on our society as a whole.

2.4 Both the Marmot review and the Dame Carol Black review highlighted the huge economic costs of failing to act on the wider determinants of health (see below for an illustration of the wider determinants of health).[7] Even before COVID-19, health inequalities were estimated to cost the NHS an extra £4.8 billion a year, society around £31 billion in lost productivity, and between £20 to 32 billion a year in lost tax revenue and benefit payments.[8]

[5] Public Health England. COVID-19: review of disparities in risks and outcomes. 2 June 2020
[6] Tabor, D. (2021) Health State Life Expectancies, UK: 2017 to 2019, Health state life expectancies, UK - Office for National Statistics. Office for National Statistics.
[7] Dahlgren, G. and Whitehead, M. (1993) Tackling inequalities in health: what can we learn from what has been tried?
[8] Public Health England. (March 2021) 'Inclusion and sustainable economies: leaving no one behind.'



2.5 For too long, however, we have mistaken NHS policy for healthcare policy. In reality, the care and treatment provided by the NHS, vital and often life-saving though it is, only accounts for a relatively small part of each individual's health and wellbeing. Significantly more important are the wider determinants of health. In many parts of the country, partnerships led by local government, the VCFSE sector and residents themselves have been working over many years to create healthier, more resilient communities, often with strong engagement from NHS primary care. The response to the pandemic brought communities, statutory and voluntary partners together to support people in many inspiring ways.

2.6 The creation of integrated care systems (ICSs), with their 4 purposes and a strong statutory framework for partnership working, provides a real opportunity to build upon this approach and suggests a welcome recognition of the need for a more holistic approach to improving the nation's health.

2.7 Indeed, ICS leaders are enthusiastic about maximising the contribution of the NHS to wider economic, social and environmental objectives. From economic regeneration to life sciences, from net zero to local labour markets, the NHS has a crucial role to play in creating thriving places.

2.8 Designing and creating services together with local residents and communities leads to more actively engaged citizens, able to lead and support change within their own lives, with a corresponding reduction in reliance on public services.

2.9 The Wigan Deal - an informal agreement between the council and everyone who lives or works there to work together to create a better borough - is an excellent example of this. In Wigan, the council invested £13 million in a Community

Investment Fund which funded bottom-up prevention ideas from local communities that supported physical activity, addressed social isolation and loneliness and promoted positive mental health. As a result of this sustained approach healthy life expectancy in Wigan bucked the trend and an additional 7 years was added in the most deprived wards.[9]

2.10 Similarly, through PCNs and Integrated Neighbourhood Teams, primary care can play an important leadership role in working with local communities to tackle health inequalities. In Tameside, Greater Manchester, Healthy Hyde PCN employs 34 people across many different disciplines, all working to tackle health inequalities. It has 6 health and wellbeing coaches working in foodbanks, schools, allotments, and providing ESOL lessons to asylum seekers and refugees. The team has clinical leadership, managerial and administrative support, and works together to identify people via clinical systems, local knowledge and working with multiple agencies.

2.11 However, empowering local leaders to work with and through their partners and local communities to improve outcomes for their populations can only happen at scale if the broader environment in which they operate is aligned to enable them to do so - something that is heavily dependent on policies pursued across government.

2.12 Particularly in view of the fourth core purpose of ICSs, to help the NHS support broader social and economic development, all parts of Whitehall should feel they have a stake in the work of Partnerships and Places and should equally strive to replicate the same sense of partnership being forged across the country in ICSs.

Enabling a shift to upstream investment in preventative services and interventions

2.13 There will never be a perfect time to shift the dial toward focusing more on preventative services and interventions. It is easy to argue - especially in the current climate of financial constraints and performance issues - that addressing these issues should be something we consider when the current pressures have died down. But that has always been the case.

2.14 The truth is, unless we make the change, the continual focus on improving flow through acute hospitals will simply channel more and more of an older and increasingly unhealthy population into acute hospitals, which will never be large or efficient enough to cope.

[9] Source: Professor Donna Hall, CBE Chair New Local, Former CEO Wigan Council; and Wigan CCG, ICS Transformation Advisor NHS England, January 2023

2.15 Despite the current pressures, I have also seen through the course of this review a greater appetite to grasp the challenge of shifting our focus to prevention, proactive population health management and tackling health inequalities than at any other time I can remember. It acts as the glue that binds all partners in ICSs. There are many things we can do now - both nationally and at system level - to create the collective conditions for us to capitalise on this.

2.16 In order to achieve a decisive shift ‘upstream’, towards prevention, proactive population health management and tackling health inequalities, we need to establish a baseline of current investment in prevention, broadly defined, within each ICS from which progress can be measured. This baseline would include the £200 million allocated nationally towards tackling health inequalities. This must also be done in a way that enables ICSs to be benchmarked against each other, helping to spread best practice and strengthen both local and national accountability.

2.17 We also need a clear and agreed framework for what we mean by ‘prevention’, broadly defined. We all recognise that ‘prevention’ involves a range of activity including primary, secondary and tertiary prevention, much of it carried out by local government and VCFSE partners as well as within the NHS itself. Furthermore, much ‘prevention’ work is embedded within other services that are also directly concerned with treatment. DHSC should establish a working group of local government, public health leaders, DHSC (including OHID), NHS England, as well as leaders from a range of ICSs, to agree a straightforward and easily understood framework. As part of this work, the group should consider the guidance to local government on the use of the public health grant.

2.18 Once this agreed framework is developed, ICSs should establish and publish their baseline investment in prevention. This should be delivered through the ICP and include both NHS and local government spending on prevention. Especially within larger ICSs, it will also be important to establish the baseline at place level; indeed the ICS view might be built up from place level. Different ICSs will approach baselining in different ways; what matters is that it is done in all systems using a consistent framework.

2.19 By autumn 2023, we should expect the framework to be completed, with all ICSs reporting their prevention investment on a consistent basis by 1 April 2024. Both the initial framework, and the baseline measures, should be reported to and considered by the proposed cross-government arrangements on health improvement I outline below.

2.20 Finally, the government, NHS England and ICS partners, through their ICP, should commit to the aim of increasing resources going to prevention. In particular, I recommend the share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years. Given the constraints on

the nation's finances, this is my most challenging recommendation; some ICSs will find it more difficult than others, depending on their current financial position as well as the strength of collaboration and common purpose between partners. But an ambition of this kind is essential if we are to avoid simply another round of rhetorical commitment to prevention.

2.21 As public finances allow, the public health grant to local authorities needs to be increased. The most recent government spending review represents the latest in 8 years of real-term squeeze on local authority funding for public health and other essential services. Investment in prevention and early help is essential if we are going to extend healthy life expectancy, reducing the financial burden to health and social care and strengthening local economies.

2.22 In addition, within the NHS itself, every opportunity should also be taken to refocus clinical pathways towards prevention. At the moment, pathways for different conditions often begin with diagnosis and focus on treatment. Instead we must shift the focus and resources towards preventing the condition occurring, diagnosing early and preventing avoidable exacerbation. I welcome the announcement of a major conditions strategy which seeks to address this issue. I also support the recommendation of the recent Health and Social Care Select Committee (HSCC) inquiry into the autonomy and accountability of ICSs that '… the major conditions strategy [should] put prevention and long-term transformation at its heart'. The prevention work done in secondary and tertiary care settings, rightly highlighted by NHS England as receiving increased priority and investment in recent years, must be seen within the wider work of an ICS on prevention. An example of this in action is the work being done under the Core20PLUS5 framework focusing on COPD, which has led to a reduction in unplanned respiratory admissions.[10] Refocusing clinical pathways on prevention will be supported by my points set out below on primary care, which has a particularly important role in embedding prevention.

2.23 ICS leaders should also challenge themselves - and expect to be challenged - to work together to use existing resources as effectively as possible. The Joint Forward Plans (JFPs) that ICBs have been asked to prepare by 30 June 2023, reflecting the system-wide priorities established through the ICP's integrated care strategy, provide an opportunity for ICSs to set out their ambitions to shift the model of care towards prevention. The process for developing JFPs has been underpinned by a much more permissive and collaborative approach from NHS England, compared with previous CCG planning exercises. The collaborative work on the 2024 to 2025 planning guidance provides another opportunity to agree how a further shift on prevention should be achieved, year on year.

[10] Core20PLUS5 (adults) - an approach to reducing healthcare inequalities

Embedding health promotion at every stage

2.24 There is currently no cross-government, national equivalent of the wide partnership involved in an ICS. To enable successful integration in systems, parallel integration across Whitehall is needed. I recommend that the government leads and convenes a national mission for health improvement designed to change the national conversation about health, shifting the focus from simply treating illness to promoting health and wellbeing and supporting the public to be active partners in their own health. To underline its importance, this could be led personally by the prime minister.

2.25 This new mission should be supported by appropriate cross-government arrangements, possibly including a revived Cabinet Committee that includes a senior minister from all relevant departments, as well as DHSC's Office for Health Improvement and Disparities, NHS England and the new Office for Local Government. An early priority should be the creation of a National Health Improvement Strategy, identifying priority areas and actions. I also support the HSCC's recommendation that DHSC should publish, as soon as possible, the proposed shared outcomes framework. This work should develop a small set of clear, high-level national goals for population health, with appropriate timescales and milestones for action. I would expect the government to consider how this framework could be used to consolidate current existing, fragmented outcomes frameworks to enable an aligned set of priorities across health and care.

2.26 These priorities should then be taken into account when setting the mandate for the NHS as well as developing NHS planning guidance and other material for systems.

2.27 It is not for this review to prescribe what this framework would look like, such a framework needs to be developed in collaboration with ICB and ICP leaders, as well as leaders from across the NHS, local government, social care providers and the VCFSE sector. It is vital that there is also full engagement and involvement with the public, patients, service users and carers (including unpaid carers), building upon the important work of Healthwatch, the Patients Association and many other patient and user advocacy groups. We should also learn from international examples, including the Australian Health Performance Framework which reports on the health of Australians, the performance of healthcare and the Australian health system, including health behaviours, socioeconomic factors and wellbeing as well as the safety, accessibility and quality of services. It provides an impressive, interactive online tool that allows the public to obtain information at national, state and local level, disaggregated by demographic and other factors.[11]

[11] The Australian Health Performance Framework (AHPF) is a tool for reporting on the health of Australians, the performance of health care in Australia and the Australian health system

2.28 The NHS Assembly, established by NHS England in 2019, brings together a wide range of partners from within and beyond the NHS, providing an invaluable private forum for advice and challenge to NHS England itself. This should continue and will be complemented by the new arrangements proposed below.

2.29 However, in view of the establishment of statutory ICSs, there is also a clear need for government to have an appropriate forum to engage with integrated care partnerships (ICPs) - the convenors of ICSs as a whole - more widely. This would provide the opportunity for a 2-way exchange between ICP leaders and the relevant government departments and agencies, allowing ICP chairs to raise matters of priority directly with ministers and officials. I therefore recommend that a national ICP Forum is established. This could be convened by government itself, if my recommendation is accepted, or alternatively by the ICS Network and the Local Government Association together. It should include representation from DHSC, DLUHC (including the Office for Local Government) and, in the context of the National Health Improvement mission, the Cabinet Office as well as NHS England.

2.30 To support the shift to a new focus on prevention, population health and health inequalities, I also recommend that the government establish a Health, Wellbeing and Care Assembly, with a membership that mirrors the full range of partners within ICSs, including local government, social care providers and the VCFSE sector as well as the NHS itself. It would also be helpful for the Assembly to be supported by a secretariat drawn from OHID and the Office for Local Government as well as DHSC and NHS England.

ICSs role in embedding population health management

2.31 Improving population health and tackling health inequalities is a complex task. While public health leaders and other experts in the field play and important role, to affect change in all parts of the system requires awareness, knowledge and skills at all levels. Population health, prevention and health inequalities should also be part of the training and continuing development for all professions and embedded in the national workforce plan to help develop the skills needed to improve health equity. ICSs themselves have the opportunity for health and social care professionals to learn from local communities, including VCFSE groups working with disadvantaged and marginalised groups, as West Yorkshire Health and Care Partnership is doing with its health inequalities academy and Cumbria and South Lancashire with their population health and equity academy.

2.32 Giving every child the best start in life, from pregnancy through to late adolescence, is crucial to reducing health inequalities across the life course. Starting with antenatal care, the first 1001 days provide a vital opportunity to support the health and wellbeing of the whole family. Barnardo’s and the Institute

of Health Equity, are partnering to shape the way ICSs improve health and address health inequalities among children and young people. In several parts of the country, local government with responsibility for children's services has led the way in establishing a Strategic Alliance for Children and Young People that brings together all the relevant NHS, education, VCFSE, childcare and other services, partnering with parents and young people themselves to create the most effective and integrated support. Every ICS should ensure that both their ICP's integrated care strategy, and through it their ICB Joint Forward Plan, include a clear articulation of the needs of children and young people within their population, and how those needs will be met through collaboration across the system.

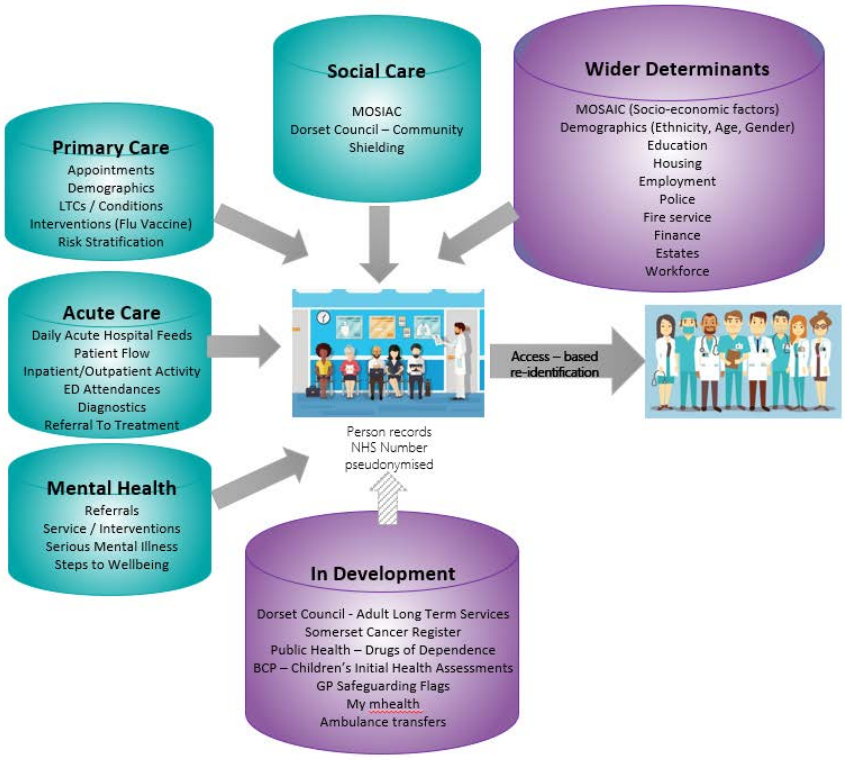
Role of data and digital tools to support the prevention of ill health

2.33 Shifting more of the focus onto prevention - underpinned by whole-system alignment on policy and funding - will radically improve our ability to do much more to tackle the determinants of poor health, with all of the associated health and economic benefits I have described.

2.34 That shift will be more impactful if we enable ICSs to connect data from multiple sources - while, of course, ensuring there are strong safeguards in place for individual privacy and confidentiality. This would transform their ability to accelerate their work around a whole suite of activity including improving individual care and outcomes; improving population health and wellbeing; tackling health inequalities; improving the wellbeing and engagement of staff; and, significantly, improving the productivity of the health and care system.

2.35 Many ICSs and partnerships within them are integrating data from multiple sources as the basis for integrated care and proactive population health management. Dorset ICS, for instance, has worked with its residents and partner organisations to establish a live linked data set, pulling in data from multiple sources, and using it as the basis for screening their fast-growing over-65's population, including for those at high risk of falls, and as a result significantly reducing the number of emergency hospital admissions. Norfolk and Waveney ICS has built on its award-winning COVID Protect approach, establishing Protect NOW, a GP-led collaboration that uses data analytics and risk stratification to

identify people at risk of undiagnosed or poorly managed Type 2 diabetes to improve patient engagement, care and outcomes.



Dorset Integrated Care System[12]

2.36 The North East and North Cumbria ICS is successfully joining up healthcare and social care data, using the OPTICA software, to streamline and simplify processes to effectively support discharge. Staff are using it as the single version of truth in hospital and community settings to help them understand where patients are in the discharge process, highlight blockages and provide actionable intelligence through comprehensive patient tracking and reporting modules. These and many other examples of excellent practice should be used both to support improvement and transformation across all systems and to contribute to work within DHSC and NHS England on wider policy development.

2.37 ICSs and NHS England need to work together to create a single view of population and personal health. To deliver this there needs to be a strong working partnership between ICSs, NHS England, local government, providers, and the VCFSE sector, which will enable systems and organisations locally to collect and utilise high-quality data. A strong partnership between different organisations locally and nationally will be vital for its success.

2.38 We welcome the proposed data framework for adult social care outlined in Care Data Matters, setting out what data the sector needs to collect, the purpose of

[12] Dorset ICS's presentation on a population health management approach to place-based care delivery

those collections and the standard to which it is collected. Adult social care providers should be fully involved in finalising the new framework, reflecting the diversity of the sector, and including those who are already making transformational use of digital and data tools as well as those for whom digitisation will be more challenging. DHSC should work collaboratively with the provider sector, alongside local authorities and other ICS partners to develop the framework, which will set out how we will improve the quality of data and rationalise collections so that we minimise the collection burden.

2.39 Further, building on the Care Data Matters Strategy, I recommend that NHS England, DHSC and ICSs work together to develop a minimum data sharing standards framework to be adopted by all ICSs in order to improve interoperability and data sharing across organisational barriers, particularly focusing on GP practices, social care provision and VCFSEs providing health and care services (who will need additional support in this work).

2.40 I also recommend DHSC should, this year, implement the proposed reform of Control of Patient Information regulations, building on the successful change during the pandemic and set out in the Data Saves Lives Strategy (2022). This reform, already agreed in principle, is essential to allow local authorities and the local NHS jointly to plan and deliver support by accessing appropriate patient information.

2.41 The Shared Care Record (ShCR), now established in all ICSs, should be a priority for further development. To support care that is integrated around individuals, there is an urgent need to enable social care providers, VCFSE providers of community and mental health services and local authorities to access the ShCR on an equal basis with NHS partners. As soon as possible, the ShCR should enable individuals (and their carers where appropriate) to access as much as possible of their own data and allow them to add information about their own health and wellbeing. Finally, the ShCR should expand beyond individual ICSs to support people being treated by a provider in a different system or needing care elsewhere in the country.

2.42 As part of the development of shared care records and EPRs, patients should be able to access their hospital as well as their GP record, for instance updating information held on the NHS Spine, checking where they are on an elective waiting list and removing themselves if they have already had their diagnostic test or procedure and so on.

2.43 NHS England has a crucial role in supporting ICSs, particularly smaller systems, with vendor management of large suppliers (including vendors of population health systems) relationships with industry and ensuring supplier accountability for building systems that conform to NHS - and wider ICS - standards including compliant reporting and interoperability with other key national systems including

the Spine. National user-groups should be established with strategic suppliers to leverage and aggregate demand, coordinate any need for changes, and ensure compliance. As part of the national framework, trusts need to adhere to international standards and the data dictionary for nationally mandated metrics and data submissions and ensure coding rules are not open to local interpretation.

2.44 There is a shortage of skilled professionals, including those who are expert at the cultural change that underpins digital transformation. In line with its new operating model, NHS England should therefore develop in-house skilled teams who can be embedded within a provider or system to train front-line staff and grow the new local capability needed to ensure successful digital and data-driven transformation.

2.45 The Data Alliance and Partnership Board, within the Transformation Directorate of NHS England, has a central role in the development of NHS digitisation and will therefore have a significant impact upon the ability of ICSs to succeed. As an immediate measure, I recommend NHS England should invite ICSs to identify appropriate digital and data leaders from within ICSs - including from local government, social care providers and the VCFSE provider sector - to join the Board. The aim should then be to develop the Board into an Integrated Data Alliance and Partnership Board, creating a national equivalent of the ICS partnership itself. Both are essential to ensure that integration and the vital shift of effort and resources described in this chapter are not held back by an NHS-dominated view of the world.

2.46 Public support and trust for this approach is essential - without it the real transformation opportunities on offer by digital and data will not be fully realised. It is vital that national and local systems work with and engage the public continually to ensure that we can have a data-literate population that we can draw upon.

Empowering the public to manage their health

2.47 The democratisation and personalisation of data and digital tools has created a population that both expects and is able to use digital tools and data to support their health and manage their care and treatment. Equally, the effort to improve the nation’s health can only succeed if we support people to become active and engaged partners in their own health, wellbeing and care.

2.48 Most people rely on increasingly sophisticated digital devices to support almost every aspect of their lives.

2.49 The nhs.uk website is the UK’s biggest health website, with an average 23 million visits a week and the NHS app is a world leading solution in the hands of over 31 million people in England - nearly 7 in 10 of the adult population. But the public can also tap into multiple sources of information and advice, of varying quality,

reliability and cost, and use increasingly sophisticated wearable and other devices to monitor and support their own health and wellbeing. Increasingly, health and care are ‘high tech’ as well as ‘high touch’.

2.50 At the same time, it is vital to recognise that many NHS patients and social care clients are amongst those least able to use digital solutions, whether because of frailty, economic disadvantage, language issues or physical, cognitive or other disabilities (including dementia). Their voice needs to be heard, within ICSs and nationally, to ensure that the design of digital and data solutions is as inclusive as possible. It is also vital for ICSs to provide digital support to people who cannot self-serve. From a high street pharmacy helping someone into a digital consultation booth and putting digital monitors on them for their remote outpatient consultation, to a dementia day centre supporting a carer to do a digital medicines assessment, digital patient engagement won’t be real until it works for the NHS’s most vulnerable users.

2.51 The response to COVID-19 rapidly accelerated digitisation, particularly in the NHS. The pandemic tapped into a deep sense of civic duty amongst millions of people who were willing to share data through real-time tracking systems in order to reduce the spread of the virus; to report their health status daily as ‘citizen scientists’, enabling faster identification of significant symptoms, the spread of the virus and new variants; and to participate in fast, large-scale and often world-leading clinical research trials to establish the most effective forms of treatment.

2.52 I therefore recommend that, building on the existing work of NHS England, the NHS App should become an even stronger platform for innovation, with the code being made open source to approved developers as each new function is developed. The NHS App is itself an open architecture, with 2 components already being open source. Extending this approach would allow innovators - including those with lived experience - to develop solutions to meet the needs of different communities, whether parents of a child with learning disabilities, adults supporting a parent with dementia or people whose first language is not English and so on. A national user group should be established for the NHS App, including people with lived experience and VCFSE groups supporting marginalized or overlooked groups, to ensure public involvement in future developments. With several ICSs developing ‘carers’ passports’, an electronic version within the app would also be invaluable.

2.53 I also recommend that the government should set a longer-term ambition of establishing Citizen Health Accounts. This should be done by requiring all health and care providers (whether NHS or local authority funded or otherwise) to publish the relevant data they hold on an individual into an account that sits outside the various health and care IT systems and is owned and operated by citizens themselves. This should go further than just EPR data and should become a mechanism to enable people proactively to manage their own health and care.

Such a Citizen Health Account would need to be linked into the NHS app functionality and should receive information from sources such as NICE; it could also be a gateway into clinical trials and improving health outcomes. Digital tools and Apps can play a vital role in enabling ICSs to improve population health outcomes, a point emphasised in my terms of reference. A practical next step would be to trial this proposed approach in a limited format working with the NHS app team and suitable third-party vendors under the oversight of an appropriately recruited citizens' panel.

