Patients and Communities Committee

Mon 22 January 2024, 15:00 - 17:00

Virtual via MS Teams

Agenda

15:00 - 15:00
0 min

Meeting Agenda

00. Patients and Communities Committee - January - Final.pdf (2 pages)

15:00 - 15:00
0 min

1. Chair's Welcome and Apologies for Absence

Aliona Derrett

15:00 - 15:00
0 min

2. Declarations of Interest

Information *Aliona Derrett*

To declare any interests specific to agenda items

For noting

02 Patients and Communities Committee Register 2023-24.pdf (3 pages)

15:00 - 15:00
0 min

3. Minutes of Previous Meeting and Matters Arising

Decision *Aliona Derrett*

To approve the minutes of the previous meeting (25.11.23)

For approval

03 NW ICB PC Committee Minutes 27.11.23 DRAFT.pdf (9 pages)

15:00 - 15:00
0 min

4. Action Log

Decision *Aliona Derrett*

To note any outstanding actions from the previous meeting not yet completed

For review, update and approval

04 PCC Action Log - Jan 24.pdf (1 pages)

15:00 - 15:00
0 min

5. Spotlight On Items

5.1. Spotlight on: Planned Care and Cancer Activity Update

Information *Sheila Glenn*

For presentation and discussion

05i Patient and Communities Directorate Presentation.pdf (5 pages)

5.2. Spotlight on: Community Mental Health Transformation

Information *Dr Ardyn Ross*

For presentation and discussion

- 05ii a MH Transformation Update AR for 220124 P&C Committee.pdf (2 pages)
- 05ii b NW Community Transformation update to P&CC 220124.pdf (21 pages)

15:00 - 15:00
0 min

6. Transformation Board Update

Information *Andrew Palmer*

For review and noting

- 06 P&CC report January 2024.pdf (8 pages)

15:00 - 15:00
0 min

7. ICS Mental Health Coproduction Strategy

Information *William Snagge and Sam Holmes*

For presentation and discussion

- 07a MH Coproduction Strategy for 220124 P&C Committee.pdf (4 pages)
- 07b ICS MH Coproduction Strategy Update 220124.pdf (9 pages)
- 07c N&W Coproduction Strategy for P&CC 220124.pdf (14 pages)

15:00 - 15:00
0 min

8. Ageing Well Programme Board - Strategic Framework

Decision *Dr Frankie Swords*

For review and sign off

- DRAFT FRONT SHEET PC&C Strategic Framework.pdf (3 pages)
- 08ii NW ICS Ageing Well Strategic Framework (Draft V3.1).pdf (19 pages)

15:00 - 15:00
0 min

9. Population Health and Health Inequalities Board Update

Information *Dr Frankie Swords*

For review and noting

- 09i 2023.12.19_PHI Board Report Cover Sheet.pdf (2 pages)
- 09ii 2023.12.19_PHI Board Assurance-Escalations- v3.pdf (2 pages)

15:00 - 15:00
0 min

10. Links Between Quality and Commissioning

Information *Karin Bryant*

For presentation and discussion

- 10i P&C Committee 22.01.24 - Commissioning & Quality.pdf (2 pages)
- 10ii P&C Committee 22.01.24 - Commissioning & Quality v0.3.pdf (5 pages)

15:00 - 15:00
0 min

11. Monitoring Mortality Rates Across the System and the Norfolk and the Norfolk and Waveney Learning from Deaths (LFD) Forum

Information *Teresa Knowles*

For presentation and discussion

- 11 ICB PCC - Mortality Monitoring and NW LFD Forum 22.01.24.pdf (6 pages)

15:00 - 15:00
0 min

12. Healthwatch Suffolk Update

Information *Andy Yacoub*

For noting

15:00 - 15:00
0 min

13. Warm and Well Campaign Update

Information *Emily Arbon and Rebecca Champion*

For noting

15:00 - 15:00
0 min

14. Any Other Business

Information *Aliona Derrett*

Meeting of the NHS Norfolk and Waveney ICB Patients & Communities Committee

Monday 22 January 2024, 1500-1700hrs

Meeting to be held via MS Teams

Item	Time	Agenda Item	Lead
1	15:00-15:10	**Chair's welcome and apologies for absence**	Chair
2		**Declarations of Interest** To declare any interests specific to agenda items *For noting*	Chair
3		**Minutes from previous meeting and matters arising** To approve the minutes of the previous meeting (25.11.23) *For approval*	Chair
4		**Action log** To note any outstanding actions from the previous meeting not yet completed *For review, update, and approval*	Chair
5.i	15:10	**Spotlight on: Planned Care and Cancer Activity Update** *For presentation and discussion*	Sheila Glenn
5.ii	15:25	**Spotlight on: Community Mental Health Transformation** *For presentation and discussion*	Dr Ardyn Ross
6	15:40	**Transformation Board Update** *For review and noting*	Andrew Palmer
7	15:50	**ICS Mental Health Coproduction Strategy** *For presentation and discussion*	William Snagge & Sam Holmes
8	16:05	**Ageing Well Programme Board Update - Strategic Framework** *For review and sign-off*	Dr Frankie Swords
9	16:15	**Population Health and Health Inequalities Update** *For review and noting*	Dr Frankie Swords
10	16:20	**Links Between Quality and Commissioning** *For presentation and discussion*	Karin Bryant
11	16:35	**Monitoring Mortality Rates Across the System and the Norfolk and Waveney Learning from Deaths (LFD) Forum** *For presentation and discussion*	Teresa Knowles
12	16:45	**Healthwatch Suffolk Update** *For noting*	Andy Yacoub
13	16:50	**Warm and Well Campaign Update** *For noting*	Emily Arbon & Rebecca Champion
14	16:55	**Any other business**	Chair

Item	Time	Agenda Item	Lead
Date, time and venue of next meeting: Monday 25 March 2024, 1500-1700hrs via MS Teams			
Any queries or items for the next agenda please contact: rachael.parker9@nhs.net			

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

Declared interests of the Patients and Communities Committee

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Aliona Derrett	Non-Executive Member, Norfolk and Waveney ICB	Norfolk and Norwich University Hospital 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 Norfolk	X			Direct	I am the Chief Executive Officer 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
		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	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
		St Stephen's Gate Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Catherine Armor	Non-Executive Member, Norfolk and Waveney ICB	Educational Association			X	Direct	Trustee, Workers' Educational Association	Dec-23	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
		Norwich University of the Arts			X	Direct	Deputy Chair of Council, Norwich University of the Arts	2019	Present	
		Evolution Academy Trust			X	Direct	Trustee, Evolution Academy Trust	2022	Present	
		Cambridge University Press Pension Schemes		X		Direct	Trustee, Cambridge University Press Pension Schemes	2018	Present	
		East of England Ambulance Service NHS Trust				Indirect	Daughter-in-law is Technician for East of England Ambulance Service NHS Trust		Present	
		Brundall Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Paula Boyce	A representative from the Health and Wellbeing Partnerships	Great Yarmouth Borough Council	X			Direct	Employee of Great Yarmouth Borough Council	2023	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.
		Emmaus, Norfolk and Waveney			X	Direct	Trustee and Board member of registered homeless charity Emmaus, Norfolk and Waveney	2023	Present	
Paul Berton	Director of Quality for care	Nothing to declare					N/A			N/A

Mark Burgis	Executive Director of Patients and Communities, Norfolk and Waveney ICB	Drayton Medical Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Lakenham Practice				Indirect	Wife is Nurse Prescriber who is currently undertaking occasional locum work at Lakenham Practice in Norwich	Aug-21	Present	Declare at any relevant meetings and remove myself from any significant discussions or decisions relating to the practice
Suzanne Meredith	Associate Director – Population health Management	Norfolk County Council	X			Direct	Employed by Norfolk County Council as Deputy Director of Public Health	2014	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.
		UKPHR		X		Direct	As part of Public Health professional requirements - Fellow of the Faculty of Public Health and professional registration on UKPHR	2014	Present	
		Hellesden Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
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.
Alex Stewart	Chief Executive, Healthwatch Norfolk	Member of Holt Medical Practice			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
Dr Frankie Swords	Executive Medical Director, Norfolk and Waveney ICB	Norfolk and Norwich University Hospitals		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
		Multiple patient charities		X		Direct	Ad hoc Clinical Advisor for multiple patient charities - Addison Self Help Group - Pituitary Patient Support Group - Turner syndrome Society	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
		British Medical Association		X		Direct	Member of the British Medical Association	1999	Present	Inform Chair and will not take part in any discussions or decisions relating to BMA
		Emerging Futures and St Martin's Housing Trust				Indirect	Husband is a mental health counsellor and undertakes work independently and with the private provider Better Help, and VCSE providers: Emerging Futures and St Martin's Housing Trust	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, St Martin's Housing Trust or Better Help

		Long Stratton Medical Partnership			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Tracy Williams	Health Inequalities Advisor	One Norwich Practices	X			Direct	Employed 10 hours a week by One Norwich Practices as a clinical Lead in the Inclusion Hub for vulnerable adults service .PCN Health Inequalities lead	Jul-20	Present	All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions, voting, procurements etc
		Norfolk and Norwich University Hospital		X		Direct	Clinical lead for Health inequalities and inclusion health N&W ICB , Attend Quality and Safety Committee and ICP Partnership/H&WB Board, Norwich Place Clinical Adviser	Apr-23	Present	
		Queens Nursing Institute		X		Direct	Member of the Queens Nursing Institute	2012	Present	
		Royal college of Nursing		X		Direct	Member of the RCN	1987	Present	
		Faculty of Homeless and Health Inclusion		X		Direct	Member of the Faculty of Homeless and Health Inclusion awarded an Honorary fellowship March 2022	2014	Present	
		Norfolk and Norwich University Hospital				Indirect	Sister employed registered nurse at NNUH		Present	
		Norfolk and Norwich University Hospital				Indirect	Brother employed in an administration role at NNUH		Present	
Andy Yacoub	Chief Executive, Healthwatch Suffolk	Nothing to Declare	N/A				N/A	N/A		N/A
TBC Jon Fox										

NHS Norfolk and Waveney Integrated Care Board

DRAFT Minutes of the Patients and Communities meeting

Held on Monday 27 November 2023

Meeting in Public

Committee members present:

- Aliona Derrett (AD), Non-Executive Director and Chair of the Patients and Communities Committee, NHS Norfolk and Waveney Integrated Care Board
- Mark Burgis (MB), Executive Director of Patients and Communities, NHS Norfolk and Waveney Integrated Care Board
- Suzanne Meredith (SM) Deputy Director of Public Health, Norfolk County Council and Associate Director of Population Health Management, NHS Norfolk and Waveney Integrated Care Board
- Alex Stewart (AS), Chief Executive, Heathwatch Norfolk
- Paula Boyce (PB), Executive Director - People, Great Yarmouth Borough Council and representing the eight Norfolk and Waveney Health and Wellbeing Partnerships
- Tracy Williams (TW), Clinical Lead for Health Inequalities and Children, Young People and Maternity, NHS Norfolk and Waveney Integrated Care Board
- Cathy Armor (CA), Non-Executive Member and Deputy Chair of the Patients and Communities Committee, NHS Norfolk and Waveney Integrated Care Board

Participants and observers in attendance:

- Jennie Starling (JS), Head of Community Commissioning, NHS Norfolk and Waveney Integrated Care Board (*representing Karin Bryant, Associate Director of Commissioning, NHS Norfolk and Waveney Integrated Care Board)*
- Karen Barker (KB), Executive Director of Corporate Affairs and ICS Development, NHS Norfolk and Waveney Integrated Care Board, for item 9
- Jon Punt (JP), Complaints Manager, NHS Norfolk and Waveney Integrated Care Board, for item 9
- Shelley Ames (SA), Senior Integration and Partnerships Manager, NHS Norfolk and Waveney Integrated Care Board, for item 11
- Amrita Kilkarni (AK), Senior Programme Manager, NHS Norfolk and Waveney Integrated Care Board, for item 11

Attending to support the meeting:

- Rebecca Champion (RC), Senior Communications and Engagement Manager (Partnerships), NHS Norfolk and Waveney Integrated Care Board, and for item 11
- Emily Arbon (EA), Head of Communications and Engagement, NHS Norfolk and Waveney Integrated Care Board, and for items 12 and 13
- Rachael Parker (RP), Executive Assistant, NHS Norfolk and Waveney Integrated Care Board (Minutes)

1.	**Chairs welcome and apologies for absence**	
	Aliona Derrett (AD) welcomed everyone to the meeting. Apologies for absence had been received from Dr Frankie Swords, Andy Yacoub, Karin Bryant and Emma Ratzer.	
2.	**Declarations of Interest**	
	None declared	
3.	**Agree Minutes from the Previous meeting and Matters Arising**	
	The minutes were reviewed and approved as an accurate account of the meeting.	
4.	**Action Log**	
	The action log was reviewed and the updates added to the log accordingly.	
5.	**Spotlight on: Primary Care including General Practice, Dentistry, Pharmacy and Optometry**	
	AD welcomed Sadie Parker (SP), Director of Primary Care for the Norfolk and Waveney Integrated Care Board to the meeting. A presentation had been circulated in advance of the meeting and was taken as read. SP gave an overview of the four primary care contracts (General Practice, Dentistry, Pharmacy and Optometry) that the ICB Primary Care Team now looks after, working closely with many other teams across the ICB e.g. locality teams for general practice and community pharmacy along with business intelligence, quality, finance, medicines management and comms and engagement teams too. AD thanked SP for her presentation and acknowledged the huge amount of work taking place across all four domains. AD invited questions from the committee. Tracy Williams (TW) also acknowleged the huge amount of work undertaken by the Primary Care team and the focus on addressing health inequalities. TW queried, in relation to accessing appointments, whether Primary Care Networks (PCNs) working together at scale, and the use of additional roles had made any impact on access. TW also asked about the approach to dentistry and community pharmacy in relation to health inequalities. SP responded that although there hasn't been a formal evaluation, the general practice team now looks very different to that of five years ago in terms of the skill mix. SP highlighted recruitment to the Additional Roles Reimbursement Scheme (ARRS) and N&W benchmarks brilliantly for this in the region. For dentistry, there is a public health consultant in both Suzanne Meredith's team and also in the regional team working with N&W on our oral health needs assessment, looking carefully at where we prioritise investment in our system,and focussing on areas of deprivation. SP added the community pharmacy needs assessment is the responsibility of county councils and public health teams through the Health and Wellbeing Boards.	

Cathy Armor (CA) thanked SP for her interesting presentation, and asked in relation to financial resilience and GPs, and the collapse of One Norwich Practices, has this led to any other GP practices coming forward to highlight their financial difficulties. SP responded that no other practices had come forward and work was already ongoing with practices struggling with resilience issues, which can be for a number of reasons. However, there are concerns there are more practices that we don't know about, who are quietly getting on with delivering services, and that is one of the reasons why the ICB primary care team has been working on a visit programme for general practice. The ICB quality team is also considering how to support general practice by building closer relationships. SP added it really is important to build those connections with practices so that we can support them, and have those conversations before they find themselves at crisis point.

In relation to dentistry, CA asked how does the general public find out that they should ring 111 if they require urgent NHS dental treatment. SP responded that work is ongoing to get information out in the public domain but it is obviously difficult to get it in front of everyone at the moment they need it. The ICB comms and engagement team has been running campaigns around primary care and materials have been provided to general practice. Local councils have also been informed and information has gone out in the ICB stakeholder bulletin, and to local providers e.g. pharmacies.

Suzanne Meredith (SM) commented that she felt the move of dentistry, pharmacy and optometry to SPs team was very positive, particularly the ability to drive local change in N&W, and also the investment in oral health promotion and prevention. It's good to see positive changes and the joining up of all the different aspects of primary care, and seeing the impact community pharmacies can have in terms of supporting the N&W system.

AD sought reassurance on some points in SP presentation as follows:

- *Patient ratings of the services they are accessing in N&W* – SP responded that we know what we're working with and each PCN has a plan based on the data and the areas they need to improve, and their chosen priorities. They are being supported by ICB locality teams and work is being closely monitored.

- *Factors being taken into account when scoring the risk on resilience* – SP responded that this came about as a result of Covid and the practice workforce being significantly impacted by the pandemic. We are aware of the significant workforce issues in some practices which impacts on their ability to deliver good access and reliable services. We also know that some practices are struggling with the below inflationary contract rises through the national conracting route. There is also the impact of other services on them e.g. people with dental pain going to practices, pharmacies closing unexpectedly because they haven't got locum cover. There's a variety of factors and what we've tried to do is score the likelihood, and the likelihood has increased quite significantly over the past two or three years.

- *Main reasons for the handing back of dentistry contracts* – SP responded the main reason being given is the national dental contract which is not as attractive to dentists, and the money is very tight for them. Contract values were set historically when the contract was first introduced many years ago.

	Costs change and it's very competitive now trying to recruit into NHS dentistry. • *Optometry NHS contractors* - SP responded that all our local optometry providers have an NHS contract AD thanked SP for her update and attending today's meeting **Forward Planner for March 2024 – Update on General Practice, Dentistry, Pharmacy and Optometry – *S Parker***	
6.	**Update on Planned and Effective Care**	
	Unfortunately, due to technical issues Sheila Glenn was unable to attend the meeting, therefore this item was deferred to the next meeting (22 January 2024)	
7.	**Ageing Well Programme Board – Terms of Reference**	
	The Terms of Reference (ToR) had been circulated to the committee in advance of the meeting. AD asked the committee for comments relating to the ToR; none were received, however AD asked MB for clarification regarding membership of the Ageing Well Programme Board, in particular whether there was representation from the Later Life Network (LLN). MB thought Dan Skipper from Age UK was representing the LLN but would check with Sheila Glenn. As there were no further comments or observations relating to the ToR these were approved and MB will take these forward once the above point had been clarified. **Action: MB to confirm the Later Life Network is represented on the Ageing Well Programme Board.** ***Post meeting update:*** *Sheila Glenn confirmed that Dan Skipper (Chair of the Later Life Network) is representing the Later Life Network on the Ageing Well Programme Board*	**MB**
8.	**Healthwatch Updates**	
	AD welcome Alex Stewart, Chief Executive of Healthwatch Norfolk (HWN) to provide an update of the work of Healthwatch Norfolk. A paper has previously been circulated to the committee which was taken as read. AS explained the update focussed on the general engagement that HWN undertakes and highlighted some key points: • In the three month period from 1 June to 31 August, HWN engaged specifically with 492 members of the general public, plus a further 1500 engaged across the three hospitals • From a primary care point of view, it's encouraging what people are saying about specific primary care surgeries. There are some very specific reviews about doctors surgeries and overall the average rating is 3.9 out of five. • Moving forward we have the opportunity to look at how we link up all the work that is going on across N&W, particularly linked to the Community	

	Voices insights and how best we can use those insights to strengthen our work with patients and communities. AD thanked AS for the update and agreed the triangulation of data is important and suggested a separate meeting with the appropriate people to move this work forward. AD invited questions from the committee. TW asked what insignts and feedback HWN have for those areas of N&W with high deprivation. AS responded that the data is at poscode level and HWN are making increased use of social media and targeting specific areas in order to get rich information. AS gave an example of how HWN have put out a specific call around gynae and paediatric services in Gt Yarmouth, and those people who might be using the James Paget Hospital, because there are some results coming out that are suggesting these services are not as good as they could be. A message has gone out in those areas requesting comments on services received. The message is going out in several different languages as well. MB commented that whilst the HWN report does highlight areas where improvements are required, it also highlights where we're doing things well and how we can build, share and learn from that. The committee agreed it will be helpful to scrutinise what the N&W population actually thinks about the services available to them and their experiences, and that a particular 'place' should be selected to focus on. Following discussion the committee agreed that Great Yarmouth should be the area of focus. AS agreed to link with Shelley Ames and Amrita Kulkarni to move this work forward. AD asked that this item comes to the next meeting in January 2024.. AD thanked AS for the update and expressed her thanks to AS and the HWN team for all the work they're doing. **Forward Planner for January – Focus on Great Yarmouth insights and experiences**	
9.	**Complaints Report**	
	AD welcomed Karen Barker (KB), Executive Director of Corporate Affairs and ICS Development and Jon Punt (JP), ICB Complaints Manager to the meeting. A paper had been circulated in advance of the meeting which was taken as read. KB explained that as well as the normal trends and information, and following the request at the last meeting, the report also included more details around GP access trends and continuing healthcare. Examples had also been included to give an insight into exactly where the complaint originated and how it was addressed. AD thanked KB and invited questions from the committee. AD began by acknowledging the inclusion of the examples and although they were very interesting, what is the ICB and wider system doing to ensure changes are actually made in relation to the issues raised in the complaints. KB acknowledged this is an area the ICB hasn't done particularly well in in the past and there are plans in place to work through this in more details. One area which is being looked at is realigning the complaints function more into a patient experience function.	

