Torbay and South Devon
NHS Foundation Trust

Council of Governors Meeting

Public

Date: **Wednesday 3rd May 2023**

Time: **2 pm to 4.30 pm**

Venue: **Board Room, Hengrave House and via Microsoft Teams**

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Council of Governor's Meeting (Public)

03/05/2023 14:00

Torbay and South Devon
NHS Foundation Trust

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6.	Update on Quality Account and CQC Preparedness			15:50-16:10	
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Torbay and South Devon
NHS Foundation Trust

DRAFT

MINUTES OF THE PUBLIC COUNCIL OF GOVERNORS MEETING

HELD ON 1ST FEBRUARY 2023 AT 14.00 PM

POMONA HOUSE

Present

		*	Richard Ibbotson (Chair)		
*	Nicole Amil		Derek Blackford		Craig Davidson
*	Dave Cawley	*	Loveday Densham	*	Eileen Engelmann
	Matthew Giles	*	Annie Hall		Steven Harden
*	Jonathan Hawkins		Mike James	*	John Kiddey
*	Peter Milford		Rosemary Rowe		Jonathan Shribman
	John Smith	*	Andrew Stilliard	*	Jean Thomas
*	Mark Tyrrell-Smith	*	Emily Wood	*	Radia Woodbridge
*	Keith Yelland				

* denotes member present / ( ) = present for part of meeting

In attendance:

*	Liz Davenport	Chief Executive	LD
*	Michelle Westwood	Chief People Officer	MW
*	Deborah Kelly	Chief Nurse	DK
*	Jon Scott	Interim Chief Operating Officer	JSc
*	Dave Stacey	Chief Finance Officer and Deputy Chief Executive	DS
*	Jane Harris	Associate Director of Communications and Partnerships	JH
*	Richard Crompton	Non-Executive Director	RC
*	Robin Sutton	Non-Executive Director	RS
*	Chris Balch	Non-Executive Director	CB
*	Paul Richards	Non-Executive Director	PR
*	Vikki Matthews	Non-Executive Director	VM
*	Siân Walker-McAllister	Non-Executive Director	SWMc
*	Sarah Fox	Corporate Governance Manager	SFo
*	Sally-Ann Reay	Membership Manager & note taker	SAR

1. OPENING MATTERS

1.1 Chairman’s welcome and apologies for absence

The Chairman noted apologies from Adel Jones, Ian Currie, Peter Aitken, Jacqui Lyttle, Joanne Watson, Oyetona Raheem, Matthew Giles, Jonathan Shirbman, John Smith, Cllr Rosemary Rowe, Mike James.

The Chairman updated Governors with regard to Jacqui Lyttle's leave of absence, explaining that she was due back at the end of February 2023.

1.2 Declarations of Interest

No declarations of interest were made.

2. Business from previous Council of Governors' Meeting

2.1 Minutes of Council of Governors' meeting held on 2 November 2022 and written resolution dated 23rd November 2022

The Council of Governors approved the Minutes of Council of Governors' meeting held on 2 November 2022 and written resolution dated 23rd November 2022.

2.2 Matters arising not covered elsewhere on the Agenda

None received.

3. Business Reports

3.1 Chairman's Report

The Chairman verbally reported to the Council of Governors on the following matters: -

- The new Acute Medical Unit (AMU) had proved a significant success in relieving the recurrent pressures, despite some initial teething problems.
- Torbay League of Friends are now established in a permanent office near to the Torbay Hospital main entrance area.
- New Acute Mental Health ward now open at the top of the Torbay Hospital site, run by Devon Partnership Trust. The Chairman praised the facilities of a brand new 21st century mental health ward, following a recent visit.
- Improvements to emergency pathway were showing results and as such this weekend the Trust had been able to offer assistance to Derriford Hospital (Plymouth). The Chairman thanked the Interim Chief Operating Officer, Chief Nurse and Medical Director for their leadership in this work.
- The substantive Chief Operating Officer recruitment process was underway and short listing was planned for the end of next week.
- Gave update on the System Oversight Framework 4 (SOF4) which covered all the Acute Providers in Devon and the Devon Integrated Care System as a whole. A variety of external visits to the Trust have been taking place by NHSE representatives. The Trust Board was meeting regularly and was fully engaged with the implementation plan in order to deliver an acceptable outcome and meet the SOF4 exit criteria .

3.2 Chief Executive's Report

The Chief Executive drew attention to her report which had been circulated with the agenda and briefed the Governors on the following points: -

- Whilst there are other Acute Providers at SOF4 level, the Devon System was the only one in SOF4 as a whole across England. NHS England focus would be on getting the system back to balance and patients treated. Acknowledgement was made of the expert national support being offered to the Devon system to help deliver the improvement plan. The Chief Finance Officer, was leading the work for the Trust.

Questions were invited and Mr Tyrrell-Smith asked at what point the Cost Improvement Plan summary would be shared with the Council of Governors. The Chief Finance Officer responded that a paper had been taken to the January 2023 Board meeting and this could be re-circulated to Governors.

- Reported on the ongoing work to reduce waiting lists both locally and system wide and addressing performance issues in key areas including the 104 week waits and 78 plus week waits. Improvements being seen in urgent emergency care targets due to the work of the new Acute Medical Unit (AMU).
- Dartmouth Health and Wellbeing Centre (HWBC) building work had been delayed but was due to open in early May. GPs were now in place at the Brixham HWBC and the planning stage for Teignmouth HWBC had now closed.
- Business cases for the New Hospitals Programme had been sent to the Treasury. Feedback was expected by end of the financial year. Other elements of Building a Brighter Future (BBF) were moving ahead via the bidding process including the new endoscopy suite and two additional theatres.
- Reported on the Electronic Patient Record (EPR) case which would be submitted in mid-February 2023, with support for the overarching principles of the model. This had been a huge piece of work under the leadership of the Director of Transformation and Partnerships
- The Peninsula Acute Services Sustainability Programme had been mandated by all Boards and clinical engagement was now taking place across three areas: Paediatrics, Medical Services and Surgical Services in order to develop the proposals.

Further questions were invited and Mr Stilliard asked if the recent industrial action had impacted significantly on local patient waiting times. He also asked if this impact been quantified? The Chief Executive responded that the setting up of an Incident Response Unit to focus on minimalising the impact of industrial action on elective care had really been effective. The Interim Chief Operating Officer, added that by the end of March 2023 there should be no patients on the over 104 week waiting list, and currently the Trust had 96 patients on the 78 week waiting list. The target to work towards the 65 week waiting list was difficult to meet with over 40,000 people waiting.

The Interim Chief Operating Officer reported that excellent work on improvements on non-elective admissions had resulted in 26 empty hospital beds at Torbay on the

previous weekend and hence able to extend support to Derriford Hospital (Plymouth). This situation had been helped directly by the interventions put in place and a fall in infection levels. Mr Stilliard asked if sufficient bed occupancy had been retained at Torbay Hospital in light of the assistance given to Derriford Hospital and the general bed occupancy rate of above 90%. The Interim Chief Operating Officer said that 14 ambulances had been diverted across, which had been within the safe remit level, and that he regarded 92% bed occupancy as an appropriate level..

The Chief Nurse, added that minimal disruption had been caused by the national nurses strikes, partly due to excellent planning but also due to the good relations maintained with the local trade unions with open dialogue and conversations to ensure a suitable balance. 100 nurses had taken strike action each day and no theatre lists had been stepped down to date, due to the precautions and planning beforehand. The Chief Executive acknowledged the excellent leadership shown by the Chief Nurse and the benefits of the good local relationship with unions.

3.3 <u>Membership Committee Chair's Report</u>

Mrs Engelman gave a short update on matters discussed at the January Committee which had been included in her report to the Council: -

- Explained the focus for 2023 is to ensure FT members are engaged and that a diversity of membership is created.
- Work would be undertaken on a yearly calendar of events to promote and obtaining more email addresses of FT members.
- Committee hoped to hold a summer "Medicine for Members" event, clinical pressures permitting.
- Excellent placement of the Membership Video to date and work continues to widen this scope to pharmacies and opticians
- Extra promotion agreed to ensure sufficient members for the new Rest of the South West Peninsula Committee.

The Chairman thanked Mrs Engelmann for her update.

4. Non-Executive Director Reports

4.1 Non-Executive Director Committee Reports:

The Chairman noted that these reports reflected the recent changes to the Non-Executive portfolio's.

4.1.1 Audit Committee

Mr Sutton gave an overview of the most recent Audit Committee held on 18 January 2023:

- The Business Assurance Framework (BAF) and Corporate Risk Registers had been received and included developments regarding statements of the Board Risk Appetite.
- Losses and Special Payments had been examined, the two main elements being i) Social Care debt and ii) overseas visitors. Detailed explanation of Social Care debt was given and steps taken to secure debt recovery which is currently in the region of 4-5% being written off. A visit had been made in November 2022 by the Office of Public Guardian and they had been impressed by the Trust's work.
- Financial waivers had reduced dramatically to £1.8m over the July to September 2022 period.
- External Auditors (Grant Thornton) had no major highlights to update. Process underway to look for an alternative external auditor firm, but in the context of a difficult marketplace with a lot of major audit companies having pulled out of the healthcare sector.
- Internal Audit reports had been received and RAG rated and only one was "red" which was currently being addressed by the People Directorate.

Mrs Hall asked for more information about the work of the Office of Public Guardian. Mr Sutton responded that they provided a central approach with regard to the public's entitlement and rights and ensured Trusts handled social debt issues correctly.

Mr Tyrell-Smith asked if Audit Committee played a specific role in the development of a Cost Improvement Programme for SOF4. Mr Sutton replied that the Audit Committee provided a check that the financial accounts were accurate and provided assurance. However the primary focus for this work lay with the Finance, Performance and Digital Committee.

The Council of Governors noted the report on the work of the Audit Committee.

4.1.2. Quality Assurance Committee

The Chairman reported on this item, as Mrs Lyttle had been unavailable to attend the January 2023 meeting. The following points were noted:

- A deep dive had been undertaken into the Stroke Service, led by Rhoda Allison (Associate Director of Nursing and Professional Practice) and an

improvement plan was now in place. The Trust had acknowledged where there were areas of concern and had a requirement to do better in terms of communications with patients and their families.
- A Clinical Negligence Scheme for Trusts (CNST) maternity recommendations at end of 2022 visit had required careful interpretation to ensure the trust licence was renewed. This issue had been elevated to the Trust Board and discussed in January 2023 and the Trust was assured it was compliant with their licence.
- Challenges continued in the obstetric workforce, with high levels of sickness compromising service delivery and the Trust had acknowledged registrars concerns closely.
- Reported on the Mortality Scorecard and the impact that correct coding by the Trust is imperative to ensure the scores were correct.

The Council of Governors noted the report of the Quality Assurance Committee.

4.1.3 People Committee

Ms Matthews gave an overview of the most recent People Committee meetings:

- Consideration of the BAF had taken place, looking at the risks in recruitment for certain specialities, retention of key teams and wellbeing of colleagues who were facing fatigue.
- Improvements in Workforce Planning were discussed, which will be led by the Chief People Officer.
- Reported on system wide workforce planning that is required, alongside that taking place at Trust level and at National level.
- Industrial action – Committee had received assurance that safety of patients was maintained, alongside respect shown to staff who wished to strike.
- Under leadership of Chief People Officer, has been a slight reset of the People Promise with a focus on a) consistent approach to leadership, appraisals and consistency on how policies applied and effect on the Trust culture b) freeing up capacity and productivity of staff.
- Performance metrics showed rising staff sickness rates, 5.6% against a target of 4% and staff turn over had risen to 30.5% (target of 14%) but this was less than many Trusts experiencing. Consequent increase in agency spend was always under evaluation.

Mrs Thomas asked if staff sickness rates were likely to show improvement, as there was a time lag on reporting the data. Ms Matthews responded that hopefully the work undertaken to address issues would start to show some lowering of staff sickness metrics. The Chief Nurse added that staff sickness had remained high into January 2023 but aim is that by March the figures will be improved.

Mr Tyrrell-Smith asked if themes are looked at within the Integrated Performance Report (IPR). Ms Matthews replied that more granular detail would be included in the future and would also extend to other metrics such as grievances. The Chief People Officer added that plan was to triangulate the key data for the

future, assessing both quantitative and qualitive elements. Mr Yelland asked if granular detail would be assessed regarding staff turnover.

The Council of Governors noted the report of the People Committee.

4.1.4 Finance, Performance and Digital Committee (FPDC)

Mr Crompton explained that he had undertaken his first chairmanship of the FPDC on 23 January 2023 and following points were to be noted:

- Discussions had taken place as to how the FPDC format might need to change in order to meet the SOF4 challenge this year.
- Examination on productivity metrics, some of which can be explained but still required further action to improve against a backdrop of a rise in staffing levels. An excellent three year Capital Strategy report had been received, which would improve longer term planning by the Trust.
- The draft financial framework for 2023-2024 had been reviewed prior to submission at the end of February.
- Deep dive report received into the Integrated Performance Report (IPR). Mr Crompton wished to acknowledge the considerable contribution made by the Interim Chief Operating Officer on this work. Recommendations would be taken forward at pace and would drive the quality framework.
- The next meeting will focus on productivity and performance and risk appetite scores will be examined.

Mr Yelland asked if the previous Well-Led Review Report could be circulated to all Governors, as not all had seen this paper as were relatively new to post. The Chief Executive agreed to re-circulate, with the caveat that it was several years old. *(Post Meeting Note: The Chief Executive will instead present on this report to the 3rd May 2023 Council of Governors, which is the first Governor meeting she can attend).*

Mrs Walker-McAllister added that Adult Social Care was also due to be inspected by the CQC this year.

The Council of Governors noted the report of the Finance, Performance and Digital Committee.

4.1.5 Building a Brighter Future Committee (BBF)

Professor Balch reported that the Committee had discussed:

- Reported on Deep Dive Reports into key risk areas including inflationary pressures and how to recruit/retain future resources in a very competitive market.
- Looked at the general appetite for risk and balance of risk. Slow progress nationally on the crucial digital infrastructure frustrating.
- Approval for Outline Business Case (OBC) still awaited and anticipate this will be communicated by the end of March 2023. These delays could mean a later delivery date at the end of the build.

- Contingency planning was taking place in case less than £497m for the New Hospital Programme (NHP) was allocated to the Trust
- Decision delays also encountered with the Electronic Patient Record (EPR) in meantime excellent conversations taking place with staff over aspirations/fears and obtaining feedback at drumbeat sessions.

Cllr Hawkins asked if the Trust was actively communicating its concerns at the highest level regarding delays to the NHP. The Chief Executive replied that considerable high level conversations had taken place and in addition Kevin Foster, Member of Parliament for Torbay Constituency, had raised a question on this issue in Parliament and assurances had been given. Mr Kiddey retorted that he had watched the Parliamentary debate and he did not feel that assurances had been made. Mr Yelland added that it was very hard for the local public and staff at present as targets and timeframes kept moving and yet expectations were very high. The Chairman said that the Trust continued to pressure its local Members of Parliament detailing that defaulting on the NHP is not an option as that the Trust estate is at the end of life and not adequate for purpose. The Chief Executive added that nationally it would appear that a growing voice of concern was being heard by politicians. Mr Crompton said that he hoped that the implications of being in SOF4 would assist decisions regarding the requirement for NHP programme.

Mr Crawley asked if Trust assured that it would receive the money from the sale of Dartmouth Hospital. The Chief Finance Officer replied that money was due to be exchanged on Monday 30 January 2023 but had been delays by lawyers but confident it would be signed this week.

The Associate Director of Communications and Partnerships, informed Governors that the new Trust timeline video was now available on the public website and on social media sites for all to see. She would share the link with all Governors in case they had not seen this for themselves.

The Council of Governors noted the report of the Building a Brighter Future Committee.

4.1.6 <u>Torbay Pharmaceuticals Board</u>

Mr Richards referred to several key issues:

- The increased profit pressures facing Torbay Pharmaceuticals (TP) as their key product Metaraminol was no longer able to achieve a high price, due to other competitors lowering the price to a few pence and in addition, the NHS had ceased to buy the drug in the volume it once did. Profits were therefore down in the latest period at December 2022.
- TP had therefore looked to other markets, beyond the NHS, and working with other partners, particularly internationally, however foreign exchange rate fluctuations and also cost of raw materials impacted. Fantastic work being undertaken by the team to re-invent products and sales markets.
- Had been some recent microbiological contamination in a few batches.
- Impressive local workforce, mainly from the Paignton area.

Mrs Hall asked what Metaraminol was used for and the Chief Finance Officer explained that it was an injectable drug primarily used in operations, which was a specialised area that TP focused on.

The Council of Governors noted the report of the Torbay Pharmaceuticals Board.

5. Governance Reports

5.1 Report of the Interim Director of Corporate Governance and Trust Secretary

The Council of Governors received and noted the report and appendices which were circulated with the Agenda.

The Council of Governors approved the Council of Governors' and Board of Directors' Engagement Policy, which had been drawn up in line with the model template from the Good Governance Institute (GGI). Mrs Thomas added that the Deputy Lead Governor, Mr Tyrrell-Smith and herself were meeting with the GGI for a post-mortem meeting in February.

The Council of Governors approved the updated Governor Code of Conduct.

The Council of Governors noted the public governor vacancy on the Governor Nominations and Remuneration Committee and that declarations of interest were welcomed.

The Chief Executive noted that Emily Long would return from maternity leave in March 2023, as the substantive Director of Corporate Governance and Trust Secretary, and placed on record thanks to Oyetona Raheem who had undertaken the interim role.

6. Governor Engagement

6.1 Feedback and questions from Members and Governors including Governor Communications Log

The Council of Governors received the Governor Communications Log. The Chairman mentioned each in turn and asked if the Governors were satisfied with responses. Mr Cawley said he had been disappointed with level of response on his question regarding TP.

7. Closing Matters

7.1 Any other business

The Chairman gave an update on Dartmouth Health and Wellbeing Centre build which had been delayed by a number of issues, including Suez Canal disruption and issues with contractors. Governors were informed that the design and build commission had not been entirely delivered but that recourse would be sought after the practical opening had been completed.

The sale of the former Dartmouth Hospital site was awaiting hand written amendments by solicitors this week in order to obtain completion. Cllr Hawkins declared an interest in this issue, as a Devon County Councillor and he expressed his view that value for money had not been obtained and asked what was happening with regard to the Dartmouth Clinic.

The Chief Finance Officer responded that there were no firm plans with regard to the Dartmouth Clinic and currently reviewing options. The issue of value for money had been discussed at length at Trust Board and total monetary value was only one of the elements taken into consideration, which included social benefit element for community. Cllr Hawkins said he did not believe this social benefit element was achieved by a high class hotel development. Mr Cawley asked about the previous maximum price valuation for the site and the price achieved and the Chief Finance Officer responded that he did not recognise the figures quoted by Mr Cawley and that he would look back at the valuations received. Professor Balch added that the developer of the site would be paying ground rent to Dartmouth Council which would be ploughed back into providing affordable housing for the town and the NHS estates team had been satisfied with the criteria achieved. Cllr Hawkins said he would welcome a meeting between the Dartmouth Governors and the Chief Executive/Chief Finance Officer to discuss issues.

Mr Tyrrell-Smith commented that the meeting had yet again over run on timing, leaving limited debate for the important business of the Private Council of Governors meeting. The Chairman apologised for running over but explained that legally required to publish the times of the meeting on the Trust website as open to the public and therefore had been unable to alter the order of the meetings around. The Chairman asked the Corporate Governance Manager to consider extending the length of the meetings in the future, if required.

7.2 Close of meeting

There being no further business the meeting was closed at 3.55pm

Dates of next meetings: 03 May 2023, 02 August 2023 and 01 November 2023 (14:00 to 16:00) .

2023

COUNCIL OF GOVERNORS: ACTION LOG

Task	Title of Topic	Priority	Assigned to:	Start Date	Due Date	Status	Notes
Task 1	Meeting 02.11.2022: Circulate COO Presentation Slides	completed	COO	2022.11.02	2022.11.03	**Complete**	Circulated by email on 03.11.2022
Task 2	Meeting 02.11.2022: Circulate Full Written Response to COG Question (ID COG-003)	completed	M.Mgr	2022.11.02	2022.11.11	**Complete**	Full response issued in Governor Newsletter (Issue 92) on page 9.
Task 3	Meeting 01.02.2023: Re-circulate the January Board paper on Cost Improvement Plan	Green	CFO	2023.02.01		**In Progress**	FT Office have requested from CFO.
Task 4	Meeting 01.02.2023: Circulate the Governance Report with caveat that it was several years old. (Update: Post meeting note- CEO will instead present on this report to the 3 May COG, which is the first Governor meeting she can attend)	Green	CEO	2023.02.01	2023.05.03	**Deferred**	(Update: Post meeting note- CEO will instead present on this report to the 3 May COG, which is the first Governor meeting she can attend)
Task 5	Meeting 01.02.2023: to circulate the link to the new Trust timeline video to all Governors	completed	ADCP	2023.02.01	2023.02.01	**Complete**	Circulated by email on 01.02.2023
Task 6	Meeting 01.02.2023: Mr Cawley asked about the previous maximum price valuation for the site and the price achieved and the Chief Finance Officer responded that he did not recognise the figures quoted by Mr Cawley and that he would look back at the valuations received.	Green	CFO	2023.02.01		**In Progress**	
Task 7	Meeting 01.02.2023: Cllr Hawkins said he would welcome a meeting between the Dartmouth Governors and the Chief Executive/Chief Finance Officer to discuss issues.	Green	CEO & CFO	2023.02.01		**Not Started**	
Task 8	Meeting 01.02.2023: The Chairman asked the Corporate Governance Manager to consider extending the length of the meetings in the future, if required.	completed	CGM	2023.02.01	2023.09.04	**Complete**	3 May COG meeting length altered in light of full agenda's, and each meeting will be taken on a case by case consideration and therefore this item is considered closed for the action tracker

Torbay and South Devon
NHS Foundation Trust

<table>
<tr><td colspan="2">Report to the Council of Governors</td><td></td></tr>
<tr><td colspan="2">Report title: Chief Executive's Report</td><td>Meeting date:
03 May 2023</td></tr>
<tr><td>Report appendix</td><td colspan="2">n/a</td></tr>
<tr><td>Report sponsor</td><td colspan="2">Chief Executive</td></tr>
<tr><td>Report author</td><td colspan="2">Associate Director of Communications and Partnerships</td></tr>
<tr><td>Report provenance</td><td colspan="2">Discussion items discussed at Board and Board Sub-Committee level</td></tr>
<tr><td>Purpose of the report and key issues for consideration/decision</td><td colspan="2">The Council of Governors ('COG') meetings are clearly a key part of our governance arrangements and throughout the COVID-19 pandemic we have endeavoured to maintain/enhance our usual communication programme with Governors via regular briefings, email, bespoke newsletters and virtual meetings.

I am also mindful of the important role that Governors provide in actively seeking feedback from members of the public and the support Governors are able to provide to us in communicating key messages.

At the previous COG meeting Governors received a high-level report on: the actions being taken to address the exit criteria for Single Oversight Framework (SOF) and the development of the single improvement plan; our ongoing work to reduce our waiting lists both locally and system-wide and addressing performance issues in key areas; urgent and emergency care: ambulance handovers, the opening of the Acute Medical Unit; the new health and wellbeing centres for Dartmouth and Teignmouth – and an update on Brixham; the new hospital programme and Building a Brighter Future; our plans for an Electronic Patient Record; and the latest updates from the Integrated Care System for Devon and the Peninsula Acute Services Sustainability Programme.

Since the last Council of Governors meeting, Governors have received a link to the video of our timeline, briefings on industrial action, Teignmouth Hospital and high-profile media coverage as well as receiving the regular fortnightly Governor newsletters.

While Governors have received operational briefings via the monthly Governor Network meetings, it is my intention at this Council of Governors' meeting to provide, along with my Executive colleagues, an update on the following key areas:</td></tr>
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Public

- the actions being taken to address the exit criteria for Single Oversight Framework (SOF) and the development of the single improvement plan – our regain and renew plan
- our ongoing work to reduce our waiting lists both locally and system-wide and addressing performance issues in key areas;
- urgent and emergency care: ambulance handovers, home before lunch and work on the complex care discharge pathway;
- the new health and wellbeing centres for Dartmouth and Teignmouth;
- our capital development programme including the new radiotherapy scanner, endoscopy and theatres expansion;
- the new hospital programme and *Building a Brighter Future;*
- an update on our Electronic Patient Record;
- the latest updates from the Integrated Care System for Devon and the Peninsula Acute Services Sustainability Programme.

Action required (choose 1 only)	**For information**	**To receive and note**	**To approve**
	☐	☒	☐

Summary of key elements

Strategic goals supported by this report

Excellent population health and wellbeing	xx	**Excellent experience receiving and providing care**	x
Excellent value and sustainability	x		

Is this on the Trust’s Board Assurance Framework and/or Risk Register

Board Assurance Framework	X	**Risk score**	20
Risk Register	X	**Risk score**	various

External standards affected by this report and associated risks

Care Quality Commission	**x**	**Terms of Authorisation**	
NHS England	**x**	**Legislation**	
National policy/guidance	**x**		

Torbay and South Devon NHS

NHS Foundation Trust

Report of the Membership Committee Chair to the Council of Governors

Meeting date:	20 April 2023
Report by:	Eileen Engelmann
This report is for:	Information☒ Decision ☐
Link to the Trust's strategic objectives:	1: Safe, quality care and best experience ☐ 2: Improved wellbeing through partnership ☒ 3: Valuing our workforce ☐ 4: Well led ☐
Public or Private	Public ☒ or Private ☐

Key issues to highlight to the Council of Governors:

- **Rest of South West Peninsula Constituency** –budget confirmed to allow for minimal cost "paid" social media advertising to increase numbers in this constituency (to be arranged by Eli McCutchion, Engagement Manager, Communications Department)
- **Assessed viewing numbers of the New Membership Video** – noted good progress to date with regard to viewing numbers across social media platforms (over 1600 viewings).
- **Some further updates on key actions were discussed:**
    - Continue to aim for a "Medicine for Members" in Summer/Autumn 2023, once more Foundation Trust resource is available. (Dementia team are keen).
    - 2023 Annual Members Meeting: Confirmed will also be Members event/s at the 21 September 2023 Annual Members Meeting and stands in TREC foyer. Committee keen to involve SWAST resuscitation demonstration and display Technology Enabled Care Systems (TECS) and to hold later in afternoon/early evening timeslot.
    - Work continues with plan for volunteers to assist in ringing FT members who have not informed us of their email, as online communication key to two way engagement for the future. Paper also being produced by Eli McCutchion on this topic, covering the wider issues that need to be considered and a meeting is being scheduled with volunteer team, FT Office and Communications Team.
    - Agreed to explore with Workplace Team about suitable Trust venues in the community that Governors could set up stall to gather feedback (positive and negative) and promote FT Membership/hand out leaflets. Governors will be asked to volunteer to attend as part of their engagement duties and it was suggested that this could be done on a Constituency basis, arranged by each Constituency group.
- **Healthy Futures Articles** – agreed themes for future articles.

Key decision(s)/recommendations made by the Committee:

1. To note the updates from the Committee meeting listed above and in particular the suggestion about wider engagement by all Governors via constituency led engagement stalls in the Trust community settings and other key locations like the discharge lounge area.

Torbay and South Devon
NHS Foundation Trust

Report to the Council of Governors Meeting			
Report title: Public Quarterly Governance Report			**Meeting date**: 3 May 2023
Report appendix	Governor Register of Interests		
Report sponsor	Director of Corporate Governance and Trust Secretary		
Report author	Corporate Governance Manager		
Report provenance	n/a		
Purpose of the report and key issues for consideration/decision	The report provides corporate governance updates on matters of relevance to the Council of Governors.		
Action required	**For information** ☐	**To receive and note** ☒	**To approve** ☒
Recommendations	To receive and note the items as shown in the Report of Corporate Governance Manager.		
Summary of key elements			

Strategic goals supported by this report

Excellent population health and wellbeing		**Excellent experience receiving and providing care**	
Excellent value and sustainability	**X**		

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework	n/a	**Risk score**	
Risk Register	n/a	**Risk score**	

External standards affected by this report and associated risks

Care Quality Commission	**X**	**Terms of Authorisation**	
NHS England	**X**	**Legislation**	
National policy/guidance	**X**		

Report title: Governance Quarterly Report		Meeting date: 3 May 2023
Report sponsor	Director of Corporate Governance and Trust Secretary	
Report author	Corporate Governance Manager	

The report provides corporate governance updates on matters of relevance to the Council of Governors.

1. 2023 Elections

The annual elections process for the Council of Governors commenced in November 2022. The contested seats were:

- Public Governor Teignbridge Constituency (2 seats)
- Public Governor Torbay Constituency (3 seats)
- Public Governor South Hams and Plymouth (1 seat)
- Public Governor Rest of the SW Peninsula (1 seat)
- Staff Governor Newton Abbot ISU (1 seat)
- Staff Governor Coastal ISU (1 seat)
- Staff Governor Torquay ISU (1 seat)

Following the close of elections on the 7th February 2023, Civica, the Trust's Returning Officer, confirmed the successful candidates for each Constituency as follows:

- Public Governor Teignbridge Constituency James Hartley
Andrew Postlethwaite
- Public Governor Torbay Constituency John Kiddey*
Alison Ramon
Andrew Stilliard
- Public Governor South Hams and Plymouth Val Browning
- Public Governor Rest of the SW Peninsula Not filled
- Staff Governor Newton Abbot ISU Jonathan Shribman
- Staff Governor Coastal ISU Not filled
- Staff Governor Torquay ISU Sal Aziz

* Following the resignation of Mark Tyrell-Smith (Torbay Constituency) which took place after the close of the election process, John Kiddey, as the Governor who received the next highest number of votes after those listed above, was appointed. John will serve the remainder of Mark Tyrell-Smith's term, ie two years.