Chapter 2: recommendations

1. The share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years. To deliver this the following enablers are required:

a) DHSC establish a working group of local government, public health leaders, OHID, NHS England and DHSC, as well as leaders from arrange of ICSs, to agree a straightforward and easily understood framework for broadly defining what we mean by prevention.

b) Following an agreed framework ICSs establish and publish their baseline of investment in prevention.

2. That the government leads and convenes a national mission for health improvement. I also support the Health and Social Care Select Committee's recommendation that DHSC should publish, as soon as possible, the proposed shared outcomes framework.

3. That a national Integrated Care Partnership Forum is established.

4. The government establish a Health, Wellbeing and Care Assembly.

5. That NHS England, DHSC and ICSs work together to develop a minimum data sharing standards framework to be adopted by all ICSs in order to improve interoperability and data sharing across organisational barriers.

6. DHSC should, this year, implement the proposed reform of Control of Patient Information regulations, building on the successful change during the pandemic and set out in the *Data Saves Lives Strategy* (2022).

7. NHS England should invite ICSs to identify appropriate digital and data leaders from within ICSs - including from local government, social care providers and the VCFSE provider sector - to join the Data Alliance and Partnership Board.

8. Building on the existing work of NHS England, the NHS App should become an even stronger platform for innovation, with the code being made open source to approved developers as each new function is developed.

9. The government should set a longer-term ambition of establishing Citizen Health Accounts.

3. Delivering on the promise of systems

3.1 The recommendation to place ICSs on a statutory footing was made following NHS England's engagement and then formal consultation with system leaders, partners and stakeholders, following a period of co-production and engagement in policy development that was widely welcomed. In making that recommendation, DHSC, NHS England and local government representatives all acknowledged that to deliver on the ambition for ICSs, the role of national government and national bodies, and the approach to oversight, assessment and performance management across the health and care system would also need to change.

3.2 I cannot emphasise too strongly the scale of the transformation involved in the establishment of statutory ICSs. Because ICSs are partnerships between all those involved in health, wellbeing and care, we can shift the dial on today's immediate and urgent problems, bringing people together to work in different ways. By doing so, we start to create a new virtuous circle of supporting health and wellbeing, and in the process reduce the pressures on NHS emergency care.

3.3 But the creation of ICSs also requires clarity about where accountability sits. Every partner and sector within an ICS operates within its own financial, regulatory and accountability framework, whether that is local government, a VCFSE organisation, a social care provider, or an individual NHS provider. ICBs and ICPs should - and in many instances already do - create the environment to support 'mutual' or 'collective' accountability: where system partners can, with mutual respect and transparency, support and challenge each other to deliver priorities they have agreed together, irrespective of where their statutory accountability sits. That local accountability can and should be strengthened in the ways described in this chapter.

3.4 The NHS, in particular, sits within a framework of national regulation and accountability that is already changing. The new and welcome NHS England operating framework reflects the move to system-based working, with NHS England expecting ICBs to identify the local shared priorities that sit alongside national NHS commitments and to play a key role in the support and oversight of NHS providers.

3.5 The framework also sets out further changes to NHS England's structure and operating model including the behaviours and values expected of all those within the NHS, with a 'One Team' philosophy and a clear expectation around behaviours - collaborative, trusting and empowering, transparent and honest, inclusive and diverse. Within each ICS, as part of their development, partners are working together to agree the values and behaviours for which they will hold themselves accountable; not surprisingly, they bear a striking resemblance in spirit, if not exact words, to those of the NHS England framework.

3.6 The need for faster, and in some cases further, change in the whole framework of oversight and accountability of the NHS itself and ICSs more widely, was a strong theme in my discussions throughout the review.

3.7 Although much of the following analysis and recommendations involve the NHS, this is not because I (or ICS leaders generally) believe the NHS is or should be the dominant partner in the new model. I believe quite the reverse. Instead, it simply reflects the fact that the necessary national oversight and accountability of the NHS needs to respect and allow space for local accountability within the whole ICS.

3.8 Integrated care boards (ICBs) have a particular position within this wider framework. They are a key partner within the wider integrated care system; with local government, they establish the integrated care partnership (ICP) that brings all partners in the system together to produce the integrated care strategy. As NHS statutory bodies, they have a statutory responsibility for arranging for the provision of health services for their residents; they take the lead in ensuring that all parts of the local NHS work together with each other and with social care and other partners; and they are accountable for the overall performance and finances of the local NHS.

3.9 They are simultaneously part of the 'one system' of an ICS while needing to see themselves - and be seen and treated as - part of the 'one NHS' team. Because ICBs are accountable for around £108 billion of the £150 billion made available annually by parliament for the NHS and for the performance of the local NHS, the need for accountability from the ICB to NHS England, and through NHS England to government, for NHS finances and performance is not in doubt.[13] But the mechanisms for accountability need to be both effective in themselves and also proportionate so that ICB leaders have the space and time to be effective partners and leaders within the wider ICS. The improvement-focused work of NHS England with ICBs needs to take full account of the need for ICBs to be 'great partners' within their ICS and not simply within the NHS itself (see below).

3.10 Where an organisation has a clear responsibility for most or all of an issue and controls the resources to deal with it, accountability sits with them. Many issues are matters for the NHS partners in a system rather than a single organisation and one of the benefits of ICBs taking statutory form is that they can provide clear accountability 'upwards' to NHS England and the government for delivery of those things that are national must-dos and which are wholly or largely the responsibility

[13] Data refers to CCG and NHS England spending for 2021 to 2022 financial year - NHS Commissioning Board Annual Report and Accounts 2021 to 2022 financial year - for the period 1 April 2021 to 31 March 2022 (england.nhs.uk) - to note £108 billion is the amount which ICBs were formally allocated in 22/23 the actual amount ICBs are responsible for is likely to be greater when considering funding streams from delegation or other one off in year funding packets.

of the NHS. It will be important to maintain clarity of accountability on these matters.

3.11 NHS England and the DHSC will continue to focus on the capability of the ICB and the effectiveness of all NHS partners, including the ICB, in ensuring clear accountability for NHS performance. The new role of CQC in relation to ICSs (see below) will include an assessment of how strong the mutual accountability between partners is within a system.

Approach

3.12 Conversations with system leaders towards the start of this review often focused on the need to reduce the top-down management of the NHS that reflects decades of hierarchical NHS management, a culture that NHS England's leaders are already changing. My recommendations build on, and are designed to deepen and entrench, their new approach. As the review progressed, however, the conversation moved from a negative view of autonomy ('freedom from') to a positive vision of self-improving systems ('freedom to') where partners work together, motivated by the common purpose of using the resources available to our communities to achieve the best possible outcomes.

3.13 It also became clear that the principle of subsidiarity must be embedded as part of this, enabling local leaders to make decisions at a level as close as possible to the communities that they affect.

3.14 In this chapter therefore, I set out the conclusions and recommendations I have reached from this review, starting with the need to work on the basis of subsidiarity, through strong, empowered Place Partnerships and neighbourhood teams.

Place

3.15 All ICSs are expected to define a clear role for 'place' level partnerships. As emphasised earlier, however, ICSs vary considerably in size and architecture, with corresponding differences in what 'place' means. At one end of the spectrum, there is a system covering around 750,000 people with a single upper tier local authority and one Health and Wellbeing Board. At the other end, there is a system covering over 3 million people, the ICS includes 13 places, 12 of which align with its own local authority area and Health and Wellbeing Board.

3.16 Although part of the impetus for this review came from concerns about top-down management of ICSs and the need for a new balance between greater autonomy and robust accountability, it is just as important that the principle of collaboration and subsidiarity is lived within systems themselves - and that the partnership

working and integration that is already delivering results locally is supported by further changes in the national framework.

3.17 In many ICSs, place partnerships, aligned with Health and Wellbeing Boards and building on their work over many years, will lead much of the work to transform local services and models of care, support population health and tackle health inequalities.

3.18 Some providers, however, report that they are finding it difficult to navigate between different versions of ‘place’ in different systems. While ‘place’ cannot and should not be defined by the DHSC or NHS England, it should be agreed by partners at system level so that there is visible and accountable leadership at place, underpinned by an integrated governance structure. place-based leaders must be enabled to feed directly into system-wide conversations, plans and funding arrangements. Where provider trusts and foundation trusts provide services within different places or systems, there needs to be close collaboration between providers, place, and system leaders to ensure the best outcomes for residents. As every system establishes its place governance and leadership, taking into account relationships with different providers, this information should be transparent and accessible for their communities.

3.19 The same ‘can do’ culture described in the operating framework should equally apply to ICSs’ relationship with their place partnerships and provider collaboratives. Indeed, we have seen examples through the course of this review where place partnerships are still ‘looking up’ to the ICB for permission and instructions instead of ‘looking out’ to the communities and neighbourhoods they serve. More mature systems are supporting their Place partnerships and provider collaboratives to drive initiatives and define their own priorities within the guardrails of the mutually agreed strategy of the ICB and ICP: this needs to rapidly become the norm across all ICSs.

3.20 In several systems, strong and mature provider collaboratives are an important engine of improvement and transformation. Collaboratives can bring together providers to improve access and reduce wait times, share best practice, staff and resources, and help overcome organisational barriers which can sometimes stop services being designed and delivered around the needs of patients and communities. While provider collaboratives, like ICBs, vary considerably in maturity and strength, they have the potential to become the core NHS delivery arm for achieving key system objectives. ICBs have an important role in convening, supporting and resourcing the development of effective collaboratives to help drive service transformation, increase provider resilience and embed a culture of collaboration across providers. It is also important for the relationship between provider collaboratives and the ICB to be clear within each system, with consistency between system objectives and the priorities of its constituent collaboratives.

Embedding a balance of perspectives

3.21 We have heard frustrations from a range of stakeholders at the limited number of mandated members of an ICB. Many feel it is impossible to have their voices heard if they do not have a seat at the table and that ICBs seem to be largely constituted from parts of the NHS rather than across the wider system; this is particularly felt by social care providers and public health leaders within local government.

3.22 It is important to remember that the 2022 Act created statutory ICSs with 2 separate, complementary bodies: an ICP bringing together the full range of partners through a statutory committee jointly created by the relevant upper-tier local authorities and the NHS, with members drawn from many other organisations and sectors; and an ICB, which is a statutory NHS body accountable for NHS performance and finances.

3.23 Given the variation in ICS constitution and size it was absolutely right that the government chose to be legislatively permissive. It was important to allow ICSs to create the architecture and governance for their ICP and ICB that enabled them best to serve their population. But as ICSs come towards the end of their first year as statutory entities, there is a valuable opportunity for them to learn from each other as well as from their own experience and adapt accordingly.

3.24 Crucially, regardless of membership, collaboration within an ICS should stretch wider than just those who are members of ICB boards. Wider partners, including social care providers, the VCFSE sector, and the independent healthcare sector should be fully engaged and their contribution better understood within the NHS.

3.25 However, I have heard a compelling case that social care providers should have a strong voice in every ICS. I agree, although reflecting the general principle of avoiding top-down directions, I believe that each system should decide how best that is done. Similarly, 20 of the 42 ICB constitutions do not specifically mention a role for public health. While public health is and should remain a crucial role of local government and may have been included through the recruitment of partner members on ICB boards, systems should also consider whether this expertise needs to be better embedded within their structures.

3.26 ICBs have been asked by NHS England to review their governance arrangements over the coming months, after their first year of operation. Each ICB should be encouraged to use this process (as many plan to do in any case) as an opportunity to engage with all system partners to consider how the ICB is operating within the overall ICS architecture. Many ICSs are using a process of self-assessment and mutual peer review to support their own self-development; this process should be actively encouraged while not forming part of any formal assessment. Within the governance review and its own self-assessment, each ICS should consider

whether it needs to do more to ensure that social care providers are involved in planning and decision making, that public health expertise is being effectively deployed within the system.

Local accountability and priority setting

3.27 Just as the care and treatment of individuals must be based on ‘no decision about me without me’, so local communities must be involved through a continual process of engagement, consultation and co-production in design and decision-making about local services. Strong and visible local accountability, recognising the principle of subsidiarity, also plays an important role in promoting legitimacy with the local population through empowering, accountable and transparent decision-making.

3.28 In many ways, local accountability is hard-wired into ICSs - through ICPs themselves as well as Health and Wellbeing Boards, Health Overview and Scrutiny Committees, Healthwatch, foundation trust governors and many other forms of patient and public involvement in system, place, provider and neighbourhood working. Health and Wellbeing Boards enable local councillors, alongside other partners, to set place-based priorities for improving health and wellbeing outcomes, to agree joint strategic needs assessments and health and wellbeing strategies for their residents. Where local government, healthcare and system boundaries do not coincide, it is particularly important that all concerned collaborate in the best interests of residents.

3.29 HOSCs are another important part of the local accountability framework, allowing councillors to scrutinise significant changes or issues in health and care provision and hold local NHS leaders to account. Although (like ICSs themselves) they may vary somewhat in effectiveness and maturity, it is important to the success of ICSs that they provide effective, proportionate scrutiny. In Greater Manchester, the HOSCs in all 10 unitary councils have already delegated this role of system oversight to a Joint Health Overview and Scrutiny Committee; a similar approach could be adopted in other equivalent systems. I therefore recommend recognising HOSCs (and, where agreed, Joint HOSCs) as having an explicit role as System Overview and Scrutiny Committees. DHSC should work with local government - through the LGA, the Office for Local Government and the Centre for Governance and Scrutiny - to develop a renewed support offer to HOSCs and to provide support to ICSs where needed in this respect. In assessing the maturity of ICSs, CQC should consider the effectiveness of system oversight provided by HOSCs or Joint HOSCs, or both.

3.30 In line with its statutory responsibilities, every ICS, through its ICP, has already developed an integrated care strategy, informed by Health and Wellbeing Board priorities (themselves reflecting their system JSNA) and co-developed by the ICP

ensuring engagement and involvement with those with lived experience, the wider local population, different tiers of local government and locally elected leaders, including elected mayors.

3.31 In response to the clearly expressed wishes of local leaders, I recommend that each ICS should be enabled to set a focused number of locally co-developed priorities or targets and decide the metrics for measuring these. These should be co-developed with place leaders and adaptable to complement place level priorities, and should be a natural extension of the ICP health and care strategy. These priorities should be treated with equal weight to national targets and should span across health and social care.

3.32 A mechanism for achieving this recommendation lies with the Joint Forward Plans. NHS England has asked ICBs in their JFPs to reflect local priorities agreed with their ICS partners, ensuring these have equal weight alongside national NHS commitments. Building on the integrated care strategy developed by the ICP, the JFP should describe the outcomes the ICS is aiming to achieve. This should include short, medium and longer-term measures that will be used to track progress as well as how different partners will contribute to these and how they will hold each other to account for doing so.

3.33 NHS England itself consulted with local government and other colleagues to develop the guidance for JFPs; as noted earlier, this was very different in tone and approach from earlier, pre-COVID approaches to local NHS planning. I have heard from several colleagues, however, particularly those in local government, social care and the VCSFE sector, that it is confusing or even inappropriate for guidance relating to ICSs as a whole, and ICPs in particular, to come from NHS England when, by statutory design, the local NHS is only one partner amongst many within the system. Initially, at least, the reference to a ‘joint’ plan prompted some confusion about whether ‘joint’ referred to all local NHS organisations, the local NHS and social care, or the system as a whole. Concerns of this kind underline the need for clearer cross-government arrangements in relation to ICSs as a whole.

Self-improving systems

3.34 In any large, complex organisation, whether national or global, it is essential to find the right balance between ‘national’ and ‘local’. ICSs, of course, are not a single organisation; they are a complex ecosystem. So is the NHS. As I have already described, the cross-sector partnerships of ICSs need to be paralleled by stronger cross-government working. But even for the NHS partners within each ICS, the ‘national centre’ is not a single entity: it includes NHS England, as the leaders and headquarters of the service, as well as DHSC and CQC. It is therefore essential

that the roles of each are clearly defined and delineated, in the way described below.

3.35 We know that high-performing organisations and systems combine high levels of autonomy with high levels of accountability. ICS leaders themselves increasingly want to create a self-improving system - empowered and strong enough to set strategy, agree plans and trajectories and to mobilise the collective time, talent and resource of system partners to realise them.

3.36 System leaders will succeed where they exercise the agency to define the 'how' and to deliver against agreed local and national priorities. The operating environment needs to allow system leaders the space to use their time and energy to collaborate, innovate, and tackle the problems their systems face and to determine together how improvement is best achieved in their local circumstances.

3.37 But recognising the considerable differences in maturity, relationships and strength of leadership across ICSs generally, and ICBs in particular, NHS England needs to reinforce the support it offers to the ICBs and other local NHS partners most in need of support. The goal should be to build the right leadership capability and partnership culture while recognising that, as a last resort, regulatory intervention by NHS England will be required.

3.38 I urge ministers, NHS England and ICSs to confirm the principles of subsidiarity, collaboration and flexibility that were set out when ICSs were being established and explicitly commit to supporting ICSs to become 'self-improving systems'. This clear goal would align all national priorities behind a dynamic, collaborative approach, informed by smart data-driven insights, enabling innovation and imaginative solutions.

3.39 As a system matures and is able to manage a wider range of issues more effectively, it should operate with greater agency. We should not see autonomy as a binary state; as something you do or do not have. For complex organisations in complex systems, the balance between what they do for themselves and what they seek or need further support in achieving is always likely to vary from issue to issue.

3.40 Mature systems and organisations are those which have the shrewdest understanding of where autonomy or support are likely to work best for them. Craving autonomy for its own sake can often be a sign of immaturity. It follows that we should think less in terms of 'earned' or 'assumed' autonomy and more in terms of a tailored combination of autonomy and support that produces effective agency. As systems mature, far more of that tailoring can be done by the systems themselves, with NHS England playing a stronger role in the less mature systems.

3.41 Inherent in this model, therefore, must be a commitment to organisational and leadership development, with a clear expectation on providers and ICBs in particular to work together and share resources to support the development of the right cultures and relationships.

Accountability relationships at the heart of system working

3.42 In the course of this review, several colleagues stressed the need for clarity within ICSs, and with NHS England, about where accountability lies for NHS organisations and partners. The new NHS England operating framework states clearly that the role of ICBs includes:

- first line oversight of health providers
- to co-ordinate and help tailor support for providers
- assurance and input to regulators' assessment of providers
- liaison or escalation to NHS England

3.43 That remains, in my view, a helpfully clear statement. Building on this, and acknowledging that different systems are at different stages of operationalising these roles and relationships, several principles are clear:

- trust chief executives are accountable for what goes on inside their trust, crucially, the quality and safety of the services they provide to patients. This statutory accountability is to their board (and in the case of FTs, also to their governors and members), as well as to NHS England
- trust chief executives and boards are also accountable to system partners - within a provider collaborative or Place Partnership where appropriate, but also with and through the ICB. They are accountable for their part in agreeing and delivering plans to improve patient outcomes and the quality, safety and accessibility of care, as well as to solve performance and productivity issues (including ambulance handovers and delayed discharges) that can only be solved by multiple organisations working together
- trust chief executives and boards are accountable to partners across the ICS (including the ICB) for their part in shaping and helping to deliver the ICS integrated care strategy and Joint Forward Plan, including their focus on prevention, population health and health inequalities
- as the organisation accountable for the state of the local NHS as a whole, the ICB is uniquely placed to understand the connectivities and inter-dependence

between different providers. They have a crucial role as the convenor of the NHS, as the statutory partner with the upper-tier local authorities that also form the ICP and leader and partner in the wider ICS

- ICBs are accountable for the performance and financial management of the NHS in their area. ICB CEOs are accountable to their boards, to system partners and to NHS England for delivery of agreed priorities and plans - including elective recovery, urgent and emergency care plans and so on. This is different from being accountable for the performance of individual trusts. As set out earlier, ICBs are accountable to both NHS England (through NHSE regions) and to their local communities

- it is the role of all system leaders collectively to challenge and support each other in relation to meeting the agreed objectives. In a growing number of systems, this is realised through a distributed leadership model where different system members at system, place and neighbourhood level all have defined responsibilities and accountabilities within their eco-system and providing appropriate support to enable transformational change

- the ICB has a critical role as the vehicle to coordinate the activities of provider collaboratives and the NHS's contribution to place-based partnerships. ICBs are vital to support and enable these partnership arrangements to deliver faster progress on service transformation, recovery, and wider delivery on long-term plan objectives

- ICBs have a direct interest in and commitment to the success of NHS providers within their system. This is partly because, as 'commissioners', they are properly concerned with quality, safety and productivity within individual providers. More fundamentally it reflects the recognition that none can succeed unless all succeed. Rightly, there is now a clear expectation that ICB chairs will be involved in the recruitment of trust and foundation trust chairs, with ICB CEOs similarly involved in CEO recruitment, helping to ensure that provider leaders understand and are committed to system working

3.44 I hope that these principles will be helpful to ICS leaders as they clarify and operationalise roles and accountabilities between partners across their system, and to NHS England as they support ICBs in making their contribution to shared local priorities.

3.45 NHS England should therefore work 'with and through' ICBs as the default arrangement. ICBs should be the first point of support for providers facing difficulties, supporting (and if necessary, challenging) the trust to agree a plan of action, mobilising system partners to agree action on wider issues that affect the trust and calling in improvement resources if required. As described in the NHS England operating framework, within their 'adult to adult' relationship, the ICB will

want to keep their NHS England regional team (and CQC if appropriate) informed on a ‘no surprises’ basis, and seek their advice on occasion, while retaining the initiative and ‘first line’ responsibility. NHS England should continue to evolve the NHS oversight framework and ensure it is being implemented as intended. There will also be times when an ICB asks the region to intervene directly. In all cases, this must be done collaboratively, with both the ICB and the region ensuring there are ‘no surprises’, whoever is in the lead.

3.46 Many ICBs will need time to develop the capacity and capability to lead all aspects of system risk management, particularly when performance pressures are so apparent in almost every part of the NHS. In less mature systems - for instance where relationships are poor or where the ICB has not yet developed the necessary capability - NHS England, in agreement with the trust and ICB, should take the lead in dealing with a trust facing serious difficulties or catastrophic failure. They should continue to involve the ICB, both so they can build insights into the trust’s difficulties (including those caused by problems elsewhere in the system), and because working in this way will help to strengthen the ICB, improve the chances of success with the trust and help the whole system to develop more effectively.

3.47 Of course, there will be occasions when NHS England needs to communicate directly with providers on urgent or other specific clinical or operational issues. It is essential, however, for NHS England to avoid working directly with providers in a way that weakens or disrupts system working, for instance by bringing in support for a trust on delayed discharges without talking to or taking account of the partnership working tackling exactly the same problem.

3.48 I recommend that, in line with the new operating framework, the ICB should take the lead in working with providers facing difficulties, supporting the trust to agree an internal plan of action, calling on support from region as required. To enable this and recognising NHS England’s statutory responsibilities, support and intervention should be exercised in relation to providers ‘with and through’ ICBs as the default arrangement. Where relationships and leadership are less mature, ICBs will need more active support from NHSE regions.

ICSs develop their own improvement capacity

3.49 ICS leaders have the clearest view of what an ICS does, how it works, the interlinkages between different parts of the system and how best to craft solutions to meet the needs of their communities and resolve the challenges within local health and care services. It therefore follows that they should play a fundamental role in their own improvement.

