Meeting of the Board of NHS Norfolk and Waveney Integrated Care Board

Tue 18 July 2023, 14:00 - 16:00

Agenda

14:00 - 14:00 0 min

Meeting agenda

- 00. 2023.07.18 NW ICB Public Meeting Agenda.pdf (3 pages)

14:00 - 14:00 0 min

1. Welcome and introductions - Apologies for absence

14:00 - 14:00 0 min

2. Minutes from previous meeting and matters arising

- 02. DRAFT NW ICB Board Part 1 Minutes 30052023.pdf (6 pages)

14:00 - 14:00 0 min

3. Declarations of interest

- 03. Board Register of Interests - July 23 (1).pdf (4 pages)

14:00 - 14:00 0 min

4. Chair’s Action Log

14:00 - 14:00 0 min

5. Action log – things we have said we will do

14:00 - 14:00 0 min

6. Chair and Chief Executive’s Report

- 06. Chair and Chief Executive's ICB Board report - Final.pdf (7 pages)

14:00 - 14:00 0 min

7. Mortality Review NSFT

- 7.1 NSFT Mortality Review Recommendations - Final.pdf (5 pages)
- 7.2 NSFT Mortality data recording May 2023 Final.pdf (60 pages)
- 7.3 Grant Thornton Action Plan Final.pdf (9 pages)

14:00 - 14:00 0 min

8. Questions from the public in relation to item 7 only

14:00 - 14:00 0 min

9. Norfolk and Waveney ICS Research and Innovation Strategy

- 09. 2023-07-18 ICS RI Strategy CY cover sheet (003).pdf (4 pages)
- 09. Research and Innovation Strategy (A4 Document) Final.pdf (13 pages)

14:00 - 14:00
0 min

Finance and Corporate Affairs

14:00 - 14:00
0 min

10. Financial Report for Month 2

- 10. ICB Finance Report - Month 02 - Board.pdf (8 pages)

14:00 - 14:00
0 min

11. Financial Plan for 2023/24

- 11. ICB Board paper - 23-24 ICB Final plan submission cover paper.pdf (2 pages)
- 11. 23-24 ICB Final plan submission.pdf (7 pages)

14:00 - 14:00
0 min

12. Governance Handbook approval Executive Leads Guidance

- 12. Gov Handbook refresh July 2023.pdf (2 pages)

14:00 - 14:00
0 min

13. Board Assurance Framework

- 13. BAF Paper for ICB Board Part 1- July 23.pdf (3 pages)
- 13. ICB Board Assurance Framework (BAF) 2023-24 LIVE V1 (3).pdf (44 pages)

13.1.

14:00 - 14:00
0 min

Committees Update and Questions from the public

14:00 - 14:00
0 min

14. Report from the Quality and Safety Committee

- 14. Quality and Safety Committee Report to Board v1.0.pdf (9 pages)

14:00 - 14:00
0 min

15. Report from the Finance Committee

- 15. Fin Com Chair Report to Board.pdf (3 pages)

14:00 - 14:00
0 min

16. Report from the Primary Care Commissioning Committee

- 16. 23-07-10 PCCC for ICB Board.pdf (6 pages)

14:00 - 14:00
0 min

17. Report from the Audit and Risk Committee

- 17. 2023.06.22-ARC Report to Board.pdf (5 pages)

14:00 - 14:00
0 min

18. Report from the Remuneration, People and Culture Committee

14:00 - 14:00
0 min

19. Report from the VCSE Assembly

- 19. Assembly July Report 18.07.23.pdf (3 pages)
- 19. VCSE Assembly July 2023 review notes.pdf (25 pages)

14:00 - 14:00
0 min

20. Questions from the Public. Where questions in advance relate to items on the agenda.

14:00 - 14:00
0 min

21. Any other business

NHS
Norfolk and Waveney
Integrated Care Board

Meeting of the Board of NHS Norfolk and Waveney Integrated Care Board (ICB)

Tuesday, 18 July 2023, 2.00pm – 4.00pm

(In Public)

Meeting venue: Norwich Research Park (Quadram Institute, Rosalind Franklin Road, Norwich Research Park, Norwich, Norfolk, NR4 7UQ); - Rooms 55b and 55c)

Our mission: To help the people of Norfolk and Waveney live longer, healthier and happier lives.

Our goals:

1. **To make sure that people can live as healthy a life as possible.**
2. **To make sure that you only have to tell your story once.**
3. **To make Norfolk and Waveney the best place to work in health and care.**

Chair: Rt Hon. Patricia Hewitt

Item	Time	Agenda Item	Lead
1.	2.00	**Welcome and introductions - Apologies for absence**	Chair
2.		**Minutes from previous meeting and matters arising** To approve the part 1 public minutes of the previous Board meeting.	Chair
3.		**Declarations of interest** To declare any interests that board members may have specific to agenda items that could influence the decisions they make. Declarations made by members of the ICB Board are listed in the ICB's Register of Interests. The Register is available via the ICB's website.	Chair
4.		**Chair's Action Log** To receive an update from the Chair on actions taken since the last meeting. There are no Chairs Action to report at this meeting.	Chair
5.		**Action log – things we have said we will do** To make sure the ICB completes all the actions it agrees are needed. There are no actions to report at this meeting.	Chair
6.	2.05	**Chair and Chief Executive's Report** To note an update from the Chair and the Chief Executive of the ICB about the work the ICB has done since the last meeting.	Chair and Tracey Bleakley

Item	Time	Agenda Item	Lead
		Presentation of the Board	
7.	2.15	**Mortality Review NSFT** • Opening remarks from the Chair • Introduction to the Mortality Review • Anne Humphrys and Caroline Aldridge response to the Mortality Review	Patricia Hewitt Tricia D'Orsi
8.		**Questions from the public in relation to item 7 only**	Chair
9.	3.15	**Norfolk and Waveney ICS Research and Innovation Strategy** To receive and note the Norfolk and Waveney ICS Research and Innovation Plan.	Dr Clara Yates
		Finance and Corporate Affairs	
10.	3.20	**Financial Report for Month 2** To receive a summary of the financial position as at month 2.	Steven Course
11.	3.25	**Financial Plan for 2023/24** To receive and approve the financial plan for 2023/24.	Steven Course
12.	3.35	**Governance Handbook approval Executive Leads Guidance**	Karen Barker
13.	3.40	**Board Assurance Framework** A review of the risks (things that might go wrong and how we can alleviate them) within the Integrated Care system.	Karen Barker
		Committees Update and Questions from the public	
14.	3.45	**Report from the Quality and Safety Committee**	Aliona Derrett
15.		**Report from the Finance Committee**	Hein Van Den Wildenberg
16.		**Report from the Primary Care Commissioning Committee**	Hein Van Den Wildenberg
17.		**Report from the Audit and Risk Committee**	David Holt
18.		**Report from the Remuneration, People and Culture Committee** – this update will be provided verbally	Cathy Armor
19.		**Report from the VCSE Assembly**	Emma Ratzer
20.	3.55	**Questions from the Public.** Where questions in advance relate to items on the agenda.	Chair
21.		**Any other business**	Chair

Item	Time	Agenda Item	Lead
Date, time and venue of next meeting: **Tuesday, 26 September 2023 via Microsoft Teams**			
Any queries or items for the next agenda please contact: **nwccg.corporateaffairs@nhs.net**			

Some explanations of terms used in this Agenda.

Please see further terms defined on our website www.improvinglivesnw.org.uk

Integrated Care System (ICS) - new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

Integrated Care Board (ICB) - an organisation with responsibility for NHS functions and budgets. Membership of the board includes 'partner' members drawn from local authorities, NHS trusts/foundation trusts and primary care.

Clinical Commissioning Group (CCG) – NHS bodies that will be replaced by ICBs on 1st July 2022.

Integrated Care Partnership (ICP) - a statutory committee bringing together all system partners to produce a health and care strategy. Representatives include voluntary, community and social enterprise (VCSE) organisations and health and care organisations, and representatives from the ICB board.

Health and Wellbeing Partnerships (HWP) - are local place-based partnerships work on addressing the wider determinants of health, reducing health inequalities and aligning NHS and local government services and commissioning.

Lived experience - knowledge gained by people as they live their lives, through direct involvement with everyday events. It is also the impact that social issues can have on people, such as experiences of being ill, accessing care, living with debt etc.

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NHS Norfolk and Waveney Integrated Care Board

DRAFT Minutes of the meeting on Tuesday, 30 May 2023

PART 1 – Meeting in public

Board members present:

- Rt Hon. Patricia Hewitt (PH), Chair, NHS Norfolk and Waveney ICB
- Tracey Bleakley (TB), Chief Executive, NHS Norfolk and Waveney ICB
- Steven Course (SCou), Director of Finance, NHS Norfolk and Waveney ICB
- Patricia D'Orsi (PD'O), Director of Nursing, NHS Norfolk and Waveney ICB
- Hein Van Den Wildenberg (HvdW), Non-Executive Member, NHS Norfolk and Waveney ICB
- Cathy Armor (CA), Non-Executive Member, NHS Norfolk and Waveney ICB
- Aliona Derrett (AD), Non-Executive Member, NHS Norfolk and Waveney ICB
- Cllr Bill Borett (BB), Chair, Norfolk Health and Wellbeing Board, and Chair, Norfolk and Waveney ICP
- Dr Hilary Byrne (HB), Partner Member – NHS Primary Medical Services
- Jonathan Barber (JBa), Partner Member – NHS Trusts (Acutes)
- James Bullion (JBu), Local Authority Partner Member
- Sue Cook (SCoo), Local Authority Partner Member

Participants and observers in attendance:

- Karen Barker (KB), Director of Corporate Affairs and ICS Development, NHS Norfolk and Waveney ICB
- Mark Burgis (MB), Patients and Communities Director, NHS Norfolk and Waveney ICB
- Jocelyn Pike (JP), Acting Director of Mental Health Transformation, NHS Norfolk and Waveney ICB
- Andrew Palmer (AP), Director of Performance, Transformation and Strategy, NHS Norfolk and Waveney ICB
- Ema Ojiako (EO), Director of People, NHS Norfolk and Waveney ICB
- Ian Riley (IR), Director of Digital and Data, NHS Norfolk and Waveney ICB
- Alex Stewart (AS), Chief Executive, Healthwatch Norfolk

Attending to support the meeting:

- Sadie Parker (SP), Director of Primary Care, NHS Norfolk and Waveney ICB (for item 8)
- Sheila Glenn (SG), Director of Planned Care and Cancer, NHS Norfolk and Waveney ICB (for item 13)
- Chris Williams (CW), Senior Support Manager, NHS Norfolk and Waveney ICB (Minutes)

1.	**Welcome and introductions - apologies for absence**	
	The Chair welcomed everyone to the meeting. Apologies were received from the following ICB Board members: • David Holt (DH), Non-Executive Member, NHS Norfolk and Waveney ICB • Stephen Collman (SCol), Partner Member – NHS Trusts (Mental Health and Community Services)	

	• Dr Frankie Swords (FS), Medical Director, NHS Norfolk and Waveney ICB • Emma Ratzer (ER), Voluntary, Community and Social Enterprise Sector Board Member The Chair noted that JBa's role on the Board had been extended for two more years. She also congratulated JBu on his secondment to the Care Quality Commission and explained that the ICB is going through the process to secure a replacement on the Board.	
2.	**Minutes from previous meeting and matters arising**	
	Agreed: The draft minutes from the meeting held on 28 March 2023 were approved as an accurate record of the meeting.	
3.	**Declarations of interest**	
	The Chair noted that declarations of interest are kept up-to-date and are available on the ICS's website.	
4.	**Chair's action log**	
	The Chair explained that there were no actions to report at the meeting.	
5.	**Action log**	
	The report was noted and the board approved the closure of actions 3, 8, 9 and 10.	
6.	**Chair and Chief Executive's Report**	
	The Chair congratulated the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust on being added to the Government's New Hospital Programme and noted that it will be an important investment for the whole system. TB introduced the item by highlighting key points from the report. Questions and comments from Board members: • HvdW noted he was pleased to read that we had achieved the national target for health checks for people with learning disabilities. The report was noted.	
	Learning from people, staff and communities	
7.	**Learning from people, staff and communities**	
	PD'O introduced the item, which focused on revisiting the learning from people, staff and communities items from the first four ICB Board meetings to find out what had changed as a result. Questions and comments from Board members: • AP explained he finds these items to be the most powerful part of the meeting, adding that he was interested to see the work on wrap around care around discharge as it will make a real difference to people.	

	• CA noted that there can be a big difference between the health and care needs of people over 65 and people over 80, and she asked how our strategy would deal with that. • PD'O explained that we're all individuals and there are many variables which impact on a person's health and care needs, adding that we need to ensure personalisation is considered when we commission services. • The Chair asked how older people with multiple conditions who have had to wait to be discharged from hospital, as well as their families, had been involved in our work on improving discharge. • PD'O explained that there were seven people with lived experience at the discharge workshop. She added that discussions were ongoing about people with lived experience attending the Discharge Programme Board, so that they could share their experience and to challenge us about how we could do better. The report was noted.	
	Items for sharing and Board consideration	
8.	**Norwich Walk in Centre outcomes and approvals**	
	MB introduced the item by noting the support of the Primary Care Commissioning Committee for the recommendations. He thanked everyone who had responded to the consultation and Healthwatch Norfolk for their support with publicising the consultation and sharing the feedback they had received. SP explained that there was overwhelming support to keep the walk-in centre open and to increase its capacity if we could. Questions and comments from Board members: • AD asked if the walk-in centre is open to people not registered with a practice. • SP confirmed that the walk-in centre is open to anyone and that people visiting the area use it too. **Agreed:** The ICB Board: • agreed to commission a new contract for the Walk-in Centre, the Vulnerable Adults Service and the Rouen Road GP Practice when the current contract expires in March 2024. • noted that a review would be conducted into what capacity could be released at the GP Practice at Rouen Road in order to create additional patient access to primary medical care at the Walk-in Centre and to support the resilience of general practice.	
9.	**Joint Forward Plan**	
	The Chair highlighted that the draft Joint Forward Plan was rooted in our Integrated Care Strategy, and recognised the enormous amount of work and engagement that had been done to develop the draft plan.	

	AP introduced the item by thanking all the people who given their time to share their views on what should be included in the plan and to system colleagues for their work to develop the draft. He noted that the draft plan had been discussed at the Patients and Communities Committee and the Suffolk Health and Wellbeing Board, and that it would be discussed at the next Norfolk Health and Wellbeing Board meeting. Questions and comments from Board members: • JBa commented that the draft plan was a good foundation for us to build on and that it would continue to be refined, adding that there had been a lot of good engagement with partners to develop it. • CA noted that it is a lengthy document and that it would be good if could be more concise. • HB commented that it is great document, but it will require a huge amount of work to deliver it. • AD and BB highlighted that prevention and early intervention are important, and that we need to be really clear in the plan about this. BB suggested that prevention could be listed as the first ambition in recognition of this. • The Chair explained that the only way to solve the problems we face now is to change focus to prevention and early intervention. In terms of the language in the plan, she recommended the communications principles from the patients association. She also suggested really highlighting the key demographic changes we are experiencing in the plan. • HB highlighted self-care and that we need to help people to know how and when to use services. She also noted the need for people to treat staff kindly, as they are increasingly experiencing more difficult interactions with patients and this is making it more difficult to retain staff. • AP noted that ultimately the plan would be judged on whether we make a difference to people's lives. **Agreed:** The ICB Board endorsed the draft Joint Forward Plan, including the ambitions and objectives.	
	Finance and Corporate Affairs	
10.	**Financial Report for Month 12**	
	SCou introduced the item, noting that the consolidated CCG and ICB year-end position was a surplus of £0.2m and the month 12 position for the Integrated Care System was a £19.7m deficit. He added that the month 12 capital funding position (Capital Delegated Expenditure Limit) was £98.1m, £0.8m lower than planned. SCou explained that we had submitted a break-even budget for 2023/24, but that there was a large amount of risk in the plan, which includes a 5.1% efficiency programme.	

	Questions and comments from Board members: • The Chair thanked partners for the work done to agree a break-even budget for 2023/24. • HvdW noted the level of risk and that the Finance Committee would be closely monitoring performance against the plan. • BB explained that where the report describes the financial position of the ICS, it should say the financial position of the NHS organisations, as it doesn't include wider partners, such as the local authorities. The report was noted.	
11.	**Additional review of the Governance Handbook**	
	KB introduced the item by highlighting key points from the report. **Agreed:** The ICB Board approved the amendments to the Patients and Communities Committee terms of reference and the Performance Committee terms of reference contained within the Governance Handbook.	
12.	**Board Assurance Framework**	
	KB introduced the item by highlighting key points from the report. The Board received and reviewed the risks presented on the Board Assurance Framework.	
13.	**IFR Drugs Policy Approval and IFR Non-Drugs Policy Approval**	
	KB introduced the item by highlighting key points from the report. Questions and comments from Board members: • PD'O asked how confident we are that colleagues in primary care were being made aware of changes and in the process for communicating changes. • SG committed to making sure that the right communications processes are in place. **Agreed:** The ICB Board approved the revised policies as per the recommendation of the Planned Care and Medicines Management Working Group.	
	Committees update and questions from the public	
14.	**Report from the Quality and Safety Committee**	
	The report was noted.	
15.	**Report from the Finance Committee**	
	The report was noted.	
16.	**Report from the Primary Care Commissioning Committee**	
	The report was noted.	
17.	**Report from the Performance Committee**	
	The report was noted.	

18.	**Report from Patients and Communities Committee**	
	The report was noted.	
19.	**Report from the Audit and Risk Committee**	
	The report was noted.	
20.	**Report from the Remuneration, People and Culture Committee**	
	The report was noted.	
21.	**Report from the Conflicts of Interest Committee**	
	The report was noted.	
22.	**Questions from the public**	
	There were no questions from the public.	
23.	**Any other business**	
	No other business was raised.	

Date, time and venue of next meeting:

Tuesday, 27 June 2023, The Green Room, Norfolk Record Office, The Archive Centre, Martineau Lane, Norwich, Norfolk NR1 2DQ

Any queries or items for the next agenda please contact:
nwccg.corporateaffairs@nhs.net

Minutes agreed as accurate record of meeting:

Signed: …… Date: ……...
Chair

NHS Norfolk and Waveney Integrated Care Board (ICB)
Register of Interests

Declared interests of the Board

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
Patricia Hewitt	Chair, Norfolk and Waveney ICB	FTI Consulting	X			Direct	Senior advisor, FTI Consulting	2015	Present	Since January 2022 I have not undertaken any work on healthcare or life sciences. Will declare at relevant meetings if a risk arises.
		Newnham College Cambridge			X	Direct	Honorary Associate, Newnham College Cambridge	2018	Present	No conflicts have arisen or foreseen
		Oxford India Centre for Sustainable Development			X	Direct	Chair, Oxford India Centre for Sustainable Development	2018	Present	No conflicts have arisen or foreseen
		ORA Choral Ensemble			X	Direct	Chair, trustees, ORA Choral Ensemble	2020	Present	No conflicts have arisen or foreseen
		Age UK Norfolk			X	Direct	Volunteer, Age UK Norfolk	2020	Present	Declaration of interest made in any relevant conversation
Catherine Armor	Non-Executive Member, Norfolk and Waveney ICB	Brundall Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Norwich University of the Arts			X	Direct	Deputy Chair of Council, Norwich University of the Arts	2019	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Evolution Academy Trust			X	Direct	Trustee, Evolution Academy Trust	2022	Present	
		Cambridge University Press		X		Direct	Trustee, Cambridge University Press Pension Schemes	Ongoing		
		East of England Ambulance Service NHS Trust	N/A			Indirect	Daughter-in-law is Technician for East of England Ambulance Service NHS Trust	Ongoing		
Jon Barber	Partner Member - Acute, Norfolk and Waveney ICB	Broadland St Benedicts			X	Direct	Non-executive Director of Broadland St Benedicts – the property development subsidiary of Broadland housing Group	2020	Present	Although risks are minimal this will always be declared as with Trust Board declaration of interests
		James Paget University Hospitals		X		Direct	Deputy CEO of James Paget University Hospitals NHS FT	2022	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Great Yarmouth & Waveney		X		Direct	GY&W Place Chair	Ongoing		
		Acle GP Partnership			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Debbie Bartlett	Partner Member - Local Authority (Norfolk), Norfolk and Waveney ICB	Norfolk County Council		X		Direct	Interim Executive Director Adult Social Services, Norfolk County Council	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Diss Parish Fields			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest

NHS Norfolk and Waveney Integrated Care Board (ICB)
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			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
Tracey Bleakley	Chief Executive Officer, Norfolk and Waveney ICB	Drayton & St Faiths Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Bill Borrett	Norfolk Health & Wellbeing Board Chair	North Elmham Surgery			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Norfolk County Council	X			Direct	Elected Member of Norfolk County Council, Elmham and Mattishall Division	Ongoing		Low risk. In attendance as a representative of the Local Authority. Chair will have overall responsibility for deciding whether I be excluded from any particular decision or discussion.
		Norfolk County Council	X			Direct	Cabinet Member for Adult Social Care and Public Health	Ongoing		
		Norfolk County Council	X			Direct	Chair of Norfolk Health and Wellbeing Board	Ongoing		
		Breckland District Council	X			Direct	Elected Member of Breckland District Council, Upper Wensum Ward	Ongoing		
		Norfolk County Council	X			Direct	Chair of Governance and Audit Committee	Ongoing		
		Manor Farm	X			Direct	Farmer within Dereham patch	Ongoing		Low risk. If there is an issue it will be raised at the time.
Dr Hilary Byrne	Partner Member - Primary Medical Services	Attleborough Surgeries	X			Direct	GP Partner at Attleborough Surgeries	2001	Present	To be raised at all meetings to discuss prescribing or similar subject. Risk to be discussed on an individual basis. Individual to be prepared to leave the meeting if necessary.
		MPT Healthcare Ltd	X			Direct	Director of MPT Healthcare Ltd	2020	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Norfolk Community Health and Care Trust (NCH&C)				Indirect	Spouse is employee of NCH&C (Improvement Manager)	2021	Present	
		South Norfolk PCN				Indirect	Clinical Director of SNHIP Primary Care Network	2022	Present	
Stephen Collman	Partner Member - Mental Health and Community, Norfolk and Waveney ICB	Norfolk Community Health and Care NHS Trust		X			Chief Executive, Norfolk Community Health and Care NHS Trust	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.

NHS Norfolk and Waveney Integrated Care Board (ICB)
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			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
Sue Cook	Partner Member - Local Authority (Suffolk), Norfolk and Waveney ICB	Suffolk County Council		X		Direct	Executive Director Adult Social Services, Suffolk County Council	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
Steven Course	Executive Director of Finance, Norfolk and Waveney ICB	March Physiotherapy Clinic Limited				Indirect	Wife is a Physiotherapist for March Physiotherapy Clinic Limited	2015	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards March Physiotherapy Clinic Limited
Aliona Derrett	Non-Executive Director	Norfolk and Norwich University Hospitals NHS FT				Indirect	My son-in-law, Richard Wharton, is a consultant surgeon at NNUHFT	2004	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Hear for Norfolk	X			Direct	I am the Chief Executive of Hear for Norfolk (Norfolk Deaf Association). The charity holds contracts with the N&W ICB.	2010	Present	
		Derrett Consultancy Ltd	X			Direct	I am the Director of Derrett Consultancy Ltd.	2018	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Norfolk and Waveney MIND				Indirect	My husband, Robin Derrett, is the HR Director at Norfolk & Waveney MIND. MIND holds contracts with the N&W ICB	2021	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		MoldovaDAR Ltd	X			Direct	I am Director of MoldovaDAR Ltd	Ongoing		Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		St Stephen's Gate Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice
Patricia D'Orsi	Executive Director of Nursing, Norfolk and Waveney ICB	Royal College of Nursing		X		Direct	Member of Royal College of Nursing	Ongoing		Inform Chair and will not take part in any discussions or decisions relating to RCN
David Holt	Non-Executive Member, Norfolk and Waveney ICB	Solebay Health Centre			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Department of Work and Pensions	X			Direct	Non-Executive Board Member, Department for Work and Pensions. Chair of the Audit Committee and Chair of the Health Transformation Programme Board	2019	May-23	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Ministry of Defence	X			Direct	Non Executive Director, Audit and Risk Assurance Committee, Ministry of Defence	2022	Present	In the unlikely event that a decision having an impact on either of the declared parties arises, a decision will be made with the

NHS Norfolk and Waveney Integrated Care Board (ICB)
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			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
		Newberry Clinic				Indirect	Wife is Consultant Community Paediatrician, Newberry Clinic (Great Yarmouth)	Ongoing		arises, a decision will be made with the relevant chair to assess the risks. Appropriate action will be taken accordingly.
Andrew Palmer	Deputy Chief Executive Officer, Norfolk and Waveney ICB	James Paget University Hospitals				Indirect	My wife works at the JPUH, in a non-decision making role	Ongoing		Any decision relating specifically to the JPUH should ideally be made by the ICB's CEO. However, in their absence the
Emma Ratzer	Partner Member - VCSE	Access Community Trust	X			Direct	I am the Chief Executive Officer of Access Community Trust, an organisation which holds contracts with NWICB	2009	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards Community Access Trust
		VCSE Assembly			X	Direct	I am CEO of a voluntary sector organisation operating in NWCCG and Independent Chair of NWVCSE Assembly	2021	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest
Dr Frankie Swords	Executive Medical Director, Norfolk and Waveney ICB	Norfolk and Norwich University Hospitals NHS FT		X		Direct	Honorary Consultant Physician and Endocrinologist at Norfolk and Norwich University Hospitals NHS FT (1 day a week)	2008	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		N/A			X	Direct	Ad-hoc Clinical Advisor of multiple patient charities - Addison Self Help Group - Pituitary Patient Support Group - Turner syndrome Society	2008	Present	
		Long Stratton Medical Partnership			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		British Medical Association		X		Direct	Member of the BMA	Ongoing		Inform Chair and will not take part in any discussions or decisions relating to BMA
		N&W VCSE provider				Indirect	Husband is a mental health counsellor and undertakes private work as well as voluntary work with N&W VCSE provider Emerging Futures	Sep-22	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of counselling services by Emerging Futures
Hein van den Wildenberg	Non-Executive Member, Norfolk and Waveney ICB	Lakenham Surgery			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		College of West Anglia			X	Direct	Governor at College of West Anglia (Note: the College hosts the School of Nursing, in partnership with QEHKL and borough council)	2021	Present	Low risk. If there is an issue it will be raised at the time.

Norfolk and Waveney
Integrated Care Board

Agenda item: 6

Subject:	**Chair and Chief Executive's report**
Presented by:	**Rt Hon. Patricia Hewitt, Chair, NHS Norfolk and Waveney ICB** **Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB**
Prepared by:	**Rt Hon. Patricia Hewitt, Chair, NHS Norfolk and Waveney ICB** **Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB**
Submitted to:	**ICB Board**
Date:	**18 July 2023**

Purpose of paper:

To update members of the Board on the work of the ICB.

Executive Summary:

The report covers the following:

A. Mortality review
B. Our first year as an Integrated Care Board and 75 years of the NHS
C. ICB organisational review and restructure
D. Government response to the Hewitt Review
E. Change of leadership at the Norfolk and Norwich University Hospitals NHS Foundation Trust
F. Meetings and visits

Report

A. Mortality review

We will discuss in depth at our Board meeting the independent review examining the reporting of patient deaths at the Norfolk and Suffolk NHS Foundation (NSFT). There are three things we want to state clearly now.

First, our thoughts are with those family and friends who have lost their loved ones and may feel distressed by this review. There is no doubt it is difficult to read. With NHS Suffolk and North-East Essex ICB, a new support service has been set up to listen to people who have been affected by the report. Just B, an independent northern charity is available to help people in Norfolk and Suffolk. It is an organisation that has no connection with services across Norfolk and Suffolk, including NSFT. More information about the service and how to access it can be found here:

https://improvinglivesnw.org.uk/just-b-support-line-set-up-to-listen-to-people-in-norfolk-and-suffolk/

Second, we are grateful for the time and dedication that Caroline Aldridge, Anne Humphrys and Emma Corlett have put into producing their response to the mortality review, particularly given how difficult and triggering that must have been for them personally. We will consider it fully as a Board.

Our third and final point is this; we will act. We commissioned the independent review because only by understanding a challenge can it be solved, and this is a problem that we need to solve. The report is clear about the actions the Trust and partners need to take, and both integrated care boards covering Norfolk and Suffolk will support NSFT and local health and care organisations to make the necessary changes.

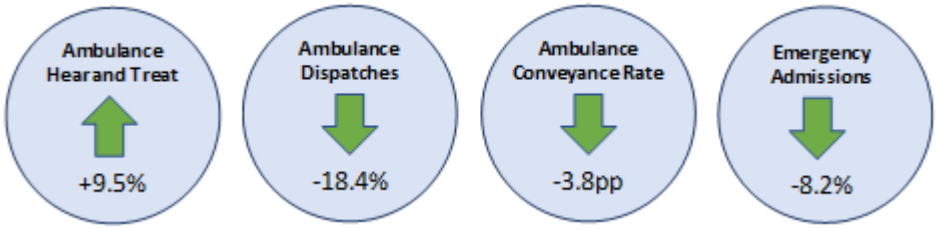
B. Our first year as an Integrated Care Board and 75 years of the NHS

The first of July marked a year since the Health and Care Act came into force and we were established as an integrated care board. During that year we have made some real progress and made changes we should be proud of; equally, there have been some very difficult challenges, not least an incredibly hard winter when we had the ‘twindemic’ of flu and COVID-19 circulating.

We have always said our success should be judged on if we are making a real difference to people’s lives. We have:

- **Reduced waits for planned care:** By April 2023 we had treated all but a few people waiting more than 18 months for routine care. Achieving this was the result of close collaboration between our hospital trusts, making effective use of all available capacity, and strengthening our relationships and mutual aid arrangements across healthcare systems.
- **Continued to make progress with pre-hospital care and managing demand for urgent and emergency care:** As a Sustainability and

Transformation Partnership we set ourselves ambitious goals. With all partners working together, including the acute trusts, community providers, EEAST, 111, social care and primary care, we beat our expectations. Compared with 2019/20, there's been:



- **Increased the number of appointments in general practice:** In 2019/20 there were 6.3 million appointments; this increased to 6.97 million in 2022/23. On top of this, general practice also delivered 925,698 COVID-19 vaccinations between April 2021 and March 2023. In April 2023, 78% of appointments were face-to-face (compared to 70% nationally) and 226,700 people were seen on the same day or the next day.

We have continued to progress, innovate and modernise how and where we provide care:

- **Protect NoW:** Building on the award winning Covid Protect, we now have Protect NoW, a GP-led, system-wide approach that couples smart data analytics to identify at risk patients and proactive personal contact. It is delivering real results, such as significant improvements in vaccination uptake and in patient engagement for Type 2 diabetes. This is helping our system to provide more anticipatory and preventative care.
- **The Wellness on Wheels Bus:** To make it easier for people to get services, support and information, particularly people who do not access services in more traditional ways, we have introduced the Wellness on Wheels Bus. It visits communities offering services such as vaccinations and screening, along with health and financial advice.
- **Carers passport:** We have created a carers passport to help unpaid carers get the recognition they need to help them to do their caring role. The passports were co-produced with local carers in a project funded by the ICB and run in partnership with Carers Voice and Caring Together. Over 1,000 passports have already been issued.

We have made good progress with two key projects in our Digital Strategy:

- The Norfolk and Waveney Shared Care Record is live following successful system testing. The Shared Care Record is a way of bringing together a person's records from the different organisations involved in their health and social care. These are then visible to the appropriate frontline health and social care professionals, at the point of care.
- We are procuring an electronic patient record for our three acute hospital trusts. The move from paper-based patient records to electronic ones will mean that staff will be able to access a patient's health and care information quickly and securely, making their experience quicker and care better.

We are making significant investment in our estates, including:

- The James Paget and Queen Elizabeth Hospitals are now both part of the national New Hospital Programme. The James Paget has opened its new concept ward and the Queen Elizabeth has started the enabling work needed.
- Norfolk and Suffolk NHS Foundation Trust has started work on building three new state-of-the-art wards and refurbishing two existing wards at The Rivers Centre, at Hellesdon Hospital.
- Investment in Diagnostic Assessment Centres at our three acute hospitals will help people to be diagnosed and treated earlier for cancer and many other conditions.
- Four Primary Care Hubs will be operational in 2024 – we are building two new healthcare facilities in King's Lynn and Rackheath, and renovating and extending two existing healthcare buildings in Sprowston and Thetford.

Importantly, our improvements are being recognised by others too:

- The Care Quality Commission (CQC) highlighted the improvements made by the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, and the Trust was taken out of the Recovery Support Programme (what used to be called special measures) in 2022.
- More recently, the CQC has recognised the improvements being made by Norfolk and Suffolk NHS Foundation Trust.
- Ofsted has also recognised the really significant improvements made by Children's Services in Norfolk over the past few years. Their most recent inspection report rated Children's Services as "good" and highlighted "exemplary" and "exceptional" areas of practice.

We are making a difference. While this is of course positive, we know we have a lot to do as a system to ensure we are consistently providing the right the level of care. Our second year will have its own challenges, there's more we need and will be doing to improve the quality of and access to care, as well as to support and grow our workforce, all of which we will need to do while living within our means.

We already had an integrated care strategy for Norfolk and Waveney, and now we have a five-year joint forward plan that sets-out the key actions we will be taking to help us tackle the challenges we face and to achieve our mission of helping people live longer, healthier and happier lives. Our new five year plan can be read here:

https://improvinglivesnw.org.uk/norfolk-and-waveney-5-year-joint-forward-plan/

The NHS turned 75 on the fifth of July. The health service is an institution and an idea that we are rightly proud of as a country, and we should all be thankful to those who work day-in, day-out, across health and social care, doing their best to care for us, our families and our friends. Over the course of its history, the NHS has continually adapted as society, technology and medicine have changed and advanced. Our five-year plan will help it to adapt the challenges we face now and put the NHS on the right footing for the future.

C. ICB organisational review and restructure

As the Board knows, the ICB is carrying out an organisational review and restructure. This is needed for two reasons: Firstly, all ICBs need to make a reduction of c35% to their running costs. Secondly, the current structure was put in place when we were a CCG and we need to review this based on what we have learnt since July and to take account of the organisation's new functions and role as a convener of the system.

The ICB's proposed new structure will be shared with staff on 20 July. We want to thank colleagues for their ideas which have informed the organisational review and for their continued dedication to their jobs while we've been going through this process, we know the current uncertainty is tough for people and that the next stage will be difficult too. As an employer we will support our staff throughout this process and we will listen to them as we consult colleagues on the proposed new structure.

D. Government response to the Hewitt Review

Since we last met, the Government has responded to both my review and the Health and Social Care Committee's report on the autonomy and accountability of integrated care systems.

I particularly welcome the Government's strong statement of support for ICSs and commitment to making them a success. This is reinforced by their commitment to reduce the number of national priorities and targets including in the new NHS Mandate and to keep in-year funding and associated reporting requirements to a minimum. I am also pleased to see the recognition of the need for stronger cross-government collaboration to support ICSs and support for leadership development that goes beyond health to care and other sectors.

I also welcome the commitment from NHS England, building on their new operating framework, to co-design the support and route map to enable all ICBs to mature and become self-improving systems. The recent work on the forthcoming ICB governance reviews is an excellent example of this new approach which I hope will be a model for the future.

The Government's response can be read here:
https://www.gov.uk/government/publications/government-response-to-the-hscc-report-and-the-hewitt-review-on-integrated-care-systems

E. Change of leadership at the Norfolk and Norwich University Hospitals NHS Foundation Trust

We want to thank Sam Higginson for everything he has done while Chief Executive of the Norfolk and Norwich University Hospitals (NNUH), particularly his leadership through the pandemic and over the last year as services have been recovering. He will be a real asset to NHS England working on the national elective recovery programme.

Nick Hulme will be the interim Chief Executive while the trust recruits a permanent replacement. He is an experienced leader and we look forward to working with him and learning from what he has been doing in Suffolk and Essex. Nick will be working with the NNUH from 14 August until February 2024 and he will also remain the Chief Executive at East Suffolk and North Essex NHS Foundation Trust during that time.

F. Meetings and visits

We wanted to highlight some the meetings we've attended and visits we've made to interesting local organisations. These have included:

As Chair, meetings and visits have included:

- With Tracey, I attended the NHS Confederation's ConfedExpo, where I spoke about my review and Tracey about provider collaboratives and systems. It was a good opportunity to share challenges and solutions with peers from across the country. I also attended the Digital Leaders Forum run by the NHS Confederation and spoke about the digital recommendations in my review.
- Also with Tracey, I attended the Norfolk Health and Wellbeing Board / Integrated Care Partnership. Amongst other things, we had helpful discussions on our Joint Forward Plan, improving pharmacy, ophthalmology and dental services, and preventing cardiovascular disease.
- I chaired a really useful session with non-executives from across our system. Tracey led a discussion about our progress as a system and plans for the future, which was followed by an insightful session about the role of non-executives in integrated care systems.
- I really enjoyed attending the East Coast Community Healthcare CIC Board meeting and finding out more about where they are at as an organisation and their plans for the future. I then met with a few colleagues from ECCH to talk through the Community Services Review and model for community services.

  We have just launched a big engagement exercise about this and are keen to hear from local people and staff about what they think of community health and social care services – all the information is available here:

  https://improvinglivesnw.org.uk/we-need-your-help-to-shape-health-and-care-services-in-the-community/
- Tracey and I were both involved in the recruitment of a new Chair for the James Paget University Hospital NHS Foundation Trust. We had some very high caliber candidates and the result will be announced shortly.

As Chief Executive, a significant focus has been on ICB's organisational review, but other meetings and visits have included:

- I had an interesting visit to Pathways Care Farm, which seeks to improve the wellbeing of vulnerable people through farming, primarily people with mental health conditions, learning difficulties or those on a rehabilitative programme.
- I attended Future Countryside, which was a though-provoking event about rural life. It was helpful to take time to discuss the provision of health services

to rural communities, as well as to consider the opportunities and challenges around the wider determinants of health for people living in the countryside.

- I chaired the East of England Learning Disabilities and Autism Board. Working with colleagues from across the region is a really good way for us to learn and to consider what more we can do, not just on health checks, but in thinking about how we can tackle the disparity in life expectancy and quality of life.

Norfolk and Waveney
Integrated Care Board

Agenda item: 7.1

Subject:	**Norfolk and Suffolk Foundation Trust Mortality Review**
Presented by:	**Tricia D'Orsi, Executive Director of Nursing - Norfolk and Waveney ICB**
Prepared by:	**Andrew Kelso, Medical Director – Suffolk and North East Essex ICB** **Tricia D'Orsi, Executive Director of Nursing – Norfolk and Waveney ICB**
Submitted to:	**ICB Board**
Date:	**18 July 2023**

Purpose of paper:

To share the detail of seven recommendations for approval by the Board.

Executive Summary:

1. Background

We want to ensure that people living with mental health conditions, as well as their wider family, friends and carers, have access to high quality mental health services. Ensuring timely and accurate reporting on mortality is an important part of achieving this wider goal.

Last year, NHS Norfolk and Waveney and NHS Suffolk and North East Essex Integrated Care Boards (the ICBs) were asked by Norfolk and Suffolk NHS Foundation Trust (NSFT / the Trust) to commission an independent review to assess mortality reporting at the Trust between April 2019 and October 2022.

In September 2022, Grant Thornton UK LLP were commissioned to undertake the review, following a procurement process. The review was commissioned for a specific purpose, to provide an independent audit of the processes used by NSFT to collect and report data relating to mortality; it was not designed to investigate the circumstances of each individual's death or to compare the levels of mortality reported by or related to NSFT with those in other parts of the country.

In line with standard audit practice, Grant Thornton produced a draft of the report which was shared with NSFT and the ICBs in February 2023 to check for factual accuracy. The Grant Thornton report was then published on 28 June 2023. A copy

of the report is included as an appendix to this Board paper and can also be read here:

https://improvinglivesnw.org.uk/independent-review-published-on-mortality-reporting-and-recording-at-the-norfolk-and-suffolk-nhs-foundation-trust/.

The report includes an action plan in response to the findings and NSFT colleagues already have work underway to deliver this. There has been a strong commitment from NSFT to review its reporting processes. The ICBs and the Trust recognise the importance of making improvements recommended by this report and are committed to bring about progress by working collaboratively. The Grant Thornton report will also be important to address any learning that could be implemented in other trusts across the country.

The contents of the report may have a negative impact on patients, families and carers, and the ICBs offer their sincerest condolences to all those affected by this report or issues related to it. A listening service has been commissioned to support affected individuals. It is run by Just B, an independent charity based in North Yorkshire, that has no connection with services across Norfolk and Suffolk, including NSFT. More information about the service and how to access it can be found here:

https://improvinglivesnw.org.uk/just-b-support-line-set-up-to-listen-to-people-in-norfolk-and-suffolk/.

An independent report in response to the Grant Thornton review which details concerns about deaths of patients under the care of NSFT (Forever Gone: Losing Count of Patient Deaths) has been written by Caroline Aldridge, Anne Humphrys and Emma Corlett, and shared with the ICBs as well as the Healthcare Safety Investigations Branch. It can be downloaded from www.learningsocialworker.com. The report has been circulated to Board members.

The ICBs and NSFT are committed to supporting and working with those affected by the issues raised in both reports.

2. Key Issues

The Grant Thornton report has concluded the following:

- NSFT has strong governance in its approach to inpatient deaths and that any on site incidents are followed up by the team.
- The Trust needs to bring the same rigour to improve the processes around the reporting of all mortality, and the understanding of all deaths for patients on its caseload, or within six months of discharge, particularly for deaths in the community.
- The process of categorising and grouping expected and unexpected deaths and the decision making involved was unclear and inconsistent.
- Such issues have led to questions of clarity within public facing documents and reduced clinical insight into the mortality information reported. This results

in a lack of confidence from external stakeholders – including regulators and the public – in the data, and in the Trust's understanding of it.

- NSFT is often reliant on other NHS providers, such as GP practices and hospitals, for cause of death information for community patients and more needs to be done by these other providers to give NSFT access to this information. In resolving these issues the Trust will need to take responsibility for the actions they are able to complete, and to be clear on the requirements of partner organisations to what additional information they need and which organisation holds it.
- To implement the necessary changes, NSFT will need to be supported by both ICBs and the other healthcare organisations within the health system to make this information available.

Following publication of the Grant Thornton report, the Trust published data on the numbers of deaths under their care (or within six months of discharge) that they are confident in reporting. The data covers the past five years and can be read on the Trust's website. The ICBs have not yet been sighted on the methodology that has been used to confirm the data, and as such are not able to comment. The executive teams at the ICBs are working with the Trust to understand the data with a view to supporting them as valid and externally reportable.

The ICBs share the concerns regarding the large number of unexpected deaths for which a cause of death is not available and the lack of verification over classification of death and are working with the Trust to make this information clearer.

After the publication of the report, concerns have been raised that the action plan is incomplete and was not co-produced with patients, their families or bereaved relatives.

3. Patient and Public Engagement

The scope of the review was discussed in advance with a representative of bereaved families.

Recommendation to the Board:

The ICB Board is asked to approve seven recommendations:

1. To offer sincere condolences to the families and loved ones of all patients who have died.
2. To receive and note the report by Grant Thornton and the action plan by NSFT contained within the report.
3. To commit to work in mutually meaningful coproduction with Norfolk and Suffolk NHS Foundation Trust (NSFT), patients, their families and communities, and bereaved relatives to make the recommended improvements, and any further improvements that may arise because of this work, and to ensure that the Trust uses the right processes to accurately record and learn from deaths.

4. To commit to work with NHS Suffolk and North-East Essex ICB, NSFT, patients, their families and communities, and bereaved relatives to better understand the deaths of patients under the care of the Trust (or within six months of discharge), both retrospectively and in the future.
5. To review and co-produce with the Trust and patients, their families, and bereaved relatives an action plan that considers the concerns raised since publication of the Grant Thornton report.
6. To note that assurance of completion of the action plan will be provided through the NSFT Oversight and Assurance Group chaired by NHS England and reported to each ICB's Quality Committee.
7. To agree in principle to a follow up audit of mortality data recording processes in the Trust in April 2024, following completion of the action plan.

Key Risks	
Clinical and Quality:	Timely and accurate reporting on mortality is vital for improving people's care and the quality of services that people receive.
Finance and Performance:	Timely and accurate reporting on mortality is vital for understanding how services are performing.
Impact Assessment (environmental and equalities):	Timely and accurate reporting on mortality is needed to ensure we can effectively assess equality impacts.
Reputation:	Timely and accurate reporting on mortality is needed to ensure that patients, families and carers have confidence in the services being provided.
Legal:	N/A
Information Governance:	Timely and accurate reporting is an important part of good governance.
Resource Required:	ICB staff will work with NSFT and other partners to implement the action plan to improve mortality reporting.
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	Timely and accurate reporting on mortality is important for the effective delivery of our transformation programmes for adult and children and young people's mental health (BAF05a and BAF05b on the Board Assurance Framework).

Governance

Process/Committee approval with date(s) (as appropriate)	

Grant Thornton

Norfolk and Suffolk Foundation Trust's mortality recording and reporting

26 May 2023

Grant Thornton

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26/05/2023

Mortality data recording review

We enclose a copy of our report in accordance with your instructions dated 18th October 2022. This document (the **Report**) has been prepared by Grant Thornton UK LLP (**Grant Thornton**) for NHS Norfolk and Waveney Integrated Care Board (ICB), Suffolk and North East Essex Integrated Care Board (ICB) and Norfolk and Suffolk NHS Foundation Trust (the **Addressees**) in connection with a review of mortality data recording at Norfolk and Suffolk NHS Foundation Trust (NSFT) (the **Purpose**).

We stress that the Report is confidential and prepared for the Addressee and the organisations named in the agreement only. We agree that an Addressee may disclose our Report to its professional advisers in relation to the Purpose, or as required by law or regulation, the rules or order of a stock exchange, court or supervisory, regulatory, governmental or judicial authority without our prior written consent but in each case strictly on the basis that prior to disclosure you inform such parties that (i) disclosure by them is not permitted without our prior written consent, and (ii) to the fullest extent permitted by law we accept no responsibility or liability to them or to any person other than the Addressee.

The Report should not be used, reproduced or circulated for any other purpose, in whole or in part, without our prior written consent, such consent will only be given after full consideration of the circumstances at the time. These requirements do not apply to any information, which is, or becomes, publicly available or is shown to have been made so available (otherwise than through a breach of a confidentiality obligation).

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The data used in the provision of our services to you and incorporated into the Report has been provided by third parties. We will not verify the accuracy or completeness of any such data. There may therefore be errors in such data which could impact on the content of the Report. No warranty or representation as to the accuracy or completeness of any such data or of the content of the Report relating to such data is given nor can any responsibility be accepted for any loss arising therefrom.

Grant Thornton

Period of our fieldwork

Our work was performed in the period between October 2022 and January 2023. This work reviewed mortality data recording and reporting between April 2019 and October 2022. We have not performed any fieldwork since January 2023 and, our Report may not take into account matters that have arisen since then. If you have any concerns in this regard, please do not hesitate to let us know.

Scope of work and limitations

Our work focused on the areas set out in our engagement letter, signed 12th October 2022.

Interviews were held with key staff using Microsoft Teams or other video conferencing applications. Analysis was completed using the data provided by the Trust.

The scope of our work has been limited both in terms of the areas of the business and operations which we have assessed and the extent to which we have assessed them. There may be matters, other than those noted in the Report, which might be relevant in the context of the Purpose and which a wider scope assessment might uncover.

General

The Report is issued on the understanding that the management of Norfolk and Suffolk NHS Foundation Trust have drawn our attention to all matters, financial or otherwise, of which they are aware which may have an impact on our Report up to the date of signature of this Report. Events and circumstances occurring after the date of our Report will, in due course, render our Report out of date and, accordingly, we will not accept a duty of care nor assume a responsibility for decisions and actions which are based upon such an out of date Report. Additionally, we have no responsibility to update this Report for events and circumstances occurring after this date.

Notwithstanding the scope of this engagement, responsibility for management decisions will remain solely with the directors of the Trust and not Grant Thornton. The directors should perform a credible review of the recommendations and options in order to determine which to implement following our advice.

Yours Sincerely,

Grant Thornton UK LLP

Grant Thornton UK LLP

Contents

Executive summary (1 of 4)

Introduction

Norfolk and Suffolk NHS Foundation Trust (NSFT) is a mental health trust in the East of England which provides care to a population of around 1.6 million. The Trust provide mental health and learning disability care for people through inpatient, community and primary care settings.

Grant Thornton has been commissioned by Norfolk and Waveney and Suffolk and North East Essex Integrated Care Boards to review the collection, processing and reporting of data related to patient deaths at Norfolk and Suffolk NHS Foundation Trust.

To do this we:

- Reviewed local guidelines, policy documentation and corporate documentation
- Interviewed key staff members involved with producing and reviewing mortality data
- Analysed anonymised patient level data from clinical and incident reporting systems
- Reviewed internal and external mortality reporting and dashboards.

We have not audited individual records to test their accuracy, nor does this report give any view on the levels of mortality or the circumstances of patients' deaths. We have reviewed mortality reporting at the Trust; we did not review the process for serious incident reporting. Our findings are based solely on the information made available to us during the review. between November 2022 and January 2023.

The Trust has been working with NHS England since September 2022 to improve its processes, particularly in relation to mortality. Changes at the organisation made after January will not be captured within our findings. The recommendations from this report will support these improvements by providing focus and clarity on issues impacting on data recording and reporting.

It should be noted that quality and consistency of mental health data is a recognised national challenge. In addition, national guidelines over mortality reporting for mental health trusts are not as clear and defined as those in place for acute trusts, giving scope for variation in their implementation across different trusts. This lack of detailed national guidance limits the opportunity for mortality data comparisons and provides a challenge for the Trust in applying a nationally consistent process.