In addition, appointments have been made to a number of vacant appointed Governor positions, as follows:

- Devon Partnership Trust Clare McAdam
- Teignbridge Council Andrew MacGregor
- Torbay Carers Strategy Steering Group Hilary Milner
- University of Exeter Medical School Chrissie Thirlwell
- Plymouth University PSMD Louise Winfield

Governors are also informed that with effect from 9th May 2023 Craig Davidson (South Hams and Plymouth) has stood down from his position as Governor. At the most recent election there was only one candidate for one vacant position in this Constituency and as such there was no need to hold an election; nor is there a secondary candidate we could approach to take up the vacant position following Craig's departure, and it will remain vacant until the next election round to appoint Governors in early 2024.

Action required: To receive and note the 2023 election update report.

2. Governor Observers

On 16th March 2023 nominations were sought from Governors to be Governor Observers.

The following nominations were received:

- Audit and Risk Committee — Andrew Postlethwaite
- Finance, Performance and Digital Committee — Sal Aziz
- People Committee — Andrew Stilliard
- Quality Assurance Committee — Val Browning
- Building a Brighter Future Committee — Dave Cawley
- Charitable Funds Committee — Alison Ramon

Governors indicated the committee they wished to observe at the point they put themselves forward and were allocated accordingly.

Action: Governors are asked to note and approve the new nominated Governor Observers for 2023/24.

3. Governor Register of Interests

Governors are asked to review the attached Governor Register of Interests and inform the CoG if there are any amendments that need to be made.

Action: Confirm Governor Register of Interests as at 31st March 2023.

4. Communication with Governors

Governors are asked to provide feedback on the methods and frequency of communication received from the Trust, to ensure it is meeting their needs. Currently the Governors receive:

- Bi-weekly Governor newsletters (via email)
- Press releases (via email)
- Healthwatch Bulletins (via email)
- Healthy Futures Magazine (via email)
- Email correspondence from the Trust on matters requiring timely notification
- Circulation of Governor Questions as they arise
- Link to Public Board agenda (via email)
- ICO News and other all staff emails

Action: Governors to consider methods and frequency of communication

5. Good Governance Institute Feedback

It is proposed that a couple of GGI recommendations be referred to each CoG meeting to provide a mechanism for consideration and action.

Action: Governors to approve approach detailed above.

6. Senior Independent Director

A Governor Nominations and Remuneration Committee was held on 3rd April 2023, where it was agreed that Professor Chris Balch should become the substantive Senior Independent Director.

Action: Governors are asked to note the above.

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REGISTER OF GOVERNORS' INTERESTS AS AT 31 MARCH 2023

SOUTH HAMS AND PLYMOUTH PUBLIC CONSTITUENCY

Governor name	Declared interests
Val Browning	Member Chillington Health Centre PPG
Dave Cawley	Managing Director of Timestep Electronics Ltd Director, Vavasour House (Dartmouth) Management Company
Craig Davidson	Trustee of Dartmouth Indoor Swimming Pool Trust

TEIGNBRIDGE PUBLIC CONSTITUENCY

Governor name	Declared interests
Eileen Engelmann	Volunteer for Alzheimer Association Work on a freelance basis for Atlas Remedial and Care as a mentor/coach for people living with dementia and for their carers
Annie Hall	Registered with Working with us Panel at Torbay Special interest in the Pituitary Society Group at Torbay Interest to raise awareness with County Lines for Devon and Cornwall Police
James Hartley	None
Michael James	Councillor for Dawlish Council Member of St Johns Ambulance Volunteer for 'Volunteering in Health Member of Cancer Research UK Member Independent Age
Andrew Postlethwaite	Sole Trader – VR Forensics
John Smith	None
Jean Thomas	None

TORBAY PUBLIC CONSTITUENCY

Governor name	Declared interests
Loveday Densham	Member of staff at Royal Devon and Exeter Hospital
John Kiddey	None
Peter Milford	Trustee, Totnes and District Swimming Pool Association Ltd
Alison Ramon	None
Andrew Stilliard	None
Lee Thomas	
Keith Yelland	None

STAFF CONSTITUENCY

Governor name	Declared interests
Sal Aziz	Devon Partnership NHS Trust Bank Administrator
Matthew Giles	None
Jonathan Shribman	Employed by Devon Doctors Ltd RNLI Medical Adviser, Dartmouth GP – COVID-19 111 Service Ad-hoc GP Locum – South Hams practices
Emily Wood	None
Radia Woodbridge	None

APPOINTED GOVERNORS

Governor name	Declared interests
Nicole Amil (Torbay Council)	Councillor – Torbay Council
Derek Blackford (NHS Devon CCG)	Employed by NHS Devon CCG as Locality Director South and West
Jonathan Hawkins (Devon County Council)	None
Andrew MacGregor (Teignbridge Council)	District Councillor, Bishopsteignton
Clare McAdam (Devon Partnership Trust)	Deputy Director Nursing & Allied Health Professions – Devon Partnership Trust Perinatal Clinical Director – South West Provider Collaborative
Hilary Milner (Torbay Carers Strategy Steering Group)	None
Rosemary Rowe (South Hams DC)	None
Chrissie Thirwell (University of Exeter Medical School)	Secretary – UK and Ireland Neuroendocrine Tumour Society Co-Chair – Board of Scientific Advisors Neuroendocrine Tumour Research Foundation (USA) European Neuroendocrine Tumour Society Advisory Board European Society of Medical Oncology NET Faculty Clinical Director SW Genomic Medicine Service Alliance Trustee – FORCE Cancer Charity
Louise Winfield (Plymouth University PSMD)	None

Torbay and South Devon
NHS Foundation Trust

Report to Council of Governors (COG)			
Report title: Briefing: NHS Standard Form Licence			Meeting date: 3rd May 2023
Report appendix	Appendix 1- Current NHS Standard Form Licence Appendix 2 – Revoked NHS Standard Form Licence		
Report sponsor	Director of Corporate Governance and Trust Secretary		
Report author	Director of Corporate Governance and Trust Secretary		
Report provenance	n/a		
Purpose of the report and key issues for consideration/decision	Brief the COG on the new NHS provider standard form licence issued on 28 March 2023, effective 1 April 2023. This briefing paper was also provided to Board on 26 April 2023.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	To receive the report and review the NHS provider standard form licence appended, noting variances from the previous superseded version.		
Summary of key elements			

Strategic goals supported by this report

Excellent population health and wellbeing		**Excellent experience receiving and providing care**	
Excellent value and sustainability	X		

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework	n/a	**Risk score**	
Risk Register	n/a	**Risk score**	

External standards affected by this report and associated risks

Care Quality Commission	X	**Terms of Authorisation**	X
NHS England	X	**Legislation**	X
National policy/guidance	X		

NHS
Torbay and South Devon
NHS Foundation Trust

Introduction

The Council of Governors ("COG") of Torbay and South Devon NHS Foundation Trust (The "Trust") are asked the note the enclosed briefing and newly issued NHS Standard Form Licence conditions, which, together with the updated cover page forms the Trust's provider licence of operation, as issued by NHS England ("NHSE"), together (the "Licence"). The Licence sets out the operational standards and regulatory oversight parameters within which the Trust must operate in the delivery of services, as directed by NHS England.

The new licence was published on 28 March 2023 and effective 1 April 2023, superseding and revoking the previous licence.

This Licence (**Appendix 1**) has been provided with annotations to facilitate the COG's review and interpretation; with newly added sections, deletions and amendments noted with additional commentary provided, where appropriate.

A summary and reflection on those changes can be found below.

Summary: Licence provisions

Enclosed as **Appendix 1** is the Licence, as noted above. Also enclosed as **Appendix 2** is the previous issue, now fully revoked and superseded.

A brief summary of these changes is provided below. Key themes and modifications:

New Condition: WS1 "Cooperation" Integrated care/system working with a positive obligation to engage

- The inclusion of this new condition creates a positive obligation on providers to cooperate and collaborate with System partners, this is a key theme of the new Licence; failure to act and to do so with the best interests of the people of Devon in mind will now fall foul of the prescribed regulatory framework and could therefore theoretically lead to regulatory intervention. Application and learning from other Trusts as the new Integrated Care System ("ICS") system embeds will be our main source of learning here.
- NHSE commentary stated that the Condition *"requires NHS trusts, foundation trusts and NHS controlled providers to consistently cooperate with ICBs, Local Authorities and other organisations that deliver NHS care when developing and delivering system plans, delivering NHS services, improving NHS services, delivering system financial plans and delivering system workforce plans"*
- Furthermore, NHSE reported that "*The condition is intentionally drafted broadly to account for the wide range of services delivered across the NHS and is supported by established good practice and the standard NHS contract; providers and systems are supported in meeting expectations through a number of resources for integrated care and clear guidance addressing health inequalities through Core20PLUS5.*"
- This condition is not extended to independent providers.

New Condition: WS2 the Triple Aim

- A new condition has been created which requires NHS trusts, foundation trusts and NHS controlled providers to have regard for and consider the likely effects of their decisions on the Triple Aim and have regard to related guidance. This aligns with the broader themes of stakeholder engagement now found within the Companies Act 2006 and related reporting (s172 reporting – the duty to act with regard to the best interests of your shareholders whilst having regard to broader stakeholders, demonstrably within decision making).
- The Triple Aim is a key element of the Health and Care Act 2022 ("HCA22") and was intended to ensure the legislative framework supports local health and care organisations to work together in the interests of the populations they serve.
  - The 'Triple Aim' (referred to as the 'duty to have regard to wider effect of decisions' in the Bill for the HCA22) is a common duty for NHS bodies that plan and commission services (NHS England and ICBs) and that provide services (Trusts and Foundation Trusts).
  - It obliges these bodies to consider the effects of their decisions on:
    - the health and wellbeing of the people of England (including inequalities in that health and wellbeing);
    - the quality of services provided or arranged by both themselves and other relevant bodies (including inequalities in benefits from those services); and
    - the sustainable and efficient use of resources by both themselves and other relevant bodies.
  - The aim (taken from supporting commentary from the HCA2022 as a Bill) is "*to encourage these bodies to not only continue a culture of working in the best interest of their immediate service users and organisations, but also on public health, prevention and reducing health disparities for the wider population, and will include working together strategically with other relevant bodies and the public. We hope that the Triple Aim will help align NHS bodies around a common set of objectives, thus supporting the shift towards integrated local health and care systems which have strong engagement with their communities. At report stage in the House of Lords, the government tabled amendments to explicitly include consideration of inequalities in health and wellbeing and the benefits of services in the Triple Aim*."
  - Furthermore, NHSE commentary stated that "*NHS England will keep under review whether developing further guidance would help support progress in this area*." As with many areas of the new Licence, whilst clear direction is set, the boundaries and demonstrable measures of compliance are less clear. We will therefore need to act in the spirit of this and await further clarity. The COGcould perhaps consider adding the satisfaction of this principle to their cover sheets, so that as with risk, collaboration and the Triple Aim is in the forefront of our thinking.

<u>New Condition: WS3 Digital Transformation</u>

- This new Condition requires NHS trusts, foundation trusts and NHS controlled providers to comply with the information standards of section 250 of the Health and Social Care Act 2012 and with guidance related to digital maturity as they pertain to cooperation and the Triple Aim. Therefore, this Condition is reinforcing the aforementioned new principles, aligned with NHS digital strategies. This will need to

align with our BBF and transformation strategies. Consideration should be given as to how we meaningfully report against this.

New Condition: IC2 Personalised care

- New Condition creating an obligation to support the delivery of personalised care and offer control and choice to patients. This replaces the Choice and Competition licence conditions within the previous Licence, which focussed on choice of provider.
- NHSE reported that *"ICBs will need to consider how to incorporate personalised care alongside other priorities included in operational planning guidance and the Long Term Plan. The Universal Personalised Care guidance, co-produced with key stakeholders including people with lived experience, can support providers to offer personalised care, including supporting patients to have better control over their own healthcare budget. Furthermore, the Personalised Care Institute has provided a range of quality assured workforce development programmes to support implementation."*
- This crystalises a principle that is likely found within our practices and delivery, consideration will therefore need to be given as to how this is articulated in line with the new Licence terminology and focus; reviewing key strategies, policies and procedures to encourage personalised care.

Amendment to existing Condition: Increased control and ability to intervene to the continuity of services (CoS) licence conditions

- NHSE reported that the intention of amending and reorganising these conditions was "*adding specific quality governance related criteria to the continuity of services (CoS) licence conditions and establishing a category of 'hard to replace' independent providers of NHS services, as designated by NHS England, to whom some of the CoS conditions will also apply*".
- The focus of this section has been to:
  - allow NHSE to define Hard to Replace Providers and apply continuity of service conditions to them;
  - introduce specific quality governance related criteria to the continuity of services (CoS), applicable to the provider and Hard to Replace Providers; and
  - make broader provision for regulatory intervention (previously limited to a provider being a going concern) which enables NHSE to take action should the COS and quality measures not be met; permitting NHSE to inspect information, oversee and appoint management to effectively direct the Trusts activities:
    - Linked closed consultation on Hard to Replace Providers: Consultation on the draft updated risk assessment framework and reporting manual for independent sector providers of NHS services - NHS England - Citizen Space
    - The specific amendments in this regard are highlighted within "*CoS 3: Standards of corporate governance, financial management and quality governance".*
  - The increased power for regulatory intervention linked to quality and system "stress" in the event of a service potentially failing is a significant change in the

Licence. Its pertinence should be borne in mind by the COGin seeking risk and assurance information. The lack of a benchmark as to what signifies acceptable “quality” is a gap. Guidance will likely be issued in due course, thought the NHS System Oversight Framework (“SOF”) could provide a mechanism for oversight alongside CQC reporting.

New Sub-Condition(s): Climate and environment

- Trusts must “*have regard to guidance on tackling climate change*” and “*have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health*”.
- This is a new focus and reporting against compliance should be considered.

Amendment to existing Conditions (now C1-3& P1): Shifting the focus of the costing conditions to support integration and improvement

- Due to the reshaping of previous provisions it was necessary to restructure this section, as outlined below. Commentary is limited here to allow analysis by finance colleagues in due course, pending further NHSE guidance, as per the *“Response to NHS England’s consultation on the provider licence*” Healthcare Financial Management Association guidance on the consultation of the Licence’s financial aspects; which identified a need for further clarity. Relevant NHSE extracts copied into the document attached for ease of reference.
- Replace:
    - Pricing Condition 1 with new Costing Condition 1: Submission of costing information
    - Pricing Condition 2 with new Costing Condition 2: Provision of costing and costing related information
    - Pricing Condition 3 with new Costing Condition 3: Assuring the accuracy of pricing and costing information.
- Remove:
    - Pricing Condition 4 (renamed as Pricing Condition 1) – to apply the rules and methods of charging for the provision of NHS services as set out in the NHS Payment Scheme.
- Update:
    - Pricing Condition 5 (local modifications) from the licence.

Streamlining reporting requirements (See NHS2)

- The changes here could have been significant, however, having reviewed the reissued ARM (Annual Reporting Manual) there will be changes in reporting mechanisms, however much of the same information will still need to be produced for the annual report.
    - Remove reporting requirements from General Condition 6 (Systems for compliance), which requires licensees to self-certify against the licence.
    - Remove Foundation Trust Condition 4/Controlled Provider condition 1, which requires foundation trusts to report on past and future compliance with the

licence (annual certification) and to prepare a Corporate Governance Statement.

  - As above, the Licence will still need to be referred to and an assurance position confirmed as well as a corporate governance statement being provided, these will simply not be reported additionally and separately going forward.

Amending the Fit and Proper Persons condition (G3)

- Adopting the changes to licence condition G4: Fit and Proper Persons as per the consultation run by Monitor in February-March 2021 and bringing it into line with current law.

Removal of obsolete sections:

- General Condition 3: Payment of fees to Monitor
- Foundation Trust Condition 2: Payment to Monitor in respect of registration and related costs
- Foundation Trust Condition 3: Provision of information to advisory panel.

Further detail of the changes can also be found on the NHSE website, link here: NHS England » NHS Provider Licence: consultation response

Conclusion

The regulatory landscape for the Trust is undoubtably changing, the HCA22, the new Licence, the Hewitt Review 2023 all indicate a change in regulatory intent with the grounding for the Integrated Care System to flourish being laid, with the focus being on the success of the individual systems for the benefit of their populations. There are strong messages of collaboration and cooperation, user experience (physical and digital), our interaction with the physical environment and the quality of service delivered, combined with greater power to take enforcement action – if necessary.

Recommendations

The COG are asked to receive and note this report, giving consideration as to how we as a Trust can embed the key themes of the Licence, illustrating a desire to act in its spirit, awaiting more detailed guidance from NHSE in due course.

Torbay and South Devon NHS Foundation Trust

Torbay Hospital
Torquay
TQ2 7AA

Licence number: 110102

Date of issue	**Version number**
1 April 2023	2

Miranda Carter
Director of Provider Development, NHS England

Version History

Version number	Date	Comments
1.0	1 October 2015	Created
2.0	31 March 2023	Modified licence standard conditions

Classification: Official

Publication reference: PR00191

NHS Provider Licence

Standard Conditions

31 March 2023

Version History

Version number	Date	Comments
1.0	26 March 2013	Created
2.0	04 April 2013	Formatting changes
3.0	27 October 2022	Draft updated licence for consultation
4.0	31 March 2023	Updated licence conditions

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Previous licence effective to 31/03/23 started at Section 3, meaning sections 1 & 2 are new.

Removal of obsolete sections:
General Condition 3: Payment of fees to Monitor
Foundation Trust Condition 2: Payment to Monitor in respect of registration and related costs
Foundation Trust Condition 3: Provision of information to advisory panel.

Amendments noted in each section.

New condition

NHSE - intention to reframe: IC1 Provision of Integrated Care - as a positive obligation that all providers take steps to integrate services and enable cooperation with other services to improve quality and reduce inequalities of access and outcomes.

Section 1 – Integrated Care

IC1: Provision of Integrated care

1. The Licensee shall act in the interests of the people who use health care services by ensuring that its provision of health care services for the purposes of the NHS:
    i) is integrated with the provision of such services by others, and
    ii) is integrated with the provision of health-related services or social care services by others and
    iii) enables co-operation with other providers of health care services for the purposes of the NHS

    where this would achieve one or more of the objectives referred to in paragraph 2.
2. The objectives are:
    a. improving the quality of health care services provided for the purposes of the NHS (including the outcomes that are achieved from their provision) or the efficiency of their provision,
    b. reducing inequalities between persons with respect to their ability to access those services, and
    c. reducing inequalities between persons with respect to the outcomes achieved for them by the provision of those services.
3. The Licensee shall have regard to guidance as may be issued by NHS England from time to time for the purposes of paragraphs 1 and 2 of this Condition.
4. Nothing in this licence condition requires the licensee to take action or share information with other providers of health care services for the purposes of the NHS if the action or disclosure of the information would materially prejudice its commercial or charitable interests.

New condition.

IC2 Personalised care and Patient Choice - to require providers to support the implementation and delivery of personalised care by having regard for relevant guidance and legislation, offering people control to manage their own health and wellbeing.
ICBs will need to consider how to incorporate personalised care alongside other priorities included in operational planning guidance and the Long Term Plan. The Universal Personalised Care guidance, co-produced with key stakeholders including people with lived experience, can support providers to offer personalised care, including supporting patients to have better control over their own healthcare budget. Furthermore, the Personalised Care Institute has provided a range of quality assured workforce development programmes to support implementation.

IC2: Personalised Care and Patient Choice

1. The Licensee shall support the implementation and delivery of personalised care by complying with legislation and having due regard to guidance on personalised care.
2. Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee must ensure people who use their services are offered information, choice and control to manage their own health and well-being to best meet their circumstances, needs and preferences, working in partnership with other services where required.
3. Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, the person is notified of that choice and told where information about that choice can be found.
4. Information and advice about patient choice of provider made available by the Licensee shall not be misleading.
5. Without prejudice to paragraph 2, information and advice about patient choice of provider made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that, as far as reasonably practicable, assists patients in making well informed choices between providers of treatments or other health care services.
6. In the conduct of any activities, and in the provision of any material, for the purpose of promoting itself as a provider of health care services for the purposes of the NHS the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.

New condition.

WS1 "Cooperation" Integrated care/system working with a positive obligation to engage"requires NHS trusts, foundation trusts and NHS controlled providers to consistently cooperate with ICBs, Local Authorities and other organisations that deliver NHS care when developing and delivering system plans, delivering

Section 2 – Trusts Working in Systems

WS1: Cooperation

1. This condition shall apply if the Licensee is an NHS trust NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.
2. The Licensee shall carry out its legal duties to co-operate with NHS bodies and with local authorities.
3. Without prejudice to the generality of paragraph 2, the Licensee shall:
   a. consistently co-operate with:
   - other providers of NHS services; and
   - other NHS bodies, including any Integrated Care Board of which it is a partner;
     i. as necessary and appropriate for the purposes of developing and delivering system plan(s).
     ii. as necessary and appropriate for the purposes of delivering their individual or collective financial responsibilities including but not limited to contributing to the delivery of agreed system financial plans in each financial year
     iii. as necessary and appropriate for the purposes of delivering agreed people and workforce plans

   b. consistently co-operate with:
   - other providers of NHS services;
   - other NHS bodies, including any Integrated Care Board of which it is a partner; and
   - any relevant local authority in England
     i. as necessary and appropriate for the purposes of delivering NHS services.
     ii. as necessary and appropriate for the purposes of improving NHS services.
4. The Licensee shall have regard to such guidance concerning co-operation as may be issued from time to time by either:

a. the Secretary of State for Health and Social Care; or
b. NHS England.

For the purposes of this condition, cooperation is considered synonymous to collaboration.

New condition.

WS2 The Triple Aim - which requires NHS trusts, foundation trusts and NHS controlled providers to have regard for and consider the likely effects of their decisions on the Triple Aim and have regard to related guidance.

WS2: The Triple Aim

1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.
2. When making decisions in the exercise of its functions which relate to the provision of health care for the purposes of the NHS, the Licensee shall comply with its duty relating to the triple aim.
3. The Licensee shall have regard to the triple aim and to any guidance published by NHS England under section 13NB of the 2006 Act.
4. In this condition, “the triple aim” refers to the aim of achieving:
   a. better health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing)
   b. better quality of health care services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services)
   c. more sustainable and efficient use of resources by NHS bodies,

and “duty relating to the triple aim” means, in relation to an NHS trust, its duty under section 26A of the 2006 Act, and in relation to an NHS foundation trust, its duty under section 63A of the 2006 Act.

New condition.

WS3 Digital Transformation - which requires NHS trusts, foundation trusts and NHS controlled providers to comply with the information standards of section 250 of the Health and Social Care Act 2012 and with guidance related to digital maturity as they pertain to cooperation and the Triple Aim. Links to: a new requirement in NHS2: Governance arrangements paragraph 3(c) and CP1: Governance arrangements for NHS controlled providers paragraph 3(c) to have systems and processes in place to meet guidance on digital maturity.

WS3: Digital Transformation

1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.
2. The Licensee shall comply with information standards published under section 250 of the 2012 Act where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).
3. The Licensee shall comply with required levels of digital maturity as set out in guidance published by NHS England from time to time where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).

Section 3 – General Conditions

G1: Provision of information

1. The Licensee shall provide NHS England with such information, documents and reports (together 'information') as NHS England may require for any of the purposes set out in section 96(2) of the 2012 Act. This requirement is in addition to specific obligations set out elsewhere in the licence. If requested by NHS England, the Licensee shall prepare or procure information in order to comply with this condition.
2. Information shall be provided in such manner, in such form, and at such place and times as NHS England may require.
3. The Licensee shall take all reasonable steps to ensure that information is:
    a. in the case of information or a report, it is accurate, complete and not misleading;
    b. in the case of a document, it is a true copy of the document requested.
4. This Condition shall not require the Licensee to provide any information which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

G2: Publication of information

1. The Licensee shall comply with any instruction by NHS England, issued for any of the purposes set out in section 96(2) of the 2012 Act, to publish information about the health care services it provides for the purposes of the NHS. The Licensee shall publish the information in such manner as NHS England may instruct.
2. For the purposes of this Condition, “publish” includes making available to the public at large, to any section of the public or to particular individuals.

Amendments.

Adopting the changes to licence condition G4: Fit and Proper Persons as per the consultation run by Monitor in February-March 2021 and bringing it into line with current law. Brings in line with reasonable care, skill and expertise obligations of Directors under the Companies Act 2006

G3: Fit and proper persons as Governors and Directors (also applicable to those performing the functions of, or functions equivalent or similar to the functions of, a director)

1. The Licensee must ensure that a person may not become or continue as a Governor of the Licensee if that person is:
   a. a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
   b. a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);
   c. a person who has made a composition or arrangement with, or granted a trust deed for, that person's creditors and has not been discharged in respect of it;
   d. a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on that person.

2. The Licensee must not appoint or have in place a person as a Director of the Licensee who is not fit and proper.

3. For the purposes of paragraph 2, a person is not fit and proper if that person is:
   a. an individual who does not satisfy all the requirements as set out in paragraph (3) and referenced in paragraph (4) of regulation 5 (fit and proper persons: directors) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936); or
   b. an organisation which is a body corporate, or a body corporate with a parent body corporate:
      i. where one or more of the Directors of the body corporate or of its parent body corporate is an individual who does not meet the requirements referred to in sub-paragraph (a);
      ii. in relation to which a voluntary arrangement is proposed, or has effect, under section 1 of the Insolvency Act 1986;

iii. which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking;
iv. which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act;
v. which passes any resolution for winding up;
vi. which becomes subject to an order of a Court for winding up; or
vii. the estate of which has been sequestrated under Part 1 of the Bankruptcy (Scotland) Act 1985.

4. In assessing whether a person satisfies the requirements referred to in paragraph 3(a), the Licensee must take into account any guidance published by

Amendments. Detail below.
Adopting the changes to licence condition G4: Fit and Proper Persons as per the consultation run by Monitor in February-March 2021 and bringing it into line with current law.
Brings in line with reasonable care, skill and expertise obligations of Directors under the Companies Act 2006
Consultation extract:
Effect of the proposed modification
Provisions relating to directors
While the proposed modification (as it applies to directors) is a technical amendment, it would have the effect of extending the scope of the fit and proper person test as set out in the licence to include:
qualifications, competence, skills, experience and ability to properly perform the functions of a director
issues of serious misconduct or mismanagement and
disbarment in relation to safeguarding vulnerable groups and disqualification from office.
In practice, licence holders are already required to comply with these requirements under the FPP Regulations. The effect of the modification is therefore simply to ensure consistency of approach in the provider licence.
The modification also removes the requirement for licence holders to ensure that there are contractual arrangements in place for dealing with directors who are unfit. These provisions are no longer necessary since the introduction of the FPP Regulations prohibits licence holders from appointing, or having in office, an unfit director.
The effect of the modification is also to remove provisions which have become redundant and brings provisions in line with current working practices, details of which are set out in paragraphs 15 to 18 below.
Provisions relating to governors
The FPP Regulations do not apply to governors of NHS foundation trusts. The effect of the proposed modification (as it applies to governors) would be limited to bringing the provisions in line with current working practices, as set out in paragraphs 16 to 18 below, and to make minor changes to the wording to provide greater clarity.
Provisions relating to directors and governors
The proposed modification would remove two provisions which are either redundant or have limited application.
The first of these provisions is the reference to Monitor's discretion to authorise any general exception to the fit and proper person requirements for NHS foundation trust directors and governors. This power has limited application because it applies only to fit and proper person requirements that an NHS foundation trust has included in its constitution and which go beyond the legislative requirements. In practice the power has never been used so the modification would simply remove a provision that is already effectively redundant.
The second is the prohibition on holding office as a director or governor for any person disqualified from holding office as a director under the Company Directors' Disqualification Act 1986. As this provision expressly relates to directors' fitness and goes beyond the legislative framework for governors, it is proposed that it is removed in relation to governors. For directors, the provision can be removed as it is already covered by the FPP test under the FPP Regulations, which would be incorporated into the licence by the proposed modifications.

Brings section into line with law: The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/5
Fit and proper persons: directors
5. --(1) This regulation applies where a service provider is a health service body.
(2) Unless the individual satisfies all the requirements set out in paragraph (3), the service provider must not appoint or have in place an individual --
(a)as a director of the service provider, or
(b)performing the functions of, or functions equivalent or similar to the functions of, such a director.

(3) The requirements referred to in paragraph (2) are that --
(a)the individual is of good character,
(b)the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed,
(c)the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed,
(d)the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity, and
(e)none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

(4) In assessing an individual's character for the purposes of paragraph (3)(a), the matters considered must include those listed in Part 2 of Schedule 4.

(5) The following information must be available to be supplied to the Commission in relation to each individual who holds an office or position referred to in paragraph (2)(a) or (b) --
(a)the information specified in Schedule 3, and
(b)such other information as is required to be kept by the service provider under any enactment which is relevant to that individual.
(6) Where an individual who holds an office or position referred to in paragraph (2)(a) or (b) no longer meets the requirements in paragraph (3), the service provider must --
(a)take such action as is necessary and proportionate to ensure that the office or position in question is held by an individual who meets such requirements, and
(b)if the individual is a health care professional, social worker or other professional registered with a health care or social care regulator, inform the regulator in question.

G4: NHS England guidance

1. Without prejudice to specific obligations in other Conditions of this Licence, the Licensee shall at all times have regard to guidance issued by NHS England for any of the purposes set out in section 96(2) of the 2012 Act.
2. In any case where the Licensee decides not to follow the guidance referred to in paragraph 1 or guidance issued under any other Conditions of this licence, it shall inform NHS England of the reasons for that decision.

