Royal Devon University Healthcare
NHS Foundation Trust

Trust Board - Reports

Reference Number: RDF1817-23
Date of Response: 09/10/23

Further to your Freedom of Information Act request, please find the Trust's response(s) below:

Please be aware that the Royal Devon University Healthcare NHS Foundation Trust (Royal Devon) has existed since 1st April 2022 following the integration of the Northern Devon Healthcare NHS Trust (known as Northern Services) and the Royal Devon and Exeter NHS Foundation Trust (known as Eastern Services).

To the Royal Devon University Healthcare NHS Foundation Trust,

I am writing to request information under the Freedom of Information Act.

1) *Please send the report into additional assurance of data quality by an external provider – as referenced on Page 77 of the trust's February 2023 public board papers: https://royaldevon.nhs.uk/media/d4dnk4gx/meeting-book-public-board-meeting-22-february-2023-for-governors-public-website.pdf*
Answer: The Trust holds this information however, this information is commercially sensitive and its release would, or would be likely to prejudice the commercial interests of the Trust and the external provider commissioned by the Trust, in particular the provider's research methodology.

In applying the exemption under Section 43(2) the Freedom of Information Act the Trust has balanced the public interest in withholding the information against the public interest in disclosure. The Trust has considered all the relevant factors in the public interest test and concluded that the benefit to the public in applying the exemption outweighs the public interest in releasing the information requested as a result of the prejudices and losses that would potentially affect the Trust and patients. As such this information is being withheld under Section 43 (2).

2) *Please send the letter from the New Hospitals Programme which sets out the trust's indicative funding envelope and milestones which need to be met – as referenced on Page 6 of the trust's July 2023 public board papers: https://royaldevon.nhs.uk/media/d4dnk4gx/meeting-book-public-board-meeting-22-february-2023-for-governors-public-website.pdf*
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3) *Please send the letter sent by the trust to Devon County Council and Devon ICB regarding a request for clarity on all funding streams to support discharge and social care, and any correspondence received in return by the council and/or ICB – as referenced on Page 5 of the trust's July 2023 public board papers: https://royaldevon.nhs.uk/media/d4dnk4gx/meeting-book-public-board-meeting-22-february-2023-for-governors-public-website.pdf*

Answer: Please find attached a copy of the letter sent by the Trust to the Chief Executive of NHS Devon ICB and One Devon Partnership on 24 May 2023, and a copy of the response dated 15 June 2023 received by the Trust.

4) *Please send the "NHSE lessons learned" report regarding the trust's integration programme as referenced on 347 of the trust's July 2023 public board papers.*

Answer: The report from NHSE was received and reviewed by the Trust and the final version issued by NHSE is attached.

NHS
Royal Devon
University Healthcare
NHS Foundation Trust

[redacted]

Chief Executive
NHS Devon & One Devon Partnership

Royal Devon and Exeter Hospital (Wonford)
Barrack Road
Exeter
EX2 5DW

Tel: [redacted]

Direct Dial: [redacted]

[redacted]

Our Ref: JMICB/3423/CTJP

24 May 2023

Dear Jane

RE: System funding arrangements for 2023/4

Following a period of detailed review we are writing in response to your letter dated 6th April regarding the 3 month extension of the 22/23 £200m schemes across North and East Devon totalling £627,420.

Firstly, we would like to underline our gratitude for the three month extension of funding support that has been provided to both of our sites through to the end of June. As we will show below, the extension of schemes has allowed us to stabilise our No Criteria to Reside (NCTR) position and we are hopeful that as the re-provision of agency funding which initiated on the 15th May 2023 begins to kick in, that we will make further progress towards our financial and operational plan target of 5% NCTR.

You will be aware that the funding discontinuity that we have experienced over the last few months has had a significant impact on delivery. The initiation of some pull back of funding for complex placements in anticipation of a ceasing of funding, saw our NCTR and G2G position suffer from the middle of February and through most of March. For this reason we have been spending time with our partners recently to fully understand current and projected funding commitments to ensure that we do not repeat a similar pattern unwittingly at the end of June and potentially lose position on our targeted reduction in NCTR patients. Therefore, over the past few weeks we have been through a careful process of review with [redacted] (ICB) and [redacted] (now Divisional Director across the whole of Community Services in RDUH) to reconcile as best we can our understanding of our collective funding streams.

We have laid out in the attached spreadsheet the full coverage of our funded positions as we understand them. You will see that in the main we have clarity on whether activities are funded or not funded in the current year, however there remain three areas where we remain unclear on the way forward that it would be helpful for us to clarify between RDUH, ICB and DCC.

We are hugely appreciative of the fact that DCC (subject to cabinet approval) and the ICB have now reached agreement on the **£16m of hospital discharge funding** continuation for the full financial year supported by a clear risk share agreement. Pleased as we are with this development, (and the positive impact this will have on 121 care and care home placements for patients with complex needs), we also know that this constitutes a loss of £2m on the previous year's position so it will need both improved contracting and better partnership working on patient pathways to deliver this change. It would be most helpful to have **written confirmation of the position** so that we can ensure that all of our staff are confident in the funding release (uncertainty and lack of audit trail on these matters is often a genuine barrier for our staff, especially those operating at the interfaces between our organisations).

We also remain concerned about three remaining funding positions where we do not yet feel that we have clarity and so are raising now to avoid any further discontinuities that could have an impact on service delivery:

- **iBCF schemes – £1.2m**
  We understand conversations continue between the ICB and DCC on a brokered position for iBCF, but as matters stand we are concerned that we may lose this funding stream at the end of June 2023. The result of this would be a significant compromising of the ability of the single point of access to coordinate and deliver assessment; and a loss of Winter focused step-down intermediate care and market management. It has been mentioned only last week by our Northern teams that it has been suggested that some of this funding is about to start being stood down – which invokes the same cliff edge problem (with operational teams turning off bookings in anticipation of funding loss) that we have been encountering in the lead up to the end of March.

- **BCF schemes – £3.3m**
  We understand that BCF funding will continue to be funded in 23/24, but given the fundamental importance of this funding provision to delivery of the Urgent Community Response team, it would be helpful to have confirmation of this funding position.

- **Agreed over-establishment of Urgent Community Response Support Workers – £1m**
  We understand that it is possible that this funding will be withdrawn at some point in the year, albeit that it is currently being funded on a monthly basis. Previously we have used this funding with DCC's agreement to over recruit staff into our Urgent Community Response team in order to mitigate the unsourced domiciliary care hours position and this has proven an effective mitigation when agency availability and recruitment have been so challenging in the current market.

The reason for wanting to have this clarity is that we have only just started to see some of the movement that we need to in our No Criteria to Reside position in order to fulfil the targets within our financial and operational plan which aim to bring us to the nationally mandated target of 5% (the underlying assumptions for which are laid out immediately below) in **figure 1**).