3.50 Quality improvement should be supported by system leadership and at a system level, including through the adoption of common improvement methodologies across systems. However, this has often been deprioritised by other work and requires investment, capability building and drive amongst partners to accomplish. This will help ensure systems drive a learning culture in all system partners and enable future-focussed thinking.

3.51 The NHS Improvement Approach being developed by NHS England will ensure that the development and adoption of improvement methodologies is prioritised across each ICS. This improvement offer should align with the principle of self-driven improvement by establishing some overarching principles that can be adopted locally, rather than prescribing a 'template' for improvement (outlining the 'what' and the 'why' but not the 'how'). It should also build on, rather than duplicate, the work being done by various improvement focused organisations including the NHS Confederation, NHS Providers, Q Community, the Royal Colleges and Academic Health Service Networks (AHSNs), which should all be seen as leaders in driving and implementing this new approach.

3.52 CQC itself is committed to making its assessment of ICSs an opportunity to support and incentivise improvement, rather than a 'box-ticking' or compliance approach. Given the experience of many provider trusts who in the past have found themselves facing overlapping and sometimes conflicting requirements from CQC and NHS England, I also recommend that NHS England and CQC work together to ensure that as far as possible their approach to improvement is complementary and mutually reinforcing.

3.53 ICSs will naturally take different approaches to improvement - some driving this more directly through provider collaboratives and others in which ICSs are developing in-house capacity to support improvement initiatives or train provider staff. Cross-ICS sharing and learning via peer-to-peer networks and collaboratives will strengthen ICSs' approaches to collectively leading improvement. This work is happening - for example through the NHS Confederation's ICS Network - but there is great potential for the 42 ICSs to think of themselves and be supported to develop as a single learning system.

In West Yorkshire ICS, for example, there are clear arrangements for system improvement agreed between the ICB and the acute provider collaborative, the West Yorkshire Association of Acute Trusts (WYAAT), which leads on certain system priorities on behalf of the ICS including the planned care and diagnostics programmes.

WYAAT collectively has (and will continue to) reviewed and made interventions in specialities with workforce challenges to ensure that equitable access for patients continues. This is clearly led and owned by WYAAT as a collaborative, with ICB involvement for oversight of system risk where required and where changes to protect access may impact the way in which patients access services in the short, medium or

long-term. The oversight approach modelled by the NHS England regional team as well as the ICB is one of improvement support, trust and mutual respect, rather than top-down performance management. By adopting a clear, well-managed structure to facilitate partnership working on health inequalities and prioritising population groups' health at system level, the ICS has ensured it can deliver improved outcomes for key groups and maximise its effectiveness across a large population.

3.54 External peer review can be a powerful tool to incentivise and support improvement. The LGA's well-established local government peer review programme provides the basis for an equivalent ICS process for use by ICSs as a whole. Peer reviews should ensure the appropriate involvement of local populations and services users and have access to bench marking tools such as GIRFT and Model Hospital. I therefore recommend a national peer review offer for systems should be developed, building on learning from the LGA approach.

High Accountability and Responsibility Partnerships

3.55 As part of this work, I have heard a clear desire from ICBs and wider system partners to move towards a model with a far greater degree of autonomy, combined with robust and effective accountability. Such a model will need to balance a high degree of autonomy with the need to sustain and demonstrate both performance improvement and effective financial controls.

3.56 In order to make progress as quickly as possible, and reflecting what I have heard with ICB leaders, I recommend that NHS England works with ICB leaders to co-design and agree a clear pathway towards ICB maturity, to take effect from April 2024. Reflecting ICB leaders' views, I expect that this new approach will include self-assessment of maturity supported by peer review mechanisms.

3.57 I have already urged all partners, locally and nationally, to commit to the goal of developing 'self-improving systems'. I have also heard a clear desire, both locally and nationally, for systems as a whole to set a high level of ambition, with the most mature systems being enabled to go further and faster in creating the transformation that, as we have argued throughout, is the most sustainable route to solving immediate performance pressures.

3.58 I therefore recommend that an appropriate group of ICS leaders (including local government, VCFSE and other partners as well as those from the NHS) should work together with DHSC, DHLUC and NHS England to create new 'High Accountability and Responsibility Partnerships'. These should start to operate from April 2024. To reinforce the cross-government arrangements needed to parallel the broad partnerships of ICSs as a whole, this working group should report regularly to DHSC and DHLUC ministers together with the chief executive of NHS England.

3.59 The design of HARPs will, of course, depend upon the work of this group. But to give an idea of the scale of ambition that I have heard from colleagues, I suggest that the framework for HARPs should include:

- a radical reduction in the number of shared national priorities and corresponding KPIs
- a collective commitment by HARP systems, including the ICB, NHS providers, and, crucially, local government and other partners, committing themselves to a small number of priorities for which they would be held accountable both locally and nationally; with clear milestones and outcomes, and linked to Joint Forward Plans
- significantly greater financial freedoms to enable partners to make best use of the resources available to them, including the public estate
- an effective data-sharing approach across multiple partners, with linked data sets enabling proactive population health management, significantly improved outcomes for population groups and substantial reductions in demand for emergency and specialist services. These data sets would also, of course, provide appropriate warning systems to departments and regulators in case performance or finances begin to diverge significantly from agreed plans
- a light-touch national accountability framework, for instance with 6-monthly reviews between NHS England, the ICB and other ICS partners
- the process for ICSs to ask for additional support, and the support available to them

3.60 This approach also recognises that not all systems are ready for advanced levels of autonomy and responsibility, while allowing those who can go faster, to do so. It also recognizes that if circumstances change, and a system is struggling, there are processes in place to provide additional improvement-focused support and help.

3.61 Testing this approach in this way will not only provide crucial learning, it will mark out a clear path for all systems, showing what is possible, and what can be expected, from a high-performing system.

3.62 Although it would not be appropriate for this review to recommend how many ICSs should adopt these new arrangements, in order to test the approach, the scale of ambition needs to be clear. I would hope that around 10 systems would be able to work in this way from April 2024.

The right skills and capabilities for ICBs

3.63 This brings me to the capabilities needed for ICBs themselves.

3.64 As this review has confirmed, the 2022 Act gives ICBs a vital new role as convenors and catalysts for change. All ICBs need to work with their partners - including place boards, provider collaboratives and local government - as well as their own staff to establish and develop people in the roles that are needed in the ICB team to facilitate acceleration of and depth of performance improvement and wider transformation across the system - and to fulfil their multiple statutory duties - working in the new, collaborative ways required. ICBs are, of course, at different stages in this process.

3.65 On 2 March, NHS England announced that ICBs' running cost allowance - already frozen in cash terms for 2023 to 2024 financial year - would be further cut by 30% in real terms over the following 2 years, with at least 20% reductions delivered in 2024 to 2025 financial year, with no provision for redundancy payments.

3.66 Everyone I spoke to during this review is acutely aware of the intense pressures upon the nation's - as well as the population's - finances, and the stress upon VCFSE partners, social care providers and local government, as well as the NHS. Local government and NHS partners, including the ICB, need to work together within individual ICSs to share corporate services and other functions, create single teams and make better use of digital tools to improve productivity. Neighbouring ICSs need to consider similar arrangements, such collaboration helps to strengthen ICSs while achieving better value for public funds.

3.67 As the Wigan Deal demonstrates, financial constraints can and should be used as an opportunity for transformation. But the scale and timing of these reductions create a real threat to the successful development of integrated care systems (ICSs), with too much time and energy from all staff, including those most essential to improvement and transformation, diverted into a restructuring that is potentially too extensive and too fast. Instead, we need to focus on striking the right balance of capability between NHS England, NHSE regions and ICBs. As NHS England implements its new operating framework, I encourage a significant move of resource into systems, supported by smaller, more experienced and highly capable NHSE regions. Without that, the restructuring risks creating a new imbalance between the national, regional and ICB teams of 'one NHS', when the original intention was of course to rebalance resources towards ICBs and ICSs as a whole.

3.68 I therefore recommend that during 2023 to 2024 financial year further consideration is given to the balance between national, regional and system resource with a larger shift of resource towards systems; and that the required

10% cut in the RCA for 2025 to 2026 financial year is reconsidered before Budget 2024.

3.69 Finally, delays and complexity with respect to the appointments process for ICB senior leaders have made it difficult for ICBs to build the right capability and governance to fulfil their statutory functions. In some cases, this has led to many months delay in approving the appointment of ICB medical directors, non-executive members and other senior roles. I therefore recommend that NHS England and central government work together to review and reduce the burden of the approvals process of individual ICB, foundation trust and trust salaries.

The role of the regions

3.70 As the chair of an ICB in level 4 of NHS England's oversight framework (SOF4), with considerable challenges in performance, quality and finances, despite many achievements and real progress, I am particularly alert to the value of a senior NHS England regional team who can provide expert advice. Regional teams can help to mobilise, support and resource sustained improvement efforts across the whole system as well as in individual providers and challenge us, in the ICB and working with all NHS providers, to go further and faster. On occasion, of course, they may also need to exercise NHS England's statutory powers of regulatory intervention.

3.71 As 'one NHS', however, we need to make sure that there is the right balance of capability between NHS England, NHSE regions and ICBs. There are a number of fixed points in determining this balance - for example, NHS England will, and should continue to hold statutory regulatory functions in relation to ICB performance. However, there is also a clear need for flexibility - with different areas needing their regions to be structured in different ways, depending on the maturity, size and challenges facing them.

3.72 A region with a small number of large systems with mature relationships and effective, experienced leaders should work in a very different way from a region with several small, relatively immature systems - and both will be different from a region with a wider mix. For the North East and North West, NHS England has already established a single regional director and team in place of the previous 2. As systems mature, the regional arrangements will continue to change, with systems individually or collectively taking on the responsibility for system and regional leadership, with regional teams focusing on their statutory roles rather than on ICSs.

3.73 In other NHSE regions, particularly those with smaller and less mature ICSs, a small number of senior people at the region who know and understand each system (with its particular geography, history, demography, provider configuration and so on) and, crucially, have built strong relationships with the key people within

the system, will remain invaluable. Those NHSE regions should maintain a role as the collective agent for ICBs and the local NHS within ICSs, and should facilitate the resolution of particularly difficult issues, such as the best configuration of vital specialist resources.

3.74 In order to make this approach a reality, NHS England regional teams should work based on a collective set of principles to support systems in translating national expectations to fit local circumstances, brokering national support for ICBs with struggling providers, and supporting less mature systems to develop their own capacity and capabilities. If an ICB requires support or further escalation, or both, then this should be agreed between NHS England Region and the ICB. Only if further escalation is required should national NHS England be involved.

3.75 Improvement rather than 'performance management' should be the dominant approach and priority. NHSE regions should operate as equal partners with ICBs, aligned with the principles as described in its operating framework: "mature, respectful and collegiate, underpinned with effective lines of communication and a 'one team' philosophy".

3.76 There is good practice already of this with examples such as the Northeast and Yorkshire 4+1 scheme and a 'compact' in the South West. Arrangements should be agreed between NHS England and ICBs for the joint governance within NHSE regions.

3.77 Strong relationships and clear oversight arrangements in West Yorkshire are supporting the system to improve care for patients. West Yorkshire ICS has been a partnership since 2016 so has had several years to build up the trust and relationships between Place, providers, the ICB and NHS England regional teams. Within the wider region, they operate on the basis of a 4 ICSs + 1 region model, agreeing regional targets with NHS England regional team and other local ICBs which are then measured at a regional level. This approach helps facilitate peer learning between ICSs to compare local approaches to delivering regional targets. In line with this approach, I would expect all ICSs to continue co-designing arrangements for regional support that best support their continuing development.

3.78 An important part of the support that regional directors can mobilise sits within the many NHS England programmes focused on particular diseases, conditions and so on. The national cancer programme, for instance, is an example of the essential role for NHS England in convening leading clinicians and scientists, national cancer charities and patient advocacy groups to drive and support life-saving changes in prevention, early diagnosis, treatment, patient experience and access. Such work can only be done once, as NHS England's new operating framework explicitly recognises and it is a task for NHS England itself as the headquarters of the service.

3.79 But the multiplicity of national programmes has created real problems, with different national programmes reaching out directly to individual providers and systems, adding to the plethora of meetings, guidance, templates, demands for data and such like. It is helpful that NHS England is significantly reducing the number of national programmes, it is equally important that planning the future support and requests from these programmes will go through NHSE regions rather than directly to providers and systems.

3.80 It will be important for ICS partners themselves, working within NHSE regions, to reinforce this new and welcome way of working; as the Messenger Review underlined, these changes in culture and behaviours take time and sustained effort to bed in.

3.81 There is now an opportunity to build on the new NHS England operating framework to co-design the next evolution of NHSE regions. I recommend that ICS leaders should be closely involved in this work, to ensure that NHSE regions can operate as effective partners, and the collective agent of the local NHS within ICSs.

Organisational development

3.82 Real, lasting change happens because people come together around a common purpose. It is the job of leaders to create the culture and behaviours, backed by the right systems and processes, to enable that to happen. Realising the potential of ICSs - and the neighbourhood teams, place partnerships and other structures within them, including ICBs - needs substantial, sustained investment in organisational development, collaborative leadership and team working across different professions, sectors and organisations.

3.83 Local government and NHS leaders at place and system level can already draw upon the support provided in collaboration between the Local Government Association (LGA), the NHS Confederation and NHS Providers. NHS England has made some organisational development support available for ICBs, drawing upon a variety of change management partners and coaches.

3.84 Depending upon its starting point, each ICS needs to sustain, develop or create its own organisational development programme across the whole of the health and care system. This should include partners from neighbourhood, place and system level arrangements across the NHS, local government, the VCFSE sector and social care providers. Because of the fragmentation and siloed working between the NHS and social care, and within the NHS itself, there is a particular responsibility upon councils with social care responsibilities and NHS leaders - in foundation trusts, trusts and primary care, as well as the ICB - to work together as part of this process of creating a common culture.

3.85 I therefore recommend that NHS England work closely with the LGA, Confed and NHS Providers to further develop the leadership support offer. Investment of this kind is a necessity, not a luxury. But within each ICS, partners need to work together to make the best possible use of limited funds, including the training and development budgets of the ICB, individual NHS organisations and local council partners. The need for such support is echoed in the HSCCs most recent inquiry of ICS autonomy and accountability. Their recommendation calls for government and NHS England to set up and fund an ICS leadership development programme, specifically targeted at supporting leaders of and within ICSs to develop the skills required to be successful system leaders. Statutory partners in ICSs should consider how they support VCFSE and social care provider partners to be fully included in organisational development. Creating shared teams between local councils and the NHS (for instance, a single integrated health and wellbeing communications team) will help to build common purpose and understanding of the very different culture, governance and financial frameworks of different statutory organisations as well as making better use of scarce resources.

3.86 The previously described goal of self-improving systems also requires sustained investment in improvement capabilities. Quality improvement should therefore be supported by system leadership and at system level (or, in very large systems, at place level).

3.87 A few systems or place partnerships have already adopted a common improvement methodology. Others have started bringing together QI leads or teams across different organisations to create a QI community. Mutual understanding, sharing learning and building a common approach will be a powerful driver of improvement and transformation across the local health and care system. When assessing the maturity and effectiveness of ICSs, CQC should take into account the extent of collaboration around organisational development and quality improvement.

3.88 In further recognition of the need to sustain and deepen culture change, I recommend that the implementation groups for the Messenger Review should include individuals with significant experience of leading sustained cultural and organisation change in local government and the voluntary sector as well as the NHS.

National organisations

Relationship between DHSC, NHS England and ICSs

3.89 Consideration now needs to be given to the relationship between NHS England, the department and ICSs themselves. The 2012 Act separated NHS England from the department, placing operational leadership in an arm’s length body. Policy

making, including setting the mandate for NHS England, remained with the department. That arrangement, confirmed by the 2022 Act, reinforced the position that NHS providers, and now NHS ICBs, are accountable to NHS England which is, in turn, is accountable to the Secretary of State and, through them, to parliament. NHS England has also taken on new functions from NHS Improvement, Health Education England and NHS Digital - making clarity of responsibility and accountability even more important than before. It is increasingly clear, however, that these arrangements are not working as intended. From the standpoint of providers and systems the apparently clear distinction between the department and NHS England can feel increasingly blurred in practice.

3.90 Everyone wants ICSs to succeed: the department and its ministers, NHS England and ICS partners and leaders themselves. The fact that all 3 can, at times, have quite different perspectives on the central issue in my terms of reference - the balance between greater autonomy and robust accountability - does not flow from any difference in the outcomes they seek. All want the best outcomes for patients and the public, improved working lives for staff and the most effective use of public funds. Their differences of perspective are driven by differences in position within the health and care system rather than different goals.

3.91 I have therefore sought to understand all 3 perspectives and reflect them here, starting with ICSs.

3.92 I have been directly involved in the development of ICSs over the last 6 years, as independent chair of a sustainability and transformation partnership (STP) and then an ICS, and now as chair of an ICB and deputy chair of the ICP. The views of system leaders are reflected throughout this report, including the clear desire for greater autonomy alongside effective accountability. They want to look outwards, not upwards. ICS leaders themselves recognise ministers' personal commitment to ICSs and welcome their increased interest. It is not only helpful but essential that ministers become as familiar as possible with how different ICSs are working, their real achievements and the challenges they are encountering. Ministerial attention can itself help to reinforce partnership working, highlight and spread excellent practice and innovation and challenge ICS leaders to go further and faster. On the other hand, many ICB leaders are concerned by the growing number of requests for detailed performance data or explanations of exactly what they are doing on a specific performance issue, duplicating or conflicting with clearly established lines of accountability. I am therefore not surprised to hear a growing number of system leaders say that "it feels as if we have 2 centres now."

3.93 In relation to NHS England, from the start of this review, I saw how easy it would be to frame the issue as "ICSs good, NHS England bad". Easy, but wrong. In the announcement of the review itself, I stressed that the review would 'build on the welcome work already done by NHS England to develop a new operating model'. Both before and since 2012, I have worked closely with what is now NHS England.

I value their clinical and operational expertise and have great respect for their many outstanding leaders. It is clear to me that the leaders and staff of NHS England are committed public servants who have a real dedication to supporting the NHS. As both the headquarters for the NHS and as an arm's length body of government they face daily challenges, but it is to the great benefit of the system and to government that they continue to tackle those challenges. NHS England deserve a good deal of credit for the changes they have already made and are continuing to make, referred to in other parts of this report. They themselves initiated STPs in the first place, giving them welcome freedom to develop in response to local circumstances. As the headquarters of our National Health Service, they continue to have a vital role in relation to the NHS as a whole that must be recognised and supported.

3.94 Nonetheless, in matters affecting the success of ICSs, including how they are regulated and held to account, NHS England needs to go further and faster in some respects. They also need to recognise that, as the headquarters of the NHS, they cannot also be the headquarters of ICSs where the local NHS is only part of a far wider partnership.

3.95 Turning to the Department of Health and Social Care: I have been Secretary of State for Health myself, working closely with the many exceptional officials who then formed the ‘department’ team. Both as an ICS leader and particularly through this review, I have leant on the policy expertise, insights and dedication of today’s officials. It is clear that ministers are committed to lightening the load of ‘must dos’ and we have seen, for example, a welcome shortening of the mandate in recent years, a trend I am confident will continue this year. Personally, I have felt the same heavy weight of responsibility for the NHS and the social care system that ministers feel today. I know what it is like, being constantly summoned to the House of Commons to deal with urgent questions or facing media interrogations about serious problems in a particular area. Like ministers today, I held the NHS to account, seeking to understand and support them but also to challenge. I expected to have the information I needed to fulfil my role. For ministers, it can also often feel as if they are in a parallel centre that is being held publicly accountable for performance as well as policy.

3.96 Nonetheless, in matters affecting ICSs, including how they are regulated and held to account, it is essential that there is clarity on roles and responsibilities and clear boundaries between operational management and wider responsibilities. This makes alignment between the department, Secretary of State and NHS England vital. The department needs to accept that provider trusts and ICBs do not report to them, and maintain the distinction between operational performance management on the one hand, and accountability and challenge on the other. And, of course, there needs to be an open, trusting and respectful relationship between NHS senior executives and ministers themselves. Just as we should expect NHS England to work ‘with and through’ ICBs in their relationship with

providers, so we should expect the department to work ‘with and through’ NHS England in its relationship with systems and providers. In both cases that does not preclude direct engagement, but it does set a default expectation for how things should normally work.

3.97 My terms of reference specifically asked me to focus on ‘real time data shared digitally with the Department of Health and Social Care, and on the availability and use of data across the health and care system for transparency and improvement’. Although I had expected to find a broad measure of agreement on this point, this proved not to be the case. DHSC and its ministers are frustrated by their inability to get data that they want. NHS England itself has changed its stance on sharing data and information with DHSC, with automated data-sharing feeds updated regularly. ICB and trust leaders themselves are increasingly concerned about multiple requests for data and information, often extremely detailed and at very short notice. As the above account illustrates, however, what appears to be a duplicative request for information from one perspective can, from another point of view, be a reasonable action to ensure that parliamentary accountability is done properly. This helps to show why effective alignment can never be found solely in the rulebook or the legislation - it depends on building relationships of trust and on mutual understanding.

3.98 Digitisation of the health and social care system, together with the rapidly growing use of smart data analytics tools, will help to provide the ‘single version of the truth’ that is an essential part of aligning all partners, locally and nationally, around the same purpose and goals. I make recommendations on that and other matters that will help both ICSs and national bodies, including ministers.

3.99 The pandemic itself provides an example of successful data sharing between NHS England, No.10 and DHSC, integrating information from the NHS on cases, symptoms and outcomes as well as population and demographic data to create a ‘single version of the truth’, updated daily and used as the basis for ministerial press conferences as well as policy decisions. And this report provides examples of the impressive results achieved within systems from data-driven approaches to identify people and communities at risk and provide them with the early intervention that is both better for them and relieves pressure on health and care services.

3.100 In order to strengthen the alignment between the department, NHS England and ICSs, I suggest a rapid stocktake - potentially led by the No. 10 delivery unit - to assess data flows for timeliness and usefulness. Its conclusions should be shared with systems, Secretary of State and NHS England as a basis for agreeing actions for using data to further support the work of all 3.

3.101 As an ICS leader remarked to me ‘real change comes from real work’ and the more that systems, NHS England and ministers can do together to make sense of

the key issues and work through practical solutions, the easier it will be for partnership working to be sustained into future challenges. I therefore suggest that DHSC ministers (along with DLUHC colleagues) build on their work with NHS England and systems to undertake shared learning from this winter. This should take the form of shared conclusions and actions during this year, and should report to the Secretaries of State for DHSC and DLUHC and the chief executive of NHS England.

3.102 For the new system we have created to succeed, we need some honest conversations about what is working and what needs to change. There are many unsung examples of effective team working between the department and NHS England and systems in all and every permutation; but there are also examples of tensions, wasted time and needless frictional costs generated by uncoordinated pursuit of organizational goals that do not take account of their wider effects. This also makes it harder for vital partners outside of the NHS - including local government, the VCFSE and social care providers - to collaborate effectively with the NHS. It can often feel to them like looking in on a purely NHS conversation that absorbs enormous amounts of time and energy that could be devoted to joint working. Everyone needs to change, and everyone needs to give a little so that the system as a whole works better.

National planning guidance

3.103 As I've previously made clear the public's immediate priorities - access to primary care, urgent and emergency care, community, mental health and social care services and elective diagnostics and treatment - are priorities for all of us, ministers, NHS England and ICSs. The level of interest in these matters rightly makes them a central part of accountability for ICBs and their partners in the wider ICS.

3.104 However, effective change in any system - particularly one as complex as health and care - needs consistent policy, finances, support and regulation over several years. Adding new targets and initiatives, non-recurrent funding or small funding pots, makes it impossible to plan new services or even recruit staff, wastes money and time, and weakens impact and accountability.