Removal of obligation to prepare and submit a certification of compliance with this provision.
Removal of obligation to prepare a corporate governance statement. See NHS2/CP1

G5: Systems for compliance with licence conditions and related obligations

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:
   a. the Conditions of this Licence,
   b. any requirements imposed on it under the NHS Acts, and
   c. the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.
2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:
   a. the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
   b. regular review of whether those processes and systems have been implemented and of their effectiveness.

Detail below:
NHSE Consultation & outcome:
To remove reporting requirements from General Condition 6 (Systems for compliance), which requires licensees to self-certify against the licence, and Foundation Trust Condition 4/Controlled Provider condition 1, which requires foundation trusts to report on past and future compliance with the licence and to prepare a Corporate Governance Statement.
Feedback and response
Responses were in favour of these proposed modifications. 79% of respondents agreed or strongly agreed with the proposed removal of paragraphs 3 and 4 from General Condition 6 of the existing licence. No respondents disagreed with the proposal. 73% agreed or strongly agreed with the proposed removal of the Corporate Governance Statement requirements for NHS trusts, foundation trusts and NHS controlled providers, including 81% of trusts and foundation trusts who responded. 10% of trusts and foundation trusts disagreed or strongly disagreed.
There was broad consensus that these proposals would streamline requirements and reduce burden. However, some respondents noted the usefulness of the Corporate Governance Statement in focusing Board attention to governance processes and compliance issues and would continue this process internally.
Many respondents also noted the range of other reporting mechanisms that would continue, such as the annual report, annual governance statements and through any CQC well-led review. These will require Boards to continue to assess their compliance with corporate governance standards, and evidence of this compliance will continue to be considered as part of well-led assessments. However, removing this requirement would mean providers will no longer have to make statements on anticipated future compliance. On balance, there was a consistent view that any reduction in duplication and regulatory burden was welcome.
Independent providers will continue to self-certify through the Risk Assessment Framework, pending consultation.
Outcome
We have removed the reporting requirements from the final modified licence.

Removed text:
3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to Monitor a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.
4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to Monitor in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

G6: Registration with the Care Quality Commission

1. The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able to lawfully provide health care services for the purposes of the NHS.
2. The Licensee shall notify NHS England promptly of:
   a. any application it may make to the Care Quality Commission for the cancellation of its registration by that Commission, or
   b. the cancellation by the Care Quality Commission for any reason of its registration by that Commission.
3. A notification given by the Licensee for the purposes of paragraph 2 shall:
   a. be made within 7 days of:
      i. the making of an application in the case of paragraph (a), or
      ii. becoming aware of the cancellation in the case of paragraph (b), and
   b. contain an explanation of the reasons (in so far as they are known to the Licensee) for:
      i. the making of an application in the case of paragraph (a), or
      ii. the cancellation in the case of paragraph (b).

G7: Patient eligibility and selection criteria

1. The Licensee shall:
    a. set transparent eligibility and selection criteria,
    b. apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee, and
    c. publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them.
2. “Eligibility and selection criteria” means criteria for determining:
    a. whether a person is eligible, or is to be selected, to receive health care services provided by the Licensee for the purposes of the NHS, and
    b. if the person is selected, the manner in which the services are provided to the person.

Cross refer to CoS3/6/7
Removal of redundant clauses from General Condition 9 (now G8)
Allow NHS England to determine and apply continuity of service conditions to Hard to Replace Providers (separate consultation on this definition/scope)
Amend relevant CoS conditions to reference Hard to Replace Providers.
This includes a mechanism added to G8 (Application of section 6 (Continuity of Service)) which sets out that the Continuity of Service conditions shall apply to licensees subject to a contractual obligation as CRS, or as determined by NHS England to be a Hard to Replace provider. CoS3 (Standards of corporate governance and financial management), Cos6 (Cooperation in the event of financial stress) and CoS7 (Availability of resources) will also be amended to refer to Hard to Replace Providers.
NHSE - We have included these provisions in the final modified provider licence due to the importance of ensuring that NHS England has regulatory powers to intervene where the loss of a national, multi-regional or large regional provider would significantly reduce capacity across the NHS and impact access to patients.

G8: Application of section 6 (Continuity of Service)

1. The Conditions in Section 6 shall apply:
   a. whenever the Licensee is subject to a contractual obligation to provide a service to a Commissioner which is contractually agreed to be a Commissioner Requested Service,
   b. whenever the Licensee is subject to a contractual obligation to deliver a service which is subsequently designated as a Commissioner Requested Service by virtue of the process set out in paragraph 2,
   c. where the circumstances set out in paragraph 6 apply (expiry of contract without renewal or extension),
   d. where the circumstances set out in paragraph 7 apply (instruction by NHS England that the Licensee must continue to deliver a service as a Commissioner Requested Service),
   e. whenever the Licensee is determined by NHS England to be a Hard to Replace Provider.
2. A service is designated as a Commissioner Requested Service if:
   a. it is a service which the Licensee is required to provide to a Commissioner under the terms of a contract which has been entered into between them, and
   b. the Commissioner has made a written request to the Licensee to provide that service as a Commissioner Requested Service, and either
   c. the Licensee has failed to respond in writing to that request by the expiry of the 28th day after it was made to the Licensee by the Commissioner, or
   d. the Commissioner, not earlier than the expiry of the 28th day after making that request to the Licensee, has given to NHS England and to the Licensee a notice in accordance with paragraph 4, and NHS England, after giving the Licensee the opportunity to make representations, has issued an instruction in writing in accordance with paragraph 4.
3. A notice in accordance with this paragraph is a notice:
   a. in writing,
   b. stating that the Licensee has refused to agree to a request to provide a service as a Commissioner Requested Service, and

c. setting out the Commissioner's reasons for concluding that the Licensee is acting unreasonably in refusing to agree to that request to provide a service as a Commissioner Requested Service.

4. An instruction in accordance with this paragraph is an instruction that the Licensee's refusal to provide a service as a Commissioner Requested Service in response to a request made under paragraph 2(b) is unreasonable.

5. The Licensee shall give NHS England not less than 28 days' notice of the expiry of any contractual obligation pursuant to which it is required to provide a Commissioner Requested Service to a Commissioner for which no extension or renewal has been agreed.

6. If any contractual obligation of a Licensee to provide a Commissioner Requested Service expires without extension or renewal having been agreed between the Licensee and the Commissioner who is a party to the contract, the Licensee shall continue to provide that service on the terms of the contract (save as agreed with that Commissioner), and the service shall continue to be a Commissioner Requested Service, for the period from the expiry of the contractual obligation until NHS England issues either:

a. an instruction of the sort referred to in paragraph 7, or

b. a notice in writing to the Licensee stating that it has decided not to issue such a instruction.

7. If, during the period of a contractual or post contractual obligation to provide a Commissioner Requested Service, NHS England issues to the Licensee an instruction in writing to continue providing that service for a period specified in the instruction, then for that period the service shall continue to be a Commissioner Requested Service.

8. A service shall cease to be a Commissioner Requested Service if:

a. all current Commissioners of that service as a Commissioner Requested Service agree in writing that there is no longer any need for the service to be a Commissioner Requested Service, and NHS England has issued a determination in writing that the service is no longer a Commissioner Requested Service, or

b. NHS England has issued a determination in writing that the service is no longer a Commissioner Requested Service; or

c. the contractual obligation pursuant to which the service is provided has expired and NHS England has issued a notice pursuant to paragraph 6(b) in relation to the service; or
d. the period specified in an instruction by NHS England of the sort referred to in paragraph 7 in relation to the service has expired.

9. The Licensee shall make available free of charge to any person who requests it a statement in writing setting out the description and quantity of services which it is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services.

10. Within 28 days of every occasion on which there is a change in the description or quantity of the services which the Licensee is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services, the Licensee shall provide to NHS England in writing a notice setting out the description and quantity of all the services it is obliged to provide as Commissioner Requested Services.

11. In this condition, a provider is a Hard to Replace Provider if it has been identified as such by NHS England based on criteria set out and managed through guidance published by NHS England and NHS England has issued a determination in writing.

12. A provider will cease to be a Hard to Replace provider if it no longer meets the criteria set out and managed through guidance published by NHS England and NHS England has issued a determination in writing that the provider is no longer a Hard to Replace Provider.

13. In this Condition “NHS contract” has the meaning given to that term in Section 9 of the 2006 Act.

Section 4 – Trust Conditions

NHS1: Information to update the register

1. The obligations in the following paragraphs of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall make available to NHS England written and electronic copies of the following documents:
    a. the current version of Licensee's constitution;
    b. the Licensee's most recently published annual accounts and any report of the auditor on them, and
    c. the Licensee's most recently published annual report,

and for that purpose shall provide to NHS England written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted and of the documents referred to in sub-paragraphs (b) and (c) within 28 days of being published.
3. Subject to paragraph 4, the Licensee shall provide to NHS England written and electronic copies of any document that is required by NHS England for the purpose of NHS foundation trust register within 28 days of the receipt of the original document by the Licensee.
4. The obligation in paragraph 3 shall not apply to:
    a. any document provided pursuant to paragraph 2;
    b. any document originating from NHS England; or
    c. any document required by law to be provided to NHS England by another person.
5. The Licensee shall comply with any instruction issued by NHS England concerning the format in which electronic copies of documents are to be made available or provided.
6. When submitting a document to NHS England for the purposes of this Condition, the Licensee shall provide to NHS England a short written statement describing the document and specifying its electronic format and advising NHS England that the

document is being sent for the purpose of updating the register of NHS foundation trusts maintained in accordance with section 39 of the 2006 Act.

Cross refer - WS3
A new requirement in NHS2: Governance arrangements paragraph 3(c) and CP1: Governance arrangements for NHS controlled providers paragraph 3(c) to have systems and processes in place to meet guidance on digital maturity.
A new requirement in: NHS2 Governance arrangements paragraph 3(b) and CP1 Governance arrangements for NHS controlled providers paragraph 3(b) - to ensure NHS trusts, foundation trusts and NHS Controlled Providers have regard to guidance on tackling climate change.

NHS2: Governance arrangements

1. This Condition shall apply if the Licensee is an NHS trust or NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.
3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:
   a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time
   b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health
   c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and
   d. comply with the following paragraphs of this Condition.
4. The Licensee shall establish and implement:
   a. effective board and committee structures;
   b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
   c. clear reporting lines and accountabilities throughout its organisation.
5. The Licensee shall establish and effectively implement systems and/or processes:
   a. to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
   b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations;
   c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions;

d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
h. to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
c. the collection of accurate, comprehensive, timely and up to date information on quality of care;
d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

Cross refer - WS3
A new requirement in NHS2: Governance arrangements paragraph 3(c) and CP1: Governance arrangements for NHS controlled providers paragraph 3(c) to have systems and processes in place to meet guidance on digital maturity.
A new requirement in: NHS2 Governance arrangements paragraph 3(b) and CP1 Governance arrangements for NHS controlled providers paragraph 3(b) - to ensure NHS trusts, foundation trusts and NHS Controlled Providers have regard to guidance on tackling climate change
Removal of requirement to produce a corporate governance statement.

Section 5 – NHS Controlled Providers Conditions

CP1: Governance arrangements for NHS-controlled providers

1. This condition shall apply if the Licensee is an NHS-controlled provider of healthcare services for the purposes of the NHS without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.
3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:
   a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time
   b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health
   c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and
   d. comply with the following paragraphs of this Condition.

4. The Licensee shall establish and implement:
   a. effective board and committee structures;
   b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
   c. clear reporting lines and accountabilities throughout its organisation and to the NHS body by which it is controlled (as defined below).

5. The Licensee shall establish and effectively implement systems and/or processes:
   a. to operate efficiently, economically and effectively;

b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations;
c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions;
d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
h. to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
c. the collection of accurate, comprehensive, timely and up to date information on quality of care;
d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and

f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

Cross refer to G8
Removal of redundant clauses from General Condition 9 (now G8)
Allow NHS England to determine and apply continuity of service conditions to Hard to Replace Providers (separate consultation on this definition/scope)
Amend relevant CoS conditions to reference Hard to Replace Providers.
This includes a mechanism added to G8 (Application of section 6 (Continuity of Service)) which sets out that the Continuity of Service conditions shall apply to licensees subject to a contractual obligation as CRS, or as determined by NHS England to be a Hard to Replace provider. CoS3 (Standards of corporate governance and financial management), Cos6 (Cooperation in the event of financial stress) and CoS7 (Availability of resources) will also be amended to refer to Hard to Replace Providers.
NHSE - We have included these provisions in the final modified provider licence due to the importance of ensuring that NHS England has regulatory powers to intervene where the loss of a national, multi-regional or large regional provider would significantly reduce capacity across the NHS and impact access to patients.

Section 6 – Continuity of Services

CoS 1: Continuing provision of Commissioner Requested services

1. The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service otherwise than in accordance with the following paragraphs of this Condition.
2. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, or during any period when this condition applies by virtue of Condition G8(1)(b), NHS England issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then the Licensee shall provide the service for that period in accordance with the direction.
3. The Licensee shall not materially alter the specification or means of provision of any Commissioner Requested Service except:
    a. with the agreement in writing of all Commissioners to which the Licensee is required by a contractual or other legally enforceable obligation to provide the service as a Commissioner Requested Service; or
    b. at any time when this condition applies by virtue of Condition G8(1)(b), with the agreement in writing of all Commissioners to which the Licensee provides, or may be requested to provide, the service as a Commissioner Requested Service; or
    c. if required to do so by, or in accordance with the terms of its authorisation by, any body having responsibility pursuant to statute for regulating one or more aspects of the provision of health care services in England and which has been designated by NHS England for the purposes of this condition and of equivalent conditions in other licences granted under the 2012 Act.
4. If the specification or means of provision of a Commissioner Requested Service is altered as provided in paragraph 3 the Licensee, within 28 days of the alteration, shall give to NHS England notice in writing of the occurrence of the alteration with a summary of its nature.

5. For the purposes of this Condition an alteration to the specification or means of provision of any Commissioner Requested Service is material if it involves the delivery or provision of that service in a manner which differs from the manner specified and described in:

a. the contract in which it was first required to be provided to a Commissioner at or following the coming into effect of this Condition; or
b. if there has been an alteration pursuant to paragraph 3, the document in which it was specified on the coming into effect of that alteration; or
c. at any time when this Condition applies by virtue of Condition G8(1)(b), the contract, or NHS contract, by which it was required to be provided immediately before the commencement of this Licence or the Licensee's authorisation, as the case may be.

CoS 2: Restriction of the disposal of assets

1. The Licensee shall establish, maintain and keep up to date, an asset register which complies with paragraphs 2 and 3 of this Condition ("the Asset Register")
2. The Asset Register shall list every relevant asset used by the Licensee for the provision of Commissioner Requested Services.
3. The Asset Register shall be established, maintained and kept up to date in a manner that reasonably would be regarded as both adequate and professional.
4. The obligations in paragraphs 5 to 8 shall apply to the Licensee if NHS England has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern.
5. The Licensee shall not dispose of, or relinquish control over, any relevant asset except:
    a. with the consent in writing of NHS England, and
    b. in accordance with the paragraphs 6 to 8 of this Condition.
6. The Licensee shall provide NHS England with such information as NHS England may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset.
7. Where consent by NHS England for the purpose of paragraph 5(a) is subject to conditions, the Licensee shall comply with those conditions.
8. Paragraph 5(a) of this Condition shall not prevent the Licensee from disposing of, or relinquishing control over, any relevant asset where:
    a. NHS England has issued a general consent for the purposes of this Condition (whether or not subject to conditions) in relation to:
        i. transactions of a specified description; or
        ii. the disposal of or relinquishment of control over relevant assets of a specified description, and the transaction or the relevant assets are of a description to which the consent applies and the disposal, or relinquishment of control, is in accordance with any conditions to which the consent is subject; or
    b. the Licensee is required by the Care Quality Commission to dispose of a relevant asset.

9. In this Condition:

"disposal"	means any of the following: (a) a transfer, whether legal or equitable, of the whole or any part of an asset (whether or not for value) to a person other than the Licensee; or (b) a grant, whether legal or equitable, of a lease, licence, or loan of (or the grant of any other right of possession in relation to) that asset; or (c) the grant, whether legal or equitable, of any mortgage, charge, or other form of security over that asset; or (d) if the asset is an interest in land, any transaction or event that is capable under any enactment or rule of law of affecting the title to a registered interest in that land, on the assumption that the title is registered, and references to "dispose" are to be read accordingly;
"relevant asset"	means any item of property, including buildings, interests in land, equipment (including rights, licenses and consents relating to its use), without which the Licensee's ability to meet its obligations to provide Commissioner Requested Services would reasonably be regarded as materially prejudiced;
"relinquishment of control"	includes entering into any agreement or arrangement under which control of the asset is not, or ceases to be, under the sole management of the Licensee, and "relinquish" and related expressions are to be read accordingly.

10. The Licensee shall have regard to such guidance as may be issued from time to time by NHS England regarding:

a. the manner in which asset registers should be established, maintained and updated, and
b. property, including buildings, interests in land, intellectual property rights and equipment, without which a licensee's ability to provide

Commissioner Requested Services should be regarded as materially prejudiced.

Amend CoS 3 and CoS 6 to include standards of Quality Governance for Commissioner Requested services and Hard to Replace Providers and provide reasonable safeguards against the licensee being unable to deliver services when standards of quality governance have fallen below expectations.
NHSE- We have included these provisions in the final modified licence given the importance of ensuring that NHS England can intervene as a regulator in the interest of patients.

CoS 3: Standards of corporate governance, financial management and quality governance

1. The Licensee shall at all times adopt and apply systems and standards of corporate governance, quality governance and of financial management which reasonably would be regarded as:
   a. suitable for a provider of the Commissioner Requested Services, provided by the Licensee, or a Hard to Replace Provider,
   b. providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern, and
   c. providing reasonable safeguards against the licensee being unable to deliver services due to quality stress.
2. In its determination of the systems and standards to adopt for the purpose of paragraph 1, and in the application of those systems and standards, the Licensee shall have regard to:
   a. such guidance as NHS England may issue from time to time concerning systems and standards of corporate governance, financial management and quality governance;
   b. the Licensee’s ratings using the risk rating methodologies published by NHS England from time to time, and
   c. the desirability of that rating being not less than the level regarded by NHS England as acceptable under the provisions of that methodology.

CoS 4: Undertaking from the ultimate controller

1. The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by NHS England, that the ultimate controller (“the Covenantor”):

   a. will refrain for any action, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will refrain from any action, which would be likely to cause the Licensee to be in contravention of any of its obligations under the NHS Acts or this Licence, and

   b. will give to the Licensee, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to NHS England.

2. The Licensee shall obtain any undertaking required to be procured for the purpose of paragraph 1 within 7 days of a company or other person becoming an ultimate controller of the Licensee and shall ensure that any such undertaking remains in force for as long as the Covenantor remains the ultimate controller of the Licensee.

3. The Licensee shall:

   a. deliver to NHS England a copy of each such undertaking within seven days of obtaining it;

   b. inform NHS England immediately in writing if any Director, secretary or other officer of the Licensee becomes aware that any such undertaking has ceased to be legally enforceable or that its terms have been breached, and

   c. comply with any request which may be made by NHS England to enforce any such undertaking.

4. For the purpose of this Condition, subject to paragraph 5, a person (whether an individual or a body corporate) is an ultimate controller of the Licensee if:

a. directly, or indirectly, the Licensee can be required to act in accordance with the instructions of that person acting alone or in concert with others, and
b. that person cannot be required to act in accordance with the instructions of another person acting alone or in concert with others.

5. A person is not an ultimate controller if they are:
   a. a health service body, within the meaning of section 9 of the 2006 Act;
   b. a Governor or Director of the Licensee and the Licensee is an NHS foundation trust;
   c. any Director of the Licensee who does not, alone or in association with others, have a controlling interest in the ownership of the Licensee and the Licensee is a body corporate; or
   d. a trustee of the Licensee and the Licensee is a charity.

CoS 5: Risk pool levy

1. The Licensee shall pay to NHS England any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the 2012 Act, including sums payable by way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid.
2. In the event that no date has been clearly determined by which a sum referred to in paragraph 1 is required to be paid, that sum shall be paid within 28 days of being demanded in writing by NHS England.

Amend CoS 3 and CoS 6 to include standards of Quality Governance for Commissioner Requested services and Hard to Replace Providers and provide reasonable safeguards against the licensee being unable to deliver services when standards of quality governance have fallen below expectations.
NHSE- We have included these provisions in the final modified licence given the importance of ensuring that NHS England can intervene as a regulator in the interest of patients.

CoS 6: Cooperation in the event of financial or quality stress

1. The obligations in paragraph 2 shall apply if NHS England has given notice in writing to the Licensee that it is concerned about:
   a. the ability of the Licensee to continue to provide commissioner requested services due to quality stress
   b. the ability of a Hard to Replace Provider being able to continue to provide its NHS commissioned services due to quality stress, or
   c. the ability of the Licensee to carry on as a going concern.
2. When this paragraph applies the Licensee shall:
   a. provide such information as NHS England may direct to Commissioners and to such other persons as NHS England may direct;
   b. allow such persons as NHS England may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them, and
   c. co-operate with such persons as NHS England may appoint to assist in the management of the Licensee’s affairs, business and property.

CoS 7: Availability of resources

1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.
2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.
3. The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS England a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:
    a. “After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.”
    b. “After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources”.
    c. “In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate”.
4. The Licensee shall submit to NHS England with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.
5. The statement submitted to NHS England in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.

6. The Licensee shall inform NHS England immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3.

7. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.

8. In this Condition:

“distribution” includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital;

“Financial Year” means the period of twelve months over which the Licensee normally prepares its accounts;

“Required Resources” means such:

a. management resources including clinical leadership,
b. appropriate and accurate information pertinent to the governance of quality
c. financial resources and financial facilities,
d. personnel,
e. physical and other assets including rights, licences and consents relating to their use,
f. subcontracts , and
g. working capital as reasonably would be regarded as sufficient for a Hard to Replace Provider and/or to enable the Licensee at all times to provide the Commissioner Requested Services.

Significant number of amendments. Some movement, some new sections, some deletions. Commentary below for interpretation to assist finance colleagues.

Section 7 – Costing Conditions

C1: Submission of costing information

1. Whereby NHS England, and only in relation to periods from the date of that requirement, the Licensee shall:
    a. obtain, record and maintain sufficient information about the costs which it expends in the course of providing services for the purposes of the NHS and other relevant information,
    b. establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information, as are necessary to enable it to comply with the following paragraphs of this Condition.

2. Licensee should record the cost and other relevant information required in this condition consistent with the guidance in NHS England's Approved Costing Guidance. The form of data collected, costed and submitted should be consistent with the technical guidance included in the Approved Costing Guidance (subject to any variations agreed and approved with NHS England) and submitted in line with the nationally set deadlines.

3. If the Licensee uses sub-contractors in the provision of health care services for the purposes of the NHS, to the extent that it is required to do so in writing by NHS England the Licensee shall procure that each of those sub-contractors:
    a. obtains, records and maintains information about the costs which it expends in the course of providing services as sub-contractor to the Licensee, and establishes, maintains and applies systems and methods for the obtaining, recording and maintaining of that information, in a manner that complies with paragraphs 2 and 3 of this Condition, and
    b. provides that information to NHS England in a timely manner.

4. Records required to be maintained by this Condition shall be kept for not less than six years.

5. In this Condition:

“the Approved Guidance”	means such guidance on the obtaining, recording and maintaining of information about costs and on the breaking down and allocation of costs published annually by NHS England.
“other relevant information”	means such information, which may include quality and outcomes data, as may be required by NHS England for the purpose of its functions under Chapter 4 (Pricing) in Part 3 of the 2012 Act and material costs funded through other public sector entities which impact on the accuracy of costing information.

Removing the competition condition: Choice and Competition Condition 2: Competition Oversight.

NHSE
Removing the competition condition: Choice and Competition Condition 2: Competition Oversight.
Commentary:
There was strong support for the removal of the competition oversight condition. 91% of respondents agreed or strongly agreed with the proposal, including 97% of trusts and foundation trusts and 79% of independent providers who responded to the question.
The 2022 Act did not transfer enforcement authority for competition oversight to NHS England as part of the dissolution of Monitor, however general competition law will still apply to prevent against anticompetitive practice.
Outcome:
NHSE have removed the competition condition from the final modified licence.

...
Shifting the focus of the costing conditions to support integration and improvement
Proposal
To replace Pricing Condition 1 with new Costing Condition 1: Submission of costing information
To replace Pricing Condition 2 with new Costing Condition 2: Provision of costing and costing related information
To replace Pricing Condition 3 with new Costing Condition 3: Assuring the accuracy of pricing and costing information.
Feedback and response
68% of respondents agreed or strongly agreed with the modifications related to costing conditions 1 and 2.
63% agreed or strongly agreed with replacing Pricing Condition 3 with the new Costing Condition 3. One foundation trust disagreed with the proposals.
Some respondents raised concerns about the resources required to provide accurate and timely costing data. We are working closely with providers to understand how best to support this. Additionally, the new assurance process will provide trusts and foundation trusts with tools and support to improve the accuracy of data before and after it is utilised in the costing process. We understand this is a shift in approach but expect this should improve patient care and outcomes by embedding data reviews into business as usual. This supports the use of quality-assured costing data in ongoing decision-making. We also expect this to remove the burden currently felt when preparing for a specific costing audit once data reviews become part of ongoing practice.
Some independent providers questioned whether they would be expected to meet the same requirements as trusts and foundation trusts. We expect independent providers to meet the same basic costing requirements to achieve value, consistency, and better patient outcomes. Any work to extend the collection of costing information to independent providers will be co-developed. This would include assessing the granularity and complexity of required data to ensure it is reasonable and providers can complete it from their own records as far as possible.
Outcome
Given the need to bring the conditions related to costing up to date, we have included the proposed Costing Condition 1: Submission of costing information, Costing Condition 2: Provision of costing and costing related information, and Costing Condition 3: Assuring the accuracy of pricing and costing information in the final modified licence.

C2: Provision of costing and costing related information

1. Subject to paragraph 3, and without prejudice to the generality of Condition G1, the Licensee shall submit the mandated information required per Costing Condition 1 consistent with the approved costing guidance in the form, manner and the timetable as prescribed.
2. In furnishing information documents and reports pursuant to paragraph 1 the Licensee shall take all reasonable steps to ensure that:
    a. in the case of information (data) or a report, it is accurate, complete and not misleading;
    b. in the case of a document, it is a true copy of the document requested;
3. This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

C3: Assuring the accuracy of pricing and costing information

1. Providers are required to have processes in place to ensure itself of the accuracy and completeness of costing and other relevant information collected and submitted to NHS England is as per the Approved Costing Guidance.
2. This may include but is not limited to
   a. Regular assessments by the providers internal and/or external auditor
   b. specific work by NHS England or NHS England nominated representative on costing related issues and
   c. use of tools or other information or assessments of costing information produced by NHS England on costing and other relevant information.
   d. Evidence of the assurance process (including work by the internal or external auditor of the provider) should be maintained and submitted as and when requested by NHS England and may be subject to follow up by NHS England. NHS England reserves the right to undertake specific work at a provider where issues are identified which may be undertaken by a nominated representative.

Section 8 – Pricing Conditions

P1: Compliance with the NHS payment scheme

1. Except as approved in writing by NHS England, the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the NHS Payment Scheme published by NHS England in accordance with section 116 of the 2012 Act, wherever applicable.

As above.

NHSE:

Amending the pricing conditions to reflect changes to national policy
Proposal
To update Pricing Condition 4 (renamed as Pricing Condition 1) - to apply the rules and methods of charging for the provision of NHS services as set out in the NHS Payment Scheme.
To remove Pricing Condition 5 (local modifications) from the licence.
Feedback and response
Respondents were in favour of these pricing condition changes, noting that the conditions need to reflect changes to policy and legislation to be effective. 63% agreed or strongly agreed with the proposed wording change to Pricing Condition 4 and 70% agreed or strongly agreed with the proposed removal of Pricing Condition 5. The remaining respondents were neutral.
Some independent providers queried whether this may apply to them in the future and others questioned whether there should be more local system input to pricing. Legislation requires NHS England to consult affected providers and ICBs about changes to the NHS payment scheme. There will always be an opportunity for providers to comment on specific proposed pricing changes before this condition would be extended to independent providers.
Outcome
We have included the modified Pricing Condition 4 and this will become Pricing Condition 1 in the final modified licence. Pricing Condition 5 (local modifications) will be removed.

Section 9 – Interpretation and Definitions

Condition D1: Interpretation and Definitions

1. In this Licence, except where the context requires otherwise, words or expressions set out in the left-hand column of the following table have the meaning set out next to them in the right hand column of the table.

"the 2006 Act"	the National Health Service Act 2006 c.41;
"the 2008 Act"	the Health and Social Care Act 2008 c.14;
"the 2009 Act"	the Health Act 2009 c.21;
"the 2012 Act"	the Health and Social Care Act 2012 c.7;
"the 2022 Act"	The Health and Care Act 2022;
"the Care Quality Commission"	the Care Quality Commission established under section 1 of the 2008 Act;
"Commissioner Requested Service"	a service of the sort described in paragraph 2 of condition G8 which has not ceased to be such a service in accordance with paragraph 8 of that condition;
"Commissioners"	NHS England and any Integrated Care Board and includes any bodies exercising commissioning functions pursuant to a delegation from NHS England or an ICB;
"Director"	includes any person who, in any organisation, performs the functions of, or functions equivalent or similar to those of, a director of: (i) an NHS foundation trust, (ii) an NHS Trust or (iii) a company constituted under the Companies Act 2006;

"Governor"	a Governor of an NHS foundation trust;
"Hard to replace provider"	has the meaning given in condition G8 of the licence; https://www.engage.england.nhs.uk/consultation/draft-updated-risk-assessment-framework-and-report/
"Integrated Care Board"	a body corporate established by NHS England by virtue of section 14Z25 of the 2006 Act;
"the NHS Acts"	the 2006 Act, the 2008 Act, the 2009 Act; the 2012 Act and the 2022 Act;
NHS Controlled provider	An organisation which is not an NHS trust or NHS foundation trust but is ultimately controlled by one or more NHS trusts and/or foundation trusts, where 'control' is defined on the basis of IFRS 10;
"NHS England"	the body named as NHS England in section 1 of the 2022 Act;
"NHS foundation trust"	a public benefit corporation established pursuant to section 30 of, and Schedule 7 to, the 2006 Act;
"NHS Trust"	an NHS trust established under section 25 of the 2006 Act;
"Relevant bodies"	NHS England, Integrated Care Boards, NHS trusts and NHS foundation trusts in accordance with section 96(2B) of the 2012 Act;
"Trusts"	means NHS foundation trusts and NHS trusts.