Figure 1 – 5% NCTR in RDUH financial and operational plan linked to bed base release

Bed Model	ED 4hour	NCTR	Ring fence	Deesc and LoS	Productivity / Performance
Bed gaps **Northern – Aug / Nov /Dec / Jan** **10-50 bed gap** **Eastern – whole year** **25-50 bed gap**	**Deliver Target** **76%** (assumptions based on D&C + UEC + original investment) Escalation to ICB on PPG streaming and UTC Factor in catchment change?	**Plan to deliver 5%** Northern currently 20% = c.50 beds **5% N = 14 (36 imp)** Eastern currently 12% = 91 beds **5% E = 35 (66 imp)**	**Hold ringfences** Cardiology Taw (to serve N&E) (12 beds) Orthopaedics Dyball and Jubilee (22 + 10 beds) General Surgery, Day Surgery, Lundy, OADM, Knapp (c. 60 beds)	**Deescalate and improve LoS** Use D&C and **UEC funds** to reduce LoS (**c. £5m**) De-escalation assumption April to September Virtual Ward NCTR HPHWD (Honiton?)	**Deliver targets** Can deliver **9%** Outpatients Deliver **improvement on 6% EIP** Deliver **improvement on 6% DC** **+ TIF** **+ Q1/Q2 smoothing** **One Devon GIRFT**

As it stands, over the last six weeks we have reduced our NCTR from over 100 patients Eastern and 60 Northern to the current level of c. 50 Eastern (on the way to a **planned 35**) and c. 40 Northern (on the way to a **planned 14**) (see **figures 2 and 3** below), but this remains a very fragile improvement trajectory since the end of March.

Figure 2 – 41 NCTR patients Northern as of 22.5.2023

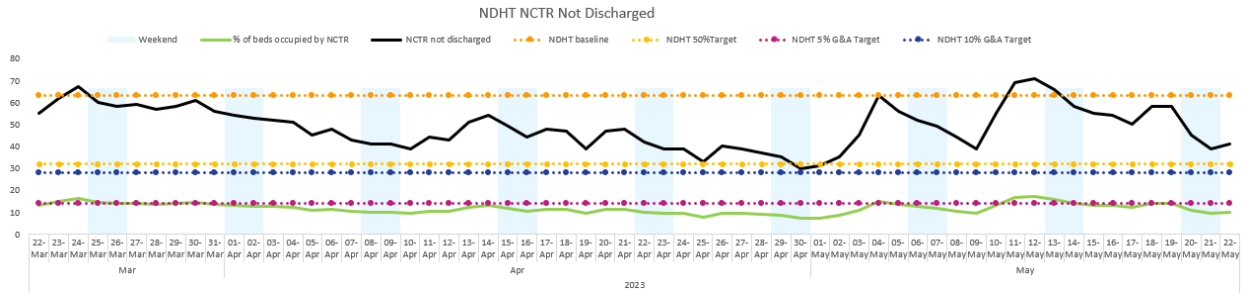
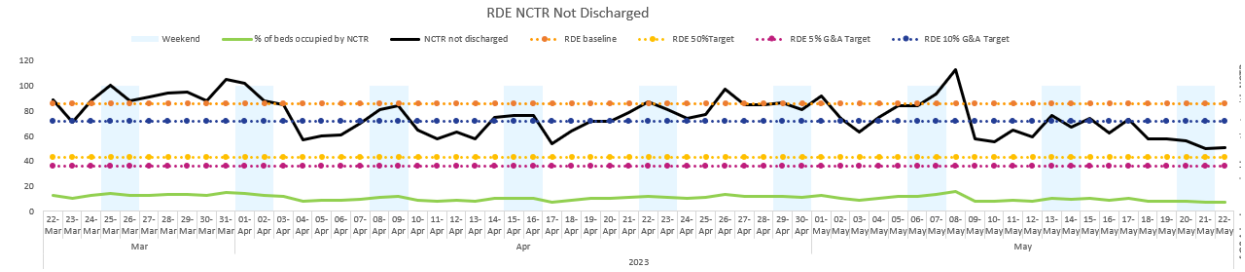
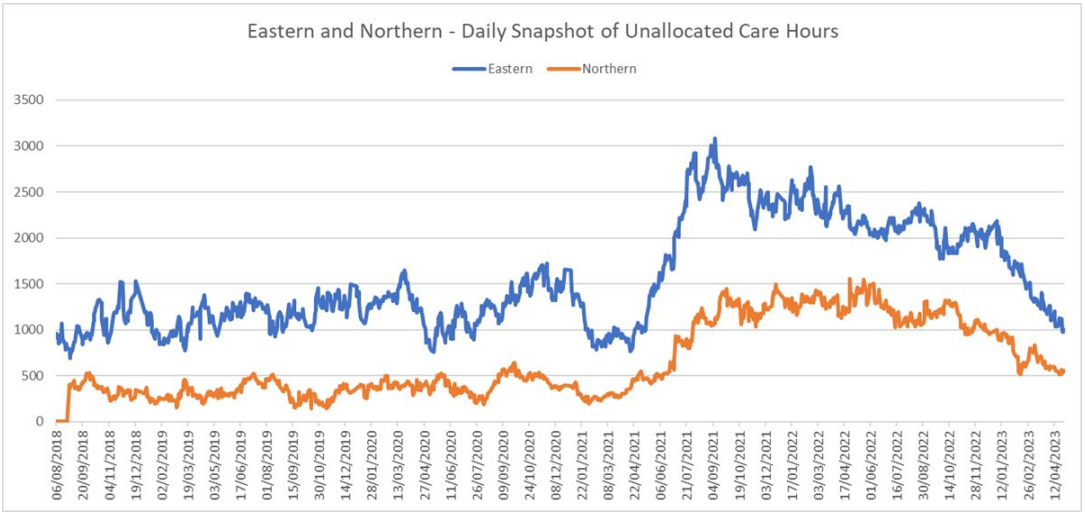


Figure 3 – 51 NCTR patients Eastern as of 22.5.2023



Clearly, we do not want to break stride on this delicate improvement trajectory which is also coupled with a positive decrease in daily unallocated care hours as in **figure 4**.

Figure 4 – unallocated care hours



With the re-establishment of agency support from 15th May now in place and additional leadership input form [redacted] and team, we are hopeful that we will accelerate our movement towards our planned NCTR target which would have a huge impact on us maintaining a bed base that allows us to maintain flow and system support alongside our Elective Recovery. Equally, if we were to move backwards on any of the funding packages outlined above, the core fundamentals of our plan are removed.

We recognise that the schemes identified above are only part of the solution to achieving the NCTR target, and that other elements which impact NCTR are within our own gift as a Trust including: how UEC is managed at the front door across the Devon system; and our own internal improvement work to ensure our pathways are efficient and effective. We have a 6 month pilot commencing this month which will bring together Hospital Discharge Teams, thus ensuring: a case management approach; consistent board round attendance for early MDT discharge planning; appropriate challenge of prescriptions of care; community pull for Pathway 1; and follow up calls 24hrs after discharge to increase confidence and risk appetite. We absolutely acknowledge the need to play our part in supporting this patient cohort.

We are enormously grateful for the active discussions that are underway to try and reach a balanced social care settlement for this year in the face of acute NHS and Local Authority funding pressures, but at the same time we do need to ask for clarity and certainty on the funding provision for the rest of the year. Short term agreements are fundamentally undermining our ability to deliver services and to provide an environment where we can drive productivity based on a shared understanding of resources.

We would be grateful for a final reconciliation of the overall funding position across the £16m and also in these three other domains as soon as you are able. We are next in Board on the 31st May 2023 and it would be enormously helpful to have a settled position by that date.