	JP added that it's for the complaints team to define whether it's an individualised issue which will need involvement from other colleagues and teams. But often complaints can be due to communication issues or a misunderstanding at a local level which can be resolved quite quickly. In relation to health inequalities, TW commented that it takes a lot for some people to speak up or complain, and she felt that some of the quieter voices in our communities that have had a bad experience just don't complain when really they should. JP agreed and added that he and Shelley Ames are involved a piece of work which should be able to identify exactly from where the contact has been received, which he would share with TW. JP added there is also another strand to this, which is if people are complaining to the commissioner of the service usually it's because they are escalating that they are dissatisfied at provider level or they may have indepth knowledge of the way that health services are commissioned. If people are having to come to the ICB then that is quite suggestive that there may be an issue and it's the tip of the iceberg, so the strengthened arrangements will hopefully mean more solidified relationships with our providers in terms of what their patient experience is telling them as well. AD asked JP if he knew the approximate percentage of complaints received from people who actually never complain to the provider, and come straight to the ICB. JP responded that unfortunately he did not know the percentage but if the complaint is purely about the provider, and unless there is a really good reason for them not to complain directly to the provider, the complaints team will usually encourage them to approach the provider. The reasons for this are that the ICB doesn't hold any patient data and it can be a bureaucratic process to get consent. However JP agreed a more formal way of capturing this information was something which required further exploration. AD thanked JP and KB for attending the meeting and asked for a further update at the March committee. **Forward Planner: Complaints progress update – March 2024 – K Barker and J Punt**	
10.	**Population Health and Inequalities Board Report**	
	AD invited MB to present the Population Health and Inequalities Board Report which had been circulated to the committee in advance of the meeting. MB took the items as read but highlighted a couple of points: • The Board had approved MB to be the deputy chair, supporting Dr Frankie Swords as chair • The work linked to PHM and HIE strategies, and the digital weight management programme MB highlighted there were no new risks identified by the Board at the October meeting but there was one item for escalation around the PMO process for equality impact assessments, but that should be going back to the next meeting in December. There were no actions for the Patients and Communities committee at this time.	

	TW added system wide engagement is underway in respect of the health and equalities strategic framework; engagement is going very well and the outcome will be presented at a future committee meeting. MB also added that health inequalities had been presented to the recent Health and Wellbeing Partnership which was very well received and supported. There was some particular interest from the children and young people team at Norfolk County Council who are keen to be involved. SM added that the population health management approach is slightly different to the health inequalities approach because it's not as broad and wide reaching, but it will be a key enabler in terms of the way we do things and useful when we're triangulating data as well. AD thanked MB, TW and SM for the update, and also thanked the Population Health and Inequalities Board for its work.	
11.	**Community Voices Update**	
	AD welcomed Amrita Kulkarni (AK) - Senior Programme Manager, Shelley Ames (SA) – Senior Integration and Partnership Manager, and Rebecca Champion (RC) - to the meeting for this item. A paper had been circulated in advance of the meeting which was taken as read. SA, AK and RC gave a quick overview of Community Voices (CV) which was borne from learning from the Covid pandemic, which shone a light on inequalities and access to healthcare and an approach was piloted that produced good outcomes. It also reinforced the importance of working with trusted communicators within the voluntary sector and also district councils. CV is not only an engagement mechanism but it also acts, looking to build health literacy in communities and support residents to access services. CV is made up of a series of discreet pilot projects looking at specific outcomes e.g. access to the vaccination programme, and access to cancer screening services which all builds the insignt bank through the conversations and supporting actions. It is also an opportunity to deliver CORE20 and CV has started to touch on some of the priority areas of the PLUS5 groups. It was noted that CV has yet to move aware from pilot into business as usual, however the Health Inequalities Framework presents opportunity for this. SA also pointed out that CV has to date been non-recurrently funded and has utilised the approach to draw down in excess of £500k of external funding with, more bids in the pipeline currently. AD thanked SA, AK and RC for the presentation and commented there is plenty of work to do to embed CV and make it work. AD asked SA what is the understanding and uptake of the various teams in the ICB about CV, and is there a proactive approach to people coming to the CV team and asking for data relating to a specific project or strategy to help understand population needs. SA responded that the CV team has worked directly with a number of teams, for example mental health, children and young people, and planned care and cancer. Conversations are taking place with the maternity team and there is an ICB workshop on 28 November	

	to discuss how CV might be used in the future as a mechanism to deliver organisation objectives internally. SA felt the uptake, engagement and links were very good. AS felt the work that has been done is tremendous, however there has been a lack of oversight of Healthwatch which has been left out of conversations. AS also made an observation about some of the language used e.g. delivery outcomes, and felt there should be more examples of 'you said, we did and as a result, this has changed'. AD agreed with AS that people need to know what the outcome and impact of asking a question is. In terms of working together, AD said there was no intentional exclusion of Healthwatch and suggested discussions can take place in a separate meeting to bring thinking and actions together and put plans in place. SA noted AS comments about language used and would link with AS about how best to facilitate Healthwatch Norfolk's involvement in this work.	
12 & 13.	**Communications and Engagement Update**	
	AD invited Emily Arbon (EA), Head of Comms and Engagement for the Norfolk and Waveney Integrated Care Board to update on the ICS Comms and Engagement Group and the Forward Plan. Papers had been circulated in advance of the meeting which were taken as read. The committee were also asked to review and approve the Terms of Reference for the Norfolk and Waveney ICS Communications and Engagement Group. EA highlighted the papers included updates on the core activities for comms and engagement for the ICB team as well as the core activities across the system. The comms and engagement team is very busy undertaking all the work outlined in the papers and leading on systemwide partnership work with colleagues including local authority, VCFSE and wider partners to coordinate partnership activity as much as possible. AD thanked EA for the update and invited questions from the committee. In relation to the forward plan, AD asked if it was possible to make a distinction in the plan between engagement and comms activities, and whether it is engagement at system level. Once these changes have been made, AD asked for the forward plan to be circulated widely to system partners and NEDs so they are aware of the work ongoing. AD also suggested the comms and engagement team utilise the VCSE Assembly more in terms of reaching the VCSE sector who will have contact with many hard to reach people in areas where we may not have an entry point at all as a health system. EA agreed to look at how information is cascaded. CA asked whether each provider also has it's own comms and engagement team. EA responded that providers do have their own teams and obviously the ICB comms and engagement team are not party to everything those teams are doing, but this is the idea of the ICS comms and engagement group which meets regularly to work on key campaigns. For example, the winter campaign is a system campaign and this year it's being led by Norfolk County Council with input from the ICB and all system providers. AD asked the committee for comments or observations regarding the Terms of Reference. AS asked for the membership list to be reviewed as there are some people listed who are no longer working for an organisation or within the N&W	

	system. EA agreed to update the membership. The committee approved the Terms of Reference.	
14.	**Any Other Business**	
	AS highlighted to the committee one item linked to the report due from the Public Accounts Committee about the potential threat to the RAAC hospitals and in the event anything happens e.g there is a serious incident linked to an acro beam that collapses in a theatre, that all hospitals across the whole country with RAAC will have to be closed. AS expressed some doubts regarding the regions emergency planning and felt it was important to flag this important item to the committee, and the potential impact it would have on patients and carers AD asked MB for his thoughts on this; MB acknowledged there were plans in place and the size and scale of the impact will be very significant, but it is on the ICB risk register and will be further developed on the register.	
Date, time, and venue of next meeting: Monday 22 January 2024, 1500-1700hrs via MS Teams		

Minutes agreed as accurate record of meeting:

Signed: …… Date: ……...
Chair

Code
RED Overdue
AMBER Update due for next Committee
GREEN Update given
BLUE Action Closed
PURPLE Action has a longer timescale

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Norfolk & Waveney ICB Patients and Communities Committee
Action Log

No	Meeting date added	Description	Owner	Action Required	Action Undertaken / Progress	Due date	Status
6	30.1.23	ICB and ICS organogram	PH	Organogram to be produced to show what the ICB and ICS does to aid public understanding, and to share on ICB and ICS websites	This is a work in progress and will be shared once finalised. This is a big task to do this across the ICS. The ICB structure was shared with HWN previously 22.5.23: Ongoing. 24.7.23: Action to remain open 25.9.23: Action clarified and updated 27.11.23: Organogram has changed to a webpage; currently being developed and will be populated once the ICB restructure is complete	25.3.24 ~~27.11.23~~ ~~24.7.23~~ ~~May~~	
11	24.7.23	Children & Young People update to come to a future meeting	R Hulme	Update to include service user / patient feedback and examples of progress made, impact and outcomes and the difference the improvements are making to residents	15.1.24: Awaiting confirmation whether R Hulme can update at May's meeting	***20.5.24 tbc***	
12	25.9.23	HWS Asthma Survey	A Yacoub	HWS to update at November's meeting on the outcome of the asthma survey	27.11.23: Asthma survey findings and key learning - agenda item for March meeting	25.3.24 ~~27.11.23~~	
16	25.9.23	Integration with VSCE	M Burgis	M Burgis to pass on AD thoughts from the meeting to D Williams around clairfying issues and improving engagement with the VCSE sector	27.11.23: MB has fedback to D Williams and the wider team and this is being acted on. VCSE Assembly update to be an agenda item for January's meeting	22.1.24 ~~27.11.23~~	
19 (actions 4 & 10 merged 27.11.23)	27.11.23 action 4 raised 30.1.23 action 10 raised 24.7.23	Lived experience representative	PH / RC	*(Action #4)* Committee members to provide feedback to PH. Reflect at March meeting as to where we are and what adaptations have been made to the current plan to take this forward *(Action #10)* MB and PH to ensure lived experience representation for the PH&I Board is linked into the Patients and Communities Committee lived experience representation work currently underway	The pack has been finalised and shared widely for comment with partner organisations, stakeholders and forums. Comments will then be factored into the final pack. Roles expected to be advertised late March 2023. 22.5.23: Working through some HMRC issues relating to payment method and policy, but hopeful that a policy already in use in some London trusts and HMRC approved, can be used in Norfolk and Waveney. 24.7.23: Ongoing. Continuing to work with HMRC and ICB Finance colleagues to ensure suitable policy is in place prior to recruitment commencing 25.9.23: Draft recruitment packs have been circulated to the committee. Still awaiting confirmation from HMRC regarding a suitable policy 27.11.23: HMRC has requested to have sight of the paperwork the ICB will use to pay lived experience representatives *27.11.23 Actions 4 and 10 merged as both linked to Lived Experience Representatives* 15.1.24: ICB Finance team still awaiting a response / update from HMRC	22.1.24 ~~27.11.23~~ ~~25.9.23~~ ~~22.5.23~~ ~~23.3.23~~	

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N&W ICB Patients & Communities Committee – 22.1.24
Item 5.1

Planned Care and Cancer Areas of Activity

Update for the Patient and Communities Committee

Sheila Glenn – Director of Planned Care and Cancer

Cancer Transformation Programme

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Background

•**National Strategy:** **National Long-term Plan** (LTP) **for Cancer** NHS Long Term Plan » Cancer, Cally Palmer
There is a **Nationally defined delivery plan** for the LTP for cancer, with a focus on improving Cancer Waiting Times (CWTs), survival and stage at diagnosis.
•**Strategic alignment:** Programme in alignment with the **EOE Cancer Alliance Strategy** and **Norfolk and Waveney ICB Clinical Strategy Objectives**.
•**Programme Governance:** is via the system **Cancer Programme Board**, linking to **Elective Recovery Board** for CWT performance issues. There is National quarterly monitoring of the implementation of the delivery plan via the Cancer Alliance.
•**Resource: 3M Fixed term cancer transformation resource** to support23/24 implementation. Additional resource of **just over 1M** allocated to the NNUH to support their CWT recovery as a Tier 1 trust.
•There is a **clinically led system cancer transformation team** which works closely with partners across the system, including: Local Acute Trusts, Primary Care Networks and GP Practices, EOE North Cancer Alliance, Big C Cancer Charity, Macmillan Cancer Support, Opening Doors, Health Innovations East, ICB Community Voices, System Diagnostics Programme and local cancer support groups

Workstreams

1. **Faster Diagnostics/Improving Operational Performance:** Support for Trusts to recover Cancer Waiting Times performance. We are measured on **4 cancer metrics** as a system. i) 62 and ii) 28-day Cancer Waiting Times (CWTs), iii) Non-Specific Symptoms (NSS) Pathway and iv) Primary Care uptake of the Faeco-immuno-chemical test (FIT). Implementation of nationally defined Best Practice Timed Tumour Site Pathways and national Faster Diagnostics projects
2. **Earlier Diagnosis:** To improve stage at diagnosis and survival rates
3. **Better Treatment and Personalised Care and improving access to psychological support**
4. **Cross-cutting: 4.1 Cancer Workforce 4.2 Patient and public involvement, 4.3 Addressing inequalities in cancer care**
5. **Evaluation:** Impact of programme/projects

Delivery to Date

1. **Faster Diagnostics/Improving Operational Performance:** As a system we are not meeting the CWTs. System and trust actions are underway to support recovery. NNUH in Teir 1 and JPUH in Tier 2. A system cancer deep dive in November. System NSS pathway in place, waiting for ICB commissioning decision re substantive funding. System FIT uptake good (85%). Trusts lead on implementation of the Best Practice Timed Tumour site Pathways. System led faster diagnostics projects re implantation of Telederm, FIT Negative colorectal pathway, Colon Capsule and Capsule Sponge endoscopy pilots and planning for hosting a regional genomic cancer service.
2. **Earlier Diagnosis:** C the Signs cancer clinical decision support tool implemented Nov 23. National Community Pharmacy pilot going live this month. Targeted Lung Health Checks lung cancer screening programme operating in Great Yarmouth and Lowestoft. Procurement for extension to West and Central localities from April 2024.
3. **Better Treatment and Personalised Care and improving access to psychological support:** The trusts lead implementation of personalised care. In place for breast and colorectal pathways. Scoping of a community approach to with Macmillan. A system psychological support model has been agreed but there are deficits in capacity.
4. **Cross-cutting:** 4.1 Workforce strategy in place and system group working on a multi-professional approach 4.2 System PPI approach agreed. Big C Cancer Academy project underway. 4.3 Health inequalities in cancer care training available online, engagement projects with LD community and Community Voices re bowel screening underway.
5. **Evaluation:** Closure report agreed for evaluation of optimal pathways, personalised care, care navigators and rapid cancer diagnosis service. Planning for **C the Signs evaluation** from April 2024.

Contact for more information: nwicb.cancerprogramme@nhs.net

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Elective Care Access

ELECTIVE RECOVERY

- Commissioning new services from NHS and Independent Sector providers (ISP)
- Arranging transfer of long wait patients to new ISP: over 1000 patients transferred since Apr 2023.
- Managing ISP performance.
- Supporting the national PIDMAS programme
- Implementing the Women's Health Hubs

CLINICAL POLICY DEVELOPMENT GROUP

- Review and approves Individual Funding requests
- Developing new policies and ensuring all policies up-to-date and accurate.
- Horizon scanning
- Owns the Clinical Threshold Policy

REFERRAL MANAGEMENT

- Supporting primary care staff to use e-Referral Systems.
- Referral Optimisation
- Designing new referral forms and clinical pathways
- Supporting Patient choice agenda.
- Managing patient complaints and queries around waiting times.

KNOWLEDGE ANGLIA WEBSITE

- ICB approved source of information for patients and health care professionals
- Team ensures information is timely, accurate and relevant.
- Approval to proceed with new website Knowledge NoW: to launch April 2024.

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Cardiovascular and Respiratory Disease

PREVENTION

- NHS Diabetes Prevention Programme – 143% referral to target. Transition to new provider
- New Alcohol Care Team established at James Paget hospital
- Launched new NHS tobacco dependency services for James Paget patients and people in the community with serious mental illness. Plans developed for new smoking in pregnancy services.
- ABC Project progressing in design stage, fully meeting JFP ambitions, case finding and intervening early with at-risk patients.
- NHS Digital Weight Management Programme – 70% referral to annual target at end Sep. Referrals more than double total 2022/23 level.
- £150k funding for Lipids optimisation / prevention secured

CARDIOLOGY / STROKE

- Heart Failure – Focussed Echo Project £280k investment secured to reduce backlog and pilot innovative approach
- £500k funding secured for stroke community catalyst projects
- Integrated Community Stroke Service model action plan developed for NHS E priority
- Personal Stroke Record is being rolled out across all 3 acutes in partnership with the Stroke Association.

DIABETES

- Improvement in Type 2 Diabetes Care Processes 49.6% March 2022 to 59% in March 2023
- New initiatives/pilots commenced:
  - Type 1 Diabetes and Disordered Eating (T1DE) pilot – only pilot in EoE.
  - Transitioning Young Adult Diabetes pilot – early successes seen. National pilot.
  - Type 2 Diabetes and the Young (T2DaY) initiative - 99% NW practices signed up
  - Type 2 Diabetes Pathway to Remission (T2DR) initiative - Mobilising provider
- Rolling out Continuous Glucose Monitoring (CGM)
- Established series of successful educational Lunch and Learn sessions
- Commenced patient recruitment drive to digital structured education packages

RESPIRATORY DISEASE

- 10,000 additional appointments for acute respiratory infections delivered via local hubs supported winter 2022/23. Established again for winter 2023/24.
- Designing integrated respiratory service model of care and care pathways.
- Building respiratory disease data provision.
- Improvement in Pulmonary Rehabilitation service. Waiting list to start PR during 2022/23 reduced from 1375 to 875 patients.
- Improved access to accurate standardised respiratory diagnostics.
- During 2022/23, 8800 Patients seen by Post Covid Assessment Service across – initial assessment, progress review and intervention.

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System Clinical Programmes

WOMENS HEALTH HUBS

- Plans in place to improve access to contraception and menopause
- Increasing access to staff training and education
- Patient education and self-help tools

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OLDER PEOPLE

- Developing Ageing Well Strategic Framework

EYE CARE

- Standardised cataract pathway & specification implemented across all NHS/ISP providers.
- Redesign of pathway and production of standardised service specifications for all key subspecialities in line with Patient Choice regulations and PSR
- 79K of funding secured to support improvement of referral management processes from community optometry.

MSK

- Service specification written and programme aligned to implement
- Pathway standardisation aligning with GIRFT guidance
- Norfolk and Waveney wide single Point of Access
- Referral Optimisation into acute services
- Fracture Liaison Service implementation

PALLIATIVE AND END OF LIFE CARE

- Undertook a review to assess how the ICB is meeting its new statutory duty.
- Developed an Operational Plan to respond to review's nine urgent actions, and six medium- long-term priorities.
- Refreshed Clinical Programme Board. First meeting in February 2024.

DERMATOLOGY

- Informal consultation process to gain feedback on proposed dermatology and skin cancer pathways.
- Norfolk and Waveney system dermatology and skin Cancer pathways agreed and going through ICB governance process.
- Plans for Task and Finish Groups to take the wider programme forwards.
- Telederm piloted at acute with plans to roll-out to the other 2 acutes.

Norfolk and Waveney
Integrated Care Board

Agenda item: 5 ii

Subject:	MH Transformation Update
Presented by:	Dr. Ardyn Ross, Mental Health Clinical Lead, N&W ICB
Prepared by:	Dr. Ardyn Ross, N&W ICB Mental Health Clinical Lead
Submitted to:	N&W ICB Patients and Communities Committee
Date:	22/1/24

Purpose of paper:

At the Committees request, the attached presentation is an update on Adult Mental Health Transformation. Its is provided for information sharing and wider awareness raising purposes.

No committee actions or decision are required.

Executive Summary:

Please see attached presentation.

Report

NW Community Transformation updat

Recommendation to the Committee:

No committee actions or decision are required.