2. Any reference in this Licence to a statutory body shall be taken, unless the contrary is indicated, to be a reference also to any successor to that body.

3. Unless the context requires otherwise, words or expressions which are defined in the NHS Acts shall have the same meaning for the purpose of this Licence as they have for the purpose of that Act.

4. Any reference in the Licence to any provision of a statute, statutory instrument or other regulation is a reference, unless the context requires otherwise, to that provision as currently amended.

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

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Classification: Official

Publication reference: PR00191

NHS Provider Licence

Standard Conditions

31 March 2023

Version History

Version number	Date	Comments
1.0	26 March 2013	Created
2.0	04 April 2013	Formatting changes
3.0	27 October 2022	Draft updated licence for consultation
4.0	31 March 2023	Updated licence conditions

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Section 1 – Integrated Care

IC1: Provision of Integrated care

1. The Licensee shall act in the interests of the people who use health care services by ensuring that its provision of health care services for the purposes of the NHS:
    i) is integrated with the provision of such services by others, and
    ii) is integrated with the provision of health-related services or social care services by others and
    iii) enables co-operation with other providers of health care services for the purposes of the NHS

    where this would achieve one or more of the objectives referred to in paragraph 2.
2. The objectives are:
    a. improving the quality of health care services provided for the purposes of the NHS (including the outcomes that are achieved from their provision) or the efficiency of their provision,
    b. reducing inequalities between persons with respect to their ability to access those services, and
    c. reducing inequalities between persons with respect to the outcomes achieved for them by the provision of those services.
3. The Licensee shall have regard to guidance as may be issued by NHS England from time to time for the purposes of paragraphs 1 and 2 of this Condition.
4. Nothing in this licence condition requires the licensee to take action or share information with other providers of health care services for the purposes of the NHS if the action or disclosure of the information would materially prejudice its commercial or charitable interests.

IC2: Personalised Care and Patient Choice

1. The Licensee shall support the implementation and delivery of personalised care by complying with legislation and having due regard to guidance on personalised care.
2. Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee must ensure people who use their services are offered information, choice and control to manage their own health and well-being to best meet their circumstances, needs and preferences, working in partnership with other services where required.
3. Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, the person is notified of that choice and told where information about that choice can be found.
4. Information and advice about patient choice of provider made available by the Licensee shall not be misleading.
5. Without prejudice to paragraph 2, information and advice about patient choice of provider made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that, as far as reasonably practicable, assists patients in making well informed choices between providers of treatments or other health care services.
6. In the conduct of any activities, and in the provision of any material, for the purpose of promoting itself as a provider of health care services for the purposes of the NHS the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.

Section 2 – Trusts Working in Systems

WS1: Cooperation

1. This condition shall apply if the Licensee is an NHS trust NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.
2. The Licensee shall carry out its legal duties to co-operate with NHS bodies and with local authorities.
3. Without prejudice to the generality of paragraph 2, the Licensee shall:
   a. consistently co-operate with:
   - other providers of NHS services; and
   - other NHS bodies, including any Integrated Care Board of which it is a partner;
      i. as necessary and appropriate for the purposes of developing and delivering system plan(s).
      ii. as necessary and appropriate for the purposes of delivering their individual or collective financial responsibilities including but not limited to contributing to the delivery of agreed system financial plans in each financial year
      iii. as necessary and appropriate for the purposes of delivering agreed people and workforce plans

   b. consistently co-operate with:
   - other providers of NHS services;
   - other NHS bodies, including any Integrated Care Board of which it is a partner; and
   - any relevant local authority in England
      i. as necessary and appropriate for the purposes of delivering NHS services.
      ii. as necessary and appropriate for the purposes of improving NHS services.
4. The Licensee shall have regard to such guidance concerning co-operation as may be issued from time to time by either:

a. the Secretary of State for Health and Social Care; or
b. NHS England.

For the purposes of this condition, cooperation is considered synonymous to collaboration.

WS2: The Triple Aim

1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.
2. When making decisions in the exercise of its functions which relate to the provision of health care for the purposes of the NHS, the Licensee shall comply with its duty relating to the triple aim.
3. The Licensee shall have regard to the triple aim and to any guidance published by NHS England under section 13NB of the 2006 Act.
4. In this condition, "the triple aim" refers to the aim of achieving:

    a. better health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing)

    b. better quality of health care services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services)

    c. more sustainable and efficient use of resources by NHS bodies,

and "duty relating to the triple aim" means, in relation to an NHS trust, its duty under section 26A of the 2006 Act, and in relation to an NHS foundation trust, its duty under section 63A of the 2006 Act.

WS3: Digital Transformation

1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.
2. The Licensee shall comply with information standards published under section 250 of the 2012 Act where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).
3. The Licensee shall comply with required levels of digital maturity as set out in guidance published by NHS England from time to time where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).

Section 3 – General Conditions

G1: Provision of information

1. The Licensee shall provide NHS England with such information, documents and reports (together 'information') as NHS England may require for any of the purposes set out in section 96(2) of the 2012 Act. This requirement is in addition to specific obligations set out elsewhere in the licence. If requested by NHS England, the Licensee shall prepare or procure information in order to comply with this condition.
2. Information shall be provided in such manner, in such form, and at such place and times as NHS England may require.
3. The Licensee shall take all reasonable steps to ensure that information is:
    a. in the case of information or a report, it is accurate, complete and not misleading;
    b. in the case of a document, it is a true copy of the document requested.
4. This Condition shall not require the Licensee to provide any information which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

G2: Publication of information

1. The Licensee shall comply with any instruction by NHS England, issued for any of the purposes set out in section 96(2) of the 2012 Act, to publish information about the health care services it provides for the purposes of the NHS. The Licensee shall publish the information in such manner as NHS England may instruct.
2. For the purposes of this Condition, “publish” includes making available to the public at large, to any section of the public or to particular individuals.

G3: Fit and proper persons as Governors and Directors (also applicable to those performing the functions of, or functions equivalent or similar to the functions of, a director)

1. The Licensee must ensure that a person may not become or continue as a Governor of the Licensee if that person is:
   a. a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
   b. a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);
   c. a person who has made a composition or arrangement with, or granted a trust deed for, that person's creditors and has not been discharged in respect of it;
   d. a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on that person.

2. The Licensee must not appoint or have in place a person as a Director of the Licensee who is not fit and proper.

3. For the purposes of paragraph 2, a person is not fit and proper if that person is:
   a. an individual who does not satisfy all the requirements as set out in paragraph (3) and referenced in paragraph (4) of regulation 5 (fit and proper persons: directors) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936); or
   b. an organisation which is a body corporate, or a body corporate with a parent body corporate:
      i. where one or more of the Directors of the body corporate or of its parent body corporate is an individual who does not meet the requirements referred to in sub-paragraph (a);
      ii. in relation to which a voluntary arrangement is proposed, or has effect, under section 1 of the Insolvency Act 1986;

iii. which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking;
iv. which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act;
v. which passes any resolution for winding up;
vi. which becomes subject to an order of a Court for winding up; or
vii. the estate of which has been sequestrated under Part 1 of the Bankruptcy (Scotland) Act 1985.

4. In assessing whether a person satisfies the requirements referred to in paragraph 3(a), the Licensee must take into account any guidance published by the Care Quality Commission.

G4: NHS England guidance

1. Without prejudice to specific obligations in other Conditions of this Licence, the Licensee shall at all times have regard to guidance issued by NHS England for any of the purposes set out in section 96(2) of the 2012 Act.
2. In any case where the Licensee decides not to follow the guidance referred to in paragraph 1 or guidance issued under any other Conditions of this licence, it shall inform NHS England of the reasons for that decision.

G5: Systems for compliance with licence conditions and related obligations

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:
    a. the Conditions of this Licence,
    b. any requirements imposed on it under the NHS Acts, and
    c. the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.
2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:
    a. the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
    b. regular review of whether those processes and systems have been implemented and of their effectiveness.

G6: Registration with the Care Quality Commission

1. The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able to lawfully provide health care services for the purposes of the NHS.
2. The Licensee shall notify NHS England promptly of:
    a. any application it may make to the Care Quality Commission for the cancellation of its registration by that Commission, or
    b. the cancellation by the Care Quality Commission for any reason of its registration by that Commission.
3. A notification given by the Licensee for the purposes of paragraph 2 shall:
    a. be made within 7 days of:
        i. the making of an application in the case of paragraph (a), or
        ii. becoming aware of the cancellation in the case of paragraph (b), and
    b. contain an explanation of the reasons (in so far as they are known to the Licensee) for:
        i. the making of an application in the case of paragraph (a), or
        ii. the cancellation in the case of paragraph (b).

G7: Patient eligibility and selection criteria

1. The Licensee shall:
    a. set transparent eligibility and selection criteria,
    b. apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee, and
    c. publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them.
2. “Eligibility and selection criteria” means criteria for determining:
    a. whether a person is eligible, or is to be selected, to receive health care services provided by the Licensee for the purposes of the NHS, and
    b. if the person is selected, the manner in which the services are provided to the person.

G8: Application of section 6 (Continuity of Service)

1. The Conditions in Section 6 shall apply:
    a. whenever the Licensee is subject to a contractual obligation to provide a service to a Commissioner which is contractually agreed to be a Commissioner Requested Service,
    b. whenever the Licensee is subject to a contractual obligation to deliver a service which is subsequently designated as a Commissioner Requested Service by virtue of the process set out in paragraph 2,
    c. where the circumstances set out in paragraph 6 apply (expiry of contract without renewal or extension),
    d. where the circumstances set out in paragraph 7 apply (instruction by NHS England that the Licensee must continue to deliver a service as a Commissioner Requested Service),
    e. whenever the Licensee is determined by NHS England to be a Hard to Replace Provider.
2. A service is designated as a Commissioner Requested Service if:
    a. it is a service which the Licensee is required to provide to a Commissioner under the terms of a contract which has been entered into between them, and
    b. the Commissioner has made a written request to the Licensee to provide that service as a Commissioner Requested Service, and either
    c. the Licensee has failed to respond in writing to that request by the expiry of the 28th day after it was made to the Licensee by the Commissioner, or
    d. the Commissioner, not earlier than the expiry of the 28th day after making that request to the Licensee, has given to NHS England and to the Licensee a notice in accordance with paragraph 4, and NHS England, after giving the Licensee the opportunity to make representations, has issued an instruction in writing in accordance with paragraph 4.
3. A notice in accordance with this paragraph is a notice:
    a. in writing,
    b. stating that the Licensee has refused to agree to a request to provide a service as a Commissioner Requested Service, and

c. setting out the Commissioner's reasons for concluding that the Licensee is acting unreasonably in refusing to agree to that request to provide a service as a Commissioner Requested Service.

4. An instruction in accordance with this paragraph is an instruction that the Licensee's refusal to provide a service as a Commissioner Requested Service in response to a request made under paragraph 2(b) is unreasonable.

5. The Licensee shall give NHS England not less than 28 days' notice of the expiry of any contractual obligation pursuant to which it is required to provide a Commissioner Requested Service to a Commissioner for which no extension or renewal has been agreed.

6. If any contractual obligation of a Licensee to provide a Commissioner Requested Service expires without extension or renewal having been agreed between the Licensee and the Commissioner who is a party to the contract, the Licensee shall continue to provide that service on the terms of the contract (save as agreed with that Commissioner), and the service shall continue to be a Commissioner Requested Service, for the period from the expiry of the contractual obligation until NHS England issues either:

a. an instruction of the sort referred to in paragraph 7, or
b. a notice in writing to the Licensee stating that it has decided not to issue such a instruction.

7. If, during the period of a contractual or post contractual obligation to provide a Commissioner Requested Service, NHS England issues to the Licensee an instruction in writing to continue providing that service for a period specified in the instruction, then for that period the service shall continue to be a Commissioner Requested Service.

8. A service shall cease to be a Commissioner Requested Service if:

a. all current Commissioners of that service as a Commissioner Requested Service agree in writing that there is no longer any need for the service to be a Commissioner Requested Service, and NHS England has issued a determination in writing that the service is no longer a Commissioner Requested Service, or
b. NHS England has issued a determination in writing that the service is no longer a Commissioner Requested Service; or

c. the contractual obligation pursuant to which the service is provided has expired and NHS England has issued a notice pursuant to paragraph 6(b) in relation to the service; or

d. the period specified in an instruction by NHS England of the sort referred to in paragraph 7 in relation to the service has expired.

9. The Licensee shall make available free of charge to any person who requests it a statement in writing setting out the description and quantity of services which it is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services.

10. Within 28 days of every occasion on which there is a change in the description or quantity of the services which the Licensee is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services, the Licensee shall provide to NHS England in writing a notice setting out the description and quantity of all the services it is obliged to provide as Commissioner Requested Services.

11. In this condition, a provider is a Hard to Replace Provider if it has been identified as such by NHS England based on criteria set out and managed through guidance published by NHS England and NHS England has issued a determination in writing.

12. A provider will cease to be a Hard to Replace provider if it no longer meets the criteria set out and managed through guidance published by NHS England and NHS England has issued a determination in writing that the provider is no longer a Hard to Replace Provider.

13. In this Condition “NHS contract” has the meaning given to that term in Section 9 of the 2006 Act.

Section 4 – Trust Conditions

NHS1: Information to update the register

1. The obligations in the following paragraphs of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall make available to NHS England written and electronic copies of the following documents:
    a. the current version of Licensee’s constitution;
    b. the Licensee’s most recently published annual accounts and any report of the auditor on them, and
    c. the Licensee’s most recently published annual report,

and for that purpose shall provide to NHS England written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted and of the documents referred to in sub-paragraphs (b) and (c) within 28 days of being published.
3. Subject to paragraph 4, the Licensee shall provide to NHS England written and electronic copies of any document that is required by NHS England for the purpose of NHS foundation trust register within 28 days of the receipt of the original document by the Licensee.
4. The obligation in paragraph 3 shall not apply to:
    a. any document provided pursuant to paragraph 2;
    b. any document originating from NHS England; or
    c. any document required by law to be provided to NHS England by another person.
5. The Licensee shall comply with any instruction issued by NHS England concerning the format in which electronic copies of documents are to be made available or provided.
6. When submitting a document to NHS England for the purposes of this Condition, the Licensee shall provide to NHS England a short written statement describing the document and specifying its electronic format and advising NHS England that the

document is being sent for the purpose of updating the register of NHS foundation trusts maintained in accordance with section 39 of the 2006 Act.

NHS2: Governance arrangements

1. This Condition shall apply if the Licensee is an NHS trust or NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.
3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:
   a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time
   b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health
   c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and
   d. comply with the following paragraphs of this Condition.
4. The Licensee shall establish and implement:
   a. effective board and committee structures;
   b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
   c. clear reporting lines and accountabilities throughout its organisation.
5. The Licensee shall establish and effectively implement systems and/or processes:
   a. to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
   b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations;
   c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions;

d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
h. to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
c. the collection of accurate, comprehensive, timely and up to date information on quality of care;
d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

Section 5 – NHS Controlled Providers Conditions

CP1: Governance arrangements for NHS-controlled providers

1. This condition shall apply if the Licensee is an NHS-controlled provider of healthcare services for the purposes of the NHS without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.
3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:
   a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time
   b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health
   c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and
   d. comply with the following paragraphs of this Condition.

4. The Licensee shall establish and implement:
   a. effective board and committee structures;
   b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
   c. clear reporting lines and accountabilities throughout its organisation and to the NHS body by which it is controlled (as defined below).

5. The Licensee shall establish and effectively implement systems and/or processes:
   a. to operate efficiently, economically and effectively;

b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations;
c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions;
d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
h. to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
c. the collection of accurate, comprehensive, timely and up to date information on quality of care;
d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and

f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

Section 6 – Continuity of Services

CoS 1: Continuing provision of Commissioner Requested services

1. The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service otherwise than in accordance with the following paragraphs of this Condition.
2. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, or during any period when this condition applies by virtue of Condition G8(1)(b), NHS England issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then the Licensee shall provide the service for that period in accordance with the direction.
3. The Licensee shall not materially alter the specification or means of provision of any Commissioner Requested Service except:
    a. with the agreement in writing of all Commissioners to which the Licensee is required by a contractual or other legally enforceable obligation to provide the service as a Commissioner Requested Service; or
    b. at any time when this condition applies by virtue of Condition G8(1)(b), with the agreement in writing of all Commissioners to which the Licensee provides, or may be requested to provide, the service as a Commissioner Requested Service; or
    c. if required to do so by, or in accordance with the terms of its authorisation by, any body having responsibility pursuant to statute for regulating one or more aspects of the provision of health care services in England and which has been designated by NHS England for the purposes of this condition and of equivalent conditions in other licences granted under the 2012 Act.
4. If the specification or means of provision of a Commissioner Requested Service is altered as provided in paragraph 3 the Licensee, within 28 days of the alteration, shall give to NHS England notice in writing of the occurrence of the alteration with a summary of its nature.

5. For the purposes of this Condition an alteration to the specification or means of provision of any Commissioner Requested Service is material if it involves the delivery or provision of that service in a manner which differs from the manner specified and described in:

a. the contract in which it was first required to be provided to a Commissioner at or following the coming into effect of this Condition; or
b. if there has been an alteration pursuant to paragraph 3, the document in which it was specified on the coming into effect of that alteration; or
c. at any time when this Condition applies by virtue of Condition G8(1)(b), the contract, or NHS contract, by which it was required to be provided immediately before the commencement of this Licence or the Licensee's authorisation, as the case may be.

CoS 2: Restriction of the disposal of assets

1. The Licensee shall establish, maintain and keep up to date, an asset register which complies with paragraphs 2 and 3 of this Condition ("the Asset Register")
2. The Asset Register shall list every relevant asset used by the Licensee for the provision of Commissioner Requested Services.
3. The Asset Register shall be established, maintained and kept up to date in a manner that reasonably would be regarded as both adequate and professional.
4. The obligations in paragraphs 5 to 8 shall apply to the Licensee if NHS England has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern.
5. The Licensee shall not dispose of, or relinquish control over, any relevant asset except:
    a. with the consent in writing of NHS England, and
    b. in accordance with the paragraphs 6 to 8 of this Condition.
6. The Licensee shall provide NHS England with such information as NHS England may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset.
7. Where consent by NHS England for the purpose of paragraph 5(a) is subject to conditions, the Licensee shall comply with those conditions.
8. Paragraph 5(a) of this Condition shall not prevent the Licensee from disposing of, or relinquishing control over, any relevant asset where:
    a. NHS England has issued a general consent for the purposes of this Condition (whether or not subject to conditions) in relation to:
        i. transactions of a specified description; or
        ii. the disposal of or relinquishment of control over relevant assets of a specified description, and the transaction or the relevant assets are of a description to which the consent applies and the disposal, or relinquishment of control, is in accordance with any conditions to which the consent is subject; or
    b. the Licensee is required by the Care Quality Commission to dispose of a relevant asset.

9. In this Condition:

"disposal"	means any of the following: (a) a transfer, whether legal or equitable, of the whole or any part of an asset (whether or not for value) to a person other than the Licensee; or (b) a grant, whether legal or equitable, of a lease, licence, or loan of (or the grant of any other right of possession in relation to) that asset; or (c) the grant, whether legal or equitable, of any mortgage, charge, or other form of security over that asset; or (d) if the asset is an interest in land, any transaction or event that is capable under any enactment or rule of law of affecting the title to a registered interest in that land, on the assumption that the title is registered, and references to "dispose" are to be read accordingly;
"relevant asset"	means any item of property, including buildings, interests in land, equipment (including rights, licenses and consents relating to its use), without which the Licensee's ability to meet its obligations to provide Commissioner Requested Services would reasonably be regarded as materially prejudiced;
"relinquishment of control"	includes entering into any agreement or arrangement under which control of the asset is not, or ceases to be, under the sole management of the Licensee, and "relinquish" and related expressions are to be read accordingly.

10. The Licensee shall have regard to such guidance as may be issued from time to time by NHS England regarding:

a. the manner in which asset registers should be established, maintained and updated, and
b. property, including buildings, interests in land, intellectual property rights and equipment, without which a licensee's ability to provide

Commissioner Requested Services should be regarded as materially prejudiced.

CoS 3: Standards of corporate governance, financial management and quality governance

1. The Licensee shall at all times adopt and apply systems and standards of corporate governance, quality governance and of financial management which reasonably would be regarded as:
   a. suitable for a provider of the Commissioner Requested Services, provided by the Licensee, or a Hard to Replace Provider,
   b. providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern, and
   c. providing reasonable safeguards against the licensee being unable to deliver services due to quality stress.
2. In its determination of the systems and standards to adopt for the purpose of paragraph 1, and in the application of those systems and standards, the Licensee shall have regard to:
   a. such guidance as NHS England may issue from time to time concerning systems and standards of corporate governance, financial management and quality governance;
   b. the Licensee's ratings using the risk rating methodologies published by NHS England from time to time, and
   c. the desirability of that rating being not less than the level regarded by NHS England as acceptable under the provisions of that methodology.

CoS 4: Undertaking from the ultimate controller

1. The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by NHS England, that the ultimate controller (“the Covenantor”):

   a. will refrain for any action, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will refrain from any action, which would be likely to cause the Licensee to be in contravention of any of its obligations under the NHS Acts or this Licence, and

   b. will give to the Licensee, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to NHS England.

2. The Licensee shall obtain any undertaking required to be procured for the purpose of paragraph 1 within 7 days of a company or other person becoming an ultimate controller of the Licensee and shall ensure that any such undertaking remains in force for as long as the Covenantor remains the ultimate controller of the Licensee.

3. The Licensee shall:

   a. deliver to NHS England a copy of each such undertaking within seven days of obtaining it;

   b. inform NHS England immediately in writing if any Director, secretary or other officer of the Licensee becomes aware that any such undertaking has ceased to be legally enforceable or that its terms have been breached, and

   c. comply with any request which may be made by NHS England to enforce any such undertaking.

4. For the purpose of this Condition, subject to paragraph 5, a person (whether an individual or a body corporate) is an ultimate controller of the Licensee if:

   a. directly, or indirectly, the Licensee can be required to act in accordance with the instructions of that person acting alone or in concert with others, and
   b. that person cannot be required to act in accordance with the instructions of another person acting alone or in concert with others.

5. A person is not an ultimate controller if they are:
   a. a health service body, within the meaning of section 9 of the 2006 Act;
   b. a Governor or Director of the Licensee and the Licensee is an NHS foundation trust;
   c. any Director of the Licensee who does not, alone or in association with others, have a controlling interest in the ownership of the Licensee and the Licensee is a body corporate; or
   d. a trustee of the Licensee and the Licensee is a charity.

CoS 5: Risk pool levy

1. The Licensee shall pay to NHS England any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the 2012 Act, including sums payable by way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid.
2. In the event that no date has been clearly determined by which a sum referred to in paragraph 1 is required to be paid, that sum shall be paid within 28 days of being demanded in writing by NHS England.

CoS 6: Cooperation in the event of financial or quality stress

1. The obligations in paragraph 2 shall apply if NHS England has given notice in writing to the Licensee that it is concerned about:
    a. the ability of the Licensee to continue to provide commissioner requested services due to quality stress
    b. the ability of a Hard to Replace Provider being able to continue to provide its NHS commissioned services due to quality stress, or
    c. the ability of the Licensee to carry on as a going concern.
2. When this paragraph applies the Licensee shall:
    a. provide such information as NHS England may direct to Commissioners and to such other persons as NHS England may direct;
    b. allow such persons as NHS England may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them, and
    c. co-operate with such persons as NHS England may appoint to assist in the management of the Licensee’s affairs, business and property.

CoS 7: Availability of resources

1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.
2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.
3. The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS England a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:
    a. "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."
    b. "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources".
    c. "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".
4. The Licensee shall submit to NHS England with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.
5. The statement submitted to NHS England in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.

6. The Licensee shall inform NHS England immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3.

7. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.

8. In this Condition:

"distribution" includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital;

"Financial Year" means the period of twelve months over which the Licensee normally prepares its accounts;

"Required Resources" means such:

a. management resources including clinical leadership,
b. appropriate and accurate information pertinent to the governance of quality
c. financial resources and financial facilities,
d. personnel,
e. physical and other assets including rights, licences and consents relating to their use,
f. subcontracts , and
g. working capital as reasonably would be regarded as sufficient for a Hard to Replace Provider and/or to enable the Licensee at all times to provide the Commissioner Requested Services.

Section 7 – Costing Conditions

C1: Submission of costing information

1. Whereby NHS England, and only in relation to periods from the date of that requirement, the Licensee shall:
    a. obtain, record and maintain sufficient information about the costs which it expends in the course of providing services for the purposes of the NHS and other relevant information,
    b. establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information, as are necessary to enable it to comply with the following paragraphs of this Condition.

2. Licensee should record the cost and other relevant information required in this condition consistent with the guidance in NHS England's Approved Costing Guidance. The form of data collected, costed and submitted should be consistent with the technical guidance included in the Approved Costing Guidance (subject to any variations agreed and approved with NHS England) and submitted in line with the nationally set deadlines.

3. If the Licensee uses sub-contractors in the provision of health care services for the purposes of the NHS, to the extent that it is required to do so in writing by NHS England the Licensee shall procure that each of those sub-contractors:
    a. obtains, records and maintains information about the costs which it expends in the course of providing services as sub-contractor to the Licensee, and establishes, maintains and applies systems and methods for the obtaining, recording and maintaining of that information, in a manner that complies with paragraphs 2 and 3 of this Condition, and
    b. provides that information to NHS England in a timely manner.

4. Records required to be maintained by this Condition shall be kept for not less than six years.

5. In this Condition:

"the Approved Guidance"	means such guidance on the obtaining, recording and maintaining of information about costs and on the breaking down and allocation of costs published annually by NHS England.
"other relevant information"	means such information, which may include quality and outcomes data, as may be required by NHS England for the purpose of its functions under Chapter 4 (Pricing) in Part 3 of the 2012 Act and material costs funded through other public sector entities which impact on the accuracy of costing information.

C2: Provision of costing and costing related information

1. Subject to paragraph 3, and without prejudice to the generality of Condition G1, the Licensee shall submit the mandated information required per Costing Condition 1 consistent with the approved costing guidance in the form, manner and the timetable as prescribed.
2. In furnishing information documents and reports pursuant to paragraph 1 the Licensee shall take all reasonable steps to ensure that:
   a. in the case of information (data) or a report, it is accurate, complete and not misleading;
   b. in the case of a document, it is a true copy of the document requested;
3. This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

C3: Assuring the accuracy of pricing and costing information

1. Providers are required to have processes in place to ensure itself of the accuracy and completeness of costing and other relevant information collected and submitted to NHS England is as per the Approved Costing Guidance.
2. This may include but is not limited to
    a. Regular assessments by the providers internal and/or external auditor
    b. specific work by NHS England or NHS England nominated representative on costing related issues and
    c. use of tools or other information or assessments of costing information produced by NHS England on costing and other relevant information.
    d. Evidence of the assurance process (including work by the internal or external auditor of the provider) should be maintained and submitted as and when requested by NHS England and may be subject to follow up by NHS England. NHS England reserves the right to undertake specific work at a provider where issues are identified which may be undertaken by a nominated representative.

Section 8 – Pricing Conditions

P1: Compliance with the NHS payment scheme

1. Except as approved in writing by NHS England, the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the NHS Payment Scheme published by NHS England in accordance with section 116 of the 2012 Act, wherever applicable.

Section 9 – Interpretation and Definitions

Condition D1: Interpretation and Definitions

1. In this Licence, except where the context requires otherwise, words or expressions set out in the left-hand column of the following table have the meaning set out next to them in the right hand column of the table.

“the 2006 Act”	the National Health Service Act 2006 c.41;
“the 2008 Act”	the Health and Social Care Act 2008 c.14;
“the 2009 Act”	the Health Act 2009 c.21;
“the 2012 Act”	the Health and Social Care Act 2012 c.7;
“the 2022 Act”	The Health and Care Act 2022;
“the Care Quality Commission”	the Care Quality Commission established under section 1 of the 2008 Act;
“Commissioner Requested Service”	a service of the sort described in paragraph 2 of condition G8 which has not ceased to be such a service in accordance with paragraph 8 of that condition;
“Commissioners”	NHS England and any Integrated Care Board and includes any bodies exercising commissioning functions pursuant to a delegation from NHS England or an ICB;
“Director”	includes any person who, in any organisation, performs the functions of, or functions equivalent or similar to those of, a director of: (i) an NHS foundation trust, (ii) an NHS Trust or (iii) a company constituted under the Companies Act 2006;

“Governor”	a Governor of an NHS foundation trust;
“Hard to replace provider”	has the meaning given in condition G8 of the licence;
“Integrated Care Board”	a body corporate established by NHS England by virtue of section 14Z25 of the 2006 Act;
“the NHS Acts”	the 2006 Act, the 2008 Act, the 2009 Act; the 2012 Act and the 2022 Act;
NHS Controlled provider	An organisation which is not an NHS trust or NHS foundation trust but is ultimately controlled by one or more NHS trusts and/or foundation trusts, where ‘control’ is defined on the basis of IFRS 10;
“NHS England”	the body named as NHS England in section 1 of the 2022 Act;
“NHS foundation trust”	a public benefit corporation established pursuant to section 30 of, and Schedule 7 to, the 2006 Act;
“NHS Trust”	an NHS trust established under section 25 of the 2006 Act;
“Relevant bodies”	NHS England, Integrated Care Boards, NHS trusts and NHS foundation trusts in accordance with section 96(2B) of the 2012 Act;
“Trusts”	means NHS foundation trusts and NHS trusts.