Kindest regards,

Chris and John

[redacted]

Deputy Chief Executive Officer
RDUH NHS Foundation Trust

[redacted]

Chief Operating Officer

CC: Bill Shields, Chief Financial Officer, ICB
Anthony Fitzgerald, Chief Delivery Officer, ICB

NHS Devon
Headquarters
2nd floor annexe
County Hall
Topsham Road
Exeter
EX2 4QD
[redacted]

15th June 2023

Chris Tidman
Deputy Chief Executive Officer
John Palmer
Chief Operating Officer
RDUH NHS Foundation Trust
Via email only

Dear Chris & John

System funding arrangements for 2023/24

Thank for your letter of 24th May and apologies for the lateness of my response.

On page 1 of your letter, you had noted that you it would be helpful to have a written confirmation of the £16m hospital discharge funding position for the DCC area. I can confirm there is now agreement in principle between Devon ICB and Devon County Council in relation to the discharge to access £16m

iBCF Schemes - £1.2m
The £1.2m detailed in your letter relates to the RDUH portion of the £2.4 million that was subject to recent discussions between the ICB and DCC. The ICB have agreed for DCC to withdraw this funding and that the uncommitted funding in the wider BCF will be prioritised as previously. This will ensure that no disinvestment is made in relation to the £1.2m iBCF schemes.

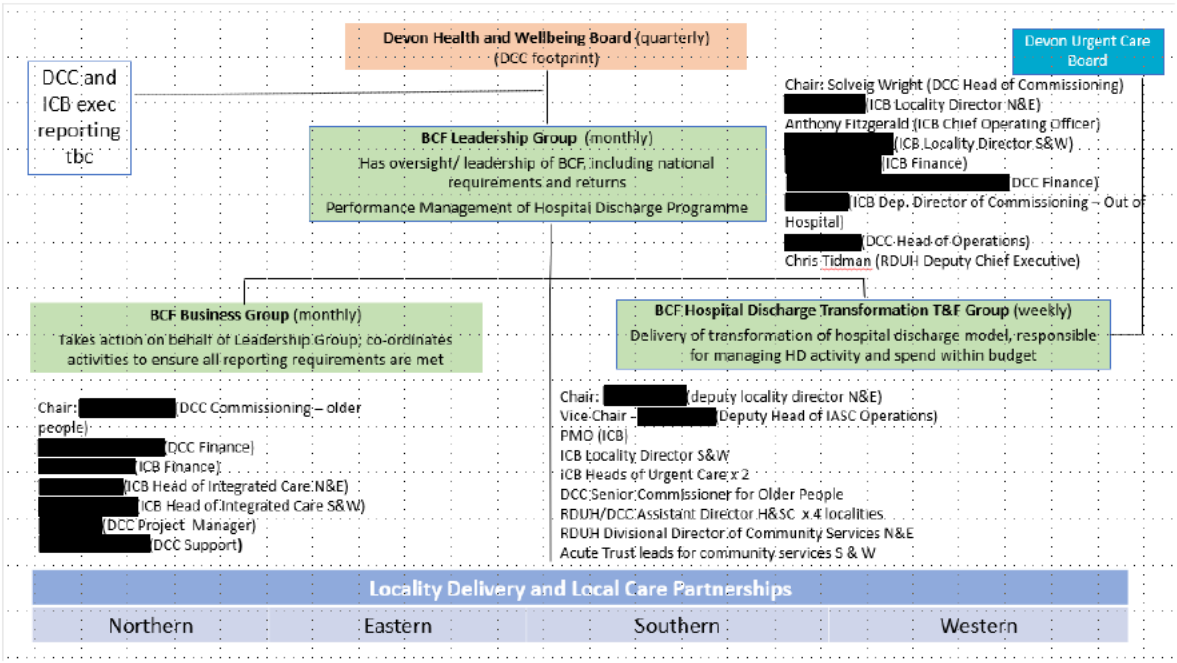
BCF Schemes £3.3m
This £3.3 million is within the core BCF funding and will continue into 23/24, however there is a plan within this year for a full review of the BCF ensuring all schemes are delivering expected outcomes and value for money. This will be led through the BCF Leadership Group.

Agreed over-establishment of Urgent Community Response Support Workers £1m
This was an agreement made by [redacted] for 22/23 only. The funding ceased for this on 01/04/23. It was communicated to RDUH there would be a need for you to take

mitigating action as RDUH would be responsible for the cost pressure and/or workforce over establishment. This was formalised at an Exec meeting between [redacted].

I am delighted to hear of the progress made in moving towards the nationally mandated target of 5% of NC2R and your recognition that the schemes identified and supported in my letter are only part of the solution to achieve the NC2R target and that other elements which impact NC2R are within the gift of your trust.

There are revised governance arrangements for these funding streams detailed below of which RDUH are a key system colleague to ensure maximum output from our joint investments



You will be aware that we have access to support from the national BCF team for DTA as a result of the support of [redacted] and [redacted]. This will no doubt support the Hospital Discharge Transformation Programme to further improve the NC2R position across North and East Devon.

I trust that this covers the points raised within your letter.

Yours sincerely

Jane Milligan
Chief Executive
NHS Devon

Cc: Bill Shields Chief Finance Officer
Anthony Fitzgerald, Chief Delivery Officer

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Lessons learned

Royal Devon University Healthcare NHS Foundation Trust

NHS England and NHS Improvement

Lessons Learned - Summary

Northern Devon Healthcare NHST (NDHT)		Royal Devon and Exeter NHSFT (RD&E)	
Transaction type:	**Acquisition**	**Overall risk rating given at time of transaction assurance (2022)**	
Transaction date	**1st April 2022**		
Transaction summary:	• In January 2018, NDHT was identified by NHSI as a challenged provider that was financially, organisationally and clinically unstable. RD&E was asked by NHSI to enter into a management agreement with NDHT and in June 2018 the Trusts entered into a Collaborative Agreement (CA). In the following years RD&E provided a significant level of leadership and management support to NDHT, leading to the establishment of a joint Executive Team. • The CA was extended in July 2020 to allow the Boards to work on the future longer-term organisational arrangements for NDHT. These arrangements were not considered to be a sustainable long-term solution by the Trusts. RD&E acquired NDHT on 1 April 2022.		