Overview

Based on the information made available to us we are unable to provide assurance over the mortality data reported at the Trust. Our findings are outlined below and are described in more detail over the next pages of the executive summary.

The Trust's intended methodology for reporting is in line with the expectations of national guidance, where it exists, and the processes in place at peer organisations. However, the Trust's implementation of this methodology requires further work to improve the reliability and usefulness of the information produced.

The Trust's mortality data management process is unclear and uses multiple systems to record and produce the data. These systems are a mix of applications, with some manual processes used to categorise and transform the data. There is no overarching documentation of the process followed and we saw no clear audit trail of the data as it moved through this process.

The reporting of mortality data to both internal and external audiences is inconsistent – this includes changes in reporting methodology and the way data is presented, and errors in two reports in the way information is interpreted and described were identified during the review.

In particular, the process of categorising and grouping expected and unexpected deaths and the decision making involved was unclear and inconsistent during our review, and the data on cause of death is not available for many community deaths. This is a key part of mortality reporting and the information produced forms part of the corporate board reporting.

These issues have led to questions of clarity within public facing documents, and reduced clinical relevance within the mortality information reported. This results in a lack of confidence of external stakeholders – including regulators and the public – in the data, and in the Trust's understanding of it.

The Trust is often reliant on other NHS providers for cause of death information for community patients and more needs to be done to provide access to this information. In resolving these issues the Trust will need to take responsibility for the actions they are able to complete, and to be clear on the requirements of partner organisations to what additional information they need and which organisation holds it. The Trust will need to be supported by the ICB and the other healthcare organisations within the health system to make this information available.

Executive summary (2 of 4)

The governance structures in place at the Trust are in line with national requirements, but operational understanding of this governance was unclear. More needs to be done to establish end-to-end oversight of the mortality data production and reporting process for all mortality, and to assure the board that mortality data reported is accurate.

Based on the evidence seen as part of our review more work is also required to support services to use the data available in order to ensure it is accurate and to understand key messages. Our experience demonstrates that data that is regularly used is data that improves.

The Trust has strong governance in its approach to deaths resulting from patient safety incidents – on site incidents are followed up by the team, as well as suicides where the coroner has notified the Trust. The Trust needs to bring the same rigour to improve the processes around the reporting of all mortality, and the understanding of all deaths for patients on their caseload. The need for further understanding of all mortality was highlighted as an issue by NHS England at the Trust's quality and safety committee.

Reporting

Within the corporate reporting documentation, board reports and annual Learning from Deaths reports, mortality data is presented inconsistently, and the methodology adopted has gone through multiple changes. This creates challenges to understand performance and fully interrogate the data presented. The lack of consistency within external documents has raised concerns about the accuracy of the data within them.

The Trust does not adopt a consistent reporting standard and has frequently changed both the methodology and presentation of mortality data in its board reports. Over eight consecutive board reports, information and the method of presentation changed six times, including how activity was broken down, how graphs were labelled, and the types of charts used. Within the board report graphs there were missing data points for some months. In others reports, a change in methodology was adopted, without being fully explained and without comparative analysis between the two methodologies being made available. This has led to confusion in both the classification of mortality between expected and unexpected deaths and the numbers of deaths which form part of Trust's mortality statistics. Although the methodology changes were appropriate, inadequate descriptions and an absence of the impact upon historic mortality data can cause confusion.

As a result, when tracking through the chronology of corporate reporting from report to report the mortality numbers lack consistency without adequate explanation of the change in methodology and no comparative information used to show how the new approach corresponds to the previous one. Additionally, in two board reports the numbers of expected and unexpected deaths were incorrectly transposed.

The presentation of the Trust's internal mortality dashboard does not always align with its public board reporting. The numbers attributed to expected and unexpected deaths have differed between reports and the dashboard. Also the volumes attributed to individual groupings of the cause of death do not always align to the dashboard. The dashboard is available on the Trust intranet and has some basic analysis such as team level information and small charts showing timeline of causes of death.

Whilst the dashboard includes basic demographic information this is not presented alongside causes of death, but at an expected or unexpected level. During the review we saw no evidence of detailed analysis of mortality information aligned to population health, understanding health inequalities, or learning from mortality aligned to deprivation or particular patient groups. This level of analysis is crucial for internal and external scrutiny and to enable services to identify opportunities to improve care.

Data processes

The Trust uses a number of systems for the mortality recording process. The Trust's electronic patient record (EPR), Lorenzo, and the incident management system, Datix, are the principal clinical systems used, supplemented by IAPTUS and SystmOne, which support two individual services. Although the bulk of mortality data management and reporting is conducted within core clinical systems such as Datix and Lorenzo, this is supplemented with the manual use of excel, which lacks the same information governance and audit standards of the clinical systems and the use of this should be minimised to mitigate any potential risks to the Trust. The mortality dashboard used for internal reporting uses these systems as its data feed. Although there are pockets of documented processes, there is no comprehensive documentation that covers the process in its entirety.

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Executive summary (3 of 4)

There are multiple methods of identifying a deceased patient within the Trust. Many are inconsistently implemented and lack definitive documentation. From the data analysed by Grant Thornton, 24% of mortality was notified and recorded directly by Trust staff across its inpatient and community teams. The remaining 76% was identified through the electronic process of reconciling patient data against the national NHS Spine, which is undertaken monthly. Other similar organisations perform this check on a more frequent basis. Historically, incorrect assumptions have been made locally that staff accessing a deceased patient's record will have completed the relevant mortality documentation required on the Trust's incident reporting system, Datix. The significance of this monthly time delay and assumptions around accessing patient records will potentially result in data reported by the Trust not being timely or accurate.

The Trust's process for determining the categorisation of death as expected or unexpected, which is a key aspect of mortality reporting and is defined below, is not clear or auditable. Where the death certificate was available, it was used to inform appropriate grouping of cause of deaths which appears on the dashboard, with different staff members assuming this was done in different ways; there was no clinical input or oversight of this step. The reliance on individual interpretation, without support, risks inaccuracies and inconsistencies in the data reported.

Definitions of expected and unexpected deaths

Expected Death: Caused by a pre-existing life-limiting condition or if the person's age and frailty made death from a natural cause a reasonable expectation at the time of their death

Unexpected death: The death of a service user who has NOT been identified as critically ill or death is NOT expected by the clinical team. If there is no known diagnosis of terminal illness or physical health complication meaning that the service user is deemed as approaching end of life or receiving palliative care. Where data or cause of death is unavailable this is defined as unexpected

Source: NSFT Mortality and Learning from Deaths Report, Jan 2022

The generic category of *'Natural cause – specific not available'* is used where no cause of death information is available to the Trust, and accounts for 77% of all recorded mortality activity. Based on the Trust's definitions these deaths are categorised as unexpected.

More should be done to understand the causes of death and contributing factors for these patients. However, the Trust faces challenges in accessing this level of information for all deaths to be included within the Trust's mortality reporting, as it is often reliant on other NHS providers for cause of death information. The Trust is also reliant on partners to provide information on community patients where the coroner has not been involved in the patient death. Improving this position will involve system-wide collaboration. This lack of information is compounded by the number of incomplete fields (null values) that are present within the reported data.

The Trust is planning to implement the Better Tomorrow dashboard, however, it should be noted that the introduction of this will not address issues with the mortality data and reporting outlined in this report, as it focuses on the review aspect of the mortality pathway.

Governance and clinical engagement

The governance structures in place at the Trust are in line with national requirements, but operational understanding of this governance was unclear. The approach to reviewing and learning from deaths was clearly understood; however, there was a confused picture around senior ownership of overall mortality data reporting. This reflects the Trust's focus on serious incident reporting instead of all mortality reporting.

As a result, there are inadequate controls over the end-to-end process of mortality reporting. We saw no evidence of checks on inputs or outputs, limited and out-of-date documentation and insufficient evidence of information governance controls over all systems used within the mortality recording process. More needs to be done to provide assurance to senior staff and the board on the accuracy of underlying data.

The Trust has a good understanding of individual patients, but more work is required to support services to use this data to understand areas of interest that could support or inform potential improvements. During the review two senior clinical leaders stated that members of the Trust's clinical staff have limited faith in their data and do not use or analyse it in a structured manner.

In the patients included in the Trust's mortality reporting our analysis noted 164 patients who were not seen for over 2 years, up to a maximum of 9 years, prior to discharge. This highlights potential issues around caseload management and data management of the discharge process that may be impacting upon the Trust's mortality data.

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Executive summary (4 of 4)

We also saw no evidence of regular clinical validation of the data used to underpin mortality reporting or feedback loop in place between clinical and information teams on mortality reporting. Our work across the NHS has shown that when data gets used its quality improves, meaning it more accurately reflects the patients treated.

A better understanding of mortality reporting will improve the opportunities for learning across the Norfolk and Suffolk health system, and improve the benefit from collaborating with primary care networks and GPs to better understand the cause of death of patients on the Trust's caseload, and with all partners in the system will help to understand the links between physical health and mental health needs.

Recommendations

Based on the findings of the review we have made 16 recommendations across four key themes. These are described on the following page and include:

- Improve the mortality data pathway to automate and digitise the production of mortality reporting
- Agree a standardised reporting structure for internal and external reporting, and provide the tools to interrogate the data
- Improve the controls over mortality reporting and ensure clinical oversight, validation and use of the information reported
- Establish a clear improvement plan to address the issues identified in this report.

These recommendations were created with visibility of the Better Tomorrow quality improvement plan and are designed to supplement the ongoing improvement at the Trust. Our recommendations are focused on the recording and reporting of mortality, and not the process of reviewing deaths which was covered as part of the Better Tomorrow plan.

The Trust is part of a wider health system alongside other providers, and some of the recommendations relate to accessing data held by other providers. For these recommendations the Trust should provide leadership to understanding their requirements in this area, but will require support from the ICBs and other partner organisations to complete the actions.

As part of this review the Trust has completed an action plan which is included on the pages following the recommendations.

Recommendations

The recommendations are structured to focus on different operational groups and their roles within the data pathway. As part of this review the Trust has completed an action plan which is included on the following pages.

Data - focuses on the technical data management to be completed by business intelligence and related teams.

1. Improve the mortality data pathway to automate and digitise the production of mortality reporting, removing manual processes for transferring and transforming the data, and introducing an audit trail where user interaction is required. The data pathway covers: data entry by clinical and service staff, clinical system configuration for capturing and codifying data, export process from clinical systems, data management within data warehouse (or through manual intervention), rules and categorisations applied to support reporting, the presentation of reporting outputs, and the process for validating these outputs.
2. Develop standard operating procedures (SOPs) for each stage of the data recording process, and ensure these are kept up to date.
3. Develop reporting tools or method of measuring incomplete data fields to feed back into the organisation, and support training.
4. Use the Spine as the definitive reference source of identifying deaths, and update this information on a weekly basis.

Reporting – relates to the process of producing internal and external reports, dashboards, and related documentation.

5. Agree a standardised reporting structure for board reports, to include thematic analysis and consistent presentations of figures, axis and scales. Clearly define the Trust's methodology for mortality recording and reporting within board reports. Any changes should be clearly documented and the impact upon historically reported figures should be described to provide continuity.
6. Align the internal dashboard with external reporting to ensure that volumes on the internal dashboard clearly reconcile to numbers within board reports.
7. Work with public health and, when in post, medical examiner to identify key themes in the data and implement timely targeted interventions.
8. Use clinical input to update the cause of death groupings which are presented as part of the dashboard, and used in board reports, so that it is clear where the Trust is awaiting data (pending), or the Trust feels this data will not be accessible or will remain unknown.

Clinical engagement - the process of engaging with clinical service staff in the use and production of mortality data

9. Establish a process of validation and use of mortality reporting and analysis at service level, aligned to corporate reporting.
10. Review the process of retaining patients on caseloads, and subsequent discharge from caseloads, to ensure it results in consistent data across the services.
11. Create supporting training programme for all staff who input data into systems that have an impact upon mortality data. Ensure that the implications and impacts of incorrect or incomplete data entry are understood by staff.

Partnership working - whilst we are recommending that the Trust takes the lead in partnership working outlined in the two recommendations below, the Trust will need support from the ICB and its partner organisations to facilitate this joint working and knowledge sharing.

12. Establish links with primary care networks to explore opportunities to improve the completeness of the Trust's mortality data (including cause of death), supported and enabled by the ICB.
13. Explore opportunities for formal data sharing agreements between the Trust and primary and secondary care in the region.

Governance - the oversight and controls over mortality data production and reporting

14. Update the Trust's Learning from Deaths policy to ensure the Trust's governance addresses the issues in this report and explicitly references community deaths. Ensure the governance in relation to all mortality is clearly understood by clinical and corporate staff involved in the production and reporting of mortality information.
15. Establish a clear improvement plan to address the issues identified in this report, and report progress to a board committee.
16. Introduce a process of assurance over mortality reporting:
    - Introduce a clear audit trail and series of checks to ensure adherence with SOPs, and report outcomes to executive leads on a regular basis
    - Introduce or commission patient level data reviews to provide assurance over the accuracy of data recording.
    - Link to the clinical validation process established under recommendation 9

NSFT action plan (1 of 7)

As part of this review the Trust has completed an action plan describing how it is going to address the recommendations. This has been included on the following pages.

Recommendation		Priority	Management responsibility	Proposed actions	Timeframe
			Data		
1	Improve the mortality data pathway to automate and digitise the production of mortality reporting, removing manual processes for transferring and transforming the data, and introducing an audit trail where user interaction is required. The data pathway covers: data entry by clinical and service staff, clinical system configuration for capturing and codifying data, export process from clinical systems, data management within data warehouse (or through manual intervention), rules and categorisations applied to support reporting, the presentation of reporting outputs, and the process for validating these outputs.	High	**Executive Lead** Chief Finance Officer (SIRO) **Lead for Delivery** Chief Digital Officer	1.Seagry consultancy and NSFT to review the technology, solutions and processes used to capture, collate and report mortality data. Interoperability, system upgrade requirement as and when required should be included as part of this review. 2. Seagry Consultancy will produce a list of actions with assigned owners to support improvement, processes and tools to assist NSFT in mortality reporting. 3. A single overarching Standard Operating Procedure (SOP) will be implemented following this work. This will include the formal change management process required when reporting requirements change. The SOP will include inputting of data, extracting of data, validating of data and reporting of data within a given timeframe. 4. An audit trail will be incorporated into the process as described in action 1.	3 months – August 2023
2	Develop standard operating procedures (SOPs) for each stage of the data recording process, and ensure these are kept up to date.	Medium	**Executive Lead** Chief Nursing Officer **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding and Medical Director for Quality	1. An overarching SOP will be developed which will detail each stage of the mortality data pathway. 2. The SOP will include roles and responsibilities within the process. 3. The SOP will describe the formal change management process when mortality reporting requirements change. 4. The Learning from Deaths policy will incorporate the requirements of the SOPs.	6 months – November 2023

NSFT action plan (2 of 7)

Recommendation		Priority	Management responsibility	Proposed actions	Timeframe
3	Develop reporting tools or method of measuring incomplete data fields to feed back into the organisation, and support training.	Medium	**Executive Lead** Chief Finance Officer (SIRO) **Lead for Delivery** Chief Digital Officer	1. Reporting tool to be developed to measure the data fields missing on clinical record system, such as demographics. All Data fields must be made as mandatory as much as technically possible to eliminate missing data and avoid human errors. 2. To be reported and included in the Care Group Quality and Performance metrics and scrutinised in the Trust's Quality and Performance meeting.	6 months – November 2023
4	Use the Spine as the definitive reference source of identifying deaths, and update this information on a weekly basis.	High	**Executive Lead** Chief Nursing Officer **Lead for Delivery** Chief Digital Officer and Director of Nursing, Patient Safety and Safeguarding	1. Develop a system that utilises NHS Spine's automatic update to Lorenzo to reduce the need for manual downloads. 2. This action is included as part of recommendation 1. 3. A weekly report will be generated to validate any reporting of Death to Trust against the Spine. This assurance check will be included as part of SOP.	3 months – August 2023
			Reporting		
5	Agree a standardised reporting structure for board reports, to include thematic analysis and consistent presentations of figures, axis and scales. Clearly define the Trust's methodology for mortality recording and reporting within board reports. Any changes should be clearly documented and the impact upon historically reported figures should be described to provide continuity.	High	**Executive Lead** Chief Nursing Officer **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding and Medical Director for Quality	1. The proposed standardised reporting structure for mortality will be presented through the Committee structure and agreed by the Board. 2. The Learning from Deaths quarterly Board report will include thematic analysis of key metrics such as age, diagnosis, cause of death and deprivation indices.	3 months – August 2023

NSFT action plan (3 of 7)

Recommendation		Priority	Management responsibility	Proposed actions	Timeframe
6	Align the internal dashboard with external reporting to ensure that volumes on the internal dashboard clearly reconcile to numbers within board reports.	High	**Executive Lead** Chief Finance Officer (SIRO) **Leads for Delivery** Chief Digital Officer, Director of Nursing, Patient Safety and Safeguarding and Medical Director for Quality	1. The Trust are working with Seagry Consultancy to agree the Mortality data pathway. Part of this work will include further development of Mortality Dashboard. 2. This will be underpinned by the work completed as part of recommendations 1 and 5. 3. The ability for Care Groups to drill down within the dashboard will be enhanced so they are able to interrogate their and other Care Groups data. 4. The improved dashboard will be supported by the Patient Safety Team and Mortality Team attending Care Group Governance meetings. 5. The newly developed dashboard will be available on the Trust's intranet.	3 months – August 2023
7	Work with public health and, when in post, medical examiner to identify key themes in the data and implement timely targeted interventions.	Medium	**Executive Lead** Chief Medical Officer **Lead for Delivery** Director of Operations (Medical Directorate) and Medical Director of Quality	1.The Norfolk and Waveney ICB have implemented a bi-monthly Learning from Deaths forum. This includes Public Health and Medical Examiners. NSFT are a member of this forum with data shared as part of this meeting. 2. Learning and themes from NSFT Mortality reviews will be shared with the ICB so wider system learning can be considered. 3. Development of Care Group reports and attendance of Mortality Team and Patient Safety Team to local governance meetings to share learning and implement targeted interventions. 4. Within the Learning from Deaths committee, the Mortality team will share local, regional and national data and learning to guide where improvements need to focus. 4. Ensure that NSFT are part of the membership of the Learning from Deaths forum in Suffolk and North East Essex (SNEE) ICB when commenced. 5. NSFT will continue to attend regional and national forums. 6. NSFT to be members of the Norfolk and Waveney ICB LeDeR forum.	6 months – November 2023

NSFT action plan (4 of 7)

Recommendation		Priority	Management responsibility	Proposed actions	Timeframe
8	Use clinical input to update the cause of death groupings which are presented as part of the dashboard, and used in board reports, so that it is clear where the Trust is awaiting data (pending), or the Trust feels this data will not be accessible or will remain unknown.	High	**Executive Lead** Chief Finance Officer (SIRO) and Chief Medical Officer **Leads for Delivery** Chief Digital Officer Director of Nursing, Patient Safety and Safeguarding	1. Review the data collected in the Trust Mortality dashboard to include all patient demographics, cause of death, diagnosis, medication etc.. to enable the drilling down both locally and strategically of key metrics. This will include 2 'unknown' cause of death categorisations 'awaiting cause of death' and cause of death not available'. 2. The Mortality process, criteria and screening will describe this requirement as part of the overarching SOP (Recommendation 2).	3 months – August 2023
Clinical engagement					
9	Establish a process of validation and use of mortality reporting and analysis at service level, aligned to corporate reporting.	High	**Executive Lead** Chief Finance Officer (SIRO) **Leads for Delivery** Chief Digital Officer and Director of Nursing, Patient Safety and Safeguarding and Medical Director of Quality	1. New Mortality Data Pathway as outlined in Recommendations 1, 3, 5 and 6 will detail the process for capturing, collating, validating and reporting mortality data. 2. Care Groups and Trust committees will be able to utilise the revised Mortality dashboard to drill down into individual Care Groups as well as maintain oversight from a Trust perspective. 3. The mortality data will be centrally produced, therefore the data will be consistent from 'Ward to Board'. 4. The dashboard will be available without patient details on the Trust intranet for all staff to review.	3 months – August 2023
10	Review the process of retaining patients on caseloads, and subsequent discharge from caseloads, to ensure it results in consistent data across the services.	Low	**Executive Lead** Chief Operating Officer and Chief Finance Officer (SIRO) **Lead for Delivery** Chief Digital Officer and Deputy Chief Operating Officer	1. The guidance which details the process for administration staff to follow describing the steps to be taken when discharging a patient from the service will be shared with all Business Managers to action. 2. Further guidance will be developed for administration staff as to the process to follow when a person on the team's caseload is found to be deceased. 3. Caseload Reviews should be carried at a minimum 6 monthly with the involvement of Medical, Nursing, Therapies and Local Manager input and should be embedded in local teams' standard practice	9 months – February 2024

NSFT action plan (5 of 7)

Recommendation		Priority	Trust management responsibility	Proposed actions	Timeframe
11	Create supporting training programme for all staff who input data into systems that have an impact upon mortality data. Ensure that the implications and impacts of incorrect or incomplete data entry are understood by staff.	Medium	**Executive Lead** Chief Finance Officer (SIRO) **Leads for Delivery** Chief Digital Officer, Deputy Chief Operating Officer, Medical Director of Quality	1. Implement training programmes focusing on the importance of mortality reporting dependent on the role the member of staff fulfils. 2. To be supported by learning bulletins which highlight the importance of accurate mortality data reporting and how this can assist in improving clinical care.	6 months – November 2023
Partnership working					
12	Establish links with primary care networks to explore opportunities to improve the completeness of the Trust's mortality data (including cause of death), supported and enabled by the ICB.	Medium	**Executive Lead** Director of Strategy and Partnerships **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding, Medical Director of Quality and Director of Operations-(Medical Directorate)	1. In order to inform the ICB where their assistance can be best be focused, the Trust will complete an audit of the available cause of death data. 2. NSFT will develop a standardised process led by the Mortality Team for contacting GPs, Coroners, Medical Examiners and clinical data systems to obtain the cause of death wherever possible. 3. This recommendation will be shared with the ICBs through the dissemination of this report and to be added as an agenda item on ICB Learning from Deaths Forums where/when in place.	6 months – November 2023
13	Explore opportunities for formal data sharing agreements between the Trust and primary and secondary care in the region.	Medium	**Executive Lead** Chief Finance Officer (SIRO) Chief Nursing Officer **Lead for Delivery** Chief Digital Officer	1. Establish formal data sharing agreements between the Trust, Primary and Secondary care within the region based on agreed parameters and guidance from clinical Leads.	6 months – November 2023

NSFT action plan (6 of 7)

Recommendation		Priority	Management responsibility	Proposed actions	Timeframe
Governance					
14	Update the Trust's Learning from Deaths policy to ensure the Trust's governance addresses the issues in this report and explicitly references community deaths. Ensure the governance in relation to all mortality is clearly understood by clinical and corporate staff involved in the production and reporting of mortality information.	High	**Executive Lead** Chief Nursing Officer and Chief Medical Officer **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding, Medical Director for Quality and Director of Operations – (Medical Directorate).	1. Following confirmation of the revised mortality data pathway, the Learning from Deaths policy will be reviewed and updated to include the SOP referenced in Recommendation 2. This will include the nationally defined focus of mortality being both community and inpatient deaths. 2. The Learning from Deaths policy will be supported by a 'policy on a page' which will be available to all staff. 3. The circulation of information and learning bulletins 'Learning from Deaths Matters' will be published and disseminated throughout the Trust. 4. This will be supported by learning events.	3 months – August 2023
15	Establish a clear improvement plan to address the issues identified in this report, and report progress to a board committee.	High	**Executive Lead** Chief Nursing Officer and Chief Medical Officer. **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding, Director of Operations- (Medical Directorate) and Medical Director of Quality	1. The improvement plan will be monitored through the Learning from Deaths and Incidents committee and reported quarterly to the Quality Committee.	3 months – August 2023

NSFT action plan (7 of 7)

Recommendation		Priority	Management responsibility	Proposed actions	Timeframe
16	Introduce a process of assurance over mortality reporting: • Introduce a clear audit trail and series of checks to ensure adherence with SOPs, and report outcomes to executive leads on a regular basis • Introduce or commission patient level data reviews to provide assurance over the accuracy of data recording. • Link to the clinical validation process established under recommendation 9	High	**Executive Lead** Chief Finance Officer (SIRO), Chief Nursing Officer. **Lead for Delivery** Chief Digital Officer, Medical Director for Quality	1. Mortality Data Pathway: an audit process will be developed and implemented every 6 months. The audit will test the comprehensiveness of the mortality data pathway. This will be supported by the weekly Spine data verification as referenced in recommendation 4. 2. External verification will be sought by an external consultancy team who are experienced in data within the NHS. 3. Newly formed mortality team will provide data for board information via the developed clinical review pathway for deaths reported via the Spine as per recommendation 9.	3 months – August 2023

Introduction and approach

Introduction and approach (1 of 3)

Background

Grant Thornton has reviewed the collection, processing and reporting of mortality data at Norfolk and Suffolk NHS Foundation Trust (NSFT) at the request of the Trust, NHS Norfolk and Waveney Integrated Care Board (ICB) and Suffolk and North East Essex ICB.

The Trust requested independent assurance over its mortality recording and reporting following public and regulatory concern over the reliability and accuracy of reported data. There is concern locally around the clarity of mortality data and the ability to monitor reporting and recording.

Structure of the report

In this section of the report we outline the methodology and approach followed by Grant Thornton along with the stated aims for this piece of work.

The main report that follows this introduction is listed and outlined below. Apart from the background and approach all sections culminate with clear recommendations for improvement, which link back to those presented in the executive summary.

1. Mortality reporting methodology: Summary of the current national mortality guidance, the methodology chosen by the Trust to record and report its mortality data and the comparison of this to other mental health trusts.
2. Processes: The detail of how the Trust enacts its methodology into a process and the challenges this presents them with. Data provided by the Trust has been analysed by Grant Thornton to provide evidence for the impact of the process challenges.
3. Clinical engagement: summary of the evidence provided by the Trust to Grant Thornton of clinical involvement in data interrogation and the evidence of data informing clinical practice in the Trust.
4. Governance: overview of the current and expected governance arrangements to provide guidance and clarity to the current mortality reporting and recording process.

National context

Nationally collected data shows the importance of understanding mortality within mental health. Public Health England's report[1] noted:

- It was estimated that for people with severe mental illness, 2 in 3 deaths were due to physical illness such as cardiovascular disease (CVD)
- Premature mortality is higher for people with severe mental illness (SMI)

Across the country there is geographical variation in mental health mortality. The NHS's mental health taskforce recommended more work to ensure the physical health needs of those living with severe mental illness were met [2].

National guidelines over mortality reporting for mental health trusts are not as clear and prescriptive as those in place for acute trusts, and we know from our work with other mental health trusts and national organisations that there are issues with the depth, consistency and relevance of clinical data. Improving the quality of mental health data was noted in the Mental Health Long Term Plan[3], highlighting a gap between physical and mental health data.

Aims and objectives of the review

The aim of the project was to provide the Trust and the ICBs with a view on the accuracy and effectiveness of processes related to the collection, processing and reporting of mortality data at NSFT. To do this, the following objectives were agreed jointly by the Trust and ICB:

- Establish the methodology for mortality data collection, processing and reporting at the Trust, including which patients are deemed to be under the Trust's care
- Understand whether the data reported accurately reflects the expected methodology
- Compare the established methodology with national guidance and practice at other organisations to understand whether the Trust is reporting in line with national expectations
- Benchmark the Trust's reported data against data from other organisations
- Provide clear expectations for the reported mortality position and make recommendations for improvement.

1. Public Health England: Health matters: reducing health inequalities in mental illness
2. The Five Year Forward View for Mental Health (england.nhs.uk)
3. NHS Mental Health Implementation Plan 2019/20-2023-24 (longtermplan.nhs.uk)
4. Office for Health Improvement and Disparities. Premature mortality in adults with severe mental illness (SMI) published 7 April 2022

Definitions [4]: *Premature mortality rate in adults with SMI* – the number of people with SMI who die under the age of 75 per 100,000 calculated for a three year period. *Excess under 75 mortality rate in adults with SMI* – the difference in premature mortality rate between people with SMI and those without SMI, calculated for a 3 year period.

Introduction and approach (2 of 3)

Our approach

We used an established method for reviewing data processes and controls. We undertook the following activities to develop a clear understanding of the processes related to mortality data production, management and reporting at the Trust.

1. Benchmarking and document review
   a) Review of national guidance
   b) Review of peer guidance / publicly available policies around mortality reporting
   c) Review of NSFT policies and guidelines associated with the mortality recording process
2. Stakeholder interviews (a full list is in the appendix of this document)
   a) Discussing processes managed
   b) Issues / blockers to completing tasks
   c) Identify further supporting documentation associated with these tasks (including training)
   d) Validation or audit processes in place
3. Data analysis
   a) Compare data to Trust's methodology and see if this was followed
   b) Compare analysed data to Trust reported data; understand any variance
   c) Explore themes within the data which may help the Trust to improve reporting and learning going forwards

In following this approach we reviewed the Trust's processes across the mortality data pathway, from data entry to reporting outputs. The steps of the data pathway we reviewed are outlined below:

Step in data pathway	Areas reviewed
Input	• Documentation and Standard Operating Procedures (SOPs) • Training and support • Data entry by clinical and service staff
Systems	• Clinical systems and connectivity • Information captured outside of clinical systems • Documentation of processes and business rules • Links and integration with national systems
Data management	• System output definitions • Database definition and management
Reporting	• Rules applied to reporting outputs • Consistency of local and national reporting • Availability of reporting to service staff • Access to and relevance of benchmarking
Service engagement	• Clinical ownership of data • Use of information and reports by services • Process for data quality improvement
Governance	• Internal and external assurance over clinical data entry • Senior oversight of national submissions • Board reporting on clinical data quality • Effective change control and accountability for data quality

Following this approach allowed us to establish the Trust's current position and compare this to national guidance. Where areas of variance between Trust methodology and data exist we have worked to understand these and have collated this information to form an agreed set of recommendations for improvement.

Introduction and approach (3 of 3)

Glossary of terms

Term	Definition
Care Review Tool	A tool developed by the Royal College of Psychiatrists based on the structured judgement review tool
Datix	A healthcare incident recording system used by the Trust
Death by natural causes	The term used by a coroner when a death is as the result of the normal progression of natural illness, with or without significant intervention. This is not a separate category reported on by the Trust in its dashboard ('*natural cause – specific non available'* is used and includes unknown information) but natural cause is referred to in Trust bord reports.
Death certificate (also known as medical certificate of cause of death)	An official document, signed by a doctor, which records when and where a patient died and the cause of death. This contains two parts for the cause of death. Part 1 lists diseases or conditions leading directly to death, or the other conditions mentioned in part 1. Part 2 lists other conditions which contributed to death but not related to the disease of condition causing it.
Expected death	As defined by the Trust, a death caused by a pre-existing life-limiting condition or if the person's age and frailty made death from a natural cause a reasonable expectation at the time of their death
Integrated care board	A statutory NHS organisation responsible for developing a plan for meeting the health needs of the local population and managing the NHS budget and services of an area.
Lorenzo	An electronic patient record system used by the Trust
Mortality	The term mortality is used in medicine as a term for death rate, or the number of deaths in a certain group in a certain period of time.
NHS Spine	The NHS Spine allows information to be shared securely through national services
Patient safety incident	Term used by NHS England to describe unintended or unexpected incidents which could, or did, lead to harm for patient(s) receiving healthcare.
Serious incident	Defined in broad terms by NHS England as an event in health care where the potential for learning is so great, or the consequences so significant, that they warrant using additional resources to mount a comprehensive response. Their occurrence demonstrates weaknesses in a system or process which need to be addresses to prevent future harm.
Statistical process control (SPC)	An analytical technique which plots data over time, helping to understand variation and guide appropriate action
Structured Judgement Review	A methodology developed by the Royal College of Physicians for reviewing mortality which is used in the NHS.
Unexpected death	As defined by the Trust, the death of a service user who has NOT been identified as critically ill or death is NOT expected by the clinical team. If there is no known diagnosis of terminal illness or physical health complication meaning that the service user is deemed as approaching end of life or receiving palliative care. Where data or cause of death is unavailable this is defined as unexpected

Main Report

Mortality recording methodology (1 of 4)

Introduction and summary

This section will focus on the national and Trust defined methodology for mortality reporting. The Trust's methodology is then benchmarked against that of other mental health organisations and the impact of regularly changing the methodology discussed.

The Trust's current mortality recording methodology aligns to the nationally expected methodology. Nationally there is a lack of end-to-end guidance on mortality reporting. There are varied definitions for key metrics nationally making comparisons and benchmarking between trusts challenging. The Trust's currently used methodology is in-keeping with other mental health trusts, with both being derived from similar national sources.

In the two years before the COVID-19 pandemic an average of 49 people per month died within six months of contact with NSFT's services. During the COVID-19 pandemic this rose to 70 but by summer 2021 this had returned to 44 [1]. In January 2022 it was reported that on average one person per month died whilst under the care of the Trust's inpatient services [2].

Defining mortality reporting

Mortality recording and reporting encompasses

(a) the definitions which, when applied, impact the number of deaths to be included within the Trust's mortality reporting
(b) the process by which the Trust gathers and processes mortality information and
(c) how this is then fed back into the organisation for interrogation, understanding and learning.

Mortality recording and reporting is distinct from serious incident or patient safety incident reporting, although there may be overlaps where a single case is reported in more than one place. A death which is the result of a serious incident or patient safety incident should be recorded in that data collection and within the Trust's mortality data. Not all deaths are patient safety incidents and not all patient safety incidents are deaths. Unexpected deaths may not reach the criteria for serious incident review. This distinction is important to understand what this report has examined, and what it has not examined. This report is focused only on mortality recording and reporting and not incident recording and reporting.

Available national guidance and analysis

In the absence of complete and detailed national guidance trusts use a combination of the available guidance, supplemented by statements made in national reports, to establish their methodology for mortality reporting. Within their mortality guidance most trusts reference National Quality Board (NQB) guidance along with the 2015 Mazars report commissioned by NHS England[3]. The latter is not national guidance but a nationally commissioned report, the recommendations of which have been adopted variably by mental health trusts.

The NQB published guidance on Learning from Deaths in 2017. NQB guidance outlines that all Trusts should have a policy on how they respond to, and learn from deaths of patients. There are nationally defined processes in place for the reporting and learning from deaths. Information should be collected and published quarterly on deaths under a Trust's care, reviews, investigations and resulting quality improvement. The NQB report was written a number of years ago and has not been replaced by more recent guidance. In the intervening period to now there remains no one single national document which offers a clear framework and supporting terminology for trusts to apply when designing and implementing their mortality recording methodology and processes.

The 2016 CQC Learning, Candour and Accountability national report, which followed the Mazars report, highlighted issues around mortality identification, reporting and reviews across acute, community and mental health providers [4]. These are summarised below:

- Variation in the way organisations become aware of deaths of people in their care.
- Many patients die having received care from multiple providers. There are no clear lines of responsibility for the provider who identifies a death to inform other providers.
- No consistent process or method for NHS trusts to record when recent patients die after they have been discharged from the service.
- Electronic systems do not support the sharing of information between NHS trusts.
- Trust boards receive limited information about deaths of people using their services other than those that have been reported at serious incidents.
- When boards receive information about deaths, board members often do not interrogate or challenge the data effectively.

1. NSFT Board of Directors public session 23rd September 2021
2. NSFT Board of Directors public session 27th January 2022
3. National Guidance on Learning from Deaths; A Framework for NHS Trusts and NHS Foundations for identifying, reporting, investigating and Learning from Deaths in Care
4. Care Quality Commission. Learning, candour and accountability. A review of the way NHS trusts review and investigate the deaths of patients in England

Mortality recording methodology (2 of 4)

National mortality terminology guidance

There is no clear single definition of either an expected or unexpected death in national guidance. Some organisations use the Mazars framework (Appendix A) with others wording their own definitions[1]. There is limited guidance, for Mental Health providers, concerning the time period from discharge for which a patient is considered “under a trust’s care”.

The lack of national guidance means key terminologies are defined locally. The exact wording can impact the number of deaths which a trust reports within its mortality statistics. A detailed comparison of locally used terminology is included the appendix. There is variation around the definition of time frames for the deaths included as part of a trust’s mortality reporting.

The Trust’s current mortality recording methodology

The Trust’s methodology for capturing deaths to be included within the Trust’s mortality reporting incorporates the steps outlined below, which are compared to national practice on slide 20:

- Defining the time period of deaths to be included within the Trust’s mortality reporting
- Monthly Spine tracing
- Categorising expected and unexpected mortality.

National Spine tracing

Accessed through clinical systems or via a designated portal the NHS Digital national Spine allows information to be shared securely between health organisations. This includes summary clinical information alongside basic demographics including birth and death notifications to support identifying patients and matching them to their health record.

When a death is notified by a health professional within their local clinical system or via the secure portal, the death notification message is generated by the Spine and then reflected in the Personal Demographics Service (PDS).

If a patient clinical record is held by multiple providers, then the notification will be acknowledged by those providers by either directly accessing the record of that patient or interrogating the Spine using a standard report called a Spine trace query. This report would notify an organisation of all the patients recorded within their clinical system that had a change in their PDS status including a date of death.

Methodology changes

Methodology changes can be positive and sometimes needed. If changes in methodology occur without explanation, rationale or context they can cause confusion for those trying to understand the data within a report. It also hampers the ability to track through reports and historical data over time. This challenge was reflected in the feedback from some stakeholder meetings. When changes are made the new methodology and the expected impact on mortality data should be explained to an appropriate level of detail within publicly facing documents to support those reading the data.

There is no formal documentation regarding the process for changing or amending the methodology of the mortality recording process. The Trust has changed is methodology on several occasions which impacts on the ability to track and compare deaths over time.

- Between October and December 2019 NSFT changed its approach to reporting of the total number of people known to its services who died. Prior to this period, data had only included people whose death was identified by reporting on the internal incident reporting system, Datix [2].
- January 2022 board reports noted that that the Trust had broadened its definition of those who have died to include people whose deaths were not notified to NSFT at the time of their death[3].
- In January 2023 the Trust changed its dashboard recording, from previously comparing unexpected and expected deaths to now using the terms ‘natural’ and ‘unnatural’. It is important that terminology used is consistent with accepted national practice (e.g. expected and unexpected).

As part of this process the Trust has noted rules which have historically been applied to data which they will change going forward. Rules were applied where deceased patients would not appear on the reporting query when a patient record had been accessed by a member of staff post date of death. It was incorrectly presumed that the individual who had accessed the record would be creating the relevant Datix entry and applying the deceased status to the record.

1. National Guidance on Learning from Deaths; A Framework for NHS Trusts and NHS Foundations for identifying, reporting, investigating and Learning from Deaths in Care
2. NSFT Paper I, Mortality Report BoD September 2020
3. NSFT Paper G, Mortality and Learning from Deaths. BoD 27th January 2022

Mortality recording methodology (3 of 4)

* The Trust's methodology is defined with the context of national guidance. In some areas the lack of specific national guidance means NSFT use a different definition to other mental health trusts. The potential issues highlighted here are discussed later in the report.

Area	Nationally accepted practice	NSFT practice	Potential issues encountered by the Trust as a result of the Trust's methodology *
NHS Spine trace (Informing source)	No clear national guidance. Most mental health trusts perform Spine traces (as detailed in the previous slide) on a weekly or daily basis.	Monthly trace from the Spine, along with deaths communicated by inpatient and community teams directly to the Trust.	The time lag between time of death and the time that the Trust learns of it will impact on the relevance reports. Data will appear to change between reports because of the time it takes the Trust to learn of a death.
Time period for deaths to be included within the Trust's mortality reporting	Trusts are required to collect and publish on a quarterly basis, at a minimum, total number of inpatient deaths and those that the Trust has subjected to case record review. Acute trusts were advised to include cases of people who died within 30 days of leaving hospital; mental health trusts were advised to consider which categories of patients were within scope for reviews[1]. Most Trusts use patients who died within six months of discharge from caseload in line with the Royal College of Psychiatrists 'Guidance for reviewers'.[4]	All inpatient and community deaths, including those within six months of discharge from the Trust. The Trust have informed Grant Thornton that their Learning from Deaths 2023 policy describes the case record review selection process in line with NQB Learning from Deaths guidance.	The Trust's approach is in line with national practice, however the details of the definition chosen impacts the number of deaths considered to be part of an organisation's mortality statistics. Changing supporting processes or not keeping accurate caseloads also impacts reported numbers.
Expected and unexpected deaths	Guidance from NQB uses the terms expected and unexpected to outline deaths which should be subject to a case review. All trusts reviewed in our benchmarking exercise split their mortality reporting between expected and unexpected[1], although some broke this down further to use the terminology natural and unnatural. The NHSE Better Tomorrow team reported they would recommend expected and unexpected to be used.	*Expected* - if it was caused by a pre-existing life-limiting condition or if the person's age and frailty made death from a natural cause a reasonable expectation at the time of their death [2]. *Unexpected* - 'The death of a service user who has not been identified as critically ill or death is not expected by the clinical team. If there is no known diagnosis of terminal illness or physical health complication meaning that the service user is deemed as approaching end of life or receiving palliative care. Where data or cause of death is unavailable this is defined as unexpected [3].	Whilst the Trust's approach is broadly in line with national practice there are issues with the process of identifying expected and unexpected deaths which are detailed later in this report. There is a risk of inconsistent implementation without clear decision-making supporting documentation and clinical input.

1. National Guidance on Learning from Deaths; A Framework for NHS Trusts and NHS Foundations for identifying, reporting, investigating and Learning from Deaths in Care
2. NSFT Mortality and Learning from Deaths Report, Jan 2022
3. NSFT Unexpected and Sudden Deaths (in-patient areas only' policy, ref no. Q11a, version 06.1
4. Royal College of Psychiatrists: Using the Care Review Tool for mortality reviews in Mental Health Trusts

Mortality recording methodology (4 of 4)

Methodology benchmarking

To benchmark how the Trust has interpreted the available national methodology, we have reviewed the NSFT approach against other mental health trusts. To achieve this, Grant Thornton reviewed the comparator trusts publicly available mortality policies. It has not reviewed their deployment or the adherence to them.

Other mental health trusts follow a similar methodology to that employed by NSFT, with trusts accessing data from within their organisation, the Spine and collating this on an incident management system. The exact processes which underpin this overarching methodology differ between organisations.

Trusts vary as to how frequently they access the NHS Spine with most employing a daily or weekly trace. Some comparator trusts are more advanced than NSFT at linking GP and public health information into their mortality methodology.

The majority of mental health trusts including NSFT count deaths within their organisation mortality data if they are an active patient or occur within six months of discharge. In some cases this is broken into more detail and is reflected in full in the Appendix. Whilst some other organisations have further stratified their reporting rules based on cause of death, six months is the common standard. Due to issues outlined later in this report relating to understanding cause of death for community patients, the Trust would potentially be unable to implement a more sophisticated attribution method using the data available.

Mental health trusts have different wording for what is an expected or unexpected death. Of the trusts' methodologies reviewed most broke down deaths into expected and unexpected, although some chose to break these categories down further. Our experience is that Better Tomorrow recommend the terms 'expected' and 'unexpected' to be referenced in board and external facing reports. This varied wording means trusts do not have comparable categories so benchmarking expected to unexpected deaths nationally is a challenge.

Some trusts choose to break down expected and unexpected deaths into further categories in accordance with the Mazars framework, detailed in Appendix A. This includes subcategories referring to natural and unnatural below the umbrella expected and unexpected terms. A comparison between the Trust's mortality terminology and that of other mental health organisations is included in the appendix of this report. There was no evidence of a Trust using just natural and unnatural as definitions.

Conclusion and areas for improvement

The mortality recording methodology used by the Trust adheres to the principles set out in the available national documentation and follows a similar interpretation to other mental health trusts. Nationally there are mortality data challenges, so the Trust does not have the ability to solve all of the current issues alone.

Monthly Spine tracing results in a lack of contemporaneous information and in this area the Trust is different to other organisations who do this more frequently.

Some parts of the Trust's methodology are prone to individual interpretation. Implementing a continuing training programme for relevant staff to ensure the recording process is consistent and efficient would reduce the risk of variation due to individual interpretation and support staff making decisions on reportable data points.

Recommendations (mapped in detail in Action Plan at the start of this report)

	Recommendation	Priority
4	Use the Spine as the definitive reference source of identifying deaths and update this information on a weekly basis.*	High
5	Agree a standardised reporting structure for board reports, to include thematic analysis and consistent presentations of figures, axis and scales. Clearly define the Trust's methodology for mortality recording and reporting within board reports. Changes should be clearly documented and the impact upon historically reported figures should be described to provide continuity.	High
11	Create supporting training programme for all staff who input data into systems that have an impact upon mortality data. Ensure that the implications and impacts of incorrect or incomplete data entry are understood by staff.	Medium

* The Spine should not be the only source of mortality information but should be the definitive reference source and be accessed in a timely manner.

Processes (1 of 6)

Introduction and summary

This section comments on how the Trust puts into action its methodology. It reviews the documentation, processes and categorisation which make up the mortality recording and reporting pathway.

The Trust currently applies its mortality methodology through processes which involve multiple steps supported by different teams or identified individuals. Some of these individual steps have well-documented procedures, but the end-to-end mortality recording process has no overarching supporting documentation.

There are a number of systems involved in the overall recording process. This should be clearly documented and undertaken in a structured and controlled manner. Where possible this should also be automated and the reliance on individual manual inputs should be removed or mitigated as this can corrupt the final output of the Trust's mortality reporting and provide incorrect data.

Multiple systems are used for the recording of deaths at the Trust, with an individual Excel sheet used between clinical systems. The end-to-end process of mortality recording is undocumented with a lack of clear rules underpinning the recording pathway. This creates points of risk with limited assurance over the whole pathway.

The Trust uses Lorenzo as its main clinical system, but SystmOne and IAPTUS are used by certain services within the organisation. Patients who have records on these systems may also have a Lorenzo record, this is dependent upon which other services they may be registered to within the Trust. Grant Thornton have not seen clear documentation of the process for death notifications in these systems and how it links to the Trust mortality reporting. The exception to this is that we have sighted an SOP for recording a death of a service user within Lorenzo.

The recording process culminates in information stored in the NSFT Mortality dashboard, which informs internal and board reports. This dashboard contains basis demographic information, although this is not aligned to the cause of death.

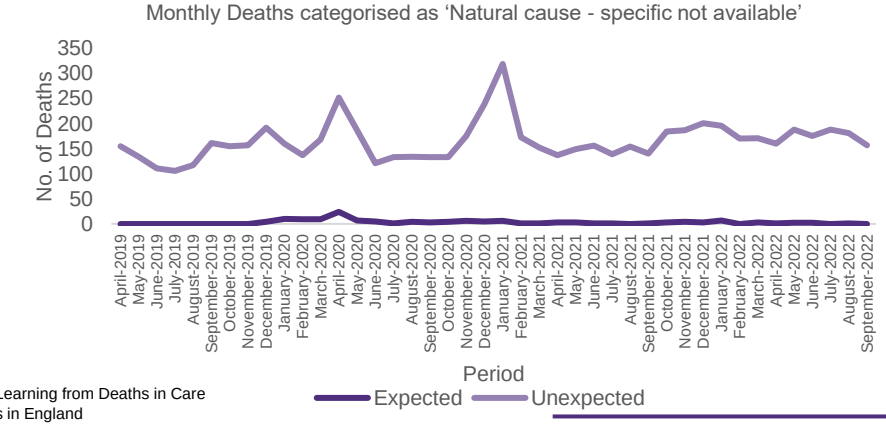
The various processes and the challenges these present are summarised on the next page.

Mortality recording documentation

Similarly to the lack of national documentation the Trust lacks documentation of the end-to end process of mortality recording. A lack of standard operating procedure covering the entire process of mortality recording results in inconsistency of data capture and input into clinical systems. Areas where detailed documentation is absent, but expected, are listed below:

- Grouping of cause of death, which appears on the Trust dashboard
- Categorisation of expected and unexpected deaths and the role undertaken by the patient safety team when reviewing Datix entries
- End-to-end mortality recording pathway
- Process for methodology changes and amendments
- No mortality specific guidance for staff completing Datix forms having been informed of a death
- No clear guidance for review decisions made by patient safety team following Datix review.

Figure 1 showing monthly unexpected and expected 'Natural cause specific non available' death totals from Datix, Lorenzo and the NSFT Dashboard from April 2019 to September 2022



1. National Guidance on Learning from Deaths; A Framework for NHS Trusts and NHS Foundations for identifying, reporting, investigating and Learning from Deaths in Care
2. Care Quality Commission. Learning, candour and accountability. A review of the way NHS trusts review and investigate the deaths of patients in England

Processes (2 of 6)

Mortality recording process step	Associated challenges and risks
Death is reported from inpatient unit, community team or monthly patient master index tracing against Spine. Deaths notified by inpatient or community team are recorded to the main Trust electronic patient record (EPR), Lorenzo.	• Monthly tracing limits simultaneous mortality data availability within the Trust resulting in reported data changing over time as the Trust becomes informed of a death. • Grant Thornton saw no evidence of a mandated timescale for recording of deaths within the Trust. The Trust have informed Grant Thornton that this is included as part of the Leaning from Deaths 2023 policy. • Multiple data sources (including Lorenzo, Iaptus, SystmOne and Datix) risk inconsistencies and potential to cause differentials as the process undertaken may vary depending on how the Trust is informed of a death. • Access rights to record deaths on Lorenzo are limited to system administrator, meaning individuals within teams cannot change the death status. There has been misunderstanding within the Trust historically that the death status had been changed within Lorenzo when users accessed a record post date of death, when it had not actually been done.
Information from Lorenzo extracted for review in a spreadsheet	• The use of excel to store and process sensitive information is minimised with audit and security policies appropriately applied where this is necessary. • Extracting data from the clinical system loses audit trail and case/effect within that system.
For notified deaths an entry should be made into Datix (Trust risk management system) by the member of staff receiving the notification of death.	• Reliance on a variety of members of staff to be aware of the need to perform this task and do so in a timely manner. • Potential for individual interpretation when completing Datix without clear mortality specific supporting guidance within the Trust. The Trust could further work on supporting staff completing Datix forms to ensure only relevant information is collected and avoiding duplication with information already within Trust clinical systems.
Datix reviewed by patient safety team to determine next steps regarding reviews and investigation.	• Isolated input in pathway. Lack of involvement at other steps adds to the limited oversight of the pathway and is an example of siloed steps in the overall pathway.
Deaths categorised into unexpected or expected. Categorised based on cause of death and basic age information held within a locally stored excel workbook.	• Patient details held outside of core Trust clinical systems require suitable audit and security policies to be applied.
Death certificate information used to group deaths into cause of death seen on dashboard.	• Process reliant on individuals meaning it is susceptible to inconsistency and it is unclear how continuity remains when key individuals are away. • Bulk of deaths informed via the NHS Spine, where cause of death information is not always available. There is a reliance on individuals to chase the detail associated with these deaths, such as the cause of death, from other parts of the healthcare system, including GPs. This is a nationally recognised challenge for mental health trusts and improvement in the Trust's data for community deaths will require partnership working.
Excel workbook informs Trust's mortality dashboard, from where corporate reports are generated.	• The use of excel outside of core clinical systems is minimised with audit and security policies appropriately applied • Across the whole pathway responsibility is dispersed across a number of staff groups/individuals for the various processes • The final dashboard appears to under-report deaths when compared to Lorenzo and Datix figures (detailed on page 26).