2. Any reference in this Licence to a statutory body shall be taken, unless the contrary is indicated, to be a reference also to any successor to that body.
3. Unless the context requires otherwise, words or expressions which are defined in the NHS Acts shall have the same meaning for the purpose of this Licence as they have for the purpose of that Act.

4. Any reference in the Licence to any provision of a statute, statutory instrument or other regulation is a reference, unless the context requires otherwise, to that provision as currently amended.

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Torbay and South Devon
NHS Foundation Trust

Report to Council of Governors(COG)			
Report title: Briefing: Hewitt review			Meeting date: 3rd May 2023
Report appendix	Appendix 1- Hewitt Review		
Report sponsor	Director of Corporate Governance and Trust Secretary		
Report author	Director of Corporate Governance and Trust Secretary		
Report provenance	n/a		
Purpose of the report and key issues for consideration/decision	Receive and note the "Hewitt Review", an independent review of integrated care systems, led by the Rt Hon Patricia Hewitt, published 4 April 2023.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	To receive the report.		
Summary of key elements			

Strategic goals supported by this report

Excellent population health and wellbeing		**Excellent experience receiving and providing care**	
Excellent value and sustainability	X		

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework	n/a	**Risk score**	
Risk Register	n/a	**Risk score**	

External standards affected by this report and associated risks

Care Quality Commission	X	**Terms of Authorisation**	X
NHS England	X	**Legislation**	X
National policy/guidance	X		

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NHS
Torbay and South Devon
NHS Foundation Trust

Introduction

The COG are asked to receive and note the “Hewitt Review”, an independent review of integrated care systems, led by the Rt Hon Patricia Hewitt, published 4 April 2023 (**Appendix 1**).

Summary

The report, which is supported by a number of recommendations, focuses on six key themes to “*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.

Key recommendations are:

- That the government leads and convenes a national mission for health improvement;
- That target setting is predominately localised within the ICS, with few National targets, rebalancing the relationships between National and Regional system partners;
- That the share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years;
- Greater focus on prevention as a means of supporting the population to manage and promote their health; with a community approach, tackling inequality;
- Noting that the government is due to publish a long-term workforce plan for the NHS imminently, that the primary and social care workforce should be supported to promote health, focussing on prevention and the government should produce a complementary strategy for the social care workforce, as soon as possible.; and
- Increased focus on performance and value for money.

Context

This briefing paper supports and builds upon the commentary within the review of the NHS Standard Form Licence, circulated under separate cover, noting the changing legal and regulatory landscape within which the Trust operates.

However, at this time the status of this report is regulatory sponsored comment. The application of these recommendations, in whole or part, would require legal and/or regulatory amendment, as some of the proposals conflict with current law.

The proposals also lack clarity, whilst key themes of supporting the Integrated Care Systems implementation and financial transformation are evident, an increased governance burden on the NHS would also be created, which may or may not add value.

At this time support and granular analysis from NHS England for the proposals is awaited, alongside their proposals to take forward the “Hewitt Review” recommendations in whole or in part.

Conclusion

The COG are advised to note this report and appended “Hewitt Review”, whilst having regard to its current status. Broader NHS England intent and commitment to change either law or regulatory standards would be required to implement much of what is proposed.

Recommendations

The COG are asked to receive and note this report.

The Hewitt Review

An independent review of integrated care systems

Rt Hon Patricia Hewitt

Published 4 April 2023

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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

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[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

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[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]

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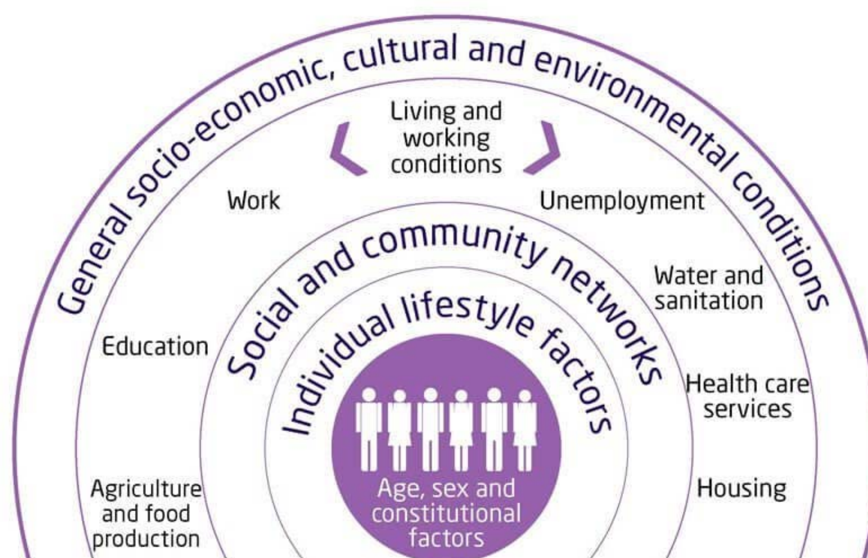
[5] Public Health England. COVID-19: review of disparities in risks and outcomes. 2 June 2020
[6] Tabor, D. (2021) Health State Life Expectancies, UK: 2017 to 2019, Health state life expectancies, UK - Office for National Statistics. Office for National Statistics.
[7] Dahlgren, G. and Whitehead, M. (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.

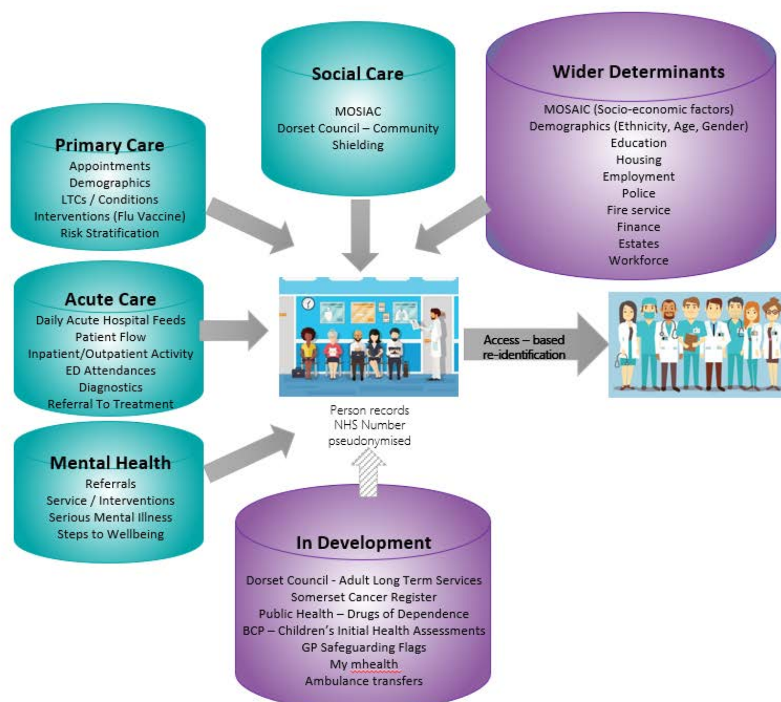
Role of data and digital tools to support the prevention of ill health

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

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[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.

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[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

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[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.

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Lead Governor Appointment Dave Cawley

Some of you will know me but most of the many new governors will not. I live in Dartmouth and spent my early years in Cornwall before moving to Cambridge to follow a career in Electronics. My wife Jill and I returned to the West Country and decided on Dartmouth, I was then in my late 40's. I was a Dartmouth Town Councillor for 12 years and was the lead in the ¾ million pound Market Regeneration. I am Chairman of the Dartmouth Patient Participation Group and many members asked me to stand as a Torbay NHS Trust Governor as they knew I could get things done !

If appointed as Lead Governor I would both lead and delegate. I am a firm believer in having people around me to help. I am not in favour of many subcommittees; we should all be part of a team helping the Trust to perform properly.

You will find me a straight talker with both competence and confidence. Annie and I did every PLACE Inspection last year - that took up 6 whole days.
We went to Newton Abbot, Totnes, Brixham, Dawlish and Torbay. I travelled 204 miles and the reports I submitted totalled nearly 2,500 words. We found that everything was mostly what we expected and our narrative scored the Torbay area amongst the best in the UK. For me especially, it was also a valuable learning experience looking in depth at our 5 hospitals.

In 2017 a report from the Governors mentioned many things such as; "Virtually no opportunity to meet NED's or time for adequate questions to be dealt with" "Over the past 12 months I have the impression we [Governors] are tolerated rather than listen to. Very poor communication" "Governors' questions are, by and large, rushed through by the Chairman et al and on occasion seem to be viewed almost as an imposition." Does this sound familiar ? It should !
I ask myself have Governors ever made a change ?

We need to reduce the amount of document and procedure revisions (this has largely been successfully completed now) and get on with the things that really matter. We should tackle things that we can actually achieve and not try to change the world, that would take too long !

Right now we need to address why it takes so long to get an answer to a question and why questions cannot be answered in real time.
We also need to meet the NED's informally in an environment where they are able to answer any questions we may have, as well as explain to us what they are doing and what their aims are.
We need to find a good time to meet, not only when the car park is less busy! but also so that the Staff Governors can easily join us.

I would be honoured if you would vote for me

Thanks Dave Cawley

Issue 01 Monday, 24 April 2023

Peter Milford, Statement to Support My Nomination to be Lead Governor

Who am I?

I was elected as a Governor for Torbay Constituency in March 2022. I have played an active role on the Council of Governors, as Governor Observer of the Audit Committee, as a member of the Governor NomRem Committee during a complex year and on the Torbay Constituency Group. I have developed good working relationships with Governors and NEDs.

I live in Paignton with my wife Rachel and was born here. I attended Torquay Boys' Grammar School and Bath University, from which I have a BSc (1978) + MBA (Masters in Business Administration, 2001). My Mum & Dad were Royal Navy, both grandads local trawlermen. I've been a keen Torquay United supporter since 1964! I became a Trustee of the Tadpool Charity in 2016. Tadpool leases Totnes Leisure Centre from South Hams Council. I chaired Tadpool during the pandemic, raising funds to keep the Centre going during a difficult time.

My career

NHS

- 1978-1984 National management trainee and hospital manager (Bristol, Oxford & London).
- 2002-2007 Director of Workforce SW Península Strategic Health Authority (Closed 2007). I secured NHS funding for Plymouth Dental School and for Plymouth University Schools of Physiotherapy & Dietetics and Exeter University School of Diagnostic Radiography.
- 2007-2016 Interim Director of Governance for Somerset Partnership Trust 2008; Director of Learning Development and Executive Director for Skills for Health 2008-2015 (UK Sector Skills Agency for healthcare). I also undertook HR related consultancy from 2007.

University Lecturer

Principal Lecturer Accounting & Finance at Bristol Business School 1991-2002, responsible for teaching, research & consultancy. I taught in two US universities on exchange. Head of the School of Accounting & Finance from 1997 to 2002, returning to the NHS in 2002.

Chartered Accountant

I trained as a Chartered Accountant in Bristol from 1984-87, qualifying 1987. I then worked in audit & healthcare consultancy for Binder Hamlyn (BDO), KPMG & Dixon Walsh up to 1991.

Why vote for me?

I am passionately committed to the principles & ethos of the NHS and want comprehensive, high quality healthcare services to continue in South Devon. I first attended Torbay Hospital as a boy after breaking my arm and have been an adult patient of the Hospital's gastroenterology and eye clinic services. All my healthcare was first class. My mum was wonderfully cared for in Torbay hospital during the last days of her life in 2012. I can offer the Council of Governors experience, knowledge and skills that would enable me to undertake the post of Lead Governor successfully on your behalf, for the benefit of the people we serve in South Devon. I hope that you will give me your trust and vote for me for the post of Lead Governor.

Governors' Log of Communications

Print date: 25/04/2023 09:47

C-O-G	Gov Newsletter	ID	Date Requested	Governor	Constituency	Summary Description	Executive Lead	Response Date	Summary Response	Status
03.05.202	Question & first section of reply listed in 03.02.2023 edition	**136a**	30.01.2023	Andrew Stilliard	Torbay	Subject: Panorama long Covid Hi, having just seen the above programme can I ask two questions. 1. When did the Trust know about the programme. 2. How many staff does the Trust have off work due to long Covid. If possible can we know on Wednesday's meeting.	L Davenport – CE	31.01.2023 and 16.03.2023	**Response to Part 2 of Question (31.01.2023)** Firstly, I need to highlight a differentiation between Long Covid as a formal medical diagnosis and the "long covid" that is simply based on the length of absence. Unfortunately, we do not have the data (I don't believe there is even anywhere to capture this) to be able to report on the former, so our data is simply based on absence duration. This proxy does potentially pose several problems in terms of trying to understand the true current diagnosed Long Covid incidence. For example: 1.Although my understanding is that there is no universally accepted medical definition of Long Covid, I believe the WHO guidance is based on symptoms lasting a minimum of 12 weeks. However, the process I inherited for reporting starts categorising someone as "long covid" earlier than this and is purely based on the month the absence started in relative to now. Strictly speaking what we're classing as 'long covid' may not actually be considered Long Covid medically. 2.As the Panorama programme showed, someone with medical Long Covid may still be working (in some altered capacity). It is possible therefore that some staff could have developed Long Covid following a mild initial illness and so do have not had a single absence that was long enough to appear as 'long covid' to us. I cannot say, however, to what extent this is the case. 3.Someone may have had a 'long covid' absence previously (that could potentially have been medical Long Covid) but now have recovered. Again I cannot say to what extent this is the case. 4.Particularly with more recent absences, process timelines and administration delays may mean an absence has not been updated so it may appear to be a 'long covid' absence but in reality they have returned and the system is awaiting update. 5.Our ability to report is only as good as the data that is entered. If an absence is not marked as COVID, then we would not treat it as such. With the caveats in place, the data we have indicates that there are: 1)13 substantive employees with a current, open-ended COVID absence on either ESR or Heath Roster that has lasted 84 days (12 weeks) or more. It so happens that at this moment in time, these are the only ones that are of a sufficiently long enough duration for us to report as 'long covid' in our daily update but the current process means this will change tomorrow as we move into a new month. 2)4 substantive employees have a current, open-ended COVID absence on either ESR or Heath Roster that has lasted more than a month (although note point 4 above). 3)ESR shows that since March 2020, a further 26 substantive employees (to the 13 current) had a COVID absence that has lasted at least 84 days that has ended. 21 of these remain in a substantive role. 4)ESR also shows that since March 2020, a further 96 employees had a COVID absence of a month (31 days) or more but less than 84 days. 88 of these remain in a substantive role. Only one of the four current employees showing as being absent for over a month has been entered into ESR. Thus the figure could rise to 99 once all information has been confirmed. Hope this covers the query as best it can. **Response to Part 1 of Question: sent 16.03.2023:** We were advised that BBC Panorama had interviewed a member of our staff for a programme on Monday 09 January 2023. At this point we did not have the detail of the allegations. Over the next few weeks we worked to establish the facts of the case, liaising with our solicitors and key colleagues, while waiting for confirmation from the BBC of a broadcast date. I am sorry for the delay.	Responded
03.05.2023	Both Q and A put in 17.02.23 edition	**136b**	06.02.2023	Andrew Stilliard	Torbay	Subject: Panorama long Covid My follow up question would be how many staff have had their contracts terminated after being off sick with Long Covid for more than 12months if any.	Michelle Westwood – CPO	14.02.2023	We have crossed referenced our spreadsheet with Selenity and can confirm we have had one staff member had their contract terminated after being off sick with Long Covid for more than 12 months. The outcome was determined following a process that explored and exhausted other options. Selenity is an on-line data base where we record all cases that come into the Helpdesk. Any Formal cases will be recorded in here and each HR Representative also record's any formal meetings on Selenity that they are involved in for their appointed ISU's. All cases are tracked and monitored through Selenity.	Responded
03.05.2023	Question 31.03.2023 and answer in 14.04.23 edition	**137**	30.03.2023	Matt Arthur	Staff Governors	Why is it that when the environmental temperature is improving, that the heating within our estate is still operational to a level that many areas are having to open windows to regulate their working environment? Is the estate infrastructure not controllable so that heating levels can be adjusted rather than it seemingly being an on/off system?	J O'Donovan - Workplace Director	04.04.2023	The Trusts Building Management System (BMS), assess both the external and internal temperatures to ensure the correct internal environmental conditions are achieved throughout. In general, our buildings have a heating setpoint of 21 DegC, with the exception of special locations (i.e. Theatres, SCBU and ICU) which have an element of local control within a given range. The system relies on sensors, valves and controllers that are placed in various locations throughout the system, these control the internal environments. Some areas of the hospital are older than others, and other areas have had a change of use, these areas are the most difficult to control. New areas, such as, Theatres, ICU and AMU have been designed with good control systems and have better stability. If there are areas that the heating is ON when the thought is that it should be OFF, this could be down to component failure rather than a system configuration (i.e. a sensor reading a lower temperature than it should, or a valve failed in the open position). Any locations experiencing these issues should raise a request to the Estates Operations Delivery Team, part of the Workplace Team, they can then investigate and rectify the fault. We proactively carryout a service on these systems, which is currently in progress, and there have been a number of devices identified as requiring replacement, which a programme is in place. In brief, the system is fully automated, based on some basic parameters, to maintain the environmental conditions as set out in the guidance.	Responded
03.05.2023	Question to go in 28.04.23 edition	**138**	Received in FT Office on 18.04.2023	Dave Cawley	South Hams	I believe it was the 22nd February over 7 weeks ago that you told us all that you had "confidence" that the sale of the Dartmouth Cottage Hospital would go through in a couple of weeks. Could you please tell me if and when this is likely to happen and also the cause of the delay.	D Stacey - CFO & Deputy CEO			Assigned

Torbay and South Devon
NHS Foundation Trust

Report to the Council of Governors			
Report title: Governor Calendar and Information Items			Meeting date: 3rd May 2024
Report appendix	Appendix 1 – Governor Calendar Appendix 2 – Governor Newsletters		
Report sponsor	Director of Corporate Governance and Trust Secretary		
Report author	Corporate Governance Manager		
Report provenance			
Purpose of the report and key issues for consideration/decision	The report provides Governors with an annual calendar of statutory business and the Governor Newsletters that have been circulated to Governor since the last Council of Governors meeting.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Council of Governors is asked to receive and note the report.		
Summary of key elements			

Strategic goals supported by this report

Excellent population health and wellbeing		**Excellent experience receiving and providing care**	
Excellent value and sustainability	x		

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework		**Risk score**	
Risk Register		**Risk score**	

External standards affected by this report and associated risks

Care Quality Commission		**Terms of Authorisation**	
NHS England		**Legislation**	
National policy/guidance			

Public

Governor Calendar & Information Items

Please find enclosed the Governor Calendar and summary of information items circulate during the period, including but not limited to: Governor Newsletters, enclosed as appendices.

Governor Calendar		
Activity:	**Date:**	**Governor obligation being discharged:**
January		
CoG Priorities Meeting	10/01	Collective working
Governor Observer reports are listed each month from the various Board Level Sub Committees and these are circulated to all Governors	Audit: 18/01 BBF: 18/01 QAC: 23/01 FPDC: 23/01	Hold NEDs individually to account for performance of Board – (Questioning NEDs on the Trust's quality and financial performance)
Observe contributions NEDs make at Board	25/01	Hold NEDs individually to account for performance of Board
February		
COG	01/02	Engagement with the Trust
Governor Only Meeting	07/02	Collective Working
Governor Observer reports are listed each month from the various Board Level Sub Committees and these are circulated to all Governors	BBF: 15/02 People: 20/2 FPDC: 20/02	Hold NEDs individually to account for performance of Board - (Questioning NEDs on the Trust's quality and financial performance)
Observe contributions NEDs make at Board	22/02	Hold NEDs individually to account for performance of Board
March		
CoG Priorities Meeting	08/03	Collective working
Governor Observer reports are listed each month from the various Board Level Sub Committees and these are circulated to all Governors	BBF: 15/03 C Funds: 15/03 QAC: 27/03 FPDC: 27/03	Hold NEDs individually to account for performance of Board - (Questioning NEDs on the Trust's quality and financial performance)
Involvement input for performance appraisals for Chair and NEDs	Through Governor Nominations and	Hold NEDs individually to account for performance of Board

	Remuneration Committee	
Observe contributions NEDs make at Board	29/03	Hold NEDs individually to account for performance of Board
April		
Governor Only Meeting	18/04	Collective Working
Governor Observer reports are listed each month from the various Board Level Sub Committees and these are circulated to all Governors	Audit: 19/04 BBF:19/04 People: 24/04 FPDC: 24/4	Hold NEDs individually to account for performance of Board - (Questioning NEDs on the Trust's quality and financial performance)
Observe contributions NEDs make at Board	26/04	Hold NEDs individually to account for performance of Board
May		
COG	03/04	Engagement with the Trust
CoG Priorities Meeting	15/05	Collective working
Governor Observer reports are listed each month from the various Board Level Sub Committees and these are circulated to all Governors	BBF: 17/05 QAC:22/04 FPDC: 22/04 Audit: 24/04	Hold NEDs individually to account for performance of Board - (Questioning NEDs on the Trust's quality and financial performance)
Observe contributions NEDs make at Board	31/04	Hold NEDs individually to account for performance of Board
June		
Governor Only Meeting	13/06	Collective Working
Governor Observer reports are listed each month from the various Board Level Sub Committees and these are circulated to all Governors	C Funds: 14/06 BBF: 21/06 People: 26/06 FPDC: 26/06	Hold NEDs individually to account for performance of Board - (Questioning NEDs on the Trust's quality and financial performance)
Observe contributions NEDs make at Board	28/06	Hold NEDs individually to account for performance of Board
Receive/question information at the Annual Planning Meetings	TBC	Hold NEDS collectively to account for performance of Board

July		
CoG Priorities Meeting	05/07	Collective working
Governor Only Meeting	11/07	Collective Working
Membership Committee	13/06	Review FT membership data to target underrepresented groups
Governor Observer reports are listed each month from the various Board Level Sub Committees and these are circulated to all Governors	Audit: 19/07 BBF: 19/07 QAC: 24/07 FPDC: 24/07	Hold NEDs individually to account for performance of Board - (Questioning NEDs on the Trust's quality and financial performance)
Observe contributions NEDs make at Board	26/07	Hold NEDs individually to account for performance of Board
August		
COG	02/08	Engagement with the Trust
Governor Only Meeting	08/08	Collective Working
Governor Observer reports are listed each month from the various Board Level Sub Committees and these are circulated to all Governors	BBF: 16/08 People: 21/08 FPDC: 21/08	Hold NEDs individually to account for performance of Board - (Questioning NEDs on the Trust's quality and financial performance)
September		
Annual Members' Meeting – planning (Membership Committee) and attendance	21/07	Representing FT Members and Public
Annual Members' Meeting - Receive annual report, quality report and accounts	21/07	Hold NEDS collectively to account for performance of Board
Governor Observer reports are listed each month from the various Board Level Sub Committees and these are circulated to all Governors	Audit: 06/09 C Funds: 13/09 QAC: 25/09 FPDC: 25/09	Hold NEDs individually to account for performance of Board - (Questioning NEDs on the Trust's quality and financial performance)
Observe contributions NEDs make at Board	27/07	Hold NEDs individually to account for performance of Board
Decide the remuneration and other terms and conditions of chair and NEDS	Yearly	Hold NEDS collectively to account for performance of Board

October		
CoG Priorities Meeting	10/10	Collective working
Membership Committee	12/09	Review FT membership data to target underrepresented groups
PLACE Assessments (2022)	12 to 26 in 2022	Ensure views of public are added into the annual PLACE Assessments
Governor Observer reports are listed each month from the various Board Level Sub Committees and these are circulated to all Governors	Audit: 11/10 People: 16/10 BBF: 18/10 FPDC: 23/10	Hold NEDs individually to account for performance of Board - (Questioning NEDs on the Trust's quality and financial performance)
Observe contributions NEDs make at Board	25/09	Hold NEDs individually to account for performance of Board
November		
COG	01/11	Engagement with the Trust
Governor Only Meeting	07/11	Collective Working
Governor Observer reports are listed each month from the various Board Level Sub Committees and these are circulated to all Governors	BBF: 15/11 QAC: 27/11 FPDC: 27/11	Hold NEDs individually to account for performance of Board - (Questioning NEDs on the Trust's quality and financial performance)
Observe contributions NEDs make at Board	29/11	Hold NEDs individually to account for performance of Board
December		
Governor Only Meeting	12/12	Collective Working
CoG Priorities Meeting	13/12	Collective working
Governor Observer reports are listed each month from the various Board Level Sub Committees and these are circulated to all Governors	People: 06/12 C Funds: 06/12 BBF: 20/12 FPDC: 18/12	Hold NEDs individually to account for performance of Board - (Questioning NEDs on the Trust's quality and financial performance)

Summary of standing and ongoing Governor obligations:

- Review of NED performance
- Seek views of Public and FT members by engagement
- Raise individual and collective questions to ensure views of FT Members and wider Public are received and responded to – as required
- Ask about CQC judgements on the quality of care at the Trust – ad hoc
- Contact Senior Independent Director – if have concerns or if direct contact is inappropriate – ad hoc
- Jointly approve amendments to Trust's constitution – ad hoc
- Approve any "significant transactions" and approve a merger, acquisition, separation or dissolution – ad hoc as required
- Appoint and, if appropriate remove the Chair. Appoint and, if appropriate remove the NEDs – ad hoc, as required
- Appoint and if appropriate remove the Trust's external auditor – ad hoc, as required
- Approve the appointment of the Chief Executive – ad hoc as required
- Decide whether the Trust's non-NHS work would significantly interfere with its purpose – ad hoc as required.
- Have their views taken account of when Trust sets its strategy.

Governors Fortnightly e-Newsletter

Torbay and South Devon
NHS Foundation Trust

Issue No. 98

Date: Friday 03 February 2023

Within this issue

- Email from Chief Executive
- Governor "Only" meeting
- Reminder: IT Drop In Sessions
- Governor Coffee Morning
- NHS Providers London Conference
- Dartmouth H&WBC Change of Date
- Governor Observer Reports
- Healthy Lifestyles Service
- Hospital News
- Core Skills Training
- Communications Department Brief
- Email Confirmations
- Governor Q & A
- Meeting List and MS Teams Links
- Healthwatch

FT Office - please contact:

Tel: 01803 655705 or

Email: Foundationtrust.tsdft@nhs.net

EMAIL FROM THE CHIEF EXECUTIVE:

Liz Davenport, Chief Executive of the Trust, issued the following email to All Staff on 02.02.2023. We enclose a full copy here in case some of the Governors have not seen it:

Dear colleagues

Our Chair, Sir Richard Ibbotson, has served us diligently for the past nine years and I know many of you know and value him both personally and professionally.

It is with sadness that I share with you today that he will be leaving us at the end of May 2023 when his current contract ends.

Sir Richard has served three three-year terms as our Chair and is an exemplary leader who has played a vital role in shaping our vision and care model, in the creation of our integrated care organisation, and in championing us locally, regionally and nationally. He has stood shoulder to shoulder with us through the good times and the bad and will continue to do so. I know many of you will miss his keen interest and his steadfast kindness – as will I.

Your Board of Directors will continue to work closely together to help us all deliver better health and care for all while addressing our current challenges and building for what we all hope will be a brighter future. We are in discussion about future arrangements for the position of Chair and I will keep you updated on progress.

There will be many opportunities over the next four months for us to show Richard our thanks and our appreciation and I know he will want to see as many of you as he can before he leaves us.

Best wishes

Liz

GOVERNOR "ONLY" MEETING

Reminder that the first of the new **Governor "Only" meetings** is scheduled for **Tuesday 07 February 2023 at 2pm-4pm** in the Boardroom, Hengrave House, Torbay Hospital.

The Agenda/papers were circulated to all Governors on 31.01.2023 by the FT Office. Refreshments will be provided. Attendance is voluntary.

REMINDER - IT DROP-IN SESSIONS - INFORMAL HELP

Reminder that the FT Office have arranged **IT Drop-In Sessions for February 2023** for our **existing Governors**. These will be informal and friendly - drop in anytime during 1pm and 4pm at the Horizon Centre, at Torbay Hospital.

No need to book, no charge and tea/coffee and biscuits provided. ☺

Please bring your usual device that you log on for Trust work - be that your mobile, your tablet, or your laptop (plus charging wires). If you usually work off a desk computer then the Horizon Centre do have a few laptops we can "lend" for the session.

These will be run by **Claire Brown who is a Trust IT Applications Trainer** and Sally-Ann Reay, Membership Manager will be attendance to assist.

(We have in addition have two slots reserved in March for the new Governors who join us on 01.03.23 as part of the new look induction programme).

DATES AND TIMES

21st February—from 1pm to 4pm—drop in (Tutorial Room 2) at Horizon Centre

27th February from 1pm to 4pm—drop in (Seminar Rooms 1+2) at Horizon Centre

INFORMAL MONTHLY COFFEE AND CHAT SESSIONS

Reminder that the next **informal Coffee and Chat session,** set up by the Lead Governor and Deputy Lead Governor, is on **Thursday 16 February 2023 at 10.30am** (one hour) and the MS Teams invite is listed at the back of this newsletter (bottom pink section).

REMINDER: TWO SPACES AVAILABLE NHS PROVIDERS LONDON CONFERENCE

Governors have recently been sent an email by the FT Office (31.01.2023) asking for nominations to attend the NHS Providers London Conference on **23 May in London**.

