NHS
Suffolk and North East Essex
Integrated Care Board

Title	**NHS Suffolk and North-East Essex Integrated Care Board Meeting**
Date	**25 July 2023**
Place	**Edmund Room, St Edmundsbury Cathedral, Angel Hill, Bury St Edmunds, IP33 1LS**
Time	**0900-1215 hrs**

Members of the public are welcome to attend to observe the meeting and the meeting will also be 'live streamed'. (a link for the live streaming will be available on the ICB website).

Questions relating to agenda items can be submitted via the following means;

1. *Please submit questions no later than 12 noon on the 20 July 2023, via email to comms@snee.nhs.uk*
2. *During the live streaming when they will be collated and asked at the appropriate time on the agenda at the discretion of the Chair*
3. *For those attending in person at the appropriate time on the agenda at the discretion of the Chair.*

The minutes of the meeting which will include answers to any questions submitted by the public will be published on the ICB website at a future date.

AGENDA

Time	No	Agenda item	Purpose	Lead
GENERAL BUSINESS				
0900	**1**	**Welcome and Introductions and apologies for absence**	Note	Will Pope (Chair)
0901	**2**	**Notification of any questions from members of the public for response at the appropriate time on the agenda.**	Note	Will Pope (Chair)
0903	**3**	**Declarations of Interest** *Declarations of interest made by members of the Integrated Care Board - Board declarations are listed in the Register of Interests which, along with the Hospitality and Gifts Register will be available on the ICB website.*		All
0904	**4**	**Norfolk and Suffolk Foundation Trust's mortality recording and reporting.** ***To receive and approve*** *a report from the ICB's Medical Director.* **'Forever Gone: Losing Count of Patient Deaths'** ***To receive*** *and note a presentation.*	Approve	Lisa Nobes *Report No: ICB 23-46* Caroline Aldridge/ Emma Corlett

0948	**5**	**Minutes of the previous ICB Board meeting held in public on 23 May 2023 and 'Extraordinary' meeting held on 20 June 2023** ***To approve*** *as a correct record the minutes of the ICB Board meeting held in public on 23 May 2023 and 'Extraordinary meeting held on 20 June 2023.*	Approve	Will Pope (Chair)
0950	**6**	**Matters arising from the ICB Board meeting of 23 May 2023 and review of outstanding actions.** ***To note and endorse*** *how we have responded to the outstanding issues which arose at the last meeting.*	Note	Will Pope (Chair)
0955	**7**	**General Update** ***To receive*** *an update from the ICB's Chief Executive*	Note	Ed Garratt *(Chief Executive)*
STRATEGY				
1000	**8**	**Improving Access to Dentistry** ***To receive and note*** *a report from the ICB's Director of Finance.*	Note	Howard Martin *Report No: ICB 23-47*
1010	**9**	**North-East Essex Alliance Update:** **'Developing People Led Approaches to Health and Wellbeing'** ***To receive and note*** *a presentation from the Head of Wellbeing and Public Health, Essex County Council.*	Note	Laura Taylor-Green/Ben Hughes *Report No: ICB 23-48*
1020	**10**	**All Age Autism Outreach Service** ***To receive and approve*** *a report from the ICB's Director of Nursing.*	Approve	Lisa Nobes/ George Martin ECC *Report No: ICB 23-49*
1030	**11**	**Improving uptake, experience and outcomes of Learning Disability Annual Health Checks** ***To receive and note*** *a report from the ICB Chief Executive*	Note	Ed Garratt *Report No: ICB 23-50*
1040	**12**	**Suffolk and North-East Essex Integrated Care Partnership (ICP) Update** ***To receive and note*** *a report from the ICP Director*	Note	Susannah Howard *Report No: ICB 23-51*
FINANCE, PERFORMANCE AND SCRUTINY				
1055	**13**	**Suffolk and North-East Essex Finance Report** ***To receive and note*** *a report from the ICB's Director of Finance*	Note	Howard Martin *Report No: ICB 23-52*
1105	**14**	**Integrated Care Board Performance Report.** ***To receive and note*** *the report.*	Note	Executive Team *Report No: ICB 23-53*
1120	**15**	**a) Current Board Assurance Framework** **b) Redesigned Board Assurance Framework (BAF)**	Approve	Amanda Lyes *Report No: ICB 23-54*

		To review and approve *the current and redesigned Board Assurance Framework*		
1125	**16**	**Pharmacy, Optometry and Dentistry – Highlight Report** ***To receive and note*** *the report.*	Note	Maddie Baker-Woods *Report No: ICB 23-55*
GOVERNANCE AND CORPORATE BUSINESS				
1130	**17**	**One Year Review of the ICB Constitution** ***To receive and note*** *a report from the ICB's Director of People and Workforce*	Note	Amanda Lyes *Report No: ICB 23-56*
1135	**18**	**Revised Terms of Reference** a) Remuneration and HR Committee and Quality Committee b) Finance Committee ***To receive and approve*** *the presented terms of reference.*	Approve	Amanda Lyes *Report No: ICB 23-57*
1140	**19**	**Health Inequalities and Prevention Committee Terms of Reference** ***To receive and approve*** *the presented terms of reference.*	Approve	Laura Taylor-Green *Report No: ICB 23-58*
1145	**20**	**Suffolk Mental Health Collaborative Terms of Reference** ***To receive and approve*** *the presented terms of reference*	Approve	Richard Watson *Report No: ICB 23-59*
1150	**21**	**Committee Minutes and Highlight Reports** ***To receive and note*** *minutes and highlight reports from the following ICB Sub Committees:* **a) Audit Committee** *The unconfirmed minutes of a meeting held on 15 June 2023* **b) Remuneration and HR Committee** *The minutes of a meeting held on 6 June 2023, extraordinary meeting held on 16 June 2023, and meeting held on 4 July 2023* *c)* **Finance Committee** *The minutes of meetings held on 9 May and 13 June 2023* **d) Quality Committee** *The minutes of a meeting held on 11 May 2023.* **e) People Committee** *The unconfirmed minutes of a meeting held on 21 June 2023* *f)* **People and Communities Committee** *The minutes of a meeting held on 3 May 2023 and 7 June 2023*	Note	Amanda Lyes *Report No: ICB 23-60*

		g) **Estates Committee** *Highlight report from May 2023 meeting.* h) **Strategic Digital Investment and Assurance Committee** *A summary of minutes of a meeting held on 5 May 2023*		
1155	**22**	**Attendance Log** ***To note and review*** *attendance at ICB Board meetings.*	Note/ Review	Will Pope (Chair)
1157	**23**	**Any Other Business**		All
1200	**24**	**Date and Time of Next Meeting:** <u>Scheduled Date:</u> 26 September 2023		
1205	**25**	**Questions from the public – Maximum 10 minutes** *Please note questions should relate to the items under discussion and must be a question rather than statement. Where individuals deviate from this requirement they will be asked to stop and will not be invited to take any further part in the meeting.*		

Exclusion of the Press and Public

The ICB Board is recommended to exclude representatives of the press, and other members of the public, from the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest; Section 1(2), Public Bodies (Admission to Meetings) Act 1960

SNEE Integrated Care Board - Board Members

Title	First Name	Last Name	Declared Interest	Type of Interest			Direct or Indirect	Date of Interest		Date of Receipt	Action Taken to Mitigate	Consent to Publish
				Financial Interests	Non Financial Professional Interests	Non Financial Personal Interests		From	To			
VCSE Sector Assembley	Kirsten	Alderson	SFC is commissioned by SCC and Health in Suffolk and frequently submits bids that have been competitively tendered.	✓			Direct		Ongoing	18/04/2023	To be declared when necessary	Yes
Primary Care Essex Partner	Freda	Bhatti	GP partner, Gt Bentley Surgery, Colchester, cCO78PJ							18/04/2023	To be declared when necessary	Yes
			NEE LMC Member							18/04/2023	To be declared when necessary	Yes
			Spouse Consultant Gastroenterologist							18/04/2023	To be declared when necessary	Yes
Provider Partner - Community	Ewen	Cameron	Nil							04/04/2023		Yes
Suffolk County Council Partner	Sue	Cook	Nil							17/04/2023		Yes
Non Executive - People, Remuneration and Diversity	Tanya	Curry	CEO for the Motor Neurone Disease Association		✓		Direct	Jul-22	Ongoing	11/04/2023	To be declared when necessary	Yes
Non Executive - Finance and Audit (Interim)	Geoff	Dobson	Former Director for Resource Management and Section 151 Officer with Suffolk County Council		✓		Direct	Apr-06	2017	26/06/2022	No further action required	Yes
			Previously Lay Member for Governance and Vice Chair of West Suffolk CCG		✓		Direct	Sep-17	Jun-22	26/06/2022	To be declared when necessary	Yes
			Non - Executive Director on the Audit and Risk Committee of Suffolk Group Holdings (Trading as the Veras Group Limited)		✓		Direct	Jan-22		26/06/2022	To be declared when necessary	Yes
			Chair of Newmarket Locality Group (made up of statutory and voluntary organisations)		✓		Direct	Nov-22		26/06/2022	To be declared when necessary	Yes
			Independent Audit Committee Member with New Anglia Local Enterprise Partnership		✓		Direct	Feb-23		26/06/2022	To be declared when necessary	Yes
Chief Executive	Ed	Garratt	Visiting Professor of Integrated Care – University of Suffolk		✓		Direct	Apr-21	Ongoing	26/04/2023	To be declared when necessary	Yes
Provider Partner - Acute	Nick	Hulme	CEO of East Suffolk and North Essex NHS Trust, an organization that could benefit from commissioning decisions	✓			Direct	Apr-13	Ongoing	05/10/2022	To be declared when necessary	Yes
Medical Director	Andrew	Kelso	Member Association of British Neurologists		✓		Direct	Jan-04	Ongoing	05/04/2023	To be declared when necessary	Yes
			Master, Essex Association of Change Ringers (Registered Charity No 292250)			✓	Direct	Jan-18	Ongoing	05/04/2023	No further action required	Yes
			Trustee, Music in Hospitals and Care (Registered Charity No 1051659)		✓		Direct	Jan-17	2020	05/04/2023	No further action required	Yes
			Consultant Neurologist at West Suffolk Hospital (holding clinics the first and third Wednesday morning of each month)		✓		Direct	Oct-22	Ongoing	05/04/2023	To be declared when necessary	Yes
Director of Finance	Howard	Martin	Nil							18/04/2023		Yes
Non Executive - Quality and Safety (Interim)	Phanuel	Mutumburi	Director for Ipswich and Suffolk Council for Racial Equality (ISCRE)	✓			Direct	Aug-20	Ongoing	15/04/2023	To be declared when necessary	Yes
			Chair IES Alliance Primary Care Commissioning Committee		✓		Direct	Dec-20	Ongoing	15/04/2023	To be declared when necessary	Yes
			Chair IES Alliance Executive Delivery Group		✓		Direct	Jul-22	Ongoing	15/04/2023	To be declared when necessary	Yes
			Trustee at Asset Education Trust		✓		Direct		Ongoing	15/04/2023	No further action required	Yes
			Trustee at Gecko Theatre		✓		Direct		Ongoing	15/04/2023	No further action required	Yes
Director of Nursing	Lisa	Nobes	Clinical visiting fellow at University of Suffolk	✓			Direct	2018	Ongoing	04/04/2023	To be declared when necessary	Yes
Chair	William	Pope	Professor at the University of Suffolk		✓		Direct	Jan-20	2020	05/04/2023	To be declared when necessary	Yes
			Joint Chair SNEE Integrated Care Partnership Board	✓			Direct	Jul-22	Ongoing	05/04/2023	To be declared when necessary	Yes
Primary Care Suffolk Partner	Nick	Rayner	Director of online pharmacy- L&R Pharma Ltd	✓			Direct	Jan-20	Ongoing	11/04/2023	To be declared when necessary	Yes
			Non-exec Director, Suffolk GP Federation CIC ltd	✓			Direct	Jan-14	Ongoing	11/04/2023	To be declared when necessary	Yes
Provider Partner - MH	Stuart	Richardson	Nil							04/04/2023		Yes
Essex County Council Partner	**Vacant**									04/04/2023		Yes
Other Regular Attendees:												
Director Ipswich and East Suffolk Alliance	Maddie	Baker-Woods	Trustee of Suffolk ArtLink		✓		Direct	Mar-20	Ongoing	24/04/2023	To be declared when necessary	Yes
Director of Performance and Improvement	Paul	Gibara	Nil							12/10/2022		Yes
Integrated Care Partnership Director	Susannah	Howard	My daughter is an employee of Healthwatch Suffolk			✓	Indirect	Jan-20	Ongoing	11/04/2023	To be declared when necessary	Yes
			My daughter is an employee of Capsule Marketing Ltd who provide occasional services to the ICB and other health and care organisations			✓	Indirect	Jan-20	Ongoing	11/04/2023	To be declared when necessary	Yes
			My step-son is an employee of St Elizabeth Hospice			✓	Indirect	2007	Ongoing	11/04/2023	No further action required	Yes
			My step-daughter is a community nurse employed by Virgin in NEE			✓	Indirect	2021	Ongoing	11/04/2023	No further action required	Yes
			I am an advocate for people living with obesity and a member of the APPG and national strategic council for obesity		✓		Direct	Jan-14	Ongoing	11/04/2023	To be declared when necessary	Yes
			I am a director and shareholder of East Harbour Group Ltd, which supplies speciality chemicals to commercial end users and to the Ministry of Defence	✓			Direct	2017	Ongoing	11/04/2023	To be declared when necessary	Yes
			I am a director and shareholder in East Harbour Property Ltd which invests in commercial properties.	✓			Direct	2022	Ongoing	11/04/2023	To be declared when necessary	Yes
Director of People and Workforce	Amanda	Lyes	Director of Workforce & People for Suffolk & North East Essex ICB	✓			Direct		Ongoing	05/04/2023	No further action required	Yes
			Visiting Senior Fellow in Integrated Care, University of Suffolk		✓		Direct	Jan-23	Ongoing	05/04/2023	To be declared when necessary	Yes
ICP Chair Suffolk	Andrew	Reid	Nil							02/05/2023		Yes
ICH Chair Essex	John	Spence	Chairman Spicer Haart Group Ltd (Estate Agency)	✓			Direct	2021	Ongoing	05/04/2023	To be declared when necessary	Yes
			Board Member Business Banking Resolution Service	✓			Direct	2021	Ongoing	05/04/2023	To be declared when necessary	Yes
			Chairman Cambridge Building Society.	✓			Direct	2021	Ongoing	05/04/2023	To be declared when necessary	Yes
			Board Member and Joint Chair Suffolk and North-East Integrated Care System (ICS)	✓			Direct	Jul-22	Ongoing	05/04/2023	To be declared when necessary	Yes
			Board Member and Vice-Chair Mid- and South-Essex ICS	✓			Direct	Jul-22	Ongoing	05/04/2023	To be declared when necessary	Yes
			Board Member Herts and West Essex ICS	✓			Direct	Jul-22	Ongoing	05/04/2023	To be declared when necessary	Yes
			Membership or other Roles in Charities/Political Parties/Pressure Groups/Public Bodies/Trade Unions. •Church of England Archbishops Council - Finance Chairman (involves inter alia Church of England Central Services Ltd & numerous other CofE bodies) •Essex Community Foundation - Life Vice President •Chelmsford Constituency Conservative Association - Member •Royal Zoological Society of Scotland - Fellow •The J's Hospice - Honorary Patron •Chelmsford Cathedral Council - Member •Royal Society of Arts - Fellow •Chartered Institute of Bankers (Scotland) - Fellow •Conservative Councillors Association - Member •Anglia Ruskin University Philanthropic Foundation - Member		✓		Direct	Jan-13	Ongoing	05/04/2023	To be declared when necessary	Yes
Director of North East Essex Alliance	Laura	Taylor-Green	Brother-in-law is a product manager for SilverCloud Health UK LTD (owned by Amwell)			✓	Indirect		Ongoing	24/04/2023	No further action required	Yes
			Close friend is employed as a nurse with COLTE surgery group (Tiptree based).			✓	Indirect		Ongoing	24/04/2023	To be declared when necessary	Yes
			NEE Alliance director with role accountability to Tendring District Council, Colchester Borough Council and Essex County Council			✓	Direct	Aug-22	Ongoing	24/04/2023	To be declared when necessary	Yes
			Mother is a Healthwatch Essex ambassador (research & general) and member of the West Mersea GP patient participation group (COLTE surgery group)			✓	Indirect	Nov-22	Ongoing	24/04/2023	To be declared when necessary	Yes
Director of Strategy and Transformation	Richard	Watson	Director of Strategy and Transformation for SNEE CCGs/ICB	✓			Direct	Jul-15	Ongoing	04/04/2023	No further action required	Yes
			Husband is employee of Hadleigh Group Practice			✓	Direct	Oct-19	Ongoing	04/04/2023	To be declared when necessary	Yes
			Deputy Chief Executive SNEE CCGs/ICB	✓			Direct	Jul-22	Ongoing	04/04/2023	No further action required	Yes

			Trustee Anglia Ruskin University Students Union			✓	Direct	Aug-22	Ongoing	04/04/2023	To be declared when necessary	Yes
			Senior Research Fellow for Integrated Care, University of Suffolk		✓		Direct	Jan-23	Ongoing	04/04/2023	To be declared when necessary	Yes
Director of West Sufofik Alliance	Peter	Wightman	Nil							18/10/2022		Yes

NHS
Suffolk and North East Essex
Integrated Care Board

ICB BOARD

Agenda Item No.	**04**
Reference No.	**ICB 23-46**
Date.	**25 July 2023**

Title	**Norfolk and Suffolk Foundation Trust's mortality recording and reporting.**
Lead Director	Andrew Kelso, Medical Director
Author(s)	Andrew Kelso, Medical Director
Purpose	Information and Approval

Recommendation:

The ICB Board is asked to approve seven recommendations:

1. To offer sincere condolences to the families and loved ones of all patients who have died.
2. To receive and note the report by Grant Thornton and the action plan by NSFT contained within the report.
3. To commit to work in mutually meaningful coproduction with Norfolk and Suffolk NHS Foundation Trust (NSFT), patients, their families and communities, and bereaved relatives to make the recommended improvements, and any further improvements that may arise because of this work, and to ensure that the Trust uses the right processes to accurately record and learn from deaths.
4. To commit to work with NHS Norfolk and Waveney ICB, NSFT, patients, their families and communities, and bereaved relatives to better understand the deaths of patients under the care of the Trust (or within six months of discharge), both retrospectively and in the future.
5. To review and co-produce with the Trust and patients, their families, and bereaved relatives an action plan that considers the concerns raised since publication of the Grant Thornton report.
6. To note that assurance of completion of the action plan will be provided through the NSFT Oversight and Assurance Group chaired by NHS England and reported to each ICB's Quality Committee.
7. To agree in principle to a follow up audit of mortality data recording processes in the Trust in April 2024, following completion of the action plan.