Key Risks	
Clinical and Quality:	NA
Finance and Performance:	NA

Impact Assessment (environmental and equalities):	NA
Reputation:	NA
Legal:	NA
Information Governance:	NA
Resource Required:	NA
Reference document(s):	NA
NHS Constitution:	NA
Conflicts of Interest:	NA
Reference to relevant risk on the Board Assurance Framework	NA

Governance

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

Norfolk and Waveney Community transformation and Pathway Integration

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Transforming community mental health services

Dr Ardyn Ross N&W ICB mental health clinical lead

Mental Health pathways

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- N&W strategy
- National context for Adult MH Community transformation
- Our local vision
- Key principles
- The New Community MH landscape
- Primary care MH and A &G
- Community Interface Service and Community therapy service
- PD/CEN, ED

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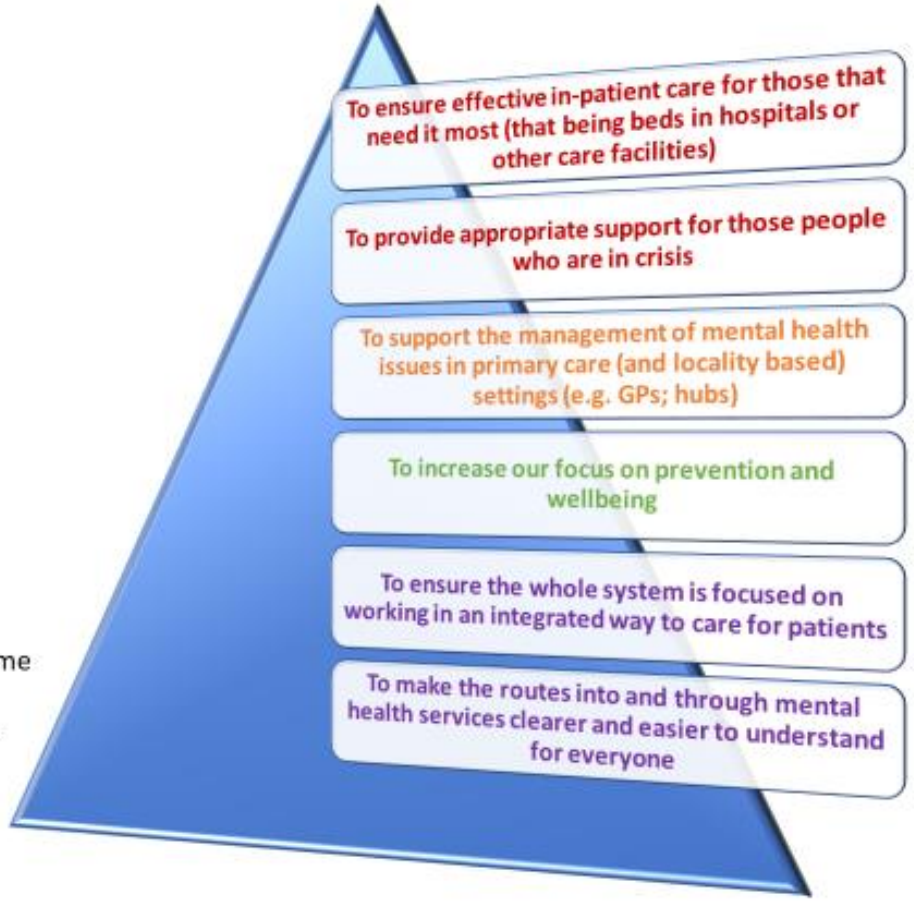
The Norfolk and Waveney Mental Health Strategy

Our Six Commitments



Colour coding:
Green = Prevention and Wellbeing Programme
Orange = Community Transformation
Red = Urgent & Emergency & Inpatient Care
Purple = All programmes

The National Headlines

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Adult Mental Health

- **Adults with SMI have been some of the most adversely affected by Covid and CoL crisis.**
- Significant baseline investment for transforming Community mental health services 2020/21**,** alongside ringfenced transformation funding
- Transformation of Community Mental Health services cornerstone of mental health transformation for adults
- Introduction of Community **Mental Health Access** metric and the development of a Community Mental Health waiting time standard (both collected through routine submissions to MHSDS).

Addressing health inequalities

- People with SMI face reduced life expectancy of 15-20 years when compared to the general population.
- IPS (Individual Placement Support) contributes to the local economy by reducing unemployment, and studies show that IPS can reduce welfare and health spend in the local systems. IPS services also provide job retention support

National Headlines

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Young people (18 – 25)

- Young people face consistent issues when trying to access mental health services including; lack of care continuity; different thresholds and concepts of what constitutes a mental disorder; different models of care and expectations for young people; different intensity of care provided for young people by adult mental health services; different potential pathways from children's to adult services, with different destinations, and; lack of training and expertise in adults services regarding working with young people.
- There are certain cohorts within this 18 to 25 age group that receive differential access to care:
  - young people who transition from children and young people's mental health services;
  - those who do not meet the criteria for adult mental health services but have continuing needs and require care;
  - people presenting to adult mental health services for the first time; high risk groups.

The Vision

- A place-based community mental health model aligned to PCNs including access to psychological therapies, improved physical health care, trauma informed care, medicines management, support for self-harm and substance misuse,
- modernisation of CMHTs to shift to whole person, whole population health approaches.
- A renewed focus on people living in their communities with long-term SMI
- A new focus on people whose needs are deemed too severe for NHS TT but not severe enough to meet secondary care “thresholds” including ED & PD (complex emotional needs).

The operating principle

A core multi-disciplinary community model working as a ‘therapeutic bridge’ between General Practice and Secondary services to facilitate timely interventions and smoother transitions and treatment pathways

A focus on meaningful trauma informed psychological therapies to meet the needs of those who require more bespoke care

Secondary care teams, to support those with the highest levels of need and a robust Care Programme Approach.

Eight Key Messages

The framework is integrated in whole system partnerships

Support, care and treatment based on complexity of need

Better serving those with complex needs and bringing together partners

Supporting high quality, NICE concordant care

Understanding the needs of our local population

Making the most of the new roles in the system and building relationships with teams

Thinking about process, access and outcomes

Co-produced change involving experts by experience and experts by training

Key principles

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- No wrong door
- Right Care, Right Place, Right Time
- Step up step down
- Single Trusted assessment
- Co-produced
- Integration with partners including locality resource
- New roles, new infrastructure (Wellbeing hubs, crisis houses, MH car)
- Holistic
- Evidenced based
- Compassionate

Community Transformation Needs-Based Pathways Map

Neighbourhood Based Care | Community Based Care | Area/System Based Care

LOW COMPLEXITY | MODERATE COMPLEXITY | MOST COMPLEX

Community Based Services

One Digital Front Door * Community Hubs/Cafes * Recovery College * VCSE Services * IPS* Social Services * Housing Support *

Primary entry points to MH Community services

Under 25 IFD– CYP Pathways

Self referral

General Practice

111 MH Option

eRS A&G

NHS TT & Social Model

PCN based MH team (GPs, MHPs, ERWs)

Community Wellbeing Hubs (one in each locality)

MHICI (MDT)

Community Interface Service

Crisis Hubs

Secondary Care Teams (includes specialist teams and CMHTs)

INPATIENT SERVICES

Population/demand triangle

Key:

- SU Entry Point
- Complexity of need
- General population demand

Urgent and Emergency Mental Health Pathways

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d Care System

"I tell everyone about this place. I think it's fantastic that you can just walk in, and someone is there to talk to."

Scan me to find out about all available mental health support.

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NHS

Community Wellbeing Hubs

A safe space to get support for your mental health and wellbeing in your community. With a focus on wellness, not illness, you'll always find a warm welcome and supportive staff to offer help, advice, or a listening ear.

Aylsham

Norwich

Gorleston

King's Lynn

Thetford

REST
Recover
Eat
Support
Talk

The REST Wellbeing Hubs in Aylsham, Norwich, and Thetford are operated by Norfolk and Waveney Mind. Visit their website for details of other services they provide.
www.norfolkandwaveneymind.org.uk

STEAM HOUSE CAFE
TRUSTED MENTAL HEALTH SUPPORT

The STEAM House Café Wellbeing Hubs in Gorleston and King's Lynn are operated by Access Community Trust. Visit their website for details of other services they provide.
www.accessct.org

Primary Care Core Team Development (MH staff working in General Practice)

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Locality	Role			2023/24 Planned		Totals in plan by March 2024
GY&W	MHP ERW			7/14 6/6		**14** **9**
North Norfolk	MHP ERW			7/12 6/6		**12** **9**
Norwich	MHP ERW			9/13 6/6		**13** **9**
West Norfolk	MHP ERW			6.5/13 6/6		**13** **9**
South Norfolk	MHP ERW			10/14 5/6		**14** **9**

Note: Roles funded from SDF 50% (to NSFT) and ARRS (PCNs) 50%. Roles must be match funded by PCNs

Community Interface service

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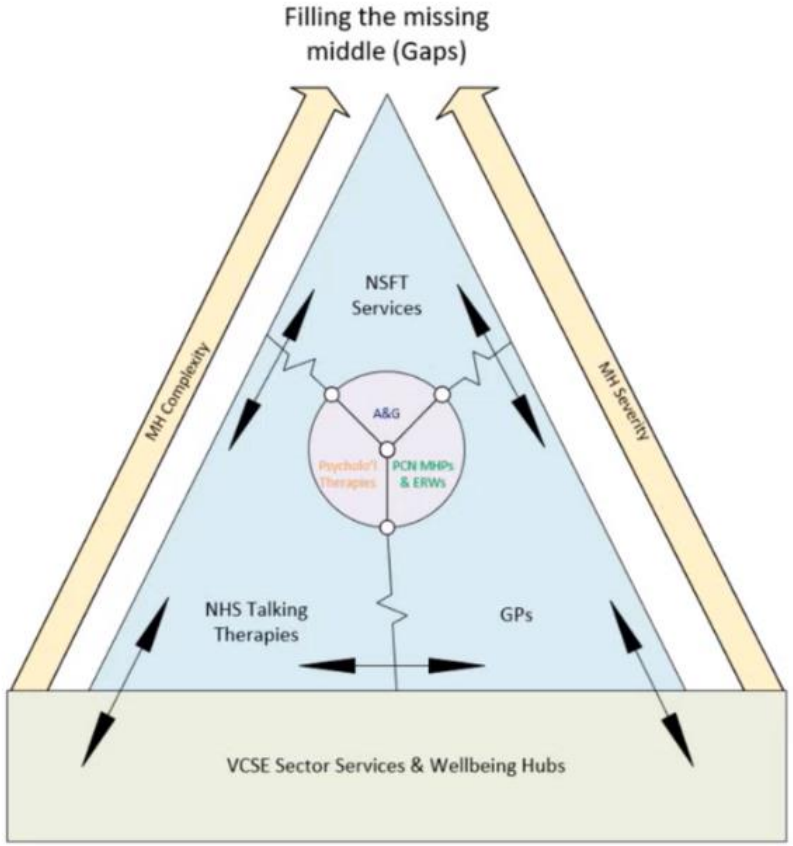
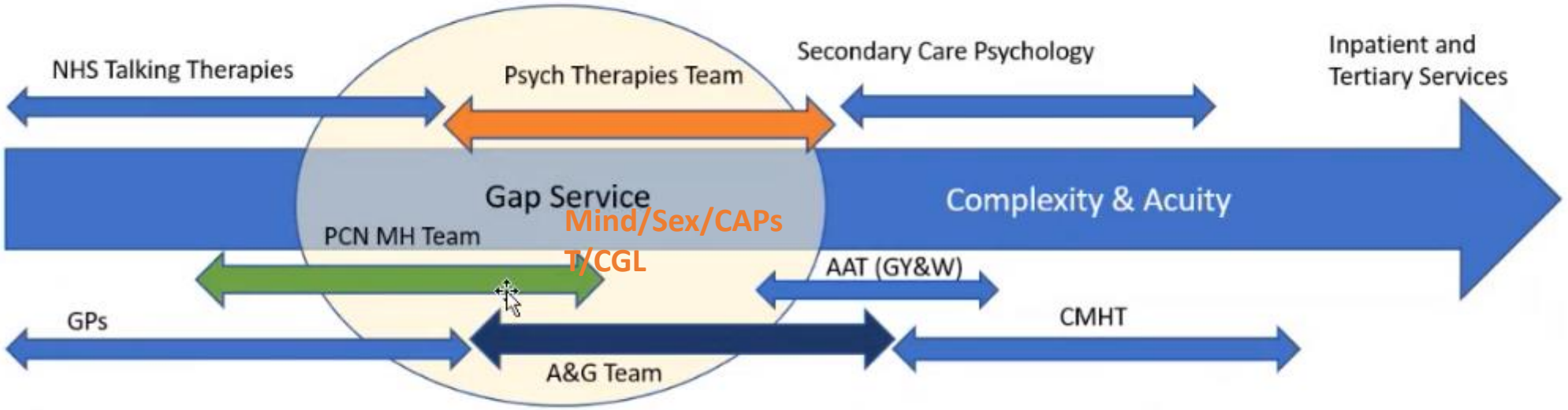


The missing middle and the development of a Community Interface Service

- People whose needs are too complex for Primary Care and NHS talking therapies but whose level of complexity does not require the full multi-disciplinary approach provided by secondary care services.
- The model illustrates complexity and severity and flow between GPs, Talking Therapies and NSFT services.
- There is a cohort of service users that fall in the "missing middle" (identified nationally).
- The **Community Interface Service** is being developed to help meet the needs of these people and bridge the gap in provision.

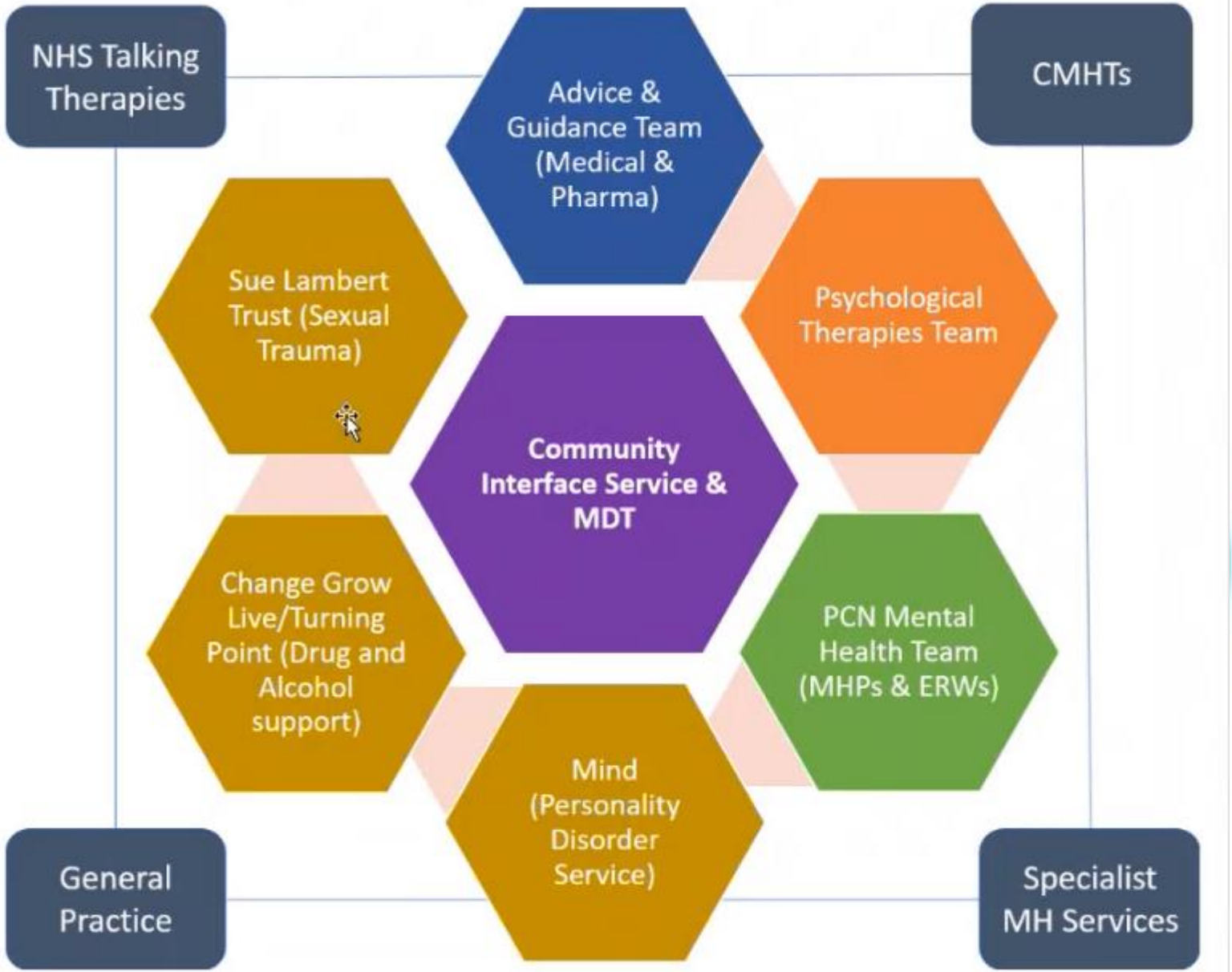
The Complexity Continuum – non-urgent – bridging the gap



Psychological Therapies – Serious Mental Health Problems (PT-SMHP)

- Ability to meet needs of "missing middle"
- Complete pathway
- Alleviate capacity and demand issues in GPs, NHS TTs and specialist services

Community Interface Service & MDT component parts



Clinical MH Advice and Guidance Gaps in Primary Care

- Diagnostic support
- Pharma decision making esp. for mood disorder, neuro disorders and for patients approaching 18
- De-prescribing
- Medication management/Optimisation
- Management of Drug shortages
- Medication counselling
- Audit
- Risk management
- A clear and accessible contact (relationship building) for specialist advice and guidance
- Step Down Support

Provision of these should support the delivery of care in Primary care, reduce referrals to CMHTs for the above purposes

Clinical Psychological Therapies Team – bridging the gaps

Norfolk and Suffolk NHS
NHS Foundation Trust

Clinical Psychology for complexity including:

- Complex Trauma/complex PTSD
- Chronic or severe depression and/or anxiety
- Drug and Alcohol Misuse
- Personality Disorders/Complex emotional needs
- Sexual assault Trauma (inc. complex dissociative presentations)
- Co-morbid mental health and neurodevelopmental disorders
- Complex physical health and mood

Evidence based treatment gaps in the community:

- Psychological formulation
- EMDR & trauma focused CBT
- Cognitive analytic therapy & schema focused therapy
- DBT informed approaches
- Adapted CBT approaches (e.g. for ASD)
- Stabilisation around emotional regulation or trauma symptoms
- Individual and group work

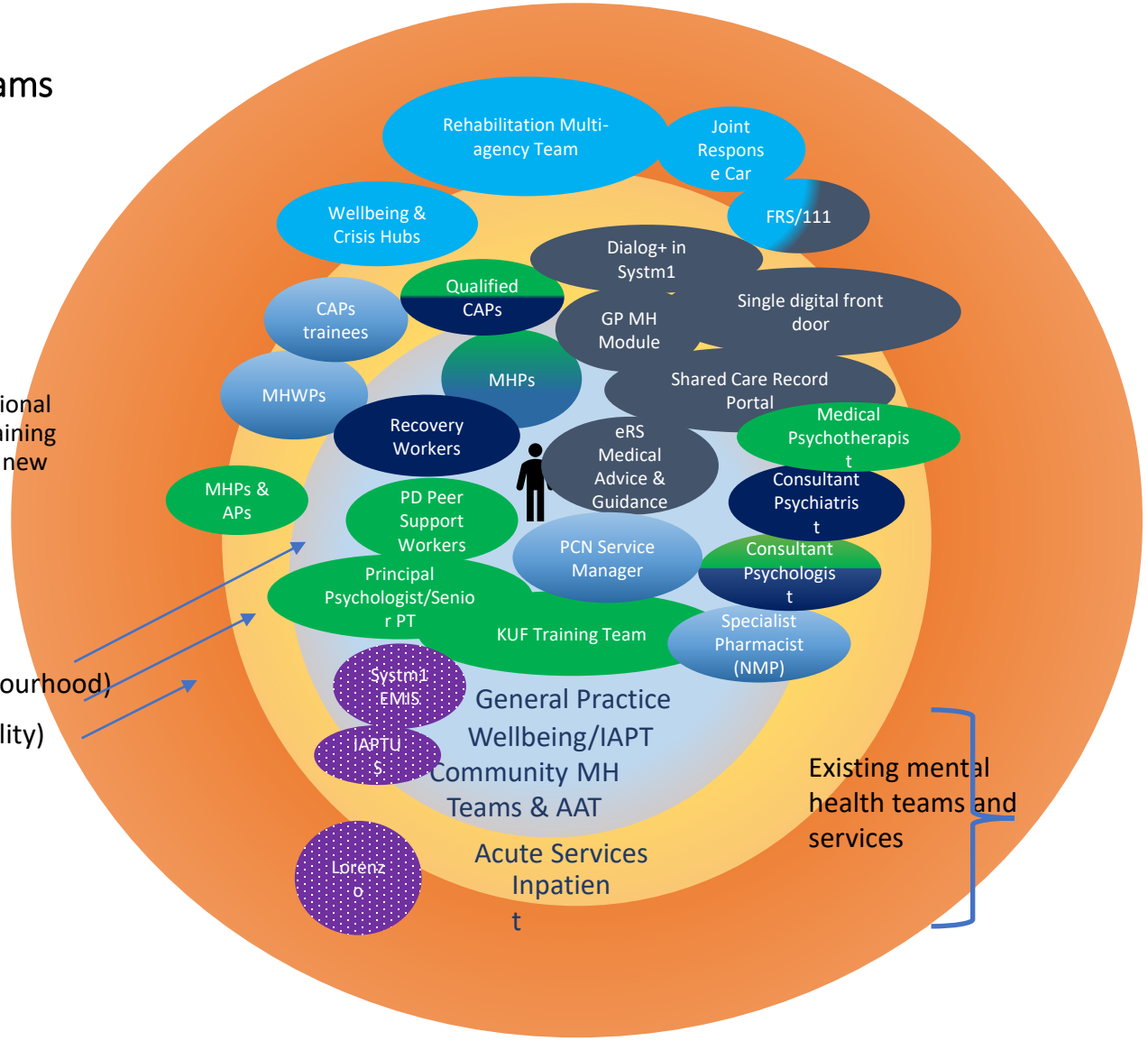
Plus:

Supervision, consultation and training to VCSE and PCN staff

Partnership working with VCSE sector including, Hoarding, PD, D&A

Developing Blended Community Teams

- New roles/placement – Phase 1
- New roles/placement – Phase 2
- Digital development
- New integrated services/teams
- Complex emotional needs – additional resource to deliver and embed training and treatment across system and new roles.