Processes (3 of 6)

Data categorisation

Within the current recording processes there are steps which require categorisation, or grouping, of data. These key decisions are needed in order to inform the final dashboard and reportable figures. This adds value in supporting the Trust to review areas of potential focus. There is no documentation associated with this process which thus relies on individuals to make reliable and replicable judgments. At points this categorisation is done by an individual with no clinical oversight for input or support.

One of the key points of categorisation is expected and unexpected deaths; this delineation is reported regularly in board reports and published externally. Accurately and reliably sorting deaths into these two categories is key, which currently relies on an undocumented judgement processes.

Causes of death, measured per month, make up the main rows of the expected and unexpected screens of the Trust's mortality dashboard. This information is taken from a patient's death certificate and then categorised into the groups displayed on the mortality dashboard. Where available this is taken from the part 1c of the death certificate, followed by 1b with 1a used if neither 1b or 1c are completed. The process of using death certificate information to inform decision making around the groupings which appear on the dashboard is not supported with clinical input or SOPs. There is inconsistent understanding across the organisation as to how cause of death information is grouped.

The Trust's mortality dashboard uses a number of catch all terms which are not defined within its reporting. These terms, described below, lack clarity for those not closely associated with the recording process.

- *Natural cause - specific not available* – Records where a death certificate is not available.
- *Specific not available* – A legacy term which should not be on the dashboard as a separate item and has been replaced by '*natural cause – specific not available*'.
- *Unascertained* – A term only used by the Trust when this has been a coroner's verdict.
- *Unspecified effects of external causes* – This has been used in the past to cover a 1a cause of death of multiple fatal injuries after jumping from a height.

The term '*Natural cause - specific non available*' accounts for 77% of the total deaths analysed in the given period. Figure 1 on slide 22 shows the deaths categorised as '*natural cause specific - non available'* in the expected and unexpected groups over the months from April 2019.

The large proportion of deaths categorised as '*Natural causes – specific non available'* poses a challenge for the Trust in understanding the deaths to be included within the Trust's mortality reporting, and then using this information to implement meaningful learning. Where the Trust has done what it can to access a cause of death, but this information is not available, it may be clearer to use terminology such as 'unknown to the Trust'.

Pending cause of death

Pending cause of death was recorded 315 times across the time period examined by Grant Thornton, 44 of these are in cases of expected deaths and 271 in cases of unexpected deaths.

The majority of these pending cause deaths are in 2022, when 189 are recorded. This reflects the Trust's reported methodology that this term is used when a death is being further investigated, for example by the coroner, and once the cause of death is confirmed this should be updated on Trust records. However, there are still five records which remain under this category from 2019 and a further 12 in 2020.

As the numbers within this category are highest in recent years, this suggests updates are happening when information is passed on to the Trust. The ongoing attribution of some deaths as far back as 2019 to 'pending cause of death' may represent several factors:

- Trust may not be updating all records when causes of death are given. This could be because of difficulties in finding out this information or because the Trust is not checking back on cases it should be updating.
- Mortality investigations, like those through coroners' court, can take a long time, so information may not be available for months or even years after a death.

Processes (4 of 6)

There are challenges in accessing information on cause of death, especially if the death was reported via the NHS Spine. Ascertaining information on cause of death in these situations involves contacting the GP practice: sometimes information is unavailable and on other occasions there are barriers to sharing the information. Grant Thornton's experience is that the medical examiner role, recommended by the NHS England's Better Tomorrow team as part of good practice, should help the Trust to create links into GPs and other organisations to improve access to more information on the cause of death. Improving the quantity of data collected for cause of death will rely not just on the Trust but partnership working across providers in the system.

The lack of this information also demonstrates the need for the Trust to collaborate with other primary and secondary care organisations in the region to ensure that the whole system is learning and improving together and not in silo. Doing this effectively may mean rethinking and improving current pathways and processes.

NULL data fields

Missing data fields, or 'NULL' fields were prevalent across the data. The number of null fields in the data set for each year is shown in the graph on the right. Whilst the 2022 total is only 11,733, compared to 15,316 in 2021, the data for 2022 only covers nine months of the year.

Analysis performed across the 'NULL' fields showed these are particularly prevalent across certain categories including 'Local Specialty' and 'site' fields. There was also a large number of NULL field entries for ward names. For many patients, who were not inpatients at the time of their death, they will not have had an inpatient ward, but in leaving fields blank the data lacks reliability when analysed as a set. Using 'n/a' when a field is not applicable to the patient in question would help distinguish a non-applicable field from a missing data.

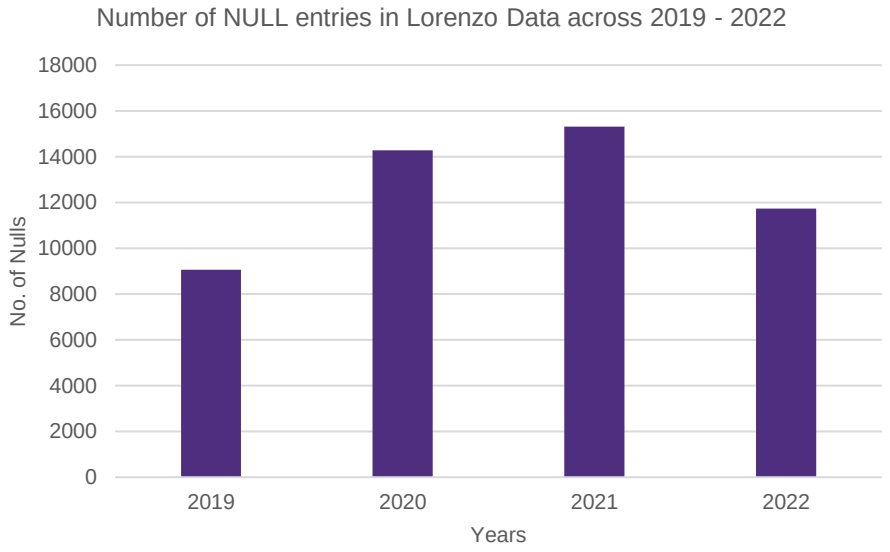
Some data fields were consistently well filled in over time. These include:

- Date of last seen appointment
- Team name
- Registered GP practice.

Lacking a fully comprehensive view of the data limits what Grant Thornton can conclude from the information provided. For the Trust, who use this same data to draw their own conclusions on mortality, the gaps in inputs significantly limit the trustworthy conclusions which can be made. Incomplete and missing fields in data limit the identification of outliers and the opportunity to target tailored interventions in the right areas.

Work to improve this may involve educating staff on what should be input into each field and enhancing staff understanding on why this information is so important. For other areas the Trust may need to consider which fields are necessary, both 'site' and 'local specialty' have two entries within Lorenzo which could cause confusion to individuals completing forms.

Figure 2 showing the total number of NULL entries in Lorenzo between 2019-2022



Processes (5 of 6)

Data gaps between systems

Grant Thornton reviewed data from DATIX, Lorenzo and the Trust's mortality dashboard covering April 2019 to October 2022. The three sources did not all cover the totality of this time period.

The data received was quality checked before analysis commenced, and it was found that the pseudonymised patient IDs were missing from both sets. IDs were mapped against both data sets to illustrate which patients were recorded on both systems and highlight the missing patients across the data. There were found to be 65 missing IDs in Datix, only three of these are attributable to the extra month of data received for Datix data. There were 324 missing IDs in Lorenzo (noting that one ID in Datix was 'Unknown' and 122 were missing/blank IDs). The disparity in data reflects the inconsistencies in recording and this difference in numbers could be deaths from other discrete peripheral clinical systems (IAPTUS, SystmOne) or deaths that occurred where incorrect reporting rules had been applied to exclude patients whose records had been accessed post death notification date.

Datix data had 259 records more than that of Lorenzo. Clinical systems other than Lorenzo are used for certain patient cohorts. These patients would have a Datix raised on death but may never have had an entry on the Lorenzo system. Without examining the other clinical systems (SystmOne and IAPTUS) we cannot be certain whether this is explains the discrepancy regarding the Datix records which do not have a corresponding Lorenzo record.

A significant number of NULL entry data fields were noted throughout the data from both systems and this is discussed later in this report. The initial quality check on the data also noted that local specialty fields in Lorenzo were included twice.

Table 1 showing Lorenzo and Datix pseudonymised ID records received by Grant Thornton from the Trust covering April 2019 to October 2022

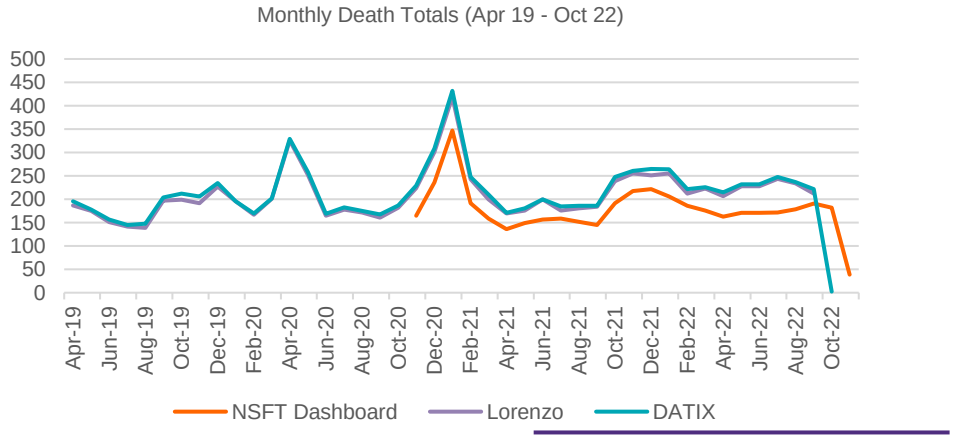
	Lorenzo	Datix
Number of Patient ID records received	8871	9130
Number of records also present in comparator source (Lorenzo for Datix and Datix for Lorenzo)	8806	8806
Number of records not represented in comparator source	65	324

Comparison of sources

The methodology and implementation of current mortality recording processes result in a discrepancy between deaths recorded on Lorenzo and Datix and those which appear in the Trust's mortality dashboard, as shown in figure 3. Following the review, the Trust described a process of validation. Included in that process were additional steps to clarify the six-month standard and a further review of those activities recorded as appointments that were indirect or non face-to-face administrative activities. At the point of review, the process around these validation steps was not available so we have been unable to provide assurance over this. The data field used for the analysis below was 'Date of last seen appointment' and within the data one patient had a discharge date that was beyond the six-month time period.

Grant Thornton has only seen a visual of the dashboard so we have been unable to explore the reasons behind the differential here nor identify which patients are not being represented within the dashboard. The Trust informed Grant Thornton that their informatics team found extra information as part of this review process, this is not included in the graph below and we are unable to quantify the gap between the NSFT dashboard and Datix/Lorenzo that this information may represent.

Figure 3 comparing monthly death totals from Datix, Lorenzo and the NSFT Dashboard from April 2019 to October 2022



Processes (6 of 6)

Conclusion and areas for improvement

In implementing its mortality recording methodology the Trust uses multiple systems that have the potential to result in differences between sources of data. Within its mortality pathway processes, the Trust exhibits deficiencies which limit the potential to provide assurance over the pathway, and thus the accuracy and integrity of the mortality data reported from it. The current process is subject to human error and individual interpretation, with the lack of documentation around these failing to give the process clarity.

For the data recording process, the reliability and trust in the data reported by the Trust, would be improved by reducing the number of manual interventions of recording and reporting, thereby minimising the risk associated with the use of multiple systems and by improving the quality of data outputs and increasing audit capabilities.

Developing documented processes including SOPs for all areas of mortality data captured across clinical systems would help to ensure reliability in key areas of the mortality recording process.

The multiple issues identified with the Trust's processes have resulted in the inconsistency in data reported from different sources. These need to be addressed to ensure there is consistency and clarity in the numbers reported internally and externally.

Incomplete or missing data fields can pose accuracy and reliability issues within the data presented by the Trust. Further clinical engagement is needed to help improve the quality of data inputted into clinical systems and reduce the number of incomplete or missing fields. Increased engagement with other healthcare providers in the area would help to minimise the gaps around cause of death information which limit the conclusions which can be reached from the current data set, especially with regard to community data. The Trust will need support from the ICB in achieving this. Documented processes with clinical support are needed to ensure categorisation and grouping is replicable and aligns to clinical interpretation.

Recommendations (mapped in detail in Action Plan at the start of this report)

	Recommendation	Priority
1	Improve the mortality data pathway to automate and digitise the production of mortality reporting, removing manual processes for transferring and transforming the data, and introducing an audit trail where user interaction is required. The data pathway covers: data entry by clinical and service staff, clinical system configuration for capturing and codifying data, export process from clinical systems, data management within data warehouse (or through manual intervention), rules and categorisations applied to support reporting, the presentation of reporting outputs, and the process for validating these outputs.	High
2	Develop standard operating procedures (SOPs) for each stage of the data recording process, and ensure these are kept up to date.	Medium
3	Develop reporting tools or method of measuring incomplete data fields to feed back into the organisation, and support training.	Medium
4	Use the Spine as the definitive reference source of identifying deaths and update this information on a weekly basis.*	High

* The Spine should not be the only source of mortality information but should be the definitive source and be accessed on a timely manner.

Reporting (1 of 5)

Introduction and summary

This section contains discussion on the Trust's national data submissions, how it presents and evidences interrogation of mortality data within its reports, and analysis of figures presented in board reports compared to data received by Grant Thornton.

The Trust reports mortality data through board, annual and internal committee reports as well as using their data as part of national submissions. Reports vary in both graphical presentation of data and the actual data included over time. This makes it hard to track information and trends over time. Frequent presentation and methodology changes also limited the assurance which can be given over the accuracy of reporting.

Board reports reviewed as part of this report contain minimal evidence of interrogation of data to investigate peaks in mortality or understand areas of interest in the wider data. Board papers make broad, generalised statements to explain peaks in data, but these are not supported within those board papers by analysis of the Trust's data. The Trust does not consistently present the information referred to in its Learning from Deaths guidance. Reports contain more detailed discussions of inpatient deaths and patient safety incidents with limited evidence of community mortality being explored using the data, or the wider learning which may come from these being explored.

Internally, whilst there is a documented line for reporting through sub-committees into the board, members of staff interviewed by Grant Thornton reflected that they felt processes were not clear. Members of staff involved in the mortality reporting process described challenges around the mortality process feeling disjointed with feedback that clinicians could readily access the information they desired to support them. Mortality information is discussed or presented within a number of different forums across the Trust including, but not limited to:

- Trust board
- PSI annual report
- Safety and Mortality Committee (Patient Safety Review Group was renamed the Safety and Mortality Committee in September 2022)
- Quality Committee
- Audit and Risk Committee.

Board reports data presentation and evidence of interrogation

Mortality reporting is presented inconsistently between reports with no clear explanations behind the rationale of changes, or their anticipated impact. There is a lack of detail and thematic analysis within reports which fails to show a level of mortality data interrogation needed to learn wider lessons, especially in regard to community deaths included within the Trust's mortality reporting.

Over the last two years mortality is discussed every four months at board level, with papers included in the supporting papers on most of these occasions. In the Appendix of this document is a series of graphs taken from Trust board papers over time exhibiting the changing presentation style and the subsequent challenge to track through board reports. The inconsistency between these is summarised in the table on the next page, but includes changes in axis, data points and the way the graphs are drawn using different styles and colours. The time periods discussed in board reports varies. In some cases, reports discuss total figures over the past 2 years and in others they refer to monthly averages.

Reporting (2 of 5)

Throughout 2021 data is reported as 'all cause mortality', but in January 2022 the data is split into inpatient and community deaths. The numbers of deaths in the subsequent community graph is higher than the previously presented 'all cause mortality graphs'. At this time, the Trust broadened their definition of those who have died to include people whose deaths were not notified to NSFT at the time of their death. The precise impact of this change is unclear. The graphs presented in January 2022 also contain gaps on the graph, which board papers comment are due to the methodology change, these gaps are not present in earlier or subsequent graphs.

The Trust takes its guidance for what to include in board reports from the NQB Learning from Deaths framework, this is included in the Trust's Learning from Deaths policy[7]. Both documents focus on the collection and reporting of inpatient deaths and deaths subject to a review. Consequently, the Trust does not have guidance in its internal Learning from Deaths policy on the level of detail which should be presented to the board for the reporting of community mortality. On a wider note, regarding data in board reports, in line with NHS Digital best practice recommendations, the Trust has moved to using SPC charts in its Integrated Quality and Performance Reports. SPC is included in serious incident graphs, but not in reporting of all mortality.

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Board report	Coverage	Data presented within graphs in board report	Presentation
January 2021 [1]	Monthly mortality 2018-2020	All cause mortality	SPC RAG colouring of upper and lower limits No data point markers or clear link to time on x axis
May 2021 [2]	April 2018 – February 2021	All cause mortality	SPC Colour of confidence interval and average lines changed Data points clearly link to months on x axis
September 2021 [3]	December 2019 – July 2021	All cause mortality	SPC Similar to that presented in May 2021
January 2022 [4]	December 2019 – October 2021	Split into inpatient and community reporting. No all cause presentation. Missing data in graph	SPC for community; Run chart for inpatient Data points marked but not clearly linked to corresponding months
May 2022 [5]	April 2020 – November 2021	Expected or physical cause mortality and unexpected or patient safety incident mortality	SPC Data points marked but not clearly linked to corresponding months
September 2022 [6]	Brief discussion of mortality in Quality, Patient Safety and Mortality Report within the Quality Assurance Committee report	No graphs presented	No graphs presented

1. NSFT Board of directors public meeting papers 28th January 2021
2. NSFT Board of directors public meeting papers 27th May 2021
3. NSFT Board of directors public meeting papers 23rd September 2021
4. NSFT Board of directors public meeting papers 27th January 2022
5. NSFT Board of directors public meeting papers 26th May 2022
6. NSFT Board of directors public meeting papers 27th January 2022
7. NSFT Q01 Learning from Deaths Version 04 Final Update Sept 22

Reporting (3 of 5)

Board report data accuracy

Below is a comparison of statements taken from NSFT board reports which is compared against the data sample that Grant Thornton received for the Lorenzo and Datix systems. The aim of this exercise was to understand the consistency of board report data against Lorenzo and Datix.

Within the January 2022 board papers data is presented split into inpatient and community groups [1]. From the data sample provided it is not clear how these groupings have been decided upon. For the purposes of this comparison, Grant Thornton have assumed that a death notified via the inpatient team is an inpatient death, and a death notified via the community team or via NHS Spine is a community death. We have not included the small number of deaths that were notified via Legal Services. To aid clarity within its reporting processes the Trust should clearly set out the definitions which it uses in mortality data reporting, and the sources of information which inform these.

From this comparison the following conclusions can be drawn:

- The expected and unexpected death numbers are flipped between the data sample and the board reports
- Board reports change between reporting total or community and inpatient figures. The granularity of splitting out inpatient and community deaths is useful. Switching between the two is challenging for readers to relate numbers to those previously reported.
- Board reports change between using total numbers or average numbers over a 2-year period.

Table 2 comparing unexpected and expected deaths as presented in the board reports of January and May 2022 to the data sample provided. [1, 2] Areas shaded in grey represented no data available (n/a) for that field in the board paper in question.

	Jan 20 - Dec 21 (Community)		Jan 20 - Dec 21 (Inpatients)		May 20 – April 22	
	Unexpected	Expected	Unexpected	Expected	Unexpected	Expected
Board Report (total)	320	2910	**n/a**	**n/a**	**n/a**	**n/a**
Board Report (monthly average)	**n/a**	**n/a**	**n/a**	**n/a**	16	153
Data sample provided (total)	3835	383	16	30	3934	345
Data sample provided (monthly average)	160	16	0.67	1.25	164	14

Reporting (4 of 5)

Evidence of data interrogation

Whilst data is presented in board reports there is limited evidence of interrogation into the data on either a routine or areas of concern basis. Where this analysis does occur, it remains high level and lacks a detailed investigation of the data.

There were efforts during the COVID-19 pandemic to evaluate the impact of the pandemic on the Trust's mortality figures [1, 2]. In this period the Trust benchmarked its expected and actual mortality against that of the region. They reached the conclusion that 'people who were in contact with NSFT's services were disproportionately affected, compared to the whole population of Norfolk and Suffolk'. The Trust explains some of the increased impact by reference to the age of the population in the Trust's area, although there is no statistical analysis of the two. Whilst this compares data in a notably challenging period for healthcare services, there is no clear evidence as to whether the peaks in data being discussed are directly attributable to deaths from COVID-19, factors associated with the pandemic or other factors not revealed due to lack of investigation of the data.

Internal reports present data differently to board reports and whilst they contain more detailed discussion this is focused on inpatient deaths and patient safety incidents. There is limited evidence of community death themes or learning beyond the expected and unexpected death categorisation stage.

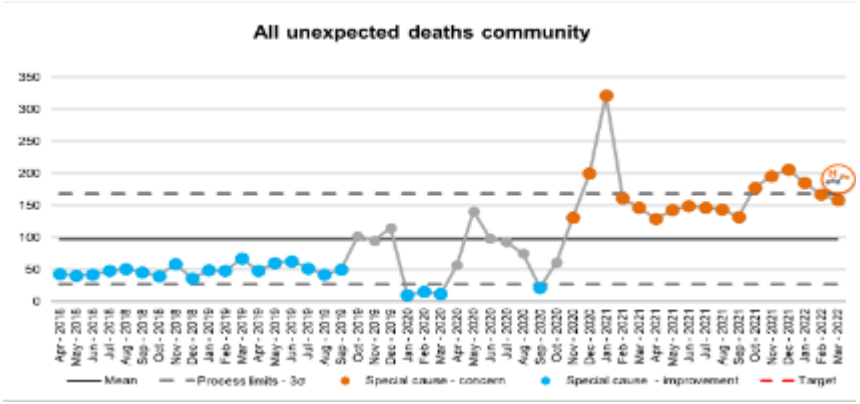
The Patient Safety Incident (PSI) annual report also contains mortality data and reporting which is again presented differently to board reports [3]. In the most recent report unexpected community deaths are pulled out as a separate graph. This graph is another example of data being presented differently across reports and the challenge to follow data through the organisation. Whilst the PSI annual report does attempt to explain the rise in special cause variation within unexpected community deaths, the factors which were identified as contributary are wide ranging and lack specificity.

'The number of unexpected deaths during this period was impacted by Covid-19 and the virus variants, there is also seasonal variation numbers being higher during the winter period. Equally the impact on physical health due to lockdown restrictions (exercise, lifestyle habits and obesity) and restricted access to physical health care is a likely factor in this increase.'

The quote is taken from the PSI annual report. Whilst the comments made may have some general and national applicability, they do not all appear to have direct relevance to the data being presented. Previous winters had seen small rises in mortality, nothing on the level of that seen in 2021. The Trust does not present any supporting evidence for their statement that the impact of lockdown restrictions on exercise, lifestyle and obesity has directly influenced their mortality data.

The Trust should be clearly evidencing, where relevant, the impact of national and local healthcare challenges on the data being presented to ensure that beyond obvious factors, such as COVID-19, it is not missing factors impacting its mortality.

Figure 4 showing all unexpected community deaths as presented in the Trust PSI annual report March 2021.[3]



1. NSFT Board of directors public meeting papers 27th January 2022
2. NSFT Board of directors public meeting papers 26th May 2022
3. NSFT Patient safety incident annual report 1st March 2021 to 30th April 2022

Reporting (5 of 5)

Conclusion and areas for improvement

Reporting between internal and external documents is inconsistent and lacks an explanation for the repeated changes, or the impact that methodological changes, have had on the figures presented. These change makes comparing the data presented over time challenging and increases concern over the reliability of the information reported.

The information contained within board reports does not consistently align to that which is recommended within NQB guidance or Trust guidance. Reports lack evidence of interrogation of the mortality data to identify the themes within the data, which could then be used for improvements and learning.

To improve this position a standardised mortality reporting structure and presentation should be developed and adopted across the Trust. This should include trend analysis to help understand variation and drive the need for timely and accurate data.

A documented change control process should be developed to approve any changes to mortality reporting methodologies. Secondly, when this happens, comparatives should be presented to ensure reporting is consistent, can be monitored and historically tracked.

Mortality data should be clear to enable internal clinical and external public confidence in reporting. Mortality data needs to have a clear, supervised, pathway through the Trust with agreed formats of presentation.

Recommendations (mapped in detail in Action Plan at the start of this report)

	Recommendation	Priority
5	Agree a standardised reporting structure for board reports, to include thematic analysis and consistent presentations of figures, axis and scales. Clearly define the Trust's methodology for mortality recording and reporting within board reports. Any changes should be clearly documented and the impact upon historically reported figures should be described to provide continuity.	High
6	Align the internal dashboard with external reporting to ensure that volumes on the internal dashboard clearly reconcile to numbers within board reports.	High
7	Work with public health and, when in post, medical examiner to identify key themes in the data and implement timely targeted interventions.	Medium
8	Use clinical input to update the cause of death groupings which are presented as part of the dashboard, and used in board reports, so that it is clear where the Trust is awaiting data (pending), or the Trust feels this data will not be accessible or will remain unknown.	High
14	Update the Trust's Learning from Death policy to ensure the Trust's governance addresses the issues in this report and explicitly references community deaths. Ensure the governance in relation to all mortality is clearly understood by clinical and corporate staff involved in the production and reporting of mortality information.	High

Clinical engagement (1 of 5)

Introduction and summary

This section focuses on the Trust's approach to clinical engagement on mortality reporting, including the approach to clinical validation and use of mortality data within the Trust. It also explores partnership working.

Within the data mortality reporting pathway there was a lack of evidence of how the collected mortality data is fed back to and used by service teams. The Trust has a good understanding of individual patients and clinical management of incidents, but more work is required to support services to maximise the use of mortality data to understand areas of interest that could support or inform how services could improve.

During the review two senior clinical leaders stated that members of the Trust's clinical staff have limited faith in their data and do not use or analyse it in a structured manner. This was reflected by other staff members we spoke with during the review who suggested a disconnect between the data production and reporting process, and its use in supporting clinical services. Moreover, there is limited evidence of the use of public health or health inequalities information to inform or supplement this data.

Clinical engagement forms part of data quality with the accuracy of information input to systems forming part of the data which is analysed in the mortality recording pathway. When clinical engagement with data is achieved this helps to improve both the quality of the data, which improves when the data is used, and subsequent improvements in patient care.

The Trust has highlighted engagement with primary care colleagues as limiting its access to death certificates which would better inform the cause of death element of the mortality pathway. The Trust attends public health and inequalities forums and undertakes work in specific areas such as suicide. To build on this, the Trust could further its engagement with public health or inequalities specialists to undertake mortality data analysis to support wider population health management. Doing so would benefit the Trust to help understand geography aligned to health inequality and allow targeted interventions.

Validation and use of data

Mortality data analysis needs to be clinically led to best understand the impact the Trust has on care provision and ensure any learning is fed back into the organisation. This needs to happen both at an organisation wide level and at a service level.

By empowering those who input data into the recording systems to use the data in practice, this will help to improve the quality of the data which is input. The Trust will need to work with services and individuals at the organisation who currently express concern about the purpose of data collection.

As well as having an organisational mortality data lead each service should have an identified lead for the mortality recording and reporting process in that area. Responsible individuals should be involved from the data entry point, working to focus on accurate, timely data entry to reporting and outcome discussion. Their knowledge of their services can help understand and inform service level data in formal outputs. These individuals should take part in the validation of mortality information and ensure feedback-loops back into services are working by tracking and reporting changes and improvement.

The need for clinical input into mortality data is shown by examination of the peak in January 2021. The most common cause of death here was '*Natural cause – specific not available'* (355), followed by 'COVID-19' (50), with the most common age profile being 65 and older (415 of 481 deaths). Examining the January 2021 raw data 'COVID-19' categorised deaths alone do not explain the spike in deaths. Table 3 below shows the number of deaths in the months pre and post January 2021. Depending on the source of death information, deaths in January 2021 increase between 111 and 203 per month from December 2020, far more than the 50 reported in January 2021. Given that the '*natural cause – specific non available*' category is used when the Trust is unable to access the death certificate there may have been deaths from COVID-19 within that category which are not reflected in the Trust's analysis.

The Trust is reliant on other providers for the cause of death in some situations and will need support from partners in helping to get a more holistic view of the causes of death of patients who are part of its mortality data.

Table 3 comparing monthly death totals from Datix, Lorenzo and the NSFT Dashboard from November 2020 to March 2021

	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
NSFT dashboard	165	236	347	192	159
Lorenzo	224	301	419	243	200
DATIX	229	229	432	248	210

Clinical engagement (2 of 5)

As discussed earlier, board reports show limited evidence of analysis into the reasons behind this spike. Within the PSI annual report there is a brief discussion exploring the possible cause for the increased number of unexpected deaths in the community. The various explanations proposed include the impact of COVID-19, seasonal variation, the impact of physical health due to lockdown restrictions and restricted access to physical health care. There does not seem to be any analysis specific to the Trust underpinning these propositions, limiting the ease of attributing these factors to the data presented.

The Trust should look to provide statistical and data analytical support for the narrative suggestions within their reporting, to ensure they make evidence-based conclusions in their corporate reporting. Clinical input into this will help to interrogate the data and may help to combat the concern as to how data is used by involving the clinical community. These processes will need to be documented and clear to avoid causing more concern.

Caseload management

According to its own definitions NSFT should only include, within its mortality statistics, deaths of patients currently under the Trust's care (inpatient or community) or within six months of discharge.

As part of this review the Trust noted an element of its case management where records of patients who had not been seen for a number of years were still being included in Trust mortality data. The figure below shows a number of patients forming part of the Trust's mortality statistics where the patient had not been seen for over a year, and some who had not been seen for over 2 years.

Figure 5 showing the time lag between date of last seen appointment and the date of discharge

The Trust should review this cohort of patients to understand why these patients were retained on caseload, whether they required further clinical input prior to their discharge and whether there is learning that can be obtained to inform future care delivery.

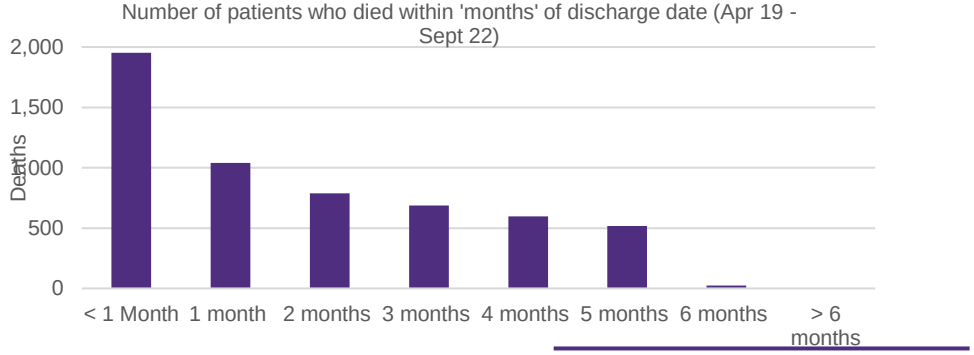
If these patients have been discharged but this status not updated they will have been unnecessarily included in the Trust's mortality figures. As part of rectifying this specific issue the Trust has informed Grant Thornton it plans to undertake the required data cleansing and provide further training to team administrators regarding appropriately closing referrals and discharging patients in a timely fashion, following the completion of their clinical care. This will help ensure that the number of deaths included within the Trust's mortality reporting accurately represent the Trust's activity.

Discharges within one month

For 1,953 patients whose death is considered part of the Trust's mortality reporting, the date of death is within one month of discharge. This includes 278 patients whose date of discharge is the same day as the day they died. Of these 158 were informed via NHS Spine, 112 via community teams, and 6 through inpatients teams.

Given the number of patients who die within a month of discharge, more work is needed to understand this cohort, ensure this data is accurate and act on any learning. The Trust is currently working with GPs through Primary Care Networks to try to improve the capture of cause of death to inform this insight.

Figure 6 showing the time lag between date of discharge and date of death



Clinical engagement (3 of 5)

A further 3261 patients, 37% of the total, had a discharge date recorded after the date of death. The majority of these were in the old age psychiatry or adult mental illness specialities, and 2699 of them were aged over 65.

There is a process question needed to ascertain why some patients are discharged on the day of death and why other records remain open for a number of days or weeks after death until they are discharged. The Trust needs to align its policy in this area and ensure staff understand and undertake their responsibilities around mortality reporting so that the data that is analysed tells the most accurate story.

Benefits of analysing by trend

Analysis of trends helps the Trust to both better understand the mortality attributed to it and, where necessary, undertake learning or changed practice. Trend analysis could be used to better inform individual services and help them to become more involved in the mortality recording process. For example, trend analysis on causes of death could help identify specific physical health causes of death, and where these are outside that expected of the local population. The Trust could use this information to target specific areas of the physical health agenda. Trend analysis will also identify variation and enable the Trust to see a deteriorating or improving pattern early, and intervene in good time if required.

Trend analysis can also be examined with regard to the accuracy and completeness of data, with the Trust being able to ascertain if there are particular services or teams that need more support to engage in the data process. The NSFT Mortality dashboard is available on the Trust intranet where it can be filtered to team level across care groups. Two senior clinical leaders suggested this information was not being accessed or used regularly by clinical staff.

Data is recorded for the registered GP practice and address of each patient. Extrapolating this information can give the broad geographical areas patients lived in. Understanding where a patient lived is important for informing detail around community deaths considered part of the Trust's mortality reporting. Geographical analysis may also help to understand areas where patients have certain physical or mental health challenges which could be targeted on a specific intervention basis.

The Trust has a Quality Improvement Plan which focuses on physical health care and includes interventions such as a smoke free programme.

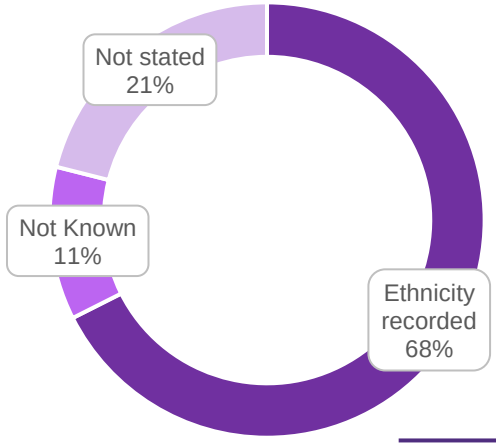
Ethnicity

In January 2022 the board requested more information within its reports to ensure there was no disproportionate impact on protected characteristics. More information was requested in future reports on what was being done on the back of this information. In order to explore this properly the Trust will need to know the ethnic representations in the community it serves in order to understand any disproportionate impact.

Between April 2019 and September 2022 1868 deaths had an ethnicity recorded as 'not stated' and 1009 as 'not known', shown in detail in the appendix. Figure 7 below shows the number of patients that had an ethnicity recorded within the data provided to Grant Thornton. Without knowing ethnicities represented within the 'not stated' and 'not known' categories, the Trust will struggle to accurately understand whether or not there is a disproportionate mortality impact on certain protected characteristics.

The Trust have informed Grant Thornton that work is ongoing to improve this recording, which is being led by the Equality, Diversity and Inclusion (EDI) practitioner and ICT.

Figure 7 showing the recording of ethnicity for mortality reporting between April 2019 and September 2022



Clinical engagement (4 of 5)

Partnership working

Understanding and learning from mortality is not only the responsibility of metal health trusts, but also primary, acute and community providers involved in a patient's care. Given the well documented challenges mental health patients can have accessing physical health care, there may be system wide learning from which the Trust and its patients could benefit.

The Trust has noted the challenges it currently has in accessing information for some patients when liaising with other providers. If providers across the system can come together the benefits extend beyond learning opportunities listed below.

Learning opportunities associated with information sharing

- Death certificate sharing to better inform causes of death
- Care learning for mortality cases where care is split between providers
- Better understanding of patient journey between services
- Better understanding of provision of care between services.

The Trust attends ICB forums on Learning from Deaths and Addressing Inequalities of Health. This provides the opportunity to facilitate better joint working, sharing data and realising the potential benefits of these forums. By working together providers in the system have the opportunity to widen their understanding of the challenges patients can face, these are outlined in the table on the right.

The Trust is also part of public health suicide prevention workstreams, where they report that their data aligns, and undertake smoking cessation work alongside Public Health England (PHE).

Area	Opportunity
Physical health	• Better understand the challenges faced by mental health patients • Work together to improve physical health care access for mental health patients
Public health and inequalities	• Better understand the correlations between social inequality and health outcomes in the system • Map publicly available public health data on to geographical areas served by the Trust • Opportunity for the ICBs to enable public health experts to work across the system and providers
Service access and availability	• Align service provision to the areas it is most needed to help address inequality • Opportunity for jointly commissioned services aligned to combat the physical health challenge faced by mental health patients

Some comparator trusts undertake more work with partner organisations to link GP and public health information into their mortality methodology. These are highlighted in the box below.

Mental Health organisation best practice

- Linking into public health data and work with public health consultants to triangulate key messages
- Central team makes decision on expected/unexpected deaths
- Work with hospital library services to research and pull information to link into mortality data
- Work with organisations in the community to proactively help mental health patients access physical health care. For example, working with local GPs on mortality of patients with Serious Mental Illness (SMI).

Clinical engagement (5 of 5)

Mortality reviews

Whilst the Trust produces an annual report of Patient Safety Incidents (PSIs), more needs to be done to undertake routine structured analysis that triangulates mortality data with mortality reviews and safety incidents. The Trust's PSI guidance states that incidents which must be reviewed include 'Acts and/or omissions occurring as part of NHS funded healthcare (including in the community) that result in unexpected or avoidable death'. [1]

The Trust has outlined set criteria to determine whether a death is subject to a Structured Judgement Review (SJR).[2] This criteria includes 'all unexpected inpatient deaths attributed to natural cause and/or end of life care. A selection of community deaths where physical co-morbidity is a cause for concern'.

The Trust also considers analysis of deaths in line with the Patient Safety Incident Response Framework (PSIIF) 2022 where: bereaved families and carers, or staff, have raised a significant concern about the quality-of-care provision; particular diagnosis or treatment groups where a 'red flag' has been raised or; deaths where learning will inform the provider's existing or planned improvement work

Data from Datix was analysed to explore the number of SJRs performed over recent years. This is shown in Appendix G. Records in Datix where a review was undertaken were collated and grouped according to the type of review. In 2021, according to Datix, there were three inpatient unexpected deaths, two of these are recorded on Datix as having had an SJR. Of the 11 SJRs recorded for the same year five were for unexpected deaths and six for expected deaths. Seven SJRs were performed for inpatients, three for those informed via the community team and one informed via the NHS Spine.

Conclusion and areas for improvement

Internal and external clinical engagement is key to understanding, interrogating and using the Trust's mortality data and this is missing across the pathway as a whole.

It is only with clinical input and engagement with mortality data, and the process of its recording, that quality of data and the themes arising from it can be identified. Our analysis shows a lack of detailed investigation of peaks in mortality data. There is a lack of proactive caseload management which impacts on the number of deaths part of the Trust's mortality reporting.

Missing field completion in the data around protected characteristics and poor caseload management further limit the accuracy of conclusions which can be drawn from the available data. The Trust needs to solidify its processes around clinical engagement to move towards a more complete set of data.

Establishing closer links with partner organisations may help to improve the completeness of mortality data and help access those partners' expertise to better inform mortality. Clinical oversight and support should be provided for data captured within the reporting process. There is particular need for support around categorisation. Finally, staff should be educated around the use of mortality data. Knowledge of how data is used will help clinical engagement with the recording process.

Recommendations (mapped in detail in Action Plan at the start of this report)

	Recommendation	Priority
9	Establish a process of validation and use of mortality reporting and analysis at service level, aligned to corporate reporting.	High
10	Review the process of retaining patients on caseloads, and subsequent discharge from caseloads, to ensure it results in consistent data across the services.	Low
11	Create supporting training programme for all staff who input data into systems that have an impact upon mortality data. Ensure that the implications and impacts of incorrect or incomplete data entry are understood by staff.	Medium
12	Establish links with primary care networks to explore opportunities to improve the completeness of the Trust's mortality data (including cause of death), supported and enabled by the ICB.	Medium
13	Explore opportunities for formal data sharing agreements between the Trust and primary and secondary care in the region.	Medium

1. NSFT Q11 Patient Incident and Patient Safety Incident Investigation (PSII)
2. NSFT Q01 Learning from Deaths Version 04 Final Update September 2022

Governance (1 of 4)

Introduction and summary

This section explores the current governance arrangements and controls over mortality data and presents the governance standard which national documentation suggests should exist.

Governance systems need to identify areas of risk and poor practice to enable timely intervention and improvement. Mortality governance should be transparent to enable assurance in the recording and reporting process. NQB guidance is clear that mortality governance processes should consider mortality rates and the results of case record reviews and investigations as part of a single governance framework.[1]

Whilst overall mortality performance is reported to the board and supporting committees there is limited scrutiny on community deaths and the underlying data. The Trust's governance over mortality focuses on serious incidents. The Trust's oversight over the end-to-end process of mortality reporting requires improvement and there are inadequate controls to ensure the data reported accurately reflects the service's understanding of their patients.

Learning from deaths guidance

The NQB Learning from Deaths guidance sets out the responsibilities expected from the board and non-executive directors, which those at the Trust will need to demonstrate [2]. These include:

- Boards must ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care
- Ensuring processes are robust and can withstand external scrutiny by providing challenge and support
- Being curious about the accuracy of data and understanding how it is generated, who is generating it and how they are doing this including whether the approach is consistent across the Trust, and being undertaken by sufficiently trained staff
- Ensure timely reviews/investigations.

From the Trust's current documentation it is not clear how these responsibilities are being consistently met.

Governance over mortality reporting at NSFT

The governance over mortality reporting at the Trust is complicated and straddles a number of corporate functions, in line with national requirements. The Trust's Learning from Deaths guidance lists responsibilities for different roles and teams within the organisation. These responsibilities are summarised in the table below [3] and the Trust's organisational governance diagram is included in the appendices of this document.

Role	Responsibility (from Trust's Learning from Death guidance)
Trust board	Ensuring robust systems to recognise, report and review deaths along with systems for learning from outcomes of reviews.
Non-Executive Directors	Testing the level of assurance that the Trust provides of safe and effective systems, Providing challenge when needed.
Chief executive	Holds overall responsibility for policy implementation.
Chief Medical Officer	Responsible for application of learning from deaths systems and assuring review outcomes with measurable actions.
Chief Nurse	Executive responsibility for the application of patient safety incident review system and patient safety incident framework and ensuring learning outcomes of reviews with measurable actions.
Medical Examiner (when appointed)	Seek assurance around the cause of death, the need for coroner notification and whether care before death was appropriate
Learning from Deaths Lead	Responsible for implementing the Learning from Deaths policy and ensure opportunities for learn from deaths
Safety and Mortality Committee	Assurance and understanding of mortality data; identifying trends and themes.
Patient Safety Team	Administration of the systems for Learning from Deaths and patient safety incidents.

1. NHS Improvement. Implementing the Learning from deaths framework: Key requirements for trusts boards July 2017
2. National Quality Board; National Guidance on Learning from Deaths 1st Edition March 2017
3. NSFT Q01 Learning from Deaths version 04 Final update September 2022

Governance (2 of 4)

The complexity of responsibility across the mortality recording, reporting and reviewing is demonstrated in this table. Some of the individuals spoken to as part of this process reflected challenges which suggested the documented process is not the experience on the ground, and there was a confused picture around senior ownership for overall mortality data reporting.

Based on the above table the board has responsibility for ensuring the processes for reporting are robust, and the responsibility for assurance and understanding of mortality data sits with the Safety and Mortality Committee. Mortality is also an agenda item within the Quality Committee, which is attended quarterly by ICBs quality leads.

The Trust has strong governance in its approach to inpatients – on site incidents are followed up by the team, as well as suicides where the coroner has notified the Trust. The Trust needs to bring the same rigour to improve the processes around the reporting of all mortality, and the understanding of wider community deaths for patients on their caseload.

This issue was highlighted by an external review by NHSE around Patient Safety Incidents. It was subsequently noted within the Trust that sight of mortality had been lost in the Patient Safety Review Group. This has since been renamed, in September 2022, the Safety and Mortality Committee, with an aim to split its focus between, on the one hand, patient safety incidents and, on the other hand, the impact that the Trust's care and treatment has on deaths in the community and inpatient populations. Grant Thornton has not seen minutes of subsequent meetings to measure progress against this aim[1] but understand that this group now meets with new Terms of Reference and workplans.

The consistency and completeness of mortality reporting to the board needs to be improved, alongside the quality and depth of analysis and narrative provided for community deaths. The board needs to ensure the data presented for monitoring is accurate, and that the analysis provided by the Trust gives them the tools to discharge their responsibilities in scrutiny and assurance over all mortality reporting, including community deaths. This is especially important given the seriousness of the subject matter and the level of scrutiny the Trust is under locally on this issue.

We have also highlighted the lack of evidence of structured clinical engagement with the data, and the lack of clinical ownership of the information reported. Governance processes at the Trust should ensure that information reported externally and nationally is a full and accurate reflection of the services' understanding of their patients.

To address this the Trust should update the Trust's Learning from Death policy to ensure the Trust's governance addresses the issues in this report and explicitly reference community deaths and the production of mortality data and reporting. It should also ensure the governance in relation to all mortality reporting and community mortality reporting is clearly understood by operational staff

Alongside this the Trust should introduce processes that cover gaining assurance over data processing, as well as ensuring data is validated with clinical staff. The mortality reported internally and externally should be subject to a clear process of senior-sign off.

It is recognised that national guidelines over mortality reporting for mental health trusts are not as clear and prescriptive as those in place for acute trusts, and that there are challenges for mental health trusts in producing consistent and accurate data. More robust controls and checks on the data will help to mitigate these issues and ensure there is clarity around the information reported by the Trust.

The table on the next page sets out how governance for the mortality reporting and recording pathway should be updated to address the issues outlined in this report. This brings together NQB guidance, learning from our experience of reviewing data quality across the NHS, and the issues identified during this review process.

1. NSFT Safety and Mortality Committee September 2022, approved notes

Governance (3 of 4)

Area	Expectation
Senior oversight	• Clear board level oversight and responsibility linked to relevant subcommittee that includes a clear focus on community deaths • Single executive level oversight of end-to-end mortality reporting processes and outputs, including sign-off of submissions and reports • Clear responsibilities for senior clinical scrutiny of community deaths • Mortality lead with end-to-end mortality data process understanding to help ensure a joined-up process
Data quality and monitoring	• Established process for service level validation of data, and provision of tools to enable analysis and interrogation of data by clinical staff • Clear feedback loops for data quality issues to be identified and addressed • Quality check of inputs and outputs against source data • Full use of internal and external audit to establish the reliability of processes and the underlying patient level data to ensure data is reported accurately
Documentation	• Clear methodology made available publicly • Documentation of pathway including named responsible individuals • Audit trail for decision making steps (e.g. categorisation of expected and unexpected)
Information security	• Use of secure systems to hold and report patient identifiable information • Clearly documented information security protocols, and regular review of access • Regular information security training for all staff across the organisation

Partnership working

The Trust faces challenges with accessing data which is primarily held within primary care and other health organisations in the area. By facilitating the sharing of key mortality data the ICBs can play a role in increasing the quality of the mortality data reported by the Trust.

Work is also required to facilitate a greater degree of cross-sector analysis of mortality data. Working with public health professionals offers the opportunity to identify areas where inequalities may be playing into the mortality picture.

The Trust is part of the East of England mortality group and should look to work with organisations in this group to learn more about how mortality data is recorded at organisations with more established pathways. The ICBs can support the Trust by sharing best practice for mortality recording and data handling across the system, and where appropriate direct the Trust to engage with experts working in the system.

Alongside this, the Trust mortality leads attend the National Mortality Leads Improvement Group led by Better Tomorrow NHSE and the mortality team attend safety committees at other trusts to learn examples of best practice.

The ICB should also support the Trust to ensure appropriate plans and resources are in place within the Trust to address the improvements required in the Trust's processes, and to hold the Trust to account for the plans it sets.

Governance (4 of 4)

Conclusion and areas for improvement

The controls over mortality reporting at the Trust require improvement, and the governance and accountability needs to be clarified and reinforced. The Trust focuses its policies and scrutiny on serious incidents and inpatient mortality, and the overall governance over mortality is complex, resulting in a lack of ownership of the end-to-end reporting process.