1. Background

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

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

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

1.4 In line with standard audit practice, Grant Thornton produced a draft of the report which was shared with NSFT and the ICBs in February 2023 to check for factual accuracy. The Grant Thornton report was then published on 28 June 2023. A copy of the report is included as Appendix 1 and can also be read here:

https://suffolkandnortheastessex.icb.nhs.uk/news/norfolk-and-suffolk-foundation-trusts-mortality-recording-and-reporting-review-published/

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

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

https://suffolkandnortheastessex.icb.nhs.uk/news/just-b-is-available-to-help-people-in-norfolk-and-suffolk/

1.7 An independent report in response to the Grant Thornton review which details concerns about deaths of patients under the care of NSFT (Forever Gone: Losing Count of Patient Deaths) has been written by Caroline Aldridge, Anne Humphrys and Emma Corlett, and shared with the ICBs as well as the Healthcare Safety Investigations Branch. It can be downloaded from www.learningsocialworker.com. The report is included as Appendix 2 to this paper.

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

2. Key Issues

2.1 The Grant Thornton report has concluded the following:

- NSFT has strong governance in its approach to inpatient deaths and that any on site incidents are followed up by the team.

- The Trust needs to bring the same rigour to improve the processes around the reporting of all mortality, and the understanding of all deaths for patients on its caseload, or within six months of discharge, particularly for deaths in the community.

- The process of categorising and grouping expected and unexpected deaths and the decision making involved was unclear and inconsistent.

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

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

- To implement the necessary changes, NSFT will need to be supported by both ICBs and the other healthcare organisations within the health system to make this information available.

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

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

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

3. Patient and Public Engagement

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

4. Recommendation

4.1 The ICB Board is asked to approve seven recommendations:

1. To offer sincere condolences to the families and loved ones of all patients who have died.

2. To receive and note the report by Grant Thornton and the action plan by NSFT contained within the report.

3. To commit to work in mutually meaningful coproduction with Norfolk and Suffolk NHS Foundation Trust (NSFT), patients, their families and communities, and bereaved relatives to make the recommended improvements, and any further improvements that may arise because of this work, and to ensure that the Trust uses the right processes to accurately record and learn from deaths.

4. To commit to work with NHS Norfolk and Waveney ICB, NSFT, patients, their families and communities, and bereaved relatives to better understand the deaths of patients under the care of the Trust (or within six months of discharge), both retrospectively and in the future.

5. To review and co-produce with the Trust and patients, their families, and bereaved relatives an action plan that considers the concerns raised since publication of the Grant Thornton report.

6. To note that assurance of completion of the action plan will be provided through the NSFT Oversight and Assurance Group chaired by NHS England and reported to each ICB's Quality Committee.

7. To agree in principle to a follow up audit of mortality data recording processes in the Trust in April 2024, following completion of the action plan.

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Grant Thornton

Norfolk and Suffolk Foundation Trust's mortality recording and reporting

26 May 2023



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26/05/2023

Mortality data recording review

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

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

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

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Addressee for our work, our Report and other communications, or for any opinions we have formed. We do not accept any responsibility for any loss or damages arising out of the use of the Report by the Addressee(s) for any purpose other than in relation to the Purpose.

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

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Period of our fieldwork

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

Scope of work and limitations

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

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

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

General

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

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

Yours Sincerely,

Grant Thornton UK LLP

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Chartered Accountants
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Executive summary (1 of 4)

Introduction

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

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

To do this we:

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

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

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

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

Overview

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

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

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

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

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

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

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

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Executive summary (2 of 4)

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

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

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

Reporting

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

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

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

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

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

Data processes

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

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Executive summary (3 of 4)

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

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

Definitions of expected and unexpected deaths

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

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

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

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

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

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

Governance and clinical engagement

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

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

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

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

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Executive summary (4 of 4)

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

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

Recommendations

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

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

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

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

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

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Recommendations

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

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

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

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

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

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

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

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

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

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

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

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NSFT action plan (1 of 7)

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

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

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NSFT action plan (2 of 7)

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

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NSFT action plan (3 of 7)

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

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NSFT action plan (4 of 7)

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

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NSFT action plan (5 of 7)

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

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NSFT action plan (6 of 7)

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

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NSFT action plan (7 of 7)

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

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Introduction and approach

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Introduction and approach (1 of 3)

Background

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

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

Structure of the report

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

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

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

National context

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

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

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

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

Aims and objectives of the review

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

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

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

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

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Introduction and approach (2 of 3)

Our approach

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

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

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

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

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

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Introduction and approach (3 of 3)

Glossary of terms

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

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Main Report

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Mortality recording methodology (1 of 4)

Introduction and summary

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

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

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

Defining mortality reporting

Mortality recording and reporting encompasses

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

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

Available national guidance and analysis

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

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

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

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

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

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Mortality recording methodology (2 of 4)

National mortality terminology guidance

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

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

The Trust’s current mortality recording methodology

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

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

National Spine tracing

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

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

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

Methodology changes

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

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

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

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

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

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Mortality recording methodology (3 of 4)

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

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

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

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Mortality recording methodology (4 of 4)

Methodology benchmarking

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

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

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

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

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

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

Conclusion and areas for improvement

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

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

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

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

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

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

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Processes (1 of 6)

Introduction and summary

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

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

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

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

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

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

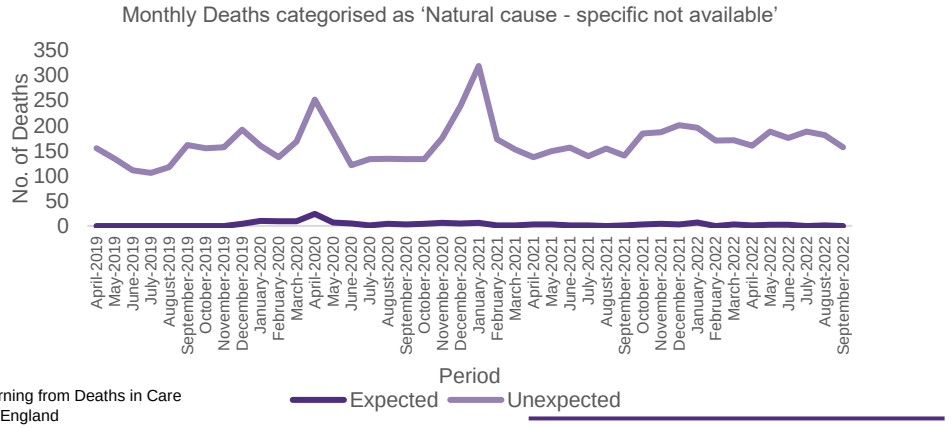
The various processes and the challenges these present are summarised on the next page.

Mortality recording documentation

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

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

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



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

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Processes (2 of 6)

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

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Processes (3 of 6)

Data categorisation

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

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

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

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

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

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

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

Pending cause of death

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

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

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

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

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Processes (4 of 6)

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

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

NULL data fields

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

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

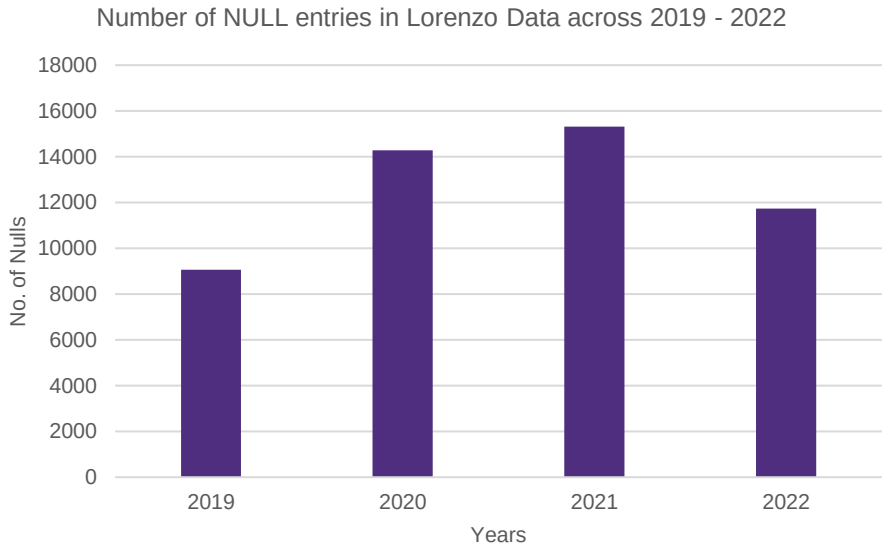
Some data fields were consistently well filled in over time. These include:

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

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

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

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



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Processes (5 of 6)

Data gaps between systems

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

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

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

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

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

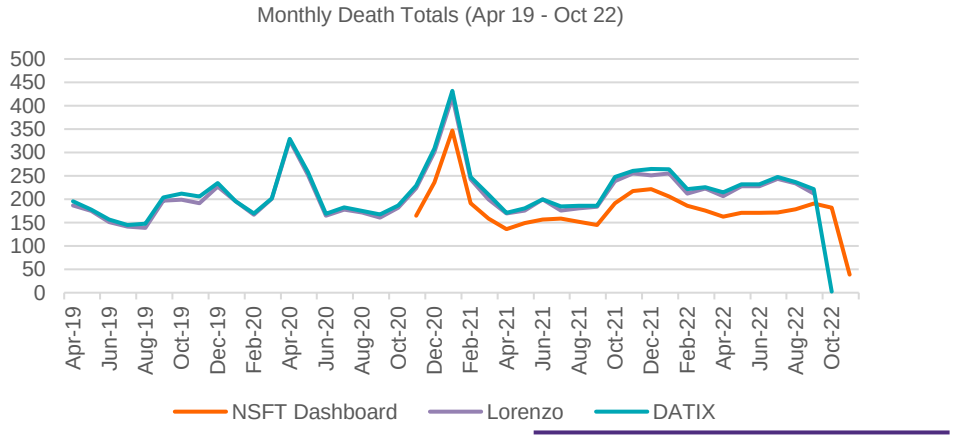
	Lorenzo	Datix
Number of Patient ID records received	8871	9130
Number of records also present in comparator source (Lorenzo for Datix and Datix for Lorenzo)	8806	8806
Number of records not represented in comparator source	65	324

Comparison of sources

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

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

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



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Processes (6 of 6)

Conclusion and areas for improvement

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

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

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

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

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

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

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

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

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Reporting (1 of 5)

Introduction and summary

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

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

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

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

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

Board reports data presentation and evidence of interrogation

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

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

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Reporting (2 of 5)

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

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

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

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

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Reporting (3 of 5)

Board report data accuracy

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

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

From this comparison the following conclusions can be drawn:

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

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

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

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Reporting (4 of 5)

Evidence of data interrogation

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

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

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

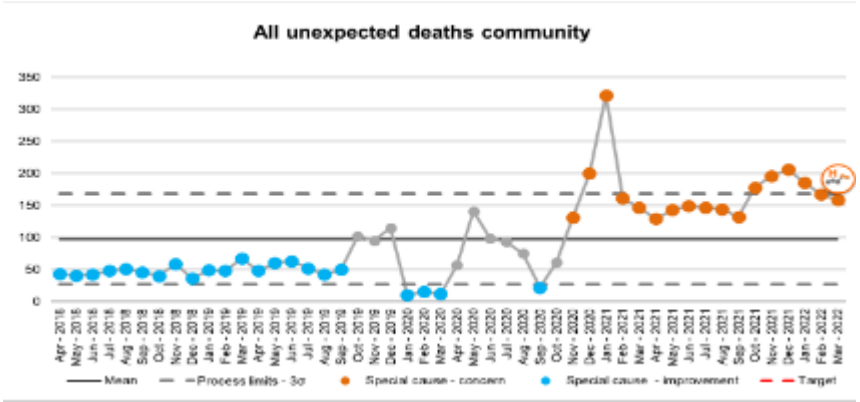
The Patient Safety Incident (PSI) annual report also contains mortality data and reporting which is again presented differently to board reports [3]. In the most recent report unexpected community deaths are pulled out as a separate graph. This graph is another example of data being presented differently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

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

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

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

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



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

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Reporting (5 of 5)

Conclusion and areas for improvement

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

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

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

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

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

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

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

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Clinical engagement (1 of 5)

Introduction and summary

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

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

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

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

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

Validation and use of data

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

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

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

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

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

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

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

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Clinical engagement (2 of 5)

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

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

Caseload management

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

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

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



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

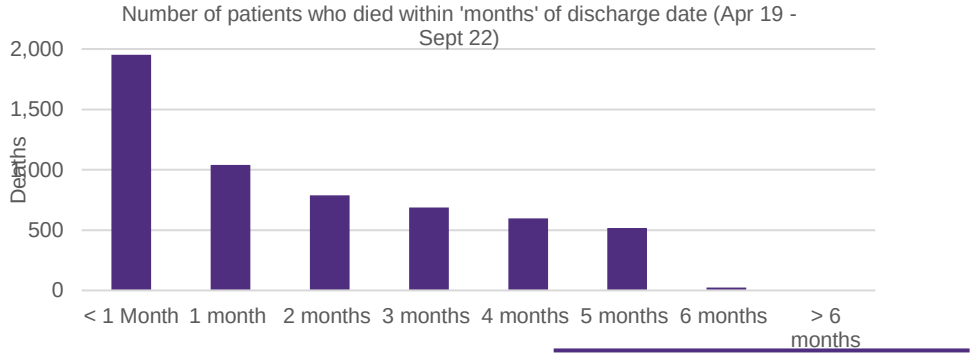
If these patients have been discharged but this status not updated they will have been unnecessarily included in the Trust's mortality figures. As part of rectifying this specific issue the Trust has informed Grant Thornton it plans to undertake the required data cleansing and provide further training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

Discharges within one month

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

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

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



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Clinical engagement (3 of 5)

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

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

Benefits of analysing by trend

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

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

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

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

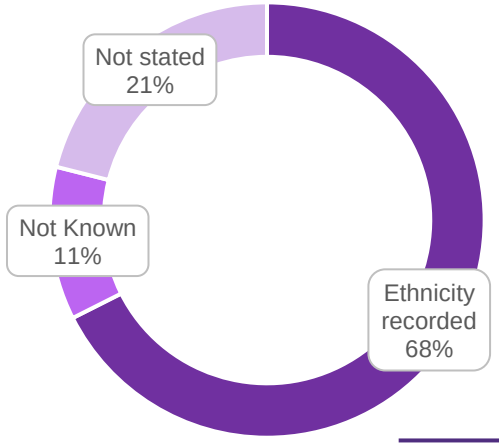
Ethnicity

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

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

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

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



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Clinical engagement (4 of 5)

Partnership working

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

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

Learning opportunities associated with information sharing

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

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

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

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

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

Mental Health organisation best practice

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

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Clinical engagement (5 of 5)

Mortality reviews

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

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

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

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

Conclusion and areas for improvement

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

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

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

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

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

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

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

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Governance (1 of 4)

Introduction and summary

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

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

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

Learning from deaths guidance

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

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

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

Governance over mortality reporting at NSFT

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

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

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

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Governance (2 of 4)

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

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

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

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

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

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

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

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

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

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

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

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Governance (3 of 4)

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

Partnership working

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

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

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

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

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

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Governance (4 of 4)

Conclusion and areas for improvement

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

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

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

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

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

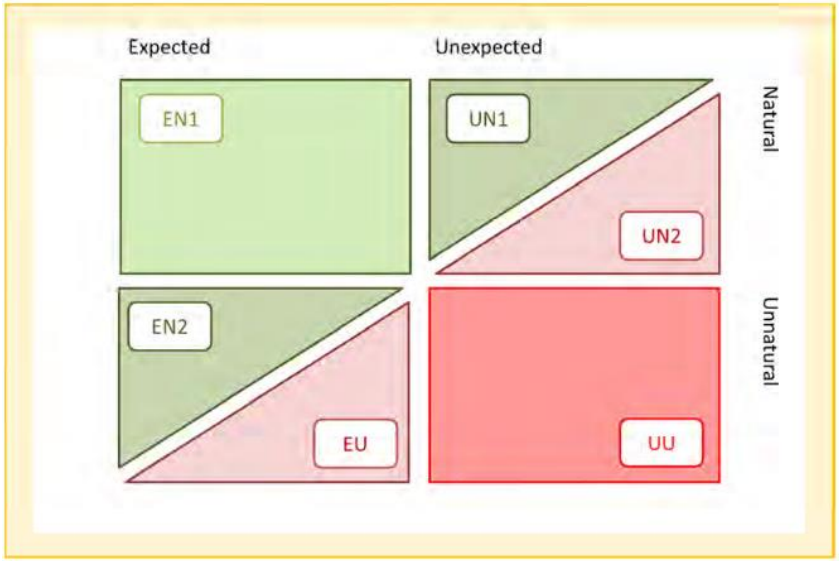
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Appendix

Appendix A: Mazars framework [1]

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



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

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

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Appendix B: Local definitions of expected and unexpected deaths

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

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

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

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

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

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

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Appendix D: Stakeholder engagement list

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

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

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

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Appendix E: Document review list

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

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

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Appendix F: Board paper comparison graphs

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

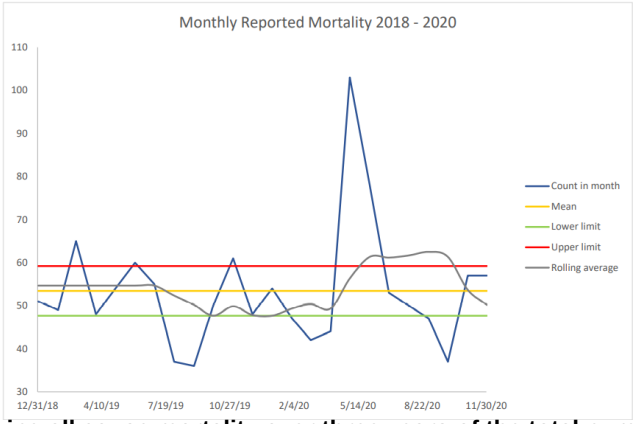


Figure 10 showing all cause mortality over three years of the total number of people who have been in contact with NSFT's services as reported in May 2021 papers. [2]