- Each Trust is allowed to book two Governors at no cost.
- **If anyone is interested - please email the FT Office by Friday 10 February at 9am.**
- If we have more than two people, then names will be pulled from a hat. Thank you.

CHANGE OF DATE:

FOR DARTMOUTH HEALTH AND WELLBEING CENTRE OFFICIAL OPENING

Governors were informed by email that the official opening date of the Dartmouth Health and Wellbeing Centre has **been altered to Tuesday 09 May 2023** (in place of Friday 05 May - in light of road closures due to the King's Coronation celebrations that weekend).

GOVERNOR OBSERVER REPORTS

Governor Observer reports from Board level sub-committees are issued with the e-newsletter for your information:

- Quality Assurance Committee GO Report of 23.01.2023
- Audit Committee GO Report of 18.01.2023

Healthy Lifestyles Service in Torbay

ICONews on 01.02.2023 announced that from 31 March 2023 we will no longer provide the Healthy Behaviours Service.

We have provided this service since 2013 and have proudly helped more than 14,000 people to take control of their health and wellbeing by stopping smoking, eating more healthily and losing weight.

Torbay Council put the service out to tender last year and we are disappointed that our bid to continue providing the service was unsuccessful.

Issue No. 98 Page 4 Date: 03 February 2023

GP Services to open at Brixham Hospital in February 2023

A press release was published on 25.01.2023 announcing that two GP practices will be opening branch sites at Brixham Community Hospital during February, meaning there is improved access for people in Brixham and surrounding areas. The full press release can be seen here (press Ctrl and click).

UNICEF praises TSDFT for helping mums and babies

A press release was published on 26.01.2023 announcing glowing feedback for the Trust's maternity team from UNICEF inspectors. The full press release can be seen here (press Ctrl and click).

New virtual tours will help parents whose babies are born early or need specialist care

Details of a series of virtual tours showcasing the South West region's 12 special care units and neonatal transport service was published on 26.01.2023. This allows parents and their families to have a full 360 degree tour of the ward. The full press release can be seen here (press Ctrl and click).

CHANGES TO MASK WEARING REGULATIONS

ICONews on 23.01.2023 announced that mask wearing in non-clinical areas could cease due to the falling risk of respiratory virus infections.

REMINDER: HOLD THE DATE

As part of the Governor Induction programme for 2023, the Trust Office have reserved a one day **Core Skills Overview training delivered by NHS Providers GovernWell Team (**virtual)

This will be offered initially to the new Governors joining on us at the beginning of March but there will be spare spaces as it can take up to 20 delegates - so if interested, and not undertaken previously, then please note the date in your diary for now: **20 March 2023.**

This course provides a comprehensive overview of the structure of the NHS and the statutory role and responsibilities of governors; and a choice of an overview of NHS finance; the importance of quality in healthcare and member and public engagement. This training builds on a trust's induction programme to help governors learn and discuss issues from a position of insight from having initial experience in their role.

Issue No. 98 Page 5 Date: 03 February 2023

COMMUNICATIONS DEPARTMENT BRIEF

Latest reported COVID-19 data

Detailed information is published weekly on NHS England's website. The information below for the latest full week published from Monday 16 January 2023 to Sunday 22 2023 is extracted from that website and presents a snapshot of our position.

The data can be found on the national NHS website here: https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-hospital-activity/

COVID-19 data snapshot – Monday 16 January 2023 to Sunday 22 January 2023

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
COVID-19 admissions and inpatients diagnosed	1	1	0	0	0	2	2
New admissions to hospital from the community	1	1	0	0	0	2	2
New hospital admissions from a care home	0	0	0	0	0	0	0
Beds occupied by COVID-19 patients	6	7	7	8	3	3	5
Mechanical ventilation beds (ICU) occupied by COVID-19 patients	0	0	0	0	0	0	0
Deaths recorded (within 28 days of COVID-19 positive test during pandemic period)	0	0	0	0	0	0	0

	04 Jan
COVID-19 discharges from hospital	1
COVID-19 related staff ab-sences	57

Discharge and staff absence information is published on a monthly basis.

Media

- Self-managing diabetes support – promoting the Healthy Living Programme which involves group sessions that aim to help people self-manage their type 2 diabetes. An accompanying video featured Michael, who talked about how beneficial he had found the course
- Cost of living affecting parents – Dr Rowan Kerr-Liddell, consultant paediatrician, spoke to ITV West Country on the importance of regularly changing nappies, following financial concerns of parents due to the rising cost of living
- New Hospital Programme updates – outlining our cohort and current business case position on the New Hospitals Programme funding, following a number of enquiries

Social Media

- Twin cot donation – sharing a picture of the first set of twin babies to use our new twin cot, funded by the generous charitable donations
- IOSH success – celebrating staff who have completed a health and safety course, which helps to further our awareness culture
- ASPIRing students – sharing a post from South Devon College about one of their learners who has joined our portering teams as part of the ASPIRE project
- easyfundraising – promoting the easyfundraising service, which sees brands donate to our charity when registered members of the public shop there
- GP services at Brixham to open in February – marking the completion of the works to accommodate GPs at Brixham Community Hospital, which will see services start in February
- Healthy Futures – promoting the latest edition of our stakeholder newsletter

We hope this information is useful, but please do give us any feedback, via the Foundation Trust Office, as it is always welcomed and helps us continually improve the information we send out.

EMAIL CONFIRMATION

The Foundation Trust Office and Comms Team regularly send you emails. Here is a listing of those sent over the period from Friday 20 January 2023 to Friday 03 February 2023:

Issued 20.01.2023	Important - "IT Drop-in sessions for Governors - available in February 2023
Issued 20.01.2023	Public Board Papers Link - Wednesday 25 January 2023
Issued 24.01.2023	One Devon Bulletin - January 2023
Issued 25.01.2023	Public and Private Council of Governors Meeting Papers for Wednesday 01 February 2023 at 2pm
Issued 26.01.2023	Dartmouth Health and Wellbeing Centre Update
Issued 26.01.2023	TEC Newsletter - January 2023
Issued 26.01.2023	Stand in GO for BBF Committee Meeting - Wednesday 15 February
Issued 26.01.2023	TSDFT News Release: Sessions provide advice and support to help self-manager diabetes
Issued 26.01.2023	Healthwatch Torbay e-bulletin 26 January 2023
Issued 30.01.2023	Confidential - coverage on BBC Panorama - from Communications Dept
Issued 07.02.2023	07 February 2023 - Governor "only" meeting at 2pm-4pm - Agenda and action tracker attached
Issued 31.01.2023	CoG Priorities Meeting Minutes and Action Log - 10.01.23
Issued 31.01.2023	Two spaces available for the NHS Providers Governor Focus Conference 2023 - Tuesday 23 May at the kia Oval in London
Issued 01.02.2023	Re. 07 February 2023 - Governor "only" meeting at 2pm-4pm - PDF version of the agenda is also attached.
Issued 01.02.2023	Our Timeline - Torbay and South Devon NHS Foundation Trust
Issued 02.02.2023	Healthwatch Torbay e-bulletin 02 February 2023
Issued 03.02.2023	Important: Dartmouth Health & Wellbeing Centre Update - Information from the Communications Department.
Issued 03.02.2023	News Release: TSDFT - Chairman to leave role at end of term of office

LEAD GOVERNOR EMAILS

Here is a listing of emails you have been sent by the Lead Governor (via the FT Office) over the period Friday 20 January 2023 to Friday 03 February 2023:

Issued 26.01.2023	Council of Governors Pre-Meet - Email from Jean

Issue No. 98 Page 7 Date: 03 February 2023

QUESTION AND ANSWERS SECTION

It was requested at the GGI Feedback session on Wed 6 July 2022 - that all current Governor questions are listed in the Fortnightly Newsletter and dates given (regardless of whether a response is still awaited). Please note that the current questions and responses are always added to the Governor Communications Log that is taken to each Council of Governors meeting.

Question ID No. 136 (Andrew Stilliard) dated 30.01.2023 re. Panorama Long Covid

Hi, having just seen the above programme can I ask two questions.
1. When did the Trust know about the programme.
2. How many staff does the Trust have off work due to long Covid.

If possible can we know on Wednesday's meeting.

Answer ID No. 136 - Response forwarded by Liz Davenport, Chief Executive on 31.01.2023 (Response to Part 2 of Question above):

Firstly, I need to highlight a differentiation between Long Covid as a formal medical diagnosis and the “long covid” that is simply based on the length of absence. Unfortunately, we do not have the data (I don’t believe there is even anywhere to capture this) to be able to report on the former, so our data is simply based on absence duration.

This proxy does potentially pose several problems in terms of trying to understand the true current diagnosed Long Covid incidence. For example:

1. Although my understanding is that there is no universally accepted medical definition of Long Covid, I believe the WHO guidance is based on symptoms lasting a minimum of 12 weeks. However, the process I inherited for reporting starts categorising someone as “long covid” earlier than this and is purely based on the month the absence started in relative to now. Strictly speaking what we’re classing as ‘long covid’ may not actually be considered Long Covid medically.
2. As the Panorama programme showed, someone with medical Long Covid may still be working (in some altered capacity). It is possible therefore that some staff could have developed Long Covid following a mild initial illness and so do have not had a single absence that was long enough to appear as ‘long covid’ to us. I cannot say, however, to what extent this is the case.
3. Someone may have had a ‘long covid’ absence previously (that could potentially have been medical Long Covid) but now have recovered. Again I cannot say to what extent this is the case.
4. Particularly with more recent absences, process timelines and administration delays may mean an absence has not been updated so it may appear to be a ‘long covid’ absence but in reality they have returned and the system is awaiting update.
5. Our ability to report is only as good as the data that is entered. If an absence is not marked as COVID, then we would not treat it as such.

Continued on next page/……..

QUESTION AND ANSWERS SECTION - Continued

With the caveats in place, the data we have indicates that there are:

1. 13 substantive employees with a current, open-ended COVID absence on either ESR or Heath Roster that has lasted 84 days (12 weeks) or more. It so happens that at this moment in time, these are the only ones that are of a sufficiently long enough duration for us to report as 'long covid' in our daily update but the current process means this will change tomorrow as we move into a new month.
2. 4 substantive employees have a current, open-ended COVID absence on either ESR or Heath Roster that has lasted more than a month (although note point 4 above).
3. ESR shows that since March 2020, a further 26 substantive employees (to the 13 current) had a COVID absence that has lasted at least 84 days that has ended. 21 of these remain in a substantive role.
4. ESR also shows that since March 2020, a further 96 employees had a COVID absence of a month (31 days) or more but less than 84 days. 88 of these remain in a substantive role. Only one of the four current employees showing as being absent for over a month has been entered into ESR. Thus the figure could rise to 99 once all information has been confirmed.

Hope this covers the query as best it can.

(**Response to the Part 1 of the Question ID. No. 136)**: has been allocated and response awaited.

HEALTHWATCH

Governors have recently been sent the Healthwatch Torbay e-bulletins as a direct method of informing you of their many activities. Therefore individual articles will no longer be extracted and listed in the Governor newsletter.

Latest Devon Healthwatch reports are listed here (Ctrl & Click) and latest Torbay Healthwatch reports are listed here (Ctrl & Click) if you wish to view.

Issue No. 98 Page 9 Date: 03 February 2023

MEETINGS LIST AND MS TEAMS LINKS SECTION

GOVERNOR MEETINGS - FEBRUARY 2023

07 February 2023	**Governor "Only" Meeting** (2pm-4pm) (Face to Face meeting - Boardroom)
16 February 2023	**Governors Coffee and Chat Session** (10.30-11.30am) (Video Conference), see MS Teams link below at bottom of page
22 February 2023	**Public Board** (11.30am) (Face to Face meeting - Pomona House, Oak View Close, Torquay, TQ2 7FF)

GOVERNOR MEETINGS - MARCH 2023

07 March 2023	**Governor "Only" Meeting** (2pm-4pm) (Face to Face meeting - Boardroom)
08 March 2023	**CoG Priorities Meeting** (2pm-4pm) (Face to Face meeting - Pomona House, Oak View Close, Torquay, TQ2 7FF)
16 March 2023	**Governors Coffee and Chat Session** (10.30-11.30am) (Video Conference), see MS Teams link below at bottom of page
29 March 2023	**Public Board** (11.30am) (Face to Face meeting - Pomona House, Oak View Close, Torquay, TQ2 7FF)

MS Teams Link: **Governor Coffee and Chat Sessions** (10.30-11.30)

Microsoft Teams meeting

Join on your computer or mobile app

Click here to join the meeting (press control button and click at same time on underlined section)

Or call in (audio only)

020 3321 5208 644531308# United Kingdom, London

Phone Conference ID: 644 531 308#

Governors Fortnightly e-Newsletter

Torbay and South Devon
NHS Foundation Trust

Issue No. 99 Date: Friday 17 February 2023

Within this issue

- Next CoG Priorities Meeting
- Alteration to May CoG Meeting
- Governor "Only" meeting
- Reminder: IT Drop In Sessions
- 13 June Cancer Presentation
- NHS Providers London Conference
- Hengrave Car Park
- Public Board
- Governor Observer Reports
- Communications Department Brief
- Email Confirmations
- Governor Q & A
- Meeting List and MS Teams Links
- Healthwatch

FT Office - please contact:

Tel: 01803 655705 or

Email:
Foundationtrust.tsdft@nhs.net

The aim of this e-Newsletter is to give you a regular round up of future items of interest and confirm items that have been sent to you by the Foundation Trust Office and other sections of the ICO.

Please continue to read this newsletter each fortnight as this is a key method of communication with Governors - thank you.

NEXT CoG PRIORITIES MEETING

The next CoG Priorities meeting takes place **on 08 March 2023 at 2pm-4pm** (face to face) at **Pomona House**. (MS Teams will be available, if required).

The agreed theme for this meeting is to discuss the topic of "Waiting Lists" which was listed in the Governors six key priorities that you have all identified as areas that you wanted to explore.

Kevin Pirie (Interim System Care Group Director) and Alex Atkins (Cancer Services Manager) will be attending to present and also answer your questions.

Executive Directors and Non-Executive Directors also have open invitations to attend these meetings. The agenda and action tracker will be issued a week in advance.

CHANGE OF DATE:

MAY CoG PRIORITIES MEETING

Governors were informed by email that the May CoG Priorities Meeting has been cancelled and will be rescheduled.

Please remove the 09 May 2023 from your diaries (2pm-4pm). This is due to a clash with the official opening of the Dartmouth Health and Wellbeing Centre.

An updated Meeting Schedule (V.8) was issued to you all on 15.02.2023 with this adjustment highlighted on page 1.

Issue No. 99 Page 2 Date: 17 February 2023

GOVERNOR "ONLY" MEETING

Reminder that the second of the new **Governor "Only" meetings** is scheduled for **Tuesday 07 March 2023 at 2pm-4pm** in the Boardroom, Hengrave House, Torbay Hospital. (MS Teams will also be available for those unable to attend face to face).

The Agenda/papers were circulated to all Governors a week in advance. Refreshments will be provided. Attendance is voluntary.

REMINDER - IT DROP-IN SESSIONS - INFORMAL HELP

Reminder that the FT Office have arranged **IT Drop-In Sessions for February 2023** for our **existing Governors**. These will be informal and friendly - drop in anytime during 1pm and 4pm at the Horizon Centre, at Torbay Hospital.

No need to book, no charge and tea/coffee and biscuits provided. ☺

Please bring your usual device that you log on for Trust work - be that your mobile, your tablet, or your laptop (plus charging wires). If you usually work off a desk computer then the Horizon Centre do have a few laptops we can "lend" for the session.

These will be run by **Claire Brown who is a Trust IT Applications Trainer** and Sally-Ann Reay, Membership Manager will be attendance to assist.

(We have in addition have two slots reserved in March for the new Governors who join us on 01.03.23 as part of the new look induction programme).

DATES AND TIMES

21st February—from 1pm to 4pm—drop in (Tutorial Room 2) at Horizon Centre

27th February from 1pm to 4pm—drop in (Seminar Rooms 1+2) at Horizon Centre

PRESENTATION CONFIRMED FOR 13 JUNE AT 3PM GOVERNOR ONLY MEETING

There was an action item arising from the January 2023 Governor only meeting to arrange for Sam Gregory and Fahida Rehman-Manby to come and present their **Head and Neck Cancer Presentation** to Governors.

Delighted to confirm that this has been arranged for the 13 June Governor Only meeting (Boardroom) for a 30 minute presentation with time for questions and answers within that. They will join the meeting at 3pm, due to clinical commitments (meeting starts at 2pm).

Issue No. 99 Page 3 Date: 17 February 2023

NHS PROVIDERS LONDON CONFERENCE

Loveday Densham (Public Governor for Torbay) has offered to attend the NHS Providers London Conference on 23 May 2023 in London.

- Loveday has asked if Governors could consider the question of "**What do we do well as a Council of Governors**" and email Loveday direct with their responses so she can share this information at the networking sessions on 23 May in London. Loveday Densham's TSDFT email address is: l.densham1@nhs.net. Thank you.

CAR PARKING RESTRICTIONS: HENGRAVE

ICONews on 10.02.2023 announced that from 20 February 2023 until the summer there will be no car parking facility in the Hengrave car park due to the construction work for a new Radiotherapy building that will house a brand-new Radiation Therapy Computed Tomography (RT-CT) Scanner. Replacement Radiotherapy parking will be allocated near the Physiotherapy Dept with new access routes and signage.

PUBLIC BOARD MEETING - 22 FEBRUARY

The February Public Board meeting is a **face to face** meeting at Pomona House, Oak View Close, Torquay, TQ2 7FF.

The Public session commences at 11.30am and attendance is **voluntary**, should you wish to observe.

Please note that if you do attend at 11.30am - you will be required to:

a. Inform the FT Office email (foundationtrust.tsdft@nhs.net) by 5pm on Monday 20 January if you plan to attend and also if you need a car parking space please confirm car registration, so we can inform Pomona House reception for registration.

b. Please let the FT Office know by 12noon on Tuesday 21 February if you have any questions on the Board papers.

c. Please be aware that you need to wait until 11.30am - please do not attempt to enter the Board meeting prior to that timeslot.

GOVERNOR OBSERVER REPORTS

Governor Observer reports from Board level sub-committees are issued with the e-newsletter for your information:

- Building a Brighter Future Committee GO Report of 18.01.2023

Issue No. 99 Page 4 Date: 17 February 2023

COMMUNICATIONS DEPARTMENT BRIEF

Latest reported COVID-19 data

Detailed information is published weekly on NHS England's website. The information below for the latest full week published from Monday 06 February 2023 to Sunday 12 February 2023 is extracted from that website and presents a snapshot of our position.

The data can be found on the national NHS website here: https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-hospital-activity/

COVID-19 data snapshot – Monday 06 February to Sunday 12 February 2023

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
COVID-19 admissions and inpatients diagnosed	0	5	0	3	4	1	6
New admissions to hospital from the community	0	1	0	2	2	0	4
New hospital admissions from a care home	0	0	0	0	0	0	3
Beds occupied by COVID-19 patients	6	6	1	6	8	10	13
Mechanical ventilation beds (ICU) occupied by COVID-19 patients	0	0	0	0	0	0	0
Deaths recorded (within 28 days of COVID-19 positive test during pandemic period)	0	0	0	0	0	0	0

	01 Feb
COVID-19 discharges from hospital	1
COVID-19 related staff absences	28

Discharge and staff absence information is published on a monthly basis.

Media

- Eleven-year-old organ donation campaigner made honorary NHS director – celebrating the appointment of Lottie as an honorary director of our organisation as a result of her organ donation campaigning and fundraising work
- Our People's Choice Award voting opens – encouraged members of the public to show our people some love on Valentine's Day by voting for their preferred finalist in the Our People's Choice Award
- Maternity report and follow up actions – responded to an enquiry following the publication of a HSIB report which outlined that we have reviewed and made a number of changes in our maternity services

Social Media

- Our People's Choice Award finalists videos – sharing videos featuring our finalists talking about what being nominated means to them
- ASPIRE students – thanking all of the students currently taking part in the ASPIRE programme in a range of departments
- Way Finder receiving a One Big Thank You – promoting one of our Way Finder volunteers, Chad's appearance on The One Show as he received a One Big Thank You
- Torquay United FC fundraising – promoting Torquay United's auction of signed FA Cup footballs, in aid of our charity
- Cancer Research UK feature – shared Cancer Research UK's post on World Cancer Day which highlighted Gary, one of our patients who is currently receiving proton beam therapy treatment for throat cancer as part of a groundbreaking research trial
- MIU and UTC promotion – promoting our minor injuries units as alternatives to emergency departments when your need is urgent but not an emergency
- Group A Strep – raising awareness of the issues of Group A Strep and signposting to advice

We hope this information is useful, but please do give us any feedback, via the FT Office.

EMAIL CONFIRMATION

The Foundation Trust Office and Comms Team regularly send you emails. Here is a listing of those sent over the period from Friday 03 February 2023 to Friday 17 February 2023:

Issued 06.02.2023	Draft NED Appraisal proforma
Issued 07.02.2023	For our discussion at Governor Only meeting this afternoon - topic of Induction Process for New Governors
Issued 07.02.2023	For Info: New Individual Governor Question (ID No.136 (b) - please see updated Governor Communications Log
Issued 07.02.2023	FW: Appraisal of NED's by Governors
Issued 08.02.2023	For Action: next CoG Priorities Meeting - 08 March 2023 at 2pm-4pm at Pomona House
Issued 08.02.2023	Minutes of Private CoG held on 1st February
Issued 08.02.2023	Governor Election Results - as at 08 February 2023
Issued 08.02.2023	Selection date confirmed for our new Chief Operating Officer - if interested please register by emailing the resourcing hub
Issued 09.02.2023	Reminder: Next Governor Coffee Morning is on Thursday 16 February
Issued 10.02.2023	Notes and Action Log - Governor Only Meeting 7 February 2023
Issued 14.02.2023	News Release: TSDFT - Show NHS People some love - please vote for your winner of the Our People's Choice Award
Issued 15.02.2023	News Release: TSDFT - Eleven year-old organ donation campaigner made honorary NHS director
Issued 15.02.2023	Important: Updated Governor Meeting Schedule (V.8) attached - 09 May CoG Priorities meeting will be rescheduled so please remove from diaries
Issued 15.02.2023	FW: Minutes of the Private CoG held on 1st February
Issued 17.02.2023	For your info: this has been sent to New Governors today to assist their induction
Issued 17.02.2023	Link to the Public Board Papers for Wednesday 22 February at 11.30am
Issued 17.02.2023	TSDFT - Healthy Futures - February 2023
Issued 17.02.2023	News Release: TSDFT– New wheels for phlebotomists thanks to League of Friends
Issued 17.02.2023	For Info: Healthwatch Torbay e-bulletin 17 February 2023

Issue No. 99 Page 6 Date: 17 February 2023

LEAD GOVERNOR EMAILS

Here is a listing of emails you have been sent by the Lead Governor (via the FT Office) over the period Friday 03 February 2023 to Friday 17 February 2023:

Issued 08.02.2023 Levanto Care Home Briefing
Issued 08.02.2023 Email from Lead Governor: to John Kiddey with copy to all Governors

QUESTION AND ANSWERS SECTION

It was requested at the GGI Feedback session on Wed 6 July 2022 - that all current Governor questions are listed in the Fortnightly Newsletter and dates given (regardless of whether a response is still awaited). Please note that the current questions and responses are always added to the Governor Communications Log that is taken to each Council of Governors meeting.

Question ID No. 136 (a) (Andrew Stilliard) dated 30.01.2023 re. Panorama Long Covid

Hi, having just seen the above programme can I ask two questions.
1. When did the Trust know about the programme.
2. How many staff does the Trust have off work due to long Covid.
If possible can we know on Wednesday's meeting.

Answer ID No. 136 (a)-
- Response to Part 2 of Question above was received and listed in newsletter 03.02.2023
- Response to the Part 1 of the Question above has been allocated and response awaited.

Additional Question ID No. 136 (b) (Andrew Stilliard) dated 06.02.2023 re. Panorama Long Covid

My follow up question would be how many staff have had their contracts terminated after being off sick with Long Covid for more than 12months if any.

Answer ID No. 136 (b) from Michelle Westwood, Chief People Officer on 14.02.2023:

We have crossed referenced our spreadsheet with Selenity and can confirm we have had one staff member had their contract terminated after being off sick with Long Covid for more than 12 months. The outcome was determined following a process that explored and exhausted other options.

Selenity is an on-line data base where we record all cases that come into the Helpdesk. Any Formal cases will be recorded in here and each HR Representative also record's any formal meetings on Selenity that they are involved in for their appointed ISU's. All cases are tracked and monitored through Selenity.

MEETINGS LIST AND MS TEAMS LINKS SECTION

GOVERNOR MEETINGS - FEBRUARY 2023

22 February 2023 — **Public Board** (11.30am) (Face to Face meeting - Pomona House, Oak View Close, Torquay, TQ2 7FF)

GOVERNOR MEETINGS - MARCH 2023

07 March 2023 — **Governor "Only" Meeting** (2pm-4pm) (Face to Face meeting - Boardroom) (MS Teams link also listed below in case required)

08 March 2023 — **CoG Priorities Meeting** (2pm-4pm) (Face to Face meeting - Pomona House, Oak View Close, Torquay, TQ2 7FF) (MS Teams link also listed)

16 March 2023 — **Governors Coffee and Chat Session** (10.30-11.30am) (Video Conference), (MS Teams link listed below)

29 March 2023 — **Public Board** (11.30am) (Face to Face meeting - Pomona House, Oak View Close, Torquay, TQ2 7FF)

MS Teams Link: **Governor Only Meeting 07 March 2023** (2pm-4pm)

Join on your computer, mobile app or room device

Click here to join the meeting

Meeting ID: 389 598 312 286
Passcode: encR2s

Download Teams | Join on the web

Or call in (audio only)

+44 20 3321 5208,,677335509# United Kingdom, London

Phone Conference ID: 677 335 509#

MS Teams Link: **CoG Priorities Meeting 08 March** (14.00-16.00)

Microsoft Teams meeting

Join on your computer or mobile app

Click here to join the meeting

Meeting ID: 320 241 352 078
Passcode: G4i6WX

Download Teams | Join on the web

Or call in (audio only)

+44 20 3321 5208 318741134# United Kingdom, London

Phone Conference ID: 318 741 134#

MS Teams Link: **Governor Coffee and Chat Sessions** (10.30-11.30)

Microsoft Teams meeting

Join on your computer or mobile app

Click here to join the meeting (press control button and click at same time on underlined section)

Or call in (audio only)

020 3321 5208 644531308# United Kingdom, London

Phone Conference ID: 644 531 308#

HEALTHWATCH

Governors have recently been sent the Healthwatch Torbay e-bulletins as a direct method of informing you of their many activities. Therefore individual articles will no longer be extracted and listed in the Governor newsletter.

Latest Devon Healthwatch reports are listed here (Ctrl & Click) and latest Torbay Healthwatch reports are listed here (Ctrl & Click) if you wish to view.

Governors Fortnightly e-Newsletter

Torbay and South Devon
NHS Foundation Trust

Issue No. 100 Date: Friday 03 March 2023

Within this issue

- Chairman's Message
- Private CoG
- CoG Priorities Meeting
- Farewell to two Governors
- Torbay League of Friends Base
- New Governors
- Core Skills Training
- Governor Coffee Morning March
- Healthwatch
- Reminder: IT Drop In Sessions
- Governor Q & A
- Communications Department Brief
- Email Confirmations
- Meeting List and MS Teams Links

FT Office - please contact:

Tel: 01803 655705 or

Email: Foundationtrust.tsdft@nhs.net

NEWSLETTER INFORMATION

CELEBRATING THE 100TH EDITION OF THE GOVERNOR NEWSLETTER

MESSAGE FROM THE CHAIRMAN

Ladies and Gentlemen,

Welcome to the centenary edition of the Governor e-newsletter!

I write this introduction in times that remain challenging. Nurses and now doctors strikes, continuing high demand, a focus on reducing waiting lists and of course the growing impact of SOF4 are all topics keeping the Trust leadership focused. The Chief Executive and I have been called up to NHSE headquarters in London on 9 March. We are there along with the Devon ICS leaders and the other provider Trust Chairs and CEOs for a Board to Board regulatory reset meeting as a key part of SOF4. A considerable amount of effort is going into the preparation for that meeting. I will of course brief you on the outcome.

In the meantime, led by the Trust office we are planning the new Governor induction programme, having adjusted it to take account of your feedback. Activity on securing the EPR that you have been briefed about continues at pace, and is involving some short notice Board meetings to ensure that the bureaucracy doesn't in any way delay the decision processes.

It is good to see our Cancer waits reducing, and sustainable progress is now definitely going in the right direction. Some but not all of the elective activity is also starting to respond to treatment. The support and guidance that we are receiving from the people advising and directing as a consequence of SOF4, together with the continuing leadership from our interim COO are having a positive effect.

May I record my thanks to Mark Tyrrell-Smith for all the time and effort he has put into CoG activities during his time as a Governor. He leaves a most positive legacy. Many thanks also to Steven Harden, Public Governor for Torbay who has finished his term of office.

Finally, it will be good to have Emily Long back this month as our substantive Trust Secretary. Grateful thanks go to Sarah Fox and Sally-Ann Reay for the way they have managed in Emily's absence.

Best wishes, as ever, **Richard**

Issue No. 100 Page 2 Date: 3 March 2023

URGENT PRIVATE COUNCIL OF GOVERNORS MEETING

Reminder that an **Urgent Private Council of Governors (CoG) Meeting** is scheduled for **Tuesday 07 March 2023 at 3pm** on **MS Teams**.