The board needs to ensure the data presented for monitoring is accurate, and that the analysis provided by the Trust gives them the tools to discharge their responsibilities in scrutiny and assurance over all mortality reporting, including community deaths. A lack of evidence of structured clinical engagement with the data, and the lack of clinical ownership of the information reported, will also impact on the accuracy of the data recorded.

The findings of this review suggest that there is a need for assurance across patient level data. This could be done internally but an external review is suggested in order to provide independent assurance.

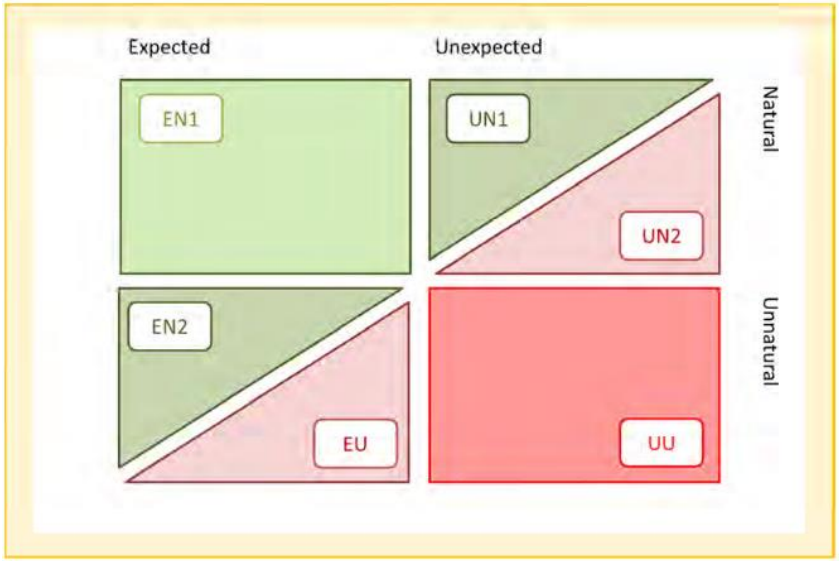
Recommendations (mapped in detail in Action Plan at the start of this report)

	Recommendation	Priority
14	Update the Trust's Learning from Deaths policy to ensure the Trust's governance addresses the issues in this report and explicitly references community deaths. Ensure the governance in relation to all mortality is clearly understood by clinical and corporate staff involved in the production and reporting of mortality information.	High
15	Establish a clear improvement plan to address the issues identified in this report, and report progress to a board committee.	High
16	Introduce a process of assurance over mortality reporting: • Introduce a clear audit trail and series of checks to ensure adherence with SOPs, and report outcomes to executive leads on a regular basis • Introduce or commission patient level data reviews to provide assurance over the accuracy of data recording • Link to the clinical validation processes established under recommendation 9	High

Appendix

Appendix A: Mazars framework [1]

Below is a framework suggested by the Mazars report for classifying deaths. The aim of the suggested framework was to ensure deaths were considered for review with a degree of consistency. The table on the right is also taken from the Mazars report and is their broad descriptions of the suggested categories. The suggestion within their report was that a similar framework should be developed for each group of service users.



Type	Description
Expected Natural (EN1)	A group of deaths that were expected to occur in an expected time frame. E.g. people with terminal illness or in palliative care services. These deaths would not be investigated but could be included in a mortality review of early deaths amongst service users.
Expected Natural (EN2)	A group of deaths that were expected but were not expected to happen in that timeframe. E.g. someone with cancer but who dies much earlier than anticipated These deaths should be reviewed and in some cases would benefit from further investigation
Expected Unnatural (EU)	A group of deaths that are expected but not from the cause expected or timescale E.g. some people on drugs or dependent on alcohol or with an eating disorder These deaths should be investigated.
Unexpected Natural (UN1	Unexpected deaths which are from a natural cause e.g. a sudden cardiac condition or stroke These deaths should be reviewed and some may need an investigation.
Unexpected Natural (UN2)	Unexpected deaths which are from a natural cause but which didn't need to be e.g. some alcohol dependency and where there may have been care concerns These deaths should all be reviewed and a proportion will need to be investigated
Unexpected Unnatural (UU)	Unexpected deaths which are from unnatural causes e.g. suicide, homicide, abuse or neglect These deaths are likely to need investigating

1. National Guidance on Learning from Deaths; A Framework for NHS Trusts and NHS Foundations for identifying, reporting, investigating and Learning from Deaths in Care

Appendix B: Local definitions of expected and unexpected deaths

The table below outlines the different approaches between NSFT and peer organisations around classifying expected and unexpected death in reporting.

Organisation	Expected death definition	Unexpected death definition
NSFT	'if it was caused by a pre-existing life-limiting condition or if the person's age and frailty made death from a natural cause a reasonable expectation at the time of their death'. [1]	'The death of a service user who has NOT been identified as critically ill or death is NOT expected by the clinical team. If there is no known diagnosis of terminal illness or physical health complication meaning that the service user is deemed as approaching end of life or receiving palliative care. Where data or cause of death is unavailable this is defined as unexpected'. [2]
Mental Health Trust in the East of England	The following subcategories are used for expected death: • Expected unnatural death – (EU) Expected but not from the cause Expected or timescale. e.g. some people who misuse drugs, are dependant on alcohol or with An existing disorder. • Expected natural death – (EN1) Expected to occur in An Expected time frame e.g. people with terminal illness or within palliative care services. • Expected natural death – (EN2) –was not Expected to happen in the timeframe. e.g. someone with cancer or liver cirrhosis who dies earlier than anticipated.	The following subcategories are used for unexpected death: • Unexpected unnatural death (UU) An Unexpected death from unnatural causes e.g. suicide, homicide, abuse, neglect. • Unexpected natural death (UN1) from a natural cause e.g. a sudden cardiac condition or stroke. • Unexpected natural death – (UN2) from a natural cause but didn't need to be e.g. alcohol dependence and where there were may have been care concerns.
Mental Health Trust in the South of England	Where a patient's demise is anticipated in the near future and his/her Doctor (GP or consultant) has seen the patient within the last 14 days before the death (for the condition that they died from). Further break down their deaths into the expected subcategories EN1, EN2 and EU	All other deaths that do not fit the criteria for expected Further break down their deaths into the unexpected subcategories UN1, UN2 and UU
Mental Health Trust in the North of England	Any death occurring at a stage in the patients' disease pathway at which death is inevitable and no active intervention to prolong life is planned or on-going.	Any death which has not been expected.

1. NSFT Mortality and Learning from Deaths Report, Jan 2022
2. NSFT Unexpected and Sudden Deaths (in-patient areas only' policy, ref no. Q11a, version 06.1

Appendix C: Local definitions of deaths to be included within mortality reporting

The table below outlines the different approaches between NSFT and peer organisations around deaths to be included within a Trust's mortality reporting which will be included in mortality reporting figures and may be subject to other mortality processes for example, structured judgement review (SJR).

Organisation	Attributable time
NSFT	Deaths within six months of the last contact with NSFT
Mental Health Trust in the East of England	Within their learning policy the Trust list out a number of categories which are listed below. • All child and infant deaths • All deaths of patient with an open/active referral • All deaths from suicide where the patient was discharged within the preceding 12 months • Deaths resulting from suspected self-harm or suicide post assessment by RAID Teams within the preceding 6 months (unless the patient had been referred into another Trust service, then use 12 months post discharge from the referred team • All inpatient deaths • Deaths of inpatients discharged in the preceding 30 days • Patients who die following transfer to an acute/general hospital • All learning disability deaths within 12 months of last contact including palliative care patients
Mental Health Trust in the North of England	Deaths up to six months after discharge
Mental Health Trust in the South of England	All deaths of people under the care of the Trust or discharged within the preceding 6 months
Mental Health Trust in the South of England	Within their learning policy the Trust list out a number of categories which are listed below. • Majority of unexpected deaths of service users/patients currently under the care of Oxford Health NHSFT or who have received a clinical interaction within the last six months. This should include unexpected unnatural and unexpected natural (UN2) • Those services which provide a 'single contact' such as street triage services/GP OOH will only need to enter such deaths if the care provided was the last care prior to death or if concerns were identified in the initial screening • All learning disability deaths • All inpatient mental health deaths • Expected deaths where any care concerns or areas for learning were identified by the clinical team • All patient who are detained
Mental Health Trust in the South of England	Deaths of patients up to six months post discharge are reportable (with the exception of those with Learning Disability, which is 12 months)
Mental Health Trust in the Midlands	All deaths of service users expected and unexpected who currently receive care from BSMHFT services including HMP Birmingham, are to be reported. Additionally deaths of patients up to six months post discharge are also reportable

Appendix D: Stakeholder engagement list

Individuals with the following roles from the Trust and external organisations were met with on at least one occasion as part of this review. Alongside this Grant Thornton also observed a session between the ICB and a local patient representative group in order to understand the wider public concerns around mortality reporting at the Trust.

Position
CCIO NSFT
Medical director for quality NSFT
Consultant Forensic Psychiatrist/Caldicott Guardian NSFT
Director for nursing for CFYP and NSFT patient safety specialist NSFT
Patient Safety Officer (Mortality) NSFT
Mortality DATIX processor NSFT
DATIX Data Manager NSFT
Chief Digital Officer NSFT
Information Governance Officer NSFT

Position
Information assurance manager NSFT
Information rights manager NSFT
BI manager NSFT
Data Protection Officer NSFT
Director of performance, transformation and strategy Norfolk and Waveney Integrated Care Board
Medical Director Suffolk and North East Essex Integrated care Board

Appendix E: Document review list

Document name
NSFT Quality Account 2020-2021
NSFT Quality Account 2021-2022
Discharge from Trust Services
NSFT 72 Hour Follow Up Standard Guideline
QO1 Learning From Deaths Version 4 FINAL update Sept 2022
ACCESS standard operating procedure
NRLS Organised data workbook period April 20 to March 21
Patient Safety Incidents and Patient Safety Incident Investigation (PSII) (Q11)
PSI annual report 21 22 v3
Unexpected and Sudden Deaths (Q11a)
Board Assurance Framework September 2022
Guidance to Governance Reporting and Accountability Framework December 2021 v5
NSFT Governance Architecture October 2021
NSFT Risk Management Framework v2.2 Nov 2021
Risk Management Strategy on a Page June 202
Risk policy v5.5 Dec 2021
East and west Suffolk QPM Report October 2022
GYAQ QPM Report October 2022
N&W CFYP Core QPPM Report October 2022
NN&N QPM Report October 2022

Document name
Minutes QAC 16th August 2022 - unconfirmed
Minutes QAC 20th July - unconfirmed
Confirmed Audit Risk Committee minutes 17th May 2022
Audit Risk Committee minutes 8th July 2022 unconfirmed
Mortality and learning from deaths BoD 23rd September 2021 Final
Mortality and learning from deaths – BoD 27th January 2022 Final
Mortality and learning from deaths report – BoD 27th May 2021
Mortality Report – BoD 28th January 2021
Mortality Report BoD 21st May 2020
Mortality Review and Learning from Deaths Reports BoD 23rd January 202
Mortality Report BoD September 2020
Norfolk and Suffolk scope document Nov 2022 v1.2
Secure services QPM Report October 2022
Wellbeing QPM report October 2022
WSN QPM report October 2022
Approved July PSRG notes 22
Approved September notes for SM

Appendix F: Board paper comparison graphs

Figure 9 showing Monthly Reported Mortality from 2018-2020 as reported in January 2021 papers. [1]

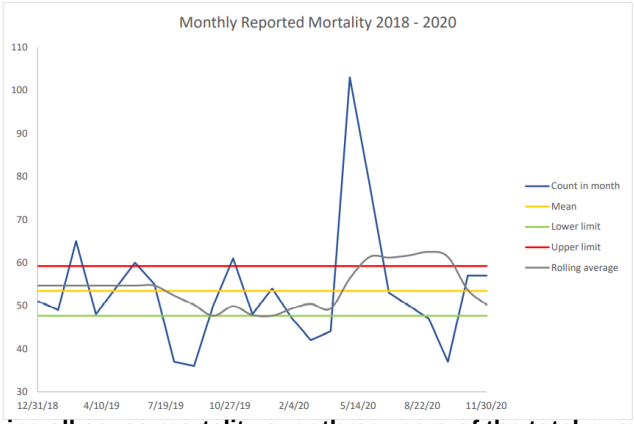


Figure 10 showing all cause mortality over three years of the total number of people who have been in contact with NSFT's services as reported in May 2021 papers. [2]

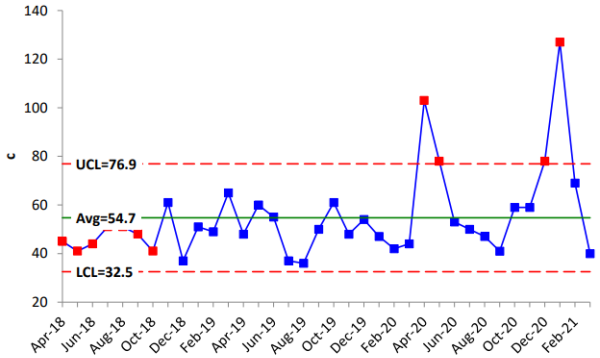


Figure 11 showing all cause mortality from December 2019 to July 2021 as reported in September 2021 papers. [3]

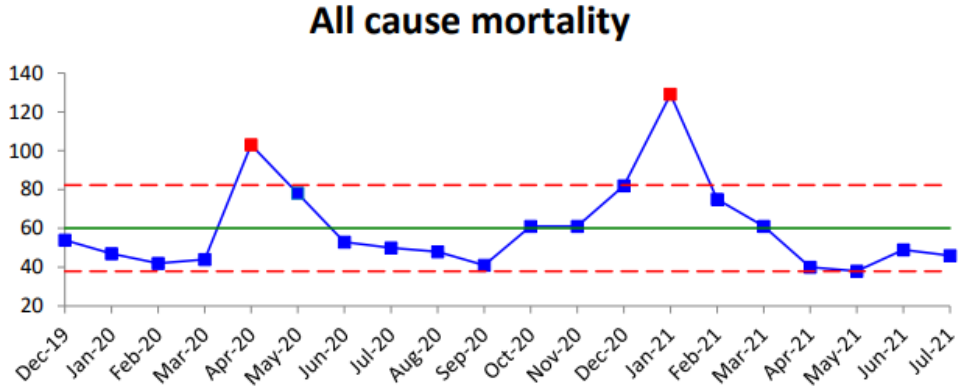
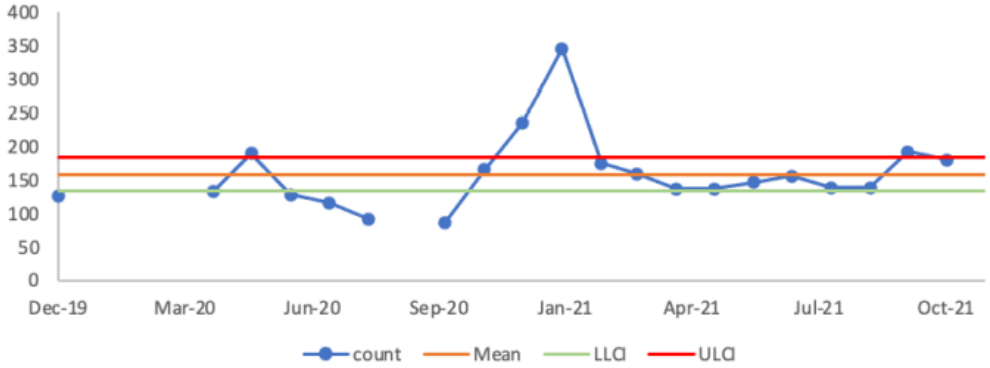


Figure 12 showing an SPC chart of community deaths within six months of contact NSFT from December 2019 as reported in January 2022 papers. [4]

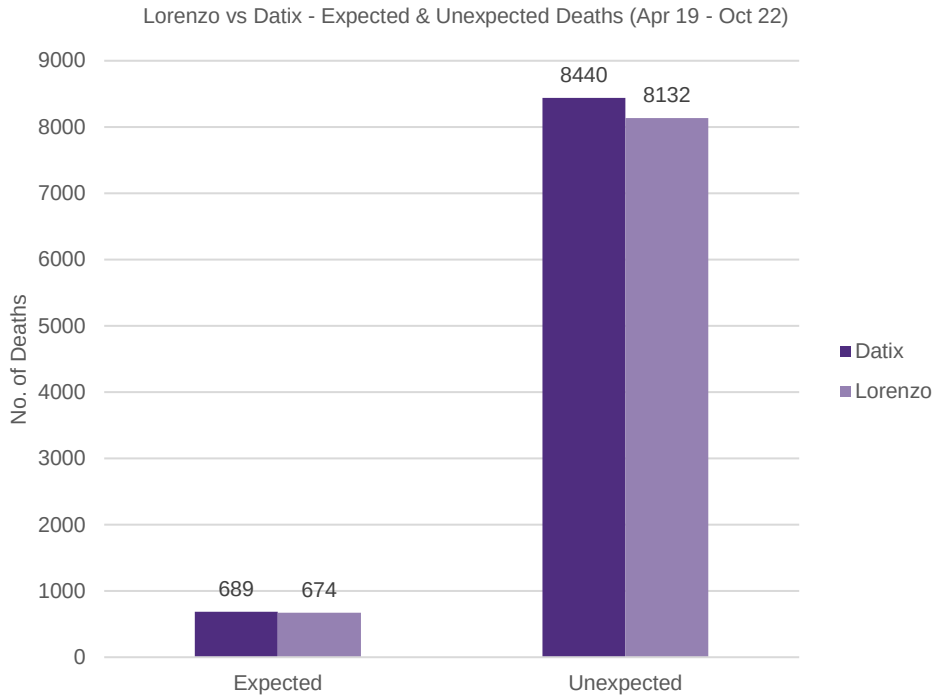


1. NSFT Board of directors public meeting papers 28th January 2021
2. NSFT Board of directors public meeting papers 27th May 2021
3. NSFT Board of directors public meeting papers 23rd September 2021
4. NSFT Board of directors public meeting papers 27th January 2022

Appendix G: Reference graphs (1 of 4)

Unexpected v expected deaths

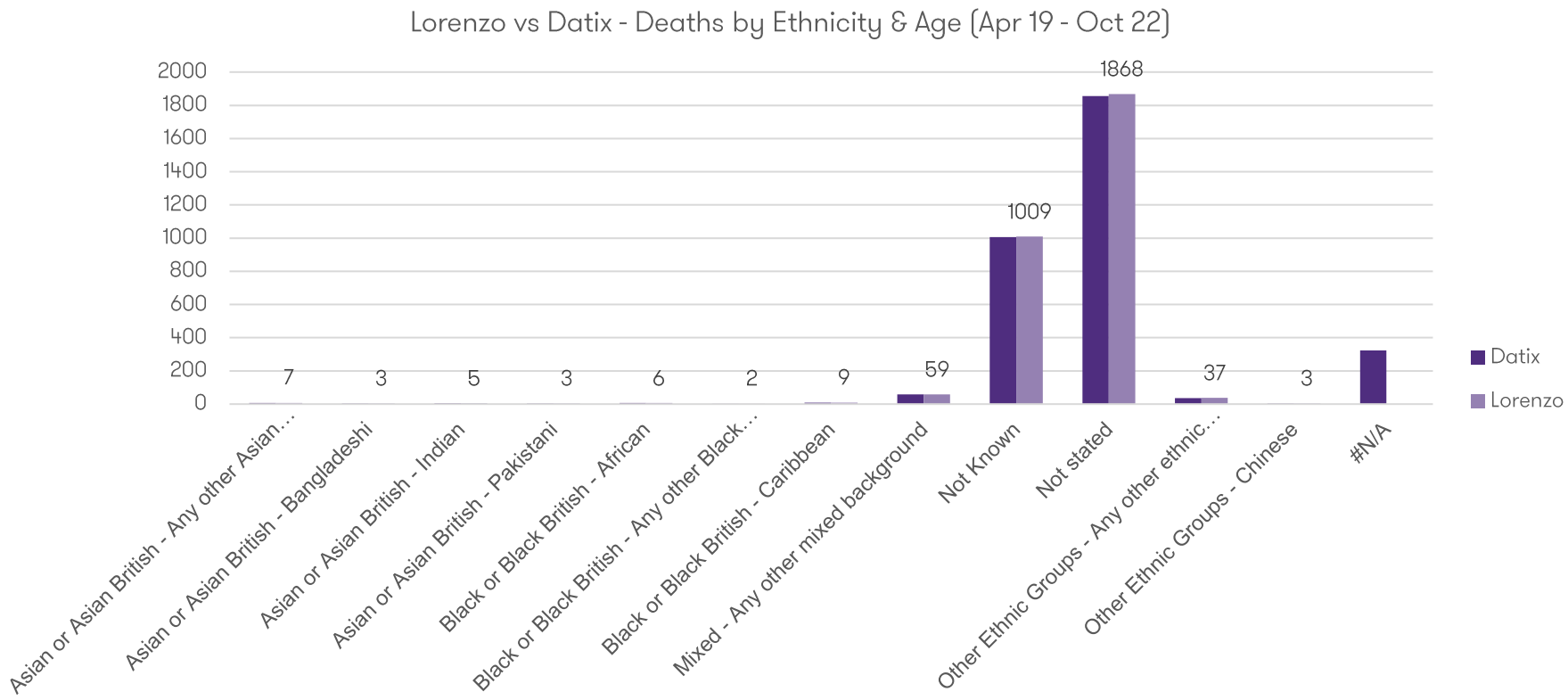
Figure 13 comparing unexpected and expected deaths from April 2019-Oct 2022



Appendix G: Reference graphs (2 of 4)

Ethnicity

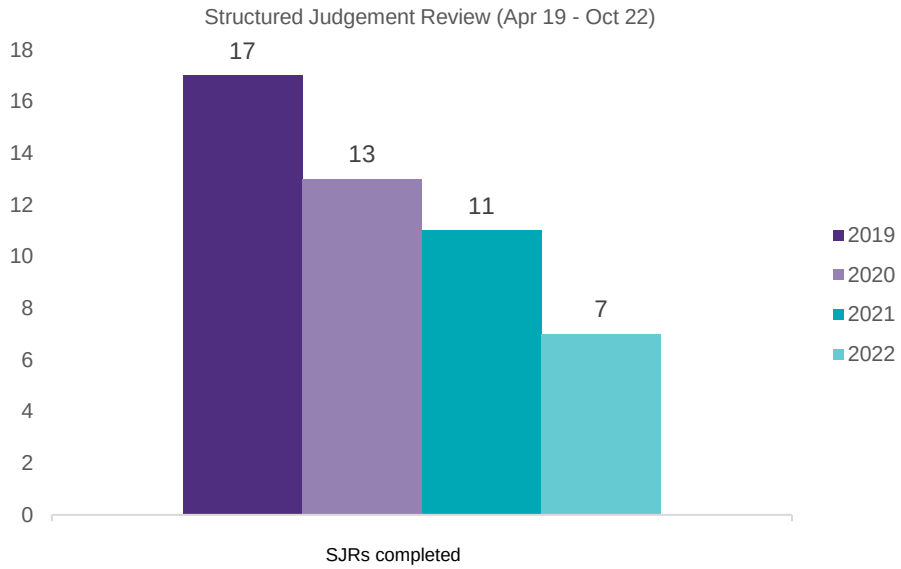
Figure 14 displaying the number of deaths for ethnicity classifications excluding white ethnicity from April 2019-Oct 2022



Appendix G: Reference graphs (3 of 4)

Structured judgement reviews

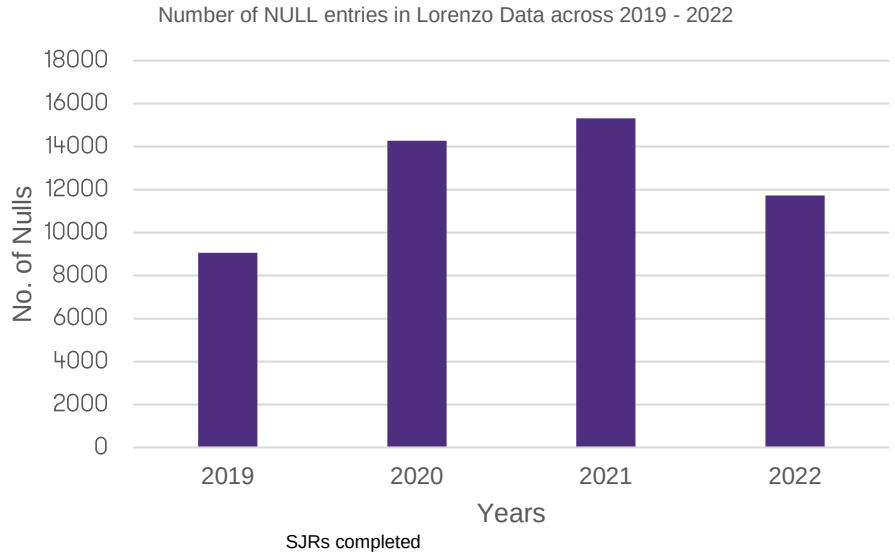
Figure 15 showing the number of structured judgement reviews performed each year from 2019 to 2022.



Appendix G: Reference graphs (4 of 4)

Missing data (Null fields)

Figure 16 showing the number of missing fields in Lorenzo data over the years analysed. Of note, 2022 data was not a complete 12 months. The table on the left shows the fields which were included as part of this analysis.



NULL Data Fields
Inpatient Discharge Date
Local Specialty 1
Local Specialty 2
Site 1
Site 2
Discharge destination
Date of lastseen appointment
Ward name
Team name
Referral closure or rejection reason
Local Authority/ Locality
Registered GP Practice

Appendix H: Data request

The following data was requested from DATIX

•Pseudonymised patient ID

•Age

•Date of death

•How was death identified

•Incident date

•Incident severity

•Unexpected/expected view

•Cause of death

•Discharge date

•DATIX rejection

•Learning disability review

•Under 18 child death review

•Service level investigation

•Serious incident

•Structured judgement review

•Other review

•Local authority/locality

•Registered GP practice

The following data was requested from Lorenzo

•Pseudonymised patient ID

•Age

•Gender (MSHDS)

•Ethnicity (MSHSDS)

•Date of death

•Date of recording of death

•Death cause recorded text

•How death was identifies

•Inpatient discharge date

•Local speciality

•Ward name

•Site

•Discharge destination

•Team name

•Date of last seen appointment

•Date of last DNA appointment

•Discharge date

•Referral closure of rejection reason

•Local authority/locality

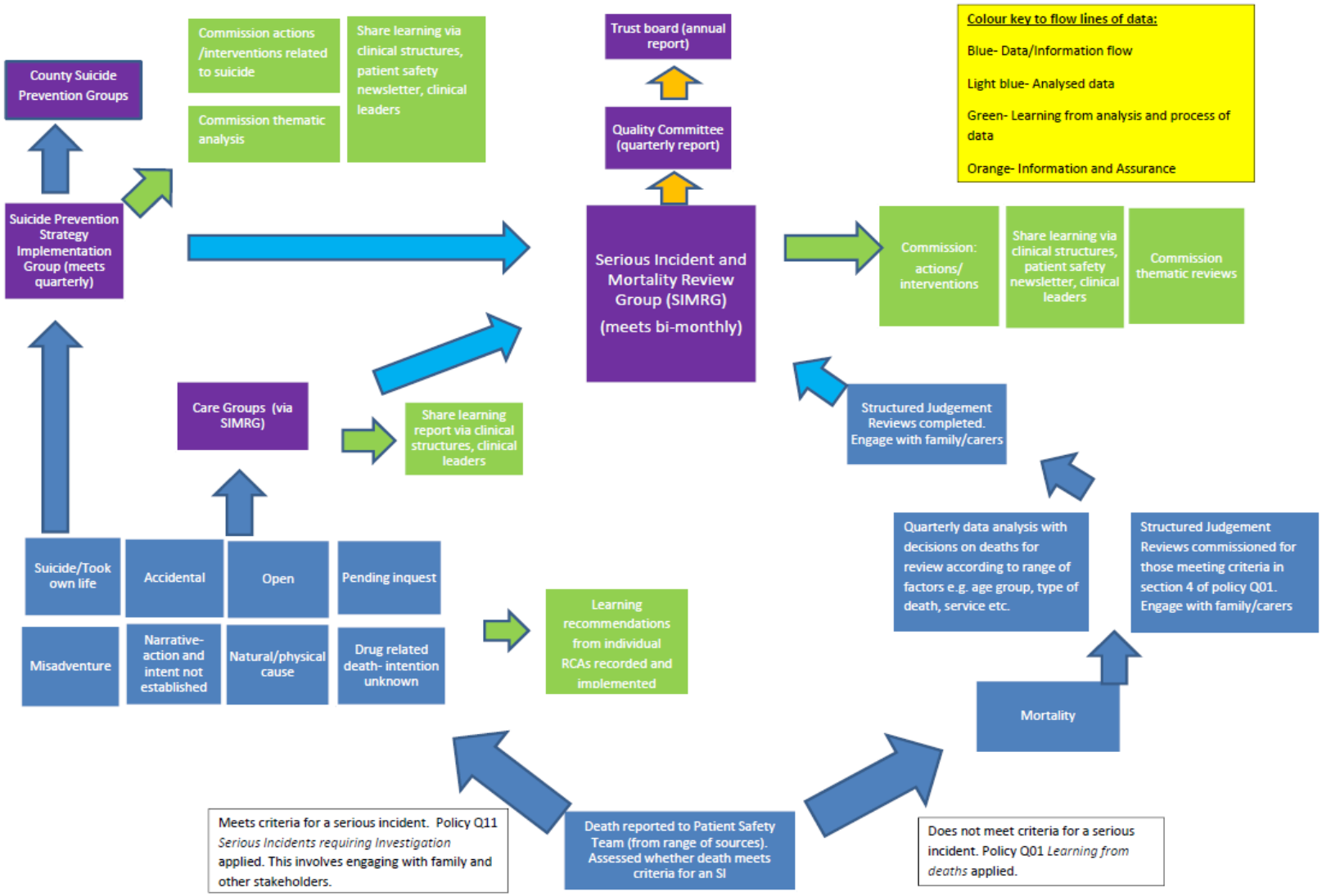
•Registered GP practice

•Dementia flag

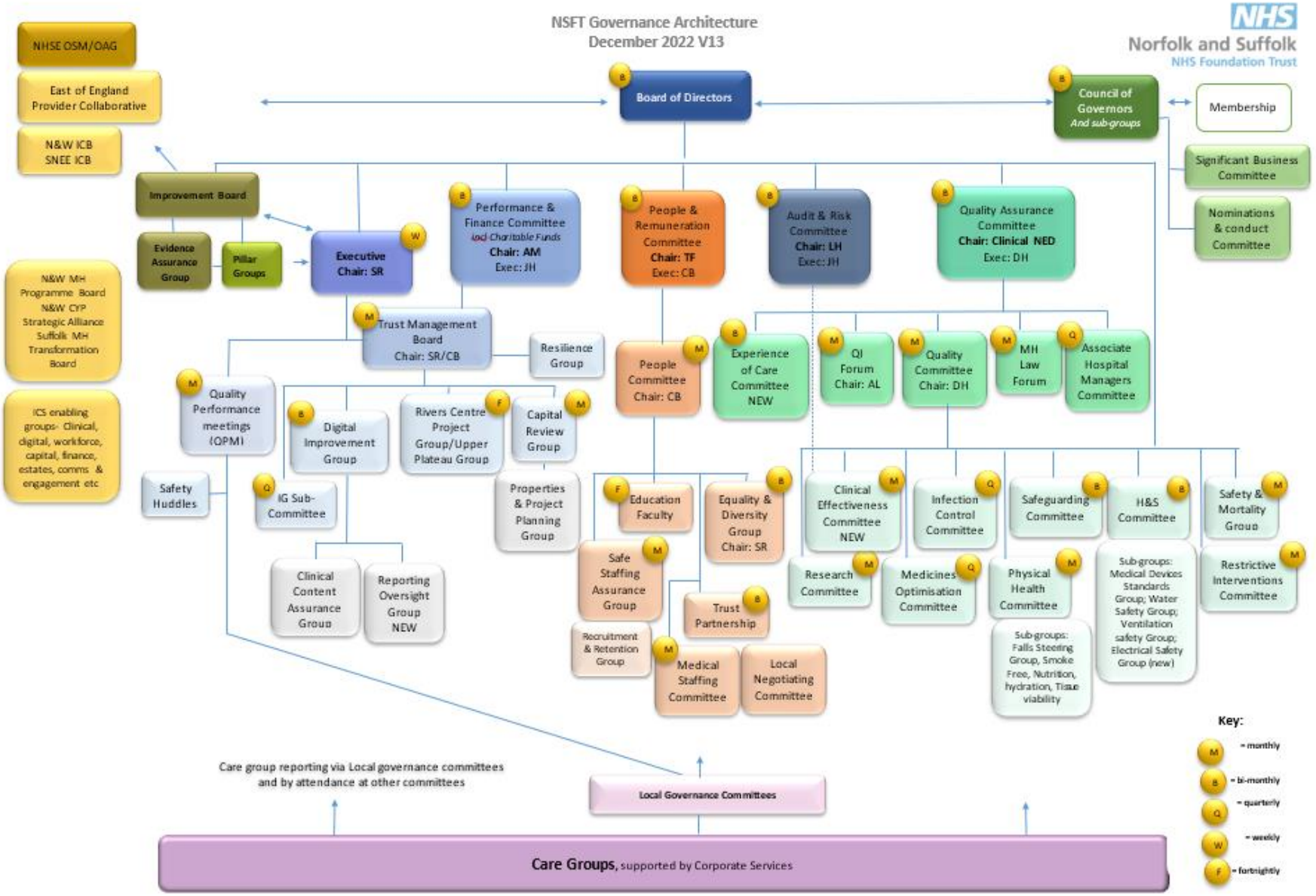
•Long term condition flag

•On end of life/palliative care pathway

Appendix I: Learning from deaths pathway



Appendix J: NSFT governance architecture



Grant Thornton - Norfolk and Suffolk Foundation Trust's mortality recording and reporting (May 2023) Improvement Plan.

DATA					
Number	**Recommendation**	**Priority**	**Management Responsibility**	**Proposed Actions**	**Timescales**
1	Improve the mortality data pathway to automate and digitise the production of mortality reporting, removing manual processes for transferring and transforming the data, and introducing an audit trail where user interaction is required. The data pathway covers data entry by clinical and service staff, clinical system configuration for capturing and codifying data, export process from clinical systems, data management within data warehouse (or through manual intervention), rules and categorisations applied to support reporting, the presentation of reporting outputs, and the process for validating these outputs.	**High**	**Executive Lead** Chief Finance Officer **Lead for Delivery** Chief Digital Officer	1. Seagry consultancy and NSFT to review the technology, solutions and processes used to capture, collate and report mortality data. Interoperability, system upgrade requirement as and when required should be included as part of this review. 2. Seagry Consultancy will produce a list of actions with assigned owners to support improvement, processes and tools to assist NSFT in mortality reporting. 3. A single overarching Standard Operating Procedure (SOP) will be implemented following this work. This will include the formal change management process required when reporting requirements change. The SOP will include inputting of data, extracting of data, validating of data and reporting of data within a given timeframe. 4. An audit trail will be incorporated into the process as described in action 1.	3 months –August 2023

2	Develop standard operating procedures (SOPs) for each stage of the data recording process, and ensure these are kept up to date	**Medium**	**Executive Lead** Chief Nursing Officer **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding and Medical Director for Quality	1. An overarching SOP will be developed which will detail each stage of the mortality data pathway. 2. The SOP will include roles and responsibilities within the process. 3. The SOP will describe the formal change management process when mortality reporting requirements change. 4. The Learning from Deaths policy will incorporate the requirements of the SOPs.	6 months –November 2023
3	Develop reporting tools or method of measuring incomplete data fields to feed back into the organisation, and support training.	**Medium**	**Executive Lead** Chief Finance Officer **Lead for Delivery** Chief Digital Officer	1. Reporting tool to be developed to measure the data fields missing on clinical record system, such as demographics. All Data fields must be made as mandatory as much as technically possible to eliminate missing data and avoid human errors. 2. To be reported and included in the Care Group Quality and Performance metrics and scrutinised in the Trust's Quality and Performance meeting.	6 months –November 2023
4.	Use the Spine as the definitive reference source of identifying deaths, and update this information on a weekly basis.	**High**	**Executive Lead** Chief Nursing Officer **Lead for Delivery** Chief Digital Officer and Director of Nursing, Patient Safety and Safeguarding.	1. Develop a system that utilises NHS Spine's automatic update to Lorenzo to reduce the need for manual downloads. 2. This action is included as part of recommendation 1. 3. A weekly report will be generated to validate any reporting of Death to Trust against the Spine. This assurance check will be included as part of SOP.	3 months –August 2023

REPORTING					
Number	**Recommendation**	**Priority**	**Management Responsibility**	**Proposed Actions**	**Timescales**
5	Agree a standardised reporting structure for board reports, to include thematic analysis and consistent presentations of figures, axis and scales. Clearly define the Trust's methodology for mortality recording and reporting within Board reports . Any changes should be clearly documented and the impact upon historically reported figures should be described to provide continuity.	**High**	**Executive Lead** Chief Nursing Officer **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding and Medical Director for Quality	1. The proposed standardised reporting structure for mortality will be presented through the Committee structure and agreed by the Board. 2. The Learning from Deaths quarterly Board report will include thematic analysis of key metrics such as age, diagnosis, cause of death and deprivation indices.	3 months –August 2023
6	Align the internal dashboard with external reporting to ensure that volumes on the internal dashboard clearly reconcile to numbers within Board reports.	**High**	**Executive Lead** Chief Finance Officer **Leads for Delivery** Chief Digital Officer, Director of Nursing, Patient Safety and Safeguarding and	1. The Trust are working with Seagry Consultancy to agree the Mortality data pathway. Part of this work will include further development of Mortality Dashboard. 2. This will be underpinned by the work completed as part of recommendations 1 and 5. 3. The ability for Care Groups to drill down within the dashboard will be enhanced so they are able to interrogate their and other Care Groups data.	3 months –August 2023

			Medical Director for Quality	4. The improved dashboard will be supported by the Patient Safety Team and Mortality Team attending Care Group Governance meetings. 5. The newly developed dashboard will be available on the Trust's intranet.	
7.	Work with public health and, when in post, medical examiner to identify key themes in the data and identify and implement timely targeted interventions	**Medium**	**Executive Lead** Chief Medical Officer **Lead for Delivery** Director of Operations (Medical Directorate) and Medical Director of Quality	1. The Norfolk and Waveney ICB have implemented a bi-monthly Learning from Deaths forum. This includes Public Health and Medical Examiners. NSFT are a member of this forum with data shared as part of this meeting. 2. Learning and themes from NSFT Mortality reviews will be shared with the ICB so wider system learning can be considered. 3. Development of Care Group reports and attendance of Mortality Team and Patient Safety Team to local governance meetings to share learning and implement targeted interventions. 4. Within the Learning from Deaths committee, the Mortality team will share local, regional and national data and learning to guide where improvements need to focus. 4. Ensure that NSFT are part of the membership of the Learning from Deaths forum in Suffolk and North East Essex ICB when commenced. 5. NSFT will continue to attend regional and national forums. 6. NSFT to be members of the Norfolk and Waveney ICB LeDeR forum.	6 months –November 2023
8	Use clinical input to update the cause of death groupings which are presented as part of the dashboard, and used in Board reports, so that it is clear where the Trust is	**High**	**Executive Lead** Chief Finance Officer and Chief Medical Officer **Leads for Delivery**	1. Review the data collected in the Trust Mortality dashboard to include all patient demographics, cause of death, diagnosis, medication etc.. to enable the drilling down both locally and strategically of key metrics. This will include 2	3 months –August 2023

	awaiting data (pending), or the Trust feels this data will not be accessible, or will remain unknown.		Chief Digital Officer Director of Nursing, Patient Safety and Safeguarding	'unknown' cause of death categorisations 'awaiting cause of death' and cause of death not available'. 2. The Mortality process, criteria and screening will describe this requirement as part of the overarching SOP (Recommendation 2).	
CLINICAL ENGAGEMENT					
Number	**Recommendation**	**Priority**	**Management Responsibility**	3. **Proposed Actions**	**Timescales**
9	Establish a process of validation and use of mortality reporting and analysis at service level, aligned to corporate reporting	**High**	**Executive Lead** Chief Finance Officer **Leads for Delivery** Chief Digital Officer and Director of Nursing, Patient Safety and Safeguarding and Medical Director of Quality	1. New Mortality Data Pathway as outlined in Recommendations 1, 3, 5 and 6 will detail the process for capturing, collating, validating and reporting mortality data. 2. Care Groups and Trust committees will be able to utilise the revised Mortality dashboard to drill down into individual Care Groups as well as maintain oversight from a Trust perspective. 3. The mortality data will be centrally produced, therefore the data will be consistent from 'Ward to Board'. 4. The dashboard will be available without patient details on the Trust intranet for all staff to review.	3 months –August 2023
10	Review the process of retaining patients on caseloads, and subsequent discharge from caseloads, to ensure it results in consistent data across the services	**Low**	**Executive Lead** Chief Finance Officer and Chief Operating Officer **Lead for Delivery**	1. The guidance which details the process for administration staff to follow describing the steps to be taken when discharging a patient from the service will be shared with all Business Managers to action.	9 months -February 2024

			Chief Digital Officer and Deputy Chief Operating Officer	2. Further guidance will be developed for administration staff as to the process to follow when a person on the team's caseload is found to be deceased. 3. Caseload Reviews should be carried at a minimum 6 monthly with the involvement of Medical, Nursing, Therapies and Local Manager input and should be embedded in local teams standard practice.	
11.	Create supporting training programme for all staff who input data into systems that have an impact upon mortality data. Ensure that the implications and impacts of incorrect or incomplete data entry are understood by staff.	**Medium**	**Executive Lead** Chief Finance Officer **Leads for Delivery** Chief Digital Officer, Deputy Chief Operating Officer, Medical Director of Quality	1. Implement training programmes focusing on the importance of mortality reporting dependent on the role the member of staff fulfils. 2. To be supported by learning bulletins which highlight the importance of accurate mortality data reporting and how this can assist in improving clinical care.	6 months – November 2023

PARTNERSHIP WORKING					
Number	**Recommendation**	**Priority**	**Management Responsibility**	**Proposed Actions**	**Timescales**
12	Establish links with primary care networks to explore opportunities to improve the completes of the Trust's mortality data (including cause of death), supported and enabled by the ICB	**Medium**	**Executive Lead** Director of Strategy and Partnerships **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding, Medical Director of Quality and Director of Operations- (Medical Directorate)	1. In order to inform the ICB where their assistance can be best be focused, the Trust will complete an audit of the available cause of death data. 2. NSFT will develop a standardised process led by the Mortality Team for contacting GPs, Coroners, Medical Examiners and clinical data systems to obtain the cause of death wherever possible. 3. This recommendation will be shared with the ICBs through the dissemination of this report and to be added as an agenda items on ICB Learning from Deaths Forums where/when in place.	6 months –November 2023
13	Explore opportunities for formal data sharing agreements between the Trust and primary and secondary care in the region	**Medium**	**Executive Lead** Chief Finance Officer **Lead for Delivery** Chief Digital Officer	1. Establish formal data sharing agreements between the Trust, Primary and Secondary care within the region.	6 months –November 2023
GOVERNANCE					

Number	Recommendation	Priority	Management Responsibility	Proposed Actions	Timescales
14	Update the Trust's Learning from Deaths policy to ensure the Trust's governance addresses the issues in this report and explicitly reference community deaths. Ensure the governance in relation to all mortality is clearly understood by clinical and corporate staff involved in the production and reporting of mortality information.	**High**	**Executive Lead** Chief Nursing Officer and Chief Medical Officer **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding, Medical Director for Quality and Director of Operations – (Medical Directorate).	1. Following confirmation of the revised mortality data pathway, the Learning from Deaths policy will be reviewed and updated to include the SOP referenced in Recommendation 2. This will include the nationally defined focus of mortality being both community and inpatient deaths. 2. The Learning from Deaths policy will be supported by a 'policy on a page' which will be available to all staff. 3. The circulation of information and learning bulletins 'Learning from Deaths Matters' will be published and disseminated throughout the Trust. 4. This will be supported by learning events.	3 months –August 2023
15	Establish a clear improvement plan to address the issues identified in this report, and report progress to a board committee	**High**	**Executive Lead** Chief Nursing Officer and Chief Medical Officer. **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding, Director of Operations- (Medical Directorate) and	1. The improvement plan will be monitored through the Learning from Deaths and Incidents committee and reported quarterly to the Quality Committee.	3 months –August 2023

			Medical Director of Quality		
16	Introduce a process of assurance over mortality reporting: Introduce a clear audit trail and series of checks to ensure adherence with SOPs, and report outcomes to executive leads on a regular basis Introduce or commission patient level data reviews to provide assurance over the accuracy of data recording. Link to the clinical validation process established under recommendation 9	**High**	**Executive Lead** Chief Finance Officer **Lead for Delivery** Chief Digital Officer	1. An audit process will be developed and implemented every 6 months. The audit will test the comprehensiveness of the mortality data pathway with the findings reported to the Learning from Deaths and Incidents Committee. 2. External verification will be sought by an external consultancy team who are experienced in data within the NHS.	3 months –August 2023

Norfolk and Waveney
Integrated Care Board

Agenda item: 9

Subject:	**Norfolk and Waveney ICS Research and Innovation Strategy**
Presented by:	**Dr Clara Yates, Associate Director of Research, NWICB**
Prepared by:	**Dr Clara Yates, Associate Director of Research, NWICB** **Dr Frankie Swords, Executive Medical Director, NWICB**
Submitted to:	**ICB Board**
Date:	**18 July 2023**

Purpose of paper:

To present the NWICS Research and Innovation Strategy

Executive Summary:

The Health and Care Act 2022 set new statutory duties on Integrated Care Boards (ICBs) around the facilitation and promotion of research, the use of evidence obtained from research and promotion of innovation. In addition, NHS England has produced guidance for Integrated Care Systems on how to maximise the benefits of research[1], with specific reference to the development of a research strategy. This guidance recognises the benefits of working together, combining expertise and resources to foster and deploy research and innovations.

The research and evaluation team at NHS Norfolk and Waveney already lead the development and management of research across primary and community care, wider community and non-NHS settings. On behalf of the ICB, the team manages 11 research grants which have bought in over £10million of research income to our system. In the last year the team has coordinated the management and supported the delivery of 83 new studies across a diverse portfolio, from quality of life for people with long COVID to community-based rehabilitation after hip fracture.

However, it is imperative that we are strategic in this work, and so the research and evaluation team has led on the development of the Research and Innovation strategy for the Norfolk and Waveney System.

[1] https://www.england.nhs.uk/long-read/maximising-the-benefits-of-research/

We have developed this strategy in collaboration with our patients, researchers, system partners and stakeholders during a series of four workshops involving 128 attendees as summarised below:

- Healthwatch Norfolk
- Healthwatch Suffolk
- Patient representatives
- University of East Anglia
- Anglia Ruskin University
- University of Suffolk
- General Practice
- The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
- Norfolk and Norwich University Hospitals NHS Foundation Trust
- James Paget University Hospitals NHS Foundation Trust
- East Coast Community Healthcare C.I.C
- Norfolk Community Health and Care NHS Trust
- Norfolk and Suffolk NHS Foundation Trust
- Integrated Care 24
- Cambridgeshire Community Services NHS Trust
- East of England Ambulance Service
- Voluntary, community and social enterprise organisations
- Clinical Research Network East of England
- Eastern Academic Health Science Network
- Applied Research Collaborative East of England
- Suffolk County Council
- Norfolk County Council

Four overarching principles, and corresponding goals, were identified within the workshops. The principles are equally important, they are inter-related and co-dependent on each other and have been used as the basis of our strategy.

Our four principles state that research and innovation in Norfolk and Waveney will be:

1. Focused on our communities
2. Driven by a confident and capable workforce
3. Collaborative and co-ordinated
4. Embedded in everything we do as a system.

These principles set the scene for research and innovation across our Integrated Care System; one that capitalises on areas of excellence and enhances opportunities where there has traditionally been less activity. Case studies within the strategy highlight work already taking place which align with the principles, for example increasing opportunities for our communities to find out about and engage with research.

This strategy was approved through the Quality and Safety Committee in May 2023 and marks the beginning of a five-year programme of work to embed a culture of research and innovation across our system. The next step will be to convene a Research and Innovation Strategic Leadership Forum to oversee the delivery of this

strategy across all system partners. The first meeting will take place in September 2023.

Recommendation to the Board:

The board is asked to note the recently published Research and Innovation Strategy for information

Key Risks	
Clinical and Quality:	Research risks are mitigated through adherence to the DHSC Research Policy Framework for Health and Social Care and review / approval of research projects by Health Research Authority (HRA). Collaborative working between CRN team, general practice and researchers reduces clinical risk. Patient access to potentially new treatments and therapies.
Finance and Performance:	Close performance monitoring ensures the flow of research monies to practices and the Research Office, ensures delivery against contracts and SLAs, and increases opportunities for patients and the public.
Impact Assessment (environmental and equalities):	Any adverse impact on equality and diversity is minimised by HRA and ethical review.
Reputation:	Achievement of targets and patient recruitment is essential for good research delivery and achievement of funding from CRN East of England. Achievement of research grants hosted by the ICB enhances ICB reputation and generates additional income in the form of RCF. R&D assessment and review ensures appropriate approvals, facilitating timely set up of studies to minimise the risks to the patient, the study, the host organisation and the reputation of primary & community care research in Norfolk & Suffolk.
Legal:	Robust performance monitoring mitigates legal risks associated with research activity. Sponsors and permission givers (GP practices) take legal responsibility for research. HRA takes responsibility for the review it conducts, and indemnity arrangements for research is assessed as part of this review
Information Governance:	All research work is compliant with information governance rules associated with data handling and research. Robust processes are in place at all

	stages of research from review by HRA and Ethics to management and roll out of studies locally and dissemination and assessment of impacts. Evaluations are planned and carried out in consultation with ICB IG team.
Resource Required:	R&E Team is fund through a variety of sources including CRN East of England, DHSC held research grants and RCF and through SLA arrangements with Suffolk and North East Essex ICB, Norfolk Community Health and Care and East Coast. Research monies are managed in line with NIHR and DHSC rules and financial governance frameworks.
Reference document(s):	Maximising the benefits of research: Guidance for integrated care systems, NHSE 2023; ICB Duty to facilitate or otherwise promote research, Health and Care Act 2022; UK Research Strategy -Best Research for Best Health May 2021; NHS Long Term Plan, January 2019 UK Policy Framework for Health and Social Care Research 2017; Duty to promote and commitment to managing Treatment Costs in Research detailed in Health and Social Care Act, 2013
NHS Constitution:	NHS Commitment to the promotion, conduct and use of research.
Conflicts of Interest:	Any conflicts have been managed in line with Norfolk and Waveney ICB policy
Reference to relevant risk on the Board Assurance Framework	Current there are no risks on the GBAF. Research has risk register in line with corporate governance requirements and research governance standards

Governance

Process/Committee approval with date(s) (as appropriate)	The Strategy was approved at the Quality and Safety Committee on 04/05/2023 and published online on 31/05/2023.