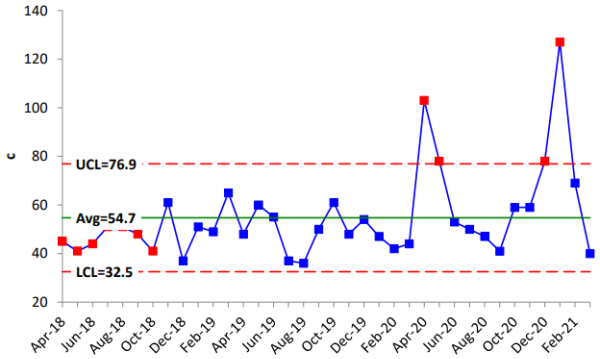


Figure 11 showing all cause mortality from December 2019 to July 2021 as reported in September 2021 papers. [3]

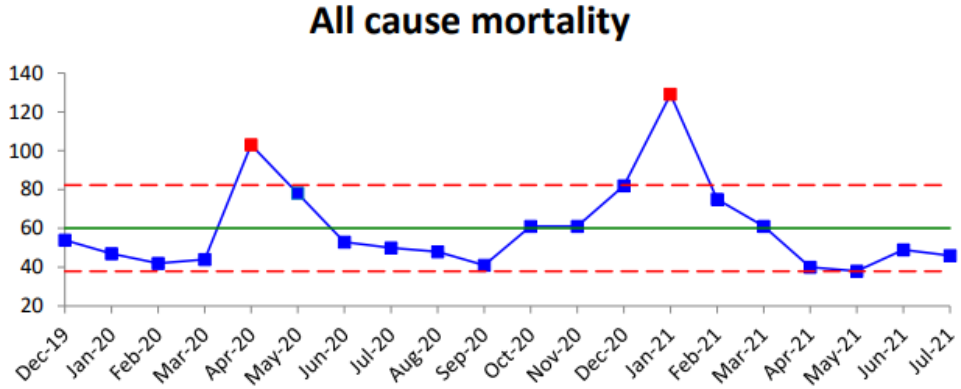
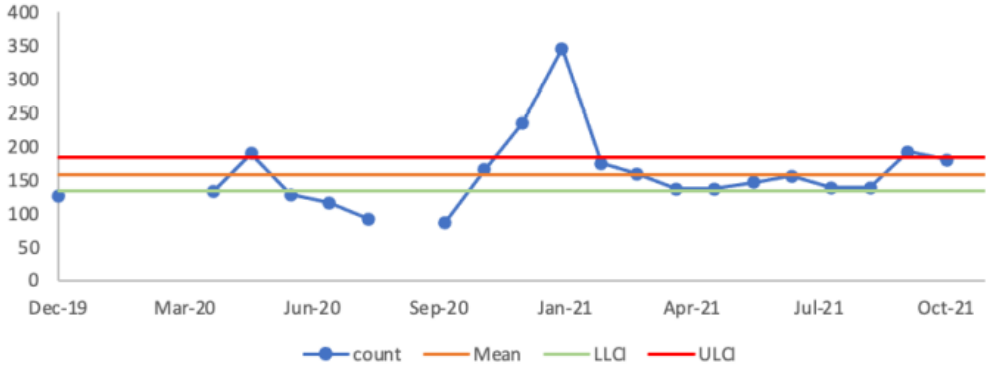


Figure 12 showing an SPC chart of community deaths within six months of contact NSFT from December 2019 as reported in January 2022 papers. [4]



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

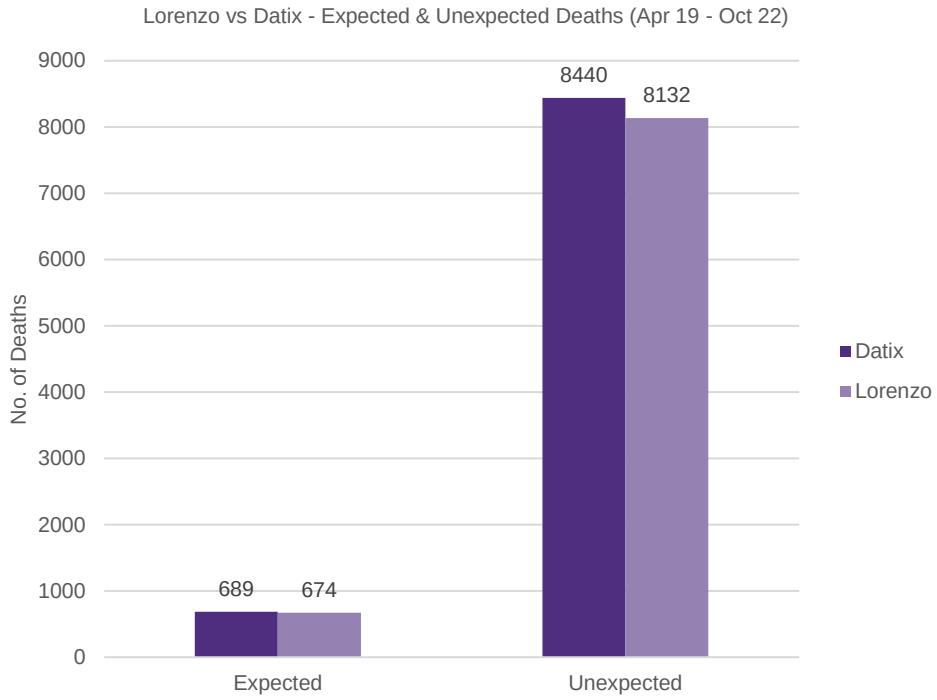
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Appendix G: Reference graphs (1 of 4)

Unexpected v expected deaths

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

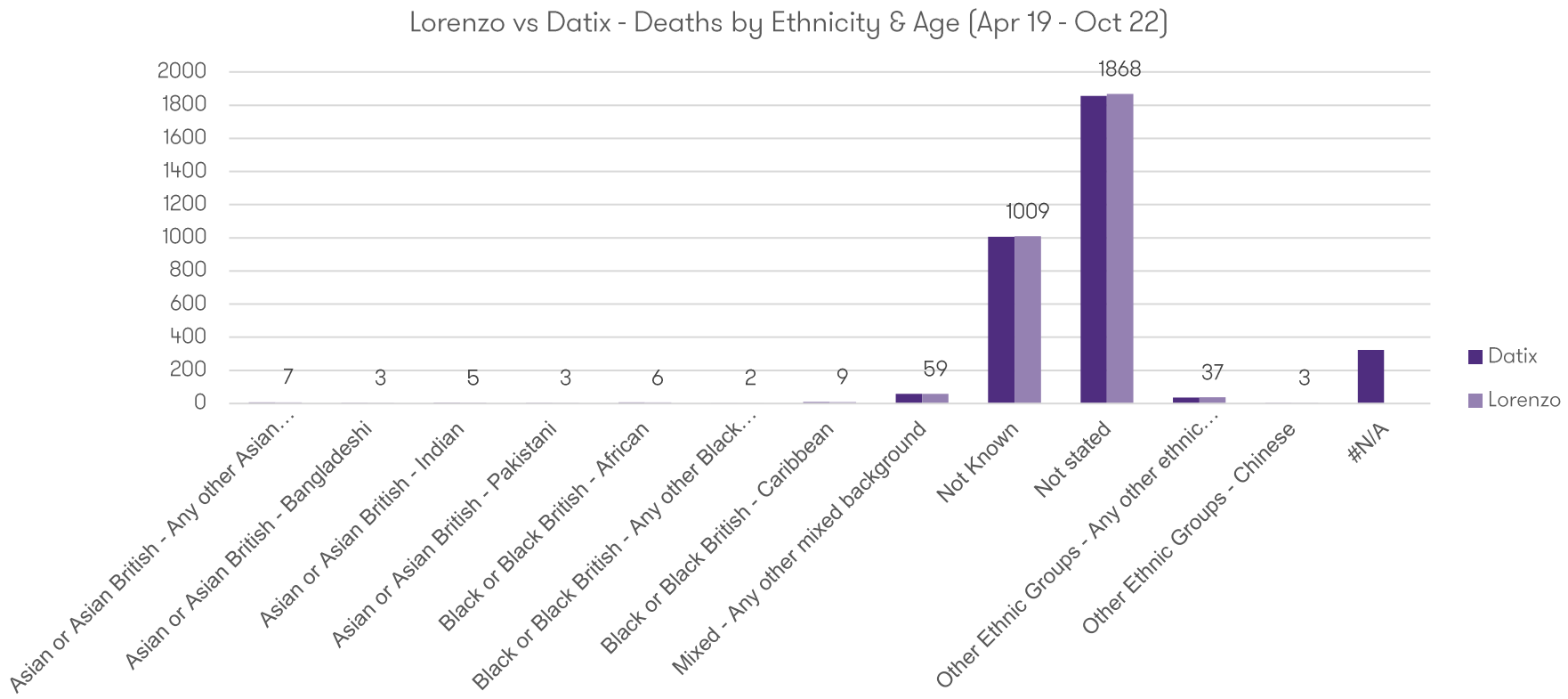


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Appendix G: Reference graphs (2 of 4)

Ethnicity

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



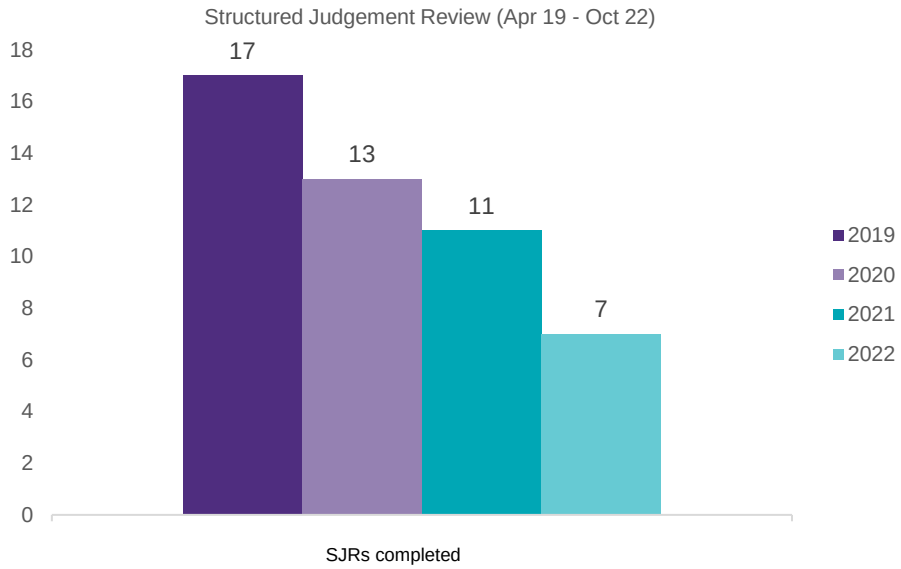
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Appendix G: Reference graphs (3 of 4)

Structured judgement reviews

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



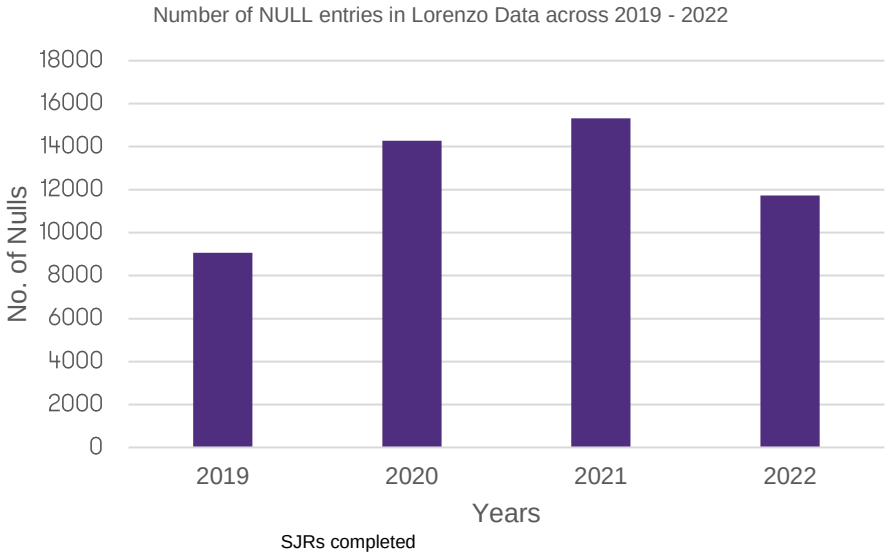
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Appendix G: Reference graphs (4 of 4)

Missing data (Null fields)

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



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

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Appendix H: Data request

The following data was requested from DATIX

•Pseudonymised patient ID

•Age

•Date of death

•How was death identified

•Incident date

•Incident severity

•Unexpected/expected view

•Cause of death

•Discharge date

•DATIX rejection

•Learning disability review

•Under 18 child death review

•Service level investigation

•Serious incident

•Structured judgement review

•Other review

•Local authority/locality

•Registered GP practice

The following data was requested from Lorenzo

•Pseudonymised patient ID

•Age

•Gender (MSHDS)

•Ethnicity (MSHSDS)

•Date of death

•Date of recording of death

•Death cause recorded text

•How death was identifies

•Inpatient discharge date

•Local speciality

•Ward name

•Site

•Discharge destination

•Team name

•Date of last seen appointment

•Date of last DNA appointment

•Discharge date

•Referral closure of rejection reason

•Local authority/locality

•Registered GP practice

•Dementia flag

•Long term condition flag

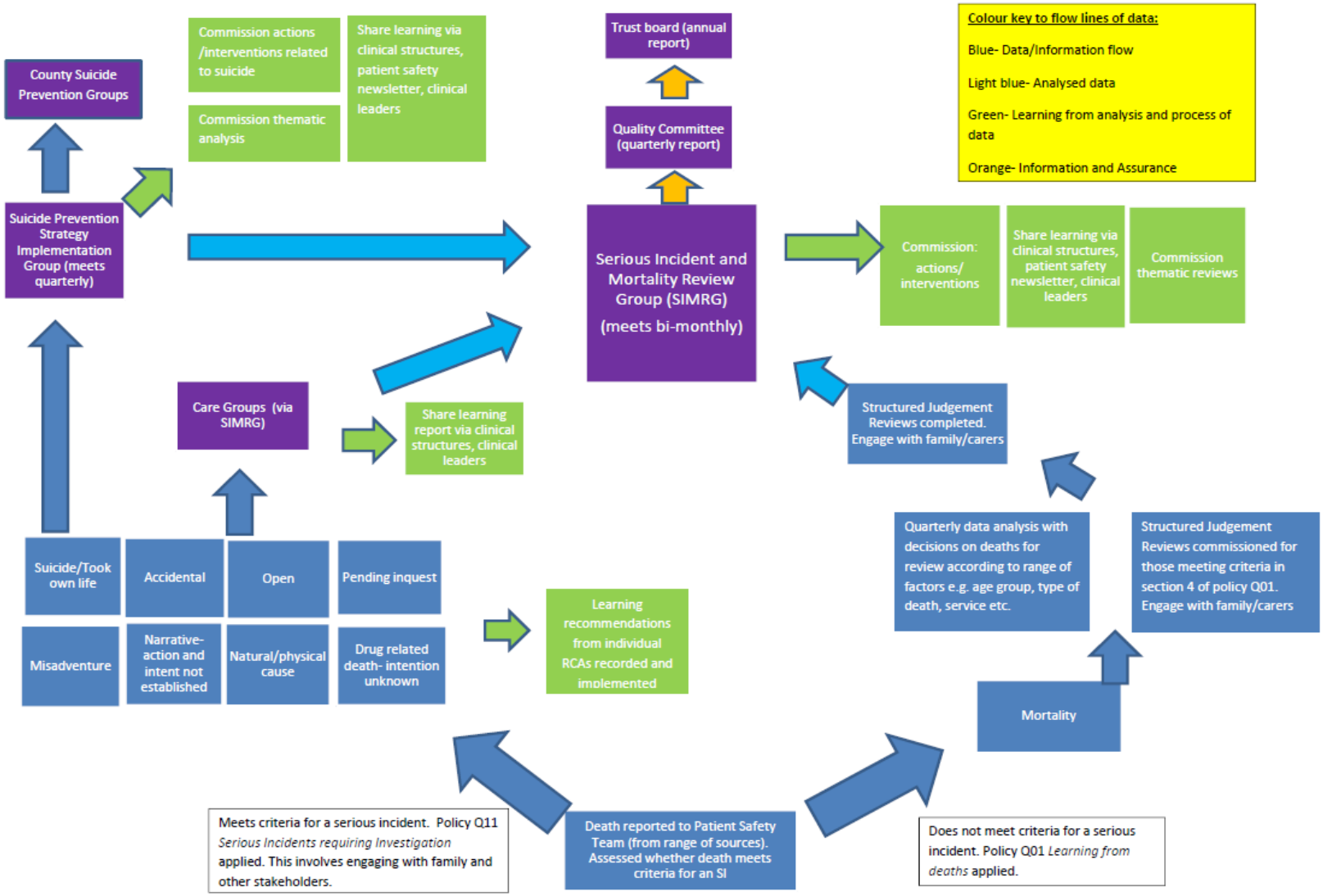
•On end of life/palliative care pathway

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Appendix I: Learning from deaths pathway