Location/setting

Primary & Community based care (Neighbourhood)

Community & Secondary Care (Place/Locality)

Acute/Inpatient Secondary Care (System)

in good health
The Norfolk and Waveney Health and Care Partnership

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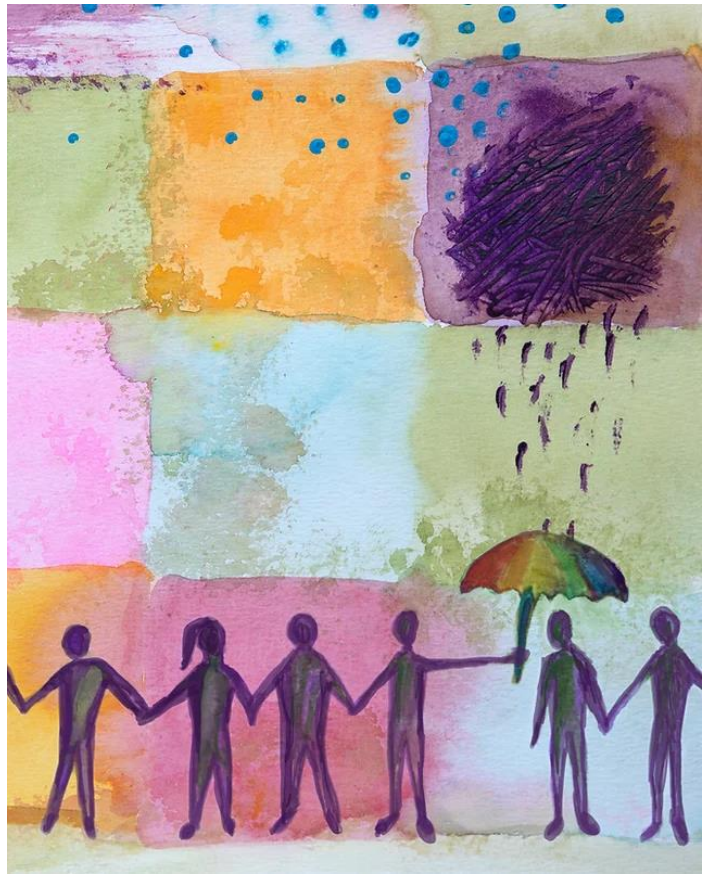
Thank you

Questions?



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Norfolk and Waveney
Integrated Care Board

Agenda item: 6

Subject:	**Report from the Transformation Board covering October – December 2023**
Presented by:	**Andrew Palmer, Director of Performance, Transformation and Strategy N&W ICB**
Prepared by:	**Liz Joyce, Head of System Transformation N&W ICB**
Submitted to:	**N&W ICB Patients and Communities Committee**
Date:	**22 January 2024**

Purpose of paper:

To provide assurance to the Committee that the Transformation Board is discharging its functions, and inviting any comments, questions, or requests for further information.

To recommend that the Committee supports the proposed approach to the Joint Forward Plan (JFP) refresh.

Executive Summary:

This is the second report of the Transformation Board to this Committee and includes details of the main work areas over the past three months.

The key areas of focus have been:

a) Joint Forward Plan (JFP)
b) Strategy alignment and the Clinical Strategy in particular
c) Improving Lives Together (ILT) programme
d) Community Services Review (CSR)
e) Transition of the commissioning of services from NHSE to the ICB
f) Reports from feeder operational delivery Groups / Boards

Future areas of focus are:

- JFP refresh and monitoring
- Alignment of strategies and plans across the system
- Single system transformation workplan
- Continued oversight of the ILT and CSR workstreams
- Co-ordination of the implementation of the Clinical Strategy in year two
- Reflecting and evaluating the work of the Board and opportunities to improve

As part of the ICB governance review, a new Commissioning and Performance Committee will replace the Transformation Board during spring 2024. Therefore, this

is likely to be the last report to the Patients and Communities Committee from the Transformation Board in its current form.

There are no risks to highlight to the Committee that the Board is responsible for, other than the current entry (number 22) in the ICB BAF in relation to the delegation of Specialised Services from NHSE to the ICB.

Context

The role of the Transformation Board is to co-ordinate the delivery of strategic transformation at system level, acknowledging that moving forward, more of the transformation will happen at place and within provider collaboratives.

The remit and responsibilities of the Transformation Board will migrate into the Commissioning and Performance Committee in due course as part of the ICB governance review.

The first report of the Transformation Board ("the Board") to this Committee was provided in September 2023. This current report highlights some of the key areas of work undertaken during the third quarter of 2023/24.

Key areas of focus

a) Joint Forward Plan (JFP)

The Board is monitoring implementation of the JFP and has a role to support and escalate / unblock any emerging issues. The first report was received in October 2023 and the second is scheduled for later this month, supported by the ICB PMO team.

The reporting format was piloted before being rolled out and aligns with the published JFP. It reports on what are we going to do, how we are going to do it, how we are going to afford it, key dates for delivery and how we will know we are achieving our objectives.

The eight Ambitions and the 21 underpinning Objectives are tracked according to what has been completed, is in progress and delayed. There were no specific escalations in October in terms of entire objectives being at risk of non-delivery or withdrawn, but some delays against the original timescales were reported for the Objectives in Ambitions 1 Population Health Management, Reducing Inequalities and Supporting Prevention, Ambition 4 Transforming Mental Health Services, Ambition 5 Transforming Care in Later Life, Ambition 6 Improving Urgent & Emergency Care and Ambition 7 Elective Recovery and Improvement. Within the context of the ICB restructure and Industrial Action this is a fair appraisal of realistic and achievable progress. All the Ambitions reported a number of measures of success and could evidence good progress within the most recent quarter.

2024/25 JFP Guidance was received on 22 December 2023 and can be found Here

It is very similar to 2023/24, noting that revised plans are expected to reflect a continuation of the priorities set out in the previous year's JFP. The annual review is an opportunity to update plans based on updated assumptions or priorities, including those set out in the 2024/25 priorities and operational planning guidance (which has not yet been published in detail) and address the last year of the original five-year plan horizon.

It is not proposed to change the eight Ambitions within the Norfolk & Waveney JFP so the JFP review will be light touch, but will include greater reference to the Community Services Review, Improving Lives Together work and the New Hospital Programme. The Committee is asked to endorse this approach.

Our revised JFP will be published on our ICS website before 1 April 2024 and approved by the ICB Board in March.

b) Clinical Strategy alignment

Linked to the JFP is a parallel workstream of system strategy alignment.

There are four strategies / frameworks for action that are outcomes from the JFP: A Population Health Management Strategy, a Health Inequalities Framework for Action, the Ageing Well Strategic framework, and vision for General Practice. These should all be published in March/April 2024.

The Board is also accountable for coordinating the implementation of the ICS Clinical Strategy. The progress report for year one was referenced in the last report to this Committee.

The clinical strategy outlined six key objectives, which was that my NHS in Norfolk and Waveney would:

- Tackle health inequalities
- See me as a whole person
- Be one service
- Reduce long waiting times
- Act early to improve health
- To be reliable.

We published a progress report against Year 1 in July 2023, which was presented to the Committee in our last report.

We undertook a huge array of work in Year 1, with 34 actions overall. The six themes within the Clinical Strategy remain current, but the learning from Year 1 was that this was overly complicated. Our ambitions for Year 2 have now been agreed through the Transformation Board and we have been explicit about which of the Year 1 actions have now been completed, are no longer relevant, have been built into business as usual for our teams or have been carried over into Year 2. Each of the six Objectives will also have a specific focus for Year 2, which includes 10 actions carried over from Year 1 and aligned with overlapping work already being monitored through the JFP.

This approach has been supported by our Clinical and Care Professional Assembly and by Norfolk and Suffolk Healthwatch, and a communications plan to share this is underway.

The six areas of focus for Year 2 are:

Objective	Year two proposed focus
1 See me as a Whole Person	People with MH needs
2 Be one high quality resilient service	Primary care, including dentistry, and clinical care for CYP
3 Reduce Long Waiting Times	Elective care including cancer care and care closer to home
4 Act Early to Improve Health	PHM, prevention and care for older people
5 Be reliable	Emergency care
6 Tackle Health Inequalities	Health Inequalities

Within the six themes are 19 new actions and 22 that are already part of our JFP. You will be able to read more about these here (https://improvinglivesnw.org.uk/norfolk-and-waveney-5-year-joint-forward-plan/) on our ICS website. We will publish progress updates at six-monthly intervals.

c) Improving Lives Together (ILT) programme

This is the System's principal joint transformation workstream and is referred to within Ambitions 6 and 8 in the JFP. The Board was involved in the determination of the three priority areas, driven by data, and these are Human Resources (HR), Digital Services and Improving Discharge from Hospital (RightCareNoW). Three Cases for Change have been received into the System, and now formally passed on to the individual Programme Delivery Groups to take forward.

There is an expectation of releasing savings and increasing productivity from these workstreams. In summary the scale of the opportunity (including both cash releasing and non-cash releasing savings) was identified as:

	£ million
HR	6.6
RightCareNoW	10-17
Digital	3.1

The governance for the ILT programme has now progressed from a single system project team overseeing the diagnostic phase and production of the Cases for Change, to three workstreams that will lead each programme. Each is being led operationally via the three existing local delivery groups which are the system's HR Directors, Digital Strategy Steering Group (DSSG), and the Discharge Board, respectively. Oversight and escalation is via the system Transformation Board where all partners are represented, with collective strategic sponsorship and the mandate

for this work from the ICS EMT. This is our most challenging piece of work, interlinked with our change culture and appetite for risk.

Each delivery group will need to consider with partners whether formal business cases requiring internal sign off by a partner are necessary.

The Norfolk & Waveney Acute Hospital Group (the three acutes as a Committee in Common) discussed the Cases for Change in January and all our System partners have been invited to take them through their own internal governance for visibility. This was discussed at the ICB EMT meeting on 18th December.

Delivery of these workstreams will remain challenging in the context of other work, but the three individual projects remain agreed as a priority by the ICS EMT.

d) Community Services Review (CSR)

The Board is also currently overseeing the review of Community Services across Norfolk and Waveney, with some external support. This review is across adults and older adults and reflects the broad range of pathways and services that fall within the scope of community services. Please note the change in reporting from April 2024; the CSR programme will report into the new Commissioning and Performance committee.

An external supplier, Tricordant, was engaged to undertake a Community Services Review to identify the optimal model needed to meet current and future demand across Norfolk and Waveney.

From March 2023 an engagement process was undertaken involving:

- Resident engagement
- >50 individual and group interviews with key leaders
- 2 system workshops, 5 Place Boards, Clinical Professionals Assembly meeting, 3 ICS EMT meetings.

They also reviewed good practice from the King's Fund and activity and financial data from comparable ICBs; testing and challenging models and assumptions.

The result was the creation of a framework to guide future planning, commissioning, and the delivery infrastructure of community health services in Norfolk and Waveney.

This framework revolves around four Strategic Impacts:

1. Proactive and personalised support from integrated teams
2. Delivering more specialist care in the community
3. Enabling healthy communities
4. Meeting local urgent and emergency care needs.

Through these impacts, community health services can make an important operational and strategic contribution to delivery of the Joint Forward Plan, system outcomes and a much desired 'left shift'.

We now enter the implementation phase. This is planned through learning from a series of agreed 'prototypes' testing new ways of working and in some cases, new models of care.

e) Transition of the commissioning of specialised services from NHSE to the ICB

In total 59 specialised services are being delegated to the six ICB's in the East of England from April 2024. In the short term the Board is overseeing what needs to be in place for the safe transition of the services and strategy development on day one. Post transition this work would move into the proposed new commissioning team at the ICB but NHSE resource will be available for all the functions as it is now, through the hosted team.

The transition work is being managed through an internal Task & Finish Group, together with NHSE. BLMK ICB will be the lead/host ICB for the NHSE Commissioning Team but all six ICB's are working closely together to develop principles of collaboration which will be reflected in a signed a Collaboration Agreement, setting out how we will plan services together and make collective decisions for example about budgets and prioritisation of transformation work. This is a significant point of principle as further services are likely to be delegated in future years and the eastern region ICB's may want to work more closely together more generally on other topics, so this starts to introduce new ways of collective working across the region.

There is a lot of work to be concluded between now and the end of March and a live risk register entry is on the BAF in relation to this transition.

f) Reports from feeder operational delivery Groups / Boards

Multiple Groups/Boards report into the Transformation Board in the current governance structure including the Planned Care & Medicines Management Group (PC&MMG), Elective Recovery Board, Diagnostics Board, Urgent & Emergency Care Board and the Cancer Alliance. The PC&MM group brings a report every month with others reporting by exception / escalation.

The Board has supported a number of recommendations brought forward by the PC&MM group within the past three months in relation to policies, specific pathways, and medicines. These include:

- Approval of the Patient Choice policy
- Approval of a new policy for joint working, to provide a robust framework to consider when and how ICB teams can work with pharmaceutical and other industries to support patient care
- Support for multiple areas of service transformation around planned care
- Noting the outcomes of individual funding request panels for both drug and non-drug treatments and supporting the review of clinical threshold policies where multiple requests arise in the same area
- A community COVID medicine service has been included within our commissioning intentions for 2024/25. People who are clinically extremely

vulnerable (CEV) may be eligible for specific treatments if they contract COVID. These are currently delivered through specifically commissioned community pharmacies with IV treatments delivered at two of our acute hospitals. These need to be provided as business as usual for 2024/2025 and so these have been added to our formal commissioning intentions for next year.

- Issues and risks relating to overwhelming demand for Specialist Weight Management Service. Work has been undertaken to risk assess and prioritise the patients at highest risk on the waiting list and options for how to manage this have been proposed. These were supported by the Transformation Board and are now going through the agreed ICB prioritisation process.
- Accreditation of independent sector providers is underway for providers of Cataract surgery and other Ophthalmology services. The need for this was also escalated to the Performance Committee.
- The need to support rapid recruitment of staff to lead on tobacco dependency services in maternity units was made and subsequently resolved through ICB Executive Management Team.

Other feeding groups have escalated key issues to the Transformation Board such as:

- The risk to elective recovery and cancer performance due to the impact of Industrial Action (this also is discussed at the Performance Committee)
- Delays in meeting diagnostic access standards for cancer which means there is a risk that patients could come to harm because their cancer treatment has not started as early as possible, as well as psychological harm from having to wait for test results. There are also medical oncology staff capacity issues and histopathology delays. These have been captured in the updated BAF cancer risk.
- Issues around the efficacy of a national lung cancer biomarker were raised. The quality impact of this and lessons learnt were also shared in detail through the Quality and Safety Committee.
- Within UEC, the Transformation Board was made aware of the risks of patient harm and the non-delivery of key performance targets – ambulance handover and impact on patients are the main concerns. We are proposing to consolidate the number of SROs, clarify and strengthen reporting lines, identify provider leads at each trust. Matthew Winn, CEO of NCH&C will lead the UEC board going forward.

Future work plan

Looking ahead at our future work plan as we transition into the new Committee, the focus will be across the following broad topic areas:

- JFP refresh and monitoring
- Alignment of strategies and plans across the system
- Single system transformation workplan
- Continued oversight of the ILT and CSR workstreams
- Co-ordination of the implementation of the Clinical Strategy in year two

- Alignment with the new operating model once developed.

Recommendation to the Committee:

1) That this assurance report is noted for information, particularly the activities of the feeder groups which are proactive and are supporting a wide range of challenging issues.
2) That the Committee supports the proposed approach to the JFP refresh.

Key Risks	
Clinical and Quality:	
Finance and Performance:	
Impact Assessment (environmental and equalities):	
Reputation:	
Legal:	JFP Guidance Here
Information Governance:	
Resource Required:	
Reference document(s):	
NHS Constitution:	
Conflicts of Interest:	
Reference to relevant risk on the Board Assurance Framework	BAF 22 Delegation of 59 Specialised Services to N&W ICB from NHS England on 1 April 2024 BAF 04 Cancer Diagnosis and Treatment

Governance

Process/Committee approval with date(s) (as appropriate)	Content of this paper is a summary of the work of the Transformation Board over the past 3 months. There were meetings held in September, October and November. The December meeting was cancelled.

Norfolk and Waveney
Integrated Care Board

Agenda item: 7

Subject:	**ICS All-age Mental Health Coproduction Strategy**
Presented by:	William Snagge - N&W ICB, Mental Health Strategic Commissioning and Sam Holmes - Rethink Mental Illness
Prepared by:	William Snagge - N&W ICB, Mental Health Strategic Commissioning and Sam Holmes - Rethink Mental Illness
Submitted to:	N&W ICB Patients and Communities Committee
Date:	22/1/24

Purpose of paper (presentation)

- To inform the Committee on work to develop and publish an all-age Norfolk and Waveney Mental Health Coproduction Strategy (please see link below), as drafted by an ICS wide working group during Q2&3 2023/24. This is further to introducing the adult mental health coproduction model to the Patients and Communities Committee in Q1 2022/23.
- To introduce the current draft strategy, and vison, and secure Committee endorsement for outline plans to develop the final strategy, and promote the development of an online toolkit, via engagement with Mental Health Provider Forum members, and grass roots community organisers and connectors.
- To provide an opportunity for Committee to feedback on this work and associated proposal to engage people who are close to what matters to people at the grass roots.

Executive Summary:

Coproduction and involvement are important, so that mental health care and support better meets individual needs (in terms of access, experience, and outcomes, and in addressing inequalities). The new Health and Care Act, also requires Integrated Care Boards (ICBs) and Trusts to adopt involvement and coproduction approaches that have regard to statutory guidance.

Earlier this financial year, a working group of ICS stakeholders, including people with lived experience of mental ill-health, NSFT, Public Health, NCC and representatives from the VCFSE sector, coproduced a draft five-year Coproduction Strategy. The work was supported by the ICS Mental Health Programme Oversight Board with guidance that: Partnership working and alignment across ICS were important; that the strategy should be all-age; should reflect statutory guidance for coproduction; and promote a mixed methods approach.

Strategy development to date has been facilitated by Rethink Mental Illness as part of their commissioned remit to facilitate mental health transformation coproduction across the ICS. Development work has built on extensive work across our Integrated Care System (ICS) to enhance coproduction of mental health transformation during 2021/22 - 2023/24.

The working group of ICS stakeholders expressed a vision for the strategy, that *by 2028, the voices of people and communities are at the centre of decision-making and governance about mental health services, at every level of the Integrated Care System.*

The aim, by the end of July next year (2024), is to have achieved awareness and consensus in the ICS for the strategy and developed an online toolkit, which is ready for organisations and groups to use.

To achieve the above, a new conversation between the ICS and people and communities is planned during Q4, 2023/24. This will include community organisers and community connectors, as well as via the Mental Health Providers Forum. The conversation aims to promote the following outcomes: -

1. Engaging groups and organisations with the vison of the draft strategy.
2. Sharing developments in mental health care and support, with the aim of beginning to build trusting and ongoing dialogue-based relationships about what matters to people, in relation to choices for people across the ICS.
3. Understanding the *what* and *how* of existing coproduction and involvement good practice - to inform an online, open access toolkit.
4. Through the above, finalising the current draft strategy and publishing the online toolkit. The toolkit will build on existing good involvement practice for understanding what matters to people and communities and enabling that to influence.