Improving lives **together**
Norfolk and Waveney Integrated Care System

Norfolk and Waveney ICS Research and Innovation Strategy 2023-2028

Executive Summary

This is the first research and innovation strategy for the Norfolk and Waveney Integrated Care System (ICS). Developed through a series of collaborative workshops, it sets out our collective vision for the next five years.

Our system is made up of a range of partner organisations working together to help the 1.1million people in Norfolk and Waveney live longer, happier and healthier lives. We know there are challenges now, and in the future, for our health and care system. For example, by 2040 our population will grow by over 110,000, with older age groups growing faster than younger age groups. We also know that as we get older our chance of having more than one significant illness increases, resulting in more complex health and care needs.

Research has a central role to play in providing the evidence we need so we can improve services, improve quality, improve outcomes and reduce unfair differences in health outcomes experienced by some people in Norfolk and Waveney. Innovations can transform how people receive care, for example by allowing them to be monitored in their own home rather than stay in hospital.

This strategy sets out four principles- that research and innovation in Norfolk and Waveney will be:

Focused on our communities

Driven by a confident and capable workforce

Collaborative and co-ordinated

Embedded in everything we do as a system.

These underpin the way in which partners and stakeholders across our system will work together to drive research and innovation. Fundamental to this is the willingness to work collaboratively, with our communities, with voluntary sector and community organisations, so that people can engage with all stages of the research process. Only by listening to our population will we understand what is important and ensure research is designed with that at the forefront.

The collaborative way in which this strategy was developed demonstrated the strong base of expertise, knowledge and enthusiasm which already exists across our system. We will harness this to ensure we embed our strategic principles and deliver against our goals.

We are looking forward to the next 5 years and are pleased to share this strategy with you.

What is the Norfolk and Waveney Integrated Care System?

The Integrated Care System (ICS) brings together all NHS organisations, local councils and voluntary, community, faith and social enterprise (VCSFE) organisations, to plan and deliver joined up health and care services for the people of Norfolk and Waveney. Figure 1 illustrates the scale and scope of the Norfolk and Waveney ICS.

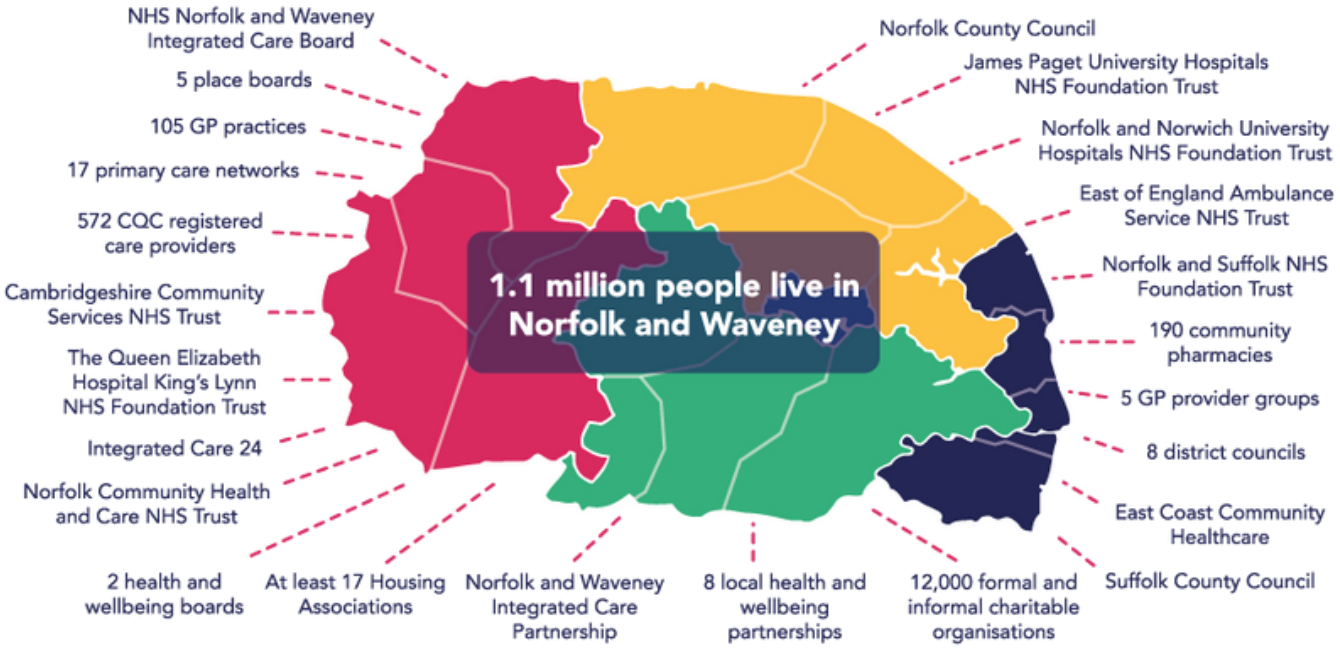


Figure 1 - The Norfolk and Waveney Integrated Care System

This new way of working started in July 2022 and will enable organisations and services to work more closely together. By bringing together partners we can address challenges that the health and care system cannot address alone, for example preventing ill health and reducing health inequalities.

The ICS's mission is to help the people of Norfolk and Waveney to live longer, happier and healthier lives by addressing three goals:

1. To make sure that people can live as healthy a life as possible.
This means preventing avoidable illness and tackling the root causes of poor health. We know the health and wellbeing of people living in some parts of Norfolk and Waveney is significantly poorer – how healthy you are should not depend on where you live. This is something we must change.

2. To make sure that you only have to tell your story once.
Too often people have to explain to different health and care professionals what has happened in their lives, why they need help, the health conditions they have, which medication they are on. Services have to work better together.

3. To make Norfolk and Waveney the best place to work in health and care.
Having the best staff and supporting them to work well together will improve the working lives of our staff and means you will get high quality personalised and compassionate care.

What is research and innovation?

At the outset, we recognise that 'research' and 'innovation' can mean different things to different people. Here, we have set out the definitions of these and other commonly used terms.

- **Research:** the attempt to derive generalisable new knowledge by addressing clearly defined questions with systematic and rigorous methods as defined in the UK Policy Framework for Health and Social Care Research[1]. Examples of research include trialling a new therapy or medication, completing a survey, or taking part in a focus group.

- **Innovation:** an invention or change that is practical, affordable and reliable and ready to be used. The innovation pathway details the steps needed to take an invention from a prototype, through manufacturing and regulations to a stage where it can be used in the real world. It includes generating real world evidence to find out the impact. If it is positive, the pathway helps to spread the invention for wider benefit.

- **Evidence:** facts or information that indicate whether something is true or valid. Evidence can come from a variety of places including, but not limited to, research projects, evaluations, quality improvement projects, audits.

- **Evaluation:** a process of investigating a service with the purpose of generating information for local decision making. It is: 'A study in which the systematic collection and analysis of data is used to judge the quality or worth of a service or intervention, providing evidence that can be used to improve it.'[2]

[1]UK Policy Framework for Health and Social Care Research - Health Research Authority (hra.nhs.uk)
[2]Best Practice in the Ethics and Governance of Service Evaluations https://arc-w.nihr.ac.uk/Wordpress/wp-content/uploads/2021/02/Full-ethics-guidelines-revised-Nov-2020.pdf

Why is research and innovation important?

Research and innovation can provide the evidence base and the innovative tools to help us achieve our system wide goals. It can transform how we deliver care and support better use of resources to address differences in life expectancy, health outcomes and preventable causes of disease. Making full use of the research evidence base when designing and implementing health and care services means they are more likely to benefit our population. Evaluating services helps to identify what works on a local level, so we can focus on providing health and care services which have the greatest benefit.

Research and innovation offer learning and development opportunities for staff, and can help with recruitment and retention, helping organisations to flourish.

Research and innovation takes place in all settings across our system and throughout the life course, from projects investigating the benefits of skin-to-skin contact for babies and parents, to understanding the best way for pharmacists to support the appropriate use of medicines in care homes.

Our local and regional stakeholders (figure 2) play key roles in ensuring research and innovation takes place within Norfolk and Waveney. They work with our system partners (figure 1), from providers of care, NHS organisations, VCFSE colleagues and, importantly, members of the public so that research and innovation meets local needs.

Figure 2 - Local and regional research and innovation stakeholders

This strategy is designed to build on and complement the existing good practice that already exists within Norfolk and Waveney, and to work with organisational research strategies to support system wide working across all partners and stakeholders within the ICS. We want to give everyone the opportunity to participate in, and benefit from, the wide and growing range of research and innovation activity within health and care.

Overarching principles

We have developed this strategy in collaboration with system partners and stakeholders during a series of workshops. Four overarching principles, and corresponding goals, were identified within the workshops, which form the basis of our strategy. The principles are inter-related and co-dependent on each other. All are equally important for research and innovation in Norfolk and Waveney.

Our four principles
Research and innovation in Norfolk and Waveney will be:

Focused on our communities

Driven by a confident and capable workforce

Collaborative and co-ordinated

Embedded in everything we do as a system

These principles set the scene for research and innovation across our Integrated Care System; one that capitalises on areas of excellence and enhances opportunities where there has traditionally been less research activity.

The following sections discuss each principle in more detail and articulate the goals for 2028 (the end of this strategy period) that sit beneath them, as developed throughout the workshops. Case studies highlight progress we have already made and on which we can build.

Principle 1: Research and innovation will be focused on our communities

By 2028 we will:

- Know who our communities are and their needs in relation to research and innovation
- Ensure research and innovation is accessible and meaningful to our communities
- Have approaches in place which support our communities to participate in all aspects of research and innovation.

We know that individuals and communities can benefit from taking part in research, which may include trying a new treatment, learning more about their condition or benefits from being monitored more closely than usual.

We want to make sure that we give our population and communities the opportunity to take part in research, and that the research works for, and is accessible to, our different populations and communities. From working alongside researchers to identify a research question, to volunteering to take part in a research study, right through to helping make sure the results of research are accessible and are used to improve health and care.

Working together, we can build on the work already underway (see case study 1) to develop a culture of shared learning and collaboration. To achieve the best outcomes for our population, our research and innovation must be centred on, accessible to and ultimately benefit the communities that we serve.

Case Study 1: Working with VCFSE organisations to increase research engagement in Great Yarmouth and Waveney

Research should reflect the communities which will ultimately benefit from it. There is a recognition locally and nationally that this is not always the case. In December 2022 a group including both Norfolk and Suffolk Community Foundation, the Integrated Care Board (ICB), the Clinical Research Network East of England (CRN EoE) and the University of East Anglia were awarded £92,000 from NHS England. The funds have been used to increase the diversity of those taking part and engaging with research, and to develop a network to support this. The project has focused on working with VCFSE organisations in Great Yarmouth and Waveney, as a diverse Coastal Community. Thirty-six staff and volunteers from 11 organisations have received 'Research Ready Communities' and 'Community Voices' training. This has enabled conversations about research to take place within communities, led by those who know them best. The conversations have been recorded on an 'Insight Bank', allowing us to analyse them and find out what our communities know about research and if there are specific barriers which make people feel unable to take part in research. The information will be used to help make future research more accessible and inclusive.

Principle 2: Research and innovation will be driven by a confident and capable workforce

By 2028 we will:

- Know who our workforce are and their needs in relation to research and innovation
- Ensure research and innovation is accessible and meaningful to our workforce
- Co-ordinate approaches for building research and innovation capacity and capability
- Influence partners to embed research and innovation within workforce strategies
- Articulate to our workforce how research and innovation makes a difference across our system.

We know that providing opportunities for staff to take part in research and innovation activity can:

- Contribute to job satisfaction
- Help organisations to recruit and retain staff
- Enhance the skills of workforce, supporting a culture of continuous improvement and quality services
- Provide an opportunity for further learning to benefit our population and workforce
- Enable individuals to build their career around areas they are passionate about and to explore new areas of interest.

This directly aligns with our system goal: to make Norfolk and Waveney the best place to work in health and care.

By understanding who our workforce are, we can understand their needs, for example training or skills gaps and identify ways to address these. Needs will be different dependent on the organisation someone works in, their role within that organisation, and their individual goals. We will ensure that opportunities to take part in research and innovation activities (see case study 2) are clearly communicated, accessible and meaningful to our workforce.

We want to develop a system which has a positive research and innovation culture, where our workforce is empowered and supported to access the many and varied opportunities to take part.

Case study 2: Research, evaluation and quality improvement scholarships led by James Paget University Hospitals NHS Foundation Trust (JPUH) and funded by the Norfolk Initiative for Coastal and rural Health Equalities (NICHE) at UEA

This scholarship provides a structured monthly programme to equip our workforce with research, evaluation and quality improvement skills. Scholars design and undertake a project related to their area of work. Following a successful pilot in 2022-23, the programme has expanded to provide 17 places, and is open to clinical and non-clinical staff in health and care organisations across the ICS. Project themes align with ICS priorities, including improving health inequalities.

Principle 3: Research and innovation will be collaborative and co-ordinated

By 2028 we will:

- Establish a system-wide leadership forum to drive research and innovation
- Define what good collaboration, co-ordination and communication looks like in research and innovation
- Explore the implementation of shared infrastructure and intelligence to facilitate research and innovation
- Influence national research and innovation organisations to enable collaborative working across the system.

Working as a system creates additional opportunities to collaborate on research and innovation activity across Norfolk and Waveney. Building on and developing existing collaborations, as well as opening up new collaborative opportunities we will develop more efficient ways of working, sharing learning and expertise and reducing duplication.

We have an opportunity to work together to develop our research infrastructure and use our collective resources to address issues that specifically affect our population and communities and meet system wide priorities (see case study 3). This also provides the opportunity to make Norfolk and Waveney an attractive place to do research and implement innovations, so our communities can have access to, and benefit from, inclusion in regional and national research.

Collaboration and co-ordination underpins the other principles outlined within this strategy, to ensure we are sharing learning and opportunities whilst not overburdening our communities; to work together in delivering opportunities for our workforce to grow and develop and learn from each other; and how we embed research across all that we do.

A system wide leadership forum will provide the strategic direction and champion research and innovation across the system. Membership will be broad, including representation from across health and care, universities, the VCFSE community, NIHR infrastructure and our other partners.

Case study 3: UEA Health and Social Care Partners (UEAHSCP)

UEAHSCP is a partnership of organisations working across Norfolk, Suffolk and North East Essex to build capacity for collaborative research. The partnership funds early stage, practice-led research and innovation projects, bringing practitioners, citizens, clinicians and academic researchers together. The aim is to improve the quality of services, our workforce and the lives of those within our communities. Current research projects and groups include palliative care, point of care 3D medical printing and children and young people's mental health. The partnership is a fantastic example of how collaborative working can benefit Norfolk and Waveney, as well as spreading good practice across our region.

Principle 4: Research and innovation will be embedded in everything we do as a system

By 2028 we will:

- Influence and support partners to incorporate research and innovation into the design, planning and delivery of services and infrastructure
- Support our workforce to understand evidence and how and how it can be used to improve the health and care of people in our communities.

We want to create a system which truly values research and innovation, where the benefits and impacts are shared and promoted across our organisations and within our communities.

Despite the known benefits, research and innovation have historically been seen as an "add-on" to health and care and as a "nice to do" if time allows. The COVID-19 pandemic demonstrated that research and innovation are essential if we want to deliver an efficient, innovative and effective health and care system. If we want to make sure that people can live as healthy a life as possible, we must embed research and innovation in everything we do.

Evidence from research activity, including the full spectrum of audit, quality improvement, evaluation (see case study 4) and research projects must be embedded in the transformation of services and when designing new pathways of care.

We know that each organisation across our health and care system will be at different stages of the journey to embed research and innovation. Our leadership forum will be instrumental in ensuring we share expertise and learning about the ways to approach this. This is not about creating a one-size-fits-all approach to embedding research and innovation across our system partners. It is about supporting each other to embed it in a way that works for individual organisations whilst supporting the wider system goals.

Case study 4: Evaluation of the Urgent and Emergency Care (UEC) Open Room

The UEC Open Room was a virtual 'room' where a small, multi-disciplinary team came together to identify if patients who had called 999 for an ambulance could be more appropriately looked after by other services, for example a community-based falls service. The aim of the Open Room was to relieve pressure on the use of emergency services in Norfolk and Waveney. An evaluation of the Open Room over the course of three months found that 419 cases were treated by a service other than an ambulance. This avoided a conveyance to an Emergency Department (ED) and a potential hospital admission. The collaborative nature of the Open Room enabled effective action and good patient outcomes. These were achieved by focused assessment, available expertise within the system, and identification of appropriate forward care or treatment options that avoided inappropriate conveyances to ED.

The results of the evaluation informed executive level discussions at the Integrated Care Board and directly influenced the future workplan for UEC in Norfolk and Waveney.

Next steps

This strategy is a starting point for our system. It details the principles and goals we have agreed are important and which we can build on together, focussing on the needs and preferences of our population and the communities in which they live.

We included many of our system partners in the workshops to develop this ambitious strategy and we have aimed to reflect the discussions and harness the collective enthusiasm for strengthening research and innovation in Norfolk and Waveney.

We have taken into account local and national research and innovation strategies and guidance in the development of this document, including the NIHR Best Research for Best Health: The Next Chapter[1] and Maximising the benefits of research: Guidance for integrated care systems[2] from NHS England. We have also aligned the Principles with the Norfolk and Waveney ICS Clinical Strategy[3] and the Quality Strategy[4], both of which recognise the benefits of research and innovation.

There will be challenges in delivering on the goals within this strategy, not least that it is wide-ranging and means we must work across organisations. We will need to be agile to make sure we can respond to national and local changes in direction and policy.

The next step is to use this strategy to develop an operational plan. This will detail the specific actions that we, as a system, can undertake to achieve each of the goals we have outlined. Success will be measured against this plan and monitored and communicated annually through the system wide leadership forum and the quality and safety committee.

We are looking forward to working together to make sure that research and innovation are at the core of how we improve lives in Norfolk and Waveney.

[1] https://www.nihr.ac.uk/documents/best-research-for-best-health-the-next-chapter/27778
[2] https://www.england.nhs.uk/long-read/maximising-the-benefits-of-research/
[3] https://improvinglivesnw.org.uk/about-us/developing-our-integrated-care-system/norfolk-and-waveney-clinical-strategy/
[4] https://improvinglivesnw.org.uk/our-work/working-better-together/quality-management-approach-qma/

Acknowledgements

This strategy has been developed by the Research and Evaluation Team at Norfolk and Waveney ICB over four workshops with input from VCFSE partners, the public, our health and care workforce, local authorities, National Institute for Health Research (NIHR) Clinical Research Network East of England (CRN EoE), NIHR Applied Research Collaboration East of England (ARC EoE), Eastern Academic Health Science Network (Eastern AHSN), colleagues at the University of East Anglia (UEA), the University of Suffolk, Anglia Ruskin University and UEA Health and Social Care Partners (UEAHSCP). We thank everyone for their input and feedback.

Abbreviations

- ARC EoE: NIHR Applied Research Collaboration East of England
- CRN East of England: NIHR Clinical Research Network for the East of England
- Eastern AHSN: Eastern Academic Health Science Network
- ECCH: East Coast Community Healthcare Community Interest Company
- ED: Emergency Department
- ICS: Integrated Care System
- ICB: Integrated Care Board
- JPUH: James Paget University Hospital NHS Foundation Trust
- NCH&C: Norfolk Community Health and Care NHS Trust
- NNUH: Norfolk and Norwich University Hospital NHS Foundation Trust
- NFST: Norfolk and Suffolk NHS Foundation Trust
- NIHR: National Institute for Health and Care Research
- QEHKL: Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
- UEA: University of East Anglia
- UEC: Urgent and Emergency Care
- UEAHSCP: UEA Health and Social Care Partners
- UoS: University of Suffolk
- VCFSE: Voluntary, Community, Faith and Social Enterprise

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Norfolk and Waveney Integrated Care System

Integrated Care Board Finance Report

May 2023

(Month 02, 2023-24)

Board: 25th July 2023

Contents

1. Executive Highlights

- This report represents the May 2023 year-to-date position of the ICB as part of the 2023/24 Financial Year.

- The ICB has reported a **Year to Date break-even position**, which is in line with the plan submission

- The **Forecast out-turn position is break-even**, inline with plan, but includes some offsetting variances, the major items being:
    - £(17.0)m Unidentified Efficiencies (all commissioning portfolios);
    - £(13.6)m Unidentified Investment Slippage in relation to Service Development (SDF) Funding;
    - £(4.0)m Combined Operational Pressures in relation to Edoxaban Prescribing Rebate loss, High Cost CHC Packages and Unfunded Pay Awards;
    - £30.6m Assumed Benefit relating to the availability of non-recurrent mitigations;
    - £4.0m of combined smaller favourable benefits to include Prior Year.

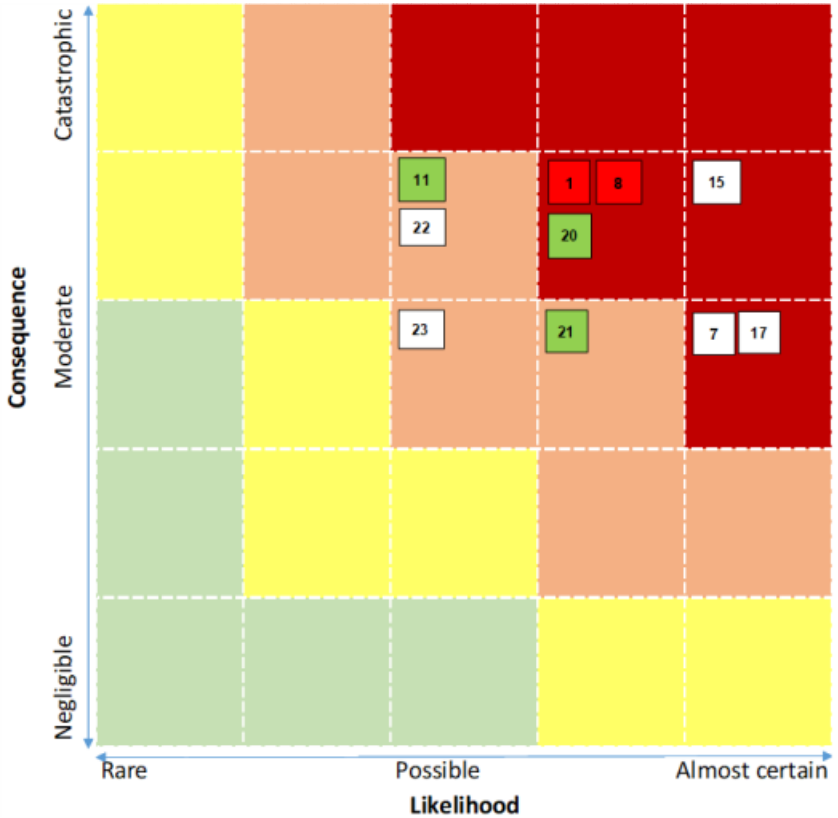
- The 2023/24 Financial Plan included £75m of unmitigated risks in-line with NHSEI guidance relating to efficiency delivery, investment slippage, service demand, inflationary pressures beyond funding, and corporate costs in relation to pay and the Re-Organisation. Of the £75m £3m has crystalised in the year-to-date position, and £35m is considered the gross risk forecast for the full year against which full year mitigations are actively being sought.

- The estimated value of potential risks to the full year position amount to £74.5m, these are items which have not yet crystalised but have been identified as having the possibility of causing a financial issue.

2. Strategic Financial Risk Register

This risk dashboard categorises the key financial strategic risks by their impact and likelihood to help the strategic focus to be on those that will cause the ICB the greatest issues.

Key: ■ = Worsening Risk □ = Stable risk ■ = Improving risk



Financial Strategic Risks	Ref.	Details	Tolerated Risk appetite	Feb-23	Mar-23	May-23
Achievement of Plan	1	Achieve the 2023/24 financial plan **(BAF 11)**	12	12	8	16
	3	Transition following end of HDP top up allocations	6	12	12	Closed
	12	Personal Health Budgets (PHB)	4	8	6	Closed
	15	Underlying deficit position **(BAF 11A)**	12	20	20	20
	16	Capita - Primary Care payments	9	12	12	Closed
	17	Inflationary pressures	9	15	15	15
	20	Impact of new prescribing guidance	8	20	20	16
	21	Impact of Direct Commissioning transfer	9	15	15	12
	22	Re-Organisation: Running Costs Reduction, Increased Pay Costs and Cost of Delivery	9	-	-	12
	23	Debt and Working Capital Management (NCC)	6	-	-	9
Demand and Capacity	4	Capacity increases in response to COVID continue	8	12	12	Closed
	7	Continuing Health Care demand growth	9	15	15	15
	10	Treatment breaks / cancelled operations	6	9	9	Closed
	11	ERF: RTT backlog and Acute demand management	9	15	15	12
Efficiency	8	Efficiency, transformation development/delivery	8	20	12	16
					-	
			Extreme	7	6	6
			High	6	7	4
			Moderate	0	0	0
			Low	0	0	0
			Total Risks	**13**	**13**	**10**

As at M02 (May) 10 risks remain live.

Since March 2023 5 risks have been closed due to not being relevant to 2023-24 (Risks 3, 16 and 4), significant reduction of risks to below those tolerated (Risk 12) or embedded in other existing live risks (Risk 10 – embedded in 11).

One risk (Risk 1/BAF 11) has increased reflecting the new 2023-24 financial year with high embedded and outside of plan financial risks to deliver.

Two new risks (Risks 22 and 23) have been added to reflect the Re-Organisation and Working Capital emerging risks.

The full risk register is shown in Appendix E.

3. Statement of Financial Position (SOFP)

The Statement of Financial Position presents the aggregate closing position of the ICB as at 31st May 2023.

Non Current assets:
IFRS16 was implemented in April 2022. The non-current assets balance includes the right of use assets for the lease of the premises at King's Lynn, Norfolk County Council and Castle Quarter. Corresponding entries are also included in both current and non-current Lease Liabilities.

Current assets:
Total current assets have increased since March 2023. The £9m balance is made up of aged debtors of £6.2m (including NCC £2.9m and NHSE £2.6m), net of a provision against this balance of £1.9m and prepayments and accrued income of £4.7m.

Trade debtors are subject to a quarterly review of bad debt for provision or write off, which are presented to the Audit Committee. Further details are presented in Appendix B.

Current liabilities:
Total current liabilities has decreased by £26m since March 2023 driven principally by ICB and system invoice accrual timing. The £200m balance is made up of trade creditors of £3m, Prescription Pricing Authority accruals of £24m, dental accruals of £4m, payroll costs including GP pensions of £3m, deferred income of £7m, prior year accruals of £101m and ICB and system invoice accruals of £58m.

Provisions include legal, staffing and estates costs.

Long Term liabilities:
The non-current payables balance is the deferred income relating to research & development which are funded in advance.

Taxpayers equity:
The ICB is directly funded by NHSE with cash allocated on a monthly basis. Any future commitments to balance the general fund shortfall will be supported by the next months cash request from NHSE. This will however continue to remain negative as the NHSE principle is that cash should only be drawn based upon one months commitment at a time.

NHS NORFOLK & WAVENEY ICB STATEMENT OF FINANCIAL POSITION	Position as at 31/03/23	Position as at 31/05/23
ASSETS EMPLOYED		
Non-Current assets		
Right-of-use Assets	1,152	1,152
Accumulated Depreciation	(147)	(184)
Total non-current assets	1,005	968
Current assets		
Trade and Other Receivables	8,676	8,973
Cash and Cash Equivalents	1,649	1,824
Total current assets	10,325	10,797
Current liabilities		
Trade and Other Payables	(225,918)	(199,616)
Lease Liabilities	(219)	(219)
Provisions for liabilities and charges (including non-current)	(4,732)	(4,732)
Total current liabilities	(230,869)	(204,567)
Long Term liabilities		
Non-Current Payables	(686)	(686)
Non-Current Lease Liabilities	(775)	(719)
Total non-current liabilities	(1,461)	(1,405)
Net assets employed	(221,000)	(194,207)
FINANCED BY TAXPAYERS EQUITY		
General fund	(221,000)	(194,207)
Total taxpayers equity	(221,000)	(194,207)

4. ICS Financial Summary

Revenue position:

The ICS reported position for M2 is,

- £11.734m Year to Date deficit, adverse to plan by £4.374m.
- Full year Forecast Breakeven, on plan.

The most significant variances are as follows:

- NNUH is £2.9m adverse to plan as a result of the impact from the Industrial Action in April, and under-delivery against the CIP programme as a result of the back ended phasing.
- QEH is £1.5m adverse to plan due to slippage in identifying CIP, which in turn is due to the continued pressure on capacity and the impact of RAAC

Revenue (surplus)/deficit £'000	Month 2 YTD			Forecast Outturn		
Organisation	Plan	Actual	Variance	Plan	Actual	Variance
	£k	£k	£k	£k	£k	£k
JPH	634	634	0	0	0	0
NNUH	1,869	4,772	2,903	0	0	0
QEH	1,700	3,243	1,543	0	0	0
NSFT	3,116	3,116	(0)	(0)	(0)	(0)
NCH&C	42	(30)	(72)	0	(49)	(49)
Provider Subtotal	**7,361**	**11,734**	**4,374**	**(0)**	**(49)**	**(49)**
ICB	0	0	0	0	0	0
N&W System Total	**7,361**	**11,734**	**4,374**	**(0)**	**(49)**	**(49)**

Capital position (Capital Delegated Expenditure Limit – CDEL):

The ICS reported position for M2 is,

- £6.2m spend, a shortfall of £3.7m to plan.
- Full year Forecast to plan.

- All organisations apart from NNUH have a YTD underspend against plan, this is mainly due to slippage/delays in project roll out and RAAC schemes.

System CDEL	Month 2 YTD			Forecast Outturn		
Organisation	Plan	Actual	Variance (Under)/ Over	Plan	Actual	Variance (Under)/ Over
	£m	£m	£m	£m	£m	£m
JPH	2.2	1.0	(1.2)	14.8	14.8	0.0
NNUH	0.9	1.6	0.7	14.6	14.6	0.0
QEH	5.3	3.0	(2.3)	31.7	31.7	0.0
NSFT	1.2	0.5	(0.6)	12.6	12.6	0.0
NCH&C	0.3	0.1	(0.2)	4.8	4.8	0.0
N&W System Total	**9.9**	**6.2**	**(3.7)**	**78.5**	**78.5**	**0.0**

Glossary of terms (1)

Term	Description
BCF: Better Care Fund	A programme which supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.
BPPC: Better Payment Practice Code	The NHS national payments code for good practice with associated mandated reporting. Sets a target of 95% compliance of paying suppliers within 30 days.
Cat M: Category M drugs	Part of the Drug Tariff which is used to set the reimbursement prices of over 500 medicines. It is the principal price adjustment mechanism to ensure delivery of the retained margin guaranteed as part of the contractual framework, using information gathered from manufacturers on volumes and prices of products sold plus information from the Pricing Authority on dispensing volumes to set prices each quarter.
CIP: Cost Improvement Programme	A provider measure of Efficiency and Productivity.
CHC: Continuing Health Care	A package of care for adults aged 18 or over which is arranged and funded solely by the NHS. In order to receive funding individuals have to be assessed according to a legally prescribed decision making process to determine whether the individual has a 'primary health need'.
GIRFT: Get It Right First Time	A national programme designed to improve the treatment and care of patients by reviewing health services. The programme undertakes clinically-led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.
GMS: General Medical Services	Contract which forms the basis of the relationship between the NHS and its GP contractors. The current contract came into force on 1 April 2004 and has been negotiated and updated annually between NHS Employers and the British Medical Association (BMA) since then. It is based upon a multi facetted formula which identifies spend and applies specific ratios resulting in an overall annual percentage pay award for each practice.
GPFV: General Practice Forward View	National development programme of investment in workforce, technology and estates designed to speed up transformation of General Practice services.
HDP: Hospital Discharge Programme	National funding stream to enable earlier discharge increasing flow in the system and release capacity in the acute hospitals.
LCS / LES: Locally Commissioned Services or Locally Enhanced Services	Services provided by GP practices that are either enhanced or additional to the core services offered. These are generally commissioned to meet a local need based on either deprivation or proximity to existing services. Includes services such as phlebotomy, anti-coagulation, atrial fibrillation and care homes. They can reduce onward referrals to Acute settings and funding is separate to practices core contracts.
Model Hospital	An NHS digital information service designed to help the NHS improve productivity, quality and efficiency. Enables health systems and trusts to compare their productivity and quality, and identify opportunities to improve.

Glossary of terms (2)

Term	Description
MHIS: Mental Health Investment Standard	The nationally set requirement for ICBs to increase investment in Mental Health services in line with their overall increase in allocation each year. This is subject to separate external audit on an annual basis to confirm compliance.
NCSO: No Cheaper Stock Obtainable	Items for which in the opinion of the Secretary of State for Health there is no product available to contractors at the price in Part VIII of the Drug Tariff, generally resulting in a higher priced product having to be used.
PHM: Population Health Management	An approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population by focusing on the wider determinants of health by using data to design new models of proactive care and deliver improvements in health and wellbeing which make best use of the collective resources.
PLICS: Patient Level Information and Costing Systems	Costing system which brings together healthcare activity information with financial information in one place. PLICS provides detailed information about how resources are used at patient-level, for example, staff, drugs, and diagnostic tests and combined with other data sources, provides trusts with a rich source of information to help understand their patients and their services.
PMS: Personal Medical Services	Voluntary option for GPs and other NHS staff to enter into locally negotiated contracts. PMS contracts offer local flexibility compared to the nationally negotiated GMS contracts by offering variation in the range of services which may be provided by the practice, the financial arrangements for those services and the provider structure (who can hold a contract).
QIPP: Quality, Innovation, Productivity and Prevention	The collective measure of system transformation efficiencies and productivity.
QOF: Quality and Outcomes Framework payments	This is a voluntary annual reward and incentive programme for all GP practices in England, detailing practice achievement results. It is not about performance management but resourcing and rewarding good practice.
Rightcare	Teams who work locally with systems to present a diagnosis of data and evidence across that population, working collaboratively with systems to look at the evidence to identify opportunities and potential threats. They use nationally collected robust data to complete delivery plans on a continuous basis, to evaluate the system and establish a base plan to maximise opportunities and turnaround issues.
Running costs / Programme costs	Running costs represent the costs of administering the ICB and the work it carries out / Programme costs represent the costs of services commissioned by the ICB.
s.117: Section 117 of Mental Health Act 1983	Entitlement to free after-care if a patient has been in hospital under specific sections of the Mental Health Act 1983. It meets the needs that a patient has because of the mental health condition that caused them to be detained and is designed to reduce the chance of the condition getting worse so avoiding a return to hospital.

Norfolk and Waveney
Integrated Care Board

Agenda item: 11

Subject:	**2023/24 Final Financial Plan Submission**
Presented by:	**Steven Course, Executive Director of Finance**
Prepared by:	**Edward Lambert, Associate Director of Financial Planning**
Submitted to:	**ICB Board**
Date:	**18 July 2023**

Purpose of paper:

To provide an overview of the final 2023/24 ICB financial plan as submitted to NHSE.

Executive Summary:

- The N&W system financial plan was submitted to NHSE on the 4 May 2023.
- The ICB and the five system NHS providers have all submitted break even plans, making the N&W system total break even also.
- An efficiency target requirement of £36.7m is included in this plan, representing 5% of the ICB's influenceable expenditure. Of this £17.9m is recurrent and £20.4m is identified.
- The ICB's reported £75m of risk to the submitted break even plan.
- Despite having a draft breakeven plan, the ICB's plan exit underlying position for 23/24 is a £57.3m deficit. This is due to significant non-recurrent measures which have been put in place to achieve the break even plan.

Recommendation to the Board:

This report is presented for information.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	The achievement of the plan impacts the ICB's reputation with NHSE.
Legal:	None
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	NHSE Planning Guidance
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	

NHS
Norfolk and Waveney
Clinical Commissioning Group

N&W ICB
2023/24 Final Financial Plan Submission

ICB Board - 18th July 2023

NHS
Norfolk and Waveney
Clinical Commissioning Group

Contents

1. Executive Summary

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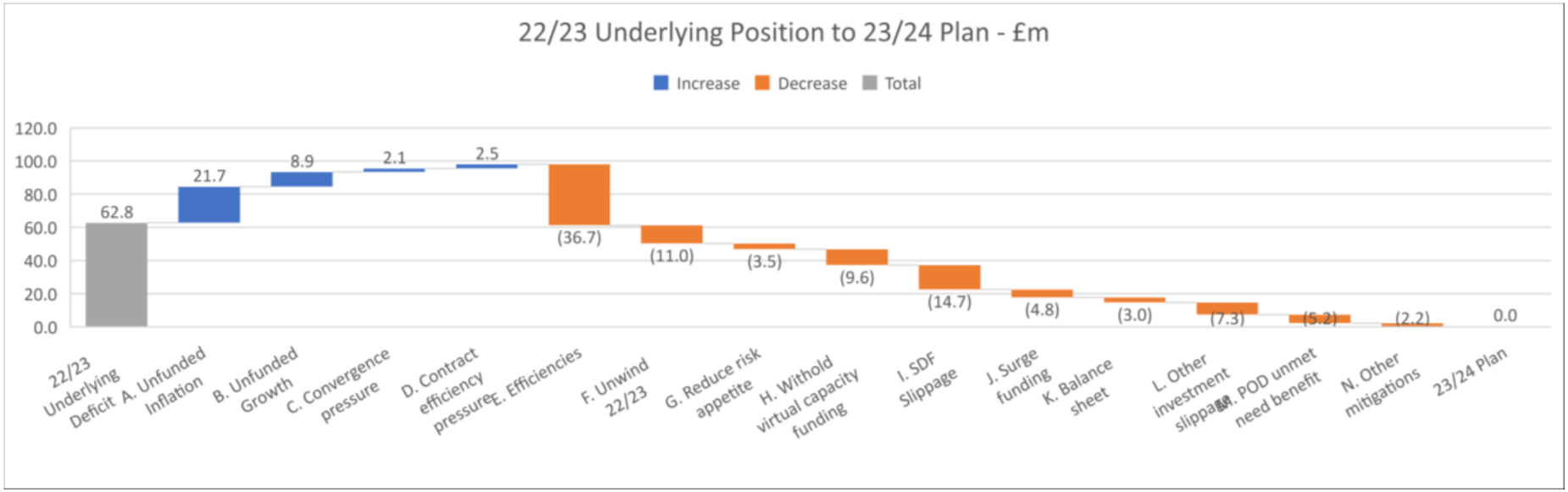
- Despite having a draft breakeven plan, the ICB's plan exit underlying position for 23/24 is a £57.3m deficit. This is due to significant non-recurrent measures which have been put in place to achieve the break even plan.

2. Final plan submission bridge

The ICB left 2022/23 with an underlying deficit of £62.8m. This is driven by unfunded inflation and growth over the years since 2019/12.



The significant movements in the ICB position are:

A. Unfunded inflation, particularly in CHC and prescribing;

B. Unfunded growth, particularly in CHC;

C. Reduced allocation for convergence;

D. Reduced allocation for expected 1.1% contract efficiencies;

E. Efficiencies, value of 5% of influenceable spend;

F. Unwinding of 22/23 financial support provided;

G. Reduced inflation assumptions in CHC and Prescribing;

H. Slippage on virtual capacity investment;

I. Service Development Fund (SDF) slippage planned at 25%;

J. Surge funding support from NHSE;

K. Use of balance sheet mitigation;

L. Defer Health Inequalities and Community transformation;

M.. One off POD unmet need benefit;

N. Various smaller mitigations;

3. Risks

Norfolk and Waveney Clinical Commissioning Group

The table on the right shows the breakdown of the ICB's reported £75m of risk to the submitted break even plan.

£52.2m of this risk is formed from mitigations which have been entered into the plan, which unless carefully managed will not be achieved. These include achievement of as yet unidentified efficiencies and slippage on investments.

The other £22.8m is formed from cost pressures which are not included in the plan, such as non-achievement of identified efficiencies and unplanned inflation.

Risk Detail £'000s	In plan but risky	Risks not in plan	Total
ICS Change to Allocations - EEAST Convergence Share	(300)		(300)
Unidentified efficiencies	(18,900)		(18,900)
Slippage on identified efficiencies (25%)		(4,300)	(4,300)
Withold physical/ virtual capacity funding excl VW	(9,600)		(9,600)
Investment slippage gap	(14,300)		(14,300)
POD Dentistry Slippage	(1,300)		(1,300)
SNEE repayment (years 2 and 3)	(6,000)		(6,000)
Unplanned Inflation and Growth: CHC		(4,000)	(4,000)
Unplanned Inflation and Growth: GP Prescribing		(4,000)	(4,000)
New technologies in Diabetes (NICE guidance on insulin pumps)		(4,000)	(4,000)
ICB Restructure Costs		(4,000)	(4,000)
ICB Unfunded 5% AfC Pay Rises		(1,200)	(1,200)
W4B Risk to Asset Ownership Transfer. Revenue risk element.		(600)	(600)
Vol org contract rises		(700)	(700)
Delivery of additional savings due to £1.75m transfer to NNUH	(1,800)		(1,800)
	(52,200)	(22,800)	(75,000)

4. 2023/24 Efficiency target

The ICB has an efficiency requirement of £36.7m (or 5% of influenceable spend), historically the target has been 3 – 3.5% of influenceable spend.

The ICB has identified £20.4m of schemes fulfilling 56% of the total requirement.

The table opposite shows the identification of schemes by expenditure area. The focus of the ICB schemes is reducing the expenditure outside of the local block NHS provider contracts, in Acute, Mental Health and Community. Of these schemes:

- £2.5m (7%) of the £20.4m identified are non-recurrent items;
- £4.2m (12%) have been evaluated as high risk;
- £16.3m (44%) remain unidentified
- Recurrent impact of these schemes is £17.9m.

Plans to identify the £16.2m gap include

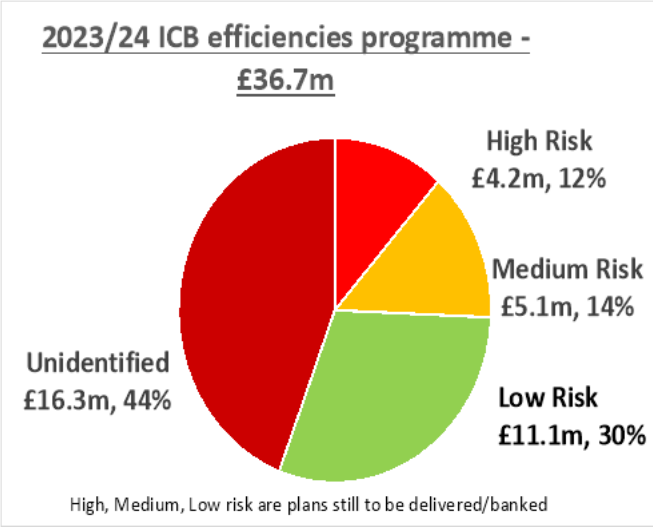
- A close the gap session with all EMT leads
- Finance to meet EMT leads individually for detailed budget review
- Review deferred income on the balance sheet
- Review all contracts **£250k** and above
- Review PMO opportunities that haven't moved to the project stage
- Review all discretionary spend
- Review the procurement pipeline
- True-up exercise
- Exploring less palatable ideas such as restriction policies

Project initiation documents (PIDs) are completed for each scheme.

Quality Impact Assessments and detailed delivery plans, are in the process of being prepared and monthly monitoring of delivery is now in place.

Efficiencies - by area	Full year 23/24		
	Plan	FOT	Variance Fav / (Adv)
	£m	£m	£m
Prescribing	£9.2	£9.2	£0.0
CHC	£5.0	£5.9	£0.9
Corporate & Other	£5.2	£5.2	£0.0
Unidentified	£17.2	£16.3	£(0.9)
TOTAL	**£36.7**	**£36.7**	**£0.0**

Recurrent	**£17.0**	**£17.9**	**£0.9**
Non-recurrent	**£19.7**	**£18.8**	**£(0.9)**



5. Draft exit 23/24 Underlying Position

- Despite having a draft breakeven plan, the ICB's exit underlying position for 23/24 is currently a £57.3m deficit. This is due to the significant non-recurrent measures which have been put in place to achieve the break even plan, which are shown on the list below.

- This underlying deficit assumes that none of the identified risks materialise and that the ICB delivers its £36.7m efficiency target recurrently. If recurrent risks materialise or any of the efficiency target is not delivered, or is delivered non-recurrently, then the underlying deficit will increase by that amount.

	£m
Break even plan	0.0
Remove investment slippage gap	14.8
Removed decreased risk appetite in CHC and Prescribing	3.5
Remove Health Inequality slippage benefit	3.2
Remove capacity funding slippage benefit	9.6
Remove financial support benefits	17.3
Remove balance sheet opportunities	3.0
Remove POD Dentistry slippage	1.3
Remove one off POD unmet need benefit	5.2
Other non-recurrent items	(0.6)
Draft 23/24 exit underlying deficit	57.3

Norfolk and Waveney
Integrated Care Board

Agenda item: 12

Subject:	**Review of the Governance Handbook**
Presented by:	**Karen Barker, Executive Director of Corporate Governance and ICS Development**
Prepared by:	**Amanda Brown, Head of Corporate Governance**
Submitted to:	**ICB Board**
Date:	**18 July 2023**

Purpose of paper:

To present an updated Governance Handbook to the Board for approval.

Executive Summary:

Introduction
A commitment was given to Parliament during consideration of the Health and Care Act 2022 that every integrated care board would identify members of its board (i.e. any member with voting rights) that would have explicit responsibility for certain population groups.

In May 2023, guidance was published requiring ICBs to have executive leads for specific population groups to use their expertise to help plan and meet the health needs of their local populations. These executive leadership roles are added to the statutory requirement for each ICB. The specific groups identified by this guidance are:

- Children and young people (aged 0 to 25)
- Children and young people with special educational needs and disabilities (SEND)
- Safeguarding (all-age), including looked after children
- Learning disability and autism (all-age).
- Down syndrome (all-age).

The Director of Nursing has been identified as the executive lead for each of the above areas (the first three areas are already included in the Governance Handbook).

Accordingly, **Section 5, Scheme of Reservation and Delegation - Decisions and functions delegated by the board to individual board members** has been updated by adding the final two bullet points above to the responsibilities of the Director of Nursing.

The Board is asked to note and approve the proposed amendments to the ICB's Governance Handbook. Once approved, the Governance Handbook will become Version 4 and will published on the ICB's website.

Recommendation to the Board:

The Board is asked to approve the amendments to the ICB Governance Handbook.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	Ensuring that the ICB has appropriate governance processes in place is a key part of maintaining it's reputation.
Legal:	Ensuring that the ICB is compliant with statutory requirements.
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	For Board approval.

Norfolk and Waveney
Integrated Care Board

Agenda item: 13

Subject:	**Board Assurance Framework (BAF)**
Presented by:	**Karen Barker, Executive Director of Corporate Affairs and ICS Development**
Prepared by:	**Martyn Fitt, Corporate Affairs Manager**
Submitted to:	**Integrated Care Board - Board Meeting**
Date:	**18 July 2023**

Purpose of paper:

To present the Board with a copy of the ICB's Board Assurance Framework (BAF) to assist the facilitation of discussions around risks impacting the ICB's ability to deliver its strategic objectives.

Executive Summary:

The Board is presented with a copy of the ICB's Board Assurance Framework and the associated risk visual.

Effective risk management is an essential part of the ICB's system of internal control and supports the provision of a fair and well-illustrated Annual Governance Statement.

The BAF categorises risks around its three aims:

1. To make sure that people can live as healthy a life as possible
2. To make sure that you only have to tell your story once
3. To make Norfolk and Waveney the best place to work in health and care

The BAF has undergone significant review since the last board meeting in May this year by the associated risk leads and ICB Executive Management Team (EMT). Accordingly, the Board is asked to note the following updates that have been made since the BAF was last presented to Board on 30 May 2023:

- **BAF04 Timely cancer diagnosis and treatment.** The board will note the change in risk title which now better describes the nature of the risk and its impact. In addition, the mitigated risk has increased to a 4x4=16. The risk actions, controls and mitigations detail the support for the proposed change.

- **BAF11 Achieve the 2023/24 financial plan.** The previous risk concerning the 2022/23 financial year closed in month 12. Subsequently, a new risk has been approved via the ICB's Finance Committee and has been added to the BAF accordingly.

- **BAF12a - Impact on Business Continuity in the event of a Cyber Attack.** The board will note the change in risk title which now better describes the nature of the risk and its impact

- **BAF13 – Personal data.** The risk rating has decreased to 3x3=9. The risk actions, controls and mitigations detail the support for the proposed change.

- **BAF18 Resilience of NHS General Dental Services in Norfolk and Waveney.** The risk has been updated to focus on delegation of dental services and as such the risk title has been amended and risk score increased to 5x4=20. The risk actions, controls and mitigations detail the support for the proposed change.