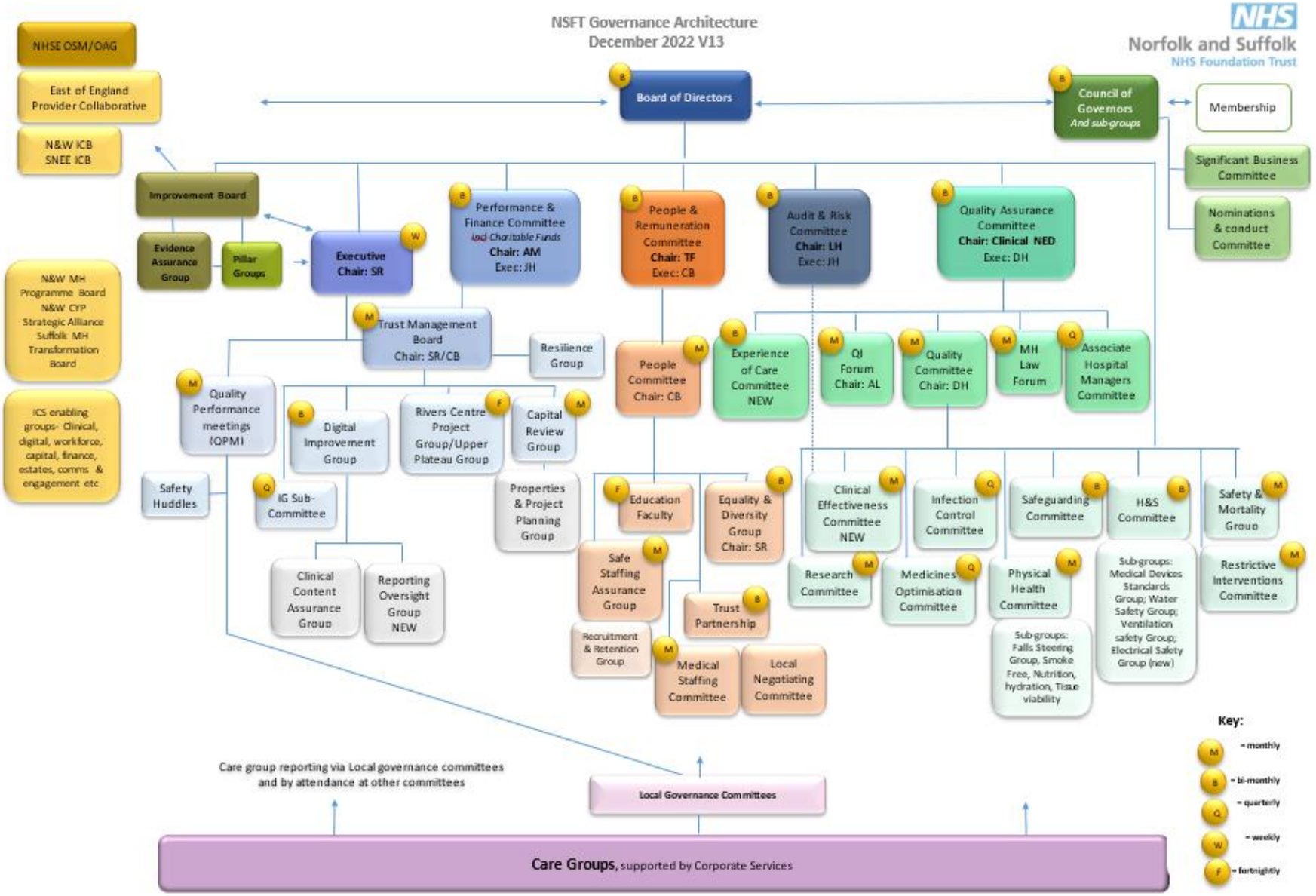


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Appendix J: NSFT governance architecture



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Forever Gone: Losing Count of Patient Deaths

An independent response to the Norfolk and Suffolk NHS Foundation Trust's mortality recording and reporting review by Grant Thornton (2023)

Dedicated to the people who have lost their lives and those left behind

By Caroline Aldridge, Anne Humphrys and Emma Corlett

7th July 2023



Trigger warning: this report contains distressing content relating to deaths including suicides

A response to the Norfolk and Suffolk NHS Foundation Trust's (NSFT) mortality recording and reporting report by Grant Thornton 2023

Introduction - as an open letter to Rt Hon Stephen Barclay MP (Secretary of State for Health and Social Care) and Rt Hon Maria Caulfield MP (Minister for Mental Health)

Every life lost to due to mental illness (which includes premature deaths from associated physical illnesses) is the loss of a precious life. This has an impact on the health and wellbeing of those left behind. It is vital to learn from deaths and to identify themes or poor practice so that actions can be taken to prevent further deaths. If a Trust cannot even count, let alone identify, who has died and why, they are not in a position to learn and improve. From the bereaved relatives and mental health campaigners' perspectives, the casual and chaotic practice that Grant Thornton reveal in their audit of NSFT is not a surprise. We had been consistently flagging up concerns about inconsistencies and poor quality of the mortality data at NSFT for years. The message conveyed to bereaved families is that their loved ones are of so little value that their deaths are not even worthy of being recorded correctly.

The key findings in Grant Thornton's report are disgraceful. They present evidence of shocking and unacceptable problems with NSFT's recording and reporting of mortality data yet in the report, governance is described as 'strong' or 'requires improvement'. Instead of providing the promised 'single truth' and verification of the mortality data, this report feels to bereaved relatives like corporate 'gaslighting' and a minimisation of deaths which further harms bereaved people.

Concerns about NSFT, including the management of mortality, are longstanding. In 2016, Verita conducted an independent review into the numbers of 'unexpected deaths'. Verita highlighted issues with data management and poor oversight from the Board and made recommendations. It is clear that these have not all been acted on. Thus another 7 years of poor practice, questionable governance, potentially avoidable deaths and grief for families.

In April 2022, NSFT was rated 'inadequate' by the Care Quality Commission (CQC) for a fourth time and campaigners stated that there had been over 1,000 deaths since 2013. NSFT said they 'did not recognise' that figure. Clive Lewis MP raised this in Parliament. We presented our concerns to a group of MPs, including the then Minister Gillian Keegan, in July 2022. We said that NSFT had 'lost count' of deaths because their systems, processes and governance were inadequate, and that reporting of deaths to the board and external bodies showed inconsistencies and gaps in data. Subsequent closer examination of the documents in the public domain suggested that 1,000 was an underestimate, and we identified at least 2,600 deaths. From the data Grant Thornton refer to, it is more likely to be several thousand deaths.

NHS England and their National Quality Board (NQB) have been aware of mortality data problems across NHS Trusts since 2016. The Care Quality Commission (2017 and 2019) committed to addressing these during inspections of trusts. Those responsible for internal and external governance, leadership and monitoring, have allowed the deaths of our loved ones and community to be lost *in plain sight*. Those whose responsibility it is to scrutinise and ensure safe practice seemed to be oblivious and unable, or unwilling, to take action.

A key aim of the review (point 1 of the Statement of Requirements) was to establish how many have died: *"Verification of the number of deaths associated with care or treatment at NSFT per year…".* In their report, Grant Thornton state: *"Based on the information made available to us we are unable to provide assurance over the mortality data reported at the Trust"* (GT report p5). Establishing how many have died under the care of NSFT proved impossible due to the impenetrability and inaccuracy of mortality data. We will simply never know how many precious lives have been lost in Norfolk and Suffolk, or why. This is heart-breaking for families. Since publication of the report the messages from the local system have consistently set a wrong tone and caused offence and further distress to bereaved families.

We have been paying attention and gathering evidence for a decade and we are convinced there have been many avoidable deaths. We respectfully suggest that we hold knowledge and understanding of the context that the system does not. We are not statisticians, neither are we people with expertise in patient safety, NHS systems or, mortality data. If *we* could see the mortality data was skewed and flawed why couldn't the people with responsibility for overseeing data gathering throughout the system? Our motivation in writing this response and in asking for specific actions is to support positive change. In the supporting evidence to this letter, we will explain in layman's terms, what the problems are, why it matters, the questions that still need answering, and what actions are needed to reassure the public that mortality data supports patient safety. We underpin our opinions with evidence. We must not see a repeat of the Verita report, where NSFT committed to acting upon the recommendations but they disappeared into a 'pit of inaction' and change did not happen.

We would prefer to work constructively with everyone. However, what the report reveals about NSFT and the wider system, and their corporate behaviours since publication, has further dented our confidence in their capability and willingness to make the necessary changes. Sir Robert Francis states: *"The experience of many previous inquiries is that, following the initial courtesy of a welcome and an indication that its recommendations will be accepted or viewed favourably, progress in implementation becomes slow or non-existent."*

Grant Thornton's report is one of at least four reviews into deaths at NSFT. None have led to the mortalities being recorded and reported with the diligence and gravitas they deserve. We are determined and persistent and will not be accepting a continuation of the status quo or tolerating any more gaslighting behaviours because too many people are forever gone.

We believe that other trusts' handling of mortality data is similarly flawed and this reflects a whole system failure. Whether by acts of commission or omission, the corruption of data within the NHS is totally unacceptable and it must be exposed and addressed. We believe this justifies a Statutory Independent Public Inquiry. We are also asking our MPs to task the Department of Health and Social Care with providing the guidance and resources to urgently address what are known national problems. These critically important issues are both historical and current, and if no action is taken now, will remain unchallenged into the future. To achieve this, we need the active involvement of government ministers.

Caroline Aldridge
Bereaved mother &
Mental health campaigner

Anne Humphrys
Carer &
Mental Health Advocate

Emma Corlett
Campaigner &
County Councillor

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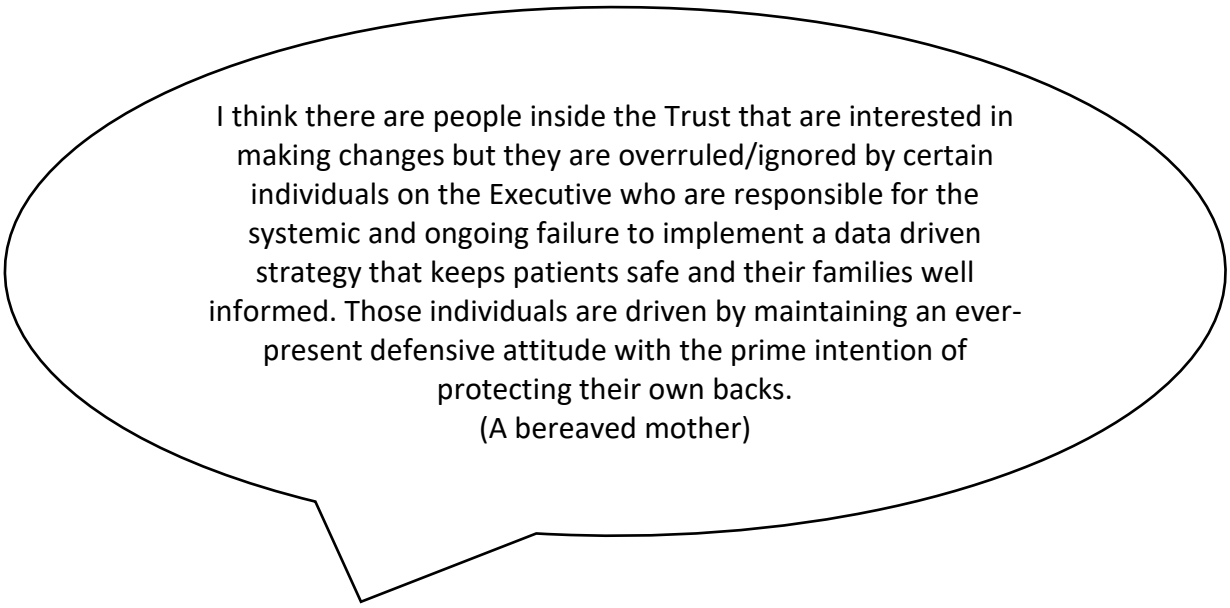
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Glossary

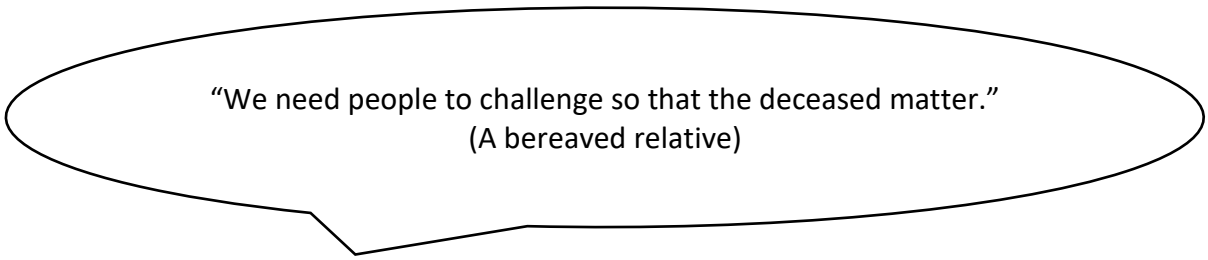
Campaign – Campaign to save mental health services in Norfolk and Suffolk
CEO – Chief Executive Officer
Chair – Chairperson of the board
CoG – Council of Governors
CPA – Care Programme Approach
CQC - Care Quality Commission
CRHT – Crisis Resolution and Home Treatment
EADT – East Anglian Daily Times
EDP -Eastern Daily Press
EqIA – Equality Impact Assessment
FOI – Freedom of Information request under data protection.
Grant Thornton - Auditors who reviewed the data and wrote the report
GT report – Grant Thornton review of mortality at NSFT
HOSC – Health Overview and Scrutiny Committee (NB: there are two covering NSFT – Norfolk HOSC and Suffolk HOSC).
HSIB – Healthcare Safety Investigation Branch
HSSIB - Health Services Safety Investigations Body
ICBs – refers to the Norfolk and Waveney, and the Suffolk and North Essex, Integrated Care Boards
NED – Non-executive director
NHSE – NHS England
NQB - National Quality Board
NRLS – National Reporting and Learning System
NSFT – Norfolk and Suffolk NHS Foundation Trust
PFD – Prevention of Future Deaths report issued by coroners
SoR – Statement of Requirements
SUF – Suffolk User Forum
Verita – independent auditors who investigated

Executive Summary

There is a plethora of evidence within Grant Thornton's report that the systems, processes, governance and culture at NSFT, surrounding mortality data recording and reporting, is extremely poor. This aligns with other evidence we have been tracking over the last decade that shows the trust has lost sight of how many of their patients were dying. For bereaved families, this compounds what is already likely to be complex and traumatic grief. The inadequate mortality data recording and reporting does not provide staff with the information they need to learn and improve. The diluting of Grant Thornton's findings (between the executive summary and body of the report), and deflection from governance to operational staff and system partners, suggests to us a culture that staff would find frightening. This mortality review not only disrespects bereaved families but also the honest, hard-working members of staff who apply due diligence to their roles.



We are stepping into a disaster zone (mental health deaths) whilst those who are employed to protect lives, through the design, commissioning and delivery of services, seem to be stepping away to distance and protect themselves. It is imperative that the whole system from government through to frontline staff involve themselves in owning and addressing the concerns we raise. The publication of Grant Thornton's report and our response means that those who say they are our colleagues or allies will need to make a choice about where they stand. This is a defining moment where people will either do the right thing or reveal themselves as complicit. The actions we have identified need to be implemented swiftly and incisively.



Key Points

- NSFT have lost count of how many people under their care have died
- There is no consistent end-to-end system to record a coherent data journey from death, through board and beyond

What did Grant Thornton find wrong at NSFT?

- Missing data
- Confusing and missing categorisation of deaths
- Consistent under-reporting of deaths attributable to NSFT
- Frequent changes in methodology
- Internal leadership and governance issues at NSFT
- Unhealthy culture
- Lack of transparency
- The quality of mortality data reflects a systems failure
- Lack of oversight and actions from regulatory and monitoring bodies
- Unsafe practice has been masked
- Inability to compare with other NHS trusts and localities
- Lack of learning from data

What needs to happen?

- A public apology for the distress caused to bereaved families
- Work in collaboration with bereaved families to repair relationships and confidence and support change
- Acknowledging the impossibility of establishing how many have died
- Creation and implementation of a credible, concrete, and co-produced plan
- Review of the 2016 Verita Report
- Answer outstanding questions
- Government intervention
- A Statutory Public Inquiry into mortality at NSFT

In preparing our response we have been limited to evidence available in the public domain. We feel that we have knowledge and experience (including lived experience) that offers analysis of Grant Thornton's report from a different perspective. We do this from a position of wanting bereaved families' concerns to be addressed and with a heart for supporting positive change. We consulted some of the bereaved families we are in touch with for their responses and have included their views. We were mindful of the distress that reading some of the content in the Grant Thornton report will cause those who have lost loved ones, so we limited ourselves to consulting only those we know to be emotionally strong enough.

Between February 2023 (when Grant Thornton submitted their report to NSFT and both ICBs) and 28th June 2023 (when the report was published), campaigners began to suspect that the delays in publication might be due to the report being re-written to present NSFT in a more favourable light.

"Suggests a culture of secrecy and closed doors. It layers pain on top of pain."
(A bereaved aunt)

On 9th May 2023, campaigners wrote to the chairs and CEOs of both ICBs and the chair of NSFT raising their concerns and specifically asking how many versions of the report there were (Appendix 1). The CEO and Chair of Norfolk and Waveney ICB, who led on commissioning the report, replied on behalf of both ICBs on 30th May 2023 (see Appendix 2). They stated:

> *"In terms of the number of drafts of the report, there was an original draft produced that was used to assess for factual accuracy … Once all the factual accuracy matters were agreed, another draft of the report was produced for approval."*

We agree with the ICB chairs and CEOs comment in their letter to campaigners that "*Only by understanding a challenge can it be solved, so it is vital we have a full and clear understanding of the situation."*

We find it hard to articulate the impact the report and the responses by the trust have had had on us personally. We genuinely believed that those individuals in senior positions who commissioned the report were, finally, going to be transparent and identify and rectify poor practice. So, we were saddened and angry to hear that in some briefings it was implied that we might not understand the data and the trust did not know how we had arrived at our concern that a 1000 people had died. To clarify, it was us who told NSFT that they were conflating terms and criteria. We provided them with our working out which was based on the data they had provided.

The impact was perhaps felt hardest by Caroline Aldridge because she is a bereaved parent who has been harmed not just by the loss of her son but by the actions of leaders at NSFT in the aftermath. Caroline details these experiences in *He Died Waiting* (2020). This replication of delay, defend, distract, deny behaviours by individuals across the local system is re-traumatising for all three of us because we have so much direct involvement with bereaved relatives.

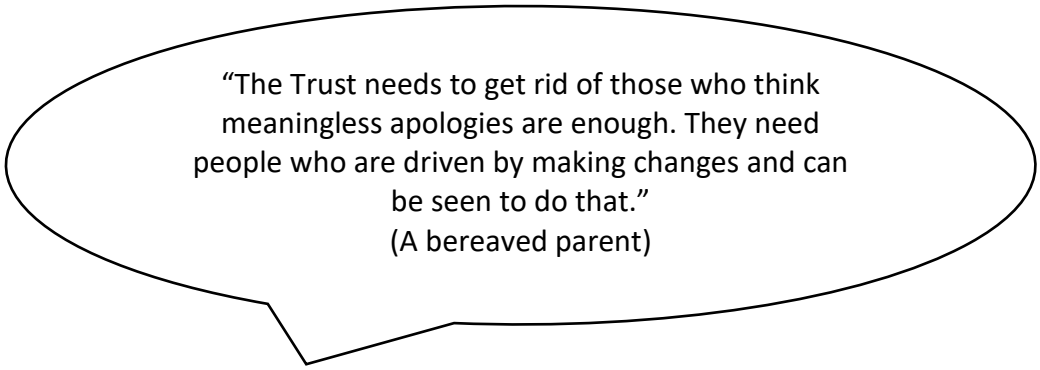
The Grant Thornton report examined 2.5 years of mortality data provided by NSFT (between April 2019 and October 2022).