3.105 The government of which I was part introduced national targets as part of a number of measures to improve NHS performance. Although controversial at the time, a small number of targets undoubtedly contributed to significant improvements in performance and productivity. Reflecting on that experience, 4 points stand out to me.

- few targets concentrate minds; the more that are added, the less effective they become

- the higher the performance standards (for instance on emergency department waits), the less they allow room for vital clinical judgement

- the combination of too many targets, performance standards that are not clinically supported and an excessive focus on hitting targets by managers or boards themselves can lead to ‘gaming’ of the targets or even a disastrous neglect of patients themselves[14]

- I also learnt that targets that focus on end-to-end pathways can be particularly powerful in joining up care between siloed organisations, such as the target initially set for patients with suspected cancer to be seen by a specialist within 2 weeks of referral by the GP

3.106 My terms of reference setting out that the review will ‘consider the scope and options for a significantly smaller number of national targets’ reflect the widely-held belief that national targets had become wholly excessive. This is exemplified with the 2022 to 2023 planning guidance expressing national NHS objectives in 133 asks across 10 domains. The 2023 to 2024 planning guidance, developed in close consultation with ICB leaders and this review itself, made welcome and significant progress, summarising national NHS objectives on a single page with 31 asks across 12 domains.

3.107 Further progress should be made in the planning guidance for 2024 to 2025. I recommend that ministers consider a substantial reduction in the priorities set out in the new mandate to the NHS - significantly reduce the number of national targets, with certainly no more than 10 national priorities. Given the need to integrate care around patients themselves, it would also be helpful if the planning guidance could focus on outcomes rather than individual NHS sectors (primary, community, acute and so on). In particular it would be helpful to focus even more rigorously on the ‘what’ and the ‘why’ rather than the ‘how’. I therefore endorse the recommendation of the Select Committee that "Targets for ICSs set by DHSC and NHS England should be based on outcomes". There may be times when greater prescription around how targets are achieved is needed, but we believe this should be done sparingly.

3.108 In turn, we can expect the planning guidance for 2024 to 2025 to reduce further the number of 'domains' and 'asks'. Building on the approach taken last year, NHS England should continue to work closely with ICBs themselves as well as the

[14]The Francis report found that the failures in Mid Staffordshire was ‘in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care.' Mid Staffordshire NHS Foundation Trust Public Inquiry. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive summary (HC 947). The Stationery Office.

department to produce the new guidance. This focus on a small number of key priorities is particularly important in the current, highly-stressed circumstances.

3.109 I would also strongly urge that the necessary focus on reducing elective care waits be matched by an equal focus on reducing waiting times for acute mental health treatment.

3.110 I understand that the reduction of the number of 'domains' and 'asks' has itself caused concern, particularly amongst those whose area is not included. It is important to stress that national standards for clinical care, including those set by NICE, remain in place and will, of course, continue to guide the care provided to patients with different conditions.

3.111 I would also suggest harnessing the enthusiasm in both NHS England and systems for a more co-productive way of developing policy. In the development of its strategies and plans (for example the UEC strategy or the primary care recovery plan) NHS England works hard to engage a broad cross section of experts and stakeholders, with systems playing an increasingly strong role in the shaping of policy. Both NHS England and ICS leaders should build on this to deepen both the involvement of ICSs in shaping policy and the understanding within ICSs of that involvement. There should be very few ‘degrees of separation’ between an ICS leader and a new policy or strategy: either they or a peer should have had a hand in shaping it.

3.112 Building on the process of engagement used by NHS England in preparing the 2023 planning guidance, NHS England should commit to further deepening this collaborative approach in developing the 2024 planning guidance. Furthermore, where significant new plans and priorities directly impacting systems are added in-year to the planning guidance framework, these plans should also benefit from a process of collaborative co-design with system leaders.

3.113 Finally, I recommend that, to support this, NHS England and ICBs should agree a common approach to co-production, including working with organisations like the NHS Confederation, NHS Providers and the LGA.

Enhanced CQC role in relation to systems

3.114 Greater autonomy for ICSs - including, in particular, a radical reduction in central targets and top-down performance management together with an increase in financial autonomy and flexibility - will enable ICS leaders to deliver both short term performance and longer-term improvements in population health.

3.115 However, greater autonomy must come with more effective accountability to patients and the public as well as to NHS England and ministers.

3.116 Having started the review with a degree of scepticism about CQC, I now strongly support their enhanced role in relation to ICSs. This will build on their core mission to inform patients and the public about the quality of care and the effectiveness of services based on their oversight and inspection of health and social care providers.

3.117 The Health and Care Act 2022 included an important new role for CQC to review ICSs, alongside a further new role to assure local authority commissioning of social care. Once CQC has put in place arrangements to review systems, developing their approach and capability in partnership with a wide range of ICS leaders both from ICBs and ICPs, they should provide clear and transparent ratings on the quality of services within the ICS, across the key domains of care services - including primary care, mental health, community services, social care and both emergency and elective care at acute hospitals. They should also make an assessment of the level of maturity and effectiveness of each ICS as a whole, including a rating of the ICS leadership itself, based on an assessment of how far ICS structures (including of course the ICP and ICB) are adding value and enabling the system as a whole to meet its objectives and improve outcomes. CQC should then use these different ratings and assessments to inform an overall judgement on the achievement, challenges and areas for improvement for each ICS.

3.118 This work - which should be led by a Chief Inspector of Systems - should draw on multiple sources of quantitative and qualitative data, including CQC's existing inspections, as well as NHS England's information on ICB and providers use of financial resources. In its review of the ICS (effectively a 'well-led' review), CQC should assess how the ICS itself (including the ICP, ICP, place partnerships and Provider Collaboratives) adds value, enabling the whole to be more than the sum of its parts. Reporting should focus on helping ICS partners to improve more rapidly, as well as providing a basis for regulatory intervention where required. We know the most effective health and care organisations and systems are those where quality, performance and financial management go hand in hand, and so ratings must take account of all of these elements - and so we would not expect the highest ratings to be given to a system where the financial position is not being well-managed.

3.119 We recognise that this will be a significant shift for CQC, although building on the work that is already underway with ICS leaders to develop the right approach and capability for their new responsibilities. As a result, 2023 to 2024 should be a transitional year, allowing CQC and ICSs to co-design the most effective approach to CQC reviews, sharing learning as both CQC and ICSs embed system working and enabling it to generate ratings that the public, as well as ICS partners themselves, can trust.

3.120 We also recognise that ICSs, and ICBs within them, are at different levels of maturity, and differentiation between them will continue to be both necessary and important. As explained elsewhere, a ‘baseline’ of increased financial autonomy and flexibility should apply in all ICSs, with further freedoms also focussed on the more mature systems and ICBs during 2023 to 2024, so that NHS England can concentrate its improvement work and financial performance management on those ICBs where it is most needed, as well as fine tuning the arrangements for financial autonomy and flexibility.

3.121 CQC have been clear that they do not want to carry out 'compliance' inspections and have seen the opportunity to capture and help scale innovation. It is vital that assessment of ICSs does not become yet another set of tick-box capability and competency requirements but is a useful tool for enabling each system to develop and improve. I welcome CQC’s recognition of that risk and their commitment to understand the very different starting-points of each ICS, how each system stands in relation to its own stated ambitions and focusing on how each ICS is adding value and developing capability as a self-improving system.

3.122 In particular, as recommended in other parts of this review, CQC should include within its assessment of ICS maturity:

- how different partners - local government, the VCFSE sector, social care providers, other ICS partners and the local NHS including the ICB - themselves assess their engagement and relationships within the ICS itself, including the extent to which both public health expertise and the social care provider sector are involved in the leadership of the system

- the strength of the system-wide integrated care strategy with Joint Forward Plans, clear priorities, outcomes and timescales, providing a local outcomes framework against which the system can be held accountable by local residents and others

- the coherence, consistency and impact of arrangements at place and neighbourhood level within the ICS

- how far the system is making progress in shifting resources towards prevention, population health and tackling health inequalities

- how well systems work with and respond to support provided by the NHSE regions within the new operating framework, including the goal of supporting ICSs to become self-supporting systems

- practical examples of ICS partners identifying priorities, agreeing a diagnosis of the problem as well as a plan of action and making progress towards agreed outcomes. This should include looking at specific pathways of care

from a patient and service user perspective. It should also take account of Ofsted's assessment of children's social care services and whether or not system partners have developed an effective strategy for prevention, population health and tackling health inequalities amongst children and young people

- whether system partners are developing a framework of mutual accountability, sharing performance and financial data transparently in order to agree a single version of the truth; developing an ability to learn from mistakes and respond effectively to problems without blame within systems (in other words, focusing on quality improvement and creating a learning and improvement culture, building on peer review, 360-degree feedback, measurement of staff engagement, role of HOSCs and psychological safety)

- whether the system is finding ways of shifting emphasis and resources towards prevention, population health and tackling health inequalities

3.123 Reviews should also share best practice and insight from other systems in suggesting recommendations for improvement and identify good practice to be shared. This would support continuous improvement and stronger relationships. CQC should be mindful to ensure their reviews can help foster stronger relationships and how they can impact fragile relationships in still developing systems.

3.124 CQC has reviewed international experience of integrated care and engaged with a number of ICSs to develop a methodology for ICS inspection. Given the scale of change this represents for the CQC itself, however, at a time when statutory ICSs are in their infancy, CQC and ICSs should work together over the coming year to develop a long-term approach to inspections and ensure that CQC develops the capabilities and skill sets needed to support successful development of ICSs.

3.125 In their first year the focus of CQC should be on calibration of their assessments and supporting improvement and sharing best practice amongst systems within their reports rather than assessment and rating.

3.126 This should be driven by co-design between CQC and systems sharing learning as both CQC and ICSs embed system working. This should include engagement with ICBs in forming a view about the ways in which clinical risk are held and managed within and between providers and other partners, incorporating this into their judgements of registered services.

3.127 I would also suggest investment in training for the CQC workforce to upskill staff and bring in colleagues with experience from systems, including where appropriate other system leaders.

3.128 While I appreciate work is beginning already on CQC's new inspection regime for adult social care and reviews of ICSs, CQC should use this year to work closely with and learn from local authorities and systems while they continue to refine and develop their methods.

The role of data for system accountability

3.129 Transparent, accurate and accessible information enables patients and the public to know whether the services they are receiving are high quality, efficient and effective. Equally, clear and effective engagement with the public builds confidence that individuals' data contributions are creating real benefits for themselves and wider society, thus underpinning further improvement and transformation. Transparent data is a powerful incentive and enabler of improvement, reflected for instance in the work of the National Joint Registry (NJR) over the last decade. Using cutting-edge data analytics, and as a globally recognised exemplar of an implantable medical devices' registry, the NJR has already helped to improve patient outcomes, inform clinical practice, ensure the quality and value of joint replacement surgery and support orthopaedic research.

3.130 To develop integrated care with timely, relevant and high-quality performance data, it is essential to ensure that there is a two-way flow between systems and national bodies.

3.131 The new Federated Data Platform (FDP), currently under procurement, should make a significant difference. The automation of data in real time will drive consistency, free systems from administrative burdens and enable effective benchmarking across providers and systems. Although the first stage of implementation is focused on NHS acute trusts, I recommend that work begins at the same time to build a close partnership between NHS England, the FDP developers, and appropriate colleagues from ICSs, local government and the provider sector including primary care, community and mental health, adult social care providers and VCFSE providers to ensure that the full benefits of the FDP can be realised in future, with all parts of the health and care system involved in its development. The strategic objective should be to create a unifying digital architecture across the entire health and care system, with the FDP itself helping to support local systems to address key challenges while also offering the opportunity to share and scale innovative tools and applications.

3.132 In particular I recommend:

- NHS England and DHSC should incentivise the flow and quality of data between providers and systems by taking SITREP and other reported data directly from the FDP and other automated sources, replacing both SITREPS and additional data requests

- data required in real-time by NHS England and DHSC should be taken from automated receipt of summaries to drive consistency; and where possible without creating excessive reporting requirements, data should enable site-level analysis

- data collection should increasingly include outcomes (including, crucially, Patient Reported Experiences and Outcomes) rather than mainly focusing on inputs and processes

- data held by NHS England (including NHSE regions) about performance within an ICS, including benchmarking with other providers and systems, should be available to the ICS itself and national government

- DHSC and NHS England work with nominated ICS colleagues to conduct a rapid review of existing data collections to reset the baseline, removing requests that are duplicative, unnecessary or not used for any significant purpose. This work should be completed within 3 months

3.133 As I stressed earlier, I understand only too well the need for NHS England and DHSC to get up to date information from systems and providers. But it is essential that information-gathering itself does not distract senior leaders and their teams (including the scarce resource of digital and data experts themselves) from the key priority of actually improving performance. Given the scale of improvement required, the present manual reporting burden placed on providers and partners in ICSs is unacceptable. Notwithstanding the severe performance issues in December 2022, in one instance one ICS received 97 ad-hoc requests from DHSC and NHS England, in addition to the 6 key monthly, 11 weekly and 3 daily data returns.

3.134 Continuing automation of data provision, shared between NHS England, DHSC and No. 10, will itself improve matters. In the meantime, further action is required to reduce the number of uncoordinated, often urgent requests for data that can only be provided through time-consuming manual means.

3.135 Even high quality data needs to be supplemented by experience and insights to understand where investment and energy should best be directed, both within systems and between systems and national bodies. For instance, although data may show the same performance challenges in 2 systems or trusts, the causes may be very different (for instance, in one case a well-led trust or system struggling with a fundamental mismatch between demand and capacity; in the other, a combination of weak leadership, antagonistic relationships and poor culture). The support or regulatory intervention required would also be very different, despite the apparent similarity in performance. Insights from systems themselves, regional teams and CQC are vital in complementing performance and benchmarking data.

Chapter 3: recommendations

10. HOSCs (and, where agreed, Joint HOSCs) should have an explicit role as System Overview and Scrutiny Committees. To enable this DHSC should work with local government to develop a renewed support offer to HOSCs and to provide support to ICSs where needed in this respect.

11. Each ICS should be enabled to set a focused number of locally co-developed priorities or targets and decide the metrics for measuring these. These priorities should be treated with equal weight to national targets and should span across health and social care.

12. In line with the new operating framework, the ICB should take the lead in working with providers facing difficulties, supporting the Trust to agree an internal plan of action, calling on support from region as required. To enable this support and intervention should be exercised in relation to providers ‘with and through’ ICBs as the default arrangement.

13. NHS England and CQC should work together to ensure that as far as possible their approach to improvement is complementary and mutually reinforcing.

14. A national peer review offer for systems should be developed, building on learning from the LGA approach.

15. NHS England should work with ICB leaders to co-design and agree a clear pathway towards ICB maturity, to take effect from April 2024.

16. An appropriate group of ICS leaders should work together with DHSC, DHLUC and NHS England to create new ‘High Accountability and Responsibility Partnerships’.

17. During 2023 to 2024 financial year further consideration should be given to the balance between national, regional and system resource with a larger shift of resource towards systems; and that the required 10% cut in the RCA for 2025 to 2026 financial year should be reconsidered before Budget 2024.

18. NHS England and central government should work together to review and reduce the burden of the approvals process of individual ICB, foundation trust and trust salaries.

19. ICS leaders should be closely involved in the work to build on the new NHS England operating framework to codesign the next evolution of NHSE regions.

20. NHS England should work closely with the LGA, Confed and NHS Providers to further develop the leadership support offer.

21. The implementation groups for the Messenger review should include individuals with significant experience of leading sustained cultural and organisational change in local government and the voluntary sector as well as the NHS.

22. Ministers should consider a substantial reduction in the priorities set out in the new Mandate to the NHS - significantly reduce the number of national targets, with certainly no more than 10 national priorities.

23. NHS England and ICBs need to agree a common approach to co-production working with organisations like the NHS Confederation, NHS Providers and the LGA.

24. As part of CQC's new role in assessing systems, CQC should consider within their assessment of ICS maturity a range of factors (set out on page 58).

25. ICSs, DHSC, NHS England and CQC should all have access to the same, automated, accurate and high quality data required for the purposes of improvement and accountability. In particular:

a) NHS England and DHSC should incentivise the flow and quality of data between providers and systems by taking SITREP and other reported data directly from the FDP and other automated sources, replacing both SITREPS and additional data requests

b) Data required in real-time by NHS England and DHSC should be taken from automated receipt of summaries to drive consistency; where possible without creating excessive reporting requirements, data should enable site-level analysis

c) Data collection should increasingly include outcomes (including, crucially, Patient Reported Experiences and Outcomes) rather than mainly focusing on inputs and processes

d) Data held by NHS England (including NHSE regions) about performance within an ICS, including benchmarking with other providers and systems, should be available to the ICS itself and national government

e) DHSC and NHS England work with nominated ICS colleagues to conduct a rapid review of existing data collections to reset the baseline, removing requests that are duplicative, unnecessary or not used for any significant purpose. This work should be completed within 3 months

4. Unlocking the potential of primary and social care and building a sustainable, skilled workforce

4.1 The review terms of reference specifically asked to look at how to empower local leaders to focus on improving outcomes for their populations and making ICSs more accountable for performance and spending, much of which can be delivered though primary and social care.

4.2 Strengthening local leaders' ability to have greater and more flexible decision-making in primary and social care, supported through a more joined up national policy approach, will not only better enable them to deliver improvements in immediate performance, it will be key to improving outcomes in the communities they serve.

4.3 In order to enable the kind of integration, collaboration and autonomy we want to see integrated care systems (ICSs) embody, we need to pull down some of the barriers that currently exist for primary care, social care and the way we train health and care workforce. Breaking down these boundaries will be fundamental to unlocking the potential of system working and reinvigorating the much-needed focus on prevention and early intervention.

Primary care

4.4 Dr Claire Fuller's timely stocktake of primary care has already set out a vision and route-map for integrated neighbourhood working where teams from across primary care networks (PCNs), wider primary care providers, secondary care teams, social care teams, and domiciliary and care staff can work together to share resources and information and form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities.

4.5 My recommendations build upon the important work and recommendations of the Fuller Stocktake, focusing on what more needs to be done within ICSs to create integrated neighbourhood teams and integrate care across the whole patient pathway. I also make recommendations on the changes needed within primary care contracting (an issue not included within Dr Fuller's terms of reference).

4.6 On 1 April 2023, all ICBs will take on responsibility for commissioning community pharmacy, optometry and dentistry, through delegation of all primary care commissioning for the first time. Instead of each element of primary care being treated as a separate silo, ICBs now have the opportunity - and the responsibility - to work with all elements of primary care to achieve the accessible, high-quality

and integrated services that residents and local communities need. Much of this work, of course, will be led and delivered with local government and VCFSE partners through place partnerships and integrated neighbourhood teams, involving collaboration with community, health and social care services, and specialist acute services as well as primary care itself.

4.7 Despite currently being constrained by nationally negotiated and held contracts with care partners, ICBs through PCNs and place partnerships, as well as system-wide, can still consider the needs of their local population and determine the best use of resources for that population. They can support the joining up of different elements of urgent care, including 111, community pharmacies and walk-in centres and ensure the most effective provision of services to meet population need without focusing solely on one area of primary care when commissioning those services.

4.8 ICSs should also play a greater role in driving primary care transformation. The Fuller Stocktake included many inspiring examples of primary care organisations delivering at scale and through multi-partnership teams; others have emerged during this review, including Medicus in Enfield, North London.

Medicus Health Partners is the second largest primary care practice in England. Working in the London Borough of Enfield, it brings together 15 practices merged into a single PMS contract, with 34 partners, a managing partner, 23 salaried GPs and a multi-professional staff totaling 370. By working at scale to listen and respond to patients, provide development and support for staff and streamline administrative and digital support services, they have been able to improve the working lives of their staff while transforming the quality of care they provide. At a time when A&E attendances and emergency admissions of patients in care homes in other parts of Enfield were rising by around 30%, Medicus worked with care homes to reduce A&E attendances by over 10% and emergency admissions by 16%. Medicus have an estates strategy that consolidates fifteen surgery premises, some of them too small old and not fit for purpose to accommodate staff or patients properly, into 9 modern health and care hubs.

Primary care contracts

4.9 I have heard repeatedly that national contracts present a significant barrier to those within the GP partnership model who want to work in innovative and transformational ways, requiring a great deal of time, goodwill, ingenuity and workarounds from practice partners and ICBs. ICBs also lack effective levers to support and secure the services in practices where practices are facing difficulties in providing a good quality of service in their area.

4.10 With ICBs taking on responsibility for NHS dentistry on 1 April, it is essential that the next stage of dental reforms, which is currently being developed and builds on

the incremental reforms made last year, is implemented as soon as possible. Without this, ICBs are simply being handed the task of improving an unacceptable situation without sufficient tools to address this. The government has already made some welcome changes, giving ICBs some flexibility to create additional services where they are most urgently needed and announcing the first set of contractual reforms in July 2022 to support fairer remuneration for dentists and increase patient access to care.

4.11 Furthermore, the contract held by GP contractors for ‘general medical services’, which is negotiated nationally between government and the BMA, provides far too little flexibility for ICSs to work with primary care to achieve consistent quality and the best possible outcomes for local people.

4.12 Contracts with national requirements can have unintended consequences when applied to particular circumstances. For instance, the national requirements and funding of Additional Roles Reimbursement Scheme (ARRS) roles for community pharmacists within PCNs, has on occasion exacerbated the problem of a general shortage of pharmacists, with some now preferring to work within primary care rather than remain in community pharmacies or acute hospitals, compounding the problem of community pharmacy closures and delayed discharges. The new responsibilities for ICBs provide an important opportunity, at place or system level, to integrate the whole primary care offer for communities, making the best use of both the staffing resource available and the premises.

4.13 The Quality and Outcome Framework (QOF) points that were an important and useful innovation twenty years ago are now out of date and are seen by GPs as well as ICBs as an inflexible and bureaucratic framework. This needs to be updated with a more holistic approach that allows for variation. The new approach must also recognize that, in order to allow primary care to refocus resources on prevention, outcomes rather than just activity need to be measured.

4.14 As the GP contract is now entering its fifth year of a 5 year agreement, and the government will be shortly considering its intentions for the next iteration of the contract, radical reform is needed, and this is the right time to make it happen.

4.15 I therefore recommend NHS England and DHSC should, as soon as possible, convene a national partnership group to develop together a new framework for GP primary care contracts. This partnership group should include a diverse range of GP partnership leaders currently delivering excellence across a range of different regions and demographics, as well as ICB primary care leaders, local government and - crucially - a number of patient and public advocates. As part of this work, NHS England and DHSC should, of course, engage with key stakeholders, including the BMA and the RCGP.

4.16 Although of course the final decision on policy and funding rests with ministers, I would suggest that this framework should enable systems to find the right solutions to fit their circumstances, including building on the partnership model, rather than sweeping it away entirely.