This replaces the Governor Only Meeting which was originally scheduled for that day at 2pm. The Agenda/papers/and MS Teams link for the Private CoG meeting were circulated to all Governors by Sarah Fox on 24.02.2023.

If you are unable to take part, please can you send your apologies asap to the Foundation Trust email (foundationtrust.tsdft@nhs.net).

CoG PRIORITIES MEETING: WEDNESDAY 08 MARCH AT 2PM-4PM

Reminder that the next Council of Governors (CoG) Priorities meeting takes place on **Wednesday 08 March at 2pm—4pm at Pomona House**, Oak view Close, Torquay, TQ2 7FF. Refreshments will be provided. This meeting is face to face - we need to test the log on facility at Pomona House, which wasn't functioning for our team last time, so can't guarantee the hybrid facility will work on this particular occaision.

- The agenda and papers were issued to Governors on 01 March 2023. The key theme for the meeting is "**waiting lists**", one of the six key priorities that Governors identified at the end of 2022. There is an **additional presentation** by Loveday Densham under Item 7.
- Please note when you arrive at Pomona House and park your vehicle, take a note of the parking bay number, as you will be asked to provide this number along with your vehicle registration when you arrive at the Reception desk.

MAY CoG PRIORITIES MEETING - IS RESCHEDULED

The original May CoG Priorities meeting clashed with the revised date for the Dartmouth Health and Wellbeing Centre official opening and the FT Office was asked to reschedule.

Delighted to announce that this has been arranged for **Monday 15 May at 10am-12noon**, face to face in the Boardroom, Hengrave House (with MS Teams available if required). The FT Office will ask if we can obtain the large meeting room in Pomona House and if it is available, we will confirm arrangements.

The key topic for the 15 May CoG Priorities Meeting is "**Seven Day Working**" and the main speaker will be Kate Lissett. FT Office will ask Governors for specific themes/questions in advance as per usual nearer to the time.

We would be grateful if you could update your diaries accordingly and we have attached the revised meeting schedule V.10 to reflect this revision.

FAREWELL TO MARK TYRRELL-SMITH AND STEVEN HARDEN PLUS "WELCOME BACK" TO JOHN KIDDEY

The Foundation Trust Office would like to say a huge thank you and fond farewell to **Mark Tyrrell-Smith**, Public Governor for Torbay. Mark recently tendered his resignation and it took effect as of 28.02.2023.

Mark has played a very active part as a TSDFT Governor, being a key player in the work on the Governor Development Programme, the associated Workstreams and Governor Priorities.

We are also sadly saying goodbye to **Steven Harden**, Public Governor for Torbay who served four years in total but decided not to stand again at this most recent election. We wish both Steven and Mark the very best wishes for their future.

We are therefore delighted to announce that **John Kiddey** has agreed to stay on as a Public Governor for Torbay. Having been the next placed candidate in the recent elections, John will cover the remaining two year term of office vacated by Mark Tyrrell-Smith. John is Deputy Chair of the Membership Committee and previously had a successful career in journalism and broadcasting.

TORBAY LEAGUE OF FRIENDS

ICONews announced on 3 March 2023 that the Torbay Lead of Friends are now established in their new base, on level 4 at the main entrance in Torbay Hospital.

If you are on the site do pop in and say hello to them and they are selling a range of items every Wednesday.

NEW GOVERNORS APPOINTED

A warm welcome to our new Governors who were appointed as of 01 March 2023:

We are delighted that you are able to join us and we now have a total of 31 out of the 33 Governor positions filled which is amazing!

- **Mrs Val Browning (South Hams and Plymouth Constituency)**
- **Mr James Hartley (Teignbridge Constituency)**
- **Mr Andrew Postlethwaite (Teignbridge Constituency)**
- **Mrs Alison Ramon (Torbay Constituency)**
- **Mr Lee Thomas (Torbay Constituency)**
- **Mr Sal Aziz (Staff Governor for Torquay Integrated Service Unit)**
- **Dr Jonathan Shribman (Staff Governor for Newton Abbot Integrated Service Unit)**
- **Professor Chrissie Thirlwell (Appointed Governor for University of Exeter Medical School)**
- **Associate Professor Louise Winfield (Appointed Governor for Plymouth University School of Medicine and Dentistry)**
- **Mrs Hilary Milner (Appointed Governor for Torbay Carers Strategy Steering Group)**
- **Mrs Clare McAdam (Appointed Governor for Devon Partnership Trust)**
- **Cllr Andrew MacGregor (Appointed Governor for Teignbridge Council)**

(Mr Andrew Stilliard was re-appointed for Torbay Constituency and Mr John Kiddey remains a Torbay Governor—filling the remainder of the term of office vacated by Mr Tyrrell-Smith).

Biographies and photographs of the new Governors will be included in future editions of this newsletter for information, as they become available.

Once all new photos have been received, the Foundation Trust Office will produce a new map/photograph poster of all Governors.

IMPORTANT:
NHS PROVIDERS CORE SKILLS OVERVIEW TRAINING ONLINE VIA ZOOM- 20 MARCH 2023

New Governors have been offered first take up on the **NHS Providers "Core Skills" Overview Training** booked by the Trust on **20 March 2023**.

This will be held virtually via zoom. (Governors were asked to note the date in their diaries in previous newsletter editions).

Timings:

Section 1—9.30am prompt start, and 12.30pm break for lunch

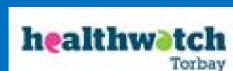
Section 2—2pm prompt start and closes at 4.30pm.

- **As there will be some spare spaces—please can Governors who had not undertaken this course previously and are interested in taking part - email the Foundation Trust Office by 9am on Friday 10 March** so we can provide full details to the NHS Providers training team and pre-reading can be issued out
- This course provides a comprehensive overview of the structure of the NHS and the statutory role and responsibilities of governors.
- It **will also** have sessions on Governor engagement with the public **and** sessions on NHS Finance. This training builds on a trust's induction programme to help governors learn and discuss issues from a position of insight from having initial experience in their role.

INFORMAL MONTHLY COFFEE AND CHAT SESSIONS

Reminder that the next **informal Coffee and Chat session,** set up by the Lead Governor and Deputy Lead Governor, is on **Thursday 16 March 2023 at 10.30am** (one hour) and the MS Teams invite is listed at the back of this newsletter.

HEALTHWATCH



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Latest Devon Healthwatch reports are listed here (Ctrl & Click) and latest Torbay Healthwatch reports are listed here (Ctrl & Click) if you wish to view.

IT DROP-IN SESSIONS - INFORMAL HELP

The FT Office arranged two **IT Drop-In Sessions** during February for our **existing Governors**. There are two more sessions arranged during March and **ALL Governors are welcome to attend - New intake of Governors and previous cohorts, are welcome.**

These will be informal and friendly - drop in anytime during 1pm and 4pm at the Horizon Centre, at Torbay Hospital.

No need to book, no charge and tea/coffee and biscuits provided. ☺

Please bring your usual device that you log on for Trust work - be that your mobile, your tablet, or your laptop (plus charging wires). If you usually work off a desk computer then the Horizon Centre do have a few laptops we can "lend" for the session.

These will be run by **Claire Brown who is a Trust IT Applications Trainer** and Sally-Ann Reay, Membership Manager will be attendance to assist.

DATES AND TIMES:

09 March—from 1pm to 4pm—drop in at Horizon Centre

14 March - from 1pm to 4pm—drop in at Horizon Centre

QUESTION AND ANSWERS SECTION

It was requested at the GGI Feedback session on Wed 6 July 2022 - that all current Governor questions are listed in the Fortnightly Newsletter and dates given (regardless of whether a response is still awaited). Please note that the current questions and responses are always added to the Governor Communications Log that is taken to each Council of Governors meeting.

Question ID No. 136 (a) (Andrew Stilliard) dated 30.01.2023 re. Panorama Long Covid

Hi, having just seen the above programme can I ask two questions.
1. When did the Trust know about the programme.
2. How many staff does the Trust have off work due to long Covid.
If possible can we know on Wednesday's meeting.

Answer ID No. 136 (a)-

- Response to Part 2 of Question above was received and listed in newsletter 03.02.2023
- Response to the Part 1 of the Question above has been allocated and response awaited.

Issue No. 100 Page 7 Date: 3 March 2023

COMMUNICATIONS DEPARTMENT BRIEF

Latest reported COVID-19 data

Detailed information is published weekly on NHS England's website. The information below for the latest full week published from Monday 13 February 2023 to Sunday 19 February 2023 is extracted from that website and presents a snapshot of our position.

The data can be found on the national NHS website here: https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-hospital-activity/

COVID-19 data snapshot – Monday 13 February to Sunday 19 February 2023

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
COVID-19 admissions and inpatients diagnosed	8	3	4	2	2	4	5
New admissions to hospital from the community	5	1	2	1	2	0	3
New hospital admissions from a care home	1	0	1	0	0	0	0
Beds occupied by COVID-19 patients	15	20	25	28	28	23	24
Mechanical ventilation beds (ICU) occupied by COVID-19 patients	0	0	0	0	0	0	0
Deaths recorded (within 28 days of COVID-19 positive test during pandemic period)	0	0	0	0	0	0	0

	01 Feb
COVID-19 discharges from hospital	1
COVID-19 related staff ab-sences	28

Discharge and staff absence information is published on a monthly basis.

Media

- New wheels for phlebotomists – celebrating the generosity of Torbay Hospital League of Friends who have provided funding for brand new trollies and equipment which will support our phlebotomy services
- Specialty careers fair – promoting the peninsula careers fair for foundation trainee doctors that we will be hosting in Torquay in March
- Teignmouth Community Hospital protest – following a protest on the future of Teignmouth Community Hospital, our response outlined our commitment to working together with local stakeholders on the future of the site

Continued on next page/……

Social Media

- Torbay SEND pledge – highlighting our partnership of organisations' commitment to improving services for children with SEND in Torbay
- Vote for new naming theme – calling on the public to vote for our new naming theme for future new buildings, wards and departments
- Hospital timeline wall – pictures of our history timeline at Torbay Hospital
- Looking for relatives – calling on members of the public to let us know if they are relatives of Mr W R Northcott, Major Kitson, Rev Hetherington, Mrs K R Bryant or others who have had wards and buildings named after them
- Meet the finalists – video of the Our People's Choice Award finalists and a link to where the public can vote for their winner
- NHS careers for military service leavers – promoting an event aimed at highlighting the opportunities available in the NHS for service leavers, veterans and their families
- 5k your way one year anniversary – promoting the 5k your way parkrun event, for those affected by cancer to take part 'their way'

We hope this information is useful, but please do give us any feedback, via the Foundation Trust Office, as it is always welcomed and helps us continually improve the information we send out.

EMAIL CONFIRMATION

The Foundation Trust Office and Comms Team regularly send you emails. Here is a listing of those sent over the period from Friday 17 February 2023 to Friday 03 March 2023:

Issued 21.02.2023	TSDFT - News Release: Specialty careers fair funded by Health Education England
Issued 21.02.2023	Important: Briefing to Governors: BBC Spotlight coverage today
Issued 23.02.2023	Reminder and also information re. "suspicious emails" - IT Drop-in sessions for Governors: available on Monday 27 February
Issued 23.02.2023	Public Council of Governors draft minutes and updated Action Tracker - from the meeting held on 01 February 2023 - for your information
Issued 24.02.2023	Notification of an Urgent Private Council of Governors (CoG) Meeting
Issued 27.02.2023	For Action: Updated "All Governors" Meeting List for 2023—Version 10—two changes
Issued 01.03.2023	Council of Governors (CoG) Priorities Meeting - Wed 08 March at 2pm-4pm - Agenda and Papers attached
Issued 01.03.2023	One Devon Bulletin - February 2023
Issued 03.03.2023	Healthwatch Torbay e-bulletin 02 March 2023

LEAD GOVERNOR EMAILS

Here is a listing of emails you have been sent by the Lead Governor (via the FT Office) over the period Friday 17 February 2023 to Friday 03 March 2023:

Issued 24.02.2023	Email sent on behalf of the Lead Governor to Mark Tyrrell-Smith with a request that all Governors are copied in

Issue No. 100 | Page 9 | Date: 03 March 2023

MEETINGS LIST AND MS TEAMS LINKS SECTION

GOVERNOR MEETINGS - MARCH 2023

07 March 2023 — **Private Council of Governors Meeting** (3pm) (MS Teams Video Conference - link re-attached listed below to assist) * Please note this replaces the Governor Only meeting which was originally scheduled.

08 March 2023 — **CoG Priorities Meeting** (2pm-4pm) (Face to Face meeting - Pomona House, Oak View Close, Torquay, TQ2 7FF) (only available face to face)

16 March 2023 — **Governors Coffee and Chat Session** (10.30-11.30am) (Video Conference), (MS Teams link listed below at bottom of page)

29 March 2023 — **Public Board** (11.30am) (Face to Face meeting - Pomona House, Oak View Close, Torquay, TQ2 7FF)

MS Teams Link: **PRIVATE Council of Governors Meeting: 07 March 2023** (3pm)

Join on your computer, mobile app or room device

Click here to join the meeting

Meeting ID: 389 598 312 286
Passcode: encR2s

Download Teams | Join on the web

Or call in (audio only)

+44 20 3321 5208,,677335509# United Kingdom, London

Phone Conference ID: 677 335 509#

MS Teams Link: **Governor Coffee and Chat Sessions** (10.30-11.30)

Microsoft Teams meeting

Join on your computer or mobile app

Click here to join the meeting (press control button and click at same time on underlined section)

Or call in (audio only)

020 3321 5208 644531308# United Kingdom, London

Phone Conference ID: 644 531 308#

Continued on next page

GOVERNOR MEETINGS - APRIL 2023

11 April 2023 — **Governor Only Meeting** (2pm-4pm) (Face to Face meeting - Boardroom, Hengrave House) (MS Teams link also listed below if unable to attend face to face)

20 April 2023 — **Governors Coffee and Chat Session** (10.30-11.30am) (Video Conference), (MS Teams link listed on page 8)

26 April 2023 — **Public Board** (11.30am) (Face to Face meeting - Pomona House, Oak View Close, Torquay, TQ2 7FF)

MS Teams Link: **Governor Only Meeting - 11 April** (14.00-16.00)

Join on your computer, mobile app or room device

Click here to join the meeting

Meeting ID: 316 133 122 699
Passcode: DHH2ee

Download Teams | Join on the web

Or call in (audio only)

020 3321 5208,,994013743# United Kingdom, London

Phone Conference ID: 994 013 743#

Governors Fortnightly e-Newsletter

Torbay and South Devon
NHS Foundation Trust

Issue No. 101 Date: Friday 17 March 2023

Within this issue

- Lead Governor and Deputy Lead Governor role
- Governor Observer Roles Refresh
- Meeting Updates
- Chief Operating Officer Update
- Blue Governor Information Folders
- Calendar Invites
- Chairman/NED appraisals
- Membership Cttee
- Trust Updates
- Governor Q & A
- Governor Observer Reports
- Communications Department Brief
- Email Confirmations
- Meeting List and MS Teams Links

FT Office - please contact:

Tel: 01803 655705 or

Email: Foundationtrust.tsdft@nhs.net

The aim of this e-Newsletter is to give you a regular round up of future items of interest and confirm items that have been sent to you by the Foundation Trust Office and other sections of the ICO.

Please continue to read this newsletter each fortnight as this is a key method of communication with Governors - thank you.

PUBLIC GOVERNORS:

LEAD GOVERNOR AND DEPUTY LEAD GOVERNOR ROLE REFRESH

The FT Office emailed all Public Governors on 16.03.23 to ask for nominations if anyone interested in standing for the role of Lead Governor or Deputy Lead Governor. The roles are **refreshed** on an annual basis in April/May, with nominations taken to the Council of Governors (CoG) meeting on 03 May 2023. If more than one Governor applies for one of the positions, a secret ballot will be held at the May CoG meeting.

Please be aware that you have to submit emails from a proposer and seconder to the FT Office by the **deadline of Monday 10 April at 9am** in order to be registered, clearly indicating who is being nominated and for which role.

GOVERNOR OBSERVER ROLES REFRESH

The FT Office emailed all Governors on 16.03.23 to invite you to consider standing for one or more of the **Governor Observer roles on the Board Level Sub-Committees.**

These roles are renewed on an annual basis in April/May each year. Details were given in the email and you can also contact Sarah Fox, Corporate Governance Manager via the FT email if you would like an informal chat to discuss.

Please email FT office by Monday 10 April at 9am stating your preference in numerical order. Thank you

PUBLIC BOARD MEETINGS

To assist New Governors we thought it would be useful to remind Governors that they are always welcome to **observe** the open Public Board sessions each month at 11.30am, but attendance is not obligatory.

Governors are sent the link to the Public Board papers prior to the meeting by the FT Office and are reminded that if you wish to attend, please let the FT Office know, so that sufficient car parking spaces are reserved at Pomona House.

GOVERNOR ONLY MEETING: TUESDAY 11 APRIL AT 2PM - 4PM

Reminder that the next **Governor Only meeting** takes place on **Tuesday 11 April at 2pm - 4pm in the Boardroom,** Hengrave House, Torbay Hospital. This meeting is face to face, however MS Teams link will be available if you are only able to attend remotely. (attendance is voluntary).

The agenda and papers will be issued a week in advance. We look forward to seeing you there. Refreshments will be provided.

MAY CoG PRIORITIES MEETING - venue update

The May CoG Priorities meeting was rescheduled for **Monday 15 May at 10am-12noon** and we can now confirm that we have managed to obtain the large meeting room at **Pomona House**, Oak View Close, Torquay, TQ2 7FF (with MS teams available if unable to join us face to face).

The key topic for the 15 May CoG Priorities Meeting is "**Seven Day Working**" and the main speaker will be Kate Lissett. FT Office will ask Governors for specific themes/questions in advance as per usual nearer to the time.

We would be grateful if you could update your diaries accordingly regarding the revised venue and we have attached the revised meeting schedule V.11 to reflect this revision.

CHIEF OPERATING OFFICER - UPDATE

ICONews on 17.03.23 announced that after due consideration of the candidates interviewed for Chief Operating Officer position on 21 February 2023, the decision was made not to appoint at this time.

The Trust will be speaking to their recruitment consultants (Gatenby Sanderson) and in the meantime, Jon Scott will continue as our Chief Operating Officer for a further six months.

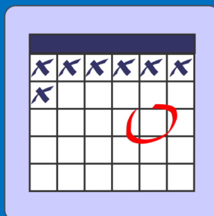
Issue No. 101 Page 3 Date: 17 March 2023

BLUE GOVERNOR INFORMATION FOLDERS - UPDATED 2023

The Foundation Trust Office have been working extremely hard in order to get the updated 2023 Blue Governor Information Folders available for the new Governors who joined us on 1 March 2023.

Please be re-assured that once these have been completed for all new Governors next week, we will print more packs ready to issue to existing Governors, with the aim that you will all have an up to date hard copy by end April 2023.

CALENDAR INVITES



The FT Office now have a list of 16 Governors who have said they are happy to receive calendar invites for Governor meetings.

If any other Governors wish to take up the offer of having calendar diary invites then please email the FT Office on foundationtrust.tsdft@nhs.net. Thank you.

We will continue to provide details (and MS Teams links) via email. Information is also included at the back of the fortnightly e-newsletter. (Please be aware that some Governors have encountered technical issues downloading MS Teams links via the newsletter).

CHAIRMAN AND NON-EXECUTIVE DIRECTORS (NEDS) APPRAISAL FEEDBACK 2023

The Foundation Trust Office issued an email on 10.03.2023 detailing the process by which feedback would be obtained from Governors to inform the Chair/NED appraisal process this year.

New Governors were included in the email for information, but are not expected to provide feedback this year or attend the workshop on 12 April at 2pm-4pm.

Could **existing Governors** who wish to provide feedback via the template - do so by **Friday 24 March** to the FT Office email and confirm their attendance at the workshop, as appropriate.

MEMBERSHIP COMMITTEE

New Governors may spot that within the meeting schedule on Page 8 of this newsletter there is a quarterly Membership Committee on 20 April 2023 in the afternoon. This is for Committee members only. However, if you are interested in joining the Committee and getting involved with the wider work of public engagement by Governors then please do contact the Chair of the Committee (Eileen Engelmann) or John Kiddey (Deputy Chair) to have a chat about what it involves. (e.engelmann@nhs.net) or (john.kiddey@nhs.net).

STAFF SURVEY RESULTS

An All Staff email was issued on 09.03.2023 summarising some of the key results of the latest Staff Survey. The Trust maintained or improved performance in four of the nine elements and also detailed areas in which more improvement work is required. More detail can be viewed online here.

INDUSTRIAL ACTION IMPACT

Recent ICONews editions gave details that it has been necessary to stop some of our outpatient appointments and some of our operations have been cancelled due to the 72-hour strike by Junior Doctors (week commencing 13 March). The Trust respect the right of our staff taking industrial action and our responsibility is to ensure we maintain patient safety and access to services for people in our community.

(SOF4) ARRANGMENENTS UPDATE

ICONews on 13.03.2023 gave an update from Liz Davenport, Chief Executive on the System Oversight Framework (SOF4) arrangements:

"The chairs and chief executives of all the provider organisations, including the integrated care system, met the national team last week. It was set up as part of our SOF 4 arrangements and is part of the regulatory framework that applies to provider organisations. Their job was to ensure the plan we have maintains the highest level of performance in terms of clinical delivery, financial performance and patient safety. It was a constructive and challenging meeting as they are keen to make sure that we continue to do our best for our population. We expect to have regular meetings during the coming months as we finalise our operating plan for 23/34 and access performance against that plan as the year goes on".

Whilst Governors can view the weekly staff e-newsletter called ICONews, they are unable to access the staff intranet called ICON. However you can view individual stories which are also uploaded to our staff website called the 'Staff Room'. This can be found by typing: https://staff.tsdft.uk into your web search browser. *(Please be aware this is for use by staff and Governors, not for the wider public).*

Issue No. 101 Page 5 Date: 17 March 2023

QUESTION AND ANSWERS SECTION

It was requested at the GGI Feedback session on Wed 6 July 2022 - that all current Governor questions are listed in the Fortnightly Newsletter and dates given (regardless of whether a response is still awaited). Please note that the current questions and responses are always added to the Governor Communications Log that is taken to each Council of Governors meeting.

Question ID No. 136 (a) (Andrew Stilliard) dated 30.01.2023 re. Panorama Long Covid

Hi, having just seen the above programme can I ask two questions.
1. When did the Trust know about the programme.
2. How many staff does the Trust have off work due to long Covid.
If possible can we know on Wednesday's meeting.

Answer ID No. 136 (a)-

- Response to Part 2 of Question above was received and listed in newsletter 03.02.2023
- Response to the Part 1 of the Question response received from Liz Davenport, Chief Executive on 16.03.2023 is listed below:

We were advised that BBC Panorama had interviewed a member of our staff for a programme on Monday 09 January 2023. At this point we did not have the detail of the allegations. Over the next few weeks we worked to establish the facts of the case, liaising with our solicitors and key colleagues, while waiting for confirmation from the BBC of a broadcast date.

I am sorry for the delay.

GOVERNOR OBSERVER REPORTS

Governor Observer reports from Board level sub-committees are issued with the e-newsletter for your information:

- Building a Brighter Future Committee GO Report of 15.02.2023
- We have also been asked to circulate the handwritten notes that Annie Hall (Teignbridge Public Governor) takes following her attendance as an observer at the monthly Feedback and Engagement Group meetings that she attends on behalf of the Membership Committee

Issue No. 101 Page 6 Date: 17 March 2023

COMMUNICATIONS DEPARTMENT BRIEF

Latest reported COVID-19 data

Detailed information is published weekly on NHS England's website. The information below for the latest full week published from Monday 06 March 2023 to Sunday 12 March 2023 is extracted from that website and presents a snapshot of our position.

The data can be found on the national NHS website here: https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-hospital-activity/

COVID-19 data snapshot – Monday 06 March 2023 to Sunday 12 March 2023

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
COVID-19 admissions and in-patients diagnosed	6	5	3	3	1	5	9
New admissions to hospital from the community	4	4	3	2	0	2	3
New hospital admissions from a care home	0	0	0	0	0	0	0
Beds occupied by COVID-19 patients	36	36	28	28	26	25	20
Mechanical ventilation beds (ICU) occupied by COVID-19 patients	1	1	1	1	1	1	1
Deaths recorded (within 28 days of COVID-19 positive test during pandemic period)	0	0	0	0	0	0	0

	01 Mar
COVID-19 discharges from hospital	4
COVID-19 related staff ab-sences	45

Discharge and staff absence information is published on a monthly basis.

Media

- Trust Chairman to serve further one-year term – announcing the news that Sir Richard Ibbotson, Chairman will be serving a further one year term
- Ambulance queues enquiry – providing reassuring messages following reports of ambulance queues and traffic control measures at Torbay Hospital
- Junior doctors strikes enquiry – responding to enquiries about the effects of strike action on services

Continued on next page/......

Issue No. 101 Page 7 Date: 17 March 2023

Social Media

- Torbay Hospital League of Friends new base – promoting the League of Friends new base in the level 4 main entrance foyer at Torbay Hospital
- Maternity services pledge – sharing the news that maternity services have signed a charter to show their continued commitment to providing a healthy and safe work environment for our people
- International Women's Day – thanking the women working across our organisation who are incredibly hard working and provide excellent care
- Devon NHS campaign survey – sharing a survey for the NHS in Devon to find out about public awareness of regional and national NHS campaigns
- Job of the week – promoting the physiotherapy career opportunities we currently have available
- Primrose award – encouraging nominations from members of the public for excellent care and support they have received from one of our healthcare support workers

We hope this information is useful, but please do give us any feedback, via the Foundation Trust Office, as it is always welcomed and helps us continually improve the information we send out.

EMAIL CONFIRMATION

The Foundation Trust Office and Comms Team regularly send you emails. Here is a listing of those sent over the period from Friday 03 March 2023 to Friday 17 March 2023:

Issued 06.03.2023	Governor Register of Interests *(previous governors only)*
Issued 08.03.2023	Important: Wednesday 08 March - CoG Priorities Meeting at Pomona House, unfortunately only able to offer face to face - not MS Teams
Issued 09.03.2023	Reminder: Next Governor Coffee Morning (online chat) is on Thursday 16 March at 10.30am - here is the link if you need
Issued 10.03.2023	20220-23 Chair/NED Appraisal Feedback
Issued 10.03.2023	Confidential Slides - NOT for onward transmission - from COG Priorities meeting held on Wednesday 8 March 2023
Issued 10.03.2023	Healthwatch Torbay e-bulletin 09 March 2023
Issued 15.03.2023	News Release: NHS Trust Chair to serve further one-year term
Issued 15.03.2023	Healthwatch Torbay e-bulletin 15 March 2023
Issued 16.03.2023	Important: Nominations for Governor Observer roles on Board Level Sub-Committees
Issued 16.03.2023	*(To Public Governors only)*: Refresh of Lead Governor/Deputy Lead Governor
Issued 17.03.2023	Governor Parking Permits

HEALTHWATCH

Governors have recently been sent the Healthwatch Torbay e-bulletins as a direct method of informing you of their many activities. Therefore individual articles will no longer be extracted and listed in the Governor newsletter.

Latest Devon Healthwatch reports are listed here (Ctrl & Click) and latest Torbay Healthwatch reports are listed here (Ctrl & Click) if you wish to view.

MEETINGS LIST AND MS TEAMS LINKS SECTION

GOVERNOR MEETINGS - REMAINDER OF MARCH 2023

29 March 2023 — **Public Board** (11.30am) (Face to Face meeting - Pomona House, Oak View Close, Torquay, TQ2 7FF) - (*Optional, attendance not obligatory).*

GOVERNOR MEETINGS - APRIL 2023

11 April 2023 — **Governor Only Meeting** (2pm-4pm) (Face to Face meeting - Boardroom, Hengrave House) (MS Teams link also listed on page 9, if unable to attend face to face) *(Optional, attendance not obligatory).*

20 April 2023 — **Governors Coffee and Chat Session** (10.30-11.30am) (Video Conference), (MS Teams link listed on page 9) *(Optional, attendance not obligatory).*

20 April 2023 — **Membership Committee** * (2pm-4pm) (Face to Face meeting - Boardroom, Hengrave House) (MS Teams link also listed on page 9 if Committee Members unable to attend face to face) *(* Committee members only)*

26 April 2023 — **Public Board** (11.30am) (Face to Face meeting - Pomona House, Oak View Close, Torquay, TQ2 7FF) *(Optional, attendance not obligatory).*

GOVERNOR MEETINGS - MAY 2023

03 May 2023 — **Council of Governors Meeting** (2pm-4pm) (Face to Face meeting — Boardroom, Hengrave House) (Attendance required - *if unable to attend please send apologies to FT Office, as these are logged).*

15 May 2023 — **CoG Priorities Meeting (10am-12noon)** (Face to Face meeting - Pomona House, Oak View Close, Torquay, TQ2 7FF) - (MS Teams link also listed on page 9 if unable to attend face to face) (*Optional, attendance not obligatory)*

18 May 2023 — **Governors Coffee and Chat Session** (10.30-11.30am) (Video Conference), (MS Teams link on page 9) *(Optional, attendance not obligatory).*

31 May 2023 — **Public Board** (11.30am) (Face to Face meeting - Pomona House, Oak View Close, Torquay, TQ2 7FF) - (*Optional, attendance not obligatory).*

Continued on next page

Issue No. 101 Page 9 Date: 17 March 2023

MS Teams Link: **Governor Only Meeting - 11 April** (14.00-16.00)

Join on your computer, mobile app or room device

Click here to join the meeting

Meeting ID: 316 133 122 699
Passcode: DHH2ee

Download Teams | Join on the web

Or call in (audio only)

020 3321 5208,,994013743# United Kingdom, London

Phone Conference ID: 994 013 743#

MS Teams Link: **Governor Coffee and Chat Sessions** (10.30-11.30)

Microsoft Teams meeting

Join on your computer or mobile app

Click here to join the meeting (press control button and click at same time on underlined section)

Or call in (audio only)

020 3321 5208 644531308# United Kingdom, London

Phone Conference ID: 644 531 308#

MS Teams Link: **Membership Committee * - 20 April** (2pm-4pm)

* Committee members only

Join on your computer or mobile app

Click here to join the meeting

Meeting ID: 318 329 973 956
Passcode: DP45PK

Download Teams | Join on the web

Or call in (audio only)

020 3321 5208 635562075# United Kingdom, London

Phone Conference ID: 635 562 075#

MS Teams Link: **CoG Priorities Meeting: 15 May 2023** (10am-12noon)

Microsoft Teams meeting

Join on your computer, mobile app or room device

Click here to join the meeting

Meeting ID: 338 360 559 014
Passcode: 4UiTAr

Download Teams | Join on the web

Or call in (audio only)

020 3321 5208,,697781559# United Kingdom, London

Phone Conference ID: 697 781 559#

Governors Fortnightly e-Newsletter

Torbay and South Devon
NHS Foundation Trust

Issue No. 102

Date: Friday 31 March 2023

Within this issue

- Lead Governor and Deputy Lead Governor role
- Governor Observer Roles Refresh
- Governor Only Meeting April
- Teignmouth Hospital Briefing
- Chairman/NED appraisals
- System Pressures
- Northcott Hall
- Public Emergency Alerts
- Governor Observer Reports
- Calendar Invites
- Governor Q & A
- Healthwatch
- Public Board
- Leonardo
- Communications Department Brief
- Email Confirmations
- Meeting List and MS Teams Links

FT Office - please contact:

Tel: 01803 655705 or

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Please continue to read this newsletter each fortnight as this is a key method of communication with Governors - thank you.