- **BAF19 Discharge from inpatient settings.** The risk rating has decreased to 4x3=12. The risk actions, controls and mitigations detail the support for the proposed change.

- **BAF20 Industrial Action.** The risk rating has decreased to 4x3=12. The risk actions, controls and mitigations detail the support for the proposed change.

There are three risks (listed below) which sit within the People Directorate that are going through a broader refresh to align to the risks held by system providers/partners. This work will conclude next month and go through the People board and the remuneration, people and culture committee for approval and will therefore be presented to Board at its next public meeting in September.

Risks within People Directorate under review

- **BAF14 #WeCareTogether People Plan**
- **BAF15 Staff Burnout**
- **BAF17 Financial wellbeing**

Recommendation to Board:

The Board is asked to receive and review the risks presented on the Board Assurance Framework.

Key Risks	
Clinical and Quality:	None
Finance and Performance:	None
Impact Assessment (environmental and equalities):	None
Reputation:	It is important the Board is apprised of the key risks in the organisation currently.
Legal:	N/A
Information Governance:	N/A
Resource Required:	Corporate Affairs risk management resource
Reference document(s):	None
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	See table.

APPENDIX 2: RISK VISUAL

Key	Aim
	To make sure that people can live as healthy a life as possible
	To make sure that you only have to tell your story once
	To make Norfolk and Waveney the best place to work in health and care

Likelihood

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
1 Negligible	1	2	3	4	5
2 Minor	2	4	6	8	10
3 Moderate	3	6	9 BAF12b BAF13	12 BAF17 BAF19 BAF20	15
4 Major	4	8 BAF12a	12 BAF03 BAF05a BAF06 BAF14 BAF15	16 BAF02 BAF04 BAF05b BAF08 BAF09 BAF10 BAF11 BAF16	20 BAF11a BAF18
5 Catastrophic	5	10	15	20 BAF07	25

Norfolk and Waveney
Integrated Care Board

NHS Norfolk and Waveney ICB – Board Assurance Framework (BAF)

Version:	3	Date:	11 July 2023

Norfolk and Waveney ICB aim: To make sure that people can live as healthy a life as possible

Principal risk: That people in Norfolk will experience poor health outcomes due to suboptimal care.

Summary of risks

Ref.	Risk Title	Risk Owner	Date risk identified	Target delivery date	Score at target delivery	2023-2024 Monthly Risk Rating											
						1	2	3	4	5	6	7	8	9	10	11	12
BAF02	System Urgent & Emergency Care (UEC) Pressures	Mark Burgis	01/07/22	31/03/24	12	16	16	16									
BAF03	Providers in CQC Special Measures (NSFT)	Tricia D'Orsi	01/07/22	31/12/24	8	12	12	12									
BAF04	Timely cancer diagnosis and treatment	Dr Frankie Swords	01/07/22	31/03/24	8	9	16	16									
BAF05a	Barriers to Full Delivery of the Mental Health Transformation Programme (Adult)	Jocelyn Pike	01/07/22	31/03/24	8	12	12	12									
BAF05b	Barriers to Full Delivery of the Mental Health Transformation Programme (CYP)	Jocelyn Pike	01/07/22	31/03/24	8	16	16	16									
BAF06	Health Inequalities and Population Management	Dr Frankie Swords / Mark Burgis	01/07/22	31/03/24	4	12	12	12									
BAF07	RAAC Planks	Steven Course	01/07/22	31/03/24	15	20	20	20									

BAF08	Elective Recovery	Dr Frankie Swords	01/07/23	31/03/24	12	16	16	16										
BAF09	NHS Continuing Healthcare	Tricia D'Orsi	01/07/23	31/03/24	9	16	16	16										
BAF10	EEAST Response Time and Patient Harms	Tricia D'Orsi / Mark Burgis	01/07/22	31/03/24	9	16	16	16										
BAF11	Achieve the 2023/24 Financial Plan	Steven Course	01/07/22	31/03/24	12	16	16	16										
BAF11a	Underlying Deficit Position	Steven Course	01/07/22	31/03/24	12	20	20	20										
BAF19	Discharge from inpatient settings	Tricia D'Orsi	25/10/22	31/03/24	6	15	15	12										

BAF02

Risk Title	System / Urgent & Emergency Care (UEC) Pressures
Risk Description	There is a risk that the Norfolk and Waveney health and social care system does not have sufficient resilience or capacity to meet the urgent and emergency care needs of the population whenever a need arises. This can result in longer than acceptable response times to receive treatment, delays in being discharged from hospital and as a result potentially poorer outcomes for our patients with associated clinical harms. The above risk manifests itself as worsening ambulance response times for patients with a life threatening and / or life changing condition and an increasing number of patients remaining in hospital when they no longer meet the nationally prescribed 'criteria to reside', The associated increase in longer lengths of stay and higher occupancy levels in all acute and community hospitals results in delays in admitting patients from our emergency departments (EDs) into a bed, this in turn congests the EDs slowing down ambulance handover leading to more crews outside hospital who are unable to be released to respond to 999 calls.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Mark Burgis	Patients and Communities Quality and Safety	Ross Collett & Karen Watts	01/07/2022	31/03/2024

Risk Scores

Unmitigated			Mitigated			Tolerated (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	5	20	4	4	16	3	4	12

Controls

- **Strategic Oversight:** UEC Programme Board oversees non-elective flow and monitors a system wide transformation programme to improve the responsiveness of our Urgent and Emergency Care pathways to ensure patients receive the right treatment in the right place at the right time; that timely discharge for non-elective patients from inpatient hospital and community beds takes place and that appropriate discharge capacity is available to meet the discharge demand from health settings.
- **Business Continuity:**
  - All Trusts, including community, 111 and primary care have business continuity plans in place to manage the operational response to in-year peaks in demand and periods where demand exceeds 'business as usual' levels.
  - A seven-day System Control Centre (SCC) and East of England Ambulance Service (EEAST) System Oversight Cell (SOC) are in place. The SCC and SOC work alongside Providers to coordinate operational responsiveness when individual or multiple providers are unable to meet demand in a timely and safe way and to escalate to appropriate levels of management when decisions to mobilise additional resources are needed.
  - Interim Winter Director in post until end of May to manage the SCC; act as a point of system escalation for operational pressures including management of any critical or major incidents for the ICS and the associated reporting to NHSE; coordinate mutual aid and support between providers at Exec level, and to lead the planning and implementation of non-recurrent "winter funding".

Specific controls to appropriately manage urgent and emergency care demand ensuring patient's needs are met:

- **Hospital 'Admissions Avoidance':** A range of 'Admissions Avoidance' schemes are in place across N&W to ensure that those patients who have an 'urgent' need but do not need the

Assurances on controls

Internal: ICB Executive Management Team; Norfolk and Waveney UEC Steering Group; Emerging 'Place' UEC Steering Groups; System Control Centre (SCC)

External: ICS Executive Management Team (CEOs Group); Trust Boards; NHSE Regional Strategic Oversight

full range of services of an acute hospital but may be at risk of an inappropriate admission are managed safely in a community setting, the core services are: ○ **111 / GP led Clinical Advice Service (CAS):** This service provides advice to healthcare professionals and the general public triaging and referring patients to the most appropriate service and setting that will best meet their needs. ○ **Urgent Community Response (UCR):** Patients that have been triaged can be referred to this service which provides a face-to-face response within 2 hours for those patients that need this 'urgent' intervention who would otherwise be at risk of admission to hospital. This community led service is underpinned by a plethora of discrete services across each 'place' that the UCR team can access to ensure the immediate need is met and that patients are referred onto appropriate health or social care services that can provide support to prevent or reduce the risk of further exacerbation. ○ **GP Streaming (ED Front Door):** is in place at all three acute hospitals to reduce the urgent care (minors) demand flowing through our EDs by providing a primary care led service to patients who walk-in to our EDs as well as redirecting them to other appropriate services in the community. ○ **Call before convey service (MDT Open Room):** Patients that have an urgent need but choose to ring 999 are held in the 999 'stack' for significant periods of time as there are insufficient resources available that can be mobilised by the ambulance service due to handover delays at hospital. The MDT Open which we are aiming to develop into a pre-hospital urgent care hub allows the transfer of these patients to appropriate community services for response both health and social care. ○ **Same Day Emergency Care (SDEC):** All three acute hospitals have SDECs in place. These are being further developed to include a wider range of symptom groups and referral routes to increase their effectiveness in avoiding 'avoidable' admissions to hospital ○ **Virtual Ward:** Virtual Ward Project established in Q3 22/23. The project intends to increase the level of acuity of patients that can safely be managed in the community by increasing community capability in a "step up" model. See "discharge" for further information on VW project and "step down". • **Creation of surge / escalation capacity:** ○ **Cohorting:** A range of cohorting measures are available at acutes to provide ED surge capacity and reduce waiting to handover at hospital. ○ **Rapid Ambulance Offload:** Arrangements in each ED enable a limited number of additional rapid ambulance handovers to release waiting ambulance crews to attend very urgent community calls where there is an extreme risk of adverse clinical outcome from delay. ○ Escalation / Surge Beds: Acute and community providers have created additional escalation / surge beds through internal operational changes and using some winter funding	

○ All acute hospitals have ambulance handover plans to improve handover performance and accommodate surges in demand. • **Specific controls to improve discharge (cross-reference with BAF19):** ○ Discharge Director is supporting Trusts to ensure best practice is in place via a 30,60,90-day plan and 100-day discharge challenge. ○ Capacity and Demand modelling work is taking place and funding made available to support an increase in capacity using non-recurrent winter funding. ○ Circa 210 beds and 190 domiciliary packages of care equivalent to an acute bed have been mobilised across N&W until 31st March 2023. • The system is now in OPEL 3, with NNUH remaining at OPEL 4. Improvement in offload delays and ambulance response times is reflected in reduced adverse incidents. This prompts a reduction of risk at M1 (2023-24). • Position continues to improve with a reduction in escalation beds at the Acute hospitals and improvement in C1 and C2 ambulance response times. Ambulance handover into ED is showing early signs of improvement, however this needs to embed and sustain before further risk reduction.	

Gaps in controls or assurances

- Clearly defined cross-reference to PHM Strategy that will reduce latent demand for urgent and emergency care through better long-term conditions management reducing condition exacerbation
- Limited alignment with Mental Health non-elective strategy and plans including the mitigation of the impact of Covid 19 which in turn will reduce latent demand on acute hospital EDs
- Central 'Winter Funding' ends on 31st March 2023 and mobilised bed stock and domiciliary care provision will reduce leading to delayed discharges from in-patient hospital and community beds, resulting in an adverse impact on flow and reduction in responsiveness of the community to meet urgent and emergency care needs.
- Winter Director and Discharge Director secondments will end on 31st May and 31st March respectively leaving a gap in system level capacity whilst UEC structure is reviewed.
- Assumptions made by our acute hospitals in the current round of operational planning highlights capacity in wider community (primary care, community, 111/CAS, 999) will be unable to meet the pre-hospital and discharge needs of our population accessing the non-elective pathways
- Insufficient capacity in social care to meet the needs of our population who require timely discharge to complete their onward care journey

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
16/03/23	National UEC Recovery Strategy - Reduce LoS in inpatient settings. This is a core action in the Joint Forward Plan (JFP) to rebalance system flow and meet operational planning target of 76% A&E 4 hour performance. Baseline average LoS is currently 8.1days for non-elective pathway	A	31/03/24
16/03/23	National UEC Recovery Strategy – Recover Ambulance category 2 response time to minimum 30mins. This is a core action in the Joint Forward Plan (JFP). Recovering to this performance will be underpinned by a range of Admissions Avoidance and Discharge initiatives to ensure we have the capacity to release ambulances to respond to category 2 calls	A	31/03/24
16/03/23	National UEC Recovery Strategy – This is a core action in the Joint Forward Plan (JFP) Meet our Virtual ambition to achieve 40 beds per 100,000 population (368 beds). This initiative will support Admissions Avoidance and Early Supported Discharge to meet the 76% A&E 4 hour target	A	31/03/24

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16	16									
Change	↓	→	→									

BAF03

Risk Title	**Providers in CQC Special Measures (NSFT)**
Risk Description	There is a risk that services provided by Norfolk & Suffolk Foundation Trust (NSFT) do not meet the required standards in a timely and responsive way. If this happens, people who use our services will not receive access to services and care that meets the required quality standard. This may lead to clinical harm, poor patient experience and delays in treatment or services.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Tricia D'Orsi	Quality & Safety	Karen Watts	01/07/2022	31/12/2024

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	**4**	**16**	**3**	**4**	**12**	**2**	**4**	**8**

Controls	Assurances on controls
• The report published on 28/04/22 gave an overall reduced rating of inadequate. The Trust was able to provide adequate assurance to mitigate the need for a Section 31 enforcement notice during the inspection. • The Trust's Improvement Plan is over seen by an Improvement Board with a focus on the areas set out in the section 29a letter and Must Do's issued in April 2022. Stakeholder engagement has been strengthened. Evidence Assurance Panel established with attendance by ICB MD and DoN. • Regular NHSE/I Oversight, and Assurance Group in place. Dedicated senior NHSE/I and ICB support has been taken up. • Staff engagement events have taken place across Trust sites and staff groups, with support from the Norfolk & Waveney and Suffolk ICBs. • Weekly internal Performance Board is driving progress. NHSE and ICB are working collaboratively to support the Trust. • Transformation plans continue to progress alongside Quality Improvement. • Strengthened leadership to support key clinical areas. • The ICB MH Strategic Commissioning Team are attending 'pillar' meetings around Culture, Leadership & Governance, Safety, Demand & Capacity and Service Offer. Each pillar is led by an NSFT Executive SRO, supported by an external consultant supporting delivery of the overarching improvement plan. ICB staff are participating in working groups. • ICB supporting Trust with data validation, completion of dashboard and South Norfolk community capacity pilot. • ICB attending Trust Quality and Safety Reviews (QSR) with frontline teams and working closely with NHSE on a governance review.	**Internal:** Clinical Governance Meetings, Quality and Safety Committee, ICB Executive Management Team (EMT), System EMT, and ICB Board. Trust CQC Evidence Panel chaired by ICB. **External**: ICB attendance at Key Trust Meetings, Care Quality Commission, System Quality Group, Norfolk and Suffolk Healthwatch organisations, NHSE/I Oversight and Assurance Group, NSFT Quality Improvement Board, NSFT Quality Pillars and NSFT Quality Committee.

• Evidence Assurance Panel is in place, chaired and supported by ICB Medical Director. • The Trust was reinspected, with its report published in February 2023. The overall rating increased from 'inadequate' to 'requires improvement'. • The Trust will continue to receive enhanced support from NHSE to sustain improvements and to support exit from NOF 4 criteria in 2023-24 Q4. Phase 2 of the Trust's improvement plan is in place. Risk has been reduced to reflect improvements but continues to be 'high' as change embeds. • A new model of care is currently in development.	

Gaps in controls or assurances

- High levels of patient acuity are being reported. Capacity is not currently able to meet demand.
- Workforce pressures. Staff sickness and absence combined with unfilled vacancies and difficulties recruiting to key posts. Impact of 'inadequate' rating on staff wellbeing and morale.
- 12hr 'decision to admit' breaches reported for patients presenting to hospital Emergency Departments, who require a Mental Health bed, which requires a systemwide health and social care solution.
- There is a risk that progress may be delayed or diluted if Norfolk and Suffolk commissioners are not aligned in their transformation programme, where relevant.
- Long term sustainability of improvements, which is required to move out of NOF4 status.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
17/12/21	Additional programme governance has been put in place around 12Hr ED breaches in order to meet the requirement for NOF 4 recovery. This brings together commissioners, service providers and other key stakeholders to implement a system recovery plan looking at early intervention and crisis support, front and back door hospital processes and the 'flow' between these areas.	G	31/07/23
25/08/22	Trust reported 80% completion of Must Do's as of end of July 2022. Evidence Panel has been set up to review compliance with Section 29a. Reinspection evidenced improvements and phase 2 of improvement plan now in place.	G	31/07/23
24/06/23	New model of care in development, focussed around standards of care and patient needs. Areas are being selected to pilot. ICB is supporting.	G	31/03/24

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	12	12									
Change	↓	→	→									

BAF04

Risk Title	Timely cancer diagnosis and treatment
Risk Description	There is a risk that patients with cancer will not be diagnosed and treated as early as possible due to the multiple impacts of the pandemic. Delayed diagnosis and treatment can lead to poorer long-term outcomes for cancer patients as well as significant psychological distress to those waiting for treatment. There is clinical risk to patients on 62-day cancer pathway and other elective waiting lists with last minute cancellations to their surgery. Recent industrial action has also impacted negatively on current backlogs. Recent SIs have shown impact on patient outcomes. There is an ongoing perception of difficulty accessing healthcare which may also be impacting on patients help seeking behaviours

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Dr Frankie Swords	Quality & Safety	Sheila Glenn	01/07/2022	31/03/2024

Risk Scores

Unmitigated			Mitigated			Tolerated (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	4	4	16	2	4	8

Controls

- **Controls:** The Cancer Programme Board works in close partnership with regional cancer screening and North EOE Cancer Alliance, to: Optimise uptake and coverage of screening, provide fixed term transformation resource and support system transformation projects which expand diagnostic and treatment capacity and transform how care is delivered to improve timeliness and efficiency. This work feeds into the
- **Elective Recovery and Diagnostics Boards**. There is a unified prioritisation and harm review process of reviewing patients on waiting lists for possible harm, to ensure that elective capacity is used to deliver care to patients in order of clinical priority at all acute trusts. There is also a quarterly presentation of anonymised key themes from cancer significant incidents at the Cancer Programme Board to share learning.

Assurances on controls

A local communication plan is in place to educate patients on worrying symptoms and encourage presentation to Primary Care.

Internal: Quarterly reports re cancer screening backlogs and bi-monthly updates re transformation progress and operational cancer services restoration into Cancer Programme Board. Monthly update on Cancer Tiering to Elective Recovery Board. Escalation of performance issues to Performance Committee. Escalation of issues/challenges to Transformation Board. Monthly regional support meetings for Cancer Tier 1 trust which are also attended by the EOE North Cancer Alliance.

External: PHE, NHSE Cancer Alliance.

Gaps in controls or assurances

- Changed help seeking behaviour for worrying symptoms has led to a fall in the number of people coming forward and led to an increase in delayed presentations (EOE Cancer Alliances estimate of approx 600 missed cancer diagnoses).
- Challenge of workforce resilience/capacity to continue to meet the backlog demand, including administrative capacity/processes to safely manage backlogs and waiting lists, exacerbated by industrial action.
- Continued surges in 2ww demand with variable performance across providers and pathways.
- Little spare capacity to support mutual aid and complex surgery is provided by the NNUH as Cancer Centre.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
17/05/22	Risk log reviewed. NNUH remains in Tier 1. Operational and workforce challenges in particular relating to industrial action impacting on cancer services restoration.	G	Ongoing

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	9	16	16									
Change	→	↑	→									

BAF05A

Risk Title	Barriers to full delivery of the Mental health transformation programme (Adults)
Risk Description	There is a risk that during a period of unprecedented mental health demand and acuity of need current system capacity and models of care are not sufficient to meet the need If this happens individual need will not be met at the earliest opportunity, by the right service or by the most appropriate person and need will escalate. This may lead to worsening inequality and health outcomes, increased demand on other services and reputational risk

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Jocelyn Pike	Quality & Safety	Emma Willey	01/07/2022	31/03/2024

Risk Scores

Unmitigated			Mitigated			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	**4**	**16**	**3**	**4**	**12**	**2**	**4**	**8**

Controls

- System wide governance framework (currently under review by N&W ICB MH Partnership Board aiming to develop System Collaborative)
- Acting Director of Mental Health Transformation appointed to lead development of system collaborative, working closely with stakeholders and MH SRO
- 22/23 N&W Planning submission agreed by NHS England & Improvement
- Finance working group meets monthly to drive robust financial arrangements Working group and process in place to manage financial slippage and deliver planned MHIS investment
- System commitment to increase knowledge skills and expertise and develop additional capacity through use of digital
- MH Workforce Lead and Programme Manager working with system partners to implement the N&W MH workforce strategy/ transformation
- Ongoing work with Population health management team to proactively contact and offer support/ physical health assessment and vaccination
- Co-developed eating disorder strategy to direct implementation of national ambitions

Assurances on controls

Internal: SMT, EMT, Board

External: N&W ICB MH Partnership Board, HWBs Norfolk and Suffolk, NW Health and Care partnership MH Forum, HOSC, Norfolk and Suffolk NHSE/I Regional MH Board and subgroups, NHSEI System Improvement and Assurance Group,

Gaps in controls or assurances

- Impact of pandemic and cost of living crisis on mental health and well-being of population leading to increased need for support and adding to capacity pressures and resilience of providers
- Organisational development required to drive forward internal cultural change. Cultural shift required as a system to enable successful transformation and ensure mental health is better understood and regarded as ‘everyone’s business’.
- Cultural, digital and operational collaboration to enable access and easily navigable mental health services, is at an early stage of development
- Conflicting priorities across complex system transformation agenda
- Intra-system Electronic Patient Record connectivity, especially at the interface of primary/secondary/social care and third sector provision, remains a challenge and priority to address
- Ability to recruit, retain and train a viable number of staff to enable service expansion and meet the MH and well-being needs of the N&W population
- Limited influence on alternative provision within a tightly prescribed talking therapies model – National NHSEI and HEE guidance is restrictive and does not allow local flexibility
- The ICB is going into restructure July 2023, Capacity and impact may be noted as the process progresses

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
29/04/22	Continuing work to develop effective partnerships and system ownership of the N&W MH Transformation Programme Plan. Co-production with Experts by Experience and Reference Group is central to initiating and sustaining positive change. Programme Assurance Group purpose and structure under review as part of current governance review. Adult system collaborative established from April 2023.		31/10/23
29/04/22	MH Workforce lead driving development of workforce dashboard, and transformation programme. Working with system partners, to set up 4 focused work groups that will implement the N&W MH workforce strategy. Close, In place, recruited new individual to the role following the last person moving on, started 10/07/2023		31/03/24
29/04/22	Developed Recovery Improvement Plans with support from NHSEI to work towards recovery of trajectories for the following: increasing Physical Health Checks for people with Severe Mental Illness, improving Dementia Diagnosis and reducing Out of Area Placement OAP). All negatively impacted by the pandemic which has increased demand and limited opportunity for early intervention. This will enhance support for areas of activity where N&W do not yet meet the national standard. Rated amber to reflect difficulties reducing use of OAP beds and eradicating 12-hour breaches during a time of extraordinary demand and pathway pressures. Work is continuing across all areas. – Close, RAP's in place and monitored via MH programme structure and NHSE		31/10/23
20/10/22	Community Transformation: Working with North Norfolk and Norwich locality leads and practices who are keen to act as pilot sites for the 'MH Integrated Care Interface'. This is a working title for the newly forming primary care-based MH Multi-disciplinary team, a group of professionals from different organisations (NSFT, NCC, VCSE and primary care) that will work together to assess and direct people to the most beneficial service according to their need. – Close, in place and functional		31/10/23

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	12	12									
Change	→	→	→									

BAF05B

Risk Title	Barriers to full delivery of the Mental health transformation programme (CYP)
Risk Description	There is a risk that during a period of unprecedented mental health demand and acuity of need current system capacity and models of care are not sufficient to meet demand. If this happens individual need will not be met at the earliest opportunity, by the right service or by the most appropriate person and need will escalate. This may lead to worsening inequality and health outcomes, increased demand on other services and reputational risk

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Jocelyn Pike	Quality & Safety	Rebecca Hulme	01/07/2022	31/03/2024

Risk Scores

Unmitigated			Mitigated			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	**4**	**16**	**4**	**4**	**16**	**2**	**4**	**8**

Controls

- Dedicated CYP strategic commissioning team now in place
- Effective System wide governance framework
- Collaboration with system partners to understand demand and capacity has begun and the shared resource is better understood.
- Development of robust understanding of the financial envelope available to drive the transformation, and investment necessary, including appropriate measures to reconcile these is still in process.
- System approach to increasing knowledge skills and expertise across agencies and developing additional capacity through use of digital. Greatly assisted by digital appointing a digital lead. Digital workstream initiated
- Financial slippage is being mitigated against protecting our ability to maintain MHIS investment
- Implementation of system wide transformation programme
- Commitment from system partners to adopting Thrive approach – mental health needs being considered and addressed in wider health and social care settings
- Additional partnership working with VCSE
- All age Eating Disorder Strategy
- Established Children and Young Peoples System Collaboratives in Norfolk and Suffolk

Assurances on controls

Internal: SMT, EMT, Integrated Care Board, Finance Committee, Quality Committee,

External: CYPMH Executive Management Group, CYP Strategic Alliance Board, HWBs Norfolk and Suffolk, NW Health and Care partnership MH Board, NHSE/I Regional MH Board and subgroups, HOSC Norfolk and Suffolk, System Improvement and Assurance Group, Children and Young People's System Collaborative

Gaps in controls or assurances

- Capacity and commitment within providers to support transformation and collaboration impacted by increased demand and historical backlog
- Capacity within the substantive CYP integrated commissioning team to deliver on the scale of transformation required.
- Conflicting priorities across complex system transformation agenda
  Intra-system Electronic Patient Record connectivity, especially at the interface of primary/secondary/social care and third sector provision, remains a challenge and priority to address.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
02/05/22	Intensive Day Support for CYP with eating disorders is due to open this month for 5 CYP and their families on a six month test & learn basis before expanding support offer to 12 CYP.	G	30/11/23

02/05/22	Development of Integrated Front Door progressing well, dedicated team in place to develop model, ensure pathways and capacity sitting behind front door will meet the need, procurement process has begun with an expected go live date early 2023. Talking Therapies collaborative being developed as part of model to increase capacity	G	31/10/23
02/05/22	Working alongside adult commissioning team to enhance support offer for 18-25 year olds in wellbeing hubs. Task and finish group set up to improve talking therapies offer for 16-25 to improve access, engagement and outcomes.	A	30/09/23
06/11/22	Recruitment remains challenging in core secondary care services. New staff in post but staff leavers nullifying effect. Requirement to address urgent presentations and increased community acuity reducing routine capacity to reduce waiting times.	R	31/10/23
06/11/22	Some mitigations through expansion of VCSE provision, successful procurement of Integrated Front Door Provider, new provider for Mental Health Support Teams and talking Therapies Collaborative – now mobilising in advance of 2023 planned start	A	31/10/23
10/01/23	Collaborative working with Suffolk and Norfolk systems to introduce short breaks provision. Capital funding in use to develop estates	G	31/10/23
10/01/23	System planning to ensure alignment of provision in Waveney with Suffolk system colleagues. Task and finish group established	G	31/10/23
10/01/23	Engagement exercise commenced to revisit ambitions and transformation plan with Norfolk and Waveney stakeholders	G	31/10/23
10/01/23	System review of provision commenced across Norfolk and Suffolk – further development of Alliance approach to ensure support accessible in most appropriate part of the system	G	31/10/23
11/07/23	Integrated Front Door established and taking referrals for mild to moderate need. Early data shows 27% of CYP have their needs met on first contact. Work continues to expand to all referrals in September. Stakeholder workshop planned for 11/07/23	A	01/10/23
11/07/23	Main provider supported to complete demand, capacity and process review of CYP waiting lists.	A	01/9/23
11/07/23	Successful bid for NHSE regional funding to create mental health care navigator team – recruitment commenced. Potential delay due to organisational restructure	A	01/10/23
11/07/23	Integrated working with local authorities to establish an integrated short stay facility using NHSE capital funding and joint funding from LA. Next steps to confirm revenue funding.	A	01/10/23

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16	16									
Change	→	→	→									

BAF06

Risk Title	Health inequalities and Population Health Management
Risk Description	Health inequalities (HI) are avoidable, unfair and systematic differences in health between different groups of people, which impact on longer term health outcomes and a person's ability to access healthcare. Core20Plus5 is the NHS Health Improvement framework for tackling HI. Population health management PHM is a system that uses data to segment the population and identify groups of people at risk of poor outcomes or inequalities, and then to proactively address these with the aim of improving population health outcomes, reduce unwarranted variation and health and care inequalities. There is a risk that the ICB will not use PHM techniques to their full potential and not meet its statutory requirements to reduce health inequalities, and deliver the Core20Plus5 commitments. If this happens, specific groups of people will experience poor outcomes which could have been prevented.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Mark Burgis / Dr Frankie Swords	Patients and Communities	S Meredith	01/07/2022	31/03/2024

Risk Scores

Unmitigated			Mitigated			Tolerated (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	1	4	4

Controls

- A specialty advisor has been appointed to lead on all CORE20PLUS5 to address inequalities, two advisors appointed to support PHM and another to lead on addressing HI in CVD.
- The NCC deputy DPH is now leading the ICB team to coordinate and lead this.
- PHM and addressing HI has been identified as a priority in our JFP.
- Plus groups now defined for N&W.
- ICB PH&I Board, HI Oversight Group (HIOG) and PHM Oversight Group (PHMOG) have been established, strategies are under development and key workstreams identified.
- Health Improvement Transformation Group (HITG) focussing on Primary Prevention reports to the ICP, established with key priorities including smoking and physical activity.
- Protect NoW used to target multiple groups to address inequalities using PHM systems.

Assurances on controls

Internal: Progress against key national delivery timelines reported and led by appropriate governance structures: Health Inequalities Oversight Group (HIOG), PHM oversight group and PH and Inequalities board.
Quarterly NHSE reporting of NHS Inequalities stocktake
Health Improvement Transformation Group (HITG), Inclusion Health Group, Integration & Partnership team linked to Place
Elective Recovery board monthly report on waiting lists per decile of deprivation index
Analysis of patients on admitted elective waiting lists has not detected any systemic health inequalities
Health Needs Assessments for Inclusion Health groups developed to be published on JSNA

External: Health & Wellbeing Partnerships, Place Boards, Clinical and Operational steering groups

Gaps in controls or assurances

- HI & PHM strategies identified as objectives in JFP due to be completed by March 2024
- Duplication of effort, energy and resources at Place and system level – lack of coordination of all mechanisms to address inequalities, further alignment required with partners and ICS governance structures.
- Capacity and lack of data – poor co-ordination relating to HI across the system, particularly with reference to Core20+5 & VCSE integration agenda, resources in wider system (i.e. local government) to support agenda.
- NHSE HI funding not ring-fenced to support emerging work programmes and respond to system priorities.
- Evaluation methodology for key work programmes – support required to ensure impact measurement

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
03/03/23	Population Health and Inequalities Board set up April 23	B	Complete

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	12	12									
Change	→	→	→									

BAF07

Risk Title	RAAC Planks
Risk Description	There is a risk of failure of the current roofing structures at two Norfolk and Waveney Acute Trusts due to their composition with RAAC Planks which are now significantly beyond their initial intended lifespan. This could affect the safety of patients, visitors and staff. The rolling programme of inspections and remedial work to detect and mitigate this also presents a risk to the system through the requirement to close areas for remedial work, further impacting patient and staff experience as well as the ability to deliver timely urgent, emergency and elective care to our patients.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Steven Course	Board/Finance Committee	Steven Course	01/07/2022	31/03/2024

Risk Scores

Unmitigated			Mitigated			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**5**	**25**	**4**	**5**	**20**	**3**	**5**	**15**

Controls

- Trusts have robust plans in place to manage a possible incident; however these only cover immediate evacuation and not reprovision
- Regional RAAC response plan is established
- Regular surveys and assessments are being carried out to determine the severity of the issue and to identify and address signs of deterioration.
- Region-wide scoping piece commissioned to look at ongoing service transition and recovery.
- Current work ongoing to address issues found on inspection as issues identified. Each issue is separately risk assessed using NHSE led guidelines for 'Best Buy' hospitals and a RAACter Scale used to assess level of issue.
- Legal position and recommendations provided by Browne Jacobson on ICB responsibilities should there be a catastrophic failure at either acute.

Assurances on controls

Internal: SMT, EMT, ICB Board

External: ICS Boards, Estates, NHSE/I, Individual trust boards

RAAC related exercises have been undertaken to provide assurance of plans and procedures in responding to an evacuation of a RAAC impacted trust.

- Feb 22 - Exercise Farthing
- Jun 22 – Exercise Walker
- Nov 22 – Exercise Fox

EPRR Core Standards incorporated a Deep Dive on health providers Evacuation and Shelter arrangements specifically due to the RAAC risk

Gaps in controls or assurances

- Lack of approval of region-wide scoping piece prevents full evaluation and plan of service transition and recovery

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
16/02/22	Scoping piece to assess service transition and recovery post RAAC failure to concluded	G	ongoing
05/06/23	QEH approved for New hospital	G	ongoing

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	20	20	20									
Change	→	→	→									

BAF08

Risk Title	**Elective recovery**
Risk Description	The number of patients waiting for elective treatment in Norfolk and Waveney grew significantly during the pandemic. There is a risk that this cannot be reduced quickly enough to a level that meets NHS Constitutional commitments. This would also contribute to poor patient experience and may lead to an increased clinical harm for individual patients resulting from prolonged waits for treatment.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Dr Frankie Swords	Quality & Safety	Sheila Glenn	01/07/2022	31/03/2024

Risk Scores

Unmitigated			Mitigated			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**4**	**4**	**16**	**3**	**4**	**12**

Controls	Assurances on controls
• The Elective Recovery Board meets bi-weekly to oversee all workstreams to improve performance and reduce harm. • Each Provider has completed waiting list clinical validation, with all patients clinically prioritised. • Unified process of clinical harm review and prioritisation in line with national guidance. • Workstreams in place to expand capacity, share learning, maximise efficiency and reduce variation in waiting times, including through mutual aid, and to transform care pathways to accelerate elective recovery, each led by a chief operating officer or medical director. • EoE funding secured for mutual aid administrative support to contact long wait patients to confirm availability, signpost to While You Wait website and confirm if transfer to alternative provider via mutual aid • EMT agreement to commission elective capacity through independent sector providers. • Trusts expected to ensure zero 65+ week waits for non-admitted patients by end Nov in order to ensure delivery of admitted March 2024 target.	Initial focus to clear all patients waiting 104 weeks was met by 1 July 2022. The next focus to clear all waiting more than 78 weeks was missed by 292 patients for 1 April 2023. Trusts providing trajectories to ensure delivery of zero 65-weeks by end Mar 24 with additional focus on clearing remaining 78-weeks by end June 23. QEH de-escalated from Tier 2 to non-tier in Feb 2023. **Internal:** Weekly and monthly performance metrics for each workstream scrutinised at biweekly elective recovery board. **External**: Trust Board Governance processes and returns to NHSEI, National contract monitoring by NHSEI and Elective Recovery Board. Weekly Tiering KLOE return from Trusts to system, region, and national teams, monitored through fortnightly Tiering meetings

Gaps in controls or assurances

- Cessation/ reduction of elective activity due to RAAC plank works at JPUH and QEH.
- Impact industrial action on elective recovery.
- Administrative resources to support validation and booking processes
- Diagnostic activity remains within block: limits opportunity to maximise use of ISP capacity

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
19/06/23	JPUH escalated to Tier 2 for elective recovery: NHSE led tiering meetings in place. Trusts predicting zero 104+ week waits by end of June.		

	JPUH predicting x120 78-week breaches by end of June – challenges in gynaecology, ENT due to consultant staffing issues. NNUH predicting x208 breaches, mainly T&O and gynae. NHSE expecting hard stop of zero 78-week breaches by end of July, however NNUH predicting clearance by end of August due to impact of further IA.											
Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	16	16	16									
Change	→	→	→									

BAF09

Risk Title	NHS Continuing Healthcare
Risk Description	There is a risk that NHS Continuing Healthcare (CHC) funded packages will not be filled by the provider either due to the complexity of the care required and/or their capacity or the proposed cost of care. If this happens significant pressures will be placed on the CHC nurses to source a package of care. Staff vacancies and absences may increase and the infrastructure to support provision of safe and effective care packages will be compromised. This may lead to increased financial cost to secure a care package, could impact on hospital discharges and admissions and poor outcomes for people requiring NHS funded care in the community.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Tricia D'Orsi	Quality & Safety	Paul Benton	01/07/2022	31/03/2024

Risk Scores

Unmitigated			Mitigated			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**4**	**4**	**16**	**3**	**3**	**9**

Controls

- Recruiting to vacant posts within the CHC team to support assessments and care sourcing.
- Commence work with finance team and contract team in NWICB and Local Authorities (LAs) to work to stabilise the market.
- Link with Local Authority (LA) workforce teams to support care providers in additional training and support required.
- Regular financial updates to Finance Committee and Executive Management Team (EMT) to monitor impact of cost of care packages.
- Monthly operational finance meetings for Quality in Care (QiC) team.
- Monitoring of time taken to secure complex care packages and escalation process for CHC team if unable to source.
- Attendance at regional meetings to support feedback and sharing of good practice and innovation.
- CHC Business Intelligence (BI) has developed relevant pictorial data sets for analysis which are included in the monthly QiC Quality report for the Quality & Safety Committee.
- Weekly meetings held with Norfolk and Suffolk NHS Foundation Trust (NSFT) and NCC to improve communication and partnership working around discharge planning. Complex discharges from acute mental health hospital beds are progressively delayed by lack of suitable complex care in the local provider market.
  Contracting, Finance and CHC teams collaborating to share relevant information regarding uplifts.

Assurances on controls

Internal: Senior Management Team (SMT); EMT; Quality & Safety Committee; Finance Committee; Board

External: NHS England/Improvement; Regional CHC Team, Joint Collaborative Forum (Norfolk County Council (NCC)), Care Market Cell (Suffolk County Council), System partners

Gaps in controls or assurances

- Ability to source and retain suitable workforce for either the NWICB CHC team or care provider market
- Lack of a whole system Care Workforce Strategy
- Ability to stabilise the care market post Covid-19 and EU Exit
- Capacity of CHC team to source or revise care packages
- From 30/06/22, funded Discharge to Assess pathway 3 ceases. CHC team does not have staff resources to manage the extent of workload that will require progressing.
- Following the CHC contract procurement in October 2022, as at 02/09/22, there are 125 CHC eligible individuals with ICB commissioned care who do not have a provider with a current NHS contract. We currently continue to commission new packages of care with some of these providers.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
11/02/22	Active recruitment into newly established roles to enhance the team's capacity and maximise clinical functionality of the team. Eight new commissioning support officers and two nurses.	B	21/06/23 Complete.
14/04/22	NSFT Discharge to Assess model to continue; currently funded through CHC. Case made to make this BAU, costing and evidence of effectiveness, shared with executive team.	B	21/06/23 Complete.
21/06/23	The ICB is working very closely with NCC to establish models of joint commissioning and agreed funding streams to apply stability into the care market. We are currently working with a consultancy firm to identify the next steps for this process.	G	30/09/23

Visual Risk Score Tracker – 2023/24												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16	16									
Change	→	→	→									

BAF10

Risk Title	**EEAST Response Time and Patient Harms**			
Risk Description	Clinical risks to patients awaiting ambulances in community – C1 and C2 response times including inability to undertake rapid release of ambulances. System-wide pressures continue affecting ambulance handover and inter-facility transfers resulting in patient harms.			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Tricia D'Orsi / Mark Burgis	Quality & Safety	Karen Watts	01/07/2022	31/03/2024

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**4**	**4**	**16**	**3**	**3**	**9**

Controls

- Daily sit-rep ensures ICB is sighted on real-time demand and resource.
- HALO role across all Acute sites to support Emergency Departments (ED).
- 999 / 111 multi-disciplinary approach via CAS at IC24 to manage some ambulance calls and dispositions
- Pre-alert and 'drop and go' processes in place with safety netting for patients waiting to be seen. Ambulance revalidations embedded.
- Proactive public comms to promote appropriate use of NHS service options. This is reinforced across seasonal campaigns.
  UEC Tactical Group continues to review system-wide SIs and identify trends / themes.
- Interfacility transfers have improved with processes in place between organisations.
- The system is now in OPEL 3, with NNUH remaining at OPEL 4. Improvement in offload delays and ambulance response times is reflected in reduced adverse incidents. This prompts a reduction of risk at M1 (2023-24).
- Position continues to improve with a improvement in C1 and C2 ambulance response times and reduced reporting of adverse incidents. Ambulance handover into ED is showing early signs of improvement, however this needs to embed and sustain before further risk reduction.

Assurances on controls

Internal: EMT, N&Q Senior Team, ICB Clinical Lead for UEC and UEC Commissioning Team, ICB Quality and Safety Committee, ICB Board, Provider Governance Forum.

External: Regional Commissioning Consortium, NHSE Regional Team, OAG and CQC.

Gaps in controls or assurances

- The Trust has seen prolonged periods of high activity. System-wide pressures impact on the ability of ambulances to handover patients at Emergency Departments (ED) and release to respond to new calls in a timely way. Incidents have been reported by Primary Care, where Health Care Professionals have assessed the need for an ambulance and experienced a significant delay in response, however this has reduced in recent months. Incidents have also previously occurred where inter-facility transfers e.g., from local acute hospitals to tertiary centres for specialist care have been delayed, however mitigations across organisations have been successful in closing this as a specific risk.
- Discharge pressures, with high numbers of patients with no criteria to reside, are improving but still impacting on patient flow through the acute hospitals.
- Significant challenge remains in social care re: capacity and workforce required to support packages of care in the community.
- EEAST continues to experience workforce challenges in relation to recruitment, retention, wellbeing and morale.

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**
21/09/21	Monitoring of Serious Incidents and associated harms. System-wide operational meetings in place daily with on-call arrangements to manage system pressures. System-wide focus on handover delays due to risk of harm to patients. UEC Tactical Group in place to enable systemwide learning and solutions. Critical incident declared on 03/10/22 and daily rhythm of Gold Command meetings in place. This is now business as usual.	**B**	31/03/23
04/11/22	Five core management pillars (cross-reference BAF02) are in place to support a system response. This is now business as usual.	**B**	31/03/23
10/01/23	Decompression measures continue to be utilised at each site (cross-reference BAF02). Escalation plan required to reduce use of escalation beds.	**G**	31/03/24

Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	16	16	16									
Change	↓	→	→									

BAF11

Risk Title	**Achieve the 2023/24 financial plan**
Risk Description	If the ICB does not deliver the 2023/24 Financial Plan of a break-even position, then the ICB may not be able to maintain spending on current levels of service, or to continue with plans for further investment. This may lead to a reduction in the levels of services available to patients

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Steven Course	Finance	Emma Kriehn Morris	10/05/2023	31/03/2023

Risk Scores

Unmitigated			Mitigated			Tolerated (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**4**	**4**	**16**	**3**	**4**	**12**

Controls	Assurances on controls
• Monthly monitoring of risks and mitigations, reported to NHSE/I. • Detailed plan for 2023/24 approved by Board and submitted to NHSE/I as part of the break-even system plan. Monthly Finance Report presented to Finance Commitiee and Board.	**Internal:** Board Reports and Minutes, Audit Committee reports and Internal Audit work plan, Finance Committee reports, Executive Management Dashboards, Delegated Budget manager review, Internal monthly review of Risks & Mitigations. **External**: ICB assurance process, early flagging of risk with NHSE/I and Protocol conditions.

Gaps in controls or assurances

- No contingency reserve in plan;
- £75m of unmitigated risks against the plan at the point of final submission, of which £52.2m (70%) assumed credits embedded within the plan relating to Efficiencies and project slippage;
- As at M02 (May 2023) £6.2m of the £75m has crystalised (8%) in the reported forecast leaving a planning assumption risk of £68.8m (92%).
- In addition to Planning Assumption Risks a further £5.7m of Net Risks have been noted at the end of M02 (May 2023) resulting in a total risk of £74.5m

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
16/06/23	Review of M02 year to date performance and assess forecast out-turn evaluated risks and mitigations.	G	Monthly to 31/03/24

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16	16									
Change	↑	→	→									

BAF11A

Risk Title	Underlying deficit position			
Risk Description	If the ICB underpins its financial position via non-recurrent funding, then, this provides a risk to future years financial sustainability due to lower allocations based on historic expenditure.			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Steve Course	Finance	Emma Kriehn Morris	01/07/2022	31/03/2024

Risk Scores

Unmitigated			Mitigated			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**5**	**4**	**20**	**3**	**4**	**12**

Controls	Assurances on controls
• Monthly monitoring of Forecast underlying Deficit throughout the year. • Analysis and understanding of underlying recurrent position, including drivers of the deficit. • ICS Medium Term Financial Model is being developed on standard assumptions. • A detailed ICB Medium Term Financial Model is being developed on assessed Risks & Mitigations.	**Internal:** Board Reports and Minutes, Audit Committee reports and Internal Audit work plan, Finance Committee reports. **External:** ICB assurance process, early flagging of risk with NHSEI and Protocol conditions.

Gaps in controls or assurances

- The ICB has an underlying deficit position with no plan at present to bring to a break-even position in the short term. The protocol condition which would be applied on a deficit forecast would require a very swift recovery of no greater than one financial year

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
16/06/23	Develop ICS and ICB medium term financial plan to determine likely future underlying position.	G	30/09/2023
16/06/23	Identify mitigations to risk in plan to include unidentified efficiencies. Ensure new schemes deliver on a recurrent basis.	G	30/09/2023

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	20	20	20									
Change	→	→	→									

BAF19

Risk Title	Discharge from inpatient settings
Risk Description	There is increased risks to patients no longer meeting the "Criteria to Reside" in both acute and community hospitals. The causes are many including significant vacancies in discharge hubs; variation in the quality of discharge documentation; a 40% shortfall in the availability of Pathway 1 domiciliary care services; insufficient resources on wards to keep people active; and insufficient pathway 2 & 3 beds. These delays leaving hospital lead to a syndrome of deconditioning as people significantly reduce their activity (less than 400 steps a day) leading to reduced functional ability, muscle wasting etc as well as worsening cognition and mood negatively impacting on the activities of daily living.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Tricia D'Orsi	Quality and Patient Safety Committee	Danny Edmonds	25/10/22	31/03/24

Risk Scores

Unmitigated			Mitigated			Tolerated (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	3	15	4	3	12	2	3	6

Controls	Assurances on controls
• Daily review of all system discharge delays. • Escalation process for problems. • Deconditioning and reconditioning programmes have had good buy in from staff across sites and we have commissioned Exercise Trainers across multiple sites as a result of the regional Deconditioning Games. • Single agreed system dashboard established. • New Transfer of Care form and processes approved for use across system Patient Transport meeting weekly x3 (one for each site). • The system has committed to commissioning of the Optica system, planned implementation starting in October 2023; this has the potential to reduce length of stay and streamline system data.	**Internal:** ICB Executive Management Team; UEC Board; Discharge Programme Board; Discharge Steering Group; ICB Quality and Safety Committee; Bi-weekly Discharge Touchpoint Meeting. Daily IMT and weekly Patient Transport Meetings. **External:** Trust Boards; 3 x Acute System Operations, Resilience and Transformation Boards; Serious Incident Gold Group; Serious Incident Tactical Group; NHSE Board Assurance Framework.