4.17 In particular, I would suggest that the work of this group should consider:

- the outcomes that we want from primary care as a whole. While it is not for this review to specify the outcomes, they should be developed closely with patients and the public over the coming months and include patient reported outcomes and experience as some of the measures for success

- the balance between national specifications and local flexibility and decision making - greater flexibility and appropriate local autonomy within a framework of national standards is needed to improve equity of access and care and to enable PCNs to take a greater role and responsibility in reducing health inequalities and population health management. ICBs, working with primary care partners at neighbourhood and ‘place’ level, need to join up the many different elements of primary care, including urgent care, making best use of clinical and other professional staff as well as premises and budgets, and taking account of the particular needs of their population and its geography and demography, to get the most convenient access and best outcomes for residents

- national standards or specifications should include clear expectations around digital and data, in line with the recommendations elsewhere

- how to incentivise and support primary care at scale. There are many different ways of achieving primary care at scale, within the context of integrated neighbourhood teams and wider place partnerships. These include: practices coming together as a single group; GP provider federations, owned collectively by partners and providing support to all member practices; free-standing practices working together within a PCN, where in future the contract (whether for core GMS services or enhanced services) might be held with the PCN rather than individual practices and partners; GPs working as part of a multi-disciplinary primary care division within a wider NHS trust and so on. The new contract needs to allow for different models, in particular allowing tailoring to local circumstances in the patient facing offer, while ensuring we capture the benefits of an ‘at scale’ model behind the scenes. This work should consider how the system can make it simple for partners who wish to move in this direction to do so, while also encouraging and incentivising others to move in this way

- how best to support struggling practices to improve. Practices that are not delivering at a high enough standard need to be supported to improve and,

where necessary, to be replaced so that residents in every community receive the support from primary care they need. This should include creating a centrally-held fund to buy out contracts or premises, or both, where that is essential to improve access, care and outcomes in a particularly disadvantaged community

Social care

4.18 I have heard a lot throughout the review about the need for social care to be better understood within the NHS. This is critical as appropriately embedding social care is essential for effective integrated working in systems, in particular at place and neighbourhood level.

4.19 Social care at its best can be described in the following terms: “We all want to live in the place we call home with the people and things that we love, in communities where we look out for one another, doing things that matter to us”.[15] This definition is widely supported as describing the diverse range of support that social care offers to enable people to live as well and independently as possible. Social care is an important sector in its own right, employing around 1.5 million people, more even than the NHS, and making a significant economic contribution, estimated in 2021 to 2022 at £51.5 billion.

4.20 While local government has crucial commissioning and market-shaping responsibilities for social care, the provision of social care - both domiciliary and residential - is the responsibility of over 18,000 different organisations, mainly in the private sector, often small and family-owned, but including a small number of very large privately-owned providers as well as a significant number of not-for-profit, charitable and social enterprise organisations.

4.21 The social care landscape is complex. Many people in the UK currently do not know what level of care they are entitled to until they are faced with a family crisis. The government has published plans for social care charging reform, although implementation is currently paused.

4.22 As a society we need to face up to the challenge of providing a decent quality of care for everyone who needs it, including many of the most vulnerable people in our communities. It is not for this review to recommend the shape that any structural or financial reform of social care should take. Instead, we need a national conversation about what we expect from our care; and what we are willing to pay for it.

[15] Routledge, M, Social Care Future, Local Government Association. (Accessed: 17 March 2023).

4.23 It is clear, however, that if health and care are to be effectively integrated and delivered at ICS level, social care needs to be a national priority for investment and workforce development, enabling delivery of the reforms of the 2014 Care Act.

4.24 ICSs also have a vital role in supporting a more sustainable social care sector at system level, by taking an integrated approach to reducing the gap between demand for care and available supply, for example by encouraging the adoption of personalised, preventative and proactive models of care.

4.25 I would therefore urge an acceleration and expansion of existing work on understanding both need and the fair cost of care, before the proposed cap on adult social care costs is implemented. The fair cost of care work, commissioned as part of the government's now delayed implementation of charging reform, is a helpful model to move towards a fairer rate of care paid by local authorities to social care providers, and is helpful to understand the social care market - however, it is currently restricted to the older adults residential care market. While it will be beneficial to see the evaluation and assessment so far, it would also be helpful to expand this work to capture working age adults and potentially children's social care. It is vital we appropriately understand the cost of providing high quality care and support for those who need it. Whether this is paid for privately or through taxes and contributions, there is a clear need for this to be paid at a fair rate that reflects their vital role in enabling the dignity and independence of the people they support and their families.

Workforce

4.26 Further change will only be possible with a strong and supported workforce across both healthcare and social care.

4.27 The government is due to publish a long-term workforce plan for the NHS imminently. Given the interdependence of health and social care, I therefore recommend that the government should now produce a complementary strategy for the social care workforce as soon as possible. This plan should set the strategic direction for a more integrated health and social care workforce. This strategy can then support local authorities, who have responsibility for adult social care provision, and ICSs, who will play an increasingly key role in joined up workforce planning.

4.28 Shared training should be encouraged, together with the development of 'passports' reflecting qualifications and experience that make it easier for people to work within the whole health and care system rather than just one part of it.

4.29 The strategy should include integrated training and continuing professional development for social care and NHS staff, supporting the vital work of multi-

professional, multi-organisational teams and making it easier to integrate care around the needs of an individual. The strategy should also set out practical support for career pathways that include both NHS and social care.

4.30 Investment in workforce development in social care should be longer term, as a minimum based on a 3-year rolling planning cycle to support multi-year investment programmes.

4.31 The example of Derbyshire integrated care system shows the value of collaborative workforce planning:

In Derbyshire the integrated care system workforce team are working with Joined Up Careers, along with the Department for Work and Pensions, Jobcentre Plus and Futures for Business, to boost recruitment to the health and care Sector-based Work Academy Programme (SWAP). The programme, led by the local city council, prepares and places new entrants into the health and social care sector in Derby and Derbyshire, particularly targeting support to increase the employment rate for individuals unemployed and or on Universal Credit who are disabled, people aged 50+, ethnic minorities (BAME) and women. As a result of this programme, 299 participants signed onto the pathways into health and social care employment project, many of whom were previously unemployed or economically inactive.

4.32 Working in this way, at place or system level, ICSs can contribute to wider social and economic development - their fourth core purpose - as well as helping to solve immediate workforce challenges.

4.33 A similar partnership approach has been taken by the Suffolk and North East Essex (SNEE) ICS to the challenge of recruiting and training more NHS dental staff in a region that does not yet have its own university dental school. In collaboration with the ICB, the University of Suffolk have established a Centre for Dental Development, which will enhance local education and training opportunities in dental therapy and hygiene, apprentice dental technicians and post graduate dentists. The Centre will sit alongside a community interest company, created by the university, that will be able to bid for future locally commissioned dental services in line with usual NHS protocol. This initiative has the potential to improve the levels of NHS dentistry provision not only in SNEE but also in neighbouring systems such as Norfolk and Waveney. It is a further example of how an ICS has built an innovative local partnership solution to a major national challenge.

A joint venture community interest community has been established by Suffolk University and the ICB to create a dental training practice, where new recruits train as dental hygienists and dental hygienists can train as dental technicians, upskilling and expanding the existing workforce but also providing badly-needed dental care for local residents

under the supervision of qualified dentists and trainers. As in Derbyshire, the apprenticeship levy is a major source of funding for this work.

4.34 I support the Messenger Review's call for systems to improve mutual awareness and provide opportunities for staff to engage beyond their professional environment, to appreciate the totality of the system, and to value diverse professional approaches. For the NHS (itself a complex system within the larger complex system that is an ICS), there should be a clear expectation that part of the training and development budgets within each NHS entity (that is, primary care practices as well as trusts and foundation trusts) and within social care (at least commissioning and, ideally, provision) should be used for shared training and development of staff with other parts of the NHS and social care. This is an essential part of creating the multi-disciplinary, multi-organisational neighbourhood teams (as well as the coherent system-wide leadership) that are at the heart of effective integrated care.

4.35 Professionals and practitioners should be offered formal and informal opportunities to develop their understanding of other parts of the system as part of their continual professional development.

4.36 Integration also goes beyond training, with a need for clear and standardised policies, governance and frameworks to enable flexibility across health and care roles. Blending some of the tasks of health and care roles can enable a better experience for the patient, increased continuity of care and a more efficient use of resource. Teaching a home carer how to dress a wound is an example of how transferring a healthcare intervention from a clinically registered practitioner to a non-clinically registered individual can potentially improve services by enabling closer alignment of different aspects of a person's care.

4.37 While delegation for certain interventions is becoming more common, it often takes place through informal agreements. This causes challenges for providers (for example around indemnity cover) and complications for regulators. Although published guidelines on delegation do exist, they are disjointed and not applicable across the whole health and care system. Without standardised governance and frameworks, it is challenging for individuals to feel supported and confident in delivering these interventions.

4.38 I therefore recommend that DHSC bring together the relevant regulators to reform the processes and guidance around delegated healthcare tasks.

4.39 To speed up the onboarding of health and care staff and enable movement across the system where necessary, commissioners may consider requiring that providers maintain health and care workers DBS certification on the existing online database. This would mean there is no wait time when a person moves job as it is centrally stored and kept up to date, and therefore just minutes for agencies to

check, confirm or print a person's DBS certificate. Consideration should also be given to the passporting of training to reduce duplication and induction times.

The digital and data workforce

4.40 Although much of the focus and investment has been on digital and data systems within acute hospitals, it is essential that we level up basic digital infrastructure in all parts of the system, instead of expecting nurses, healthcare assistants and care workers looking after people with complex conditions and multiple needs to write down essential information on paper and then spend precious time going back to the office to input the data manually.

4.41 The skills needed to deliver data and digital transformation require a professional and highly skilled workforce at the system and provider level. Many health and care staff are well-versed in the use of digital tools; as the digitisation of health and care intensifies, staff at every level need to feel equipped and confident to use the tools available. As I heard frequently from clinical CIOs and other experienced leaders, new systems including electronic patient records are not primarily about technology: they are about transforming clinical and administrative processes to achieve better outcomes for patients, with digital tools enabling but not themselves delivering the necessary transformation. Major 'IT' programmes require substantial time and effort before, during and after implementation in culture, behaviours, and leadership, developing more medical, nursing and AHP CIOs and ensuring that all staff are comfortable with the tools they need to use.

4.42 The health and care system urgently needs to develop, train and recruit more specialists in fields such as data science, risk management, actuarial modelling, system engineering, general and specialized analytical and intelligence. Unfortunately, the Agenda for Change framework for NHS staff makes it impossible for systems to pay competitive salaries for these skilled professionals, with the result that too many ICBs and providers recruit the necessary staff on short-term contracts. I therefore recommend that ministers and NHS England work with the trade unions to resolve this issue as quickly as possible. National workforce planning needs to include steps to ensure that systems can build digital capability, upskill their current workforce and develop clear pathways for progression. ICSs themselves, working with local schools and further education providers, can create new routes into digital roles along the lines of the local academies that have successfully used apprenticeships to recruit and develop trainee nurse associates. As NHS England completes its own reorganisation, it would also be helpful if skilled staff could be seconded or transferred directly into those ICBs that need most support, with a specific focus on data science, cyber security, and analytical skills.

Chapter 4: recommendations

26. NHS England and DHSC should, as soon as possible, convene a national partnership group to develop together a new framework for GP primary care contracts.

27. The government should produce a strategy for the social care workforce, complementary to the NHS workforce plan, as soon as possible.

28. DHSC should bring together the relevant regulators to reform the processes and guidance around delegated healthcare tasks.

29. Currently the agenda for change framework for NHS staff makes it impossible for systems to pay competitive salaries for specialists in fields such as data science, risk management, actuarial modelling, system engineering, general and specialized analytical and intelligence. Ministers and NHS England should work with trade unions to resolve this issue as quickly as possible.

5. Resetting our approach to finance to embed change

5.1 Instead of viewing health and care as a cost, we need to align all partners, locally and nationally, around the creation of health value. That shift is entirely in line with cross-government public spending principles, with their strong focus on public value and the outcomes that are being delivered for citizens.[16] As individuals, there is nothing more valuable than our own health and wellbeing and that of the people we love. But good health also has a wider value to our society and economy. Recent analysis finds that every pound of public money invested in the NHS can generate £4 on average through gains in productivity and increased participation in the labour market.[17]

5.2 Today, however, we are not creating the best health value that we could from the current investment in the NHS. The evidence from other healthcare systems as well as our own demonstrates that there is a proven opportunity, whatever the total spend, to create greater health value by investing in primary and secondary prevention and by shifting care from acute to community and primary care settings ('allocative efficiency'). At the same time, within each element of healthcare, there are multiple opportunities to improve technical efficiency by enabling our most valuable resource - our people - to work more effectively (replacing paper systems with shared digital records, for example, or ensuring that every operating theatre session is fully utilised) and to significantly improve the use of our building and equipment.

5.3 Medicare, the publicly funded programme for people over 65 in the US, provides compelling examples of the improvements in outcomes, quality and value for money that can be achieved at scale through an integrated approach, with a single budget for the healthcare needs of a population group rather than fragmented payments to different providers. Such an approach typically involves earlier screening of older patients, with fewer ED visits and about 30% fewer hospital admissions. One of the Medicare providers demonstrating the value of this 'upstream' approach is the Florida-based group, ChenMed.[18]

Founded in Miami, Florida, ChenMed operates under the Medicare Advantage model, which as part of the wider government-funded Medicare programme specifically provides government funding to support those over 65 with more complex needs or in areas of high deprivation. ChenMed's care model invests heavily in primary care and prevention to

[16] HM Treasury, Managing public money, last updated September 2022
[17] NHS Confederation, Carnall Farrar, Analysis: The link between investing in health and economic growth. 2022.
[18] Commonwealth Fund - Transforming Care: Reporting on Health System Improvement (March 2016)

improve outcomes, experiences and the time patients spend at home. This model uses rigorous risk stratification combined with high intensity proactive care to deliver these outcomes. Prioritising high frequency, longer GP visits enables GPs and core care teams to evaluate patients and conduct risk stratification to ensure they can focus on patients at highest risk of inpatient admission. This approach focusing on primary care and prevention has had remarkable results, generated significant value for those supported by ChenMed and resulted in a 40% reduction in inpatient hospital days compared to the Miami average.

5.4 There are many other examples of the value of this kind of proactive, prevention and outcome-focused care, reflected in the Fuller Stocktake as well as this report and elsewhere. Working at many levels - through place partnerships, integrated neighbourhood teams and provider collaboratives, as well as system-wide, ICSs provide the opportunity for urgently needed improvements in both allocative and technical efficiency.

Financial accountability

5.5 As mentioned earlier, integrated care boards (ICBs) are accountable for £108 billion of the £150 billion made available annually by parliament for the NHS.[19] Ensuring that taxpayers' money is used to the best possible effect is a moral as well as a legal duty. Robust financial accountability, both to local residents and to parliament through NHS England and ministers, is therefore non-negotiable. But the creation of integrated care systems (ICSs) means that ICBs' accountability for NHS finances also needs to sit within a wider framework of local accountability for ICSs (including the mutual accountability of ICS partners to each other for achieving their agreed goals).

5.6 NHS England, DHSC and HM Treasury should therefore work with ICSs collectively, and with other key partners including the Office for Local Government and the Chartered Institute of Public Finance and Accountancy (CIPFA) to develop a consistent method of financial reporting that will give the public the information they need to hold their local systems to account, without creating burdensome new reporting requirements. Obviously much of local councils' budgets are devoted to responsibilities other than health and are therefore outside the scope of ICS-related work. We would also expect this group to review the implementation of recommendations related to greater financial autonomy and encourage proactive management of funds and good financial practice. Working across organisations and with ICSs in this way would provide a further opportunity to build in practice

[19] Data refers to CCG and NHS England spending for 2021 to 2022 financial year - NHS Commissioning Board Annual Report and Accounts for 2021 to 2022 financial year NHS Commissioning Board Annual Report and Accounts 2021 to 2022 financial year - for the period 1 April 2021 to 31 March 2022 (england.nhs.uk) - to note £108 billion is the amount which ICBs were formally allocated in 22/23 the actual amount ICBs are responsible for is likely to be greater when considering funding streams from delegation or other one off in year funding packets.

the collaborative arrangements that are needed at national level to support those within ICSs.

5.7 The aim should be for an ICS to show its residents, local Health and Wellbeing Boards, oversight committees and Healthwatch, as well as national bodies, how much it is collectively spending from all public funds on prevention, population health management and reducing health inequalities; or on supporting mental health as well as treating mental illness; as well as, within the NHS, how effectively money has been spent for instance with respect to rates of operating theatre utilisation. As the financial framework for ICSs develops, this information should be transparent and enable a clear link between spend and health outcomes, as well as between quality, safety and productivity within the NHS itself.

Funding settlements

5.8 One of the main themes in the submissions received in response to the call for evidence was the perverse effects of ‘penny packets’ of funding in particular. Concern has been raised in relation to funding for discharge, and for investment in digital transformation.

5.9 An additional source of frustration and inefficiency is ‘non-recurrent’ money that is in practice ‘recurrent’ but that cannot be properly planned for because it is not in the baseline allocations. For instance, ‘winter funding’ is often provided (in October or November) in order to ramp up community health and social care beds, that will then be stood down in April, before being restored the following winter - when the ‘new’ beds simply return the situation to what it was a few months earlier.

5.10 Instead, funding should be largely multi-year and recurrent. The approach taken by the 2023 to 2024 priorities and operational planning guidance in converting some key non-recurrent funding into recurrent funding has been particularly welcomed in supporting planning over a longer term.

5.11 I therefore recommend ending, as far as possible, the use of small in-year funding pots with extensive reporting requirements. Additional funding pots should be considered only in limited, carefully considered exceptions rather than the rule. If they are required, funding should have:

- a reasonable turnaround time and duration to have a realistic impact. When setting the duration national organisations must consider the length of time needed to mobilise and wind down funding

- restrictions and reporting requirements to be proportionate to the size and duration of the funds, to ensure they are not disruptive to system working, as well as to prevent non-take-up by some systems. In other words, small

amounts of time-limited money require maximum flexibility to get the best results

5.12 Further, the fact that funding settlements for the NHS, social care and public health are announced and allocated at different times throughout the year is a fundamental issue for the integration of services between and within the different parts of the system and impedes the ability of ICBs, ICPs and local authorities to plan effectively at system level. As well as this, differential approaches to funding across local authorities in the same ICB also impact on the system's ability to deliver equitable standards of care across an ICS.

5.13 I recommend that DHSC, DLUHC and NHS England align budget and grant allocations for local government (including social care and public health which are allocated at different points) and the NHS so that systems can more cohesively plan their local priorities over a longer time period.

Financial flexibility for intra-system funding

5.14 In order to facilitate greater self-governance, I recommend that systems should be given more flexibility to determine allocations for services and appropriate payment mechanisms within system boundaries, and the NHS payment scheme should be updated to reflect this.

5.15 Flexibility for intra system funding allocations should include the reduction in hypothecation of funding allocated to systems, either by provision or condition. This will enable local systems to allocate funding to maximise health value for their local populations.

5.16 While the reduction of hypothecation is crucial and should continue, I have heard mixed views over the course of this review as to how far this should be taken. On the one hand some called for an end to all hypothecation including mechanisms such as the Mental Health Investment Standard (MHIS) on the basis that local systems should be able to determine where and how monies should be spent to maximise health and care outcomes. On the other hand, much of the evidence I received identified the MHIS as an effective tool to incentivise spend in an area where there are clear issues in achieving parity of esteem and one which had been long underfunded. As such, at this stage I do not believe systems are in a place where we can remove all hypothecation, particularly the MHIS. However, where hypothecation remains there needs to be a clear focus on delivering outcomes for populations and moving spending upstream towards prevention within hypothecated budgets.

5.17 It is important to recognise the role for consistency, and as such I recommend national guidance providing a default position for payment mechanisms for inter system allocations should be further developed.

5.18 This will also require strengthened local analytical resource to assess what will deliver the greatest value for local populations. For smaller systems this analytical resource could be shared for instance across a regional footprint. This should be supported by national analysis drawing on national and international evidence.

5.19 These proposals do not imply a complete “letting go” by national organisations - rather, a move away from the volume of conditions that so often come with national funding and a move towards greater ICS autonomy, held to account by NHS England.

Simplifying and broadening delegation and pooled budget arrangements

5.20 As part of greater flexibility in managing funding within systems, pooling budgets allows local leaders to make holistic decisions about how best to allocate resources across their health and care systems - both to ensure better use of resources to address immediate needs, but also to support long-term investment in population health and wellbeing.

5.21 Pooled and aligned budgets have been routinely and successfully used across systems for some time; a minimum of £7.2 billion has already been committed to the BCF this year with 90% of local areas consistently agreeing that delivery of the BCF in other years has improved joint working between health and social care.[20] However, we have heard from the system that these methods for pooling budgets can be unnecessarily bureaucratic and narrow and do not allow for effective transparency.

5.22 Section 75 of NHS Act 2006 provides the legal mechanism for creating formal pooled budget arrangements between the NHS and LAs to carry out health and care related functions. I recommend that the government accelerate the work to widen the scope of s.75 to include previously excluded functions, (such as the full range of primary care services) and review the regulations with a view to simplifying them.

5.23 In the medium term reviewing the legislation would be helpful with a view to expanding the range of the organisations that can be part of s.75 arrangements to

[20] Department of Health and Social Care (2022) Better Care Fund Framework 2022 to 2023. (Accessed: 30 March 2023).

include social care providers, VCFSE providers and wider providers such as housing providers.

Ensuring efficient delivery of care

5.24 While there is considerable scope to improve public value through shifting resources “upstream”, there is also scope to improve public value by addressing the costs of delivering care.

5.25 There is an opportunity to address unwanted variation in cost and opportunities to improve ways of working through improvements in technical efficiency. The increasingly urgent need to maximise value for public money is hampered by the continuing difficulty in establishing the real cost of delivering care (for example whether fixed costs are included, how administrative costs are applied and so on.) and the narrow focus on episodes of care, rather than complete pathways that include prevention, early intervention and support in the community (including from the VCFSE sector).

5.26 There are fundamental productivity challenges that systems, if using the appropriate tools, can address. For example, with the exception of the height of the pandemic, performance against the 4-hour A&E target has been declining for a decade, despite the fact that emergency medicine has been the fastest growing clinical specialty in the NHS and, in that time, there’s been a near doubling in the number of (full time equivalent) emergency medicine doctors.[21] This combination of significantly more clinicians but declining productivity emphasises the need to move resources upstream (including by integrating appropriate specialist clinicians within wider neighbourhood teams) as well as rapidly improving productivity within emergency care and acute hospitals themselves.

5.27 Across all parts of the health and care system, there are many opportunities to use digital technologies to reduce administrative burdens on both clinical and other staff (for example moving to real time data dashboards rather than cumbersome paper based data collection); ensure that clinical and other staff are spending the maximum possible time on care and treatment (for example reducing journey times through smart scheduling or optimising theatre scheduling); and to support multidisciplinary working (for example using decision management tools to support a wider range of clinical staff to provide safe and effective care).

5.28 The 7-day-a-week, emergency ophthalmology service provided by Moorfields in partnership with the London Central ICB is a striking example of digitally-enabled, consultant-led transformation that has effectively eliminated waiting times for

[21] Rees, Sebastian, Hassan, Hashmath The A&E crisis: what’s really driving poor performance? Reform, (February 2023)

emergency care in one speciality. Equally, University Hospitals Birmingham has transformed its skin cancer pathway, using telehealth tools in the community and artificial intelligence support for diagnosis, significantly reducing the need for hospital appointments. By connecting primary, community, intermediate care and acute hospital teams through high-speed broadband networks, digital stethoscopes and similar smart diagnostic tools, we can bring the NHS to its patients.

5.29 Systems can play a crucial role in ensuring efficient delivery of care by their partners. Fundamental to this is improved data sharing accompanied by an actuarial approach to data and risk to understand how money is being spent and how effectively it can be spent across a system. The data sharing between NHS England, DHSC, ICBs and providers discussed previously helps to establish a 'single version of the truth' that will allow all concerned to understand the overall performance of the system and its component parts. There is already considerable benchmarking data available (for example GIRFT and Model Hospital Schemes) and this should be expanded to more areas, in particular in areas which are particularly data poor such as mental health, community services and primary care. Given this data, system leaders must feel empowered to work with partner organisations to drive improvements in productivity. Alongside such benchmarking and reflecting the fully integrated approaches of leading systems referred to earlier, it is also essential to adopt clean sheet design approaches or zero-based budgeting to set out what best practice care or processes should look like and calculate what different interventions should cost.