There are some curious inconsistencies between the executive summary and some of the evidence cited within the body of the report, which portrays a starker and more concerning picture. Likewise, the conclusions in the Grant Thornton report somewhat understate the gravity of the issues and their recommendations do not reflect the seriousness of the findings they present.

What is missing from Grant Thornton's report is enough curiosity or analysis of why the inadequacies surrounding mortality data have occurred. Of equal concern to us are some of the other issues Grant Thornton raise which have patient safety and delivery of care implications although it is harder to discern.

> *"These issues have led to questions of clarity within the public facing documents and reduced clinical relevance within the mortality information reported. This* results *in a lack of confidence of external stakeholders - including regulators and the public - in the data, and in the Trust's understanding of it"* (GT report p5).

We would like to see recommendations be translated into robust actions that reflect the severity of the findings. We would like to see granular detail about how inadequacies will be remedied and assurance that there will be actual independent scrutiny. We believe it is time NSFT either provide verifiable mortality data or own the impossibility of this given their mortality data processes and offer a full and unreserved apology. Precious loved ones are forever gone and their families deserve the truth and to know things will change.

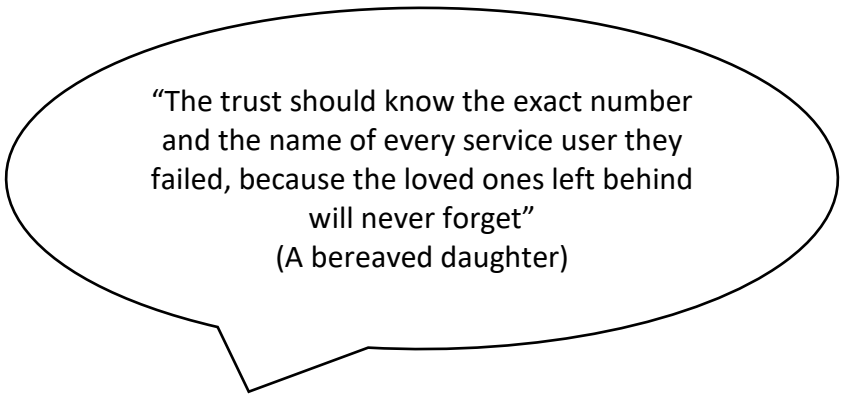


NSFT have lost count of how many people under their care have died

Our starting point in analysing Grant Thornton's report is to hold in mind that datafication of people dehumanises them and that we are not counting numbers, but humans who have lost their lives. Counting lost lives is not a neutral act and when mortality data obfuscates humanity and the grief of those left behind, it renders some of those most vulnerable and neglected in life to be invisible in death.

> *"The truest story to be told on these dashboards is a simple fact that someone, somewhere, is forever gone. The most fragile lives are broken, and those most desperately held onto are lost. If we were to approach death counting with the intentionality of individual mourning, how would we react differently and who would finally notice?"* (Raji, 2020).

Nevertheless, we believe that keeping count of deaths is important. It demonstrates that the lives lost matter and that the trust cares about each individual under their care and management.



"It matters because it was a person who mattered to us. Losing count suggests our relatives weren't worth NSFT's time."
(A bereaved relative)

When asked how many service-users had died since 2014, NSFT's Deputy CEO referred the Norfolk Health Overview and Scrutiny Committee (NHOSC) on the 8th September 2022, to the commissioning of Grant Thornton's report, saying:

> *"It's not that we don't know [the number of deaths]. It's that there is a difference of opinion so we are taking a different approach and this review will provide a single version of the truth on deaths in our trust"*[1].

If the trust know how many they think have died, why did they consistently refused to answer questions and provide a figure? At the outset it seemed that the primary purpose of Grant Thornton's review was to establish how many have died and the first point in the Statement of Requirements for the Grant Thornton report (SoR) states: *"Verification of the number of deaths associated with care or treatment at NSFT per year…".* We note that the aim to verify the number of deaths in the SoR was missing from the aims and objectives in Grant Thornton's report. It is disappointing that they did not explain why this requirement was not addressed. Presumably their mandate was changed. But the decision-making surrounding that is not transparent.

Nevertheless, it is clear from the report that Grant Thornton would have been unable to establish how many had died, and provide the promised single version of the truth, due to multiple issues that will impact on the reliability and usefulness of the information provided by NSFT.

Given the how unreliable and chaotic Grant Thornton found the data to be, we were surprised NSFT published numbers alongside the publication the report. Until NSFT can come up with verifiable figures, our opinion will continue to be that they do not know or do know but will not reveal them. The evidence presented in the Grant Thornton report suggests that it is the former. The figures NSFT published on 28th June 2023 are based on flawed data and are misleading.

It is vital that NHS trusts have good quality data to draw on:

> "*High quality data is important to the NHS as it can lead to improvements in patient care and patient safety. Quality data plays a role in improving services and decision making, as well as being able to identify trends and patterns, draw comparisons, predict future events and outcomes, and evaluate services*." (NHS England, 2023)

[1] Video of NHOSC meeting 2:02:10

"If the data isn't there or it's kept hidden, whether through ineptitude or deliberately used to hide the facts, it makes challenges very difficult. I suspect both. A bit like having a bow with no arrows."
(A bereaved mother)

There are multiple issues with the mortality data and poor systems and processes at NSFT. That these include basic errors. Some of NSFT's processes rely on manual inputting which can corrupt the final output of the Trust's mortality reporting and provide incorrect data. Of the many data errors described in the report, the loss of some patient IDs (GT report p30) means that any hope of tracking back and verifying the data is lost. This is a basic error. There might be some double counting but equally there might be deaths that were missed. We discuss the discrepancies in death numbers and what this looks like to the public in the body of our report.

NSFT disputed the death figures campaigners cited. We had collated these from NSFT's published documents and spotted discrepancies. We realised that they had lost count because they could not say what the correct number of deaths was. NSFT need to either provide a verifiable figure or admit they do not know. Each life lost is heart-breaking. It is difficult to find words to express what this means to bereaved relatives. It leaves them feeling their loved ones are demeaned to a point where they do not even feature in statistics let alone be seen as people whose lives, and deaths, mattered. Put simply, there are bereaved families who, despite this report, still have no idea whether their loved one has been counted.

"This suggests that patients' lives are not worthy of being counted."
(A bereaved aunt)

"My son's mental health and suicide has impacted hundreds of people, his family, his peers, his friends. The cost is unimaginable. To not count his death. To not understand his death. Why would we not want to learn what can be done better, or understood better to improve other people's chances?"
(A bereaved mother)

There is no consistent end-to-end system to record a coherent data journey from death, through board and beyond

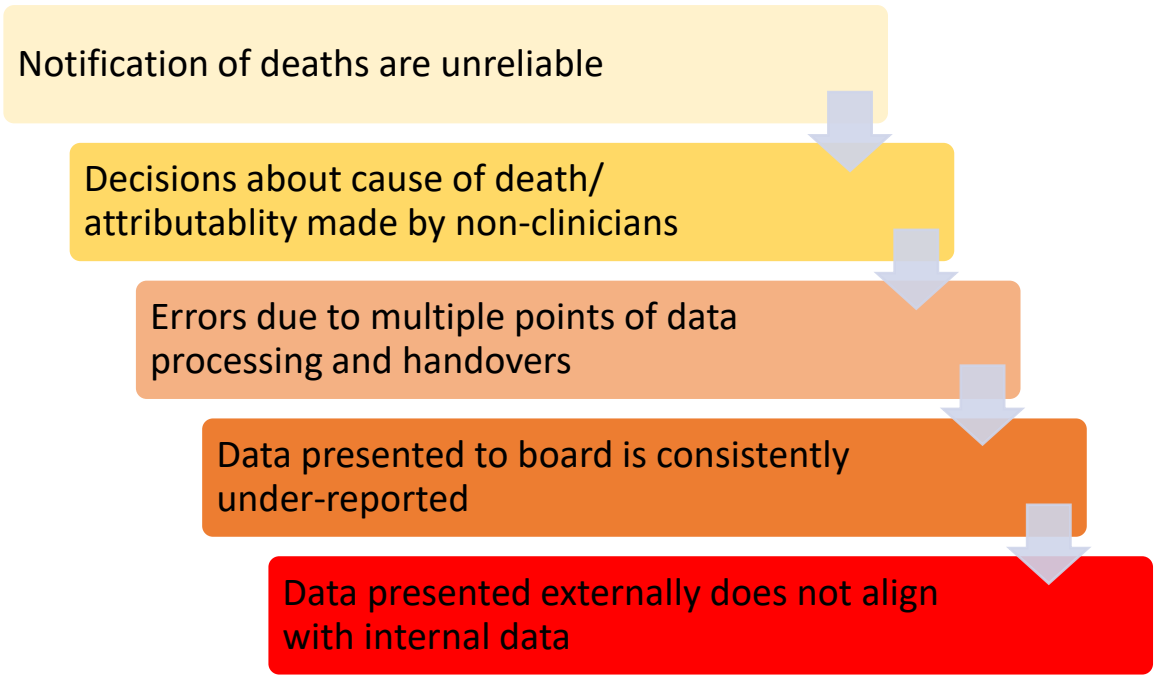
> *"Our Trust monitors and reports on the death of all people who have contact with our services, whether their death was due to natural causes or unexpected, regardless of cause"* (NSFT 2022 Annual Report).
>
> But: *"Although there are pockets of documented processes, there is no comprehensive documentation that covers the process in its entirety"* (GT report p6).

Grant Thornton are clear that there is no end-to-end data journey and they describe NSFT's poor and inadequate mortality data management. For some of our loved ones, the data is flawed, incomplete or skewed, from the day they died. In the following weeks and months, the fragmented and error ridden processes compound the problems because there are multiple points at which the data can be further corrupted.

Somehow, the data that is presented to the board for scrutiny via the dashboard is consistently an under-representation. And, at the points where data leaves NSFT, any hope of the statistics reflecting the true picture is further reduced due to missing data that regulatory bodies do not seem to challenge. This is an exemplar of Reason's Swiss Cheese Theory of error in that every layer of the system has holes that align. These are the gaps that our loved ones have fallen through.

The data journey is complex and there is no end-to-end system but we have attempted to make sense of it, based on the points raised in the Grant Thornton report, in our discussion and analysis.

Figure 1: The journey that mortality data goes on from death through to public scrutiny



Summary of our analysis

It is worth noting here how overwhelmed we were at the sheer number of concerning points Grant Thornton's report raised. This is a dense report and each page flagged up many issues that merited reflection and discussion. We have not followed Grant Thornton's order of points because we wanted our response to provide a coherent narrative. Each of the points below are the things we feel are important in Grant Thornton's report and will be discussed in more detail in the long-read section of our response.

Compounding factors

	Page(s)
Missing data	
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The misuse of 'null' fields skews the data.	33
There are missing patient IDs, which alone is inadequate practice by an NHS trust, and in this case, makes tracking back impossible.	33
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NSFT have changed the way they report on Prevention of Future Death numbers in a way that minimises them.	77-78
Changes in methodology	
"Over eight consecutive board reports, information and the method of presentation changed six times" (GT report p6).	38
The presentation of mortality data in graphs changes and the statistics are not presented accurately and accessibly.	38

There have been changes in inclusion and exclusion criteria which make comparisons impossible.	39
The mortality data in board papers is impenetrable and overshadowed by patient safety data.	39-41, 49-50
It seems NHSE's *Better Tomorrow* have been working with NSFT and have/will (it is unclear which) change the methodology used.	40
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Culture	
Long standing concerns about the culture at NSFT	41-43
Staff have limited faith in the data.	68
Transparency	
The board, external stakeholders, and the public, are not presented with data that is understandable, consistent, and reliable.	43
What is visible is so lacking in credibility that it should have raised alarms across the system long before this report was commissioned.	43
Some important reviews into mortality have not been published.	43-45
NSFT cannot exercise a Duty of Candour, if they do not know which families to exercise this to.	45

Accountability

The quality of mortality data reflects a systems failure	
There are similarities to the Francis Report.	45-46
Internal leadership and governance issues at NSFT	
There is poor governance over the process.	47
There are no clear lines of accountability for mortality data.	50-51
There is a longstanding lack of 'curiosity and challenge' from the Board and Council of Governors.	47-49
The recommendations of the Verita report in 2016 have not all been implemented.	90-91
Lack of oversight and action from regulatory and monitoring bodies	
Integrated Care Boards need to be more involved in requiring NSFT to gather and use mortality data, and hold them to account.	52-53
The Care Quality Commission have not consistently demonstrated oversight of mortality at NSFT across successive inspections.	53-56
National Quality Board have not updated their guidance since 2017 which indicates a lack of national interest.	56
It is unclear what part NHS England have played with regard to mortality data.	56-58
It is unclear what the Better Tomorrow support for NSFT is and whether this is linked, as it should be, to the wider system.	59-60, 93
NSFT do not consistently upload their mortality data to the National Recording and Learning Service and this seems to go unchallenged.	60-61
Concerns about mortality have been raised by independent scrutineers but these have not been taken seriously enough.	61-64

Why the poor mortality data matters

Unsafe practice has been masked	
Bereaved families are distressed and horrified by the findings of the report.	64-65
The issues are serious enough to merit a Healthcare Safety Investigation Branch inspection.	65-66
It would be prudent to ask the Health and Safety Executive to offer a view of whether this merits investigation.	66
Comparison with other NHS trusts and localities	
It is difficult to compare with other NHS trusts and this is a longstanding issue.	67
Identifying excess deaths is difficult due to the poor quality of the mortality data	67-68
Lack of learning from data	
The promises to bereaved families and others about learning lessons have been broken.	68
The quality of the data and the systems used do not support trend analysis to improve the quality of care.	29
The data quality impacts on partnership working with other organisations across the system.	38-39
The data necessary to deliver the best care for community patients waiting for, or under the care of the trust, is impacted.	58
The data gathered during Covid masked deaths and was not investigated.	70
With high numbers of deaths occurring within 1 month of discharge, the issue of unsafe discharges needs urgently investigating.	71-72
No understanding of a cohort of patients who have been open to NSFT but not seen by clinicians in the months or years preceding their death. This raises issues about a lack of follow-up of at-risk patients.	72-73
There needs to be more exploration of the role coroners play in gathering and using mortality data and monitoring trends.	73

The following quotes from Grant Thornton's report, which asserts 'strong governance' over mortality data give an indication of how concerning the issues with NSFT's mortality data are:

"The Trust exhibits deficiencies which limit the potential to provide assurance over the pathway, and thus the accuracy and integrity of the mortality data reported from it" (p31).

"The generic category of 'Natural cause - specific not available' is used where no cause of death information is available, and accounts for 77% of all recorded mortality activity" (p7).

"There were found to be 65 missing IDs in Datix ... [and] 324 missing IDs in Lorenzo" (p30).

"The Trust's process of determining the categorisation of death as expected or unexpected, which is a key aspect of mortality report … is not clear or auditable" (p7)

An evaluation of Covid-19's impact on NSFT's mortality figures: "…reached the conclusion that 'people who were in contact with NSFT's services were disproportionately affected, compared to the whole population [of Norfolk and Suffolk]'" (p36).

"The end-to-end process of mortality recording is undocumented with a lack of clear rules underpinning the mortality pathway. This creates points of risk with limited assurance over the whole pathway" (p26).

Between April 2019 and September 2022: "For 1953 patients whose death is considered part of the Trust's mortality reporting the date of death is within one month of discharge. This includes 278 patients whose date of discharge is the same day as they died" (p38).

"Between April 2019 and September 2022 1868 deaths had an ethnicity recorded as 'not stated' and 1009 as 'not known' …[therefore] the Trust will struggle to accurately understand whether or not there is a disproportionate mortality impact on certain protected characteristics" (p39).

Actions required

Working with bereaved families NB: this might not be possible because NSFT cannot confidently identify who **all** their bereaved families are.	
Unreserved public apology to bereaved families	82-83
Going forward each bereaved family needs to have their loss fully acknowledged, including confidence that their loved one's death is counted and learnt from.	83
Bereaved families need to be involved in the actions, responses and monitoring of the Grant Thornton report.	84
National, ICBs, and trust policies, on working collaboratively and transparently with bereaved families, must move from policy to reality.	84-85
A co-produced and fully resourced reparation plan is urgently needed.	21, 80-81, 83, 87
Establishing how many people have died	
Admission by NSFT that they are unable to provide this information and acknowledgement of the seriousness of this.	86
A credible and transparent plan and resources from the system about how the number of deaths might be identified.	86
A full stop to the continuation of the current poor mortality data so that going forward we can have confidence that all deaths are correctly identified, categorised and reported.	86
Retraction of the data published by NSFT on 28.6.23 because it is at best incomplete and at worst misleading and totally inaccurate.	104-106
Critique of Grant Thornton's action plan	
The recommendations do not reflect the severity of the report findings.	86
The action plan needs reviewing to re-focus oversight and governance away from the finance director to clinical staff (pages 10-16).	87-88
The priority level given to the recommendations has not considered what the priorities would be for bereaved families, service users and carers.	87-88
The action plan has not been co-produced with system partners and key stakeholders, which is a missed opportunity.	89
There are key recommendations missing from the action plan, which can be drawn from the findings of the report.	86-87
Creation of a credible and concrete plan	
A transparent and accountable process that ensures the basics are right and there is an effective end-to-end mortality data journey.	90
A swift and wise response that avoids further drift is needed because there are current risks.	90
Robust external oversight and management of the action plan by local and national bodies.	90
Clarity about how NSFT will work collaboratively with their system partners, from across both counties, to ensure a consistent approach to mortality data.	90
Review the Verita Report	
The Verita Report made a number of recommendations pertaining to unexpected deaths at NSFT. These need to be reviewed to see which remain outstanding or only partially implemented.	90-91

Outstanding recommendations need to be implemented	90-91
Answer outstanding questions	
There are key questions that still need answering before the public and external stakeholders can feel confident in the mortality data.	91
A meeting with the wider system to discuss our findings to support them in taking action.	91
The HSSIB to undertake a national investigation into deaths following a discharge from inpatient or community services.	93
Government intervention	
Independent Statutory Public Inquiry	93-94
The Department of Health and Social Care, our region's MPs and the Minister to be proactive and fully involved in further exploring what has gone wrong at NSFT, and ensuring the situation is remedied and sustained.	94
A meeting with the Minister for Mental Health and the region's MPs to discuss Grant Thornton's report and our response.	94

The wider picture

NSFT sits within the wider health and social care system. Grant Thornton touch on some national issues that have contributed to some poor practice regarding mortality at NSFT. The problems here echo those that have been flagged up in other NHS investigations and there seems to us to be a trans-trust endemic problem that has grown over decades. It is ten years since Sir Robert Francis published his report into the Mid-Staffordshire NHS trust. In January 2023 he, and Rachel Power, CEO of the Patients Association, wrote to the Secretary of State expressing concerns and asking for government intervention:

> *"This level of crisis in the NHS is a serious threat to patient safety and it is clear lives are being lost as a result. What we are witnessing across the NHS is the Mid-Staffs scandal playing out on a national level, if not worse".*

In our analysis of, and response to, Grant Thornton's report we are mindful of the responsibility each part of the system has played in inadequacies relating to mortality data. We wonder if the conditions, guidance, and monitoring that has enabled NSFT to get into such a mess is, in part, due to a societal 'shoulder shrug' that views some lives as having less worth than others. It is as if in every sense they do not count. And their deaths are not worth counting. Is this a reflection of 'societal stigma' concerning mental health? Or are concerns such as these about NSFT to be found in NHS Acute Hospital trusts too?