REMINDER TO PUBLIC GOVERNORS:

LEAD GOVERNOR AND DEPUTY LEAD GOVERNOR ROLE REFRESH

The FT Office emailed all Public Governors on 16.03.23 to ask for nominations if anyone interested in standing for the role of Lead Governor or Deputy Lead Governor. The roles are **refreshed** on an annual basis in April/May, with nominations taken to the Council of Governors (CoG) meeting on 03 May 2023. If more than one Governor applies for one of the positions, a secret ballot will be held at the May CoG meeting.

Please be aware that you have to submit emails from a proposer and seconder to the FT Office by the **deadline of Monday 10 April at 9am** in order to be registered, clearly indicating who is being nominated and for which role.

GOVERNOR OBSERVER ROLES REFRESH

The FT Office emailed all Governors on 16.03.23 to invite you to consider standing for one or more of the **Governor Observer roles on the Board Level Sub-Committees.**

These roles are renewed on an annual basis in April/May each year. Details were given in the email and you can also contact Sarah Fox, Corporate Governance Manager via the FT email if you would like an informal chat to discuss.

Please email FT office by Monday 10 April at 9am stating your preference in numerical order. Thank you

GOVERNOR ONLY MEETING: TUESDAY 11 APRIL AT 2PM - 4PM

Reminder that the next **Governor Only meeting** takes place on **Tuesday 11 April at 2pm - 4pm in the Boardroom,** Hengrave House, Torbay Hospital. This meeting is now being held via MS Teams only (it was previously face to face). (attendance is voluntary).

The agenda and papers will be issued a week in advance.

We look forward to seeing you there. Refreshments will be provided.

TEIGNMOUTH HOSPITAL BRIEFING

Governors were emailed on behalf of Jane Harris, Associate Director of Communications and Partnerships on 22.03.23 with a briefing regarding the outcome of Devon County Council (DCC) Overview and Scrutiny Committee (OSC) discussion on 21 March in relation to Teignmouth Hospital.

Full details were given in the briefing and the Communications Department will keep Governors informed as these matters progress.

CHAIR/NON-EXECUTIVE DIRECTORS (NEDS) APPRAISAL WORKSHOP 12 APRIL, 2PM-5PM— NOW VIA TEAMS ONLY

Governors were emailed by FT Office on 10.03.2023 detailing the process by which feedback would be obtained from Governors to inform the Chair/NED appraisal process this year.

New Governors were included in the email for information, but are not expected to provide feedback this year or attend the workshop on 12 April 2023.

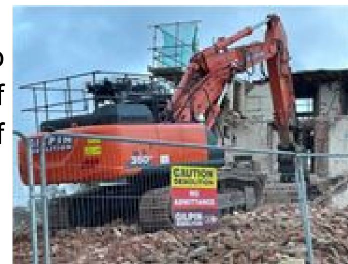
Please could all other Governors confirm if they plan to attend by emailing the FT Office (foundationtrust.tsdft@nhs.net). Thank you.

SYSTEM PRESSURES ACROSS DEVON

ICONews of 20.03.2023 gave an update from Dave Stacey, Deputy Chief Executive on system pressures across Devon, with lower discharges than usual, impacting on flow. In addition there was a significant increase in Covid-19 cases.

GOODBYE TO NORTHCOTT HALL

ICONews on 24.03.2023 gave an update on the recent work to demolish Northcott Hall, which took just over a week. This is part of the work to make way for new developments to our estate as part of the Building a Brighter Future (BBF) programme.



PUBLIC EMERGENCY ALERTS

ICONews reported on 24.03.2023 on the new system that will give the Government and emergency services the capability to send an alert directly to mobile phones when there is a risk to life.

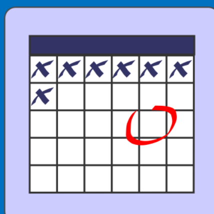
A UK-wide alerts test will take place in the early evening of Sunday 23 April, which will see people receive a test message on their mobile phones. Please be aware that the alerts will only ever come from the Government or emergency services. More information can be found on the Government website (link here)

GOVERNOR OBSERVER REPORTS

Governor Observer reports from Board level sub-committees are issued with the e-newsletter for your information:

- People Committee GO Report of 20.02.2023
- Building a Brighter Future GO Report of 15.03.2023

CALENDAR INVITES



The FT Office now have a list of 16 Governors who have said they are happy to receive calendar invites for Governor meetings.

If any other Governors wish to take up the offer of having calendar diary invites then please email the FT Office on foundationtrust.tsdft@nhs.net. Thank you.

We will continue to provide details (and MS Teams links) via email. Information is also included at the back of the fortnightly e-newsletter. (Please be aware that some Governors have encountered technical issues downloading MS Teams links via the newsletter).

Issue No. 102 Page 4 Date: 31 March 2023

QUESTION AND ANSWERS SECTION

It was requested at the GGI Feedback session on Wed 6 July 2022 - that all current Governor questions are listed in the Fortnightly Newsletter and dates given (regardless of whether a response is still awaited). Please note that the current questions and responses are always added to the Governor Communications Log that is taken to each Council of Governors meeting.

Question ID No 137— (Matt Arthur) dated 28.03.2023 re Heating

Why is it that when the environmental temperature is improving, that the heating within our estate is still operational to a level that many areas are having to open windows to regulate their working environment? Is the estate infrastructure not controllable so that heating levels can be adjusted rather than it seemingly being an on/off system?

HEALTHWATCH

Governors have recently been sent the Healthwatch Torbay e-bulletins as a direct method of informing you of their many activities. Therefore individual articles will no longer be extracted and listed in the Governor newsletter.

Latest Devon Healthwatch reports are listed here (Ctrl & Click) and latest Torbay Healthwatch reports are listed here (Ctrl & Click) if you wish to view.

PUBLIC BOARD

To assist New Governors we thought it would be useful to remind Governors that they are always welcome to **observe** the open Public Board sessions each month at 11.30am, but attendance is not obligatory.

Governors are sent the link to the Public Board papers prior to the meeting by the FT Office and are reminded that if you wish to attend, please let the FT Office know, so that sufficient car parking spaces are reserved at Pomona House.

Welcome to Leonardo our interactive adult trauma simulator

We recently welcomed Leonardo into our emergency department (ED) thanks to £64,000 and £1,400 innovation bids we won to buy him.

Leonardo is a hi tech, lifelike, fully interactive adult trauma simulator that can be programmed to display a range of symptoms and conditions, from cardiac arrest to respiratory issues. With the ability to simulate real-time responses, the simulator provides realistic training for our staff to develop their skills.

He will be used to train doctors in acute and ED trauma situations as well as enable multidisciplinary training for allied health professionals across a range of clinical skills areas.

Issue No. 102 Page 5 Date: 31 March 2023

COMMUNICATIONS DEPARTMENT BRIEF

Latest reported COVID-19 data

Detailed information is published weekly on NHS England's website. The information below for the latest full week published, from Monday 20 March 2023 to Sunday 26 March 2023, is extracted from that website and presents a snapshot of our position.

The data can be found on the national NHS website here: https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-hospital-activity/

COVID-19 data snapshot – Monday 20 March 2023 to Sunday 26 March 2023

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
COVID-19 admissions and inpatients diagnosed	4	8	5	2	6	3	2
New admissions to hospital from the community	3	4	4	2	5	3	1
New hospital admissions from a care home	0	0	0	0	0	0	0
Beds occupied by COVID-19 patients	42	27	30	36	38	28	29
Mechanical ventilation beds (ICU) occupied by COVID-19 patients	1	1	1	2	2	2	2
Deaths recorded (within 28 days of COVID-19 positive test during pandemic period)	0	0	0	0	0	0	0

	01 Mar
COVID-19 discharges from hospital	4
COVID-19 related staff absences	45

Discharge and staff absence information is published on a monthly basis.

Media/social media activity

Media

- Ward recognised with nursing excellence award – release celebrating Dunlop ward who were recognised as our 2022 annual DAISY award winner
- New Hospital Programme update – received enquiries about our NHP progress ahead of an expected announcement following the budget

Social Media

- BME leadership programme – congratulating the first of our cohorts who completed the BME leadership programme which supported their own individual development
- Quality board stands – encouraged staff and visitors to say hello to the team at main entrance and find out more about our new ward quality boards
- World Social Work Day – celebrating the contributions of our social workers and thanking them for the vital role they play in helping individuals and families in need
- Sexually Transmitted Infections – sharing information on free, confidential STI testing following a rise in cases nationally
- Fundraising for our charity – encouraging people to take part in upcoming fundraising events for our charity, with reduced entry fee charity places on offer
- Totnes Minor Injuries Unit temporary closure – raising public awareness that our MIU at Totnes was closed one day this week
- Healthy Futures – promoting the latest edition of our newsletter Healthy Futures

We hope this information is useful, but please do give us any feedback, via the Foundation Trust Office, as it is always welcomed and helps us continually improve the information we send out.

EMAIL CONFIRMATION

The Foundation Trust Office and Comms Team regularly send you emails. Here is a listing of those sent over the period from Friday 17 March 2023 to Friday 31 March 2023:

Issued 21.03.2023	For Information: the presentation slides from NHS Providers at the Core Skills training - which some of the New Governors attended on Monday 20 March
Issued 21.03.2023	Private and Confidential - not for Onward Transmission (Private Council of Governor notes from 07 March 2023)
Issued 22.03.2023	Important: briefing for Governors re outcome of DCC OSC discussion yesterday re. Teignmouth Hospital
Issued 24.03.2023	For your Information: FW: 2023 local elections: pre-election considerations for NHS Providers
Issued 24.03.2023	TSDFT Public Board of Directors - 29.03.2023
Issued 29.03.2023	Chair/NED Appraisal Workshop—12th April
Issues 31.03.2023	Chair/NED Appraisal Workshop—12th April (to inform Governors the workshop would now be via Teams only)

MEETINGS LIST AND MS TEAMS LINKS SECTION

GOVERNOR MEETINGS - APRIL 2023

11 April 2023	**Governor Only Meeting** (2pm-4pm) (via Teams) (MS Teams link also listed on page 9, if unable to attend face to face) *(Optional, attendance not obligatory).*
12 April 2023	**Chair/NED Appraisal Workshop (2022/23)** (2pm-5pm) (via Teams). Teams link and papers will be circulated to those who have confirmed they are attending on 11th April 2023. *(Optional)*
18 April 2023	**New Governors (only) Post First Month Workshop** (3pm) - Boardroom or MS Teams link has been sent if you prefer (*Optional—New Governors only)*
20 April 2023	**Governors Coffee and Chat Session** (10.30-11.30am) (Video Conference), (MS Teams link listed on page 9) *(Optional, attendance not obligatory).*
20 April 2023	**Membership Committee** * (2pm-4pm) (Face to Face meeting - Boardroom, Hengrave House) (MS Teams link also listed on page 9 if Committee Members unable to attend face to face) *(* Committee members only)*
26 April 2023	**Public Board** (11.30am) (Face to Face meeting - Pomona House, Oak View Close, Torquay, TQ2 7FF) *(Optional, attendance not obligatory).*

GOVERNOR MEETINGS - MAY 2023

03 May 2023	**Council of Governors Meeting** (2pm-4pm) (Face to Face meeting — Boardroom, Hengrave House) (Attendance required - *if unable to attend please send apologies to FT Office, as these are logged).*
15 May 2023	**CoG Priorities Meeting (10am-12noon)** (Face to Face meeting - Pomona House, Oak View Close, Torquay, TQ2 7FF) - (MS Teams link also listed on page 9 if unable to attend face to face) (*Optional, attendance not obligatory)*
18 May 2023	**Governors Coffee and Chat Session** (10.30-11.30am) (Video Conference), (MS Teams link on page 9) *(Optional, attendance not obligatory).*
31 May 2023	**Public Board** (11.30am) (Face to Face meeting - Pomona House, Oak View Close, Torquay, TQ2 7FF) - (*Optional, attendance not obligatory).*

Continued on next page

MS Teams Link: **Governor Only Meeting - 11 April** (14.00-16.00)

Join on your computer, mobile app or room device

Click here to join the meeting

Meeting ID: 316 133 122 699
Passcode: DHH2ee

Download Teams | Join on the web

Or call in (audio only)

020 3321 5208,,994013743# United Kingdom, London

Phone Conference ID: 994 013 743#

MS Teams Link: **Governor Coffee and Chat Sessions** (10.30-11.30)

Microsoft Teams meeting

Join on your computer or mobile app

Click here to join the meeting (press control button and click at same time on underlined section)

Or call in (audio only)

020 3321 5208 644531308# United Kingdom, London

Phone Conference ID: 644 531 308#

MS Teams Link: **Membership Committee * - 20 April** (2pm-4pm)

* Committee members only

Join on your computer or mobile app

Click here to join the meeting

Meeting ID: 318 329 973 956
Passcode: DP45PK

Download Teams | Join on the web

Or call in (audio only)

020 3321 5208 635562075# United Kingdom, London

Phone Conference ID: 635 562 075#

MS Teams Link: **CoG Priorities Meeting: 15 May 2023** (10am-12noon)

Microsoft Teams meeting

Join on your computer, mobile app or room device

Click here to join the meeting

Meeting ID: 338 360 559 014
Passcode: 4UiTAr

Download Teams | Join on the web

Or call in (audio only)

020 3321 5208,,697781559# United Kingdom, London

Phone Conference ID: 697 781 559#

Governors Fortnightly e-Newsletter

Torbay and South Devon
NHS Foundation Trust

Issue No. 103

Date: Friday 14 April 2023

Within this issue

- Chairman's Message
- Questions for COG Priorities Mtg May
- Governor Only Meeting 18 April
- Governor Coffee Morning
- New Governors (only) Workshop
- Trust News Updates
- Governor Observer Reports
- Governor Q & A
- Healthwatch
- Communications Department Brief
- Email Confirmations
- Meeting List

FT Office - please contact:

Tel: 01803 655705 or

Email: Foundationtrust.tsdft@nhs.net

The aim of this e-Newsletter is to give you a regular round up of future items of interest and confirm items that have been sent to you by the Foundation Trust Office and other sections of the ICO.

Please continue to read this newsletter each fortnight as this is a key method of communication with Governors - thank you.

MESSAGE FROM THE CHAIRMAN

Ladies and Gentlemen,

I hope that you all had a good Easter.

I draft this on the first day of the national Junior Doctors' strike. Walking round Torbay hospital today, we are coping. My personal assessment is that coverage is being delivered but there is little option for flexibility in the event of staff illness or increased demand during the week. The impact on our Community Hospitals is, of course, less profound. I judge that we owe a thank you to all our Trust staff for their flexibility during these periods of industrial action.

On walkabout, I saw the new patient chairs which Torbay Hospital League of Friends has funded in our emergency department. These will be a great asset, being employed when patients are on the emergency pathway but do not need admitting to a hospital bed.

It was good to see Governors attending our most recent Board meeting in Pomona House. Whilst it is unquestionably the right thing to do, our ICS is giving up Pomona as a cost saving so we won't be able to use it after the summer. My aim is to return Board meetings to our own Boardroom, infection control restrictions permitting. The implications of Governors not being regularly on site, being able to meet with execs and NEDs before and after Board meetings have been significant and sad. I do hope that we can return to pre-pandemic ways of working here.

Turning to SOF4, as you are aware, the system operating plan submission has been made. It has been a quiet week on the system front following a great deal of work and activity whilst the submission is considered at regional and national level. I will of course inform you whenever there is a response. As a Trust we are getting on with implementing our Regain and Renew plans and I would hope to brief you on how our SOF4 response is progressing when we meet next week.

It will be good to spend time with you face to face on 18 April.

Until then, every best wish,

Richard

Issue No. 103 Page 2 Date: 14 April 2023

ANY QUESTIONS FOR COG PRIORITIES MEETING:

Reminder that the next **CoG Priorities Meeting** on **15 May at 10am-12noon** is on the topic of **"Seven Day Working"** and Governors were asked by email on 12.04.23 to reflect if they had any themes/issues or specific questions on this topic.

Please let the FT Office know by Wed 26 April at noon so these can be shared in advance with the speaker, Kate Lissett, to ensure the meeting addresses the key points you wish to be covered.

Thank you to those Governors who have responded to date.

GOVERNOR ONLY MEETING - TUES 18 APRIL (2pm)

The Agenda and papers for the next **Governor Only meeting** on **18 April at 2pm-4pm** in the Boardroom, Hengrave House were emailed out on 11.04.2023 by the FT Office. Sir Richard Ibbotson will be joining you for the first hour to answer any questions from Governors. Refreshments will be provided.

MS Teams link was emailed for those unable to join face to face, but please be aware this is a less beneficial experience. (MS Teams Link also provided on page 8 of this newsletter).

INFORMAL MONTHLY COFFEE AND CHAT SESSIONS

Reminder that the next **informal Coffee and Chat session,** set up by the Lead Governor and Deputy Lead Governor, is on **Thursday 20 April 2023 at 10.30am** (one hour) and the MS Teams invite is listed at the back of this newsletter.

NEW GOVERNORS (ONLY) WORKSHOP

Reminder for the **New** Governors (only) that your **Post First Month Workshop** will now **commence at 4pm**, straight after the Governor Only meeting on **Tuesday 18 April**, for one hour, in the Boardroom. A MS Teams link has been sent if unable to attend face to face.

You will be joined by Emily Long, Director of Corporate Governance and Trust Secretary, Jean Thomas (Lead Governor), Sarah Fox (Corporate Governance Manager) and Sally-Ann Reay (Membership Manager).

TRUST NEWS UPDATES

CARE HOME HYDRATION PROJECT CUTS HOSPITAL ADMISSIONS

A recent Trust press release publicised the Care Home Hydration Project which community dietitians in Torbay and South Devon are running to help prevent injuries and illnesses linked to dehydration.

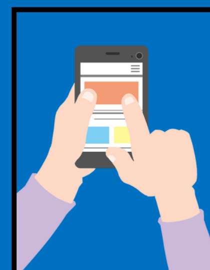
Since the project began, there has been a reduction in admissions to hospitals from project homes in the local area for conditions associated with dehydration. Between May 2021 and November 2022, the number of falls requiring hospital admission fell by 63% and incidences of urinary tract infections requiring antibiotics were reduced by 18.5%.

The project was recently used as a national case study promoting good practice by NHS England Community Health Services, and has also been highlighted as part of the Enhanced Health in Care Homes (EHCH) framework programme refresh.

South West Regional Pilot Project to develop a late effects of radiotherapy service

Suzanne Hill, a therapeutic radiographer working at Torbay Oncology Unit has been selected to take part in a south west regional pilot project to develop a late effects of radiotherapy service, to benefit people who may be experiencing ongoing effects from the radiotherapy they received to treat their cancer. These might be physical or psychological effects months or even years after treatment has finished, such as bladder or bowel changes, skin changes or pain or swelling in the treated area.

DIGITAL HEALTH



ICONews on 05.04.2023 gave an update on the work undertaken by Kyra Boyle, the Trusts first digital futures post graduate fellowship in digital health.

Her work aims to reduce anxiety by giving young visitors an awareness of a hospital environment in an enjoyable and engaging way and providing them with an interactive resource to use on the day of their visit. This work is now being piloted with real patients.

You can find out more by watching the excellent video: iMayFlower Studentship - Adolescent Mental Health App - YouTube (click control key and enter)

GOVERNOR OBSERVER REPORTS

Governor Observer reports from Board level sub-committees are issued with the e-newsletter for your information:

- Quality Assurance Committee GO Report of 27.03.2023

QUESTION AND ANSWERS SECTION

It was requested at the GGI Feedback session on Wed 6 July 2022 - that all current Governor questions are listed in the Fortnightly Newsletter and dates given (regardless of whether a response is still awaited). Please note that the current questions and responses are always added to the Governor Communications Log that is taken to each Council of Governors meeting.

Question ID No 137— (Matt Arthur) dated 28.03.2023 re Heating

Why is it that when the environmental temperature is improving, that the heating within our estate is still operational to a level that many areas are having to open windows to regulate their working environment? Is the estate infrastructure not controllable so that heating levels can be adjusted rather than it seemingly being an on/off system?

Answer ID No. 137 - Response from Jake O'Donovan, Workplace Director on 04.04.2023:

The Trusts Building Management System (BMS), assess both the external and internal temperatures to ensure the correct internal environmental conditions are achieved throughout. In general, our buildings have a heating setpoint of 21 DegC, with the exception of special locations (i.e. Theatres, SCBU and ICU) which have an element of local control within a given range.

The system relies on sensors, valves and controllers that are placed in various locations throughout the system, these control the internal environments. Some areas of the hospital are older than others, and other areas have had a change of use, these areas are the most difficult to control. New areas, such as, Theatres, ICU and AMU have been designed with good control systems and have better stability.

If there are areas that the heating is ON when the thought is that it should be OFF, this could be down to component failure rather than a system configuration (i.e. a sensor reading a lower temperature than it should, or a valve failed in the open position). Any locations experiencing these issues should raise a request to the Estates Operations Delivery Team, part of the Workplace Team, they can then investigate and rectify the fault.

We proactively carryout a service on these systems, which is currently in progress, and there have been a number of devices identified as requiring replacement, which a programme is in place.

In brief, the system is fully automated, based on some basic parameters, to maintain the environmental conditions as set out in the guidance.

HEALTHWATCH

Governors have recently been sent the Healthwatch Torbay e-bulletins as a direct method of informing you of their many activities. Therefore individual articles will no longer be extracted and listed in the Governor newsletter.

Latest Devon Healthwatch reports are listed here (Ctrl & Click) and latest Torbay Healthwatch reports are listed here (Ctrl & Click) if you wish to view.

Issue No. 103 Page 5 Date: 14 April 2023

COMMUNICATIONS DEPARTMENT BRIEF

Latest reported COVID-19 data

Detailed information is published weekly on NHS England's website. The information below for the latest full week published, from Monday 03 April 2023 to Sunday 09 April 2023, is extracted from that website and presents a snapshot of our position.

The data can be found on the national NHS website here: https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-hospital-activity/

COVID-19 data snapshot – Monday 03 April 2023 to Sunday 09 April 2023

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
COVID-19 admissions and in-patients diagnosed	2	1	2	4	0	0	0
New admissions to hospital from the community	1	1	1	4	0	0	0
New hospital admissions from a care home	0	0	0	0	0	0	0
Beds occupied by COVID-19 patients	30	26	20	8	9	6	6
Mechanical ventilation beds (ICU) occupied by COVID-19 patients	1	1	1	0	0	0	0

	05 Apr
COVID-19 discharges from hospital	13
COVID-19 related staff absences	55

Discharge and staff absence information is published on a monthly basis.

Media/social media activity

Media

- Care home hydration project cuts hospital admissions – celebrating the success of a dietitian-led hydration project which supports local care homes to encourage good hydration for residents
- Parking charges issue – supported a BBC Spotlight viewer to successfully rescind their parking charge notice following a hospital admission by working with our car park provider

Continued on next page/……

Social Media

- Choosing the right service – sharing a variety of 111, choose well and appropriate help resources during the expect busy period of Easter bank holiday and junior doctors strikes
- Visiting our area on holiday – highlighting pharmacies as a great source of support for visitors to our area
- Dartmouth Royal Naval College Easter donation – thanking the Royal Navy for their kind donation of Easter treats for patients on Louisa Cary ward and across Torbay Hospital
- Theatre recruitment event – promoting our dedicated recruitment support event for theatres
- Job of the Week – promoting an exciting opportunity for a ward clerk to join the Totnes Community Hospital team
- Accessing dental services – details on how to access dental treatment in an emergency over the bank holiday

We hope this information is useful, but please do give us any feedback, via the Foundation Trust Office, as it is always welcomed and helps us continually improve the information we send out.

EMAIL CONFIRMATION

The Foundation Trust Office and Comms Team regularly send you emails. Here is a listing of those sent over the period from Friday 31 March 2023 to Friday 14 April 2023:

Issued 31.03.2023	TECS Newsletter March 2023
Issued 31.03.2023	Healthwatch Torbay e-bulletin 31 March 2023
Issued 31.03.2023	One Devon Bulletin - March 2023
Issued 04.04.2023	TSDFT News Release: Care home hydration project cuts hospital admissions
Issued 04.04.2023	Important - Change of date of next Governor Only meeting - altering from 11 April to 18 April (2pm-4pm) in Boardroom
Issued 05.04.2023	For Information: briefing on communication activities to support with Easter pressures and junior doctor industrial action
Issued 06.04.2023	Message from Jon Scott, Chief Operating Officer - we need your help - preparing for industrial action and bank holidays
Issued 06.04.2023	Healthwatch Torbay e-bulletin 06 April 2023
Issued 11.04.2023	Agenda for next Governor Only Meeting - Tuesday 18 April at 2pm
Issued 12.04.2023	For Action: next COG Priorities meeting - 15 May 2023 at 10am-12noon at Pomona House
Issued 13.04.2023	Reminder: next Governors Coffee Morning is on Thursday 20 April at 10.30am on MS Teams (one hour)
Issued 13.04.2023	For Info: Notes, Action Tracker and paper from COG Priorities Meeting which took place on 8 March 2023

Continued on next page

MEETINGS LIST AND MS TEAMS LINKS SECTION

GOVERNOR MEETINGS - APRIL 2023

18 April 2023 — **Governor Only Meeting** (2pm-4pm) (Boardroom) (MS Teams link also listed on page 8, if unable to attend face to face) *(Optional, attendance not obligatory).*

18 April 2023 — **New Governors (only) Post First Month Workshop** (4pm-5pm) - Boardroom (MS Teams link has been sent if unable to attend face to face) (*Optional - New Governors only)*

20 April 2023 — **Governors Coffee and Chat Session** (10.30-11.30am) (Video Conference), (MS Teams link listed on page 9) *(Optional, attendance not obligatory).*

20 April 2023 — **Membership Committee** * (2pm-4pm) (Face to Face meeting - Boardroom, Hengrave House) (MS Teams link also listed on page 8 if Committee Members unable to attend face to face) *(* Committee members only)*

26 April 2023 — **Public Board** (11.30am) (Face to Face meeting - Pomona House, Oak View Close, Torquay, TQ2 7FF) *(Optional, attendance not obligatory).*

GOVERNOR MEETINGS - MAY 2023

03 May 2023 — **Council of Governors Meeting** (2pm-4pm) (Face to Face meeting — Boardroom, Hengrave House) (Attendance required - *if unable to attend please send apologies to FT Office, as these are logged).*

15 May 2023 — **CoG Priorities Meeting (10am-12noon)** (Face to Face meeting - Pomona House, Oak View Close, Torquay, TQ2 7FF) - (MS Teams link also listed on page 8 if unable to attend face to face) (*Optional, attendance not obligatory)*

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Continued on next page

MS Teams Link: **Governor Only Meeting - 18 April** (14.00-16.00)

Join on your computer, mobile app or room device

Click here to join the meeting

Meeting ID: 316 133 122 699
Passcode: DHH2ee

Download Teams | Join on the web

Or call in (audio only)

020 3321 5208,,994013743# United Kingdom, London

Phone Conference ID: 994 013 743#

MS Teams Link: **Governor Coffee and Chat Sessions** (10.30-11.30)

Microsoft Teams meeting

Join on your computer or mobile app

Click here to join the meeting (press control button and click at same time on underlined section)

Or call in (audio only)

020 3321 5208 644531308# United Kingdom, London

Phone Conference ID: 644 531 308#

MS Teams Link: **Membership Committee * - 20 April** (2pm-4pm)

* Committee members only

Join on your computer or mobile app

Click here to join the meeting

Meeting ID: 318 329 973 956
Passcode: DP45PK

Download Teams | Join on the web

Or call in (audio only)

020 3321 5208 635562075# United Kingdom, London

Phone Conference ID: 635 562 075#

MS Teams Link: **CoG Priorities Meeting: 15 May 2023** (10am-12noon)

Microsoft Teams meeting

Join on your computer, mobile app or room device

Click here to join the meeting

Meeting ID: 338 360 559 014
Passcode: 4UiTAr

Download Teams | Join on the web

Or call in (audio only)

020 3321 5208,,697781559# United Kingdom, London

Phone Conference ID: 697 781 559#