5.30 DHSC and NHS England should undertake work to share examples of pathway redesign where systems are moving to a 'could cost or should cost' funding model rather than what they 'do cost', based on efficient models of care and utilisation of staff or facilities - building on the analysis undertaken by GIRFT and others. These should increasingly look at the whole pathway, including the vital work of the VCFSE sector and local government, rather than individual episodes of care.

5.31 'Should cost' modelling should be indicative rather than compulsory, providing useful input for decision-making within ICSs as well as between ICS partners and helping to create the necessary level of ambition for multi-year transformation.

5.32 Further, to ensure effective and efficient care delivery, there needs to be improvement support for systems and the organisations within them. It is highly encouraging that NHS England's Recovery Support Programme has developed from a provider-facing programme to one that also supports systems facing the greatest challenges. The breadth of that programme - embracing financial challenges but also quality and productivity ones as well - is a very helpful reflection of the appreciation in NHS England and in systems of the interconnectedness of many of the challenges facing the health and care system. NHS England should ensure that systems are able to draw upon a full

range of improvement resources to support them to understand their productivity, finance and quality challenges and opportunities. This should include more robust productivity and sophisticated modelling tools which include but go beyond GIRFT and Model Hospital to enable all systems to understand their real productivity challenges and opportunities.

In NW London ICS, the ICB finance team are working closely with finance directors from across NHS trusts to understand the scope of productivity opportunities.

For example, the ICB supported the deployment of external support to quantify current utilisation of operating theatres across all 4 acute trusts and to work with clinicians and managers to realise this significant improvement opportunity. Work has also been funded to support community trusts to count and measure consistently to allow for productivity (costing, inputs and outputs) assessment and comparison beyond the historic approach that has focused mainly on the acute hospital productivity element of patient care. Similar work is being undertaken across mental health trusts and primary care providers. Across all local care providers the ICB is supporting local leaders to identify where the primary, community and mental health real estate could be used more effectively to allow poor quality buildings to be exited.

Across all areas of health and care, the ICB is supporting the wider system to drive consistency of approach by aligning commissioning decisions to standardise service specifications, and to simplify pathways and reduce variation.

Transparency of information enables more effective and consistent comparison and understanding of workforce and other cost inputs to an overall population- based approach to outcomes. This will, in turn, provide the means by which the ICB's ambition to redistribute resources and enable investment in prevention and targeting health inequalities can be realised.

Payment mechanisms

5.33 Financial flows and payment mechanisms can play an important role in ensuring improved efficiency in care delivery. Responses to the call for evidence exposed contrasting views about the use of a payment by results including concerns that it creates perverse incentives for organisations, encouraging overtreatment of patients, discouraging joint-working focused on shifting towards early intervention and undermining efforts to address health inequalities.

5.34 What is clear is that current approaches are not effective in driving value-based healthcare and while payment by results can help drive activity in a particular direction, it is important to recognise that it needs to be adopted in the context of wider system reform, incentivising prioritisation of resources on upstream activity.

5.35 Many health systems in other parts of the world, including those that are entirely or largely taxpayer-funded, are developing payment models that support and incentivise a focus on health. Meanwhile, NHS funding remains over-focused on treatment of illness or injury rather than prevention of them and ICS partners struggle to work around over-complex, uncoordinated funding systems and rules in order to shift resource to where it is most needed. There are lessons from other systems that we should draw on.

5.36 I therefore recommend that NHS England work with DHSC, HM Treasury and the most innovative and mature ICBs and ICSs, drawing upon international examples as well as local best practice, to identify most effective payment models to incentivise and enable better outcomes and significantly improve productivity. It should consider a number of potential models including:

- incentives for individuals or communities to improve health behaviours
- an incentive payment-based model - providing payments to local care organisations (including social care and the VCFSE sector) to take on the management of people's health and keep people out of hospital
- bundled payment models, which might generate a lead provider model covering costs across a whole pathway to drive an upstream shift in care and technical efficiency in provision at all levels
- payment by activity, where this is appropriate and is beneficial to drive value for populations

5.37 This work should lead as quickly as possible to the testing of new models in practice within a selection of systems, enabling further development and refinement through collaborative learning and action.

Capital expenditure

5.38 The call for evidence repeatedly raised that a lack of capital, inflexibility in use of capital and the layering of different capital allocation and approvals processes from different departments and agencies are major barriers to improvement and productivity.

5.39 While ICS level CDEL allocations have been introduced to give greater ability to direct their operational budget in line with their systems priorities and local needs, there are still some issues around how providers work across system boundaries. In particular, accessing capital to support population need rather than just in their headquartered ICS. For instance, an ICS that urgently needs Tier 4 mental health beds within its own area for patients currently sent out of area finds that its mental

health partner trust is unable to develop the necessary provision simply because the trust is headquartered in a different system.

5.40 To take a different example, even with the hugely important Diagnostic Assessment Centres and Community Diagnostic Centres, some ICBs have found that the configuration that best meets the needs of their particular residents is rejected as not meeting the national specification. The laudable attempt by DHSC ministers to find faster, cheaper ways of creating urgently needed new services have, unfortunately, on occasion added further delays.

5.41 ICS leaders have the perfect opportunity to work together not only within the NHS but with local government partners to make the best possible use of the public estate and scarce public sector capital. I therefore recommend that there should be a cross-government review of the entire NHS capital regime, working with systems, with a view to implementing its recommendations from 2024.

5.42 This should build on findings from the independent review of the NHS capital allocation process conducted by Richard Murray in 2021, which I understand NHS England took forward in their planning guidance.

5.43 A cross-government review should consider:

- how government could move towards a 10-year NHS capital plan, with initial freedoms over larger sums for, say, 5 years tested and developed within more mature systems
- reviewing delegated limits and approval processes across HM Treasury Cabinet Office, DHSC, and NHS England with a view to having a simpler more streamlined approval process and giving more mature systems greater responsibility for prioritizing and managing capital expenditure
- how to allow greater year-on-year flexibility to support more efficient use of capital and support invest to save or save to invest
- clarifying the government position in use of private finance and government involvement in primary care capital
- how to enable providers working across systems (particularly mental health, specialised and ambulance providers) to access capital to support population need rather than just in their headquartered ICS
- incentives for more efficient system-wide property management and considering reform of CDEL to enable void space to be filled and co-location across the NHS and local authorities

Strengthening and embedding a culture of research and innovation

5.44 Throughout this review, I have heard about the need to embed innovation throughout the health and care system. As care pathways as transformed across systems, it is essential that ICSs build a culture of importing and exporting "what works", and that they innovate and transform in partnership with academia and industry. Academic Health Science Networks (AHSNs) should be seen as integral to that ambition, with ICBs ensuring that their AHSNs are aligned with local strategic priorities in order that best practice that meets the needs of their populations can be spread and adopted at pace and at scale.

5.45 To give just one example of this in practice, Imperial College Healthcare, itself an AHSN and part of the North West London Acute Provider Collaborative, has worked with primary care partners to transform its entire heart failure pathway. Equipped with a remote heart failure monitoring app to detect any abnormalities, patients are freed from multiple face-to-face follow-up appointments. Costly emergency hospitalisations have been significantly reduced. Above all, health outcomes have been improved.

5.46 Rather than each of the 42 systems to be constantly reinventing the innovation wheel locally, each investing relatively small individual budgets, ICBs can mobilise this expertise as a cost-effective and productive part of their contribution to system infrastructure. Regional AHSNs should work together, and with the national AHSN Network to identify and spread best practice, innovative pathways, enabling each system to import proven interventions including from academia and industry from elsewhere in the country, while ensuring that their own innovative approaches become part of the wider pool. Case studies such as West Yorkshire and South Yorkshire[22] demonstrates how embedding an AHSN to deliver an "innovation hub" for an ICB provides the right expertise for the system, as well as allowing the AHSN to efficiently transfer best practice between systems and regions.

5.47 Systems should feel empowered to engage with AHSNs, National Institute for Health and Care Research (NIHR) as well as regional and national academic communities to proactively draw on their support and skills. This should align and support ICBs with the duty placed on them to facilitate and utilise research for the improvement of health and care services. Therefore, it is vital that we build a thriving research community which can easily access and utilise the wealth of data that systems collect to undertake well-developed and valuable research to support systems to drive transformation and enable wider economic growth.

[22] NHS England Strengthening local partnerships and driving innovative solutions using innovation hubs

Specialised commissioning or tertiary services

5.48 I wanted to note briefly, that during this review, several clinical and other leaders expressed concerns about the place of specialised services within the new landscape of ICSs. Unfortunately, it has not been possible in the timescale of this review to consider this issue in detail.

5.49 Specialist units, whether free standing or within larger trusts, are global leaders within clinical research and care. They deliver cutting-edge care and are a catalyst for innovation, supporting pioneering clinical practice in the NHS. As such they need to be viewed and supported as national assets within the context of the life sciences strategy and plans for delegation of the commissioning of the services they provide.

5.50 Following extensive engagement over the last 2 years, NHS England is in the process of delegating some of its responsibilities for specialised commissioning to the new ICSs from 2024. I have heard both from some specialist leaders who still have concerns with the new approach, as well as from others who are supportive of the proposed delegation and believe ICB pathways can deliver improved outcomes and more efficient delivery of care.

5.51 During 2023 to 2024 joint committees of ICBs and NHS England are being established to take on a subset of those specialised services. As these new arrangements are put in place, it is essential that they are kept under review to ensure the critical role of these specialist service providers is appropriately maintained through any new arrangements and these provider organisations continue to be engaged.

Chapter 5: recommendations

30. NHS England, DHSC and HM Treasury should work with ICSs collectively, and with other key partners including the Office for Local Government and CIPFA to develop a consistent method of financial reporting.

31. Building on the work already done to ensure greater financial freedoms and more recurrent funding mechanisms, I recommend:

a) Ending, as far as possible, the use of small in-year funding pots with extensive reporting requirements;

b) Giving systems more flexibility to determine allocations for services and appropriate payment mechanisms within their own boundaries, and updating the NHS payment scheme to reflect this; and

c) National guidance should be further developed providing a default position for payment mechanisms for inter system allocations.

32. DHSC, DLUHC and NHS England should align budget and grant allocations for local government (including social care and public health and the NHS).

33. Government should accelerate the work to widen the scope of s.75 to include previously excluded functions (such as the full range of primary care services) and review the regulations with a view to simplifying them. This should also include reviewing the legislation with a view to expanding the scope of the organisations that can be part of s.75 arrangements.

34. NHS England should ensure that systems are able to draw upon a full range of improvement resources to support them to understand their productivity, finance and quality challenges and opportunities.

35. NHS England should work with DHSC, HM Treasury and the most innovative and mature ICBs and ICSs, drawing upon international examples as well as local best practice, to identify most effective payment models to incentivise and enable better outcomes and significantly improve productivity.

36. There should be a cross-government review of the entire NHS capital regime, working with systems, with a view to implementing its recommendations from 2024.

6. Annex A: the journey of the review

6.1 In November, during his autumn statement, the Chancellor of the Exchequer announced an independent review to consider the oversight and governance of integrated care systems (ICSs).

6.2 While the Secretary of State for Health and Social Care appointed me to lead this review, the report has only been possible due to the generosity of hundreds of individuals and organisations who have given up their time and engaged with us over the last 5 months.

6.3 During this review, I have engaged with over a thousand leaders from across ICBs, ICPs, local government, NHS trusts and foundation trusts, social care providers, VCFSE groups, academics and others with an interest in the success of ICSs.

6.4 We have also heard from over 400 respondents via our call for evidence - and we are grateful to everyone who responded from across the health and social care sector, patients, the public and wider voluntary sector. Throughout this review, we have been keen to capture the views of all partners involved in the day-to-day business of ICSs and their partners, and their responses has made this process richer and better informed at every step.

6.5 I am especially grateful to the work of colleagues who led and contributed to the 5 workstreams, that produced the majority of my recommendations. Colleagues from patient and service user groups, local government, the voluntary community faith and social enterprise sector and the social care provider sector, as well as the NHS, were included in the work streams, reflecting the partnerships that constitute ICSs.

6.6 Each workstream held a wide range of meetings in order to gather evidence from across the system. They reviewed the call for evidence responses, expert papers and data as well as a range of qualitative information from across the system.

6.7 From late January 2023, each workstreams also held a ‘town hall’ online event in which wider stakeholders were able to hear and contribute to the developing thinking of each workstream.

6.8 The review team also engaged with system partners more widely. This includes but is not limited to, engagement with:

- DHSC, NHS England and CQC
- chairs and CEOs of ICBs and chairs of ICPs

- trust and foundation trust leaders
- social care providers
- primary care providers (including general practise, dentistry, optometry, and community pharmacy) and leaders of primary care networks and partnerships
- a wide range of voluntary, community, faith and social enterprise stakeholders (including organisations representing children, mental health and the role of patient and public voice within health and care services)
- local government, including councillors, CEOs and directors of public health, adult social care and children's social care
- Healthwatch
- national trade union representatives

6.9 In engaging widely, and seeking a range of views, I believe that we have established a number of recommendations that can be widely supported, and which will enable ICSs to succeed.

Published to GOV.UK in pdf format only.

www.gov.uk/dhscwww.gov.uk/dhsc

Quarterly Maternity Services report **Acting Head of Midwifery and Gynaecology**

The enclosed report provides information about safety issues in Maternity, the themes and trends and the identified learning and action plans, including:

- The number and summary of Serious Incidents (SIs) declared for Maternity Services **
- The number of Healthcare Safety Investigation Bureau (HSIB) cases reported **
- The number of Perinatal Mortality Review Tool (PMRT) case reviews*
- Themes and Trends from all investigations and case reviews**
- Risk Register
- Number and summary of Complaints
- Staff engagement and feedback including Safety Champion Feedback
- Patient feedback and engagement
- The progress in implementing Saving Babies Lives Care Bundle v2*
- The progress with maternity staff training*
- The progress with clinical workforce planning*
- Maternity Continuity of Carer Plan
- Ockenden Report recommendations update
- Appendix 4 – MTW Care Quality Commission (CQC) Maternity Ratings (2014 inspection)

The report also provides assurance of progress in meeting the requirements of the Ockenden Report and Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme which each recommend that this information is shared with the Trust Board on at least a quarterly basis

*Clinical Negligence Scheme for Trusts (CNST) - Maternity Incentive Scheme requirement
**Ockenden recommendation requirement

It should be noted that appendix 1: Serious Incident Investigation Report – Main, appendix 2: HSIB Maternity Investigation MI-009626 (October 2022), and appendix 3: HSIB Maternity Investigation MI-008664 (October 2022) have been submitted to the 'Part 2' Trust Board meeting, as a supplementary report, as such reports contain confidential information that is not suitable for the public domain.

Which Committees have reviewed the information prior to Board submission?

- 'Main' Quality Committee, 08.03.23
- Executive Team Meeting, 18.04.23

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Report to: Trust Board

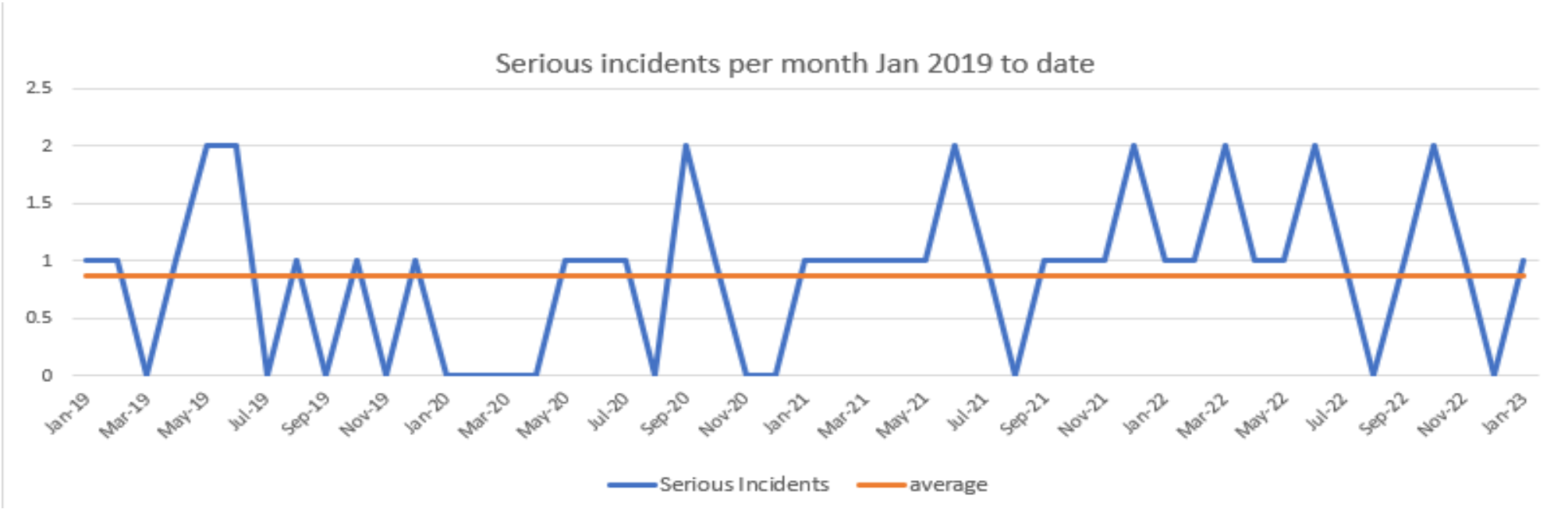
Report from: Maternity Services

Date: February 2023 (reporting period December 2022 – January 2023)

Subject: Maternity Services Quarterly Update Report

Summary - This report provides an overview of the following for December 2022 – January 2023:

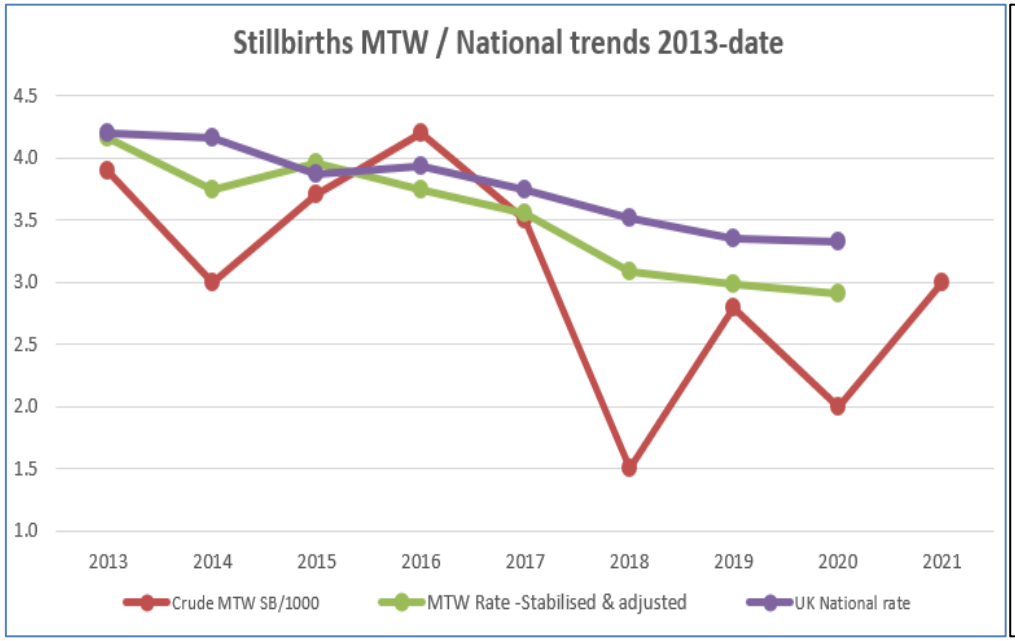
Number of Internal SI's Declared - 1 case:		
STEIS Ref	***Clinical Area***	***Synopsis***
2023/2292	Delivery Suite, TWH	Never event – retained swab following spontaneaous vaginal delivery, with episiotomy sutured by obstetric registrar. Swab count record not signed by two attendants as per policy. Serious incident declared. Investigator to be confirmed.



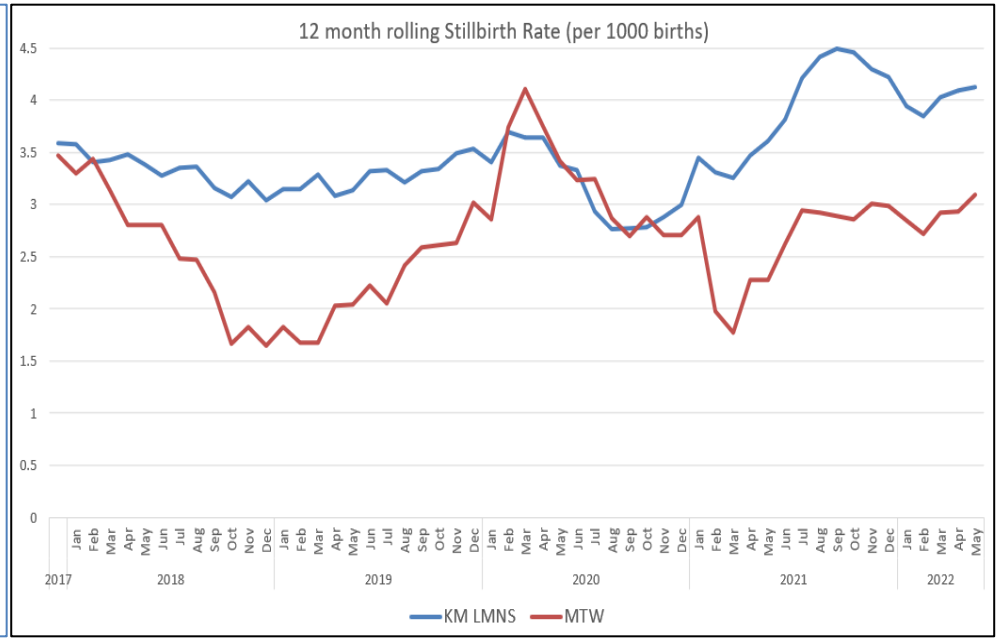
Number of HSIB reported cases: 1 case reported		
Baby born on 29 Jan 2023 Transferred to tertiary neonatal unit for cooling, case yet to be assigned HSIB or SI reference numbers		
HSIB reports received: 1 – findings and actions:		
Ref and summary	***HSIB Recommendations***	***Trust Actions***
MI-011972 Life threatening maternal anaphylaxis following administration of premedication in labour. Baby born in poor condition. Transferred to tertiary unit. Neonatal death at 7 days of life	No safety recommendations	

Summary of PMRT – No case reviews in December 22 – January 23			
Stillbirths and late fetal losses reviews completed	***Parents informed of PMRT review and invited to contribute their perspective/ concerns/ questions***	***Grading of care of the mother and baby up to the point the baby was confirmed as having died***	***Cause of death***
0			
Case number	***Contributory factor***	***Issues***	***Actions***
0			
Number of neonatal deaths (For review)	***Parents informed of PMRT review and invited to contribute their perspective/ concerns/ questions***	***Grading of care of the mother and baby up to the point the baby was confirmed as having died***	***Cause of death***
0			

Trends in stillbirths since 2010:



Trends in stillbirths since 2018 in LMNS:



Themes and Trends from all investigations and case reviews
• Reduced growth velocity not appreciated therefore additional surveillance not initiated • Clear guidance needed to support staff on how to manage reduced growth velocity if not reaching small for gestational age criteria • Non-attenders to Triage must be followed up to ensure safety • Improved escalation and communication pathways required in Triage • Gap and Grow pathway to be followed in accordance with guideline

Risk Register		
New Red risks		**Mitigation for new risks**
3014	Lack of CTG machines on TWH maternity unit	• CTG's to be kept ready for use in corridors and not left in rooms • Staff awareness of issue (via Facebook, email and handover) • Sufficient equipment for IIA (Sonic aids) • In contact with EME to get parts and machines back as quick as possible • Staff aware to datix when lack of equipment impacts on patient care in order to monitor risk

Complaints	
Number of new and themes from new formal complaints	**Key themes identified from closed complaints**
7 amber complaints received Main themes: • Communication / insensitivity • Delayed care / pain relief • Incorrect treatment / procedures not followed • Concern about care	13 Complaints closed 1 upheld, 3 partially upheld, 9 not upheld Themes: • Ensure good communication and explanations, in both planned and emergency procedures and contacts • Concerns about inconsistent advice • Concerns about lack of support and care in pregnancy, labour and postnatal period

Staff Engagement

Staffing Matters

- Buddy role implemented and well received according to initial feedback. Audit in progress, lead by PMA.
- Recruitment event in January was successful with 4 new midwifery recruits. Future recruitment event planned for March.
- First International Recruit Midwife arrived 2 weeks ago. Further recruit arriving shortly.
- Collaboration CCCU and ICB in progress to consider increasing student capacity following withdrawal from the William Harvey Hospital.