"D was my brother for 49 years. He was a huge part of my life and I adored him. If you cannot even count his death, how can you learn from it?"
(A bereaved sister)

"It feels terrible and it worries me that nothing is changing and many more deaths will follow."
(A bereaved aunt)

Harm upon harm

Since publication of Grant Thornton's report, we have been staggered by NSFT's response to its publication. Rather than reassure, these confirm that NSFT still do not seem to grasp their data is fundamentally flawed and that they continue to manipulate data to try and minimise how many deaths there have been. Their communications messages have been crass, lacked sincerity and/or humility, and further distressed the bereaved relatives we are in touch with.

To coincide with publication there should have been an action plan in place and clear signposting for sources of support for bereaved relatives. We have all had distressed people contacting us via any means they can because there is no mechanism for people to express their concerns and seek clarity or help. This includes members of NSFT's staff who felt unable to work and have been left totally unsupported. They have expressed a general feeling of how can they continue 'working for truth twisters' (this is our polite paraphrasing). Likewise, bereaved people who are involved in working with NSFT to improve things have been left wondering if they are naïve and have been used in tokenistic ways. Did nobody think beyond learning their carefully worded comms lines and consider taking some responsibility for the fallout?

The damage to confidence and trust is huge. Any clumsy attempts to be seen to do the right thing now could be counter-productive and further traumatise people. The ICBs and NSFT need to urgently look at co-producing a reparation plan.

Long read response with supporting evidence

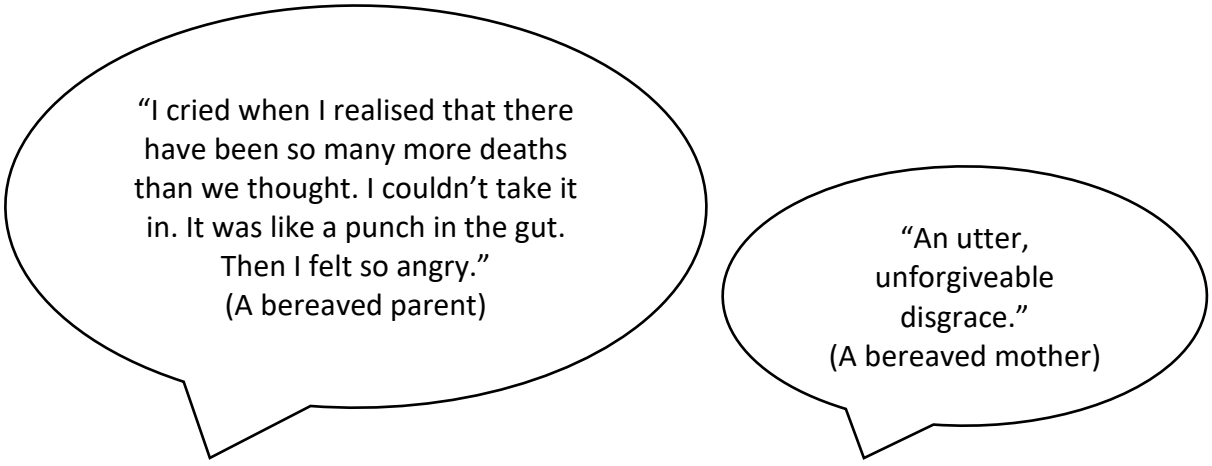
The positives

We would like to acknowledge the positives relating to Grant Thornton's report. Although we note these things we have yet to see evidence of the impact for some of them.

- The reinstatement of board papers to the website, following a request from campaigners, has assisted us in our analysis.
- Some of the recommendations of the 2016 Verita report into 'unexpected deaths' at NSFT have been acted on.
- The quality of serious incident reporting is better.
- NSFT created a suicide prevention strategy.
- There is a governor improvement plan which has a section on holding the non-executive directors to account for the performance of the board.

The scale of deaths is much worse than we knew - we still do not know how many have died

Although the figures are unreliable, it would be fair to conclude from Grant Thornton's findings that there is under rather than over reporting. Several times Grant Thornton cite numbers in thousands when referring to a short timeframe. Each of these exceeds the numbers we found for a nine-year period. It is devastating for bereaved families to read some of the statistics presented in Grant Thornton's report.



The discrepancies between NSFT's different internal data sources should be a red flag. For example:

> *"…depending on the source of death information, deaths in January 2021 increase between 111 and 203 per month from December 2020, far more than the 50 reported in January 2021"* (GT report p37).

We are left questioning - did 50, 111, or 203 people die in January 2021? And let's not forget these are human beings whose lives have been cut short, not numbers.

We believe it is important to try and establish the scale of loss at NSFT. We do not know why Grant Thornton side stepped answering this question. However, we have used the data they cited to create averages and apply these over the 9-year period (that the refuted 1,000 deaths applied to). Depending on which sets of figures shared by Grant Thornton (that they gleaned

from different NSFT data sets) are used, there is huge variation in our extrapolated guesstimates. To be clear our possible totals are guesses not verifiable statistics. Which is not unreasonable because the 'official' data seems to be little more credible than guesses too. From the data NSFT shared on 28.6.23 (11,379 over 5 years) we can see that our figures over 9 years are in the right 'ball park'. What our guesstimates show is how nonsensical the NSFT mortality data is.

Table 1: Possible numbers of deaths from 2013-2022. There are 'guesstimates' created by taking monthly averages from data presented in Grant Thornton's report and applying them over the 9-year period.

On page 37, table 3 shows 1,099 (total across row 1) deaths reported on the dashboard over a 5-month period (a monthly average of 219). If this figure is used to create an average per month and applied over 9 years then there could be as many as **23,738** deaths.
On page 53 the graph comparing unexpected deaths from April 2019 to October 2022 (42 months) is 8440 on Datix and 8132 on Lorenzo. These would be an average of 200 and 193 per month respectively. The total deaths over 9 years would be **21,702** (Datix) and **20,920** (Lorenzo).
If we take the average deaths per month from *only* Datix figures (9130) taken over a 3.5 year period the average is 217 per month (p30). If this was applied over 9 years the number of deaths would be circa **23,477**.
If we take the 1953 deaths attributable to the trust over a 41 month period (p38) then the average per month is 48 and the 9-year total is **5,184**.
On page 39 it states that some 3261 patients represented 37% of a sample of patients in an unspecified time period (presumably only the years Grant Thornton were reviewing). 100% would be **8,813** deaths. Without knowing the timescale we cannot scale this up.
On page 39 it states between April 2019 and September 2022 1868 deaths had an ethnicity recorded as 'not stated' and 1009 as 'not known'. The total is 2877 which averages at 70 per month. Applied over 9 years this is **7,560.** This is only part of a larger data set where ethnicity is known.

This figures NSFT have submitted are:

The total number of deaths NSFT reported to NHS England via their annual accounts is **6,864** However, the second half of 2016/17 and all of 2019/20 are missing from data available to us.
The total number of deaths NSFT reported to NRLS is **267** from March 2014-February 2023. NB: There is some missing data from April - September 2017, April 2019 to January 2022 and 6 months in the last year.

We cannot comprehend the staggeringly high possible numbers of deaths there have been at NSFT. It is too heart-breaking to contemplate the scale of loss. Whichever set of data we choose (other than NRLS which is a small sub-sample), the numbers cited in the report vastly exceed either the disputed 1,000 or the circa 2,600 that campaigners had identified. How these statistics can be reduced to the numbers reported to the board is beyond credible. For example, **just 1 death in 2 months was reported in April 2023's board papers**.

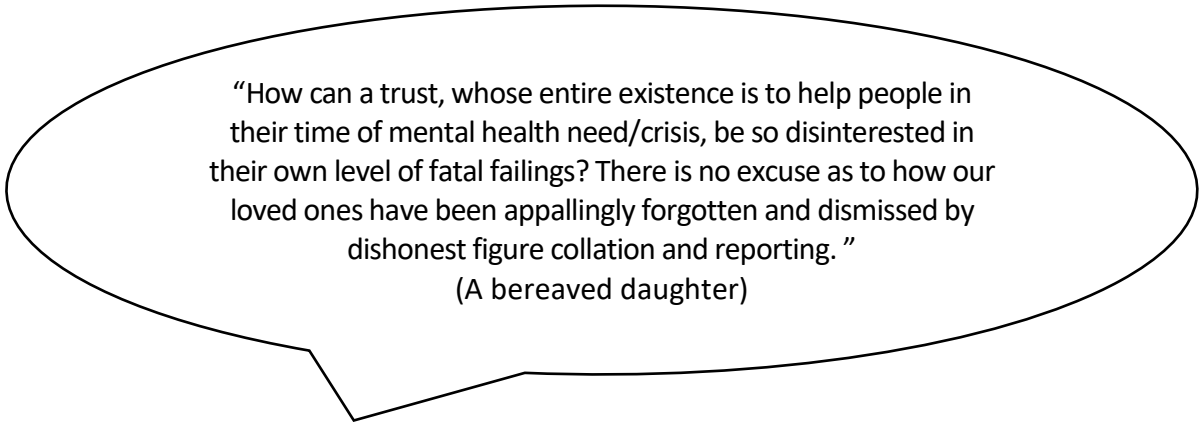
The death statistics submitted to NHSE show a dramatic increase in deaths over the last decade:

Table 2: Deaths reported by NSFT to NHSE in Annual Quality Accounts

NB: It is likely that the methodology changed in 2016

2013-14	32
2014-15	14
2015 – 16	24
2016-17	25 (second half year not submitted)
2017-18	560
2018-19	564
2019-20	Missing- presumably due to Covid-19
2020-21	829
2021-2022	1929
2022-23	2864[2]
Total	**6,841**

Another whole year has passed since campaigners challenged the death statistics. It is now 10 years since the disastrous 'radical redesign' at NSFT which saw death rates start to rise. Another year of deaths. There is an incalculable number of people who will have died this year and should be added onto the above totals.



There is no end-to-end data journey

High quality data is: *"fit for their intended uses in operations, decision making and planning"* (NHS England, 2018). Mortality data begins with death notification and identifying the death of someone under the care and treatment of the trust has occurred. Then the cause of death is established and categorised. This data is used to determine which deaths should be subject to reviews or investigations. Mortality data is presented internally to the board and externally to NRLS and NHS England. For various legitimate reasons these things might not occur sequentially. Grant Thornton found there was no end-to-end data journey. Nevertheless, we shall attempt to follow the data using the information in their report:

[2] NSFT Annual Quality Account 2022-23 pg. 81

Notification of death

> *"Grant Thornton have not seen clear documentation of the process for death notifications in these systems and how this links to the Trust mortality reporting"* (GT report p 27).

Death notifications are recorded on Datix, Lorenzo, IAPTUS, or SystmOne by health professionals and these trigger a death notification message to the NHS spine so providers can access and update their own records (GT report p6). Most trusts check the spine daily but NSFT checks less frequently which "*…results in a lack of contemporaneous information and in this area the Trust is different to other organisations who do this more frequently…"* (p25). NSFT's Learning from Deaths policy says:

> *"There is no mandated timescale for the recording of deaths within the trust, this is overseen by the attending medic, Medical Examiner and/or Coroner. In some instances, the trust receives late notifications of deaths, this is due to the information not being available via the national spine in a timely way, and is currently beyond the control of the trust"* (NSFT, 2023 p7).

We noticed in January 2021's board papers that:

> *"… NSFT has supported Real Time Surveillance (RTS) of suspected suicide in Norfolk and Suffolk. RTS allows timely awareness of where people are thought to have taken their own lives. RTS means that we do not need to wait for coroners' verdicts to spot where there are changes in rates of suspected suicides. RTS includes people who have never been in contact with NSFT's services. The RTS programme in Norfolk is now reporting weekly on numbers of people suspected to have taken their lives in real time. The Real Time Surveillance programme in Suffolk is yet to supply data but this is expected imminently".*

We were somewhat confused by this. We are unsure of whether this was started and stopped, or whether Grant Thornton were provided with this information about a system used by NSFT, because there is no mention of it in their report.

The NHS Digital *Mortality Data Review* (2020) acknowledged that there are national problems with the timeliness of death notifications and not all deaths are reported on the NHS Spine in a timely manner. NSFT check the spine less frequently than comparator trusts. The frequency which NSFT checks the national spine is within their direct control.

In the executive summary, it states that the Trust *"…is often reliant on other NHS providers for cause of death information"* (GT report p5). Surely, this is true of all trusts. *"Some comparator trusts undertake more work with partner organisations to link GP and public health information into their mortality reporting"*. Helpfully, Grant Thornton provide some examples of best practice (p40).

Trust staff identify 24% of deaths and the other 76% are identified via a monthly 'spine trace query' of the electronic database (the NHS spine) (GT report p7). Therefore, there is going to be a time lag for a substantial proportion of the death notification data.

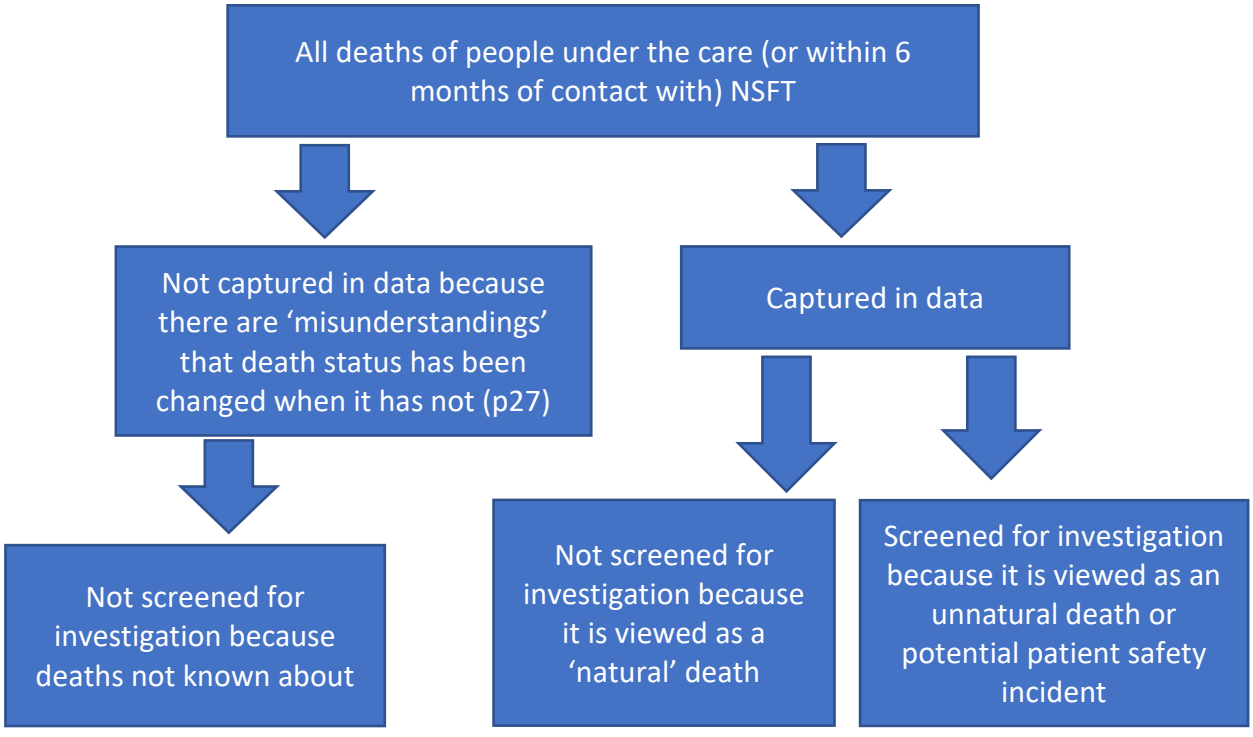
> *"All deaths will be reported on the incident reporting system by the patient safety team, regardless of origin e.g. family member, GP, national spine"* (NSFT's *Learning from Deaths Policy,* 2023 p7).

If a death is notified to NSFT it might in fact *not* be inputted to the various systems. For example, NSFT had applied rules that meant if a staff member had accessed a patient record after their death *"it was incorrectly assumed that the individual who had accessed the record would be creating the relevant Datix entry and applying the deceased status to the record"* (GT report p23). Similarly, there have been misunderstandings *"..that the death status had been changed within Lorenzo when users accessed a record post date of death, when it had not actually been done"* (GT report p27). If, as this report suggests, governance is poor, how can we be assured this will happen, and even if it does, that there will be adequate interrogation of the information?

So, at this very first point in the mortality data journey, verification of death and notifying it on the system, there is confusion and inconsistency. This is doubly alarming given that Verita highlighted similar issues which NSFT told NHOSC and their own Governors they had addressed.

The validity and the integrity of the data is compromised and this begs the questions – How many deaths were not recorded at all? We will never know how many of those unrecorded deaths should have been investigated. How can we share Grant Thornton's confidence that patient safety processes will pick up and investigate all the deaths it should when the first point in the process is so fundamentally flawed? We have illustrated this below. We are convinced that NSFT do not know how many people fit into the different categories:

Figure 2: Flow chart illustrating why not all deaths are screened for investigation NB: This is a logical analysis based on the information presented in the report



In the following weeks and months after a death
Decisions about cause of death and whether attributable to the trust are made. Once NSFT have established a cause of death, they are categorised. Not all errors lead to adverse outcomes and not all adverse outcomes are attributable to failings in care. So, a critical element is for trusts to establish proximity to the service and to the unexpected severe outcome (death). Not all deaths will occur concurrently or in the immediate period after contact with a health service and a care failing might not have a fatal consequence in the following days and months (Kelsey, 2017 p22). Additionally, several agencies might be involved. Therefore, each death should be assessed to establish cause and the likelihood of the death being related to mental illness and/or proximity to services. In addition to establishing a literal 'cause of death' (a citation on a death certificate) it seems important that at this stage the broader question of why someone has died must be considered. For example, a cardiac arrest might be defined as 'natural causes' but if it might be linked to mental illness (medication, lifestyle, high distress levels) then cause might include narrative/contributory elements. It is vital those making these decisions have the right clinical skills and systems in place to support consistency and validity.