Comments and feedback from the Committee are welcome in relation to this work.

Committee member involvement in making connections with community groups or organisations to join conversations around the draft strategy and development of the toolkit, as part of the current phase of work, would also be appreciated.

Further information and involvement queries should be addressed to samantha.holmes@rethink.org

Reports (linked below and/or attached): -

- Slides presented to 22/1 Committee.

ICS MH Coproduction Strateg

- Draft ICS Mental Health Coproduction Strategy.

N&W Coproduction Strategy for P&CC 22(

Recommendation to the Committee:

- To note work to develop and publish an all-age Norfolk and Waveney Mental Health Coproduction Strategy (please see link below), as drafted by an ICS wide working group during Q2&3 2023/24.
- To note the current draft strategy, and vison
- To endorse outline plans to develop the final strategy, and promote the development of an online toolkit, via engagement with Mental Health Provider Forum members, and grass roots community organisers and connectors.
- To feedback on this work and associated proposal to engage people who are close to what matters to people at the grass roots.

Key Risks	
Clinical and Quality:	No clinical risks were identified in the work. No quality risks are noted.
Finance and Performance:	No financial risks are noted.
Impact Assessment (environmental and equalities):	Not applicable.
Reputation:	In sharing developments in mental health care and support, with the aim of beginning to build trusting and ongoing dialogue-based relationships about what matters to people, in relation to choices for people across the ICS, there is a risk that the ICS is not able to respond to any new needs identified, esp. given current financial constraints. This will be mitigated through clear definition of the parameters within which the ICB is able to operate and influence change, as part of planned engagement work.
Legal:	The Health and Care Act requires Integrated Care Boards (ICBs) and Trusts to adopt involvement and coproduction approaches that have regard to statutory guidance for coproduction.
Information Governance:	Not applicable.
Resource Required:	Not applicable.
Reference document(s):	Not applicable.

NHS Constitution:	Not applicable.
Conflicts of Interest:	Not applicable.
Reference to relevant risk on the Board Assurance Framework	Not applicable.

Governance

Process/Committee approval with date(s) (as appropriate)	N&W Mental Health ICS Partnership Board approved plan presented to commence development of an all-age ICS Mental Health Coproduction Strategy (Feb 23). N&W ICS Mental Health Oversight Board (new) endorsed the draft all-age ICS Mental Health Coproduction Strategy, developed by ICS Working Group (July 23).

Improving lives together

Norfolk and Waveney Integrated Care System

N&W ICB Patient and Communities Committee

Development of an ICS Mental Health Coproduction Strategy

William Snagge - N&W ICB, Mental Health Strategic Commissioning

Sam Holmes - Rethink Mental Illness

Why was a N&W MH Co-production Strategy needed?

- Building on extensive work across our Integrated Care System (ICS) to enhance coproduction of mental health transformation during 21/22 - 23/24.

- Recognising that the approach visioned in 20/21, and supported by the ICS Mental Health Partnership Board, now needs to go wider and deeper - in terms of promoting partnership, sharing good practice, and enabling good involvement of people and communities in mental health care and support provision, on a long-term basis.

- To identify the driving elements and factors, that will move us from the current co-production position to a desired position in five years' time - for ICS mental health care and support in Norfolk & Waveney.

Why are coproduction and involvement important?

Because it's the right thing to do

So that mental health care and support better meets individual needs (in terms of access, experience and outcomes, and in addressing inequalities).

Because we are required to

Building on the previous legal duty to *involve*, the new Health and Care Act, requires Integrated Care Boards (ICBs) and Trusts to *adopt involvement and coproduction approaches that have regard to statutory guidance*, and outline how systems will work with people and communities, in sustainable, ongoing dialogue.

Goals in developing the draft strategy

Development of a framework and toolkit (including structure, process, roles, and ways of working) for lived experience to effectively influence ICS mental health transformation, services and support.

Through the above, ICS mental health services and support across Norfolk and Waveney **reflect and respond to a wide range of lived experience information particularly about inequalities.**

Tracking and evaluating lived experience evidence base and thread of influence.

Through **continuous improvement**, the ability to identify specific structural elements, processes, resources, roles, ways of working, that may need adjusting based on learning in implementation - are understood and can be addresses and adjusted.

Progress to date

2023/24 Q1 & Q2

Rethink Mental Illness (commissioned by the ICB to facilitate this work) orientation sessions & established an all-age ICS-wide Working Group to co-produce a draft all-age strategy.

Drafts strategy published and shared with ICS Mental Health Partnership Board.

Draft strategy published on ICS website.

Draft strategy shared with Mental Health Providers Forum to support wider awareness raising and enlist support around community engagement and next phase of development.

Parker Rachael
16/01/2024 10:01:17

Overview of draft Strategy

Draft Vison

In five years', **the voices of people and communities are at the centre of decision-making and governance about mental health services, at every level of the Integrated Care System.**

Co-production leads to a culture shift towards seeing mental illness as a long-term condition. From ‘fixing’ people to focusing on their recovery, supporting them on an ongoing basis, towards a better life.

A toolkit helps people use co-production in the design, development and delivery of mental health services and support, across the ICS, on an ongoing and sustainable basis.

A final strategy and toolkit are published in Q1, 24/25.

Link to relevant web page

Link to draft Strategy

Next steps

2023/24 Q3 & Q4

Opening the conversation between the ICS and people and communities:

- Engaging groups and organisations with the vison of the strategy.
- Sharing developments in mental health care and support, with the aim of beginning to build trusting and ongoing dialogue-based relationships about what matters to people, in relation to choices for people across the ICS.
- Understanding the *what* and *how* of existing coproduction and involvement good practice - to inform an online, open access toolkit.

Through the above, finalising the current draft strategy and publishing the online toolkit.

Continuing the conversation with people and communities.

Patient and Communities Committee input

Q&A

Welcome **comments or feedback** from the Committee

Member involvement in making connections with community groups or organisations we can have conversations with around the draft strategy and the toolkit as part of the current phase of work, also much appreciated.

Further information & involvement queries: - samantha.holmes@rethink.org

End

Parker, Rachael
16/01/2024 10:01:17

Coproducing for better mental health outcomes for the people of Norfolk and Waveney

5 Year Coproduction Strategy

DRAFT

coproduced in 2023

Contents

Introduction

Better mental health outcomes for the people of Norfolk and Waveney of all ages, including children, will happen when services meet needs in the most effective ways possible. And if lived experience of care and support is valued equally to other expertise in the Integrated Care System.

Coproduction is when the feedback, views and ideas of people and communities flow into how care and support is offered and action is taken as a result. This includes carers and families. Collective lived experience priorities are effectively represented by people with lived experience in deciding what to do for better outcomes. Changes made as a result of coproduction are shared with the people often. There is an ongoing conversation so people and communities can respond about how experiences and outcomes are affected by changes. This way of working values power sharing between people and communities, and services and the system.

Coproducing mental health care and support in Norfolk and Waveney will help us reach our goals as an Integrated Care System. These goals are:

- To ensure people can live as healthy a life as possible.
- To ensure people only have to tell their story once.
- To make Norfolk and Waveney the best place to work in health & care.

All Integrated Care Systems in England are being asked to join up public engagement, participation, involvement and coproduction activities so people and communities are at the heart of the systems. Last year statutory guidance was published with the new Health and Care Act to guide systems in their approach.

There are already some good examples of coproduction around mental ill health in Norfolk and Waveney, including 'I Statements' for adult outcomes and the children and young people charter for coproduction.

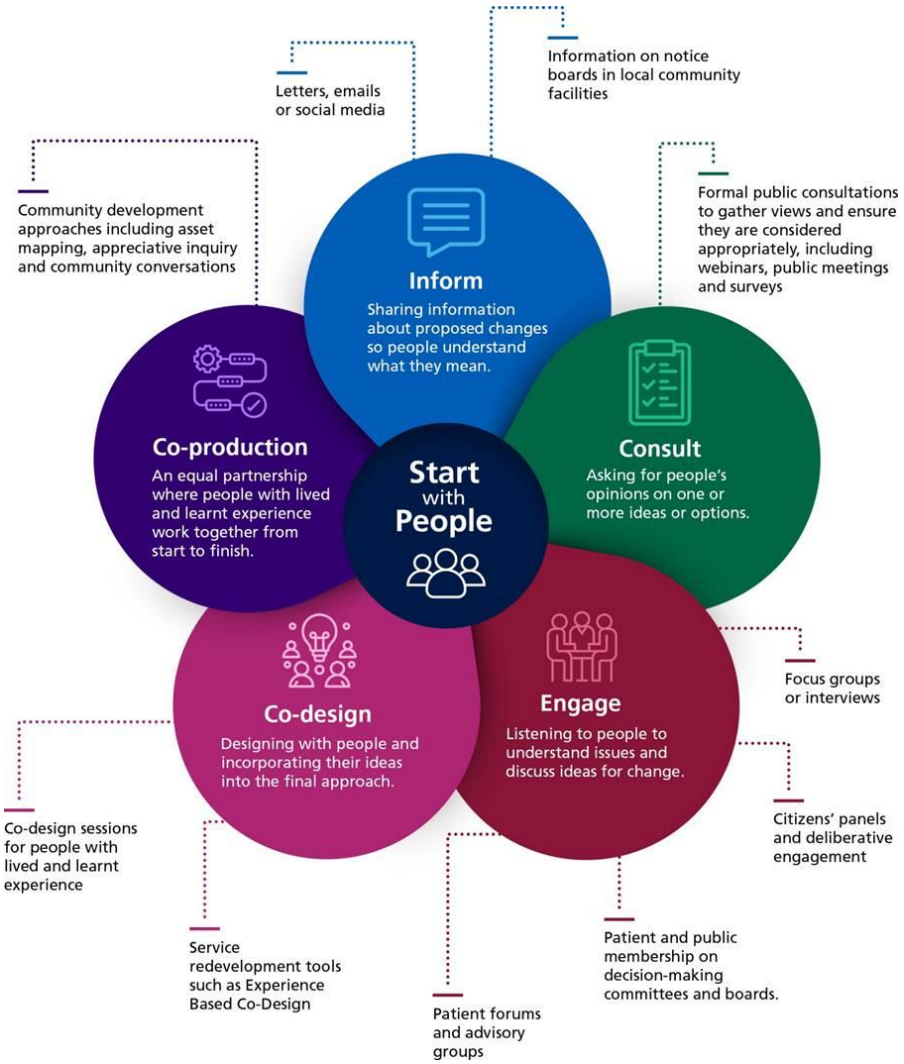
Rethink Mental Illness' coproduction team have been supporting the Adult Mental Health Transformation and have facilitated the coproduction of this draft strategy. Rethink are a national charity facilitating coproduction in a number of Integrated Care Systems across England.

Vision and approach to coproduction

Our vision for coproduction in five years' time is that the voices of people and communities are at the centre of decision-making and governance about mental health services, at every level of the Integrated Care System.

We believe this strategy will lead to a power shift from the system and services to the people and communities, so it is more balanced. We also believe it will lead to a culture shift towards the de-stigmatisation of mental illness through greater awareness and understanding.

Our approach is to follow the ten principles in the statutory guidance for coproduction which you can read more about here: Working in Partnership with People and Communities. It includes the ambition that partners in the integrated care system should work together to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This guidance is summarised as:



Norfolk and Waveney ICS People and Communities Hub

A people and communities hub was developed by NHS NWICB for the Improving Lives Together ICS website to act as a focal point for an on-going piece of work to deliver the national People and Communities guidance and to develop our approach over time. The first working draft of our approach aims to build on learning during the COVID-19 pandemic, and to develop our vision to improve our collective ability to listen to what people are saying across Norfolk and Waveney about what matters to them. We can do this by going out to the communities we serve, and by building on existing community engagement assets among our ICS partners including the VCSE sector.

Feedback and insight can be joined up across ICS partners and channelled into decision making structures, so that insight shared in one part of the ICS is gathered and heard by other partners across the system.

All the partners in our ICS are talking and listening to people & communities every day. Our vision is that people would tell their story of lived experience once and it's heard by everyone in the ICS. We want to build on the existing engagement and insight that happens across all our system partners and find ways of working together to share and learn from this insight. Working together will also mean we can pool our resources and work more efficiently across the ICS.

As of July this year the people and communities hub also now includes a specific section which aims to offer a systemwide focal point for the promotion of co-production. This is when people with lived experience work with those who design services and projects in an equal partnership. Whilst there is some co-production activity within the system there is still plenty of room for further development and improvement.

Children and Young People

Our approach to coproducing with children and young people will use creative engagement strategies so both younger and older children can make substantial contributions towards the improvement and development of complex care systems. It will also be in line with the Flourish work being led by Norfolk County Council to co-ordinate and promote engagement with children and young people across the system.

Why create a coproduction strategy?

A strategy is helpful to plan what to focus on to achieve a vision or goal over time.

Our vision for five years' time is ambitious and to achieve it we need everyone who is working closely with people with lived experience, including carers and families, to know what the plan is and what they can do to help achieve the vision.

We are creating this coproduction strategy so we have a better chance of achieving our vision and the benefits that come with this. This reason for following the statutory guidance together is so that mental health services will meet people's needs in the most effective ways possible. The benefits of coproducing can be described as:

Experience of care and support is better	Recovery based approaches recognising full range of needs	Individual outcomes are better
Wellbeing for all involved	Joined up approaches	People are part of the solution

How is this strategy being developed?

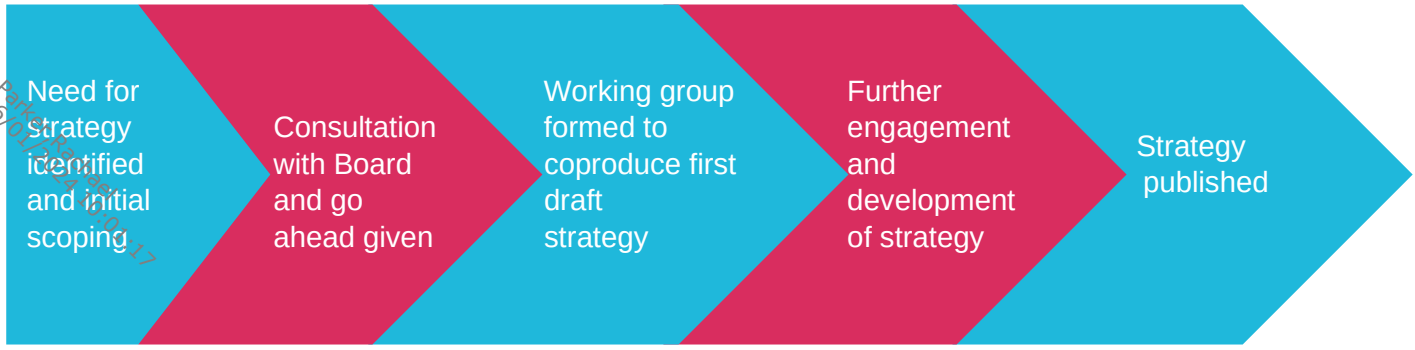
In early 2023 the Mental Health Programme Oversight Board recognised the need for a whole Integrated Care System mental health coproduction strategy. It tasked a working group made up of people with experience of coproducing from different organisations and people with lived experience to start thinking together about the strategy.

Integrated Care Board	Lived Experience Leaders	Norfolk & Suffolk NHS Foundation Trust
Charities and community organisations	Healthwatch	Social Care and Public Health

This strategy will build on a bring together the lived experience involvement activity that is already strong across Norfolk and Waveney for better mental health outcomes.

The next step will be to share this draft strategy with a wide range of people who support others to have a voice to inform mental health and wellbeing services. They are linked to a wide range of in organisations, including smaller charities and community groups, schools, colleges and universities. They will be able to test the Coproduction Toolkit and be part of developing it. They will be key to reaching the vision in five years' time.

The journey so far:



Equality, diversity and inclusion

By building connections with people who work closely with people in communities, this strategy aims to improve the way mental health care and support is offered to more people who could benefit. So they feel it could be something for them, and they know how to give it a try.

We will work closely with Community Voices which is a Norfolk and Waveney information sharing, community listening, capacity building and action project. We will also aim to work with other community engagement and listening projects in the Integrated Care System, including those focusing on physical health. We will share information about what is already there to help, and what is planned, in a way that is meaningful to communities of identity, including race, age, gender, neurodivergence and
Autism and other disabilities.

People who support people already in communities will be part of the conversation themselves. They know what matters, and will be invited to information and insight sessions to be part of flowing lived experience into the Integrated Care System to make a difference. They can show the system the value of community help and action, and be part of the solution together with the people they are close to.

Equality Impact Assessments will be part of the Toolkit and an essential for system and service development.

This strategy includes coproducing with children and young people for better mental health outcomes, and the strong activity that is already happening.

What do we need to focus on to achieve the Vision?

- Maintain space on the Integrated Care System website where people can find out ways of being involved and use the Coproduction Toolkit
- Training and support for people involved, including people in lived experience roles, and staff
- Offer regular exchange and sense making sessions about what matters to people and how the Integrated Care System is changing
- Focus on understanding what the Integrated Care System needs to know so mental health care and support offers are inclusive and culturally sensitive
- Get people together who are already coproducing to make sure collective lived experience insights turn into collective action
- Learn together by sharing coproduction activities and outcomes, and examples of good practice, making the most of lived experience to make a difference
- Share examples of good coproduction practice and updated/new resources on the Integrated Care System website as inspiration for action

What are the next steps?

This strategy has been asked for by the Norfolk and Waveney Integrated Care System Mental Health Oversight Board. This initial version will be shared with the Board in July for feedback.

The next step will be to share the draft strategy with people who are already involving people in organisations and communities – for their feedback.

This will also give an opportunity to share how care and support offers are developing, to gather lived experience insights that are already known, and understanding about current involvement projects, for example, the Children and Young People's Charter.

These insights will be applied to ongoing development of care and support around mental health challenges.

The Integrated Care System will support people to have conversations about what is helpful and ideas for improvement and innovation through the toolkit and several sharing sessions in each Place each year.

We will learn and develop together, towards our five year vision for coproduction of mental health care and support in Norfolk and Waveney.

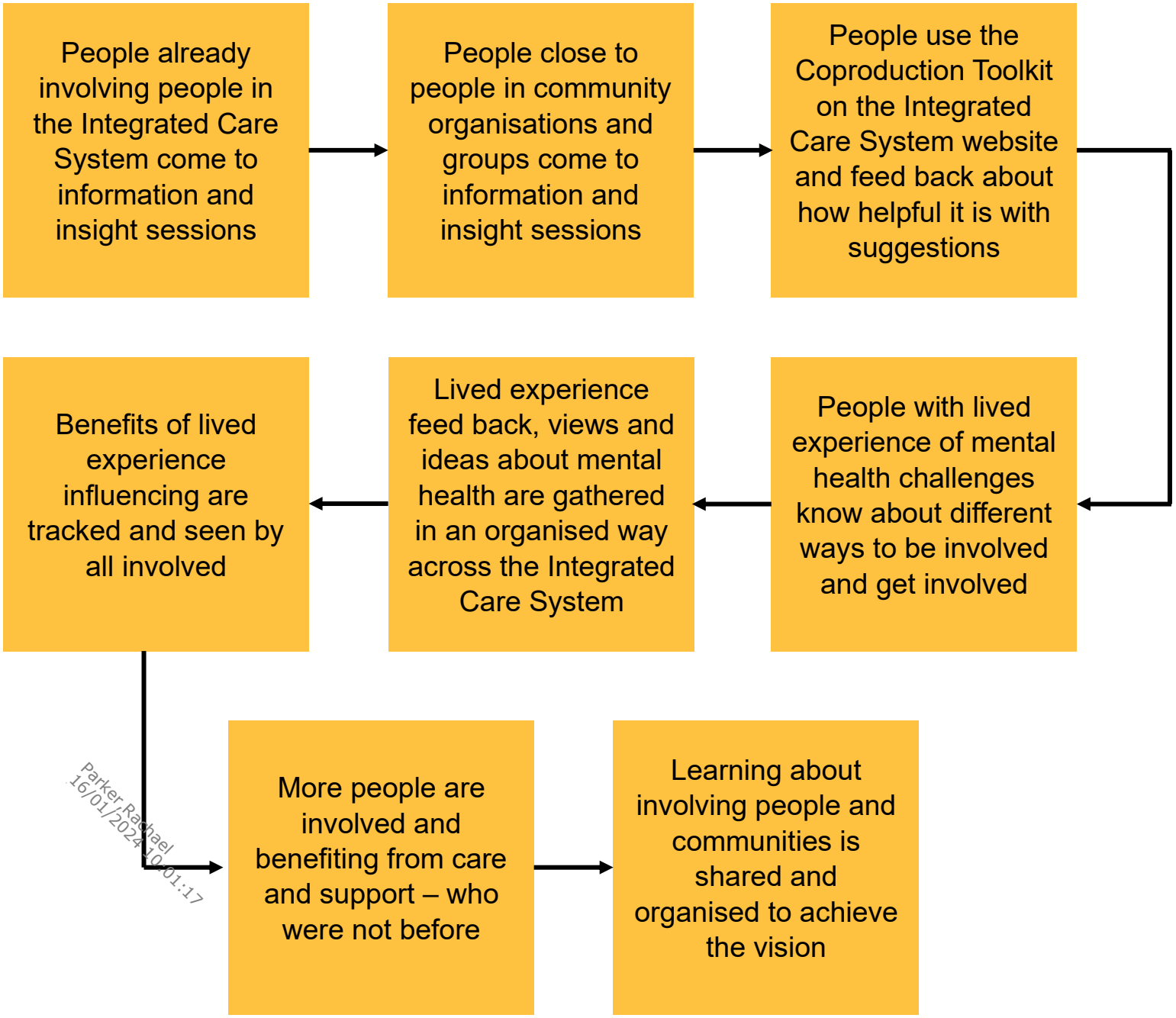
How will we know if this strategy is working?