Lessons learned scope and purpose	The scope of this lessons learnt exercise was developed by reviewing the pre-transaction assurance work findings, discussion with regional colleagues and review of relevant documents provided by the trust. The areas we identified as being of particular relevance for follow up were: cultural integration, clinical integration, workforce, digital integration, corporate integration and the extent to which the transaction has enabled change and improved sustainability in challenged services. The lessons identified within this document are based on the reflections of the leaders we interviewed; in places the pack may therefore reflect a range of views based on leaders' own experience of integration. The pack is not intended to provide an evaluation of the transaction but instead to identify key learnings for other integration activity, and to improve NHSE's processes. In places, a lesson we have identified may be relevant for both future trusts undertaking a transaction and the NHSE team carrying out transaction assurance.
Overall findings from lessons learned review	Integration was ongoing at the time of our review, with design of new divisional structures just commencing. The trust noted that running structures in parallel may have inhibited integration and it would have been preferable to have new structures in place from day 1 alongside harmonisation of certain key policies. The trust has been working on integrating teams culturally and provided an update on the tools and approaches being used to facilitate this, including the particular importance of getting teams together face to face at an early stage. Early integration of the communications team was felt to have been effective in ensuring aligned messaging. The trust also highlighted that strong effective clinical leadership at specialty level is essential in supporting integration of clinical teams. Trust feedback was widely positive about the new EPIC electronic patient record (MyCare) which was overall felt to be an important enabler of integration and has allowed teams to collaborate more effectively. Implementation at the Northern site was informed by lessons learnt from earlier implementation at the Exeter site, and was felt to have gone more smoothly as a result. We provide an update on four challenged services at Appendix 1. Cross site working arrangements are in place in some of these (e.g. Acute Medicine, gastroenterology) but in other services this has proved difficult due to capacity limitations of the team at the Eastern site. We heard a range of feedback around factors which impact the feasibility of cross site working. We heard that the Northern site provides a pleasant and friendly working environment, but that the length of the journey is challenging. The trust continues to explore initiatives to mitigate this. As yet it is too early to tell if the transaction will have an overall impact on recruitment and retention. Clinical leads in the challenged services highlighted that there were upsides and downsides to roles being offered across both the Eastern and Northern sites. Some of the specialties have managed to make appointments but there is ongoing reliance on locums, especially in specialties with national shortages.

Lessons learned – Findings 1 of 6

Areas of explorations	Findings from the meetings
How were cultural differences between the Trusts identified, and what were the differences between the cultures?	• Although not required by NHSE's assurance process at the time, RDUH chose to conduct its own engagement exercises and set up a cultural dashboard. • The cultural roadmap was found to be a useful benchmarking tool. • Pre-merger, RD&E was felt to be overall more hierarchical and more driven by processes/policies (more corporate). As a result of the challenges faced and its smaller size, NDHT had developed a more agile culture. • RDUH executives were able to obtain useful soft intelligence about frontline culture through in person presence.
How were cultural integration activities undertaken and how did the trust ensure it didn't feel like a takeover?	• The Trust was aware of the risk that the integration could feel like a takeover. Legally, the transaction was an acquisition of NDHT but the leadership wanted it to feel more like a merger and for the new trust to be 'better together'. • The Trust is trying to counter the risk that one trust is perceived as more dominant as it continues to work on integration, through the messaging and language that is used and through behaviours. For example, ensuring that trust-wide meetings are not always held at the bigger site i.e. Exeter. • Joint appointments to the Board have been made from both the legacy Trusts. Doing so may have helped NDHT staff feel it was an inclusive process. • There was a sense that culture does not need to be uniform across the sites as long as policies, clinical practice, and standards are aligned.
How has the Trust ensured that it adopts best practices from both the legacy Trusts while shaping the culture of the new organisation?	• RDUH aims for its people to have mutual respect and appreciation for each other. • The Trust has used the integration to think how they can best redesign services. Shared learning has been really beneficial and has contributed to the workforce plan which is due to be published. In Acute Medicine, Eastern has shared their guidelines with Northern, and views Northern as having innovative ways of managing patient paths. The sites are about to embark on wholesale alignment of clinical practice and guidelines. • Leaders we spoke to varied in how successful they thought the attempt to take the 'best of both' had been, which may reflect underlying challenges in the services. Some leaders commented that they had observed a clear commitment for both sites to have an equal voice, but in some services (e.g. stroke, where the Northern service is fragile and there is no substantive consultant) leaders commented that it felt the expectation was that support would flow one way from Eastern to Northern. • The trust told us that in an ideal world, the approach would be to work collegiately to compare approaches and then decide the best way to move ahead. We were told there had also been instances of patronising behaviour between certain teams which needed to be addressed.

Lessons learned – Findings 2 of 6

Areas of explorations	Findings from the meetings
What actions are the most essential to support cultural integration?	• Merging the Communications team across both Trusts since the beginning has been very helpful. • Key to genuinely listen to people and allow the conversation to grow. • Make people feel included and demonstrate flexibility to incorporate different views. • Align key policies early on, even if they weren't too different to begin with. • The trusts recognised their different cultures and were explicit that whilst they did not need a single uniform culture, they would not tolerate variation in clinical practice, policies, standards etc. However, sometimes staff have challenged service change on cultural grounds, as they do not understand that culture is about behaviours and values and not standards and processes. By delaying integration of teams (meaning they have continued working as before), it has made it harder for the trusts to come together culturally. Integration should be planned for early, even if only as a blueprint. • Early exposure and familiarising teams with each other early on is important for integration. People from the merging Trusts need to be brought face-to-face with each other (even if that needs involving senior leadership). In contexts where there are pre-existing challenging relationships, it can be helpful to do this in a neutral space and in a social context. • The key thing is to allow colleagues to get to know each other as people rather than through the lens of pre-existing professional relationships and reputations. • Using appropriate language i.e. referring to the name of the combined Trust and stop referring to sites as per the names of the legacy trusts that they were a part of
Have any specialties/teams been more challenging to integrate culturally?	• Yes, although it is more about people than cultures. Some specialties like gastroenterology and orthopaedics have been more difficult to integrate. People that have an allegiance to any particular part or are feeling threatened or anxious are likely to be the most difficult to integrate. • Without careful handing, there may be tendencies for staff at the bigger hospital to come across as arrogant/patronising towards the smaller hospital which will inhibit successful integration

Lessons learned – Findings 3 of 6

Areas of explorations	Findings from the meeting
How has the transaction impacted recruitment and retention?	• It is too early to say whether the transaction has impacted overall recruitment and retention levels. • Gastroenterology, under a joint clinical lead, has successfully recruited to one out of two posts. An enhanced competitive financial package was introduced which involved additional payments upon achievement of some pre-defined KPIs. • Despite significant effort, recruiting substantively in specialties such as stroke, diabetes and acute medicine continues to be challenging owing to overall national skills shortages and vacancy levels, coupled locally with the distance between and rurality of the sites. • In Stroke, it was felt that it has been harder to recruit at Eastern since the merger, given the requirement to support Northern. Candidates will be expected to work at both sites, which are located far from each other (60-90 mins travel). They will also need to settle into two different teams and sites. This can make the role less attractive. • Specialties are being creative to make roles more attractive. For example, Diabetes and Endocrinology are considering a combined clinical and academic role. They are also offering an enhanced package, although there is concern this still may not prove sufficient given the volume of higher paid locum work that is available. • RDUH is building on the brand value of RD&E given the association of NDHT as a troubled trust.
Have the recruitment efforts succeeded to turn locum posts into permanent positions?	• To date there has been limited success in the challenged services we spoke to in converting locum posts into substantive posts, noting these relate to specialties with national skills shortages and that locum work is lucrative. Diabetes had hoped to convert two locums into substantive posts, but the locums are leaving. It is not thought their departure is related to the merger. • Specialties are trying to support and retain long term locums, where recruitment is likely to prove challenging. For example, Diabetes & Endocrinology included some managerial experience within a locum's clinical role, and Acute Medicine Eastern onsite presence at Northern has allowed greater support for locums.
Has being a single organisation helped to facilitate cross-site working?	• In Acute Medicine, the number of Eastern consultants present at Northern once-a-week has increased from one to four. Gastroenterology now has some consultants who work at both sites. • Some of the clinicians we spoke to mentioned that the Northern site is pleasant to work at – once people have experienced this, they have then been more receptive to the idea of working across sites. However, breaking the ice and getting them to take the first step can be quite difficult because the distance between the sites is significant and people worry about making the journey and the impacts it will have on them. • It helps to have positive examples of people's experience of cross site working. • There is increased willingness amongst Acute Medicine ACPs to consider some cross-site working. • The Trust has not fully finalised T&Cs for people to be working cross-site. Early integration of some key policies (e.g. travel expenses) might have helped. • Eastern Stroke service said consultant capacity has been insufficient to allow onsite presence at Northern. However, even if one day a week was possible, it is seen as challenging to manage hyperacute patients with such limited presence and can cause consultants to feel uneasy/exposed. HfOP Eastern service has had capacity to provide some on-site support for Northern.