In the trust's Patient Safety Incident Response Plan 20-23 it states *"**all** unexpected community deaths will be subject to Mortality Screening (incorporating the RCPsychs guidance tool) and an Early Learning Review (ELR) to ascertain if there are concerns related to care and service/treatment delivery"* (p10). This is part of deciding whether a patient safety incident review is necessary. What is not clear is where in the journey this occurs and who does this screening. Grant Thornton do not mention this in their report.

Grant Thornton's portrayal of the categorisation of deaths could be described as a 'catalogue of errors' which we explore in more depth in the relevant sections of this report. These include: Categorisation of deaths being undertaken by non-clinicians; changes in methodology; changing criteria and definitions; and the use of 'natural non-specified cause of death'. Collectively, these issues mean that attribution of deaths to the trust is at best unreliable, and at worst, a misrepresentation.

Contributory factors of death being incorrect was an issue Verita found in 2016 (page 40). They cited the example of 'heroin overdose' being used on several occasions when the root cause *"derived from care management problems*". This miscategorising absolves the trust from accountability and could be argued to be misrepresentation. From Grant Thornton's report we can make an educated assumption that miscategorisation is an embedded, long-standing problem.

In order to try and understand what should happen when a death occurs, we looked at NHS Digital (2020) information on mortality data. There are clear systems for verification and certification of deaths within health and social care and these were updated and clarified to speed up the flow of data from death to inclusion in ONS statistics (NHS Digital, 2020 pages 5-8).

There is a national issue with recording deaths particularly where there are delays in issuing death certificates and the data within healthcare systems might not be complete because they are "*not an enforced method of reporting deaths*" (NHS Digital, 2020 p3). Nevertheless,

"*an 'informal' death flag*" is usually placed on NHS Digital's Personal Demographics Service (PDS) by any spine-connected institution (NHS Digital, 2020 p3). 14% of deaths are referred to coroners and the majority of these will receive a death certificate within a few days although 0.1% might take longer than a year (NHS Digital, 2020 p6). Trusts generally manage delays in certification by tracking patient deaths where they are waiting for a coroner to rule the cause of death.

At NSFT they use the category 'pending' when waiting for a cause of death to be confirmed. Some of these pending deaths go back as far as 2019.

> The *"Trust may not be updating all records when causes of death are given. This could be because of difficulties in finding out this information or because the Trust are not checking back on cases it should be updating"* (GT report p28).

During the timescale covered by the report cause of death was 'pending' in 315 cases; 44 'expected' deaths and 271 'unexpected deaths' (GT report p28). We have not been able to ascertain from the report what percentage of overall unexpected deaths the 271 'pending cause of death' are. We wonder if anyone is able to provide this with confidence and factual accuracy. The inability of NSFT to 'ID track' individuals adds to this problem.

The death certificate information which is used to group the causes of death on NSFT's dashboard is *"…reliant on individuals meaning it is liable to inconsistency and it is unclear how continuity remains when key individuals are away"* (p27) and this is *"…not supported by clinical input or SOPs"* (GT report p29). Where a cause of death is unknown and/or there is no death certificate, NSFT use the Natural – non specific cause of death' category (GT report p28). In Grant Thornton state:

> *"Where, the Trust has done what it can to access a cause of death, but this information is not available, it may be clearer to use terminology such as 'unknown to the Trust"* (GT report p28).

We agree that clearer terminology is important, however, we think the term 'unknown to the Trust' is ambiguous. We wonder how many deaths waiting for Coroner's conclusions and death certificates an incorrectly recorded as 'natural'.

NSFT's use of 'natural' and 'unnatural' instead of 'expected' and 'unexpected' is not consistent with accepted national practice. In the papers we have looked at the terms unexpected, unanticipated, unascertained, potentially avoidable are used synonymously. There is nothing in NSFT's *Learning from Deaths Policy* that explains the use of 'natural' to categorise deaths with unknown causes (NSFT, 2023). NSFT used to use expected and unexpected but, for reasons that are unclear and have not been explained in their publicly available information, they stopped. From the evidence presented by Grant Thornton it seems NSFT does not have a reliable system for categorising deaths. It is disappointing that the recommendations do not include stopping using natural/unnatural and use definitions and categorisations in line with national guidance where it exists.

There are multiple points of data processing and handovers that are potential for errors. It seems as if the quantity of data handoffs and systems involved in the recording processes

have opportunities for failure and inaccuracy across the data pathway (GT report p22). There is too much reliance on individual manual inputs and the use of Excel spreadsheets which can lead to errors. There is ample evidence within the final report to suggest human error and information governance risks.

At some point before or after a death, patients are discharged from services on NSFT's systems. Between April 2019 and September 2022:

> *"… for 1953 whose death is considered under the management and care of the Trust the date of death is within one month of discharge. This includes 278 patients whose date of discharge is the same day they died"* (GT report p38).

From the graph linked to this point on page 38, it seems that over 5,000 people died within 6 months of discharge in a 42-month period alone. If the figures in the graph are correct, then each week an average of 11 patients who are discharged will die within a month and an average 27 per week within 6 months (GT report p38).

The data presented in Grant Thornton's report can be interpreted in different ways. For example, discussion surrounding date of death and date of discharge (see above) is confusing and open to different interpretations. On balance, we think this is most likely this a reflection of the ambiguous nature of the data provided to Grant Thornton by NSFT.

There are gaps in the data which further distort it. For example, a high percentage of 'null' data and information on protected characteristics.

Grant Thornton highlight numerous examples of changes in methodology in data recording. Regular methodology changes impact on the reliability of data and trend analysis, and limit the ability to track changes over time, which can lead to frustration and mistrust of mortality data.

> *"Methodology changes can be positive and sometimes needed. If changes in methodology occur without explanation, rationale or context they can cause confusion for those trying to understand the data in the report. It also hampers the ability to track through reports and historical data over time"* (GT report p 23).

What we, and others, observe is that the frequent changes in methodology may in some instances be necessary but at NSFT these are so frequent it has become impossible to track and compare mortality data year-on-year. Or sometimes even month-on-month.

Thus, we see how the data has been further distorted and obscured as it winds its way through the system over time. *"Internal and external clinical engagement is key to understanding, interrogating and using the Trust's mortality data and this is missing across the pathway as a whole"* (GT report p41). We are curious about the chains of supervision and accountability that have enabled this muddle to go on for so long.

When the data goes to board

> "*Following the review, the Trust described a process of validation. Included in that process were additional steps to clarify the six-month standard and a further*

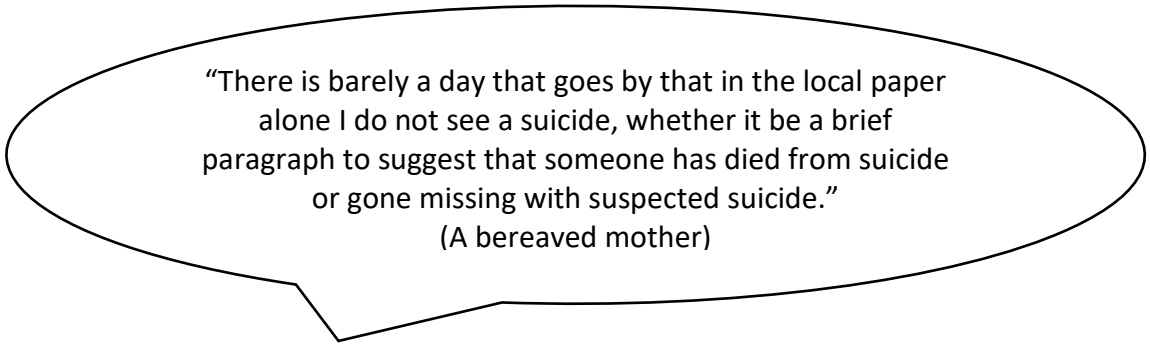
review of these activities recorded as appointments that were indirect or non face-to-face administrative activities" (GT report p30).

We are curious about who makes the decisions about what figures to present to the board and who is overseeing those who generate and collate the data. The conversion into data for the dashboard seems to us, as outsiders, a critical point where deficiencies and inconsistencies within the raw data should be checked for accuracy. However, Grant Thornton refer several times to a lack of checks and auditing of mortality data.

Somehow, rather than picking up omissions and inaccuracies and correcting them, the numbers of deaths are arbitrarily reduced without it being clear why. For example, between January 2020 and December 2021, 3835 were in the data sample provided to Grant Thornton but only 320 were cited in the board report (p34).

There are concerning basic errors such as "…*the expected and unexpected death numbers are flipped between the data sample and board reports"* (p34). Why did no one in the chain of governance notice this?

There is a lack of alignment between patient safety incident and mortality data. Not all patient safety incidents are deaths and not all deaths are patient safety incidents (GT report p22). This confusion and misalignment results in the mortality data almost slipping from sight. The mortality figures in January 2023 and April 2023's board papers, have just 5 deaths recorded within a 4-month period. This is incomprehensible and hard to reconcile with the figures in the Grant Thornton report or with our observations.



NSFT's board usually meets bi-monthly. We have examined every set of papers since 2014. Often the figures presented in the bi-monthly meetings do not correlate with those in the AGM papers and to the Annual Reports lodged with NHS England. Grant Thornton's report does not seem to identify a single place where all data (mortality, patient safety and serious incidents) are brought together and analysed systematically for board and public scrutiny. This is incompatible with the view that there is 'strong governance' (GT report p6). It is also incompatible with NSFT's self-assessment that they were *"on track to be in the top quarter of trusts for quality and safety by 2023"* (NSFT briefing for Norfolk HOSC March 2021). We find the trust's lack of insight into their problems with mortality deeply concerning. Saying something, and even believing it, does not make it true – that is magical thinking.

We agree with Raji (2020) who says that there is a sense that the people believe that numbers are objective and they will protect organisations. She says:

"If I could see faces and names on my dashboards, perhaps it would be harder to ignore the human being hiding and much easier to understand the weight of meaning that this count holds".

Within Grant Thornton's report we see how the numbers are presented in ways that minimise how many have died and obscure the individuals who have lost their lives. Even important details such as their ethnicity or cause of death are not clear.

When the data is reported externally
Grant Thornton describe it is a challenge for them, as auditors, to follow data through the organisation.

"There is no overarching documentation of the process followed and we saw no clear audit trail of the data as it moved through this process" (GT report p5).

Consequently, it is not surprising that data extrapolated for external stakeholders seems at times almost random. We do not say this lightly. From our perspective we never know if we will see single figures through to thousands; any number and type of categorisations; data presented monthly, annually or biannually; or as totals, averages or rolling averages in the statistics available in the public domain. In short, the mortality data presented to the board lacks the validity, integrity and completeness that would be expected from good quality NHS data.

The presentation of the Trust's internal mortality dashboard does not align with its external reporting. We created a table that compared deaths reported to the board with deaths reported to NRLS.

Table 2: Comparison of deaths reported to the board and NRLS

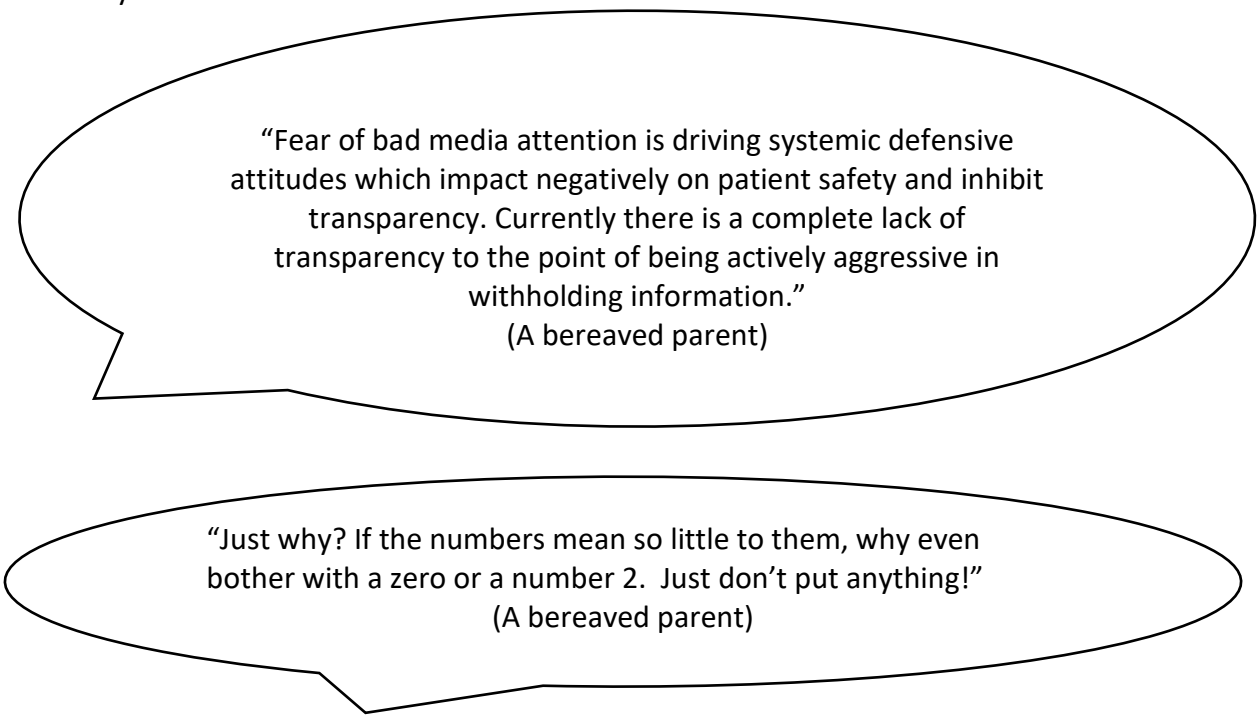
	Deaths reported in board papers	Deaths reported to NRLS
September and October 2022	**1**	**29**
November and December 2022	**4**	**3**
January and February 2023	**1**	**0**
March and April 2023	**0**	**13**

Once again, we have found inexplicable discrepancies in mortality data presented for public scrutiny.

As evidenced above, mortality data goes through a series of reductionist processes without clinical justification. Nationally, these processes have developed because NHS trusts are overwhelmed with deaths that could merit investigation and therefore it has been decided to focus on investigating particular types of death or themes with a view to learning from them. In NSFT's Patient Safety Incident Response Plan (2022-23), the processes NSFT use to select deaths to investigate are detailed. They are in effect using a purposive sampling methodology and (in line with NRLS criteria) only reporting a sample of deaths. What concerns us is the way

this small sample often get presented as *the* mortality rates. Additionally, NSFT are presenting one thing internally and another externally which is very concerning.

We asked bereaved relatives their views on the low figures presented in board papers and externally:



Compounding factors

In this section, we will draw on some compounding factors identified within Grant Thornton's report. Some refer to poor processes and practice but others to more nebulous concepts such as culture or transparency.

Missing data

There is data missing within NSFT systems. From the action plan and the Trust's responses we can see there are significant gaps. We are puzzled why these are not detailed in the report. Grant Thornton state that data has been provided by third parties and they *"…will not verify the accuracy or completeness of any such data. There may be errors in such data that could impact on the content of the report"* (p2). Within the body of their report they cite specific pieces of missing data. For example, that they only saw a visual representation of the dashboard (GT report p30). It is difficult to extrapolate accurate data from graphics and it was highlighted in the report how poor NSFT graphs are. We are curious about why Grant Thornton did not have access to the data that the dashboard is based on. Without the numerical data to support the dashboard graphic, NSFT were unable to show its 'working out'.

Grant Thornton list the mortality data documentation which is *"absent but expected" (*p26). This includes: categorisation of deaths; categorisation of expected/unexpected deaths; the role of the patient safety team reviewing Datix; end-to-end mortality recording pathway; methodology processes for changes/amendments; guidance for staff completing Datix when informed of a death; and guidance for reviewing decisions once Datix review complete.

"Missing data fields, or 'NULL' fields were prevalent across the data" (GT report p29) and analysis showed this was particularly so for 'local speciality' or 'site' fields and this means analysis will lack reliability (GT report p29). Data on speciality or site is critical for identifying problem areas and addressing any spikes in deaths.

Grant Thornton checked pseudonymised patient IDs before analysing the data. They were unable to verify whether there was any double counting because 324 Datix and 65 Lorenzo records had missing IDs (p30)

"Between April 2019 and September 2022 1868 deaths had an ethnicity recorded as "not stated' and 1009 as 'not known" (GT report p35). In the NSFT Board papers citing the September 2021 'mortality and learning from deaths paper' NSFT's Chief Medical Officer stated that 72% of the 133 people who died within 6 months of contact with NSFT between May and July 2021 had their ethnicity recorded but all of these were identified as White British (p 44/45). Of those 133 people the cause of death was unidentified in 1 in 3 cases and 83% of those with a known cause was due to natural causes (p45).

It was difficult to analyse the statistics regarding ethnicity because what Grant Thornton reports is similar to information in the CQC 2022 report and in 2021 board papers. However, the descriptors are in places the same but the numbers differ, when reporting the same time periods. This left us feeling confused and concerned that cutting and pasting information between reports might be leading to errors.

The omissions in recording of ethnicity is of great concern. This is however an issue that was first identified decades ago. The 2004 Bennett Inquiry Report (into the death of David Rocky Bennett at the Norvic Clinic) found *that "No indication that his racial, social, or cultural needs were adequately attended to"* and they therefore made several recommendations. Recommendation 7 - *"there should be a mandatory requirement to include details of each person's ethnic origin".* At the time, NSFT staff were trained on the importance of recording ethnicity. The Bennett Inquiry Report also emphasised that staff should be culturally competent and for the organisation to be proactive in challenging *"overt and covert racism and institutional racism"* (p 67). In September 2022, board papers reported on NSFT's cultural transformation programme and stated that:

> *"… ongoing and historical issues are contributing to an unhealthy culture in the trust … there are deep pockets of discriminatory and marginalising behaviour widespread across the trust. This includes racism, sexism and homophobia among others"* (p40/41).

That ethnicity is still not even recorded, and when it is everybody is White, indicates that racism is endemic. For two decades, NSFT has been stuck in a revolving programme of eliminating racism that seems to have made no progress at all.