We will use Principle 10 from the People and Communities Statutory Guidance to reflect and learn together each year by organising in person and online spaces to do this.

> *Learn from what works and build on the assets of all Integrated Care System partners – networks, relationships, activity in local places.*

We will also provide a way for people to feed back using the website.

The Mental Health Programme Oversight Board will monitor and offer challenge where necessary.



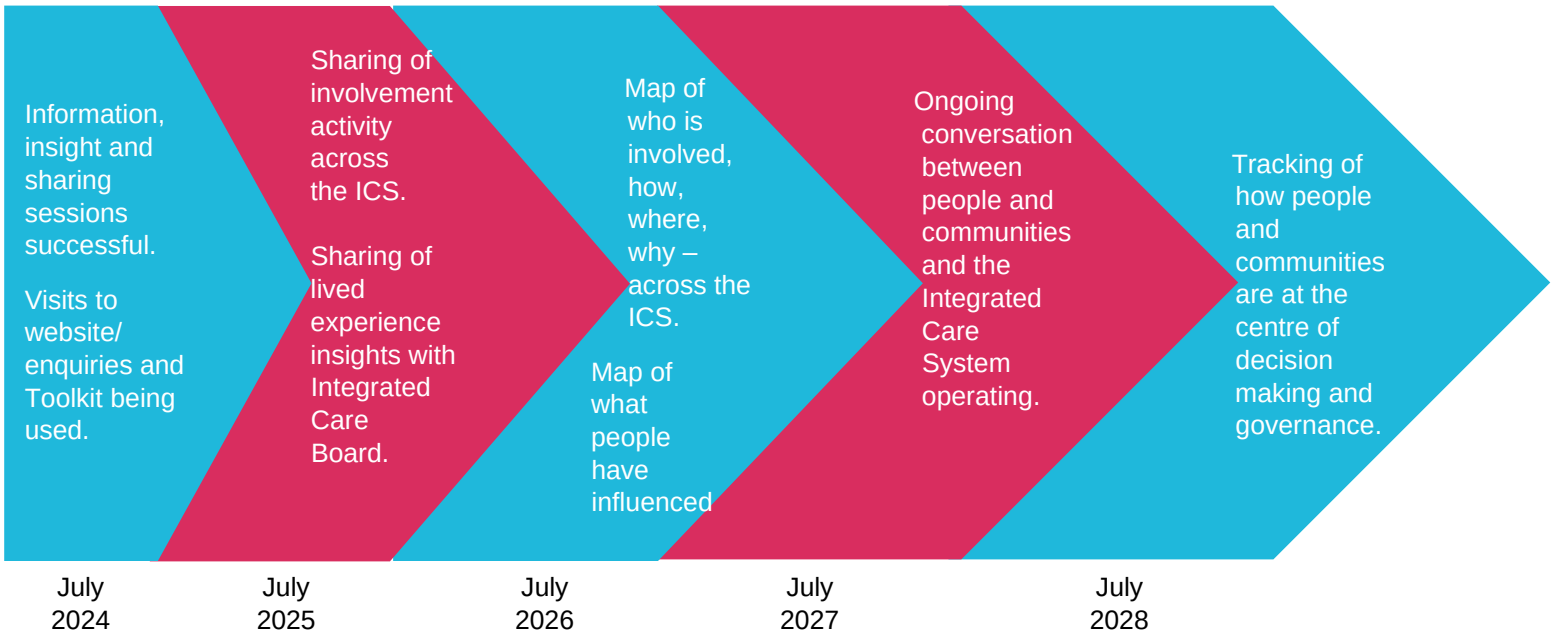
What are the key check-in points?

We expect to see progress towards our vision for coproduction in five years' time as the following key check-in questions. This progress will be reviewed by the People and Communities Committee.

How much different organisations and groups are joining up to involve and coproduce across the Integrated Care System will be a key focus.

We hope people will find the sharing sessions and Toolkit helpful, share what they are doing to involve and coproduce with people and communities, share insights with the Integrated Care Board, and champion the ongoing conversation with the Integrated Care System.

As a reminder, our coproduction vision for the next five years is that the voices of people and communities are at the centre of decision-making and governance about mental health services, at every level of the Integrated Care System.



What could the Toolkit include?

Here is a first idea of what we think could be helpful to have on the Integrated Care System website to guide a wide range of people who want to involve people with lived experience for better mental health outcomes in Norfolk and Waveney. There would be tools and resources to click through to.

Stage 1: Understanding your need for action

- Does your project need to understand what matters to people?
- Will your project be more successful if you bring in lived experience?
- Have you asked if the Integrated Care System already has lived experience information and insight about what matters relating to the focus of your project?
- Have you identified the focus for what you think you need to understand more about from people with a particular type of lived experience?
- Who can help you to identify the focus for lived experience involvement?
- Do you need/have lived experience partners working with you from start to finish?

Stage 2: Your knowledge and capacity to engage, involve and co-produce

- Have you looked at the ICS website to see what training and examples of good practice are available?
- Are you comfortable about hosting safe spaces for conversations about mental ill health topics and ways of sharing information, asking and listening to feedback, views and ideas?
- Are you able to support people in involvement activity and roles?
- Have you thought about equalities, inclusion and diversity factors in relation to your project? Have you connected with the Health Inclusion Group? Have you done an Equality Impact Assessment?
- Do you know about current lived experience priorities and I Statements?

Stage 3: Doing your project

- Do you already have people trained, supported and appreciated in roles for your activity? Do they know what's in it for them – do they feel valued and supported?
- Are you involving people with lived experience from the beginning in the planning of your project? Are you agreeing with them what success looks like and the best ways of achieving this?
- Are you and people with lived experience involved asking the ICS what lived experience information (data) already exists that is relevant to your project?
- Do you have a plan to do further community engagement and listening?
- Are you tracking lived experience information into insight into influence into action?

Stage 4: Reflecting on your project and sharing

- Have you banked your lived experience insights with the ICS?
- Have you reflected on how much lived experience was involved in your project and the difference it made?
- Have you reflected on what went well, what could have gone better, and what to do differently next time?
- Have you shared your example and learning with colleagues and also the ICS?
- Will you look for further training, coaching or support with coproduction?

Thank you for reading this co production strategy.

We’d love to hear from you if you’d like to find out more.

Please contact*

samantha.holmes@rethink.org

*Rethink Mental Illness are a national charity facilitating coproduction in a number of Integrated Care Systems across England. They are commissioned to support coproduction on the Norfolk & Waveney Integrated Care System Adult Mental Health Programme.

Or visit the Norfolk and Waveney ICS coproduction area online, linked here

Norfolk and Waveney
Integrated Care Board

Agenda item: 8

Subject:	Ageing Well Programme - Strategic Framework Final Version
Presented by:	Dr Frankie Swords, Medical Director
Prepared by:	Sheila Glenn, Director Planned Care & Cancer
Submitted to:	People & Communities Committee
Date:	22 January 2024

Purpose of paper:

The paper outlines the Ageing Well Strategic Framework. This was a key objective of the JFPs 5th Ambition - Transforming Care in Later Life.

PC&C is asked to note the multi stakeholder approach, progress and outputs, and approve this system strategic framework and next steps for adoption.

Executive Summary:

Context
The population of Norfolk and Waveney is older than the UK average, with 1 in 4 currently over 65. By 2040, modelling suggests that the number of people over 75 will increase by a further 55%.

Life expectancy in Norfolk and Waveney is good and slightly better than the national average. But this hides a lot of variation between different groups of our population and those living in different areas.

Our healthy life expectancy is below the national average. We have more older people living with multiple long-term conditions, particularly back pain, depression, and diabetes. We need to think and plan differently about how we co-design and deliver services for our older population and focus attention and resources on inequalities and prevention.

Older people living well has identified as a key ambition within the Norfolk and Waveney Joint Forward Plan – Ambition 5

We want our services to be designed with, and centered around, the individuals who use them; to close gaps in our services and address inequalities across Norfolk and Waveney.

We began exploring the potential themes for our ageing well strategy at a stakeholder workshop on 23 May 23. We brought together representatives from the VCSE sector, including 9 experts by experience (older people) themselves, district and local authorities, primary care and other NHS providers, to really focus on what we could do differently in Norfolk & Waveney.

Following the workshop, there were a series of meetings with key stakeholders and groups, and also engagement of the Later Life Network and ICB health Inequalities leads. The outputs of these engagements were tested against, and blended with, the findings of a desk top review of research and best practice evidence.

Many of the original workshop stakeholders, plus others, attended a follow up workshop in December 23, where the themes and content of the draft Ageing Well Strategic Framework were tested and refined. The outputs of this workshop were used to create the final version attached.

There was a clear sense from participants, that we need to challenge a largely medicalised model of care for older people. There was also a strong steer to better align with our social care and VCSE partners

The Ageing Well Programme Board are undertaking a review of current provision of services against the strategic framework. This will help give us to develop a baseline and identify gaps / overlaps in provision.

Over the next three years, our intention is to become disrupters of the status quo and to radically redesign services for our population as they age. Are workstreams will be examining what we need to start, stop and change to transform so that our services are timely, easy to access and designed around the needs of people as they age.

The next steps are:

- ICB/ICS sign-off of the Ageing Well Strategic Framework at P&CC
- Creation of the programme workstreams and appointment of leads
- The Ageing Well Programme Board will co-ordinated and oversee the development of the implementation plan and ensure that existing work across the ICB and system is aligned
- Programme board to oversee the delivery of the Ageing Well Strategic Framework priorities

Recommendation:

That P&CC would approve the strategic framework and acknowledge the significant engagement, codesign and evidence that has been undertaken to develop it .

Key Risks	
Clinical and Quality:	• A consistent approach to frailty and a review of anticipatory care for older people will improve care and reduce unwarranted clinical variation.
Finance and Performance:	• A consistent approach, with a strong clinically led review and evaluation of effectiveness and value for money, will ensure there is equitable investment of resources across the ICS (which in turn will lead to equitable demands on acute resources)
Impact Assessment (environmental and equalities):	• Age is a protected characteristic. The Integrated Care System will be able to demonstrate an appropriate and equitable response to the health needs of this population.
Reputation:	• Risk of damage to reputation if service failure occurs. • There will need to be an appetite for change as this is about professionals working differently together, and in partnership with families and carers.
Legal:	• No issues identified
Information Governance:	• Issues may be identified in the course of this work. The ICB and partners are asked to ensure appropriate teams are involved and engaged in a timely manner.
Resource Required:	• Input from the Integrated Care Board and system partners to the Programme. • Appropriate Programme and administrative support.
Reference document(s):	• Please see paper
NHS Constitution:	• No issues identified
Conflicts of Interest:	• No issues identified
Reference to relevant risk on the Board Assurance Framework	• No specific risk

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

Norfolk and Waveney Integrated Care System

Ageing Well Strategic Framework

The ambition

The Norfolk and Waveney Integrated Care System's (ICS) mission is to help the people of Norfolk and Waveney to live longer, healthier, and happier lives. The ICS has published a clinical strategy setting out what we want clinical services across Norfolk and Waveney to deliver over the next 5 years. The ICS has also published a more detailed Joint Forward Plan which includes eight ambitions. One of these is the ambition to transform care in later life.

It is imperative that we support our increasingly ageing population and enable them to experience the best possible quality of life, and to maintain their independence for as long as practicable.

To do this, we have developed a shared mission, vision and strategic framework informed by the evidence base, our local data, and the views of older people who live in Norfolk and Waveney and those who work or volunteer across health and care in our system. We will use this to transform our services and make them fit for our ageing population, to deliver services which are:

- more focussed on the prevention of ill health and promote wellbeing in later life;
- less reactive and more proactive in managing conditions associated with older age,
- and focus on the needs of the whole person including the needs of their families and carers and not on singular conditions or problems.

The context

Norfolk and Waveney have an older population compared to the rest of England. About 1 in 4 of the population is aged 65 and over and about 1 in 30 is aged 85 and over.

Across Norfolk and Waveney life expectancy is slightly longer than the average across England and is currently 80 years for males and 84 years for females. However, there are significant variations in life expectancy between the most deprived and least deprived areas of Norfolk and Waveney which is over 8 years for males and over 6 years for females. Furthermore, the healthy life expectancy across Norfolk is lower than the average for England at about 62.7 years for males and about 62.4 years for females and this figure has decreased over the last few years. This means that the period that older people spend in ill health in Norfolk is getting longer. There are inequalities across Norfolk that mean there is unjust variation across both life expectancy and healthy life expectancy, which is affected by the social and economic environments that people live and work in, for example healthy life expectancy in males varies from 70.5 in the least deprived areas of Norfolk to 52.3 years in the most deprived. A similar pattern follows for females. (Public Health Profiles - OHID).

Older people are already more likely to be living with multiple health conditions. Common conditions that are more prevalent in older age include dementia, heart disease, hypertension (high blood pressure), respiratory disease, mental health conditions such as depression, cerebrovascular disease, joint problems, diabetes, and sensory impairment. These conditions can also interact, meaning that an older person who could have maintained independence and quality of life with any one of these diseases, might struggle to do so with the combination of conditions. That means older people might be expected to attend multiple specialist clinics, be under the care of multiple professionals, and be prescribed multiple medications (polypharmacy).

We must coordinate this care better, and make sure that the person and their family or carers are at the centre of all that we do.

As well as improving the care and support for older people already living with these conditions, we also need to try to prevent or delay them for as long as possible. Long term, that will enable older people to live more of their later life without disability and improve healthy life expectancy.

Becoming an Integrated Care System in 2022 means that the NHS across Norfolk and Waveney is working much more as a partnership with local government, local authorities, voluntary, community and social enterprise (VCSE) organisations. So, we now have the opportunity to work together, to improve the planning, integration, and delivery of services for older people and those who care for them.

Our intention is to review current services across out ICS to identify any gaps and duplication whilst also trying to reduce inconsistencies across Norfolk and Waveney. We will aim to make the best use of our existing services, and look to improve and redesign these services, where required in consultation with older people and those who represent them.

It is imperative that we support our older population to maintain the best possible quality of life and reduce the years of living with disability and ill health to enable older people to retain their independence for as long as is feasible. This work will be led through public health, working closely with wider ICS health and care colleagues, to support people in our community, to prevent or delay ill health for our older population where possible.

We are determined to improve and simplify access to treatment, support and care. It is paramount that the right services are in place to support older people to receive care closer to home, and where possible to prevent the need for a hospital admission. For example, through the virtual ward or hospital at home where people are cared for in their usual residence, with the support of remote monitoring and health interventions from skilled health and care professionals.

When older people do have needs that require a hospital admission, we want to improve their experience of hospital care, and minimise their length of stay to reduce the risk of harm. Older people particularly those are living with frailty, dementia, or cognitive impairment, are at high risk of hospital acquired harms such as infection, deconditioning, delirium and loss of independence. Furthermore, the longer they remain in a bedded environment, the more likely they are to eventually be discharged to residential care rather than return home. We will promote the need for early supported discharge, and the provision of good quality, compassionate, palliative and end of life care where appropriate.

The Norfolk and Waveney ICS's strategic framework and approach will take a holistic approach to ageing well. This will enable us to review and adapt our service delivery to ensure it is designed around, and with, our residents, to support them to age well. We know that NHS health care is a relatively small part of what influences health outcomes for people and we will engage and support our partners to help improve the wider determinants of health.

Approach to strategy development

A blended approach has been adopted in the development of this strategic framework. The ICB hosted an Ageing Well Workshop May 2023 where 85 participants from ICS partner organisations, voluntary organisations, charities and members of the public including older people and their carers attended. This was used to develop the overall aspiration, shared vision and strategy for older people. Seven key areas of focus were identified through this work.

A desk top review of best practice was then undertaken to sense check the outcomes of the workshop – particularly considering the British Geriatric Society (BGS) Joining the Dots report March 23 and subsequently the Chief Medical Officer's Annual Report: Health in an Ageing Society, November 2023.

A steering group reviewed the outcomes of both the workshop and desk top review. The key findings were fed back to multiple stakeholders in one to one interviews to sense check this.

The steering group then combined the outcomes of that sense check to draft the strategic framework. This led to the refinement of the seven initial areas to give a new list of nine strategic goals.

The draft strategic framework and proposed initial priorities were then shared, and ratified, at a follow up workshop December 2023.

The steering group has also tasked the place boards and key providers and stakeholders identified from the initial workshop to begin collating the services already available across the ICS and to start mapping them against the strategic framework to help identify initial work programmes.

Initial Workshop findings

From this workshop and desk top review 7 key areas of focus were initially identified which correlated with the touchpoints highlighted by the British Geriatric Society.

1. **Enabling independence and promoting wellbeing of older people and their carers.**
2. **Population-based, proactive, anticipatory care to prevent ill health in older people.**
3. **Facilitating an integrated urgent community response, re-ablement, rehabilitation and intermediate care for when older people do need urgent support.**
4. **Frailty attuned acute hospital care so that when older people require admission, it is person centred and holistic.**
5. **Reimagining outpatient and ambulatory care so that when older people have long term conditions, they are managed in a coordinated way not in isolation.**
6. **Enhancing health care support for long term care at home and in care homes, so that people living in care homes get the best possible care where they live, and so we reduce the need for emergency admissions from care homes.**
7. **Providing coordinated, compassionate palliative and end of life care.**

There was a clear recommendation that services should be easier to access, and that older people and their carers should be more involved in the planning and delivery of their care. Workshop attendees also felt strongly that there needs to be a shift to empowering older people to make decisions about their care and to be better supported to prevent ill health and frailty wherever possible. Attendees want us to provide services that are designed to deliver:

- **What matters most to the older person themself**
- **To support older people to live happy, healthier lives**
- **To enable older people to live as independently as possible for as long as possible and to "age well".**

As a result, it was recommended that we should consider three stages of ageing when we design and coordinate our services and actions:

a) Preparing for Later Life Phase: focus on preventative activities that promote and extend healthy active life.