Lessons learned – Findings 4 of 6

How has the EPIC (MyCare) implementation gone?	• RDUH implemented EPIC, a unified Electronic Patient Record (EPR), at the North Devon site in October/November 2022 (slightly delayed by COVID-19 with an initial planned implementation date of July 2022), having previously implemented the EPR at the Exeter site in October 2020. • MyCare has been very helpful in enabling cross-site working and it has made the provision of remote advice and support more robust. It is now significantly easier to look at and to maintain patient records and notes. The clinicians we spoke to were universally positive about the system overall, even if some difficulties were noted. No significant concerns were raised about interoperability with other clinical systems. • In Acute Medicine, it would be difficult to work jointly without MyCare. It has facilitated implementation of a Virtual Ward for Northern based on Eastern paths, allowed senior support for SDEC and has more involvement with junior doctors in Eastern. • For Stroke, Eastern has been able to provide remote support to Northern when their consultants are on leave. • In Diabetes, many staff had undergone MyCare training before it went live. This helped significantly, especially as EPIC is not intuitive and takes more than two weeks to learn. There have been some challenges with implementation. • Since going live some glitches have come to light. Response time to these changes requested by users is very slow and is limited by available resource in the Trust's EPIC team, and in the external EPIC team if any rebuild is required. Specific nuances relating to Endocrinology have been difficult to adopt into the software. • It can be difficult for clinicians to manage multiple contexts/settings in the system. Although both sites are using the same system they have separate 'instances' for Exeter and Northern and switching between these can result in errors in where information is recorded and needing to make corrections. • For Trusts implementing EPIC, the trust fed back that they should try and get most of their customisations and nuances incorporated in the system build itself, rather than requesting changes later.
Did the Trust have sufficient resources for EPIC (MyCare) implementation?	• EPIC is fairly complex to learn • People undergoing training before MyCare was officially launched was helpful, but timing of this needs to be carefully considered to ensure it's not too early to be useful nor too close to go-live • Trusts should focus on training as many people as possible on EPIC, before the system actually goes live • Protected time/ backfill for resources should be made available for them to be able to train themselves in using MyCare. Whilst hard to create this time, it saves time after as you have become faster • Trusts should try and avoid an overlap between the EPIC launch phase and the holidays/ pressure periods
What worked well in terms of other digital integration/digital support	• Implementation of a 3rd party recruitment system, Career Gateway (in addition to NHS jobs) resulted in 50% of new applications coming in from outside the NHS. It has been used across shortage specialties and more widely. • Using the same incident reporting software (Datix) across both sites was helpful and was an enabler of integration.
Other lessons as regards digital integration?	• RDUH flagged the need for the trust's digital integration strategy to be aligned with the ICS digital roadmap, to ensure strategic fit with longer term system ambitions but also so resource needs can be understood. • If other system implementations/integrations will be occurring simultaneously then resources may need to be reallocated, as the programmes can be resource intensive.

Lessons learned – Findings 5 of 6

Areas of explorations	Findings from the meeting
Has being a single enlarged organisation helped the Trust? In what ways?	• Eastern Diabetes & Endocrinology has helped Northern to reduce their waiting lists. • There are better recruitment prospects at former NDHT sites as a single large Trust (using the RD&E brand value). They have recently been able to push for a robust HR package to be able to attract the right talent. • As a single large Trust, they now have resources to get job adverts and job descriptions ready earlier, which helps the overall hiring process • RD&E has been offering training sessions to new appointments being made at NDHT
What's the Trust's view of the current level of sustainability versus before the merger, in various clinical services?	• Overall, RDUH considers that the Northern services are more robust now than when RD&E first came in to provide support under the Collaborative Agreement. Northern is in its best shape in the past 5 years, with the Oncology department now outperforming national averages. The next two years will be vital. If it doesn't work, the configuration of services may need to be reviewed. • In particular, Acute Medicine is more robust now, with more clinical leadership and alignment. There are now four Eastern consultants who provide one day pw at Northern. Amid the national shortage of these consultants, it will not be possible to manage without locum cover. However the regular presence of Eastern consultants at Northern is helping to retain the locums, ensuring consistency for patients. • Stroke is no less fragile post merger. The clinical lead considered that it could now be harder to recruit to Eastern, given postholders must cover both sites. With the added pressure of working at Northern, the existing consultants at Eastern have also started questioning their future at RDUH. Eastern stroke services has had no capacity to provide onsite presence at Northern. It has tried to support through sharing of advice, support and pathways, but these have not been adopted. This has created frustration and demotivation for Eastern stroke. However, Northern has felt unable to move forward without this on-site presence. • In HfOP, new vacancies include sessions at the North Devon site so support can be offered – face to face, support with virtual ward and telephone support. We were told that it is easier to do this in HfOP because the work is less acute and a single session is therefore more useful. • Gastroenterology is in a better position than pre merger. It now has a joint clinical lead and some Eastern consultants who work partially across site. • Diabetes & Endocrinology – staff changes (which we understand are unrelated to the merger) have meant that they have been unable to convert the current long term locum positions to substantive.
Any potential pitfalls other transactions should be aware of when integrating clinical services?	• Some teams may have a mismatch in expectations. In Stroke, the clinical lead felt Northern were expecting on-site, physical presence, beyond sharing ideas, protocols, guidelines, joining the MDT discussions etc. Eastern did not feel they had capacity to provide this. As a result both teams might feel disappointed by the mismatch in expectations. • It is particularly difficult to provide support when the bigger team also has vacancies – both services feel stretched • Be really conscious that you don't want to undo one service while trying to improve another and in the process end up damaging services at both sites • Don't underestimate the bandwidth of staff which is required to support cross-site working