Gaps in controls or assurances

- Insufficient capacity within existing care market.
- Workforce pressures. Staff sickness and absence combined with unfilled vacancies and difficulties recruiting to key posts. This is improving due to longer term contracts being offered, but is still a risk, particularly for Acute hospitals.
- Underutilisation of criteria led discharge. This is currently a system priority.
- 7-day working needs to embed fully. This is improving but is still a risk.
- Managing workforce capacity in community settings to meet changes in demand and surges. This is showing signs of recovery, as recruitment is improving.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
9/11/22	Roll out of criteria lead discharge to all wards has commenced.	A	30/09/23
9/11/22	Establish task and finish group to explore strengthening the role and contribution the VCSE sector can make to discharge. System workshop took place on 07/06/23.	G	31/07/23
22/06/23	Additional ICB beds funded to commence 01/07/23. 12 in West, 23 in Central and 13 in East. These will support pathway 2 discharges. Funding runs until end of December 2023.	G	14/07/23
22/06/23	New allocation of £2.69m into the system has been utilised to increase pathway 2 capacity, over 2023-24 quarter 2 and 3.	G	14/07/23

22/06/23	System awarded capital investment for modular build at NCH&C, with a potential of 48 beds. Planned to mobilise in January 2024.								G	31/01/24		
Visual Risk Score Tracker – 2022/23												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	15	12	12									
Change	→	↓	→									

Norfolk and Waveney ICB aim: To make sure that you only have to tell your story once

Principal risk: That people in Norfolk will have their time wasted due to lack of integration and poor data sharing between different providers of health and care. This could lead to frustration for patients and staff, and introduce errors due to multiple handovers of information

Summary of risks

Ref.	Risk Title	Risk Owner / Operational Lead	Date risk identified	Target delivery date	Score at target delivery	2023-2024 Monthly Risk Rating											
						1	2	3	4	5	6	7	8	9	10	11	12
BAF12a	Impact on Business Continuity in the event of a large-scale Cyber Attack on N365 National Tenant	Ian Riley	01/03/2023	31/03/2024	6	8	8	8									
BAF12b	Impact on Business Continuity in the event of a Cyber Attack on the ICB	Ian Riley	01/03/2023	31/03/2023	6	9	9	9									
BAF13	Personal data	Ian Riley	01/07/2022	31/03/2023	6	12	9	9									

BAF12a	
Risk Title	**Impact on Business Continuity in the event of a large-scale Cyber Attack on N365 National Tenant**
Risk Description	Current heightened risk of hostile cyber-attack affecting the UK may, via a ransomware, brute force, DDOS (Distributed denial of service) or social engineering attack, impact on the ICB's ability to maintain business continuity, if access to data stored within Office 365 on the national NHS tenant, is compromised.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Ian Riley	Board	Anne Heath	01/03/2023	31/03/2024

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**2**	**4**	**8**	**2**	**3**	**6**

Controls	Assurances on controls
• NCHC are already signed up to receive CareCERT alerts. Remedial action is implemented where necessary • Windows 10, Threat Protection and MDE are in place for ICB and Primary Care devices • Secure boundary protection is in place • Ivanti, SCCM patching process to prevent Ransomware getting on the network The process for accessing the out of hours support provided by NHS Digital to resolve major incidents will be established • As of November 2022, NHSMail is protected by Microsoft Safe Links & Attachments • The local Cyber Resilience group provides early access to Cyber intelligence allowing organisations in the local health community to be better prepared for cyber-attacks. • Annual IT Health checks (Penetration tests) undertaken to identify weaknesses in ICT/Cyber controls • SDWAN (Software Defined Wide Area Network) implemented across the ICB • The ICB's ICT provider are an exemplar in terms of Cyber Security • Leaver processes for NHS mail accounts are now standardised for the ICB so all leavers have their NHS Mail accounts disabled • MFA mandatory for non ICB Staff provided with an ICB NHS Mail address	**Internal:** Cyber Security Assurance Manager, Head of Digital, IG Working Group, NWICB N365 Technical Workstream Delivery Group **External**: National Cyber Security Operations Centre, NHSE, NCHC, MTI Technology Limited (technical partner to NHSE)

Gaps in controls or assurances

- Making MFA mandatory for ICB staff provided with an NHS Mail address
- There is no regional Cyber Security Operations Centre (CSOC) available to provide expert technical resource to support business continuity, data recovery and cyber breach remediation – although there is evidence of NHSE providing this function to other organisations.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
01/03/23	Work with NCHC as part of their ICB IT Service Delivery to roll out MFA to all ICB staff before 31/03/24 deadline. how to get help if you have fallen for a phishing email		31/03/24
01/03/23	Ensure a confirmed position from NSHE that they would provide		21/08/23

	techncial resource to support business continuity, data recovery and cyber breach remediation	

Visual Risk Score Tracker – 2023/24												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	8	8	8									
change	→	→	→									

BAF12b	
Risk Title	**Impact on Business Continuity in the event of a Cyber Attack on the ICB**
Risk Description	Risk via a Phishing attack on the ICB which could result in a data breach of patient/personal information and/or financial extortion. This could happen through one of the following top three risks identified by the IG Working Group: - 1. Ransomware attack 2. Lack of user awareness Phishing/social engineering

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Ian Riley	Board	Anne Heath	01/03/2023	31/03/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**3**	**3**	**9**	**2**	**3**	**6**

Controls	Assurances on controls
• From March 2024 MFA on NHS Mail will deploy as part of national policy from NHSE (MFA pilot for Digital IG Data and Finance staff being delivered) • NCHC are already signed up to receive CareCERT alerts. Remedial action is implemented where necessary • Windows 10, Threat Protection and MDE are in place for ICB devices • Secure boundary protection is in place • Since November 2022, NHSMail is protected by Microsoft Safe Links & Attachments • InTune with mobile device management rolled out to staff using ICB issued and personal devices to access NHS Mail and MS Teams. • MFA mandatory for non ICB Staff provided with an ICB NHS Mail address. • Cyber security behaviour change support and awareness package with clear guidance developed to include: ➢ how to spot and report a phishing email ➢ how to get help if you have fallen for a phishing email ➢ campaign to improve password security ➢ campaign to raise awareness of giving your data away on social media ➢ campaign to encourage self-enrolment for MFA ➢ provision of a channel dedicated to cyber awareness and information	**Internal:** Cyber Security Assurance Manager, Head of Digital, IG Working Group, NWICB Technical Workstream Delivery Group **External**: National Cyber Security Operations Centre, NHS Digital, NCHC, MTI Technology Limited (technical partner to NHSE)

Gaps in controls or assurances
• MFA mandatory for ICB provided with an NHS Mail address • There is no regional Cyber Security Operations Centre (CSOC) available to provide expert technical resource to support business continuity, data recovery and cyber breach remediation – although there is evidence of NHSE providing this function to other organisations.

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**

01/02/23	Conduct Phishing Simulation to test user awareness of Phishing, providing specific Phishing Awareness training to those members of staff who click links and/or enter their credentials		21/08/23
01/03/23	Work with NCHC as part of their ICB IT Service Delivery to roll out MFA to all ICB staff before 31/03/24 deadline.		31/03/24
01/03/23	Ensure a confirmed position from NSHE that they would provide technical resource to support business continuity, data recovery and cyber breach remediation		21/08/23

Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	9	9	9									
change	➔	➔	➔									

BAF13

Risk Title	Personal data
Risk Description	There is a risk that the ICB's constitution and statutory / delegated functions will not permit it to process personal data without consent, since the protection of the current COPI Notice ceased on 30 June 2022; particularly functions that have been stood up during the pandemic. This also includes the risk to the CEfF (the access to controlled financial data pertaining Patient Identifiable Data). The ICB has not as yet been given legal right to access personal confidential data

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Ian Riley	Audit and Risk	Anne Heath	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	5	20	3	4	12	3	3	9

Controls	Assurances on controls
• Guidance from the ICS Establishment CoP suggests that all functions currently conducted by a CCG can transition to an ICB Constitution for NHS Norfolk and Waveney ICB allows for the transition of all functions delivered by the CCG	**External:** ICS Establishment COP and EOE IG ICB Transition Group **External**: IG Working Group and Population Health and Care Operational Delivery Group

Gaps in controls or assurances

- Functions established under the COPI Notice, which the ICB wishes to continue will need to move to BAU with supporting Data Sharing or Data Processing Agreements.
- Buy in from GP Practices to enable the ICB to continue to use primary care data for functions such as the Virtual Support Team, after the COPI Notice has expired.

Updates on actions and progress

Date	Action	RAG	Target completion
11/01/23	PHM team are engaged with practices for signatures of agreements. IG team are seeking regular updates for assurance that agreements are being signed and continue to chase up for these.		31/03/2023
10/01/23	NHSE Section 251 agreement has been extended to September 2023. Invoice validation to be in-housed and ICB has requested a change to ensure the ICB team are covered to continue this processing. The PHM team have an up to date list of practices that have signed up to the data processing contract (awaiting latest list to be sent to IG) which allows the ICB to process data on their behalf. The ICB will not process data for practices that have not signed up. The ICB has initiated and have all acute providers signed up to a PHM data sharing framework which allows for the primary care and acute data to be combined and the ICB and risk stratification supplier to support PHM projects.		

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	9	9									
Change	→	↓	→									

Norfolk and Waveney ICB aim: To make Norfolk and Waveney the best place to work in health and care

Principal risk: That people will not want to work in health and care in Norfolk and Waveney leading to difficulties recruiting and retaining staff. This could lead to difficulties in providing our services

Summary of risks

Ref.	Risk Title	Risk Owner / Operational Lead	Date risk identified	Target delivery date	Score at target delivery	2023-2024 Monthly Risk Rating											
						1	2	3	4	5	6	7	8	9	10	11	12
BAF14	#WeCareTogether People Plan	Ema Ojiako	01/07/22	01/04/24	3	12	12	12									
BAF15	Staff Burnout	Ema Ojiako	01/07/22	31/03/23	4	12	12	12									
BAF16	The resilience of general practice	Mark Burgis	01/07/22	31/03/23	12	16	16	16									
BAF17	Financial Wellbeing	Ema Ojiako	01/08/22	Ongoing	12	12	12	12									
BAF18	Resilience of NHS General Dental Services in Norfolk and Waveney	Mark Burgis	01/04/23	31/03/23	6	12	12	20									
BAF20	Industrial action	Ema Ojiako	14/11/22	31/03/23	6	16	16	12									

BAF14				
Risk Title	**#WeCareTogether People Plan**			
Risk Description	There is a risk that there is failure in the implementation of our *#WeCareTogether* People Plan in respect to improving health and wellbeing, creating new opportunities, maximising skills of our staff and creating a positive and inclusive culture at work. If this happens then we will not achieve our goal to be the 'best place to work'. This may lead to increased sickness and turnover, high vacancies and poor patient care, and our people may experience bullying and discrimination.			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Ema Ojiako	People and Culture	Emma Wakelin	01/07/2022	01/04/24

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	**4**	**16**	**3**	**4**	**12**	**1**	**3**	**3**

Controls	**Assurances on controls**
ICB controls • Staff Involvement group in place provides forum for reps from the ICB to discuss internal topics relating to our people • SMT – review of ToR for this group to ensure the role and remit aligns to requirements of ICB, this will include oversight and management of some people functions • OD plan implementation – Plan has been running for 24 months but would benefit from enhanced resource to address all elements of people within an effective organisation • Director of People has commenced in post and will continue to progress work with ICB DoN and MD to collaborate on workforce transformation • Director of people to Chair ICB People Board and Remuneration, people & Culture Committee for oversight and assurance System Alignment • Monthly Health and Wellbeing Board Systems Leads meeting to respond to the emerging needs and issues in place. • Bi-weekly Workforce Workshops commenced which showcase workforce transformation activity and allow our staff across ICB and ICS to attend to hear more, ask questions, and collaborate on the #WCT programme • Monthly Workforce Governance meetings in place to steer discussions on: growing our own; up skilling staff. *#WeCareTogether* People Plan has over40 key projects to help us achieve our goal. • Inclusive Culture: Monthly EDI Systems Inclusions meeting to; develop a system plan to shape and support an inclusive and just culture; respond to any emerging needs and issues; support focus groups to enable staff to have a voice in shaping this work. *#WeCareTogether* system wide People Plan in place since August 2020.	**Internal:** EMT, SMT, SIG

Gaps in controls or assurances
• Lack of clarity for People Function within ICB – People Director or Director of Governance portfolios to be agreed. Insufficient internal people resource to deliver requirements of people function to ensure the ICB is a healthy and effective organisation. Review of statutory people functions and those required to transform the ICB is underway which will include key risks and mitigations for EMT to review. • Greater focus on internal staff communication and engagement is required • Change in roles for Health and Wellbeing, EDI, and Freedom to Speak up Guardians represents a risk until we identify replacements • Lack of dedicated resource to effectively analyse our 'people data'; a 'people dashboard; that is reviewed and considered with the same scrutiny as operational and financial performance • Lack of significant and consistent progress/focus on WRES standards. • Lack of sight on impact of retention, wellbeing as a result of Covid retirement flight risk, burnout, might undermine our grow, attract and retain strategy. Increasing sickness levels against historic picture. High vacancies and sickness levels.

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**
26/12/21	• We now have 4 workstreams (system recruitment, reducing sickness, bank & agency, e-rostering) mapped to our SOF 4 plan for workforce. These workstreams will be monitored at the monthly system finance meetings and the WDG. These themes will reduce workforce risks on implementation. • System pressures and conflicting priorities for organisations have impacted on the delivery of these programmes resulting in delays and a lack of decision making on core elements of the programmes. • Newton Europe diagnostic work will support plans for a review of HR process and practice with strategic input from Director of People. Director of People has commenced in post and is working with Director of Governance to realign portfolio's	**A**	31/3/23
30/03/22	Workforce Dashboard to monitor high level milestones and assess progress in place.	**B**	Complete
01/04/22	EDI lead commenced in role to support focus on WRES and Inclusion across the system.	**B**	Complete
19/08/22	ICS people plan #WeCareTogether will be refreshed (national mandate) – resource secured to lead this work which will ensure ICB staff are included	**G**	Ongoing
14/11/22	Refresh continues with c250 people engaged since August to review progress since 2020 and consider where updates are required for the #WCT People Plan. Refresh launch planned for early 2023 alongside updated #WCT platform which will develop over time to be a single point of access for people seeking support to join N&W ICS and to reach their potential working with us	**G**	March 2023

Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	12	12	12									
Change	→	→	→									

BAF15

Risk Title	Staff burnout
Risk Description	Burnout is measured by three elements. • Exhaustion - an imbalance between work demands and individual resources. • Individual strain - an emotional response of exhaustion and anxiety, which is heightened by not feeling effective • Defensive coping - changes in attitudes and behaviour, such as greater cynicism System pressures (increasing activity, workforce vacancies, sickness, and resilience) have increased the risk of fatigue and exhaustion. We are seeing increases in poor physical and mental wellbeing, low morale and motivation. The transition from CCG to ICB also presents a risk of staff feeling unsettling and anxious in line with a change process which will require focussed support to lead people. The narrative that we are failing to meet targets (clinical and financial) is constant. Individuals need to feel they are making a difference. This could lead to an increase in staff absence rates (short and longer term), retention and most worryingly significant mental and physical issues. If this happens this could have a significant impact on the services that they deliver.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Ema Ojiako	People and Culture	Jo Catlin	01/07/2022	31/03/23

Risk Scores

Unmitigated			Mitigated			Tolerated (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	1	4	4

Controls	Assurances on controls
• We are seeing an increase in ICB staff requesting support from System Workforce Team – in particular line management culture change, new ways of working, developing teams. • The Staff Involvement Group and Senior Management Team continue to flag issues regarding economic and cost of living rises – agreement to add as a new risk to ICB corporate risk register as the impact of lifestyle pressures will impact on people's resilience and increase likelihood of burnout • Discussion at future EMT regarding the Internal People function is tabled, the incoming People Director is a HR professional and we will seek their guidance on future form and function Despite the 2022 pay increase, with the pension contribution changes some of our staff will be worse off. Add this to the cost-of-living pressures (see BAF17) this could further demotivate	**Internal:** SMT, EMT, ICB Board, Staff Involvement Group, Wellbeing Guardian **External**: ICS Boards, NHSE/I

Gaps in controls or assurances

- Changes in NHS legislation, increased/additional workload and pressures post pandemic
- Issues are not new, they have been enhanced by the pandemic – longer term culture change required to support staff (especially in our approach to Flexible Working to support our people to obtain a better work/life balance)
- Currently no dedicated budget or resource to support health and wellbeing initiatives
- Change in roles for Health and Wellbeing, EDI, and Freedom to Speak up Guardians represents a risk until we identify replacements

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion

October 2021	Established H&WB Champions and Steering Group, utilising NHS H&WB Diagnostic and resources to shape actions and approach • H&WB summit held in September to commence ICS H&WB strategy • Continued support at organisation and system level to support staff wellbeing, this includes a focus on financial wellbeing, and our CV19 Resilience hub for health and social care staff • Presentation at Clinical Director and through Medical Director briefings highlighted H&WB offers in place for Primary Care Workforce, this will also be captured in medical Director Blog in November for a wider audience Business case for ICB to implement Vivup, Employee benefit scheme to be proposed to ICB SMT on 17/11. Other Trusts in ICS already use or are implementing the use of Vivup so this will enable ICB to level up and offer equitable support for our staff	**G**	31/01/23
May 2022	In response to NSS results, pilot new approach to wellbeing conversations, incorporating available resources and support. Fully implement in July 2022	**B**	Complete
May 2022	Communications and engagement review has now completed with findings to be presented to EMT in August/September	**B**	Complete
May 2022	Refocussed Extended Senior Leadership agenda to focus on the People Promise values and to include regular updates and opportunities to receive updates, share information, and collaborate on the change process for the ICB. Meetings now held face to face to encourage collaboration and enhance relationships ICB Leadership Summit to be held 16/11 with EMT and Senior members of the ICB as a starting point in a redesign and development of how EMT and Snr leads work together in the ICB	**G**	September 2022

Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	12	12	12									
Change	→	→	→									

BAF16

Risk Title	**The resilience of general practice**
Risk Description	There is a risk to the resilience of general practice due to several factors including workforce pressures and increasing workload (including workload associated with secondary care interface issues). There is also evidence of increasing poor behaviour from patients towards practice staff. Individual practices could see their ability to deliver care to patients impacted through lack of capacity and the infrastructure to provide safe and responsive services will be compromised. This will have a wider impact as neighbouring practices and other health services take on additional workload which in turn affects their resilience. This may lead to delays in accessing care, increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured general practice services.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Mark Burgis	Primary Care	Sadie Parker	01/09/2020	31/03/2024

Risk Scores

Unmitigated			Mitigated			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**4**	**4**	**16**	**3**	**4**	**12**

Controls	Assurances on controls
• Locality teams and strategic primary care teams prioritised around supporting the resilience of general practice. All practices have previously been supported to review business continuity plans • PCN ARRS (additional roles reimbursement scheme) funding has increased again in 2023/24 • Primary care workforce and training team working closely with locality teams to ensure training available to support practices and PCNs in setting up and maintaining services • Interface group with representation from primary, community and secondary care system partners • Standard contract requirements on interface – gap analysis and action plans, including monitoring being reviewed by contracts team	**Internal:** Executive Management Team, workforce steering group, primary care strategic planning meetings, establishment of new medical operational delivery group **External**: Primary Care Commissioning Committee, NHS England via delegation agreement and assurance framework, Health Education England, Norfolk and Waveney Local Medical Committee

Gaps in controls or assurances

- Practice visit programme, CQC inspections focused on where there is a significant risk or concern
- Vacancies within primary care, workforce, quality and locality teams impacts the level of support which can be provided to practices. Potential for organisational change to also impact on support available going forward
- Continued reports of poor patient behaviour across practices, decrease in patient satisfaction with general practice through GP patient survey, consistent with national position
- Progress on interface action planning process across Trusts impacted by ongoing pressures
- Reporting process for inappropriate transfers of workload from community and secondary care providers to general practice not yet fully utilised by practices, leading to under-reporting of issues
- Workforce and capacity shortages across community pharmacy and dental practices, and ongoing drug shortages, are having an impact on general practice and the rest of the system
- Lack of clarity on primary care budgets leading to delays (or potential ceasing) of work to support resilience and transformation in general practice

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
25/04/23	• CQC inspections have recommenced.		30/06/23

	• Practices have declared QOF and IIF achievement and the finance team is working through QSSP calculations, expect to be able to make payments to practices within QOF deadlines. • Interface reporting procedure has been finalised with input from LMC and interface group members. Themes being reported monthly to interface group. Contracts team leading discussions with Trusts on action planning to prevent inappropriate transfer of work. Radiology requesting programme of work ongoing and slow to progress due to complexities identified relating to national IRMER guidelines • Working through new GP contract requirements to identify where support can be provided. • Updated comms campaign being planned to provide information to patients on clinical triage and the different roles now operating as part of the general practice team • Awaiting final budgets so programmes of work can be finalised, eg resilience funding • Target date and tolerated risk score will be reviewed as part of new BAF group work		
13/06/23	• Support from internal ICB teams for practices rated inadequate or RI continues. Bite size training sessions to share learning are ongoing • 67 practices benefitted from the quality, stability and support payment with a total investment from the ICB of £788,020 • Interface reporting was encouraged intensively for 2 weeks in May to maximise understanding of issues facing practices. Significant increase in reporting with themes reported to the working group. Pace of developing Trust action plans is slow • Ongoing support being provided by locality teams to support development of PCN access recovery plans in line with national contract requirements. System plan under development with regional assurance meetings underway • Attended Norfolk Health Overview and Scrutiny Committee to discuss the issues and ICB plans to support patient access • Comms campaign launched with focus on the additional roles forming part of modern general practice • Agreement of final primary care budgets still awaited, causing delay to some areas of work • Publication of national guidance to support investment of primary care system development funding to enable delivery of system and PCN access recovery plans, however budget availability may impact on this		30/09/23

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16	16									
Change	→	→	→									

BAF17				
Risk Title	**Financial wellbeing**			
Risk Description	There is a risk that in the current climate staff will become increasingly under pressure to maintain cost of living. As well as financial wellbeing, this will also impact on peoples physical, mental and social wellbeing – which is likely to impact on resilience and productivity at work. People may also consider alternative employment which offers more flexibility or increased income, take on secondary jobs, or access other avenues outside of workspace to increase financial wellbeing. We also anticipate this will affect working arrangements – for example, reluctance to attend f2f meetings because of fuel or parking costs, or an increase in requests for office working in the winter to reduce personal heating bills which will affect the space available at our sites (e.g. NCC).			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Ema Ojiako	People and Culture	Emma Wakelin	01/08/2022	ongoing

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	**4**	**16**	**4**	**3**	**12**	**4**	**4**	**12**

Controls	Assurances on controls
• Monthly Staff Involvement Group Meetings in place with representation from all Directorates provides a safe space to highlight risks and issues for staff wellbeing that can be responded to • Weekly staff briefings will have regular inputs from SIG members with information and guidance for support and to demonstrate that we hear and are doing what we can to support staff needs • Recognition that financial wellbeing can affect any member of staff regardless of salary – SMT and EMT to recognise this to ensure compassionate and mindfulness to all staff • Identification of an Employee Reward and Benefit Programme. Many other organisations in our system offer this but the ICB does not have anything in place. They also offer an integrated Employee Assistance Programme (EAP) to support wellbeing and advice on financial management. We do have an EAP which we currently pay for, but sits in isolation under HR. Perhaps not utilised as much as it could be. Plans will include potential alignment to ICS Partner organisations to maximise offer for our system workforce. • Close working with ICS partner organisations coordinated through the ICB System Associate Director of Workforce Transformation and HRD network. This includes a T&F group for financial wellbeing with reps from NHS Providers, LA, and ICB. EoE Regional Teams (HEE/NHSEI) also provide support, resources and regular updates on national responses.	**Internal:** SMT, EMT, ICB Board, Staff Involvement Group, Remuneration People & Culture Chair **External**: HRDs, N&W People Board

Gaps in controls or assurances
• This is a macro issue, relatively outside of our control. The country's economic climate shows no sign of easing • Currently no dedicated budget or resource to support health and wellbeing initiatives nor a dedicated Health and Wellbeing Co-ordinator with expertise in all elements of wellbeing. This would be beneficial as we currently rely on volunteer HWB champion roles. • Change in roles for Health and Wellbeing, EDI, and Freedom to Speak up Guardians represents a risk until we identify replacements

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**
14/11/22	Review of financial support offers underway – requested by EoE regional workforce team and DoF Network	**G**	18/11/22
Sept 2022	Following a period of engagement and discussions within ICB, business case to implement Vivup – the Employee Benefit Scheme for ICB staff will be presented ICB SMT on 17/11. Other Trusts in ICS already use or are implementing the use of Vivup so this will enable ICB to level up and offer equitable support for our staff. Aim to have this in place for staff to access before 25/12	**G**	24/12/22

Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	12	12	12									
Change	→	→	→									

BAF18

Risk Title	**Resilience of NHS General Dental Services in Norfolk and Waveney**
Risk Description	Primary Care Services became the responsibility of the Integrated Care Board from 1st April 2023, the risk is the unknown resilience, stability and quality of dental services, and critical challenges relating to the recruitment and retention of dentists and dental care professionals and the limitations of the national dental contract, leading to a poor patient experience for our local population with a lack of access to NHS general dental services and Level 2 dental services.

Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Mark Burgis	Primary Care	Sadie Parker	01/04/2023	31/03/2025

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**5**	**4**	**20**	**3**	**2**	**6**

Controls	**Assurances on controls**
• ICB primary care team recruited and in place working alongside newly recruited Quality Dental Nurse in Quality team and Finance colleagues, and Planned Care Team (for secondary care dental services) • Ring fenced dental budget for investment • Active engagement with dental contractors, LDC and Local Professional Network (and Managed Clinical Networks), regular dental newsletter in place • Dental Development Group established to engage with key stakeholders to agree short term plan by Sept 2023 • Dental Services Delivery Group established reporting to PCCC • Dental Strategy and local workforce plan to be in place by March 2024 • NHS England Long Term Workforce plan published June 2023 • NHS Business Services Authority performance/quality management reporting and quality framework in place with regular meetings established with the ICB. Access to eDen dental data management reports and dashboard for ICB staff. • Clinical expertise provided by NHSE through the LPN and Dental Advisor roles for 2023/2024 • Oral Health Needs Assessment in final development to inform commissioning plans	**Internal:** EMT, Primary Care Commissioning Committee, Dental Services Delivery Group **External:** NHS England, Norfolk and Waveney LDC, regional Local Professional Network and Managed Clinical Networks, Healthwatch Norfolk/Suffolk, NHS Business Services Authority

Gaps in controls or assurances

- The level of the unmet need for general dental services and the associated financial consequence of this once addressed (if possible) given the transfer for funds was based on 2022-23 current expenditure which are below budget required to meet population need
- Concern around the financial consequences due to dental contracts currently being returned or removed from providers, resulting in temporary and more expensive contracts with reduced activity and higher UDA (Unit of Dental Activity).
- Lack of access to NHS dentistry services is an area of quality concern. This impacts on some of our most vulnerable patient groups.
- Significant workforce shortfalls across general dental services, Level 2 services and secondary care dental services and a lack of comprehensive workforce data to support planning

- Lack of knowledge about the resilience and stability of existing dental services

Updates on actions and progress			
Date opened	**Action / Update**	**BRAG**	**Target completion**
Jan 2023	As agreed at May Executive Management Team and PCCC, this content of this risk (previously on the transition of services) has been replaced by the resilience of NHS general dental services. Active engagement with the dental profession to understand the challenges they are facing. Monthly meetings with the LDC and LPN established. Dental Development Group has met twice with regular meetings established for 2023/2024 to agree short term commissioning plans by September 2023 and the Dental Strategy by March 2024 Engagement with other ICBs in the region to agree regional approach to commissioning where appropriate and beneficial Workforce data analysis underway. There are no NHS dental practices accepting new NHS patients in Norfolk and Waveney – propose to increase risk rating to 20 due to the current state of provision.		30/09/2023

Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	16	16	20	20								
Change	→	→	↑	→								

BAF20

Risk Title	Industrial Action (IA)
Risk Description	Trade Unions representing NHS staff have advised the Secretary of State for health and Social Care that they are in dispute over the 2022/23 pay award. We have multiple professional groups now engaged in industrial action, including Nurses, Therapists, Paramedics and Junior Doctors. To date, strike action has affected the following local NHS organisations: • NHS N&W Integrated Care Board (ICB) • Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUHFT) • Norfolk and Suffolk NHS Foundation Trust (NSFT) • Norfolk Community Health and Care (NCH&C) The system is also impacted by other strike actions that impact on our staff, including Teachers. There is an ongoing resilience risk, related to consecutive and simultaneous periods of IA.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Ema Ojiako	Quality and Safety	Emma Wakelin & Karen Watts	14/11/2022	31/03/2024

Risk Scores

Unmitigated			Mitigated			Tolerated (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	4	3	12	2	3	6

Controls	Assurances on controls
• Ballot and any strike action that follows must comply with specific legal requirements. There are structured thresholds that need to be met before industrial action can be taken, at least 50% of all members eligible to vote needs to be met before industrial action can be taken. • Only members of a union who have balloted members and received support for strike action in accordance with legal requirements can strike, those who are employed on Agenda for Change terms by an NHS employer. • Only members of a union who are on duty for an employer on strike can strike, employees who are on long-term sick or maternity leave cannot strike. • Employee protection, any employee who takes part in lawful industrial action is protected against unfair dismissal. • NHSE have started negotiations at a national and local level, with established lines of communication with Trade Unions (TU) to manage the impact of any action. • N&W Task and Finish Group for coordination has been set up with strategic oversight of Directors of Nursing (DoNs) and HRD. • Multi-agency exercise planned for ICB and system partners to test emergency preparedness, week beginning 14/11/22. • Communication plan through the national team to ICB Comms Lead in progress. • ICB have reviewed clinical staff for potential redeployment. • As of April 2023 the system has now managed a number of strike days; for nurses, junior doctors, physiotherapists and ambulance staff.	**Internal:** N&W Task and Finish Group, ICB Executive Management Team (EMT), System EMT, Quality & Safety Committee, ICB Board. Emergency Planning and Preparedness meetings. **External**: NHSE regional and national oversight. Directors of Nursing (DoNs) and HRD networks.

Processes are established for System incident command and control. • The Norfolk & Waveney system is managing IA well, mitigating risks and working together to maintain safety.	

Gaps in controls or assurances

- The impact of ongoing industrial action on staff and service users is significant. Impact on recovery of the elective programme and other high-risk areas such as UEC and discharge is as yet not fully known.
- There is the potential for this to impact on health inequalities.
- There is currently a lack of a consistent and streamlined national process for safety derogations, for organisations to follow. This is being mitigated as far as possible by local plans.

Updates on actions and progress

Date Opened	Action / Update	BRAG	Target Completion
14/11/22	NHS England has provided the ICB with advice and guidance on preparations to plan for minimal disruption to patient care, emergency services can operate as normal.	B	31/03/23
14/11/22	Negotiations have commenced at a national and local level to gain a clearer picture on how services will operate on days of strike action to ensure patient safety is not compromised	B	31/03/23
14/11/22	ICB will support Trusts to be prepared by, • Consolidating completion of Trust's self-assessment templates for return in the event of IA. • Set up a N&W Task and Finish Group for coordination with a rhythm of meetings. Strategic oversight by Directors of Nursing (DoNs) and HRD	G	30/09/23
14/11/22	ICB will share information on confirmed industrial action, including information on derogations across the system. • ICB will work with system comms teams and our HRD and DoN networks to ensure information and system planning is consistent across the system including with TUs to manage impact of any action.	G	30/09/23
14/11/22	Testing system preparedness will be coordinated with wider winter planning. Exercise Artic Willow planned for week commencing 14/11/22.	B	21/11/22
14/11/22	Communications will be through ICB Comms Lead content provided by National team including messaging for the public commenced. Guidance and support for decision making around operational delivery and engagement with staff taking industrial action will be shared by the Comms Team.	G	30/09/23
14/11/22	ICB have reviewed clinical staff for potential deployment. Face to face clinical skills training commenced for ICB staff	B	31/12/22

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16	12									
Change	↑	→	↓									

Agenda item: 14

Norfolk and Waveney
Integrated Care Board

Subject:	**Quality and Safety Committee Report**
Presented by:	Aliona Derrett, Quality and Safety Committee Chair Tricia D'Orsi, Executive Director of Nursing
Prepared by:	Evelyn Kelly, Quality Governance & Delivery Manager
Submitted to:	Integrated Care Board Meeting
Date:	18 July 2023

Purpose of Paper

To provide the Board with an update on the work of the Quality and Safety Committee for the period of 30 March to 18 July 2023.

Committee:	**Quality and Safety**
Committee Chair:	Aliona Derrett
Meetings since the previous update:	**01 June 2023,15:00 – 17:00** **06 July 2023, 14:00 – 17:00** A decision was taken to lengthen the Committee meeting, from July onwards.

Overall objectives of the committee:

To seek assurance that the Norfolk and Waveney system has a unified approach to quality governance and internal controls that support it to effectively deliver its strategic objectives and provide sustainable, high-quality care and to have oversight of local implementation of the NHS National Patient Safety Strategy. To be assured that these structures operate effectively, that timely action is taken to address areas of concern, and to respond to lessons learned from all relevant sources including national standards, regulatory changes, and best practice.

To oversee and monitor delivery of the ICB key statutory requirements, including scrutiny of the robustness and effectiveness of its arrangements for safeguarding adults and children, infection prevention and control, medicines optimisation and safety, and equality and diversity. To ensure that patient outcomes from care are collected and measured, to inform outcomes-based commissioning for quality.

To review and monitor those risks on the BAF and Corporate Risk Register which relate to quality, and the delivery of safe, timely, effective, and equitable care. To consider the effectiveness of proposed mitigations and to escalate concerns to risk owners and operational leads/forums as agreed by Committee Members.

To approve ICB arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and secure continuous improvement in quality. To seek assurance that commissioning functions act with a view to supporting quality improvement; developing local services that promote wellbeing and prevent adverse health outcomes, equitably, across all patients and communities in Norfolk and Waveney.

Main purpose of meeting:	**01 June 2023: regular meeting of the Committee covering all standing items plus the following focus areas:** • Infection Prevention & Control Quarterly Update • Ambulance and Urgent & Emergency Care (UEC) Resilience • Mental Health Transformation • ICB Quality Oversight Arrangements • ICS System Quality Group • Update from People & Communities Committee **06 July 2023: regular meeting of the Committee covering all standing items plus the following focus areas:** • Ophthalmology (Eye Care) Waiting Lists • Discharge Transformation Programme • Care Market Support • Children's Neurodevelopment Disorder Pathway • Eating Disorder Treatment Provision • ICS Local Maternity & Neonatal System • Equality and Diversity • Palliative and End of Life Care
BAF and any significant risks relevant / aligned to this Committee:	**Quality and Safety Committee BAF risks:** BAF02: System Urgent & Emergency Care BAF03: Providers in CQC 'Inadequate' Special Measures BAF04: Cancer Diagnosis and Treatment BAF05a: Mental Health Transformation Programme BAF05b: CYP Mental Health Transformation Programme BAF06: Health Inequalities BAF08: Elective Recovery BAF09: NHS Continuing Healthcare BAF10: EEAST Response Time and Patient Harms BAF19: Discharge from Inpatient Settings BAF20: Industrial Action **CLOSED** BAF01: Living with COVID-19 **Quality and Safety Committee Significant Risks:** SR03: EEAST Special Measures & Workforce Resilience SR04: Surge Capacity to Support Local Acute Trusts SR05: Workforce Absence and Moral Injury SR06: Public Trust and Reputational Damage SR07: BCG Immunisation SR08: Eye Care (Ophthalmology) SR09: Elective Long Waits SR10: Care Provider Capacity System-Wide Impact SR11: Compliance with Deprivation of Liberty Standards SR13: Neuro-Developmental Service Provision SR14: CYP Mental Health (Allocation of Case Managers) SR15: CYP Mental Health (Crisis Team Capacity) SR16: CYP Mental Health Waiting Lists SR18: LD CAMHS Psychiatry Provision SR19: CYP Podiatry Provision in Central Norfolk SR20: CYP Speech and Language Therapy Provision SR21: CYP Service Disruption (Changes in Workforce)

	SR22: Digital Maternity Care Records SR26: Deconditioning and Hospital Acquired Infections SR43: Tuberculosis Service Capacity SR44: Wheelchair Service Waiting Times **NEW** SR45:12hr Decision to Admit Breaches: NOF 4 Exit Criteria **NEW** SR46:12hr Decision to Admit Breaches: Patient Experience **NEW** SR47: Familial Hypercholesterolemia Services **NEW** SR48: Lynch Syndrome Pathway (Cancer) **NEW** SR49: Equitable Access to End of Life Care **CLOSED** SR12: 12 Hour Decision to Admit Breaches **CLOSED** SR17: CYP Mental Health Integrated Front Door Committee also has oversight of a small number of risks that do not currently meet the BAF or Significant Risk threshold: • Learning Disability and Mental Health Hospitals Discharge • s117 Mental Health Act Aftercare Personal Health Budgets • Local Commissioning Issues (Community Epilepsy, Community Neurology and Adults Speech & Language Therapies) • **NEW** Maternity & Neonatal Workforce
Key items for assurance/noting:	**Committee Meeting on 01 June 2023** **Infection Prevention & Control (IP&C)** An update was received from the ICS IP&C and Antimicrobial Stewardship (AMS) Partnership, which provides a forum for joined up collaborative working; current system priorities include AMS, C. Difficile and Gram-Negative Infection Reduction and development of a system MRSA Pathway. Committee discussed the risk (SR43) around variation in TB Nurse provision across the system footprint, particularly within West Norfolk. A second briefing paper for the ICB EMT is being prepared and a risk analysis is currently taking place. Antibiotic prescribing remains above target in primary care but well below national averages in secondary care. Targeted work is ongoing by the ICB Medicines Optimisation Team to support Practices and PCNs with outlying prescribing rates. The ICS 'Gloves Off' Project has started to show a significant reduction in unnecessary non-sterile glove use, which has the potential to improve patient experience, and reduce infections, expenditure, and environmental impact. Catheter reduction and hydration projects are also good examples of systemwide targeted quality improvement projects. **Ambulance and Urgent & Emergency Care (UEC) Resilience** Committee was briefed on themes in learning from adverse incidents, impacting on both service users and staff. Risk around delayed interfacility transfers to specialist sites outside of the ICS footprint has been successfully mitigated, with the Acute Integration Project coordinating the alignment of process and pathways across the Hospitals. The Hospital Ambulance Liaison Officer (HALO) roles and EEAST Health Care Professional (HCP) line also continues to have a positive impact. Staff wellbeing and the importance of support for staff was highlighted and plans were discussed around the development of a mechanism for communicating with frontline staff across all providers, about system improvement work. Committee was updated

	on the National UEC Recovery Plan and the key areas of focus for Norfolk and Waveney to improve patient flow and safety. Members discussed the potential for further expansion of the virtual ward, to support admission avoidance as well as discharge. The UEC pathway for people at the palliative and end of life stage was highlighted as requiring focused review. Members reflected on the workforce challenge, noting opportunities to support processes for clinical decision making and the use of advanced practice roles. **Mental Health Transformation** The ICB Mental Health Transformation Team provided oversight of the following redesign and improvement priorities, overseen by the ICS Mental Health Partnership Board: • Transformation of Mental Health Services • Embedding Wellbeing and Crisis Hubs • Alternatives to Hospital for Service Users in Crisis • NOF 4 Exit Plan for 12 Hour 'Decision to Admit' Breaches Committee recommended a review of Population Health Management data to provide insight into the mental health needs of the local population, building on the predictive work on Dementia diagnosis rates that has started to take shape. Committee asked how service user views are being incorporated into the work described above and heard that the Partnership has a dedicated Expert by Experience Reference Group which has been established to help shape the crisis avoidance community initiatives, through the lived experiences and reflections of people who have used these services in the past. The Chair noted that an external evaluation of initiatives would also be beneficial and highlighted the need for the system to proactively promote and empower communities to utilise new services and support. **ICB Quality Oversight Arrangements** The ICB Nursing & Quality Team provided an update on the ICB core functions related to quality surveillance, assurance, and governance. This includes: • Serious Incident Management • Patient Safety Improvement • Continuous Quality Improvement • Infection Prevention & Control The Team is also engaged with clinical elements of procurement, contracting and clinical pathway design and transformation work across the ICB and wider system. Provider Members welcomed the continued development of a collaborative and supportive approach, since the transition from CCG to ICB and reflected that this is working well. Committee Members also received a briefing following the ICS EMT workshop to agree Place approach and priorities for 2023/24; supporting UEC (including admission avoidance) and providing care closer to home for Norfolk and Waveney residents. Committee welcomed an update on progress as this work develops.

	ICS System Quality Group Committee were briefed on the latest System Quality Group escalation report, which was reported into the East of England Quality Group, for the period of April 2023. It was shared as assurance of the SQG function in relation to quality surveillance, early identification of shared risks and quality improvement across the system. Previous escalations were updated: • UEC Resilience and Ambulance Response Times • Impact of Continued Industrial Action • GMC Enhanced Monitoring of Medical Education at NNUH • CQC Section 29a Warning Notice at JPUH Committee also noted that learning from a patient safety incident at an LD Residential Home had been shared with the regional and national teams and safety information around fire risk associated with the use of emollient creams has been re-circulated. New escalations were fed into the regional forum for discussion across systems. This included early learning from the Norfolk and Waveney system Urinary Catheter Quality Improvement Project. The LMNS outlined their local response to the national work around minimising staff exposure to Entonox (Nitrous Oxide) in Maternity settings. The ICB Executive Director of Nursing flagged emerging trends in quality issues being reported within social care settings. **Update from People & Communities Committee** Committee were updated on the work of the ICB Patients and Communities Committee, which provides the ICB Board with assurance that its functions are being delivered in a way that meets the needs of patients and communities; based on engagement and feedback from local people and groups, and which has an active focus on reducing health inequalities. Committee reflected on opportunities for both Committees to support and share priorities across their delegated functions and collaborate on the oversight of service development and improvement. **Committee Meeting on 06 July 2023** **Ophthalmology (Eye Care) Waiting Lists** Committee were updated on the progress of the system waiting list review and planned care improvement programme. The highest risk areas in terms of the potential for harm, continues to be Glaucoma and Medical Retina Pathways, which are the immediate system priority areas. The Chair raised a question around the pace of the work and received assurance that short term mitigations are being scoped to create capacity and strengthen the safety netting of patients, alongside the ongoing pathway transformation objectives. The ICB Executive Director of Nursing asked about how patients on waiting lists can escalate concerns about changes in their vision and Committee heard that this can be undertaken through dedicated emergency phone lines that are in place across the Hospitals, or via Community Opticians who are able to refer into secondary care directly. Committee accepted recommendations, to continue to receive updates on the ongoing risk and the improvement programme.

	Discharge Transformation Programme Committee was briefed on progress against the six priorities of the system programme, developed using the diagnostic work that around length of stay, delayed discharge for patients with no criteria to reside and overall discharge activity and flow: 1. Intermediate Care 2. 'Out of Acute Hospital' Capacity 3. Optica Digital Discharge Management System 4. Hospital Processes and Flow 5. Integrated Transfer of Care 6. Mental Health Discharges Committee reflected on the combined focus on long term transformation and short-term resilience and preparation for Winter 2023/24. Committee discussed the ongoing impact of industrial action and the risk relating to the upcoming Consultant strike. The VCFSE sector and Carer groups continue to be engaged in conversations around discharge support and Place is providing local delivery mechanisms and feedback on plans and interventions. **Care Market Support** Committee received an update from the ICB Quality Improvement Nurses, on their work with the local authority Social Care Quality Monitoring Officers, joining up support and development opportunities for the local care market. Headlines included the collaborative programme of quality visits and assessments, the newly refreshed system Care Market Quality Forum, admission avoidance projects and staff education and 'Champion' programmes. Committee were also briefed on the work of the 'Teaching Care Homes' practice development and research forum. **Children's Neurodevelopment Disorder Pathway** Committee were briefed on the continued challenges in capacity on the pathway, set within the context of growing need. Independent provision procurement to support backlog reduction has been successful, however, the current funding plan is finite, and the backlog continues to increase. Patient choice options were discussed, and a further challenge was identified around quality oversight of services that are not commissioned by the system. Committee reflected on ongoing work to develop the diagnostic pathway and improve the education and support offer, in collaboration with the local authority and education providers. Committee noted and supported the escalation of a paper to the ICS EMT to agree a formal review of the pathway. **Eating Disorder Treatment Provision** Committee received an update on interventions in place to maximise service accessibility, as a response to a sustained increase in need, following pandemic lockdown. This included an increase in specialist staffing, embedding of the FREED First Episode and Rapid Early Intervention Programme, a new bespoke 'Enduring Needs' Pathway and ongoing education and upskilling of the wider workforce to increase understanding and awareness of eating disorders.

	Committee reflected on the significant improvements in 'referral to treatment' times and a downturn in need for hospital admissions and specialist placements, which indicates that these interventions are having a positive impact, with people being able to access support earlier and services working together more effectively. HOSC oversight provides additional scrutiny to this area of service provision and improvements in data collection and quality have strengthened oversight. Committee noted the update and agreed that the risk related to access can continue to be managed within the ICB Mental Health Transformation Team. **ICS Local Maternity & Neonatal System** Committee was briefed on the outcomes of the recent LMNS Board Away Day which identified the direction of travel and response to the national three-year Maternity Delivery Plan, pulling together recommendations and learning from the Ockenden and East Kent reviews. Committee noted that equality and diversity of the Norfolk and Waveney population is central to plans and reflected on the local priorities around prevention of Obstetric Anal Sphincter Injury (OASI), deep dive on prevalence and causes of Pre-term Births and smoke-free pregnancies. Committee heard that the lack of Digital Care Record infrastructure and a national issue with the E3 Maternity recording platform is currently the highest risk to the programme, along with skill-mix and capacity to develop newly qualified Midwives and smoking rates in pregnant people. Committee reflected on the need for more public health focused maternity support roles, to support families to access health improvement initiatives. James Paget University Hospital attended to give an update on their CQC warning notice related to their Maternity Services and heard the progress on a comprehensive governance review and establishment of new roles to support leadership, governance and risk management and safeguarding. The ICB Executive Director of Nursing reflected on the CQC findings and emphasised that there is useful insight and learning for the whole system, across all maternity services, and that system collaboration is required to support JPUH on their improvement journey. **Equality and Diversity** Committee received an update on workstreams delivering focused work around reducing health inequalities for people accessing services. This included: • Spring 2023 COVID-19 Vaccination Programme • Castle Quarter Wellness Hub and Wellness on Wheels Bus • Asylum Seeker Health • Advancing Mental Health Equity Committee noted the Community Voices engagement approach, and the opportunity that these networks offer to collect data and evidence around the quality and accessibility of services, from disadvantaged communities. The Chair requested that the next update include some patient feedback on the initiatives listed above, particularly around the Wellness on Wheels Bus and its mobile health improvement offer. Committee were also briefed on the 'My Story, My Voice, My Words'

	Project to co-create a digital solution for vulnerable, homeless adults who must repeatedly relate the soundtrack of their lives to health and care professionals. Working in partnership with the patient cohort and a local housing trust, this initiative will enable opportunities for individuals to have an audible voice and to develop trusting relationships with primary care teams. **Palliative and End of Life Care** Committee received a comprehensive update on work of the planned care programme, which delivers the ICB statutory responsibility for the development of Palliative and End of Life Care Services with a focus on understanding and reducing unwarranted variations in provision, improving quality, and developing and future-proofing the specialist workforce. Committee reflected on the opportunities provided by Place-based working, to develop bespoke models of delivery that work for local communities, while delivering consistent and equitable outcomes. Committee discussed opportunities to improve processes around primary care and prescribing and noted that the ICB Medicines Management Team is leading this area of work. Committee reflected on the importance of considering health inclusion groups within this work and linking with children's hospices to look at quality and resilience of services across age groups. Excellent work in the children's space was acknowledged.
Items for escalation to Board:	No additional escalations were requested. See risks and issues noted above.
Items requiring approval:	Committee approved the following ICB policies: • **New** ICS Infection Prevention & Control Strategy (June 2023) • **New** ICB Quality Visit Protocol (July 2023)
Confirmation that the meeting was quorate:	**Quoracy (as per Governance Handbook):** there will be a minimum of one Non-Executive Board Member, plus at least the Director of Nursing or Medical Director. The June and July 2023 meetings were quorate, as defined above.

Key Risks	
Clinical and Quality:	This report highlights clinical quality and patient safety risks and mitigating actions.
Finance and Performance:	Finance and performance are intrinsically linked to quality, in relation to safe, effective, and sustainable commissioned services.
Impact Assessment (environmental and equalities):	N/A
Reputation:	See above.
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A

NHS Constitution:	The report supports the clinical quality and patient safety elements of the NHS Constitution.
Conflicts of Interest:	Committee member's interests are documented and managed according to ICB policy.

Norfolk and Waveney
Integrated Care Board

Agenda item: 15

Subject:	**Finance Committee Report**
Presented by:	**Hein van den Wildenberg, Non-executive Member, Finance Committee Chair**
Prepared by:	**Emma Kriehn-Morris, Interim Director of Commissioning Finance**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**18 July 2023**

Purpose of paper:

To provide the Board with an update on the work of the Finance Committee up to including the 5th July 2023

Committee:	Finance Committee
Committee Chair:	Hein van den Wildenberg
Meetings since the previous update	Last update provided: 30.05.2023 Subsequent Meetings: 25.04.2023
Overall objectives of the committee:	The objective of the committee is to contribute to the overall delivery of the ICS objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan and strategy, consistent with the ICS Strategic Plan and its operational deliverables.
Main purpose of meeting:	To gain assurance on the financial position of the (NHS entities in the) ICS and ICB.
BAF and any significant risks relevant / aligned to this Committee:	BAF 11 – Achieve the 2022/23 financial plan BAF 11A – Underlying deficit position
Key items for assurance/noting:	The main items discussed at the Finance Committee were as follows, **<u>(NHS entities in) ICS</u>** 1. The position year-to-date at May (Month 2) is a £11.7m deficit, which is £4.4m adverse against the plan. Whilst presently all six organisations report a full year forecast of break even, there remain signficant risks to this delivery.

	The committee will monitor closely in the months ahead the expenditure trajectory versus budget. 2. The Year-to-Date system CDEL (Capital) expenditure as at May (Month 2) was £6.2m, £3.7m below plan, due to slippage/delays in project roll-out and RAAC schemes. **ICB** 1. The ICB has reported a year to date (Month 2) break-even position, and forecasts a full year break even position. 2. The estimated value of potential risks to the full year position amounts to some £75m, these are items which have not yet crystalised but have been identified as having the possibility of causing a financial issue.
Items for escalation to Board:	1. The ICB significant financial risk in the 2023/24 financial plan.
Items requiring approval:	None
Confirmation that the meeting was quorate:	Confirmed the meeting was quorate.

Key Risks	
Clinical and Quality:	Not applicable
Finance and Performance:	It is important that there is scrutiny of financial management of the ICB and this function is performed by the Finance Committee.
Impact Assessment (environmental and equalities):	Not applicable
Reputation:	Ensuring effective committees and order of business essential for maintaining the reputation of the ICB
Legal:	Finance Committee is a statutory committee of the ICB.
Information Governance:	Not applicable.
Resource Required:	None.
Reference document(s):	Not applicable.
NHS Constitution:	Not applicable.
Conflicts of Interest:	Not applicable.

Main messages for Finance Committee report to ICB Board.

The points below follow from the July 4 finance committee.

Part 1 (System overview: NHS entities within ICS)

- The position year-to-date at May (Month 2) is a £11.7m deficit, which is £4.4m adverse against the plan. Whilst presently all six organisations report a full year forecast of break even, there remain signficant risks to this delivery.

- Factors impacting the year to date deficit include phasing of efficiency delivery and the impact of industrial action.

- The estimated net value of potential risks to the full year position amounts to some £110m, these are items which have not yet crystalised but have been identified as having the possibility of causing a financial issue

- The agency costs for the first two months are some £ 10m, some £ 3m over budget. The forecast agency costs for the year is £ 10m over budget, largely occurring within one acute hospital.

- A Spotlight was held on the Norfolk & Norwich University Hospital (NNUH), where the NNUH CFO provided further detail on the current financial year outlook, and the recovery trajectory for coming years.

  Pressure points year to date include delivery efficiency schemes, and impact of industrial actions on pay and income loss, and use of independent sector to achieve activity.
  .
  The committee heard that the Elective Recovery Fund, which is presently foreseen to end in 24/25, has a significant impact on NNUH's financial recovery.

Part 2 (ICB specific)

- The ICB has reported a year to date (Month 2) break-even position, and forecasts a full year break even position.

- The estimated value of potential risks to the full year position amount to £74.5m, these are items which have not yet crystalised but have been identified as having the possibility of causing a financial issue. These include as yet unidentified efficiency savings and reliance on investment slippage.