Staff Engagement & Welfare

- Triangulation of staff feedback data to feed into Divisional Peoples Plan
- OD plan development in progress
- PMA team accepted 4 new trainee PMAs to support nationally recommended caseload ratio. Training to commence in March.
- Postnatal ward structure improvement plan completed, with positive feedback and increase in morale.
- Task and finish groups in progress to review arrangements for on calls in all areas and recruitment processes

Safety Champion Feedback

Themes:

- Immediate through appropriate ward managers/ Matrons. Feeds into local ward safety improvement plans
- Escalated to senior Triumvirate to be incorporated into Directorate and Divisional Operational and strategic planning
- Recruitment processes improved to enable an inclusive and fair process
- Midwifery on calls and rostering working groups in progress
- Preceptorship support improved to support new and junior midwives.
- Triangulation of actions from multiple staff feedback & MSC data to feed into Divisional development plan

Actions:

- Immediate through appropriate ward managers/ Matrons. Feeds into local ward safety improvement plans

- Escalated to senior Triumvirate to be incorporated into Directorate and Divisional Operational and strategic planning
- Recruitment processes improved to enable an inclusive and fair process
- Midwifery on calls and rostering working groups in progress
- Preceptorship support improved to support new and junior midwives.
- Triangulation of actions from multiple staff feedback & MSC data to feed into Divisional development plan

Patient Feedback and Experience

Friends and Family feedback

- The number of responses averaged 140 per month, with a positive feedback range 94-95%.

Maternty Voices Partnership

- MVP work plan incorporates strategies to achieve regular calls for feedback, quarterly “walk the patch” and “15 steps”, establishment of a robust co-production process and stakeholder engagement with quality improvement projects.

- Plans to add information to staff communications to support discussions and increase awareness of MVP with service users.

Progress with Implementation of Saving Babies Lives Care Bundle version 2

Element	*Compliance data*		*Actions*
Smoking in pregnancy	CO monitoring at booking	94%	
	CO monitoring at 36 weeks	96%	
Fetal growth restriction	Pregnancies where a risk status for fetal growth restriction is identified at booking	100%	
	Pregnancies where a risk status for fetal growth restriction is identified at 20 week scan	98%	

Reduced fetal movements	Women who receive information about reduced FMs by 28 weeks	100%	
	Women attending with RFM who have a computerised CTG	97%	
Fetal monitoring	Staff attended annual MDT fetal monitoring training	95%	
	Lead midwife (0.6 wte) and Lead obstetrician (0.1 wte) appointed	100%	
Preterm births	Live births <34 weeks having full dose of steroids within 7 days of birth	86%	All cases reviewed to ensure steroids given appropriately
	Live births occurring more than 7 days after first course of steroids	4%	All cases reviewed to ensure steroids given appropriately
	Singleton live births < 30 weeks receiving MgSO4 within 24 hours before birth	100%	All cases reviewed to ensure MgSO4 given appropriately
	Women giving birth in an appropriate care setting for their gestation	100%	All cases reviewed to ensure transferred considered appropriately
Progress with maternity multidisciplinary staff training			

Compliance with maternity specific training	*November 2022*
Fetal monitoring	95%
Neonatal resus (PROMPT*)	84%
Practical Obstetric Multi-professional Training (PROMPT)	84%
Gap & Grow - e learning (annual update)	49%
Gap & Grow workshop	91%
Avoiding Term Admissions to Neonatal Unit (ATAIN)	92%
Infant feeding (Baby Friendly Initiative Day)	91%
Infant Feeding Annual Update	76%

Focused efforts in recent months improved overall compliance in time for CNST declaration. Reduction in overall compliace due to sickness rates affecting attendance in December / January. However, a robust schedule has been put in place to ensure compliance is maintained across the year as the Maternity learning and development team have adopted a new approach to booking staff for mandatory training for 2023.

Fetal Wellbeing midwives are focused on improving compliance with the e-learning update for GAP & Grow through raising awareness among the maternity team and requesting ward managers to facilitate staff to complete e-learning during working hours.
The recently introduced Fetal Surveillance Study Day includes a face to face workshop update which has been well attended and is better evaluated than the e-learning which is mandated by the Perinatal Institute, who provide the growth assessment programme.
.

Progress with clinical workforce planning

Workforce	*Latest review*	*Progress with actions*
Maternity workforce	Nursing and midwifery workforce review – October 2022	Business cases to be developed to support increases in staffing which have been identified Birthrate+ review date to be confirmed before March 2023 (funded by LMNS)
Obstetric medical workforce	Audit of consultant attendance against Royal College of Obstetricians & Gynaecologists' recommended attendance in given clinical situations	Audit presented to trust board
Anaesthetic medical workforce	Obstetric anaesthetic cover meets national recommendations	
Neonatal medical workforce	Neonatal medical cover meets national recommendations	
Neonatal nursing workforce	Nursing and Midwifery Staffing Review – October 2022	Business case in progress for NNU BCP to meet BAPM recommendations
Maternity Continuity of Carer Plan		

Phoenix Young Parent Continuity Team

- Established team continues to work effectively, with some challenges due to maternity leave absence
- Funding for additional support staff and specialist training received following successful bid for *Enhanced Midwifery Continuity of Carer Pilot Funding* for 2022/23 and 2023/24. This requires commitment to:
  - Participate in quarterly assurance reporting.
  - Participation in the NIHR-commissioned evaluation of the Enhanced MCoC pilot.
  - Inform the regional NHSE MCoC lead as soon as possible if for operational reasons, the launch of any team is significantly delayed or can no longer go ahead, or if in future a launched team has to be suspended for staffing reasons.

Future Plans

- Further continuity teams are not currently able to be established until improvements in staffing numbers are achieved. Discussions with LMNS arranged to discuss feasibility of any potential teams to be started in 2023/24

- MCoC – long term plan timeline trajectory is yet to be agreed. Under review by Divisional Triumvirate

Ockenden Report Recommendations

The action plan to complete the safety actions which were incomplete or which had insufficient evidence as assessed by the Regional team was presented to Trust Board in December 2022.

Work continues to meet the recommendations.

Perinatal Quality & Safety Dashboard	Included in appendices
Related Regulatory Requirements	Response to the Ockenden Report, December 2020 & April 2021 CNST Maternity Incentive Scheme – year four, May 2022 Transforming perinatal safety, December 2020

Author:	Susan Powley, Head of Midwifery
Paper reviewed by:	Maternity Board Divisional Board - Governance
Action Required by the Trust Board	

Maidstone and Tunbridge Wells NHS Trust

CQC Maternity Ratings (NB - Maternity Department full inspection in 2014)	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Requires improvement	Requires improvement	Requires improvement	Good	Good	Requires improvement

Maternity Safety Support Programme	No	If No, enter name of MIA

2022

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Findings of review of all perinatal deaths using the real time data monitoring tool	0 cases											
Findings of review of all cases eligible for referral to HSIB	1 case Themes: 41/40 Shoulder dystocia, cord snapped. Baby sent for cooling to Medway											
Report on:												
*The number of incidents logged as moderate or above and what actions are being taken	2 moderate incidents 1 serious incident Themes: - - 1 x unintended injury during monofer infusion - bladder injury at emergency caesarean section - retained swab - never event											
*Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training - MDT Emergency Skills	88%											
*Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training - Fetal Monitoring in labour	TBC											
*Minimum safe staffing in maternity service to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively												
Service User Voice Feedback - number of IQVIA (FFT) responses	193											
Service User Voice Feedback - % positive responses	95%											
HISB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	No											
Coroner Reg 28 made directly to Trust	No											
Progress in achievement of CNST 10	MIS year 4 compliance reported to Trust Board and ICB for declaration in February											

Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend the Trust as a place to work or receive treatment (Reported Annually)	75%

Proportion of specialty trainees in Obstetrics and Gynaecology responding with 'Excellent' or 'Good' on how would they rate the quality of clinical supervision out of hours (Reported Annually)	78%

Maidstone and Tunbridge Wells NHS Trust

CQC Maternity Ratings (NB - Maternity Department full inspection in 2014)	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Requires improvement	Requires improvement	Requires improvement	Good	Good	Requires improvement

Maternity Safety Support Programme	No	If No, enter name of MIA

2022

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Findings of review of all perinatal deaths using the real time data monitoring tool	0 cases	3 cases Themes: - HSIB case x 1 - intrapartum IUD - 2 x unexplained stillbirths	2 cases Themes: - 2 x 23 week fetal loss	3 cases Themes: - 1 x 33 week stillbirth following antepartum haemorrhage - 1 x 34 week stillbirth following reduced fetal movements and reduced growth - 1 x neonatal death following unplanned home breech birth at 28 weeks	1 case Themes: - 1 x 32 week stillbirth following antepartum haemorrhage	1 case Themes: - 1 x 37 week unexplained stillbirth followed by postpartum haemorrhage and ITU admission	1 case Themes: - 1 x 32 week stillbirth following placental abruption	3 cases Themes: - 1 x 38 week unexplained stillbirth - 1 x 28 week unexplained stillbirth - 1 x 22 week late miscarriage	2 cases Themes: - 1 x 38 week unexplained stillbirth - 1 x 26 week stillbirth following severe pre-eclapmsia	1 case Themes: - 1 x 34 week stillbirth following severe pre-eclapmsia	0 cases	1 case Themes: - 1 x 39 week stillbirth, low risk pregnancy Cause of death undetermined
Findings of review of all cases eligible for referral to HSIB	0 cases	1 case under investigation 1 final report received - Recommendation: The Trust to ensure that there is a consistent approach that is used to monitor baby's growth in pregnancy	0 cases	1 case under investigation	0 cases	2 cases under investigation 2 final reports received Safety recommendations reating to fetal monitoring in labour and MDT handover of care following ambulance transfer	1 case under investigation 1 final report received Safety Recommendation: The Trust to ensure staff undertake intermittent auscultation (IA) in line with national guidance, and are supported to recognise and act on changes in IA	0 cases 1 final report received Safety Recommendations for MTW and SECAmb relating to transfer pathways and MDT communication on emergency admission	0 cases 1 final report received Safety Recommendation: The Trust to ensure staff undertake intermittent auscultation (IA) in line with national guidance, and are supported to recognise and act on changes in IA	0 cases 2 final reports received 1. Safety Recommendation: The Trust to collaborate with SECAmb to improve communication, admission and handover pathways. The trust to ensure that staff are supported to escalate when an accurate trace of a fetal heart rate cannot be obtained 2. No Safety Recommendations MTW commended for MDT working and request from HSIB to share case as an example of good practice	0 cases 1 final report received No Safety Recommendations	1 case 1 final report received No Safety Recommendations
Report on:												
*The number of incidents logged as moderate or above and what actions are being taken	1 serious incident Learning shared: - Rectovaginal fistula identified 13 days post birth. Investigation ongoing - led by external investigator	1 moderate incident 1 serious incident (HSIB case) Themes:	3 moderate incident 2 serious incident Themes: - 2 x Bladder injury at CS - Unplanned return to theatre with massive obstetric haemorrhage - 2 x stillbirth with undetected growth restriction	1 serious incident (HSIB case) Themes: - Ambulance admission following antepartum haemorrhage. Instrumental delivery to expedite birth. Neonatal resuscitation, NNU admission, transfer to tertiary unit for cooling, treatment withdrawn, neonatal death	2 moderate incidents 0 serious incidents Themes: - delay in escalation (transfer to TWH from MBC) - delay in acting on complication of treatment (blood transfusion)	0 moderate incidents 2 serious incidents Themes: - error with administering O2 during neonatal resuscitation - stillbirth (HSIB case)	0 moderate incidents 1 serious incident Themes: - maternal anaphylaxis in labobour, baby born in poor condition,transferred for cooling, neonatal death - (HSIB case)	2 moderate incidents 0 serious incidents Themes: - unexpected admission to NNU following maternal sepsis - massive obstetric haemorrhage	0 moderate incidents 1 serious incidents Themes: - unexpected admission to NNU and therapeutic cooloing following resuscitation and hypothermia	3 moderate incidents 2 serious incidents Themes: - complaint received about preceived assault during examination in labour - 2 x maternal admission to ITU following PPH - unexpected admission to neonatal unit - missed opportunity to diagnose pre-eclampsia	2 moderate incidents 1 serious incident Themes: - - 1 x maternal admission to ITU following delayed diagnosis of severe pre-eclampsia - unexpected admission to neonatal unit - massive post-partum haemorrhage	0 moderate incidents 0 serious incident
*Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training - MDT Emergency Skills	68%	71%	76%	77%	73%	77%	76%	80%	82%	84%	96%	89%
*Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training - Fetal Monitoring in labour	51%	62%	50%	54%	63%	66%	70%	71%	81%	81%	93%	89%
*Minimum safe staffing in maternity service to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively												
Service User Voice Feedback - number of IQVIA (FFT) responses	114	132	124	220	205	239	196	114	135	90	141	88
Service User Voice Feedback - % positive responses	99%	92%	94%	97%	87%	99%	96%	95%	92%	85%	93%	94%
HISB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	No	No	No	No	No	No	Ockenden Insights Visit	HEE visit relating to CCCU Midwifery Degree course - failed accreditation	Insights visit feedback - action plan review	No	No	No
Coroner Reg 28 made directly to Trust	No	No	No	No	No	No	No	No	No	No	No	NO
Progress in achievement of CNST 10	- Additional training sessions arranged to improve compliance following period of staffing difficulties. - Awaiting job evaluation for Fetal Surveillance Midwife. - Awaiting update from MIS Collaborative Advisory Group following 3 month pause from Dec 2021	- Additional training sessions in place to improve compliance following period of staffing difficulties. - Fetal Surveillance Midwife recruitment in progress. - Awaiting update from MIS Collaborative Advisory Group following 3 month pause from Dec 2022	- Continued challenges with attendence at training sessions due to ongoing staffing difficulties. - Fetal Surveillance Lead Midwife appointed - Awaiting update from MIS Collaborative Advisory Group following 3 month pause from Dec 2022	- Continued challenges with attendence at training sessions due to ongoing staffing difficulties. - MIS Collaborative Advisory Group update following pause . Next submission of compliance is due Jan 23	- Continued challenges with attendence at training sessions due to ongoing staffing difficulties. Risk assessment planned following need to cancel training due to staffing challenges and high activity - Working with leads for each element to gather evidence and develop action plans for new submission date.	- Continued challenges with attendence at training sessions due to ongoing staffing difficulties. Risk assessment planned following need to cancel training due to staffing challenges and high activity - Working with leads for each element to gather evidence and develop action plans for new submission date.	- Continued challenges with attendence at training sessions due to ongoing staffing difficulties, but progress being made to meet full compliance - Working with leads for each element to gather evidence and develop action plans for new submission date.	- Continued challenges with attendence at training sessions due to ongoing staffing difficulties, but progress being made to meet full compliance - Working with leads for each element to gather evidence and develop action plans for new submission date.	- Training compliance steadily improving with projections for compliance by deadline for submission - evidence gathering and development of action plans continues to meet submission date.	- Training compliance steadily improving with projections for compliance by deadline for submission - evidence gathering and development of action plans to meet submission date ongoing, with some challenges identified.	- Training compliance now reached recommended levels with future planning to keep on track - all actions either on track or achieved - LMNS assurance visit planned for 8 Dec	- Training compliance peaked at recommended levels with future planning to keep on track. However, sickness absence impacted attendence in late December. - all actions either on track or achieved - LMNS assurance visit planned for 8 Dec

Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend the Trust as a place to work or receive treatment (Reported Annually)	75%

Proportion of specialty trainees in Obstetrics and Gynaecology responding with 'Excellent' or 'Good' on how would they rate the quality of clinical supervision out of hours (Reported Annually)	78%

Maidstone and Tunbridge Wells NHS Trust

CQC Maternity Ratings (NB - Maternity Department full inspection in 2014)	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Requires improvement	Requires improvement	Requires improvement	Good	Good	Requires improvement

Maternity Safety Support Programme	No	If No, enter name of MIA

	2021											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Findings of review of all perinatal deaths using the real time data monitoring tool	2 cases Themes: - Extreme prematurity x 1 - HSIB case x 1	1 case Themes: - HSIB case x 1	3 cases Themes: - HSIB case x 2 - MTOP - fetal anomaly x 1	5 cases Themes: - MTOP fetal abnormalitiy x 2 - Unexplained death x 2 - fetal cardiac anomaly x 1	1 case Themes: - MTOP fetal anomaly x 1	3 cases Themes: - Prematurity x 4 - Unexplained death x 1	2 cases Themes: - Prematurity x 2 - Unexplained death x 2	3 cases Themes: - Extreme prematurity x 1 - Unexplained stillbirth x 1 - Term stillbirth - placental abnormalities, GDM on insulin	1 case Themes: - Covid infection at 23 weeks - IUD at 24 weeks	1 case Themes: - IUD at 36+6 weeks - placental abruption	1 case Themes: - Difficult birth at MBC - Extensive neonatal resuscitation required - Transferred for cooling	1 case Themes: - IUD at 35 weeks - Unexplained stillbirth
Findings of review of all cases eligible for referral to HSIB	2 cases Themes: Case 1 - Escalation during neonatal resuscitation Case 2 - No safety concerns	1 case Themes: Patient information - fetal movements in labour Guideline for risk assessment in Triage	2 cases Themes: Guideline for obstetric / MDT review in Triage Review process for identifying indication for IOL when prioritising cases	0 cases	1 case Themes: GAP pathway not followed (incidental finding) No safety recommendations	0 cases	1 case Themes: GAP pathway not followed (incidental finding) No safety recommendations	0 cases	1 case Investigation completed - report in circulation prior to publishing	1 case Investigation in progress	1 case Investigation in progress	1 case Investigation in progress
Report on:												
*The number of incidents logged as moderate or above and what actions are being taken	4 moderate incident 1 serious incident Learning shared: - MDT Communication - Guidelines updated	1 moderate incident 1 serious incident Learning shared: - 1:1 feedback - situational awareness	1 moderate incident 1 serious incident Learning shared: - 1:1 feedback - obstetric cover for Triage - review of guideline for care in latent phase of labour	0 moderate incident 1 serious incident Learning shared: - reminder to staff to follow fetal growth assessment programme	5 moderate incident 2 serious incident Learning shared: - reminder to follow ED pathway for unwell maternity patients - review of process for follow up of investigation results - review of pathway for booking caesarean section - 1:1 feedback	1 moderate incident 1 serious incident Learning shared: - importance of timely follow up of urgent investigation results - importance of MDT working and clinical overview - failure to follow swaab count policy in theatre	2 moderate incidents 2 serious incident Learning shared: - assess risk of bladder injury at LSCS - ensure staff with appropriate experience available for complex surgery - growth assessment policy not followed	0 moderate incident 0 serious incident	1 moderate harm 0 serious incident Learning shared: - consider FSE if loss of contact on CTG - rotate from OP to OA, if possible, for instrumental births - provide 1:1 care in labour in any location. Document and escalate if not possible - always connect CTG to centralised system - raise awareness of risk of dropping baby at instrumental birth	0 moderate incident 1 serious incident Learning shared: No learning idenitifed IUD of unknown cause in latent phase of labour - reported for investigation by HSIB	1 moderate incident 1 serious incident Learning shared: -Skills drills for community based midwives to be reinstated - Clear pathway for neonatal resuscitation at MBC required - Importance of acting on abnormal findings (urinalysis)	0 moderate incident 2 serious incidents Learning shared: - Patient with known PPROM who presents with a change of symptoms under 30/40 should have senior involvement. There should be a low threshold for admission in this clinical situation
*Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training - MDT Emergency Skills	66%	73%	82%	91%	98%	99%	98%	89%	84%	76%	81%	75%
*Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training - Fetal Monitoring in labour	50%	56%	53%	53%	69%	74%	68%	67%	65%	55%	55%	52%
*Minimum safe staffing in maternity service to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively												
Service User Voice Feedback - number of IQVIA (FFT) responses	179	74	282	254	243	191	145	106	82	55	154	65
Service User Voice Feedback - % positive responses	98%	99%	96%	99%	97%	97%	96%	92%	92%	91%	90%	98%
HISB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	No	No	HSIB quarterly engagement meeting	CQC engagement meeting	Letter from HSIB requesting additional support for staff involved in investigations - action plan developed	HSIB quarterly engagement meeting	No	No	HSIB quarterly engagement meeting	No	No	HSIB quarterly engagement meeting
Coroner Reg 28 made directly to Trust	No	No	No	No	No	No	No	No	No	No	No	No
Progress in achievement of CNST 10							Declaration of compliance submitted 22/07/2021	Maternity Incentive Scheme - Year 4 guidance published. Action planning commenced	Kick off and planning meetings arranged with leads for each safety action and project lead	Planning and progress meetings arranged with leads for each safety action and project lead	Planning and progress meetings continue with leads for each safety action and project lead	Amendments to Maternity Incentive Scheme - Year 4 guidance published. Action planning continued when staffing and activity permits

Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend the Trust as a place to work or receive treatment (Reported Annually)	75%

Proportion of specialty trainees in Obstetrics and Gynaecology responding with 'Excellent' or 'Good' on how would they rate the quality of clinical supervision out of hours (Reported Annually)	78%

NHS Maidstone and Tunbridge Wells NHS Trust

The final planning submissions for 2023/24	**Director of Strategy, Planning and Partnerships / Chief Finance Officer**

Please find enclosed an update on the Trust's final planning submissions for 2023/24.