Lessons learned – Findings 6 of 6

Areas of explorations	Findings from the meeting
How progressed is the integration of clinical services, and what factors have affected this?	• The Trust took a deliberate decision not to begin to review the divisional structure until one year post transaction. Whilst at executive clinical leadership level they have been working very closely, in retrospect the trust considers they underestimated the importance of operational integration for moving forward. With hindsight, it would have been better to have started planning operational integration a year in advance of merger and to have had divisional structures in place for day 1. Having two sets of operational management and governance structures across sites has made it hard to get teams working together. • Clinical integration hasn't happened fully yet and has been challenging for some specialties with consultant shortages and/or capacity challenges. For example, Stroke (where both Eastern and Northern have constraints) said integration has been neither smooth nor successful. • The early focus has been on the eight high risk specialties, encouraging lower risk specialties to progress where they felt able to. There has been some positive progress with informal integration, where teams have come together naturally. • Single, strong clinical leadership is key to integrating specialties cross-site. This has proved positive for Gastroenterology and Acute Medicine. However, capacity issues has meant this has proved difficult for specialties such as Stroke and has made it hard to move forward. • Clinical service integration has been challenging owing to large distances and high travel time between the two sites. It is particularly key for clinical leads to visit both sites. Earlier harmonisation of some key policies e.g. travel expenses would have assisted integration. • Consultants from Eastern that work at Northern once a week reflected that there is an adjustment period to establish credibility with teams at Northern and get to know their colleagues. Feedback on the working experience at Northern has been positive ("friendly teams and a nice environment") and the consultants we spoke to said it was a nice place to work if you get over the travel time, which is regarded as significant. • Datix being used across both sites has been an enabler of integration, alongside EPIC (discussed elsewhere).
Has anything proved to be more challenging than anticipated?	• Identifying and implementing effective single clinical leadership across both sites has been challenging in some specialties. In Acute Medicine, clinical leadership of Northern has been more challenging than anticipated, as it's harder to influence through one day per week presence. • It can disrupt the continuity of care to split sessions between different consultants, for instance in the context of cross site working where consultant presence on site is limited (e.g. one day per week) and where support arrangements mean multiple consultants share support for a patient across a given week. • The trust considers it may have underestimated the difficulties posed by travel time between sites and the reluctance of staff to travel. There is now a travel group in place to try to overcome the distance and long travel time between the sites. This has involved exploring ideas such as dedicated carriages with Great Western Railway and minibuses to and from stations.
Any reflections on the NHSE transaction assurance process?	• If performance is looked at only on a site by site basis (e.g. SSNAP ratings) it can inhibit integration because clinicians will not want 'their' site to deteriorate in pursuit of better overall performance.

Lessons learnt for other trusts

Lessons learned – for other trusts 1 of 5

Theme	Lessons learned / recommendation
Culture	Importance of diagnosing, mapping path to desired culture and having a way of monitoring this (e.g. cultural dashboard).
Culture	Importance of encouraging honest and open feedback during staff engagement activity. Allowing genuine conversation helps in understanding the existing culture and can help the leadership to focus on areas of concern in the messaging during the merger process.
Culture	Avoid perceptions that one trust is being favoured (either the acquired trust or the acquirer). E.g. hold meetings at both sites, establish mechanisms to take the best of both in terms of policies/processes, avoid assumptions that a certain approach will be followed just because one trust is bigger or needs more support.
Culture	Manage risk that the transaction is perceived as a takeover and retain institutional knowledge, for example, through making appointments from both legacy trusts to the enlarged Trust Board and senior leadership team below Board level.
Culture	Merging the Comms team across both Trusts from the beginning to form a single team was helpful. This has helped shape a consistent narrative and maintain consistency in the messages being passed on by the Trust leadership, leaving less room for misinterpretation, rumours, myths etc.
Culture	Important to be careful about the language being used in all merger related communications to avoid the impression that one trust is being favoured - focus on the formation of a new organisation. Taking care to refer to the name of the combined Trust and stop referring to sites as per the names of the legacy Trusts. Avoid always holding meetings at one site, as this will limit attendees.
Clinical integration	Single, strong clinical leadership is key to integrating specialties cross-site. It is essential to have the right person in place, so trusts will need to start the leadership campaign early. Clinical leads will need to visit both sites, even if travel is difficult/lengthy.
Clinical integration	Align key policies early on, even if they weren't too different to begin with (particular thought to be given to employment related terms which facilitate joint working, such as employment T&C and related policies like expenses)
Clinical integration	Delaying integration of teams makes it harder to come together culturally. Integration should be planned early, even if only at blueprint level.
Clinical integration	Where teams have cultural differences between sites, or challenging relationships, it helps to bring them together face to face at an early stage ie pre merger. This helps to break down barriers and debunk myths. Investing in a social, rather than work setting can be helpful, to expose people to each other rather than to professional reputations. Face to face is much more effective than virtual introductions, and neutral ground has proved helpful. It may need senior leadership presence to facilitate in the early stages.
Clinical integration	Currently, different divisional and operational structures retained from the legacy trusts makes it difficult for clinicians to work together. The decision to not start work on a new divisional structure until after a year of the merger has proved to be a barrier to clinical integration. Although the approach will vary, trusts should consider if it may be desirable to have divisional structures in place on the date of merger. Planning for new structures and operational integration should in any event begin well in advance of merger (a year was suggested).
Workforce	As a single large Trust, better access to HR support and resource to get job adverts and job descriptions ready early, which is helpful. As a bigger trust it may be easier to offer a robust and comprehensive HR package to be able to attract the right talent. Being able to use the brand value of the legacy trusts can be helpful (although note potential risks if appointments are to a joint team that will be perceived as being stretched by the transaction and new working requirements)

Lessons learned – for other trusts 2 of 5

Theme	Lessons learned/recommendation
Cross site working	Challenges faced by RDUH in relation to cross-site working: (a) The trusts underestimated the impact of the distance and lengthy travel time between sites on the willingness of staff to travel, especially in the winter. Also, on the bandwidth to support working at the other site. It feels different for an executive team used to travelling between sites than it does for clinical teams who may not have done it before. (b) When staff only have a limited presence at one site, it takes time to build trust and establish credibility with the team. (c) Variation in pathways between sites makes it harder for staff to work cross site, as they are unfamiliar. (d) Limited on site presence makes it more challenging to support hyperacute patients such as stroke from the other site, and consultants may feel uneasy to take on responsibility for these type of patients because of the physical distance involved. (e) The extent and nature of support that can be provided for a fragile or challenged service on one site may be limited by capacity at the other site, if stretched. f) When recruiting to substantive roles, cross-site working may increase attraction (experience in the larger site, opportunities for research, reputation etc). However, in services where conditions are high pressure, requiring cross-site work may also make recruitment more difficult.
Cross site working	• Set up a dedicated travel group early on, to identify and explore options to overcome the challenge of distance/travel time between sites. This should have broad representation. • Where there is lengthy distance/travel time between sites, consider the willingness and bandwidth of staff to support cross-site working when setting up those arrangements. • Bottom out T&Cs in relation to cross-site working and key differences in pathways and procedures in advance of merger. • When designing roles and services, carefully consider the potential recruitment impact of a cross-site work requirement, whether this will be positive or negative and what steps/adjustments may be needed. This should be considered on a case by case basis. • Where cross site working could be challenging, managing expectations so any support that is provided does not come as a disappointment (e.g. being clear that support may come in the form of joint MDTs, sharing of pathways and protocols rather than on site presence)
Workforce	In national shortage specialties, where there are many locum roles available, it can be challenging to recruit to substantives. Enhanced packages may help but may not be sufficient to overcome lucrative locum work. Where there is limited prospect of recruiting to substantive roles eg due to national shortage, providing support for existing locums or enhancing their roles may help to retain them longer term.