- Spotlights covered included:

  - Efficiency and Transformation Schemes

  - ICB Pay costs

Norfolk and Waveney
Integrated Care Board

Agenda item: 16

Subject:	**Primary Care Commissioning Committee Report**
Presented by:	**Hein van den Wildenberg, Non-Executive Member**
Prepared by:	**Sadie Parker, Director of Primary Care**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**18 July 2023**

Purpose of paper:

To provide the Board with an update on the work of the Primary Care Commissioning Committee for the June and July 2023 meetings.

Committee:	Primary Care Commissioning Committee
Committee Chair:	Deputy chair is Hein van den Wildenberg, Non-Executive Member
Meetings since the previous update on 28 March	12 June 11 July
Overall objectives of the committee:	The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act, and since 1 April 2023 the commissioning of dental, pharmaceutical and optometry services under a Delegation Agreement with NHS England.
Main purpose of meeting:	To contribute to the overall delivery of the ICB's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to bring care closer to home and to improve and transform services by providing oversight and assurance to the ICB Board on the exercise of the ICB's delegated primary care commissioning functions and any resources received for investment in primary care.

BAF and any significant risks relevant / aligned to this Committee:	**BAF16 – the resilience of general practice** **Current mitigated score – 4x4=16** There is a risk to the resilience of general practice due to several factors including the ongoing Covid-19 pandemic, workforce pressures and increasing workload (including workload associated with secondary care interface issues). There is also evidence of increasing poor behaviour from patients towards practice staff. Individual practices could see their ability to deliver care to patients impacted through lack of capacity and the infrastructure to provide safe and responsive services will be compromised. This will have a wider impact as neighbouring practices and other health services take on additional workload which in turn affects their resilience. This may lead to delays in accessing care, increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured general practice services. **BAF18– risk amended to the resilience of NHS dental services in Norfolk and Waveney** **Current mitigated score – 5x4=20** Primary Care Services became the responsibility of the Integrated Care Board from 1st April 2023, the risk is the unknown resilience, stability and quality of dental services, and critical challenges relating to the recruitment and retention of dentists and dental care professionals and the limitations of the national dental contract, leading to a poor patient experience for our local population with a lack of access to NHS general dental services and Level 2 dental services.
Key items for assurance/noting:	<u>June</u> • Holt Medical Practice – proposed closure of Blakeney branch surgery site. Committee members noted the practice's intention to engage with its population as the next stage of the process. • Oral health needs assessment – the regional public health consultant for dentistry provided an update on the draft needs assessment, which would support development of our short and longer-term plans. • Severe mental illness health checks – while the percentage of health checks completed in 2022/23 had improved significantly compared to previous years, at 55.2% it remained short of the

	national 60% target. It was noted the target would increase to 73% in 2023/24. This remains a risk on the PCCC register. • Delegated commissioning transition – members received a report on the completed transition and the new responsibilities around community pharmacy, dental and optometry services. A baseline position was provided along with early plans for developing our approach to address the known challenges • Care Quality Commission reports for Mattishall and Lenwade surgeries, Hellesdon and Orchard Surgery were noted. Mattishall and Lenwade had received a follow up inspection related to their warning notice and improvements were noted. Committee noted the action planning and progress made to address the areas highlighted by the CQC. Hellesdon were rated good, and Orchard Surgery's had improved their previous rating of inadequate to good across all domains. • Estates Report. • Digital Report. • Prescribing Report. <u>July</u> • Delivery plan for recovering access to primary care – members noted the work underway to deliver against the national plan, including the requirement to report in public to ICB Board in November and March. Discussion centred on how to triangulate workforce, access, resilience and other work programmes with the risk register on general practice resilience. • Primary care complaints and contacts – the report and themes were noted, following the delegation of responsibility for complaints, it was expected the volume would increase significantly. This would be monitored through the operational delivery group going forward and brought to committee every 6 months. Themes would be vital for informing our public campaigns. • Workforce and training – committee was updated on the training needs analysis, health and wellbeing survey and the new workstreams associated with dental, pharmacy and optometry services. 81% of GP practices are now approved as learning organisations.

	• TIAA audit report – the report and its recommendations were noted. Progress had already been made and lessons learned were being used in developing our approach to contract monitoring dental, pharmaceutical and optometric services. The quality team were working on a quality assurance plan which would be brought to a future committee meeting. Discussion centred on the concern about the lack of primary care data and performance insights available to the committee, and as such the visibility of primary care to the rest of the system. • Pharmaceutical Services Regulation Committee Terms of Reference – the new terms of reference for the PSRC hosted by Hertfordshire and West Essex ICB on our behalf were noted. Reports would be brought to future committees. • Prescribing report • Finance report – concerns were expressed at the forecast overspend in the primary care budget at this early stage in the year, and the lack of mitigations. Members wanted to understand their role in addressing any variations versus budget and taking any action, and this would be included in the next report.
Items for escalation to Board:	The resilience of general practice, summarised in BAF16 continues to be of concern in the system, despite the significant activity being undertaken. The ICB's progress on its plan to recover access to primary care and address interface issues would be brought to the ICB Board in November and March. The resilience of dental services, summarised in BAF18 is of grave concern, with the short-term plan due to be presented to committee in September. Committee accepted the TIAA audit report and noted the ongoing work to improve the reporting of primary care data and performance insights, both to committee and to ICB Board through the performance reports. Without this data, the current visibility of primary care was of concern. Committee expressed concern at the forecast deficit for the primary care budget, based on our allocation from NHS England at this early stage of the year.
Items requiring approval:	<u>June</u>

	• Joint Forward Plan – members approved the primary care section of the JFP which focused on stabilising dental services and supporting the development of integrated neighbourhood teams in line with the Fuller recommendations. • Primary Care Estates Project: Attleborough – Primary Care Estate Capacity – members noted the update and approved to formally engage the market for third party capital investment to design and deliver a long-term solution for the town. • Annual E-declaration for GP practices against their contractual requirements – the update was noted and the action plan to follow up non-compliant declarations was approved. This would be monitored through the new operational delivery group going forward. • Scheme of delegation – members approved the operating model and mobilisation of the Operational Delivery Groups set out within the Committee's Terms of Reference and agreed by the ICB Board in February 2023. <u>July</u> • Members approved the risk register, including the increase in risk score to 5x4=20 for BAF18 on the specific dental risks of access, workforce and quality. • Covid anti-viral supply – members approved the new arrangements for training and providing supplies through nominated community pharmacy as an interim measure towards supply as business as usual.
Confirmation that the meeting was quorate:	Yes, and Debbie Bartlett was also welcomed as the new Local Authority Member and would be chairing the committee from the August meeting.

Key Risks	
Clinical and Quality:	Care Quality Commission inspection reports are brought to committee meetings
Finance and Performance:	Finance reports are noted monthly, detailed performance reports are reviewed on prescribing, learning disability and severe mental illness health checks uptake. Access data is reviewed annually through the GP Patient Survey report. The annual contractual e-declaration requirement for practices is reported.

Impact Assessment (environmental and equalities):	N/A
Reputation:	The committee meeting is held monthly in public and includes membership from the Local Representative Committees, Healthwatch Norfolk and Suffolk and the Health and Wellbeing Boards in Norfolk and Suffolk
Legal:	Terms of reference, primary medical services contracts, premises directions and policy guidance manual
Information Governance:	Any confidential or sensitive information is heard in private
Resource Required:	Primary care commissioning team
Reference document(s):	Primary medical services regulations, statement of financial entitlements, premises directions and policy guidance manual, delegation agreement with NHS England
NHS Constitution:	N/A
Conflicts of Interest:	Arrangements are in place to manage conflicts of interest

Norfolk and Waveney
Integrated Care Board

Agenda item: 17

Subject:	**Audit and Risk Committee Report**
Presented by:	**David Holt, Non-Executive Member**
Prepared by:	**Amanda Brown, Head of Corporate Governance**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**18 July 2023**

Purpose of paper:

To provide the Board with an update on the work of the Audit and Risk Committee for the period 11 May 2023 to 22 June 2023.

To request that membership of the Committee is updated:

- the Non-Executive Member who Chair's the Finance Committee to step down after the September 2023 meeting, and
- the Member from the VCSE Assembly Board joining the membership of the Committee from September 2023.

Committee:	Audit and Risk Committee
Committee Chair:	David Holt, Non-executive Member
Meetings since the previous update on 30 May (date of previous Board meeting)	• 22 June 2023
Overall objectives of the committee:	This Committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.
Main purpose of meeting:	The main purpose of this meeting was to review the ICB Annual Report and Accounts and the former CCG's Annual Report and Accounts and recommend their approval to the Board.

	• **Internal Audit Summary Internal Controls Assurance Report** This report provided an update on the work of internal audit and progress against plan. Three final reports have been issued since the last meeting, two of which were advisory audits. This includes the Primary Care Delegated Commissioning Report which received limited assurance. In addition, fieldwork has commenced on one of the 2023/24 audits with two other audits having been scoped with dates arranged for the audits to begin. The Committee spent some time discussing the Primary Care Delegated Commissioning audit outcome of limited assurance. The Director of Primary Care and Associate Director of Primary Care Commissioning both attended the meeting to provide an update on progress and plans in place to complete internal audit recommendations. A practice visit programme is being implemented but it was recognised that there are challenges in the resources available. Visits are planned to start in July and adjustments have been made to the programme to take account of the learning from the TIAA report. • **Head of Internal Audit Opinions for the ICB and former CCG** It was reported that the ICB received three substantial assurance audits, four reasonable assurance audits and one limited assurance audit. The Head of Internal Audit Opinion for the ICB is reasonable assurance. The CCG had one substantial assurance audit for the three-month period 1 April 2022 to 30 June 2022. The Head of Internal Audit Opinion for the former CCG is reasonable assurance. • **Draft Audit and Risk Committee Annual Report** The Committee reviewed the report and approved it with one amendment to a typing error on the date. • **Summary Paper, Service Auditor Reports (SAR)** The Committee discussed this report that summarized the SARs for organisations from which the ICB receives services for example, Shared Business Services, Employee

	Service Records etc. A number of the SARs received a qualified assurance audit. The meeting discussed the impact of these results and what mitigating actions can be taken by the ICB to reduce potential impacts. A follow up report will be brought to the next Committee meeting in September. • **ICB Annual Report and Accounts** At the time of the meeting external auditors reported that they had not fully completed their audit. Splitting one financial year into two periods and producing two reports has been challenging. The two audit reports presented for the year are both relatively clean, and it was reported that there was a timetable through to completion for the outstanding areas and that the audit is in a good position for signing on the 29 June. The ICB had no adjusted differences to report, and two unadjusted differences. The Committee approved the unadjusted differences. • **CCG Annual Report and Accounts** The CCG had no adjusted differences but one unadjusted difference relating to the prescribing accrual. The Committee approved the unadjusted differences. External audit confirmed that in terms of assurances there was nothing to report with no indications of management override and a full suite of assurances has been received. This will lead to unqualified opinions for both the CCG and ICB. The CCG opinion will have a modified matter added relating to the closure of the CCG. There is a control observation within both sets of accounts relating to the non-signing of contracts for provision of services and it is an audit recommendation for this to be resolved in the next financial year. The Committee discussed the Audit Results Reports for the ICB and CCG produced by external audit and the Letters of Representation. External audit confirmed that there was no matter that needed highlighting and that any potential adjustment is likely to be insignificant. • The Committee confirmed the draft Annual Report and Accounts for both the ICB and the CCG. It was noted that any additional amendments made to the documents

	from 16 June to 22 June would be presented to the Board meeting on 27 June. • The committee agreed to recommend the approval of the ICB and former CCG's Annual Report and Accounts to the Board at its meeting on 27 June 2023.
BAF and any significant risks relevant / aligned to this Committee:	BAF reference numbers and detail of any significant relevant risks completed here.
Key items for assurance/noting:	For example, what was the main focus of the meeting?
Items for escalation to Board:	
Items requiring approval:	
Confirmation that the meeting was quorate:	

Key Risks	
Clinical and Quality:	Internal audit reports provide assurance on internal control processes
Finance and Performance:	The Committee monitors the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.
Impact Assessment (environmental and equalities):	None
Reputation:	The Committee supports the ICB reputation by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.
Legal:	It is a statutory requirement for the ICB to have an audit and risk committee.
Information Governance:	This Committee provides assurance to the Board that there is an effective framework in place for the management of risks associated with IG.
Resource Required:	None
Reference document(s):	None
NHS Constitution:	N/A
Conflicts of Interest:	The Committee is responsible for satisfying itself that the ICB's policy, systems and processes for the management of conflicts (including gifts and hospitality and bribery) are effective including

	receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

Norfolk and Waveney
Integrated Care Board

Agenda item: 19

Subject:	**VCSE Assembly July Report**
Presented by:	**Emma Ratzer, CEO Access Community Trust Partner Member - VCSE**
Prepared by:	**Emma Ratzer, CEO Access Community Trust Partner Member - VCSE**
Submitted to:	**ICB Board**
Date:	**18 July 2023**

Purpose of paper:

To update the Board on the on the work of the VCSE Assembly.

Executive Summary:

The Norfolk and Waveney ICS VCSE Assembly continues to run as a pilot until the end of September 2023.

A six month 'VCSE Partnering Lead' post, appointed in April this year, is leading a review of what we have learned during the pilot period, with proposals for our next steps, in the form of a Road Map, to be presented for the consideration of the VCSE Assembly Board on 26th July 2023 and then into the ICB.

As part of this review process we have used our June Board meeting to reflect on our combined experiences. Invites went out to over 50 individuals, representing our current ICS partners and a variety of VCSE organisations. We asked delegates to bring their system experience and perspective in order to shape the functions that will best empower full VCSE sector engagement. The session was originally for existing board members only but we did want to bring some wider perspective., hence the increased number of attendees.

<u>Self-evaluation tool</u>
We used a health & wellbeing partnership self-evaluation tool developed by The Kings Fund and the National Lottery, which has already been adapted and utilised to support a review of our Health & Wellbeing Partnership Boards. The framework has been further adapted to support a review of our VCSE Assembly. It consists of two parts:

1. An assessment of maturity based on seven partnership ‘working themes’. These are standard to the H&WP Board assessment, and participants were asked to identify which box they think applies across each of the themes ahead of the meeting. A cumulative stakeholder perspective ‘heat map’ was shared with lived experience context to bring this to life.

2. An assessment of maturity based on the priority ‘key functions’ for our VCSE Assembly. The majority of our time on 30th June was spent ensuring that we have a shared understanding as to what these key functions are, how far we have come as an Assembly in delivering against them and the steps that we will need to take in order that we can create an environment in which they can be achieved.
The supporting PDF to this introduction gives a full overview of the session, discussions and comments. There is also a copy of the heat map completed by individuals prior to the event.

Next Steps
Our overall Road Map for the future is currently being written and being supported by the Assembly Operations Group and a group which includes ICB, NCC, district council and VCSE representation.

Report

Recommendation to the Board:

For noting and comment .

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	
Legal:	
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A

Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	

Improving lives together
Norfolk and Waveney Integrated Care System

VCSE Assembly Self-Assessment Heat Map June 2023
Partnership working themes, maturity matrix
14 responses in total received from Assembly board members & wider stakeholders, scores in bottom left of each box.

		Levels of Maturity				
		Not Yet Established	**Networking** Partners share information and talk with one another for mutual benefit	**Cooperation** Partners support one another's activities but have no formal agreement in place	**Coordination** Partners are engaged in mutual projects and initiatives, modifying their own activities to benefit the whole	**Collaboration** With a formal agreement in place, partners work toward developing enhanced capacity to achieve a shared vision
Partnership working Themes	**Vision**	There is no clear vision for the future, or there are competing visions 1	A vision exists, but it means different things to different people 12	There is a vision that is stretching bit achievable. People see how they can fit into it. 1	The vision sets a clear direction that people but into. It is articulated in different ways	The vision is embedded in everything people do. It flows from top to bottom and is aligned with public outcomes
	ICS integration	There is no integration, or there is some across different parts of the ICS which are not joined up 5	The integration structure attempts to define the future in too much detail or doesn't cover everything it should. 8	Integration considers service users and contains enough examples to bring it to life 1	It's clear how the VCSE will sit alongside different parts of the ICS. It's possible to assess progress as integration evolves	The VCSE is at the heart of system integration. Outcomes for different changes across the ICS are aligned. It's clear how to bridge the gap between the current and future states
	Plan	Planning is not joined up. Plans are not flexible or achievable 4	Plans are beginning to be joined up. Ambition and achievability need more focus 10	Plans have the right level of detail and balance of tight and loose planning	Planning is informed, coherent and mature, supporting both transformation and business as usual	Planning is joined up and fully resourced. Plans adapt as transformation progresses
	Leadership	Leaders talk about the role of the VCSE on occasion. They make some effort to canvass views but avoid difficult messages	There is support for expanding the role of the VCSE at the top, and some change agents. There are meetings and ways to submit ideas 10	There is sufficient ownership of VCSE development. Leaders talk about it. There are visible role models. 4	Leaders tell a consistent VCSE development story. They 'push' and 'pull' as needed to create the right environment for change	Leaders embody VCSE as an integral part of our ICS and create an environment of trust where it's safe to speak freely
	Collaboration	Collaboration across boundaries is limited 1	There is some understanding of stakeholders. Collaborative behaviour isn't yet commonplace 11	Many decisions are made across boundaries. Shared outcomes are starting to be developed 2	Roles, responsibilities, and incentives reflect the need to collaborate, leading to new ways of working	The VCSE Assembly compromises for the greater good and leads the way in transforming our communities
	Accountability	Responsibilities and accountabilities for transformation are unclear 8	There is a growing level of accountability for transformation 5	There is broadly the right structure around transformation, with a focus on making decisions at the right time 1	People are becoming empowered and accountable for making decisions	Clear governance results in decisions being made at the right level and at the right time to drive progress
	People	The impact of transformation on people, ways of working and culture is not understood 9	The impact of transformation on people, ways of working and culture is understood 2	Plans are in place to address the impact on people, ways of working and culture 2	Plans to deliver new skills or ways of working are being realised and people are engaged 1	Ways of working needed for the future are adopted. Mature workforce planning exists

Notes of the Norfolk & Waveney ICS VCSE Strategic Review Session

Held on Friday 30th June 2023 via MS Teams

No	Item	Action owner
1.	**Welcome, Background & Context** Tony Osmanski chairs today's session. Tony reminded colleagues that when we started engagement with VCSE we were looking at whether there was one single voice for whom we could engage to help deliver the health and social care agenda, and it emerged there are thousands of organisations, from large to small, therefore it was clear there was not going to be just one voice/point of contact. Since Emma's appointment as Assembly Chair in May 2021, the ICB has asked for proof of concept before long term funding could be considered. Emma, as Chair of the Assembly, has a place at the ICB Board making it possible for the VCSE to have an equal voice on that Board. To go beyond September, we need to demonstrate our proof of concept. The roadmap can be presented to the ICB Board so they can make an informed decision regarding the future of the Assembly. Therefore, today is an opportunity to reflect on our combined experiences of the Assembly and help inform the presentation to the ICB.	
2.	**Partnership Working 'Heat' Map Summary** There is an ask to look at the roadmap of the Assembly going forward and help to review what we have learned over the last year of the pilot scheme, and to help us decide what we want to take from that learning and by what means we want to structure how we move forward. The roadmap will be taken to the Assembly Board at the end of July and this session was set up as a strategic review. Daniel highlighted the VCSE Assembly self-assessment heat map (partnership working themes and maturity matrix). Responses were received from Assembly Board members alongside wider stakeholders; scores are shown in the bottom left of each box. This has given us a strong understanding of where we sit against those different indicators.	
3.	**Lived Experience 1: Vision, Leadership, Collaboration** Emma Ratzer, VCSE Assembly Chair Vision – It is hoped that today will be the beginning to find that shared ambition and that we can have a shared vision which we all understand. Leadership – Beginning to see there is support for the Assembly across the ICS Partners and Emma has been asked to participate more, however, there is still a	

	long way to go. The Assembly pilot ends September. The addition of Daniel's role has been helpful to get more individuals from the voluntary sector sitting at strategic tables. Collaboration – This is still very difficult for us to see. There is collaboration happening at strategic level and the various systems, but difficult for us to see and difficult to find a way to make that visual. It is hoped that the roadmap will help.	
4.	**Lived Experience 2: ICS Integration & Planning** Rachel Hunt, Head of integration & Partnerships, Gt Yarmouth & Waveney Rachel is reflecting from her role within the GYW Place. We have done a lot of work to ensure the thinking around the Assembly model is aligned to the broader thinking around our ICS structures, particularly at Place function. Place is still in its infancy and still developing, therefore, how the voluntary sector is a key partner, and an important part of the Place model, is still emerging. There is still a lot to do but needs to run in parallel with the maturity and development of our wider integrated system. We do have connectivity within our Place Boards and Health & Wellbeing Partnerships. The next part is around practically how we embed that and make steps forward to be able to deliver on the plans that we make together.	
5.	**Lived Experience 3: Accountability & People** Lee Gibbons, VCSE Place Lead, South Norfolk Lee reflected on his experience since joining the Assembly. There are many smaller organisations that have direct contact with our Place populations. These organisations are relevant and do have links to the ICS/ICB priorities. Lee feels unsure of his role and responsibilities as Place Lead and feels he has yet to have the opportunity to involve VCSE in discussions. The question often received from his VCSE colleagues is 'why, what is it going to change for me and my community?' As he is not working within the ICB he often feels a bit of an outsider and does not always understand the agenda and the language being used and feels out of step with the conversations (discussions often occur outside of the meetings), but Lee did wish to thank those within the ICB who have supported him. The only thing we all want to do is make the lives of our populations better, and this is best achieved working in partnership with all sectors. We are all working to ensure this happens regardless of the challenges it presents.	
6.	**Key functions for our VCSE Assembly** 1) We are connected with our VCSE communities at Place. Building a community 'membership' of our VCSE Assembly for Norfolk & Waveney. 2) VCSE community leaders are embedded in our Place-based partnerships with shared and supportive leadership. 3) We have a sound understanding of the local wider determinants of health and the early intervention and preventive needs of our communities.	

	4) We have a shared system wide methodology for measuring the impact of VCSE interventions and the added social value that the sector brings to our communities. 5) We build the trusted relationships which empower citizens in our communities to move beyond transactional interventions and into sustainable behaviour change. 6) An ICB / ICS funded work programme dedicated to VCSE partnering is operating across each place with accountability and monitoring which supports shared learning across our ICS. Daniel stated that this Assembly is for all of us and is a vital part of the ICS, although we are going through some growing pains. We are seeing raised understanding and perspective around what can be done, and is already being done, in the community by the voluntary sector to help build resilience and engage with communities early and to offset acute demand. Daniel is keen to get an understanding of the Assembly and to produce a work programme, asking ourselves what are we going to do? what is the difference this Assembly is going to make? The proposed six functions build on the Memorandum of Understanding work previously undertaken. This proposes the core and strategic functions of the Assembly going forward. Daniel would like to test these today and start to shape them.	
7.	**Break Out Rooms** Delegates moved into break out rooms. Notes were taken and discussions recorded using Jamboard: Group 1; 1) VCSE Membership & 2) Place Partnerships Facilitated by Philippa Gregory, Senior integration & partnerships manager Group 2; 3) Early Intervention & 4) Impact & Social Value Facilitated by Shelley Ames, Senior integration & partnerships manager Group 3; 5) Empowering Practice & 6) VCSE Work Programme Facilitated by Daniel Williams, VCSE Partnering Lead	
8.	**Group review of each function** **Feedback from Group 1: VCSE Membership & Place Partnerships** This group focussed primarily on the membership issue. There was a lot of discussion around the language used and a key theme was having common understanding and ensuring it is accessible to everyone. There was consideration around what the membership is for and what is the intention or aim as people are being asked to contribute their time – so what are the outcomes, keeping in mind the practicalities of being in the VCSE sector. This links to what are we talking about when we discuss integration and working together; is there any value in contributing and are we all sharing information in the best way possible?	

	It is recognised that one person or organisation cannot represent the entire VCSE sector. There are specialisms within the sector, and we need to acknowledge that and also take that as an opportunity. There is also an issue that as individual organisations we each have a sovereignty, and we also need to acknowledge competition for contracts and the limited resources within the sector. It is noted we have not got it right when we talk about representation. The Assembly is not there to represent the voice of the voluntary sector for all the reasons mentioned. The word 'representation' may be seen as a bit of a red herring. We are about to launch the membership scheme and we are tyring to make sure that anyone who signs up will have equitable access to information at Place Boards. We may have evolved away from a membership model to a network model, and it might be helpful to think of the Assembly as a strategic engagement network as a way of bringing in the collective VCSE expertise and knowledge. Whatever language we end up using, we need to make sure that our public sector partners also understand that. We need to look at how we can help change the culture across the whole of the integrated care sector. This would work both ways, and we need to be mindful of the language we use and be clear around what we are saying too. **Feedback from Group 2 Early Intervention & Impact & Social Value** It had been agreed on both functions having a place. There was discussion around having a sound understanding of the wider determinants of health and early intervention and prevention needs of our communities. We need to be clear on the language to ensure everyone recognises what is meant by wider determinants and prevention. These are open to interpretation, so we all need to be clear. This is not just about understanding local need. Having that understanding could be supported by a commitment in sharing resources, particularly around data and qualitative insights. We always use the word health, but we also should include social care need. A key point raised was around the triangulation of data and how we make that accessible to everyone. There had been discussion around a system-wide methodology for measuring impact of VCSE interventions and the added social value the sector brings to our communities, also recognising the inherent challenge in demonstrating impact of prevention, how do we prove something that has not happened? The wider function of the Assembly may be to make sure people are empowered to be an active part of the system, alongside their impact. It had been questioned whether the same VCSE measurements would be applicable in the NHS or could be comparable for other VCSE organisations. We need to try and make sure the whole system understands and agrees the impact assessments and measurements rather than just to produce them within the VCSE bubble. When we say 'we' we should mean the whole system as a collective 'we'.	

	Having that shared language and shared understanding across the system is fundamental. It was commented that it is difficult to try and justify what the impact and success of something is against the services commissioned for a one-year period and measure if it has worked and then having to use those impact measures to try and find recurrent funding. On one hand we have population health data and on the other personal impact data. One of the gaps we have at the moment is a shared understanding of each component i.e. primary care, acutes or social care all have their own targets. We are missing how can a solution drive impact to all those outcomes? If we had understanding that something ticks off everybody's aims and objectives, that would be more powerful then what we are doing at the moment. We should have integrated outcomes and targets. Impact needs to be built into both commissioning and service redesign right at the beginning and needs to include everyone involved in that definition of impact. There is concern that when we talk of impact and commissioning there is a danger we start looking at what has the greatest impact. We need to look at whether we are talking about individual or collective impact and funding accordingly, otherwise smaller groups may be excluded. **Feedback from Group 3 Empowering Practice & VCSE Work Programme** A key message as a whole was 'so what'? This discussion focussed on trusted relationships and empowering citizens. This was seen by the group as an important objective. We quickly go to procurement and how does procurement facilitate, or not, this type of relationship. We know the value of a trusted relationship is not understood in a health system i.e. current costed procurement, but does translate into a social lens. It is really important that the sector and the citizens we are there to serve are engaged in collaboration and co-production when building specifications. It is felt things are improving and there is a shared system wide understanding beginning to evolve, but we do not have consistent shared language as a system around what happens earlier in the pathway and building resilience, and therefore potentially offsetting some of the more acute issues. It was commented that historically commissioning is not always helpful for VCSE, but there is recognition that we need to start a fresh with a new approach to commissioning and it has been helpful to have a commissioning team in place to go to directly to answer any questions. This shows a shift in culture. Our greatest challenge as a system is the expectation to demonstrate savings and impact within a 12-month period, this is not always achievable in that time frame. We need to recognise that achieving financial savings and delivery of the right outcomes will take time, and this is a difficult one to land. If we do not fund and support VCSE adequately it will be a false economy. We must consider the opportunity of the use of evidence-based data.	

	As a system, we cannot just say we want a culture of trust, we need to be able to demonstrate that. Commissioning and co-production are examples of how we can create a culture of trust. It was commented that having more face-to-face meetings can help, and you cannot beat that level of face-to-face communication and trust it engenders. The VCSE Assembly could help statutory partners not get blown around by national policy and last-minute budget changes as there are some things that are not in the control of statutory organisations. It is important to support that and look to see what we can do for a longer-term plan. Trust is a function in itself and does require work to develop. It was not convinced that our six functions are around building that culture of trust, therefore, could this be a seventh function? It was felt that trust is not standalone and should underpin all six functions rather than be separate; to be a value more than a function. It was asked for comment around whether the Assembly should have a funded work programme to build across all of the objectives. As we move forward there will be things we want to do as timed pieces of work, as well as longer term cultural issues. The Assembly chair wants to be held to account and having a work programme will allow that to happen. The work programme does need to add value to the system and would need to be focused and linked to the overall system forward plan. Daniel will be driving and developing the roadmap and he is encouraged with the coalescence from today's discussions. A key focus of the roadmap is around what are the real enablers that are going to help us share responsibility as a system. This is a challenge for our whole ICS around how we all work together. Daniel will aim to reflect our aspirations within our roadmap and set a work programme that will move VCSE 'doing' across our system forward.	
9.	**Prioritisation Polls** Prioritisation scoring using Mentimeter for the two questions below: • Which are the priority functions for our Assembly? • Where are we at on a maturity scale 1-5? Priority for the six functions ranking results: 1. VCSE work programme (15) 2. Impact and social value (12) 3. VCSE membership (9) 4. Early intervention (7) 5. Empowering practice (4) 6. Place partnerships (1) There was discussion around the importance of Place, however, it was felt this is not very clear for the sector at the moment and therefore the score does not necessarily reflect that this isn't a priority for us but perhaps it just needs more clarity.	

	Colleagues were then asked to rate progress against each of those six functions out of five. This showed most were scored at one or two.	
10.	**Next Steps** Mark Burgis, ICB Executive Director Patients & Communities talked about next steps. There has been discussion today around how we empower voluntary organisations to be an active part in the system. Sometimes some of the statutory organisations have a lot to learn about the opportunities as well as the challenges. The power in the sector and how we work together is enormous. The ICB has declared its priorities in the Joint Forward Plan, and it is essential there is a focus on health inequalities, inclusion, and prevention. There is recognition around all of our financial challenges, but how can we join this up and work better together? The biggest comments noted from today to address are: • How will I know it when I see it? • So what? • Why? It is acknowledged that nothing happens without resources. Mark referred to the current ICB organisational change and the challenging targets faced within the ICB. As part of that work there is opportunity to think about what resources we need to support and progress this agenda. Therefore, the next steps will be trying to push this agenda forward, recognising there may be small first steps. We may be clear on our long-term ambitions, but it is about the doing now rather than talking.	
11.	**Final Summary Comments** Tony Osmanski made final remarks. Tony thanked everyone for attending today and for everyone's contribution; the feedback has been enlightening. It is acknowledged that we have a shared purpose and common challenges between all of us. Tony is getting the message that there is a lot of support for the concept of having a joined-up approach within the VCSE, but recognising the complexity of operating within the health and social environment. There is definitely a disconnect between the language used in health, local government and other sectors and we should be striving for language quality. We need to demonstrate the benefits of the Assembly, particularly for the grass roots organisations. We must not forget the issue of organisations individual sovereignty. There have been some great discussions regarding defining integration (data, funding, and joint working) but it is also about the need for greater integration around joint outcomes, targets and key performance indicators.	

	It is agreed that the Assembly is not setting out to be representative of the whole VCSE sector. There is still a need to change perception of the Assembly within the public sector, and we need to develop a culture of trust and transparency and develop the way we can demonstrate the value of the VCSE through co-production and shared outcomes. It is interesting to see the priorities coming through, and there is clearly a need to clarify what we mean by Place. Tony hoped that there has been opportunity today to assess our perceptions fully of the Assembly performance and focus in on some of the key functions. The next steps will culminate in a report to be presented to the ICB Board.	

Copy of the comments posted within the MS Teams Chat during the session:

Digital solutions are going to be the key to getting communication and engagement right within the system.

It seems that whatever we call it, it needs to be a way to keep the VCSE in the room and champion integrated solutions from the local communities.

Important to move away from prescriptive, pre-determined impact measures.

We look at topics in silo with other partners rather than looking at thematic commissioning that transcends all the organisations and brings them together with a common outcome.

As we shift away from traditional commissioning towards delivering shared outcomes - the preventative agenda will directly affect so many health conditions.

There is a wider whole ICs system pattern which hopefully VCSE colleagues can help challenge and change.

You only get the outcomes you measure. This misses all the impact elsewhere and the ripple effect such as positive impact on carers and wider support networks - ripple effects can be vast and unmeasured.

As a system we aren't great at 'ripple effect mapping' and capturing the wider outcomes of our collective work. This one is an issue for statutory services as much as it is VCSE - in fact I would suggest demonstrating impact is a collective challenge. In a lot of ways 'we' could learn a lot from the VCSE, so this one must be both ways.

Impact isn't just around numbers, if you change health behaviours for 4 people you could be saving the system £££££.

Impact is often measured in numbers and £s, but rarely based around what matters most to the people/clients/patients. We don't start with finding that out as much as we should in health and social care.

We need to get braver in terms of scale and timeframes of commissioning.

With a shared long-term vision, the VCSE can help our statutory partners to 'hold a course' over the longer term.

There is a solution, which is to have more co-production. More openness about the health/care challenges at a strategic level with the VCSE, rather than service level, will help foster more shared responsibility of aims, objectives and language... and teamwork... and more of an opportunity for VCSE to influence and shape solutions.

Empathy for our lived experience as providers is part of trust.

We need a long-term plan but we have some short term issues - many VCSE organisations struggling financially now and decisions on ICB funding which until recently has tended to roll over could prove fatal if decision to withdraw or realign is made en masse.

As long as we recognise the need to facilitate the development of that trust (both ways), alongside doing what we say we are going to do by delivering the functions, then that makes sense.

It's great that we recognise the need for culture change around trust. This will include acceptance that sometimes organisations will get things wrong or with hindsight do it differently.

Unfortunately funding for short term pieces of work i.e. winter funds comes with strings attached and there is nothing we can do about it as it is set by central government, and trust me we have some very creative thinkers when it comes to how monies can be spent, or carried over, but if you are given money in February to be spent by the end of the financial year what exactly can you do??

Absolutely support the need for a work programme and accountability for the work of the Assembly, there will be development needs for the VCSE along the way and these will need to be addressed.

Echo the thoughts that integration is about all partners and progressing our culture together, focused on a strengths-based approach.

Can we understand how we compare to other ICSs in view of maturity matrix and VCSE integration?

Not sure the wider ICS is clear and agreed about Places hence it is tricky for VCSE, especially as H&WB partnerships are alternative Place vehicles.

Would welcome VCSE colleagues view on the Place Partnerships - because my view is that the sector already has community reach and works 'at Place'.

There needs to be a shared agreement and understanding on what place is... Place is an enabler.

We can harness the collective partnership energy at a Place level, but recognise tons happens at Place already, but maybe it's not visible or connected across health, social care and VCSE.

Grounding the work programme in Place feels vital.

Exploring the difference between providing support and services at Place for individuals (and how this can be improved with joint working) and how we begin to improve health and well-being at Place level by looking at those aspects which impact on peoples' health and well-being might be helpful for us all to consider.

Place can also be a hotbed of test and learn, with an eye on system scaling. Good interventions should not just live in one place and where economies of scale can be achieved... we need to be agile and enabled to start local and where there is strong impact evidence, expand the benefits and quickly! we can't forget there is value in a system-wide approach to some challenges and opportunities.

I think it would be great to have a follow up session where we collectively think through the solutions/the practical 'how' in relation to taking these functions forward. We've spent quite a lot of time today (rightly) re-defining the challenges, but I'd love the opportunity to think about how we address them with the people in this room.

To be fair the whole system is still very much in development and so always going to be lots to do at this stage.

Would be very interested in the wider value of the Assembly in terms of its ability to influence national agenda. I hear at many national conversations that people are frustrated with the response - what can we do when it comes from central govt or it’s national policy. Well, individually not much but nationally, the voice of Assemblies and similar structures can and should be influencing this.

-End-

Instructions

Each group has two VCSE Assembly functions to consider.

Please consider and use post-its to feedback on:
- Is this a priority function for the VCSE Assembly?
- Do these functions apply to both System and Place?
- Does the language reflect the clarity of function that we require? Please suggest changes

Please also consider whether there are any functions that are not on the list, but you feel should be. Add these to slide 9.

1. We are connected with our VCSE communities at place. Building a community ‘membership’ of our VCSE Assembly for Norfolk & Waveney.

2. VCSE community leaders are embedded in our place based partnerships with shared and supportive leadership.

3. We have a sound understanding of the local wider determinants of health and the early intervention & preventive needs of our communities.

List of functions

4. We have a shared system wide methodology for measuring the impact of VCSE interventions and the added social value that the sector brings to our communities.

5. We build the trusted relationships which empower citizens in our communities to move beyond transactional interventions and into sustainable behaviour change.

6. An ICB / ICS funded work programme dedicated to VCSE partnering is operating across each place with accountability & monitoring which supports shared learning across our ICS.

Group 1 - Function 1:
We are connected with our VCSE communities at place. Building a community ‘membership’ of our VCSE Assembly for Norfolk & Waveney.

Is this a priority function for the VCSE Assembly?

has to be the user experince

Do these functions apply to both system and place?

Does the language reflect the clarity of function that we require? changes?

Yes, as previously said the VCSE is not one voice but many together

what are we compiling a membership for? what would the contribution be?

Are we a 'membership' assembly, that VCSE join and gain a value from - or are more about engagement, that reaches out to them with news, opportunities etc

the role of place is vital to support collaboration around shared priorities and tap into the expertise in local communities. how do we effectively do this?

do we all have a shared understanding of place?

Are we 'building' a community membership, or is the ICS/Assembly going out to the existing communities?

links to power dynamic

issue of sovereignty and competition. is the assembly a loose alliance?

how can we help to drive collaboration between VCSE orgs so they can be empowered to secure funding and participate in these new ways of working?

what does community mean in this context?

acknowledging the specialisms and knowledge within the sector - one person cannot represent all areas of the VCSE sector

time investment vs outcomes. are we considering this? funding?

trust - how can we build it?

need to all be on the same page before we start something new

what do we mean by integration? are we sharing information? working together effectively?

Pragmatism - if the smaller end of the VCSE is not part of the solution, it would be better if NHS said they won't resource our inclusion - we cannot all be involved.

Group 1 - Function 2
VCSE community leaders are embedded in our place based partnerships with shared and supportive leadership.

Is this a priority function for the VCSE Assembly?

Is this a culture piece for all in our place? are the place partnerships well understood by all in place?

need to be able to show the value to the sector

need to move from the vision to be able to ground the integration ambitions in something that's tangible

Do these functions apply to both system and place?

how can we help the leaders to be identified? who are these individuals?

how can we ensure the place partnerships can add value to the local VCSE sector and directly have a line of sight to local communities?

Let's get over proving prevention. The impact methodology is there - to use proxies, prove attribution and return on investment. It takes those in power to value prevention.

Does the language reflect the clarity of function that we require? changes?

terminology - not always clear, clarity of meaning, understanding of Place, how does it all fit together?

the need for simplicity in language - enable shared understanding

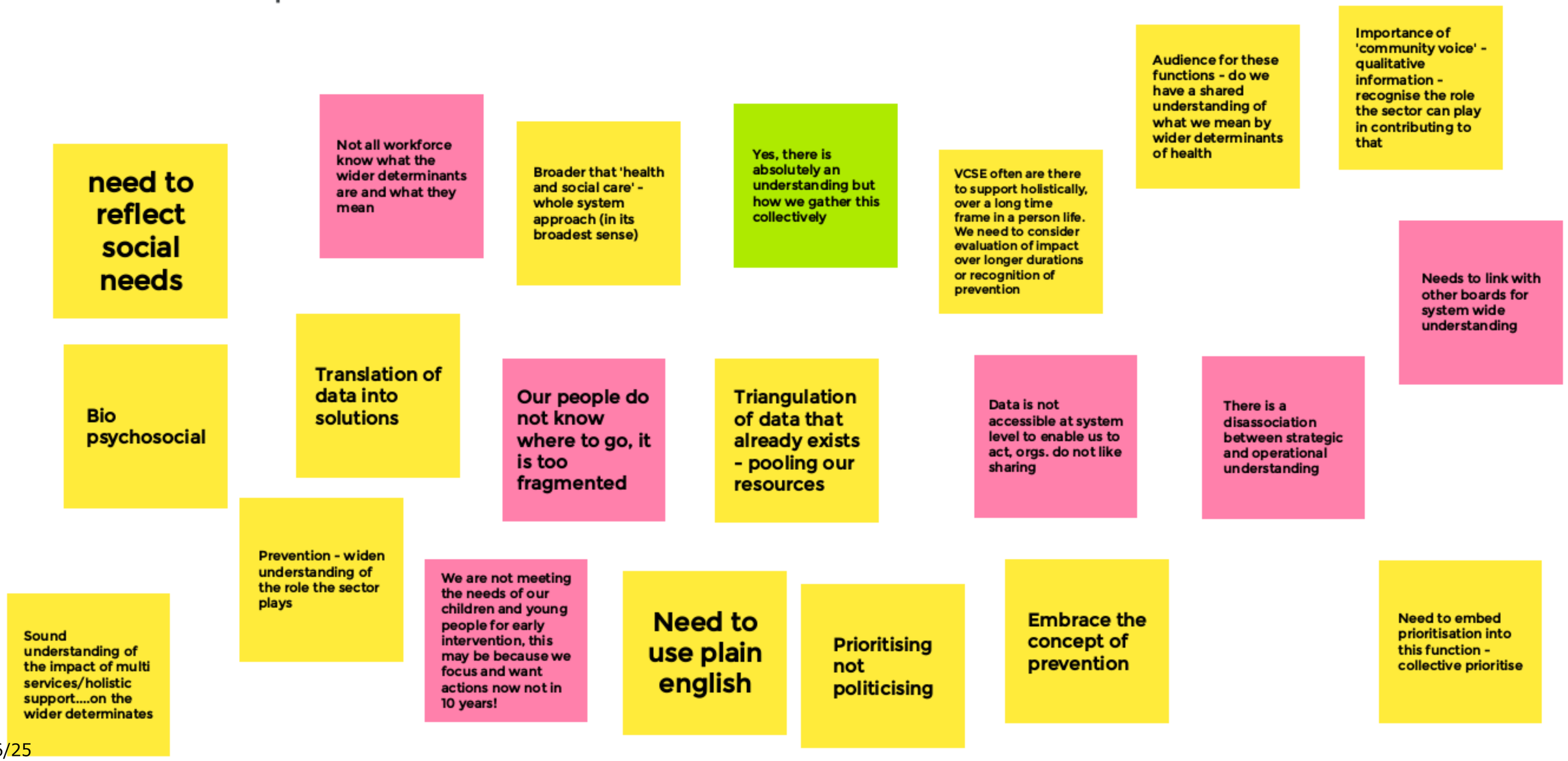
should we recognise VCSE as 'another' place leader and not call out VCSE separately?

What do you actually want from the VCSE?

'our place' - can we define this?

Group 2 - Function 3

We have a sound understanding of the local wider determinants of health and the early intervention & preventive needs of our communities.



Group 2 - Function 4

We have a shared system wide methodology for measuring the impact of VCSE interventions and the added social value that the sector brings to our communities.

Group 3 - Function 5

We build the trusted relationships which empower citizens in our communities to move beyond transactional interventions and into sustainable behaviour change.

Is this a priority function for the VCSE Assembly?

Do these functions apply to both system & place?

Does the language reflect the clarity of function that we require?

Resonates in terms of direct work with service users. Want to give them tools to sustain. Limited time to reflect this within commissioning arrangements.....they are improving now.

Historically service specifications are not always written with VCSE / service user at the table.

Changes to procurement rules to happening quickly enough

VCSE is good at empowering practice but might not identify with the term. Contracting doesn't fully cost the building of the relationship.

What about prevention & reducing health inequalities. Surely solution is that they don't need our services.

There are now co-production contracts out there

Some VCSEs finding experience with commissioners positive

Sector not supporting itself well enough to share experience; infra-structure / Assembly etc

We need to think more about the ways in which we shape the services themselves. We easily get stuck on procurement / commissioning. What's the step before this?

Group 3 - Function 6:
An ICB / ICS funded work programme dedicated to VCSE partnering is operating across each place with accountability & monitoring which supports shared learning across our ICS.

Is this a priority function for the VCSE Assembly?

Do these functions apply to both system & place?

Does the language reflect the clarity of function that we require?

Explicit expectations of members, who have shared accountability

Roles and responsibilities will need to be clear to ensure effective partnership working. Agree with the function being a part of the assembly approach

Maybe evaluation instead of monitoring?

Safe space - really hear what Lee opened with today. Simplify language, encourage engagement from all sector partners.

Be clear on the difference between ICB and ICS.

Missing functions:

Create a culture of trust

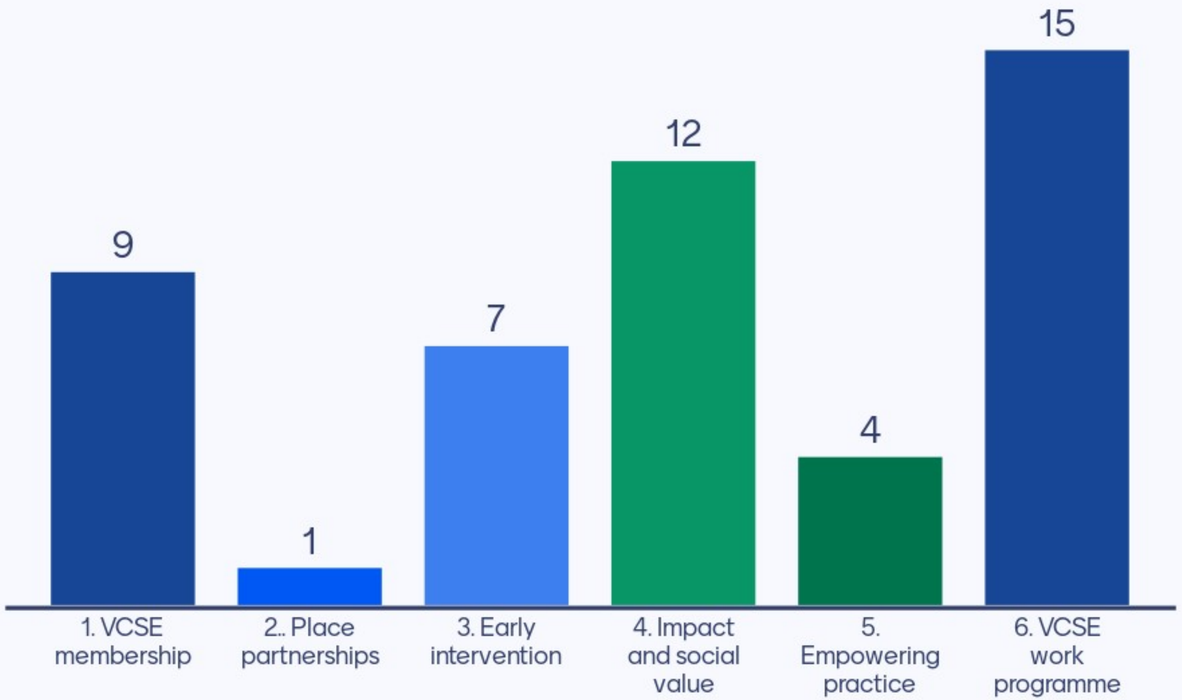
VCSE Assembly Strategic Review

Friday 30th June 2023

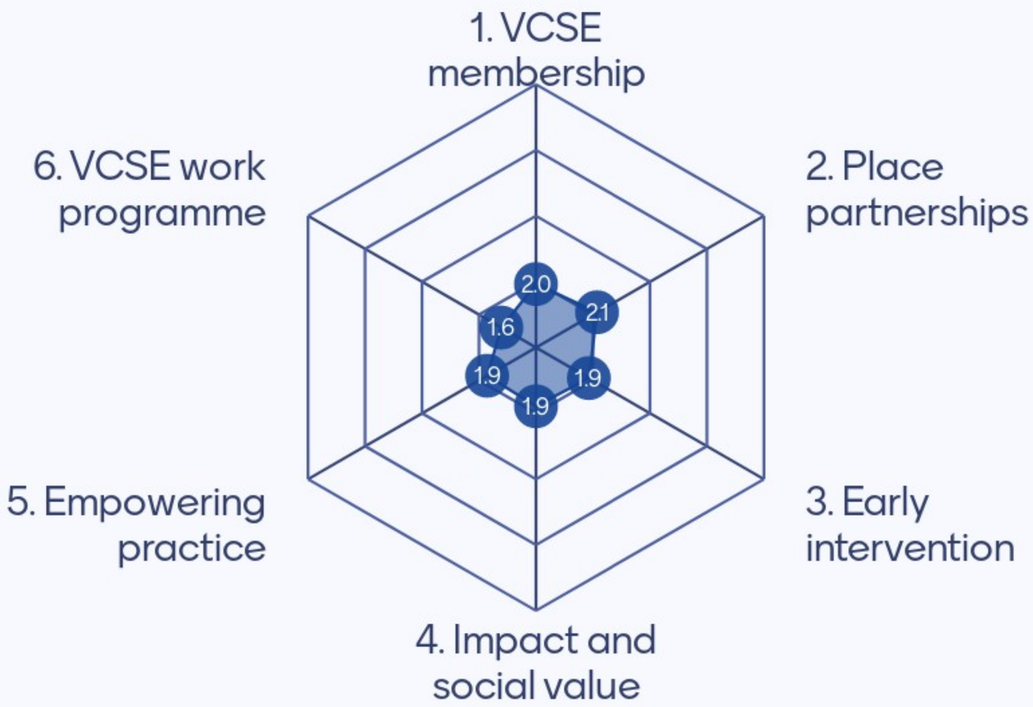
Temperature Check

Instructions

Which of these functions do you think should be prioritised? You may select 2 functions.



Please rate progress against these functions out of 5 (5 being high)



Thanks! 🚀