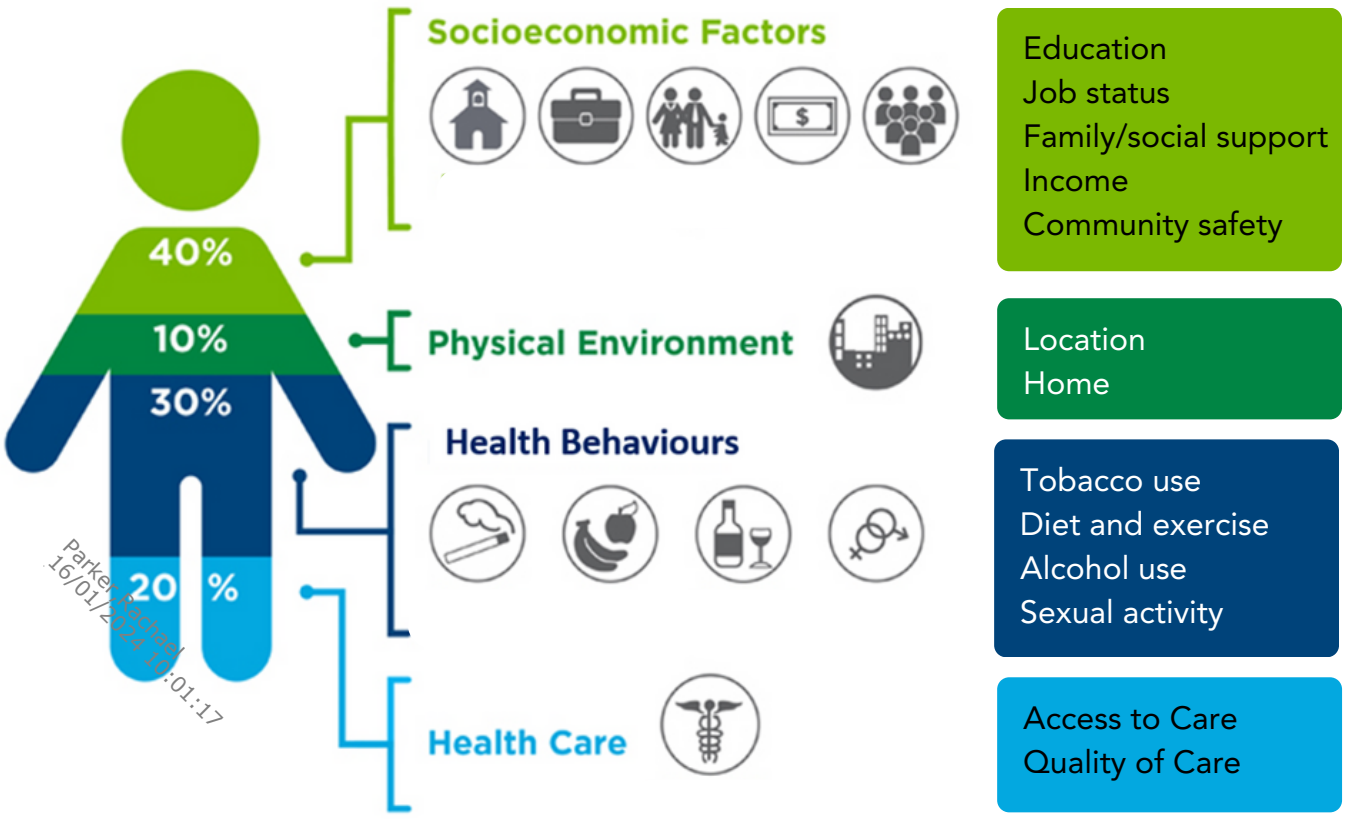
b) Active ageing phase: Time between healthy active life and frailty. Focus upon maximising independence and coordinating care to reduce the impact of long-term conditions on daily life, postponing frailty and other vulnerabilities, preparing and adapting one's environment and personal networks, and compressing the period of time spent in dependency and or frailty, before end of life.

c) Frail and more vulnerable older people phase. Frailty is used to describe a state of health experienced by some people, most often older adults. It describes how some individuals lose their in-built reserves and become increasingly vulnerable to sudden changes in their health, which may be triggered by events such as an infection or change in medication or environment.

Best practice findings and recommendations

The wider determinants of health in later life are influenced by a broad range of factors, and so it is recommended that these are taken into account when planning future service provision, rather than focussing upon those aspects traditionally encompassed within health care services in isolation. In essence, moving from a medical model to biopsychosocial model of care.

The factors that influence a person's health outcomes are shown in the image below.



The British Geriatric Society "Joining the Dots" (2023) report provides 12 recommendations that we will use to underpin our strategic framework.

British Geriatric Society - Joining the Dots - 12 recommendations

Recommendation 1
Demonstrate a strong system leadership that creates a shared vision for healthy ageing and preventing and managing frailty.

Recommendation 2
Appoint a senior officer or non-executive Board member with a specific role to seek ongoing assurance on the quality of health and social care for older people and their carers.

Recommendation 3
Publish baseline, then annual, State of Ageing reports on system-wide outcome indicators related to care for older people including feedback from patients and carers to reflect their experience.

Recommendation 4
Develop a system-wide strategy and costed implementation plan for a population health approach to the prevention and management of frailty, including a specific focus on dementia and falls.

Recommendation 5
Commission or deliver inter-professional education aligned with the Skills for Health Frailty Core Capabilities Framework and which build capacity for Comprehensive Geriatric Assessment, quality improvement and integrated practice in all disciplines across the system.

Recommendation 6
Develop an integrated Workforce Plan to build adequate specialist and generalist multidisciplinary capacity and skill mix to care for older people with complex needs.

Recommendation 7
Protect and preserve the right to rehabilitation for all older people who need it, in line with the principles outlined by the Community Rehabilitation Alliance.

Recommendation 8
Publish an older people equality and diversity impact assessment and action plan.

Recommendation 9
Engage and involve older people, carers and communities as equal partners with health and social care professionals in co-design, delivery and monitoring the impact of these services and support

Recommendation 10
Provide support to enable the lived experience of older people and carers, including those with dementia and mobility, sensory or communications needs, to inform quality improvement and assurance.

Recommendation 11
Work with public health, housing, community and voluntary sector partners to build social capital, mobilise community assets and adopt place-based approaches to create inclusive, compassionate age- and dementia- friendly communities.

Recommendation 12
Make use of existing guidelines and resources and the expertise held within the BGS community.

Further to the BGS Joining the Dots publication, the Chief Medical Officer has also published his annual report which focuses upon Health in an Ageing Society (2023). The recommendations from this report provides the high-level context and direction for our Ageing well strategic framework. This report provides 6 cross-cutting strategic recommendations. The ICS Ageing Well programme board will cross reference, and map, which existing and new ICS strategies (or areas of work) will have responsibility for inputting and/or implementing these. However, the Ageing Well board will maintain an overall overview.

Chief Medical Officer's Annual Report: Health in an Ageing Society, November 2023

Recommendations

A) Older age is becoming increasingly geographically concentrated in England, and services to prevent disease, treat disease and provide infrastructure need to plan on that basis. **Resources should be directed towards areas of greatest need**, which include peripheral, rural and coastal regions of the country. The NHS, social care, central and local government must start planning more systematically on the basis of where the population will age in the future, rather than where demand was 10 years ago.

B) **Primary Prevention**. Making it easy and attractive for people to exercise throughout their lives is one of the most effective ways of maintaining independence into older age. Reducing smoking, air pollution and exposure to environments that promote obesity are other examples where the State has a major role to play in delaying or preventing ill health and disability over a lifetime and into older age.

C) **Delaying disease** to the greatest possible extent, to delay the period of disability in older age, should be the aim of public health and medicine. Science is continuously developing new tools to help do this, but we are often extremely poor at maximising the use of the tools we have. The longer people live with risk factors such as hypertension or high cholesterol the earlier the start of their disabilities will be. Secondary prevention is predominantly the responsibility of the NHS but is currently under-prioritised. Screening programmes help to delay or stop the onset of serious disease and therefore prevent ill health in later life. It is essential that we prioritise secondary prevention and screening services, and to do more to extend these services to groups with reduced access and historically low uptake.

D) The medical profession needs to respond to the inexorable rise of multimorbidity. The single most important way to achieve this is to recommit to maintaining **generalist skills as doctors specialise**. NHS organisations also need to minimise the probability that the same person has to attend multiple clinics for a predictable cluster of diseases.

E) The health and care needs of older adults are often not recognised because the relevant data are not systematically collected or aggregated in one place. For example, epidemiological data on health conditions contributing to disability such as hearing loss and mental health is not routinely available for older adults. To plan appropriately, organisations including the NHS, Office for National Statistics (ONS), and central and local government need **systematically to collect and share data on the health and care needs of older adults**, including by ethnicity, sex and other protected characteristics.

F) **Research** 1) It should be unacceptable to have exclusion criteria based on older age or common comorbidities. 2) Research into multimorbidity, frailty and mental health needs to be accelerated. 3) Social care research needs to be a core component of health research programmes. The lack of inclusion of social care in health research is a significant gap.

Norfolk and Waveney's Strategic Framework

Our framework consists of the following:

- A mission statement which describes the purpose of the ageing well programme,
- A vision statement demonstrates what it will look like when we have delivered against this mission,
- And a strategic framework of 9 goals to cover all of the work that we need to deliver against the 3 different phases of ageing.

Mission: To have health, carer and support services, that are fit for our ageing population - supporting people as they age, to lead longer, happier healthier lives.

Vision: Norfolk and Waveney will be a place where people in later life and their carers:

- **are helped to age well, living happier, healthier lives, living as independently as possible, for as long as possible;**
- **feel heard and respected, and know they will be treated as individuals;**
- **experience services that ask, 'what matters most to you' and proactively act upon their answer.**

How will we do this?

This will require partnership working between NHS organisations, local government, voluntary, community, faith and social enterprise organisations, independent (private) providers and the public. The ICS will facilitate the development of new models of care using this framework, that can be delivered to meet N&W population needs, improve health, care, wellbeing and reduce inequalities.

To deliver better, more personalised and integrated services to our ageing population we propose the following strategic framework. This will form the backbone of all of our operational plans at System, Place and provider level.

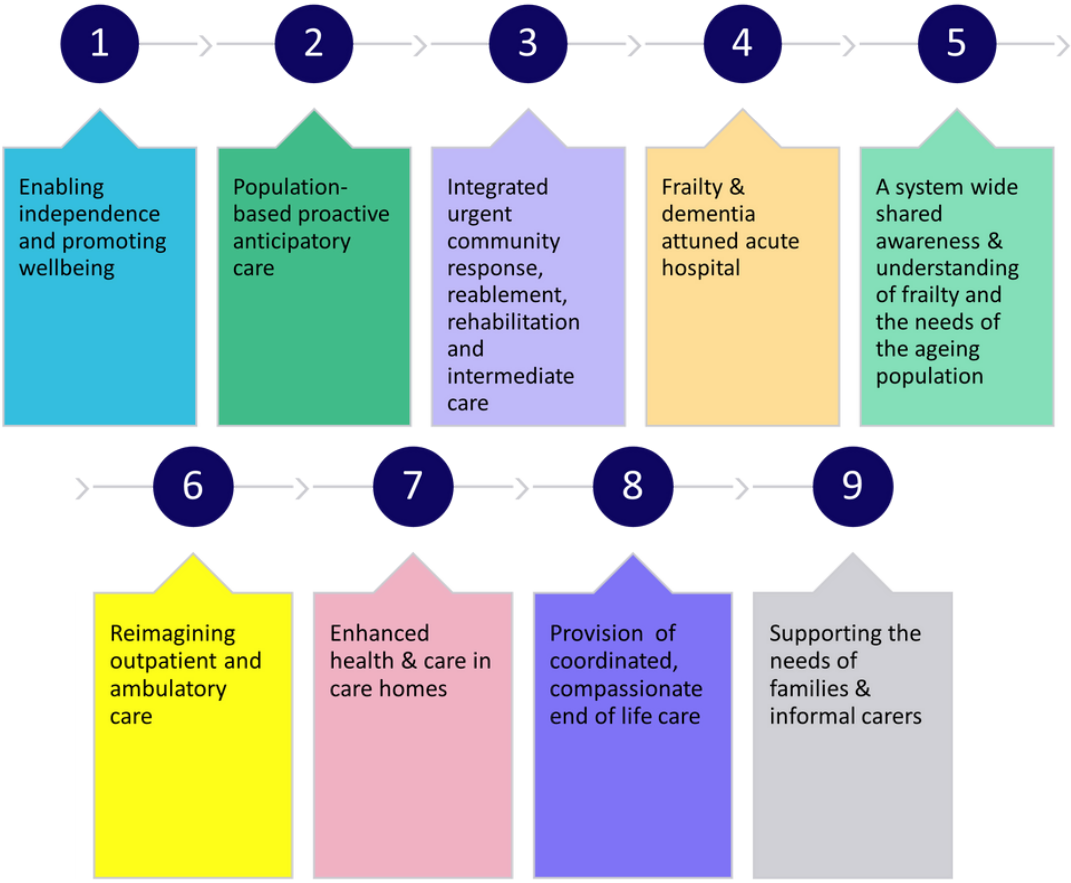
Following feedback and the wider desktop review and national publications, the initial 7 strategic goals have been revised and expanded into 9. This framework should inform ICS partners', thinking, planning, commissioning and delivery of services for people as they age.

All of services for older people need to be aligned to one (or more) of these 9 areas. The ICS will work with all the system partners to map the services they provide against this strategic framework to identify gaps, reduce duplication and inform future decision-making. Where a service is not in line with the framework, we will work with the provider, to transform that service.

Where gaps are identified, and we do not currently have services to address an area of the framework, we will aim to address those together, to improve and better integrate health and care for people in Norfolk and Waveney as they age. This means that in time, all 9 strategic goals will be addressed across all of our localities and they will be seen as interdependent with other appropriate ICB/S plans and strategies.

The Ageing Well Programme

Nine strategic goals underpin the Strategic Framework



This framework should inform ICS partner's thinking, planning, commissioning and delivery of services for people as they age. Older people, their carers' and loved one's views are properly represented in decision making, design and evaluation of services.

When reviewing and designing our services we will use the 3 phases of ageing to designate which phase of ageing the service is aiming to address:

1. Preparing for Later Life phase
2. Active Ageing Phase
3. Frail and more vulnerable older people phase

Ageing Well Programme: Strategic Matrix

	9 Goals **Areas of focus for improving quality of life outcomes and the care and support for older people**	**Preparing for later life phase**	**Active Ageing Phase**	**Frailer and more vulnerable older people phase**
1*	Enabling Independence and promoting wellbeing			
2*	Population-based proactive anticipatory care			
3*	Integrated urgent community response, reablement, rehabilitation and intermediate care			
4*	Frailty and dementia attuned acute hospital care			
5	A systemwide shared awareness and understanding of frailty and needs of the ageing population.			
6*	Reimagined outpatient and ambulatory care			
7*	Enhanced health in care homes			
8*	Provision of co-ordinated, compassionate palliative and end of life care.			
9	Supporting the needs of families and informal carers			

Contextualising the Matrix

The N&W Integrated Care System's ambition for ageing well, is to work with all system partners to improve and better integrate health and care for older people in Norfolk and Waveney.

The focus of the strategic framework for people in older age is about improving quality of life rather than longevity. As a system we have agreed there will be a clear focus upon upstream interventions and education to prevent or delay the period of time that people are unable to live independent, happier, healthier lives.

Commissioning services for older people starts with understanding the assets in local communities and the needs of the local population. The matrix is a means of beginning to consider the different levels of complexity helps to target interventions and resources to where they will have most impact (BGS 2023). It is recognised that some of these areas of the 9 goals of the matrix overlap but it is hoped that the manner in which they have been created will allow organisations to identify where they are currently working, where they will be able to support future service development and improvement and any omissions or duplications in current provision.

1 Enabling Independence and promoting wellbeing

Key aim is prevention and health promotion to reduce risks of developing ill health and improving opportunities for healthy ageing. Implementing a combination of age friendly environments and targeted approaches which support and enable people to stay healthy, happy, and independent for as long as possible, Reducing the risk of developing physical and mental health conditions, and encompassing emotional and spiritual wellbeing recognising the wider determinants of health for older people and those living with frailty when promoting healthy lifestyle advice and behaviours including increasing physical activity, improving nutrition, weight management, smoking cessation, alcohol intake reduction, reducing social isolation and improving brain health.
If we delay the point at which people get life-limiting conditions for as long as possible, disease may occur only shortly before their eventual death, or not at all, improving quality of life and reduced years of living with disability.
Enabling independence and promoting wellbeing also includes efforts to improve and/or mitigate the wider determinants of health including good work, housing and adaptations, the built environment such as public spaces, transport and mobility in a whole system approach.
Case example: North Norfolk Health and Wellbeing Partnership has signed up to become an Age Friendly Community.

2 Population-based proactive anticipatory care

Proactive anticipatory care targets people at risk of poor health and social outcomes such as those living with multiple health conditions and frailty, to offer tailored support to stay well and reduce likelihood of developing further progression of frailty resulting in poorer health and wellbeing. Individuals at risk of poor outcomes are identified using validated population level screening tools combined with professional judgement. Those who are identified as presenting with significant or escalating risk of deterioration or poor outcomes are offered a proactive comprehensive assessment of their health and social care needs. In partnership with MDT professionals, older people their families and carers develop a personalised care plan which considers their individual wishes and preferences and goals of care.

3 Integrated urgent community response, reablement, rehabilitation and intermediate care for older people

Integrated urgent community response, reablement, rehabilitation and intermediate care should be delivered by implementing a holistic and coordinated approach with the aim to prevent unnecessary hospital admissions, facilitate timely discharge from hospital and reduce the need for long term care and support by promoting independence and care closer to home. This model recognises the importance of multi-disciplinary team working in delivering short term hospital level care at home or resources that optimise recovery.

- **Urgent community response.** This involves rapid response to people in acute or crisis situations such as acute illness or injury. It may include ambulatory care, assessment and stabilisation of the presenting health and care needs.
- **Reablement.** Reablement focuses on supporting individuals to regain the independence and functional abilities after a period of illness or injury and should not just be confined to physical ill health.
- **Rehabilitation.** Focuses on specialised care and therapy for people with long term conditions or disabilities. It aims to maximise their potential and quality of life through targeted intervention to specific needs.
- **Intermediate care.** Intermediate care provides a bridge between hospital and home to prevent admission or enable discharge by providing care closer to home which can be home based or bed based.

4 Frailty and dementia attuned acute hospital care

Older people living with frailty and /or dementia are especially vulnerable to harms in acute hospital settings such as falls, infections, deconditioning and delirium. There is a need to ensure that people living with frailty and /or dementia are identified, and their holistic needs are assessed in a timely manner across the whole hospital. Many older people living with frailty/ and or dementia who have an emergency admission could return home on the same day if appropriate resources are available to assess, diagnose and treat their acute needs in a timely manner at the front door which reduces the risk of further morbidity and mortality.

5 A systemwide shared awareness and understanding of frailty and needs of the ageing population

There is a need for a systemwide shared understanding and awareness of frailty and the needs of an increasingly ageing population. There is also a need for raising awareness, across society inclusive of those affected, their families and carers which incorporates risk reduction strategies. Moreover, we need a skilled workforce and development opportunities that increase the number of professionals with the appropriate skills, knowledge, and training to meet the needs of those affected across health, social care, voluntary and public sector organisations who are able to understand the multifactorial determinants that can impact on those living with frailty in line with a comprehensive geriatric assessment for example. Consideration should be given to mapping of where skill and resources are currently available and alignment of the workforce whilst considering capacity and resource to meet current and future demand.

6 Reimagined outpatient and ambulatory care

Older people often have multiple conditions and may also be living with frailty which are considered in isolation and are often faced with repeating their story to multiple professionals. These conditions and the treatments offered can interact, there are opportunities to improve outcomes by offering resources that coordinate care by adopting a more person centred as opposed to condition specific approach. This could include one stop outpatient/frailty/ dementia clinics or ambulatory hubs, clinics to avoid multiple appointments and more holistic person-centred care. These approaches may consider the less medical, wider determinants of care and consider a quality of life to be as important as years of life.

7 Enhanced health in care homes

People living in care homes should expect the same level of support as if they were living in their own home. This can only be achieved through a whole system, collaborative approach, between health, social care, VCSE sector and care home partners. It is recognised that there are varying approaches to implementation. There is a need to ensure that there is appropriate provision available to reflect the care elements set out which are Enhanced primary care support, MDT support including coordinated health and social care, falls preventions , reablement and rehabilitation including strength and balance, high quality palliative and end of life care, mental health and dementia care, joined up commissioning and collaboration, workforce development, data, IT and technology. Further details on sub elements to support matrix development can be found at The Framework for Enhanced Health in Care Homes , NHS England)

Case Example

The Enhanced Health in Care Homes (EHCH) model moves away from traditional reactive models of care delivery towards proactive care that is centred on the needs of individual residents, their families and care home staff.

8 Provision of co-ordinated, compassionate palliative and end of life care

People can die at any age, and palliative and end of life care should be available to support our whole population. However, end of life care for older adults living with multiple health problems and frailty is different from dying with a single disease. The range of trajectories of decline includes sudden death, slow progressive deterioration such as is the case with dementia and frailty, catastrophic events (such as stroke or hip fracture), and periods of prolonged uncertainty associated with fluctuating episodes of acute illness, delirium, or functional decompensation (BGS 2023). The two leading causes of death in England and Wales in 2022 (ONS 2022) were Alzheimer's disease and dementia and Ischaemic heart disease. In 2017 45.6% of deaths occurring in people aged over 75 years old occurred in hospital, 19.7% at home and 39.8% in a care home. Consequently, it is important to understand the level of resource that is available and accessible to older people and reduce inequalities in place of death and access to palliative and end of life care and advance care planning.

9 Supporting the needs of families and informal carers

Family members and other informal carers supporting older people make a substantial contribution to the health and social care economy, but more older people are also becoming carer. It has been suggested that there are over 2m carers aged 65 and over, 417,000 of whom are aged 80 and over across England and Wales. A substantial proportion of older workers already balance work with caring responsibilities, particularly women: almost one in four female workers care, compared with just over one in eight male workers. Family and informal carers can experience detrimental effects to their health, wellbeing and financial stability so need support in their own right and are entitled to a carers assessment, so it is vital that there are mechanisms that support identification of carers. As well as being seen as valuable contributors to care they should also be supported to remain in work or education should that be their preference. There should be local services available that offer accessible information, practical and emotional support, and advice. Services such as befriending, peer support, respite, educational and coping support can build carer resilience.