Which Committees have reviewed the information prior to Board submission?
- Finance and Performance Committee, 25/04/23

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Information and discussion

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Finance Update

Revised Financial Plan 2023/24

	£m
Draft Plan Feb	**-15.4**
Elective Recovery	2.5
Plan Submitted Mar	**-12.9**
PFI inflation value confirmed	-0.8
Workforce phasing improvement	1.1
Reduce Winter Funding	1.0
Non Recurrent benefit	2.1
Non Pay improvements	0.8
Additional Income	1.4
Elective Care Recovery / growth	0.9
Counting and Coding	1.0
Contingency	1.0
Revised deficit	**-4.5**
Assumed National inflation support	2.7
Further stretch	1.8
Proposed submission May	**0.0**

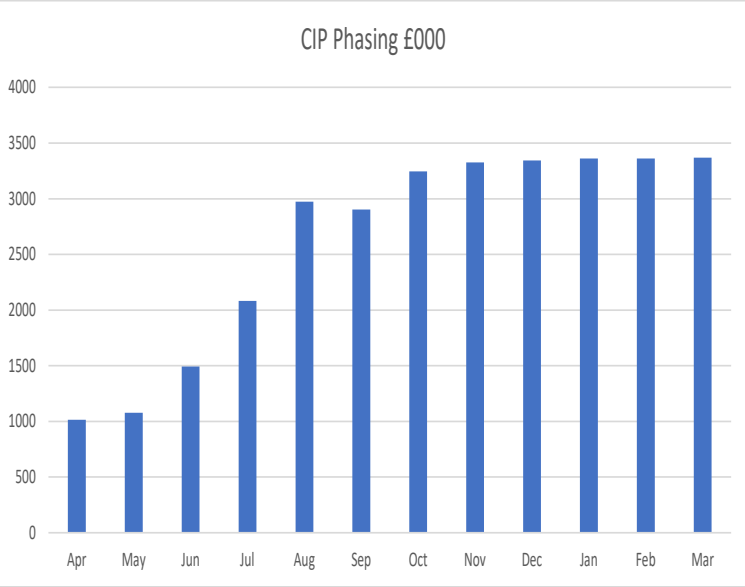
- The Trust is delivered a breakeven position in 2022/23 but has a underlying deficit position of £32.1m due to non recurrent measures implemented in 2022/23 and non recurrent COVID funding.

- In March the Trust submitted a plan with a deficit of £12.9m which was an improvement of £2.5m on the February submission.

- A further pressure of £0.8m has arisen from the PFI inflation value being confirmed in March 23.
- The Trust has reviewed assumptions and made the following improvements to the plan;
    - Workforce phasing – see next slide
    - Reduction in Winter spend – Winter Plan to be agreed in next few months
    - Non recurrent benefits
    - Non Pay improvements
    - Additional income including Deferred income
    - Benefits from elective care / recovery not at full cost.
- In addition the Trust is expecting to receive an additional £2.7m income to support excess inflation.
- A further stretch target of £1.8m would put the Trust in a breakeven position.

Cost Improvement Plans

- The Trust has set a £30m savings target for 2023/24, which is 4.4% of operating expenses. In addition there are £1.5m rollover of schemes from 2022/23.
- In order to meet a breakeven position the Trust would need to increase the CIP target by a further £1.7m.



- The breakdown by scheme is shown. Currently there are £7.1m of schemes which are unidentified which have been phased from October 2023.
- The Trust has identified potential income opportunities of £4.4m which contribute to the reduction in deficit since the March submission. Additional income cannot be classified as CIP for reporting purposes but the same governance and monitoring will apply to the income schemes.

Efficiency Plan Risk

£'000

	Pay	Non Pay	Income	Total
High Risk	12,827	5,915	1,127	**19,869**
Medium risk	137	4,520	447	**5,104**
Low Risk	4,158	2,357	61	**6,576**
Total Efficiencies	**17,122**	**12,792**	**1,635**	**31,549**

Efficiency Plan Status

£'000

	Pay	Non Pay	Income	Total
Fully Developed	138	3,936	441	**4,515**
Plans in Progress	2,802	517	469	**3,788**
Opportunity	9,932	5,432	719	**16,083**
Unidentified	4,250	2,907	6	**7,163**
Total Efficiencies	**17,122**	**12,792**	**1,635**	**31,549**

Types of Scheme	£m
Agency	6.5
Business Case Benefits	1.9
Core Services	2.2
Covid Reductions	2.7
Divisional Efficiencies	5.0
Patient Flow	4.6
Outpatient Productivity	0.1
Unidentified	7.0
	30
FYE 22/23	1.5
Total CIP	**31.5**

Improvements included in plan but not Classified as CIP	
Elective income (net of costs)	3.4
Counting and Coding	1
Further Stretch	1.7

Agency Target

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
Total Pay £m	33.2	34.1	33.7	33.5	33.0	33.1	33.3	33.4	34.1	34.4	34.1	34.9	404.8
Agency Spend £m	1.3	1.3	1.1	0.8	0.7	0.7	0.6	0.6	0.9	0.8	0.6	1.0	10.4
Agency %	**3.80%**	**3.91%**	**3.18%**	**2.51%**	**2.17%**	**2.07%**	**1.89%**	**1.82%**	**2.52%**	**2.41%**	**1.65%**	**2.82%**	**2.56%**
National Target	3.70%	3.70%	3.70%	3.70%	3.70%	3.70%	3.70%	3.70%	3.70%	3.70%	3.70%	3.70%	3.70%
System Target	4.40%	4.40%	4.40%	4.40%	4.40%	4.40%	4.40%	4.40%	4.40%	4.40%	4.40%	4.40%	4.40%

- The Trust is currently forecasting to spend £10.4m in agency which is 2.56% of the total pay spend. This is 1.2% better than the target set by NHSE.
- The Kent and Medway System has set a local target for the Trust to use a maximum of 4.4% of agency. The Trust is currently forecasting to achieve this target.
- The increase towards the end of the financial year is due to additional costs associated with winter and the Kent and Medway Elective Orthopaedic Unit

Next Steps

CIP

- Work on CIP plans and additional income to continue.
- A new governance for CIP monitoring is being implemented.
- The potential for counting and coding changes is being validated.
- Consider increasing CIP target by £1.8m for stretch target to breakeven

Workforce

- Workforce controls for temporary staffing to minimise use of agency
- Further work required to understand the impact increasing staff in post. This should include removal of agency covering vacant posts. Recruit to turnover to be reviewed if risk of being over established.
- Pay bridge to explain increases in pay compared to 22/23 pay costs.

Capital

- The Trust's capital plan for 2023/24 remains the same as the March submission. However there have been some changes in relation to the IFRS16 and this will be confirmed in detail at the March Trust Board.

Key Assumptions

C	
Pay	AFC Staffing – 2.1% inflation uplift which incorporates pay award and incremental drift – As per Planning Guidance
Non Pay	Drugs 1.3% and Other non pay (5.5%) – As per Planning Guidance PFI
CNST	CNST based on notified levels (£1.4m increase to 2022/23 core charge)
Reserves	Assumes £1.2m contingency reserve plus £2.5m cost pressures reserve
Depreciation and PDC	Depreciation and PDC charges are based on 2023/24 planned levels
PFI	Increase is based on February RPI published on 22nd March.
CIP	The Trusts total CIP target for 2023/24 is £30m which if delivered will lead to a £12.9m deficit in 2023/24
Capitalised Leases	The plan does assume leases of buildings and land which are not yet at business case approval stage. This is to ensure there is potential capital coverage for the capital element of the lease as per IFRS16. HMT has not yet confirmed the value of any IFRS16 allocation to the DHSC

NHS Maidstone and Tunbridge Wells NHS Trust

Quarterly report from the Freedom to Speak Up Guardian — Freedom to Speak Up Guardian

The latest quarterly report from the Freedom to Speak Up Guardian (FTSUG) is enclosed.

Which Committees have reviewed the information prior to Board submission?
N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Discussion

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Board of Directors (Public)

Freedom To Speak Up Guardian Report Q4 (January 2023 – March 2023)

Action Requested / Recommendation

Discuss the content and recommendations outlined in the report.

Summary

This is the fourth quarter report for the period January 2023 to March 2023 presented to the board by the Freedom To Speak Up Guardian (FTSUG). The purpose of this report is to identify trends, issues; and provide a progress report on the Freedom to Speak Up function.

The interim Deputy Freedom To Speak Up Guardian, Natalie Hayward, who was appointed as maternity cover for Ola Gbadebo-Saba, has herself now left to go on maternity leave. Ola will resume on the 9th May.

The Freedom to Speak Up Guardian received **twenty-one** concerns raised in the last quarter. In Q4, as in previous quarters, the majority of concerns raised relate to cases where staff feel unfairly treated or harassed at work, with **nine** cases logged in the respect and dignity category.

Concerns were received through various routes including: direct contact with the FTSUG, anonymous portal logs, safe space champions.

Author: Christian Lippiatt, Freedom To Speak Up (FTSU) Guardian

Date: April 2023

Freedom To Speak Up Non-Executive Director	Maureen Choong
Freedom To Speak Up Executive Lead	Sue Steen
Freedom To Speak Up Guardian	Christian Lippiatt
Deputy Freedom To Speak Up Guardian	Ola Gbadebo-Saba (maternity leave)

The FTSU Agenda is to:

- Protect patient safety and quality are
- Improve experience of workers
- Promote learning and improvement

By ensuring that:

- Workers are supported in speaking up
- Barriers to speaking up are addressed
- Encourage a positive culture of speaking up
- Ensure issues raised are used as an opportunity for learning and development

2022/23 year data collection

Quarter	Month/Year	MGH	TWH	Satellite Sites	Unknown	No. of Contacts
Q1	April-June 2022	7	9	2	5	23
Q2	July – September 2022	7	13	8	9	37
Q3	October – December 2022	11	20	0	5	36
Q4	January – March 2023	6	9	0	6	21

During the last quarter, the FTSU Guardian has made presentations to the Sexual Health Department at their away day and visited Crowborough Birthing Centre to promote speaking up and recruit Safe Space Champions. We also attended the Trauma and Orthopaedic Department and the Theatres Department at their respective Clinical Governance meetings where we presented FTSU data specific to their areas, discussing issues and concerns. We would like it noted the effort and dedication the TWH Theatres Safe Space Champion has shown to the role, their colleagues and patients in improving care and experiences. There are visits planned to promote speaking up and aims to recruit Safe Space Champions for staff based in Canterbury and Paddock Wood during the coming quarter.

With the majority of cases being around dignity and respect, workplace relationships and behaviours continues to be the main area of concern for staff. With satellite site visits taking place and planned, it is hoped greater interaction between these sites and the FTSU Guardian will take place.

The number of "unknown" factors in reporting is a frustration to analysis. With the new In-Phase reporting system coming on line (replacing DATIX) and the new Intranet, it is hoped we can better support staff in providing more information and detail when making anonymous reports through these routes. Whilst wanting to keep it quick and simple to raise a concern, it can be difficult to address the concern aside from categorise it when details are scant.

Themes/Issues

Theme	Number
Patient Safety	**2**
Bullying/ Harassment	**9**
Fraud	**1**
Health & Safety	**3**
*Other	**6**
Total	**21**

*Breakdown of 'Other' category	Number
Concerns outside of MTW	1
Window cleaning	1
Parking	1
Windows blocked by corporate vinyl graphics	1
EV charging at TWH	2
Total	**6**

Concerns falling under the “other” category are escalated and raised with relevant Managers as appropriate. In many cases the concern being “closed” upon passing the concern on. In some cases it may remain open until a response has been received from the Manager.

The quarter 4 data (Appendix B) has been fairly consistent over the last 4 years with Tunbridge Wells Hospital (TWH) seeing the increase this last quarter. There is no particular theme or department accounting for this increase.

Annual Review

The 2022/23 statistics (Appendix C) evidence bullying and harassment as being the main reason people speak up through the FTSU route with patient safety and health and safety almost equal in second place. This would suggest there is still more work organisationally around growing a culture of compassion, dignity and respect. The FTSU Guardian works closely with teams in the People Directorate to continue building and embedding initiatives to support this such as mediation, respectful resolution, organisational development and compassionate leadership.

TWH has seen an increase in speaking up and this is partly attributable to how active Safe Space Champions are on that site. The role of the Safe Space Champions is clearly crucial in enabling staff to speak up and as such we will continue to grow this team of volunteers.

In October 2020 we took the initiative to capture information from staff speaking up as to how they identify in terms of BAME or Non-BAME. This was in recognition of the initial report from Sir Robert Francis in 2015 identifying minority groups being less likely to speak up. Further to this, we will widen our data capture to ask if staff speaking up would be happy to disclose any protected characteristic to help evidence how effective our interactions and promotion of speaking up is within these staff groups. In recognition of this work and data capture, we have contacted the National Guardians Office to suggest that they may consider requesting all FTSU Guardians across the NHS capture this data to help understand if we are succeeding in reaching staff groups that we know are less likely to speak up.

Annual Staff Survey

Generally, feedback from staff in the last survey has shown a decreasing picture across the board following improvements during the height of the pandemic years. In response to feeling secure raising concerns about clinical practice and confidence in the organisation addressing concerns, these questions have roughly returned to 2019 – pre-pandemic – levels.

One area that has bucked the trends is staff feeling safe in raising concerns about “anything” that concerns them in the Trust (as opposed to specifically clinical practice).

Appendix A: Staff Group who have raised concerns

Staff Group	Number
Nursing & Midwifery	5
Medical	0
Unknown	11
AHP's	0
Corporate Services	0
Administration, Clerical & Maintenance/Ancillary	5
Total	**21**

Appendix B: Comparison of concerns logged and staff group

Year	Concerns
2018/19	9
2019/20	39
2020/21	49
2021/22	107
2022/23	117

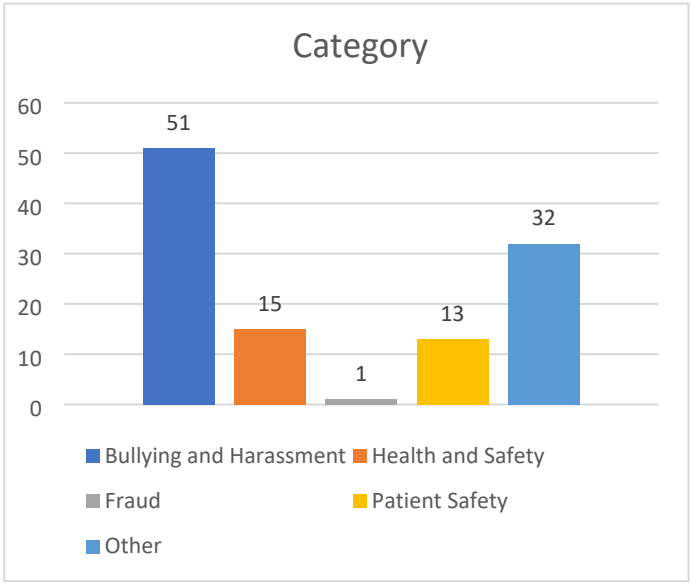
Notes; FTSU Guardian started in October 2018 1 day per week alongside working another full time role.

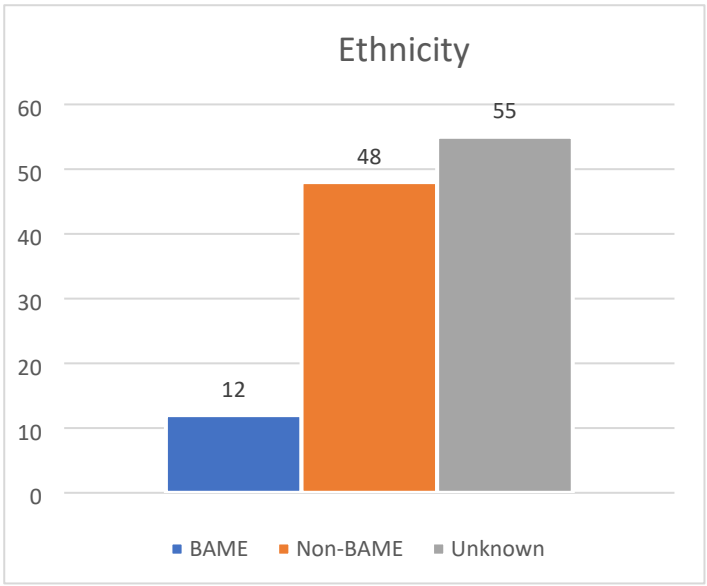
Deputy FTSU Guardian started in October 2020 4 days per week.

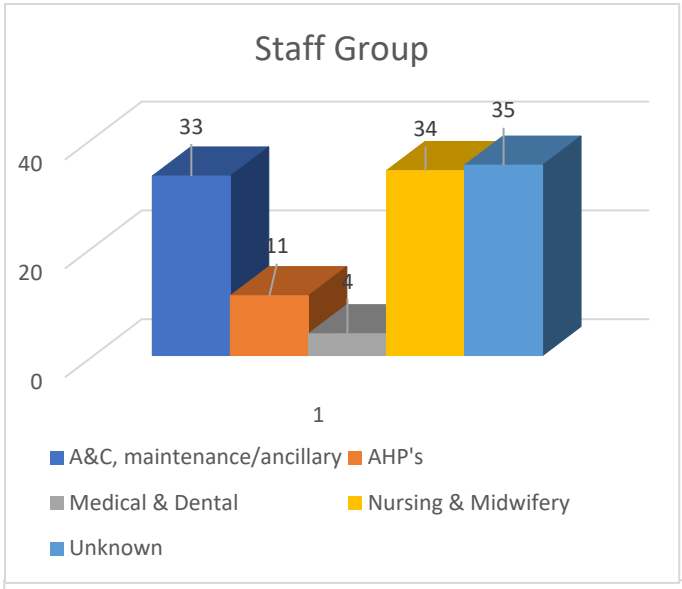
Total concerns logged	Q4 2020	Q4 2021	Q4 2022	Q4 2023
Maidstone	6	7	7	6
Tunbridge Wells	1	4	5	9
Satellite Sites	0	0	0	0
Unknown	0	5	3	6
Total	**7**	**16**	**15**	**21**

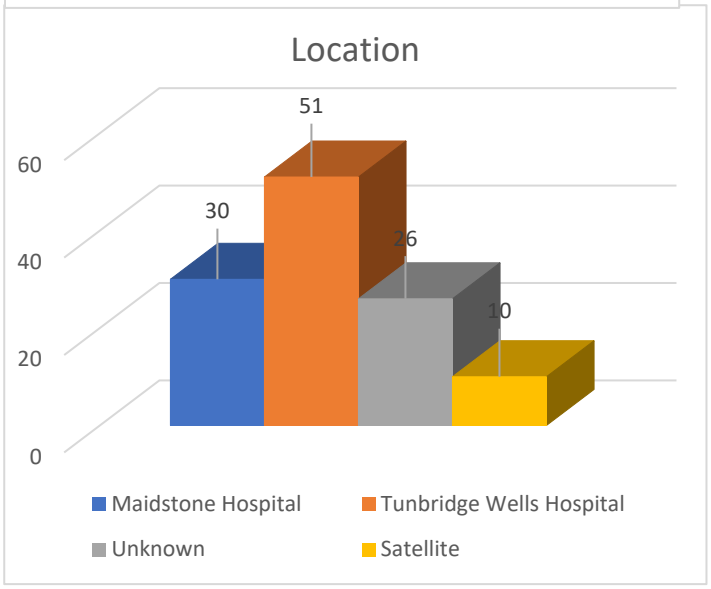
Appendix C: 2022/23 Statistics

The category “unknown” features highly. This aspect will be targeted over the coming year to improve data capture.

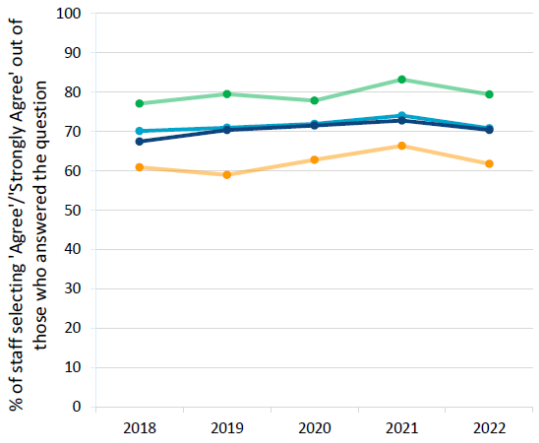





Staff Group
40
20
0
33
11
4
34
35
1
A&C, maintenance/ancillary
AHP's
Medical & Dental
Nursing & Midwifery
Unknown

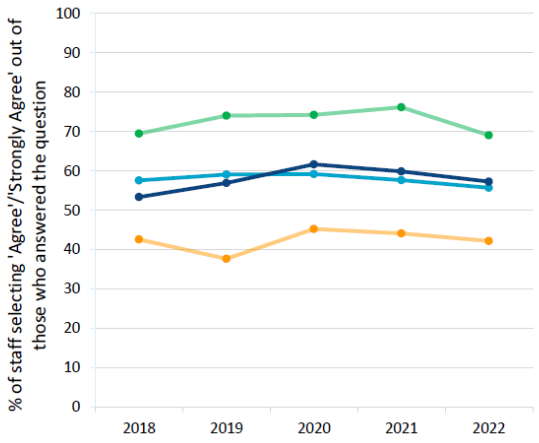

Location
60
40
20
0
30
51
26
10
Maidstone Hospital
Tunbridge Wells Hospital
Unknown
Satellite

Q19a I would feel secure raising concerns about unsafe clinical practice.



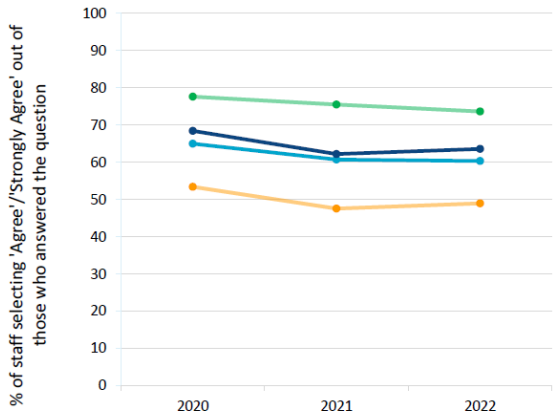
	2018	2019	2020	2021	2022
Your org	67.5%	70.4%	71.5%	72.8%	70.4%
Best	77.1%	79.5%	77.9%	83.2%	79.4%
Average	70.1%	71.0%	71.9%	74.1%	70.8%
Worst	60.9%	59.0%	62.8%	66.4%	61.8%
Responses	1822	2930	3152	3356	2883

Q19b I am confident that my organisation would address my concern.



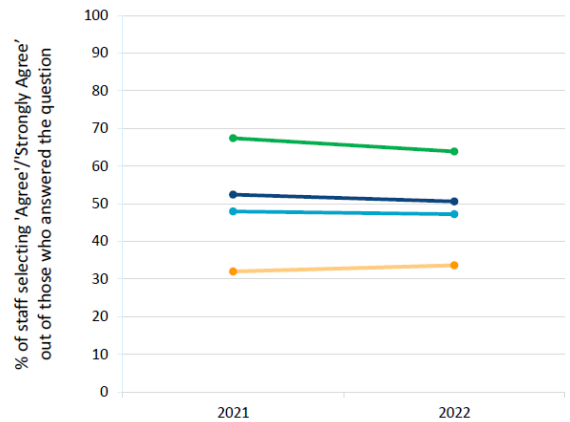
	2018	2019	2020	2021	2022
Your org	53.4%	56.9%	61.7%	59.9%	57.3%
Best	69.5%	74.0%	74.2%	76.2%	69.1%
Average	57.6%	59.1%	59.2%	57.7%	55.7%
Worst	42.6%	37.7%	45.3%	44.1%	42.2%
Responses	1825	2924	3144	3344	2868

Q23e I feel safe to speak up about anything that concerns me in this organisation.



	2020	2021	2022
Your org	68.4%	62.2%	63.6%
Best	77.6%	75.5%	73.6%
Average	65.0%	60.7%	60.3%
Worst	53.4%	47.6%	49.0%
Responses	3165	3356	2874

Q23f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022
Your org	52.4%	50.6%
Best	67.4%	63.9%
Average	48.0%	47.2%
Worst	32.0%	33.7%
Responses	3349	2868