Lessons learned – for other trusts 3 of 5

Theme	Lessons learned/Recommendation
Corporate Integration	If the integration programme board (IPB) is wound down in advance of integration being finalised, transacting trusts should consider how remaining integration risks will be spotted, escalated and remediated. If there isn't an overarching integration governance structure to capture these risks they may remain in the specialties/teams they relate to and are not appropriately resolved. Transacting trusts should also consider and plan for how to sensibly wind down IPB/PMO structures and retain the distinction between integration and transformation.
Corporate Integration	RDUH felt that their focus on the PMO/IPB functions resulted in the integration executives feeling that they were neglecting how people in the organisation were feeling. Transacting trusts should employ, maintain and appropriately manage mechanisms in place for monitoring staff morale and sentiment in the organisations towards the transaction. This could be covered by staff surveys, staff briefings etc.
Corporate Integration	RDUH felt that the corporate integration process could have been better planned and the pace with which they were trying to deliver the PTIP was particularly challenging. RDUH specifically pointed to process mapping getting neglected at the expense of planning for assets and people. All aspects are important so transacting trusts should think about how they can effectively balance these needs. They should consider if there is sufficient time pre-transaction to complete these tasks and, where there is not time, develop plans to mitigate any integration risks.
Corporate Integration	It is essential that transacting trusts identify PTIP actions to understand what is critical/non negotiable for a safe and legal day 1 landing, what is a priority but not essential, and what are longer term priorities.
Corporate Integration	RDUH found resourcing requirements were understated and should have been wider – in particular the PMO would have benefitted from more resource in People and Digital teams. RDUH are aware that staff shortages played a role due to the location of the trusts but felt their integration resource was never sufficient. This resulted in some slippage in some digital services and People team actions. The feedback really heightens the importance of transacting trusts properly planning and ensuring that they have maximised the available resources and sought to mitigate areas where resources may be deemed insufficient. It is key that they are realistic about timescales and what is achievable with the resources available.
Corporate Integration	Transacting trusts should consider the impact of the timing of the transaction. For instance, a lot of trusts prefer a 1st April transaction for accounting purposes but with significant clinical integration programmes it may be advisable to pursue a mid-year transaction to avoid issues such as winter pressures.
Corporate Integration	RDUH stated that sometimes the merger rationale felt disconnected to ICS strategy/objectives. It is important to maintain clear comms with the ICS and align enabling strategies with the ICS strategies.

Lessons learned – for other trusts 4 of 5

Theme	Lessons learned/Recommendation
Digital Integration	RDUH emphasised the benefit of implementing a unified EPR. If transacting trusts are not currently able to plan to implement or are planning unified EPR implementation at a later date post transaction, they should consider any potential risks/limitations by not having the system in place as soon as reasonably possible post-transaction.
Digital Integration	Transacting trusts that are seeking to implement a unified EPR should, where possible, engage with other trusts, systems, regions and national teams (if relevant) with knowledge and/or experience on unified EPR implementations to help pre-empt any potential pitfalls or useful approaches.
Digital Integration	Whilst RDUH did not encounter any major interoperability issues with their EPR implementation, transacting trusts should be mindful that interoperability will vary by EPR when conducting integration planning and subsequent options appraisal.
Digital Integration	RDUH did encounter some unforeseen issues regarding data and reporting with the new EPR: • **Moving from manual reporting to system driven reporting:** This created some complexity as developing the BI scoreboards for teams took time, as did engaging with teams and configuration managers. • **Cross-site 'instances' resulting in errors in patient records:** EPIC has a manual 'instance' selection for each of the Eastern or Northern sites. This can result in updates to patient records being made on the 'wrong' instance. This requires correction, re-entry and creates a duplication of work. This appears to be an inherent risk with EPIC's EPR and any transacting trusts that are considering implementing EPIC should be mindful of this and factor it in to any training considerations and/or develop a clear plan to bring the 'instances' together. • **EPIC required significant training time to bring people up to speed with the new system:** Transacting trusts should consider if they have budgeted adequate training time, specifically clinical time, as there are intrinsic complexities in trying to manage rotas and other commitments to get clinicians available at the same time for training. The timing of training is also crucial. If it is too early prior to implementation, staff can forget, if it is too late, there is a risk of slippage or not everyone being suitably trained in time for implementation. • **Other digital system implementations were delayed due to needing to allocate resources to EPIC**: RDUH delayed its Learn+ system implementation in order to prioritise the EPR. RDUH noted an 'intrinsic slowness' in the pace at which change is implemented in an NHS environment and this should be factored into any implementation design and planning. It is crucial that transacting trusts accommodate for this accordingly and understand where clinical demands are and where to prioritise thoughtfully. Transacting trusts should also be cautious of being overambitious with digital demands.
Digital Integration	RDUH found that resourcing their system implementations to the required level is challenging and changes frequently. They also found that it can also be difficult to find adequate digital expertise. Transacting trusts should consider other system implementations/integrations that will be simultaneously occurring as resources may need to be reallocated based on the priority of systems. Transacting trusts should ensure they utilise a digital roadmap, which details timelines for new system implementations and how they plan to integrate different systems.
Digital Integration	EPR implementation should be strategically planned to avoid an overlap between the EPIC launch phase and known pressure periods and holiday times.

Lessons learned – for other trusts 5 of 5

Theme	Lessons learned/Recommendation
Digital Integration	RDUH's implementation of a 3rd party recruitment system, Career Gateway, resulted in 50% of new applications coming in from outside the NHS. The system was mainly used for medical roles in the first instance. RDUH noted a general lack of awareness outside the NHS of NHS Jobs and were able to mitigate some of the issue and recruit from a wider pool. Transacting trusts in similar circumstances should look at implementing 3rd party recruitment systems.
Digital Integration	RDUH experienced some difficulties when implementing a single financial ledger and procurement system. Most notably around training staff and getting them to understand the scale of change and slipping timelines leading to difficulties with data migration. RDUH's finance and procurement system was not ready in time and because of the delay they were unable to do sufficient testing, which delayed implementation further. As it got delayed further, data migration became more difficult. Transacting trusts should ensure properly planned timelines incorporating training plans and how data migration will be managed in various scenarios.
Digital Integration	RDUH also encountered issues with accessing legacy data (such as supplier contracts), so transacting trusts should be encouraged to properly consider how legacy data can be accessed.
Digital Integration	RDUH also stated there would be benefit in 'binding the suppliers with the plan to change procurement systems' to smooth implementation. Transacting trusts should consider contract terms and begin early discussions with suppliers when implementing a new procurement system to mitigate risks such as legacy data access or supply chain issues/delays arising from a new system.
Digital Integration	Trusts should ensure they explain how any new system implementations align with ICS strategy and have been considered with existing systems in common across system providers.
Digital Integration	For Trusts implementing EPIC (and other new EPRs), they should try and get most of their customisations and nuances incorporated in their system build itself. Response time to changes requested by users can be extended which results in people working on the system with glitches over a prolonged period of time.