Case Example: Norfolk and Waveney ICS developed a Carer Passport in 2022 to recognise the value and listen to the voice of unpaid carers, and those members of our community who “look after someone”. To date over 2000 passports have been issued.

Useful resources

- BGS Joining the Dots - A blueprint for preventing and managing frailty in older people.pdf
- Chief Medical Officer's Annual Report 2023 – Health in an Ageing Society (publishing.service.gov.uk)
- Death registration summary statistics, England and Wales - Office for National Statistics
- Death in people aged 75 years and older in England in 2017 - GOV.UK (www.gov.uk)
- https://www.england.nhs.uk/long-read/providing-proactive-care-for-people-living-in-care-homes-enhanced-health-in-care-homes-framework/ Version 3, November 2023
- Public health profiles - OHID (phe.org.uk)

Appendices

Appendix 1
Service Design Self-Assessment Check list (Principles)

Ask what matters,
listen to what matters,
do what matters!

- Focus upon prevention and upstream interventions across end-to-end pathways (avoiding duplication and waste)
- Aligned and informed by the health inequalities and population, health management
- Older people, their carers' and loved one's views are properly represented in decision making, design and evaluation of services
- We will consider the whole person, their carer's and their environment (Healthcare & wider determinants)
- No health without mental health
- Supporting the needs of carers and care homes

Glossary

Older people	Refers to people aged 50 and above
Healthy Life Expectancy	A measure of the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health
Frailty	Refers to a person's mental and physical resilience, or their ability to bounce back and recovery from illness and injury. It is used to describe a particular state of health often experienced by older people but can apply to people of any age
Age-friendly Community	This is a place that enables people to age well and live a good later life. Somewhere that people can stay living in their homes, participate in the activities they value, and contribute to their communities, for as long as possible. There are eight domains for action including outdoor spaces and buildings, social participation, and civic participation and employment

Norfolk and Waveney
Integrated Care Board

Agenda item: 9

Subject:	**Population Health & Inequalities (PH&I) Board – 19/12/2023 – Assurance & Escalation Report**
Presented by:	**Dr Frankie Swords**
Prepared by:	**Dr Frankie Swords**
Submitted to:	**N&W ICB Patients and Communities Committee**
Date:	**22 January 2024**

Purpose of paper:

To provide assurance and escalate any issues of concern from the Population Health & Inequalities (PH&I) Board to the Patients and Communities Committee.

Executive Summary:

The Population Health & Inequalities Board (PH&I) Board meets bi monthly and was last held on Tuesday 19 December 2023. The report details points of assurance and escalation as well as a high level risk overview summary.

Report

Please find attached document.

Recommendation to the Committee:

To review points for assurance.

Key Risks	
Clinical and Quality:	Health inequalities 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. Population Health Management is a systematic way of working to understand the health and care needs of our population and put in place new models of care to deliver improvements in health and well-being. This work is fundamental to the delivery of our ambitions in relation to Prevention and addressing Health Inequalities. There is a risk we do not achieve the impact we seek if we do

	not develop the infrastructure, the culture and approaches advocated as best practice.
Finance and Performance:	None identified
Impact Assessment (environmental and equalities):	N/A
Reputation:	None identified
Legal:	None identified
Information Governance:	None identified
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	1. The NHS provides a comprehensive service, available to all 3. The NHS aspires to the highest standards of excellence and professionalism 4. The patient will be at the heart of everything the NHS does 5. The NHS works across organisational boundaries 6. The NHS is committed to providing best value for taxpayers' money 7. The NHS is accountable to the public, communities, and patients that it serves
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	BAF 06

Governance

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

Population Health & Inequalities (PH&I) Board - Points of Assurance / Escalation [19/12/2023]

Improving lives together
Norfolk and Waveney Integrated Care System

Item No.	Meeting Name	Date of meeting where item was raised	Details of Item for Escalation	Requested Outcome/Support	Financial Implication (if any)	Is item recorded on Risk Register	"EXAMPLE" Board Decision	Fed back to Meeting Group Date
10.	PH&I Board	10/10/2023	ICS PHM & HI Strategies	The PH&I Board supported the ongoing progress with PHM and HI Strategy. both on track for completion March 2024.	N/A	N/A	For assurance	
13.	PH&I Board	10/10/2023	HI06 No PMO process for Equality Impact Assessments (EIAs)'risk	The PH&I Board approved the mapping EIA delivery to be completed as part of the HI Framework engagement. A task and finish group will be set up and detailed plans to implement a system wide process for EIAs will be presented April 24	N/A	HI06	For assurance	
14.	PH&I Board	19/12/2023	Armed Forces Community –Plus Group	The PH&I Board agreed for the armed forces community to be included as an additional Plus Group. Further scoping around work programme & alignment of work to support this group with governance structures required.	N/A	N/A	To note	
15.	PH&I Board	19/12/2023	PHM Communications Toolkit	A national PHM Communications toolkit has been developed, under consideration for local use by the PHM team.	N/A	N/A	To note	
16.	PH&I Board	19/12/2023	NHSE Statement on Inequalities	In November NHSE published a statement on information on health inequalities which sets out the powers available to collect, analyse and publish information. The HI team will bring recommendations for implementation to next meeting.	N/A	N/A	To note	
8.	PH&I Board	19/12/2023	Community Health and Wellbeing Workers Pilot – Watton	This pilot project has successfully supported individuals living in an area of high deprivation and other household members with multiple aspects of self management, improving screening uptake, attendance and supporting digital and health literacy	N/A	N/A	For assurance	
10.	PH&I Board	19/12/2023	Data Hub update	The board note progress with data hub and potential to use this to address HI and support PHM projects in future.	N/A	N/A	To note	

PH&I Board - New Risks [19/12/2023]

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Programme Risks as of 19/12/2023 – PH&I Board

The PHM November 2023 and HI December 2023 versions of risk registers were reviewed at this meeting.

The overarching BAF06 PHM &HI risk continued to score at 12

The PHM team reported 4 risks and no risks scored above 15. The PHM team in the previous report had reported 5 risks, 2 of these were closed in October's risks register review ('PHMI01 Support and investment of the data hub' and 'PHMI03 ICS Data Sharing Agreement') and the remaining 3 risks had no changes to risk description or scoring. A new risk of 'PHMI18 Lack of allocated PHM Budget. Impacting PHM projects and Protect NoW VST team' was added which scored as a 10.

The HI team reported 7 risks and no new risks were added.
The HI team were previously requested to formally review the risk scoring and mitigations against Risks 'HI03 – Lack of coordination of HI workstreams' and 'HIO5 – No HI ring fencing of NHSE funding allocations'. HI03 has been reduced to a score of 12 and HI05 remains at a 16.
'HI06 No PMO process for Equality Impact Assessments (EIAs)'risk has been reviewed and a paper provided to the PH&I Board (see item 13 of the assurance report).

Norfolk and Waveney
Integrated Care Board

Agenda item: 10

Subject:	**Links between Quality and Commissioning**
Presented by:	**Karin Bryant, Associate Director Local Commissioning**
Prepared by:	**Jane Hackett, Pathway Redesign Manager**
Submitted to:	**N&W ICB Patients and Communities Committee**
Date:	**22 January 2024**

Purpose of paper:

To answer the question posed by the Patient and Communities Committee:

Update requested to help the committee understand how the commissioning teams link, specifically around the services being commissioned and how they are performing in terms of quality.

Executive Summary:

The response to this question has been provided by the Local Commissioning Team.

The Local Commissioning Team is only one of several commissioning teams across the ICB and is unfamiliar with how other *commissioning teams link, specifically around the services being commissioned and how they are performing in terms of quality.*

The conclusion of the Local Commissioning Team is when Quality and Commissioning work together the inputs and outputs for a piece of work are improved, driving better care and outcomes for patients.

Report

A slide deck to be presented to the Committee.

Recommendation to the Committee:

This item is for information and discussion, no recommendations are made.

Key Risks	
Clinical and Quality:	Quality involvement in commissioning is essential to ensure consideration of clinical risk, patient outcomes, clinical efficacy and safety of new / changed service or pathway
Finance and Performance:	Not applicable
Impact Assessment (environmental and equalities):	Quality involvement in commissioning is essential to ensure consideration of environmental and equality aspects of a service or pathway change are given proper consideration
Reputation:	Joint working between Quality and Commissioning demonstrates a commitment to achieving best outcomes for patients
Legal:	Joint working between Quality and Commissioning demonstrates a commitment to achieving best outcomes for patients
Information Governance:	Information Governance forms a part of any commissioning pathway
Resource Required:	Not applicable
Reference document(s):	Not applicable
NHS Constitution:	Joint working between Quality and Commissioning is in the spirit of the spirit if the principles that guide the NHS
Conflicts of Interest:	Not applicable
Reference to relevant risk on the Board Assurance Framework	Not applicable

Governance

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

Action:

Links between commissioning and quality teams;

Update requested to help the committee understand how the commissioning teams link, specifically around the services being commissioned and how they are performing in terms of quality.

Response From:

Local Commissioning Team

Links Between Commissioning and Quality Teams

Quality and Safety Committee

- Associate Director for Local Commissioning is a member of the Quality & Safety (Q&S) Committee
- Local Commissioning Team has 7 risks held by the Q&S Committee
- Risk scores ranging from **12** to **16**
- In April 2023, the Local Commissioning Team submitted a deep dive paper for all its risks
- Regular Liaison with Quality Governance and Delivery Manager to ensure risks remain relevant and meaningful

ICS Quality Strategy

Members of the Local Commissioning Team have attended and contributed to the ICS Quality Strategy workshops; we have provided perspective and insight on how services are run, how they compare to other services across the system, what issues have arisen and how they have been resolved

Links Between Commissioning and Quality Teams

Quality Improvement Example - Catheters

- System wide quality improvement programme focused on reducing the use of urinary catheters in both community and acute settings for all patients
- Led by the ICB; shared leadership between Pathway Redesign Manager; Senior Infection Prevention and Control Manager and Senior Nurse
- Excellent working partnership which plays to the strengths of the individuals enabling the work programme to move forward and succeed:
    - Clinical dialogue taking place with providers, supported by a commissioning dialogue
    - The project is steered by the advice and expertise of the Quality Team Nurses
    - The project is facilitated by the experience of the Commissioner

Other examples of joint working:

- SOS Bus reprovision
- Lower Limb Wound Care Project
- TB nursing service
- NSFT inpatients unable to access community services
- Nasogastric (NG) and Nasojejunal (NJ) tubes SOPs

Quality in Commissioning

The Local Commissioning Team

- Invites members of the Quality Team to appropriate working groups
- Works closely on the development of service specifications to ensure they meet quality criteria and providers report on measures to assure the ICB quality standards are met
- Works closely with the Quality Team when investigating risks and issues relating to patient safety e.g. long waits, risk of patients being harmed.
- Attends the ECCH and NCHC Quality Meetings with the Quality Team
- Proactively communicates with the Quality Team when ad-hoc issues arise
- Support the Quality Team on any quality issues they identify with a local service

Quality is represented on the Commissioning & Place Moderation Panel (part of the ICB's Prioritisation Process) which is managed by the Local Commissioning Team.

Links Between Commissioning and Quality Teams

Some Observations

- The Local Commissioning Team is only one of several commissioning Teams across the ICB and is unfamiliar with how other commissioning *teams link, specifically around the services being commissioned and how they are performing in terms of quality*
- Approaches to the Quality Team are often informal and through team members we are familiar with; does this need to be formalised?
- The many and varied demands on the Quality Team means it is not always able to fully commit to supporting a piece of commissioning / attending relevant meetings

When Quality and Commissioning work together the inputs and outputs for a piece of work are improved, driving better care and outcomes for patients

Thank you

NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 11

Subject:	**Monitoring Mortality Rates Across the System and the Norfolk and Waveney Learning from Deaths (LFD) Forum**
Presented by:	**Teresa Knowles, ICB Senior Nurse / Patient Safety Specialist**
Prepared by:	**Teresa Knowles, ICB Senior Nurse / Patient Safety Specialist**
Submitted to:	**ICB Patients and Communities Committee**
Date:	**22 January 2024**

Purpose of paper:

To provide an update to the ICB Patients and Communities Committee on monitoring mortality rates across the system and the work of the Norfolk and Waveney Learning from Deaths (LFD) Forum regarding mortality metrics, identifying areas for further investigation, and sharing learning from individual deaths, including HM Coronial Regulation 28 notices, across our system.

Executive Summary:

- This paper provides an overview of mortality monitoring across the system, the work of the N&W Learning from Deaths (LFD) Forum and the rollout of the Medical Examiner service. It includes details on how deaths are registered and scrutinised and the system's duties to learn from the deaths of our patients.
- The N&W Learning from Deaths (LFD) Forum meets on a bi-monthly basis and is formally accountable to the Quality and Safety Committee and provides an annual update to that Committee. It also provides an assurance and escalation report after every meeting to the System Quality Group.
- Medical Examiner scrutiny is not mandated in the current non-statutory system. However, once the new death certification reforms come into force from April 2024, there will be an independent review of all deaths in England and Wales. This will either be provided by independent scrutiny by a Medical Examiner or by investigation by a Coroner.

Recommendation to the Committee:

To note the content of the report.

Key Risks	
Clinical and Quality:	It is imperative that the ICB understands the themes and reasons behind the deaths that occur in Norfolk and Waveney, to ensure that learning is shared to continuously improve the care provided to our patients and their families and to minimise avoidable deaths and harm.
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	N/A
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	https://www.england.nhs.uk/establishing-medical-examiner-system-nhs/
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	**Principal risk:** That people in Norfolk will experience poor health outcomes due to suboptimal care. BAF 1,2,4,6,8,10,11

Governance

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

Report

Monitoring Mortality Rates Across the System and the Norfolk and Waveney Learning from Deaths (LFD) Forum

I Background: How deaths are registered

After a person dies, the doctor who attended the deceased during their last illness is legally required to complete a medical certificate of cause of death (MCCD, often referred to as a death certificate). The certifying doctor must arrange for the MCCD to be transferred to the registrar and must also advise the informant that the MCCD has been issued.

This MCCD provides a permanent legal record of the fact of death. It also provides the informant with an explanation of how and why the person died and gives them a permanent record of information about the medical history, which may be important for their own health and that of future generations. The MCCD also enables the family to register the death. Deaths are required by law to be registered within 5 days of their occurrence unless there is to be a Coroner's post-mortem or an inquest. No onward arrangements can be made by the family, until after the death has been registered.

Information from death certificates is also used to measure the relative contributions of different diseases and conditions to mortality. Information on deaths by underlying cause is important for monitoring the health of the population, designing, and evaluating public health interventions, recognising priorities for medical research and health services, planning health services, and assessing the effectiveness of those services.

II Scrutiny of deaths

It is not always possible to issue an MCCD after a death. This may be because the death was unexpected and the person did not see a doctor during the 28 days prior to their death, or because the death was sudden, violent, or if it falls into one of the specific categories of potentially 'unnatural' causes. In these cases, the death will be referred to His Majesty's Coronial service.

However, in April 2019, a national Medical Examiner system was introduced. Medical Examiners provide an additional level of scrutiny to all deaths occurring in hospitals which have not been reviewed by a Coroner.

The Medical Examiner is a senior doctor who has not been involved in the care of the patient. They perform an independent scrutiny of the person's records and speak to the next of kin to determine whether there have been any concerns with the care of the patient before liaising with the doctor directly involved in their care. Only after that discussion can the doctor directly involved issue the MCCD.

The Medical Examiner can flag if they consider that a specific death requires a more in depth analysis. This will generally take the form of a Structured Judgement Review (a retrospective analyses of case notes with comments generated on the quality of

care delivered and whether harm had occurred) to look for any areas of learning to improve the care of future patients, or they may determine to make a referral to the Coroner to investigate the cause of death.

This scrutiny is now statutory for all NHS providers and so 100% deaths occurring in acute hospitals across Norfolk and Waveney are now scrutinised by a Medical Examiner. The Medical Examiner service is currently being rolled out to include all deaths in the community as well, in preparation for this becoming a statutory requirement from April 2024.

III Duties to learn from deaths

Nationally, mortality metrics are calculated and published for every acute hospital: the 'SHMI' and 'HSMR'.

The Summary Hospital-Level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. This is produced by NHS England and considers multiple factors. It also includes deaths occurring within 30 days of discharge from hospital.

The Hospital Standardised Mortality Ratio (HSMR) is produced by the national Dr Foster system and is calculated on the basis of deaths which have occurred in hospital only. It calculates how many deaths have occurred due to the commonest causes of death in the UK, compared to how many would have been expected to occur for this number of hospital admissions. HSMR is generally felt to be less useful than the SHMI for these reasons.

Every hospital is scored as 'above,' 'below' or 'as expected' for both SHMI and HSMR. Trends are important and useful for hospitals, and alerts are also issued where the mortality rate appears higher than expected for a given diagnosis. However, neither of these metrics look at whether an individual case was expected or unexpected or whether it might have been potentially preventable. That can only be detected by an individual review of the case (either by the Coroner, or through a local Structured Judgement Review or similar).

All hospitals have a responsibility to learn from the deaths of patients admitted under their care. Every hospital has a Learning From Deaths Forum to review their overall SHMI and HSMR metrics, and to put processes in place to review individual cases to identify any learning and in particular whether a death might have been potentially preventable. These reviews are undertaken if a serious incident or complaint has arisen during the care of that patient, and where concern has been raised for example by the Medical Examiner.

Hospitals will also undertake additional reviews in particular areas, for example most conduct a full review of the care of every patient who dies during an admission to their intensive care unit. They also perform regular thematic reviews if a local alert is issued or concern raised, for example if there has been a change in the overall number of deaths occurring in a specific area, population group or with a specific

clinical condition, or if any concerns are raised nationally for example following tragic high profile cases which are well reported.

These individual and thematic reviews are undertaken to ensure that learning is shared within the organisation. These Learning From Deaths groups report to their Boards (typically through their Quality Committees), and learning is also shared at a Regional level across the East of England.

IV The Norfolk and Waveney Learning from Deaths Forum

The Norfolk and Waveney system wide Learning From Deaths Forum was established in February 2023 and works closely in partnership with Public Health and multiple stakeholders. This forum bi-monthly and has met on five occasions to date.

The key aim of the forum is:

- To improve the health outcomes of our population with particular focus on those at most risk of health inequalities by learning from deaths which have occurred across Norfolk and Waveney.

The initial areas of focus have been:

- To support the implementation of the Medical Examiner programme for all community deaths.
- To share and review public health mortality data and trends, including deep dives into specific vulnerable populations.
- To share learning and good practice system wide, and escalate any concerns from:
  - Individual organisation's Learning From Death Forums,
  - Medical Examiner scrutiny of community deaths,
  - Prevention of Future Deaths / Coronial Regulation 28 Reports,
  - Independent investigations and Serious Case Reviews,
  - Maternal and Neonatal deaths.
  - Safeguarding Adult and Children Reviews.
  - Child Death Reviews,
  - Learning Disability Mortality Reviews (LeDeR).

At every meeting, an oversight of system wide and providers' mortality metrics is reviewed, there is an update on the community roll out of the Medical Examiner programme as well as any themes identified by the Medical Examiner teams. A review of all new and outstanding HM Coronial Regulation 28 Notices is also presented each time with onward escalation to the System Quality Group as appropriate.

Following the initial meeting, the forum has developed a rolling programme of deep dives. At each meeting, one provider trust presents a deep dive into their mortality metrics, and any key themes and shared learning from their internal Learning From Deaths groups. To date, the three acute trusts and the mental health trust have presented with the community trusts due to present at a future meeting.

An annual programme of other deep dives has also been developed. To date the following areas have been presented:

- Public Health data and trends in mortality.
- Deaths occurring in people known to palliative care services.
- Deaths occurring in people living with Severe Mental Illness (SMI).
- Suicide prevention.
- Drug and Alcohol Partnership data and thematic reviews.

V Conclusions

The NHS East of England regional team continues to hold a quarterly Learning from Deaths Forum to share learning between NHS providers.

However, the Norfolk and Waveney ICS Learning from Deaths forum aims to bring together a much broader group of system partners to use the learning from deaths occurring anywhere in our system to inform our work, with the aim of improving health outcomes and reducing health inequalities of our population. The Forum also provides oversight and a route of escalation to the ICB Board and region.

VI Recommendation

The Committee is asked to note the content of the report.