Lessons learnt for NHSE

Lessons learned – for NHSE team 1 of 4

Theme	Lessons learned	Recommendation
Culture, integration and workforce	Setting up a cultural dashboard and cultural roadmap provided a useful structure and schedule to follow in the process of shaping the new organisational culture.	For future assurance reviews, in addition to exploring the current understanding of culture and cultural development plan, we should ensure we examine how the trust plans to monitor culture over time as part of full business case (FBC) Key Lines of Enquiry (KLOE) I2.
Culture, integration and workforce	In order for staff to view the merger as an inclusive process cultural integration needs to be undertaken in a fair manner i.e. without bias towards any particular Trust.	For acquisitions in particular, the review team should examine plans to ensure the acquired trust's voice is heard and institutional memory is not lost; consider governance structures/board representation, mechanisms for understanding culture at acquired trust, physical presence of senior leaders on the acquired site and key comms events (e.g. location of trust wide events)
Clinical integration	Single, strong clinical leadership is key to integrating specialties cross-site. It is essential to have the right person in place, so trusts will need to start the leadership campaign early. Clinical leads need to visit both sites, even if travel is difficult/lengthy.	As part of FBC review, examine the role that clinical integration champions will play and the trust's plans to appoint to key clinical lead roles across the combined service teams. Look for evidence that the trust will start leadership campaigns early and be creative, to get effective strong clinical leads in place to integrate services across sites. Confirm that leads will visit both sites, even if travel is difficult/lengthy.
Clinical integration	Wholesale alignment of clinical guidance and practices for the different clinical streams across both Trusts needs engagement and agreement from a range of stakeholders, particularly where there are interdependencies with other specialties. Delays in alignment can inhibit cross-site working.	The review team should evaluate the readiness / plans of the Trusts for alignment of clinical guidance and practices, during the FBC stage. Trusts will need a plan to harmonise key policies especially where these policies will act as an enabler for clinical teams to work differently. This should be considered as part of implementation planning. Further, agreements should be made with the Regional team to monitor the progress of such alignment plans.
Clinical integration	If performance is looked at on a site by site basis (e.g. SSNAP ratings) it can inhibit integration because clinicians will not want 'their' site to deteriorate in pursuit of better overall performance.	When assuring transactions and when designing and monitoring post transaction commitments (if relevant), the review teams should carefully balance the role of site level performance metrics in the context of overall incentives to integrate.
Cross site working	Various challenges faced by RDUH in relation to cross-site working: • Willingness of staff to travel • Bandwidth to support the other site • Time to build trust and establish credibility • Variation in pathways/protocols • Capacity and willingness to support from a distance, particularly in hyperacute services • Impact on recruitment at both sites (both benefits and potential disbenefits- consider how appealing will respective roles be if they involve a requirement to work cross site?)	When examining patient benefits proposals which will be enabled by cross site working, consider the extent to which these type of challenges have been understood and planned for, and what further mitigations are being considered.

Lessons learned – for NHSE team 2 of 4

Theme	Lessons learned	Recommendation
Workforce	In national shortage specialties, where there are many locum roles available, it can be challenging to recruit substantive members of staff. Enhanced packages may help but may not be sufficient to overcome lucrative locum work.	While evaluating the deliverability of savings / benefits projected by Trusts from converting locum posts into permanent positions, review teams should consider factors including: • National skills shortages • How the brand value and appeal of the role may change as a result of the transaction • How the offer will compare with opportunities being offered by other providers in the region • Remoteness of the location of hospital sites, demographic and other challenges associated with the geographical region of the hospital sites • Whether the trust is thinking creatively about how to make posts attractive e.g. research, management time
Workforce	Where there is limited prospect of recruiting to substantive roles eg due to national shortage, support for existing locums or enhancing their roles may help to retain them longer term.	• Where transaction benefits case relies on successful hiring, consider whether a 'Plan B' has been developed in the event that this is not successful
Corporate Integration	RDUH found that maintaining the IPB and PMO post transaction has been useful to keep moving integration along. They also noted that the IPB helped them identify 'integration risks that are not necessarily operational risks'.	• We should explore how long transaction governance structures are planned to be in place, and consider the potential impact on integration and any mitigations in place on if transacting trusts intend to wind down their transaction governance structures soon after go-live date.
Corporate Integration	RDUH stated that sometimes the merger rationale felt disconnected to ICS strategy/objectives. It is essential to maintain clear comms with the ICS.	• We should consider how convinced we are about the ICS's buy in to the transaction, how well sighted have they been on transaction progress and whether plans have been co-created. • We should also look at how we properly test that merger rationale is genuinely aligned with ICS strategy. We will need to examine whether the merger rationale has been collaboratively developed/tested between the merging trusts and the ICB, what communication is taking place, and how enabling strategies e.g. digital are being aligned.
Corporate Integration	RDUH were requested by NHSE to set out post-transaction commitments. The trust found these commitments to be quite useful and helped them keep focus on the year post-transaction. RDUH stated it was straightforward to report against the commitments and was 'easy to absorb' into the PTIP.	• Where commitments are identified, there should be clear post-transaction expectations, detailing what is being reported, when, where and how it is reported, and how any follow up processes will work. Objectives should be SMART. • We should also consider what role the system should have in monitoring/overseeing any post transaction commitments.

Lessons learned – for NHSE team 3 of 4

Theme	Lessons learned	Recommendation
Corporate Integration	RDUH replicated other trusts to inform the design of their governance structures. They specified that the guidance on the NHSE website could have been more helpful.	• We should consider if guidance on common governance structures observed in trusts post-transaction would be a useful tool to transacting trusts. This should be considered in conjunction with the Quality Governance team.
Corporate Integration	RDUH also suggested the inclusion of some points for inclusion in the PTIP, including information covering: 1) What pitfalls are you going to come up against? 2) When constructing the PMO, what skillset would you need? 3) Understanding the expectation of a realistic time-frame for the management of change process 4) More guidance around the business case, in particular templates for the PTIP. RDUH referred to other trusts' PTIPs but a standard template would have been useful.	• NHSE to consider updates to the transaction guidance or supplemental guidance to include commentary on PTIP contents as suggested by RDUH and any other trusts. • To consider potential for development of template or sample PTIPs to be shared with merging trusts.
Corporate Integration	RDUH found the PTIP format being used 'could be made easier, by breaking the actions down into critical, non-critical etc.'	• We should consider feedback in future Lessons Learnt exercises on PTIP contents and if it warrants amending the guidance for trusts and providing more clarity in particular on critical day 1 actions.

Lessons learned – for NHSE team 4 of 4

Theme	Lessons learned	Recommendation
Digital Integration	RDUH found that it required significant training time to bring people up to speed with the new EPR.	• We should consider if transacting trusts have budgeted sufficient training time for new EPR systems particularly if being undertaken alongside other system implementations or integration activity.
Digital Integration	RDUH flagged that ‘there is no joined up organisational structure within the NHS and hence, system implementation is customised and time consuming for each trust’.	• Feed back to regional digital leads and frontline digitisation programme to understand if there is support that can be provided to transacting trusts to help them increase the speed of new system implementation and customisation. For example, providing them with NHSE and/or peer contacts.
Digital Integration	System implementations need to align closely with wider ICS digital strategy and system counterparts need to understand the status of digital transformation so expectations are realistic.	• NHSE transaction review teams should ensure appropriate levels of questioning to the system, covering how involved the system has been on transacting trusts digital integration plans, any impacts on capacity and other significant digital changes happening in the system. It will be key to understand how the trust's plans align with the wider ICS digital roadmap. • Whilst already considered as part of the I3 KLOE, this lesson reemphasises the point to ensure that systems buy into and ideally are involved in co-creating transacting trusts’ digital plans.