We suggest it would also be prudent for mortality data to be checked for other protected characteristics. There seems to be an urgent need for NSFT and the two ICBs to undertake Equality Impact Assessments (EqIA) to ensure that mortality data is understood and responded to lawfully under the Equality Act 2010, by ensuring that anyone with a protected

characteristic is not being discriminated against. This will of course be a challenge because the data does not capture things like ethnicity well enough.

Grant Thornton presented a graph showing month by month the numbers of deaths from ethnic groups other than white. It shows the percentages of ethnicity recorded (68%), not stated (21%, and not known (11%) (GT report p39). It is clear then that *only* 68% had their ethnicity recorded which is not good enough.

Setting this in context, there are national issues relating to mortality data and ethnicity, with a likelihood of deaths in ethnic minority populations being underestimated - one issue is the way ethnicity is not recorded on death certificates[3]

Reading Grant Thornton's report, we can see there are many important questions that need answering. There is nothing in the action plan that will support NSFT and the ICBs ability to identify trends across different cohorts of patients or across different services. Some examples (this list is not exhaustive) of very basic questions that NSFT and commissioners could not currently answer are:

How many patients under the care of NSFT, waiting for assessment or treatment or within in 6 months of discharge who have died since 2013:

- Are black or from a minority ethnic heritage?
- Have a disability?
- Are looked after or care-experienced?
- Are carers?
- Under 18?
- Are on a waiting list?
- Have a diagnosis of schizophrenia?
- Are over 75?
- Are LGBTQ+
- Are under the care of the crisis team?
- Under the care of each locality?
- Are pregnant or post-partum?

We cannot see how NSFT and commissioners have met their public sector equality duty when they have no way of knowing whether their services are less safe for any patients with a protected characteristic or in a vulnerable cohort.

The Grant Thornton report is as impenetrable, in terms of its use of unclear language and jargon, as NSFT's board papers. Where are the 'easy read' versions? Or translations? Or even copies in large enough print for those who cannot read tiny font? We think an easy read version of Grant Thornton's report is needed but we would not trust NSFT or the ICBs to produce this in a way that accurately reflects the contents.

[3] https://www.nhsrho.org/blog/ethnic-inequalities-in-mortality-rates-and-life-expectancy-in-england-and-wales-why-we-should-treat-experimental-statistics-with-caution/

Confusing and ineffective categorisation of deaths

Fundamental in mortality recording is: establishing how someone receiving services (or within 6 months) from NSFT, has died; determining whether this is an expected death or unexpected death; and whether the death might be attributable to mental illness or their care and treatment; so that NSFT can include or exclude from the deaths in their figures. We are in no doubt from Grant Thornton's report that establishing which deaths NSFT should include in their statistics is a chaotic process. The reasons for this are unclear.

NSFT are deciding whether or not to include deaths without even determining the cause of death and they are conflating 'natural deaths' with deaths where the cause is unknown. Trusts usually use the terms expected and unexpected to categorise the deaths attributable to them, although there is no standardised definition nationally (GT report p23). At some point, and for unclear reasons, NSFT started using the terms natural and unnatural which differs from practice at other trusts: *"There was no evidence of a trust using just natural and unnatural as definitions"* (GT report p25) which makes them an outlier. We believe that this confusion could mask the numbers of deaths attributed to NSFT because the exact wording can impact the number of deaths which a trust reports.

Unpicking physical and mental health related deaths

It is known people with mental illness die earlier than the general population[4]. Often this is due to physical illness associated with mental illness. This might be due to reasons such as lifestyle or poverty but they could be more directly linked to the care and treatment of someone by mental health services. For example, Public Health England suggest that 2 in 3 deaths of people with mental illness were due to conditions such as cardio-vascular disease. People with severe mental illness often have physical co-morbidities which *"increase the risk of premature death"*, however, *"research shows, SMI is rarely recorded as an underlying cause of death …and indeed, is often not recorded on death certificates even as a contributory cause"* (Office for Health Improvement and Disparities, 2023).

Mental health providers should undertake physical health checks, the ICBs are responsible for ensuring primary and secondary care services are performing them[5]. The latest data[6] shows there is a significant amount of work to be done. Our analysis of the Grant Thornton report leads us to question if the high percentage of deaths due to natural causes might, in part, be due to NSFT's practice regarding physical health checks and shared care agreements. This is something we feel the ICB mental health collaboratives should explore.

From the processes described by Grant Thornton, we have no confidence that deaths due to physical causes, where mental illness was a contributing factor, would be included. For example, self-neglect, malnutrition or inability due to mental illness to safely manage medication for physical conditions such as epilepsy or diabetes. This is due to the lack of clinical input at the earliest stages where natural and unnatural deaths are categorised.

[4] https://www.gov.uk/government/publications/premature-mortality-in-adults-with-severe-mental-illness/premature-mortality-in-adults-with-severe-mental-illness-smi

[5] https://www.england.nhs.uk/mental-health/adults/cmhs/

[6] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2023/05/Physical-Health-Checks-SMI-Statistical-Press-Notice-2022-23-Q4.pdf

A clear example of someone with diabetes, who struggled to manage it due to mental illness, is Eliot Harris (a PFD was issued in August 2022). Diagnostic over-shadowing will be difficult to identify and address without accurate data.

'Non-compliance with care processes' and 'poor self-management of conditions' is linked to early death for people with a serious mental illness (Great Yarmouth and Waveney et al CCGs, 2019). There have been Prevention of Future deaths and inquests reported in the media where people with mental illness have died because their physical health needs have not been met.

As previously discussed, NSFT records 'natural cause-specific not available' where a death certificate is not available. How do they know it is natural if they do not know the cause? These self-described 'natural-non-specific deaths' account for 77% of NSFT's total deaths. Grant Thornton say:

> *"The large proportion of deaths categorised as 'natural causes-specific not available' poses a challenge for the Trust in understanding the deaths to be included within the Trust's mortality reporting, and then using this information to implement meaningful learning…"* (GT report p28).

Our data only comes from that in the public domain and we accept that we are having to interpret data that has been diluted to suit different audiences. However, we found an anomaly relating to deaths by natural causes that merits explanation or further investigation. In January 2021 the board papers state: "*56% of those who died in the last 6 months can confidently be said to have died of 'natural causes",* but in Grant Thornton's report it states that between May and July 2021 77% of deaths were due to natural causes (p28). Curiously, in April 2022's annual report to NHSE (April 2021 -March 2022) natural causes had risen to 94% of deaths but the spike in deaths that the trust attributed to Covid was in January 2021. We cannot make sense of a) why there is such a huge jump in the proportion of deaths being 'natural' and b) why no one has noticed or commented on it.

Similarly, there is confusion in NSFT's mortality data about expected deaths and unexpected deaths which Grant Thornton say *"currently relies on undocumented judgement processes"* (p28). They say *"… accurately and reliably sorting deaths into these two categories is key…" (*p28). We agree and want to see evidence that this happens.

Lack of clinical oversight

From the Trust's responses and the report action plan it is clear that clinical categorisations that inform reporting were, and might still be, being made by non-clinical staff. Why is this not in the report? It is not clear from the report which staff undertake categorisation and whose responsibility it is to provide the necessary oversight and supervision. Likewise, it is not clear to what extent senior staff were aware of this practice and their role, if any, in checking for factual accuracy.

In NSFT's recently updated *Learning from Deaths Policy* it does state there is a 'Clinical Decision Panel' but this seems to have a purpose of deciding which deaths should be reviewed (NSFT, 2023 p7). We note that on 18th June 2023 the policy on the public facing NSFT website

is one dated 2017. It is not clear from the GT report whether this panel has a clear view of all deaths.

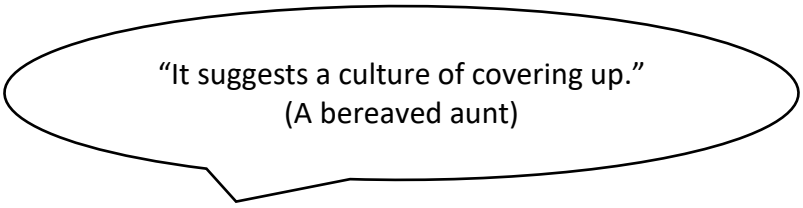
National guidelines are not clear

Within the Grant Thornton report there are several references to the way the terminology and categorisation of deaths is not nationally agreed and open to misinterpretation and that this had been identified by the 2015 Mazar's report. NSFT were fully aware of this difficulty because Verita highlighted it to them (Verita, 2016 p72). This national issue continues which indicates to us a whole system failing. Rather than addressing this issue by adopting clear and consistent terminology, NSFT further compounded it by creating their own categories that no other trust used.

The Verita report noted a *"…lack of national [unexpected deaths] data on which to base analysis"* (p13) thus limiting *"meaningful comparisons between mental health trusts".* They went on to state this was outside NSFT's control but recommended that NSFT inform NHS England (Verita, 2016 p19). If NSFT reported this to NHS England (and they told Norfolk HOSC that they would), then NHS England have not addressed the problem. It remains a live risk. We believe that it should be of interest to the ICBs to find out whether NSFT did report this to NHS England at the time, and if so what actions NHS England took in response.

Consistent under-reporting and minimising of the deaths attributed to NSFT

The mortality dashboard appears to under-report the mortality figures it is concerning that the dashboard does not capture all of the deaths held within the Trust's clinical system. For example, there are discrepancies between the data entered on Datix and Lorenzo and these differ from the data presented to the board (GT report p30). It is implied in the report that the chaotic and inconsistent approach to data management might be the cause of under-reporting. However, we feel exploring why this under-reporting occurs merits further comment and why this has not been picked up and challenged needs further investigation. There is insufficient evidence available to us at this stage to rule out deliberate obfuscation and a minimisation of any harm caused to protect organisations' reputations.



As members of the public we cannot make any sense of the data and we are familiar with such documents. Due to our personal experiences and the high level of contact we have with bereaved relatives, we have become attuned to people who die who might be attributable to NSFT. We often look at the numbers quoted in board papers and on NRLS in disbelief because the numbers do not tally with what we see and hear in our communities. In NSFT's Improvement Programme, under 'What will be different this time?' it states:

> *"Meaningful and valid measures developed with stakeholders, that triangulate reported data with what can be seen and heard. Improving data quality and insight,*

as well as integrated performance oversight a key part of improvement work" (slide 9).

With regards to mortality data there is a very long way to go.

We would like to see the action plan address the many shortcomings highlighted by Grant Thornton co-produced with bereaved relatives. There needs to be independent oversight of the plan by people who have a high level of statistical processes and auditing skills. There also needs to be a willingness to work alongside people who have identified and raised concerns, to ensure what is promised is delivered.

Changes in methodology

On page 23, Grant Thornton detail some of the changes in NSFT's methodology surrounding their criteria for including deaths in their statistics which call into question the overall governance. Were these changes due to chaotic and incompetent processes or a deliberate attempt to obscure or mislead? We do not know.

Over eight consecutive board papers there were six changes in methodology this included *"how activity was broken down, how graphs were labelled, and the types of charts used"* (GT report p6). On page 33 there is a table showing these changes. Appendix F shows examples of the different forms of graphs and criteria used to present mortality data to the board (GT report p52). As an example of discrepancy or difference in the way data is presented we have looked at the data for May 2020. Figure 9 shows c. 105 deaths, Figure 10 shows c. 83, Figure 11 shows c. 78 deaths, and Figure 12 shows c. 140 deaths. These figures appear incompatible with each other and do not tell a coherent or credible story. How can it be that the numbers of deaths in the subsequent community graph is higher than the previously presented 'all cause mortality' graphs? We are left wondering how a conclusion of strong governance can be justified.

We have looked at all board papers for 2023 to date. There have been more changes in methodology since Grant Thornton's audit. Reporting death figures has been dropped and it requires persistence in searching within the papers to find the minimal references to mortality that are there. It has required a lot of time to track deaths at NSFT due to the methodology changes which make it very difficult to compare like-for-like data. It is now nearly impossible for the public to track death rates which does not align with promises of transparency.

We noted in the March 2023 papers *"recalculation of the average and control limits from July 2022 following evidence of reduction over a period of seven months"* which looks like it might be referring to deaths. We have no idea what this means. If it is referring to mortality then it is another methodology change that could further obscure the data.

Concurrent with the publication of Grant Thornton's report, NSFT published an overview of their mortality data (see Appendix 3). We are incredulous that having been heavily criticised by Grant Thornton for frequent changes in methodology, because it obfuscates and confuses, at the first opportunity NSFT published data that included changes in methodology. See section 'Harm upon harm' for more detailed discussion. This leaves with a feeling of despair and concern that NSFT that incapable of change. It is as if those responsible for mortality

recording and reporting cannot understand and retain information that indicates they need to stop certain behaviours.

Inclusion criteria
Over the years. NSFT have made some fundamental changes in their inclusion/exclusion criteria and who they count in their mortality statistics. This *"impacts on the ability to track and compare deaths over time"* (GT report p23). Aside from drug and alcohol related deaths no longer being included because services were outsourced, there are whole groups who have been missing from the data. We have been flagging up that it was impossible to compare like with like deaths for years. It is unclear but from Grant Thornton's report precisely what has been included in NSFT attributable deaths but we picked up the following:

- Between October and December 2019, NSFT changed to reporting the total number of people known to their services who had died, previously the data only included those identified on Datix (GT report p23). The evidence is clear that Datix only accounts for some of the deaths. This means before October 2019 (and possibly after December 2019) a sizeable, but unquantifiable, proportion of deaths that should have been included were not.

- In January 2022, NSFT *"…broadened its definition of those who had died to include people whose deaths were not notified to NSFT at the time of their death"* (GT report p23). We have no information about what this means in terms of inclusion/exclusion criteria or where NSFT found deaths attributable to them that they had not been notified about. Grant Thornton evidenced that NSFT had multiple flaws in the way they identified those who had died and their notification systems were poor. One interpretation could be that before January 2022 NSFT were not gathering data via NHS Spine checks but were reliant solely on deaths they were notified of. Another interpretation could be that NSFT were only including deaths they were notified of within a short timeframe around the time of their death. As the process of death notification is prone to delays this would be equally concerning. Either way, an incalculable number of people under their care and management who died will simply not have been counted.

We have noticed, and been concerned about, the way data has been manipulated and presented for public scrutiny over the last decade. Campaigners have been raising concerns about the way methodology changes apply to mortality reporting for years. Frankly, it is beyond comprehension why these things would not have been challenged by the board.

How mortality data is currently presented to the board
The presentation of data to the board is poor. Even if the data gathered was not flawed, incomplete and skewed because of all the points where errors might be made as outlined in the data journey above, it would fail to be useful for a host of other reasons. The report does not provide evidence to show that NSFT is able to identify deaths across different service lines, care groups or diagnosis. E.g. youth service, eating disorder, learning disability, adult community, older people, dementia etc. This is essential information for thematic analysis, learning and improvement.

"Whilst the dashboard includes basic demographic information this is not presented alongside causes of death but at an unexpected or expected level. During this review we saw no evidence of detailed analysis of mortality information aligned to population health, understanding health inequalities, or learning from mortality aligned to deprivation or particular patient groups" (GT report p6).

"The data is poor. Just like the service."
(A bereaved aunt)

Grant Thornton mention the work being done with NHS England's *Better Tomorrow* team. But this did not correlate to their recommendations. They wrote, NSFT are planning to introduce NHS England's *Better Tomorrow* dashboard. We fail to see how this will address issues with mortality data and reporting outlined in this report. Grant Thornton state that the *Better Tomorrow* quality improvement plan (which focussed on the process of reviewing deaths not recording and reporting of mortality data) would *"supplement the ongoing improvement at the Trust"* (p8). However, there is no mention of the *Better Tomorrow* work in the action plan presented in the final report. Instead we find action points to improve the mortality data pathway being undertaken by the Seagry consultancy (GT report pages 10 and 12). We are confused about who is doing what and concerned that the die is cast for a series of methodology changes without explanation or alignment to NSFT's other data processes.

We are in no doubt from the evidence we have gathered that until NSFT get the basics right, in terms of identifying and correctly categorising the deaths attributable to them, any attempts to improve things down stream will be futile.

We have been tracking and raising issues with nonsensical mortality data in board papers for years. Caroline Aldridge mentioned this in her aforementioned speech to MPs in July 2022 and she provided Grant Thornton with information about the inconsistencies in presentation of mortality data to the board for them to verify themselves.

We looked at the latest board papers to try to understand what this looks like currently. The board has adopted a format which means a lot of information is presented on a single sheet. The mortality data is literally in the small print. It is reported minimally within the patient safety section, hence our argument that the governance of mortality data is linked to patient safety. There are also mentions of mortality in the transforming culture and exit criteria from the Recovery Support Plan sections.

Firstly, the January 2023 board papers -
In the Quality and Safety Executive Summary, no numerical data on deaths was presented in the graphs relating to patient safety incidents. The mortality data was presented in a series of confusing statements as follows:

"The number of confirmed or suspected suicides remains within special cause, now this constitutes an improving shift. Unnatural death incidents reported as patient safety incidents in line with the patient safety incident (PSI) priorities remain in normal or common cause variance … There have been four patient safety incidents reported

> *as patient safety investigation priorities all were patient deaths; this metric remains in common (normal) cause variation"* (p54).

Then, on page 57 it says: "*There have been four patient safety incidents reported in this period, two of which occurred outside of this reporting period. Two of the incidents relate to inpatient deaths…"* and on page 58, *"There was one fixed point ligatures in this period, resulting in the tragic death of a patient".*

We are left wondering how many people had died.

More recently, the April 2023 papers stated there was only 1 mortality (a homicide) within the 2-month reporting period.

This data presentation epitomises the confusing way death numbers are presented within patient safety data. There is a glossary which explains the terms used. However, without numerical anchors, statements such as 'within special cause', 'improving shift' and 'remains in common (normal) variation' are meaningless. Surely, nobody reading these papers can make sense of this bafflegab. We are genuinely puzzled why governors and scrutineers are not noticing or challenging this. Or, how this demonstrates 'strong governance'.

We are equally puzzled by the CQC's view. They wrote: *"Papers for Board meetings and other committees were of a reasonable standard and contained appropriate information"* (CQC inspection report, 2023 p16). The CQC concluded their inspection in November 2022 but Grant Thornton continued to examine data until January 2023. Presumably the CQC and Grant Thornton had sight of the same board papers, therefore it is concerning that their conclusions differ so widely. We wonder if the CQC were made aware of the commissioning of Grant Thornton's report and had the opportunity to cross-reference information. If not, this seems a missed opportunity.

Culture

There is a plethora of evidence that links culture to patient safety and to learning lessons from errors or investigations and inquiries. Goodwin (2019) analysed the cultures at trusts associated with avoidable deaths (including Mid Staffs, Morecombe Bay, Bristol Royal infirmary) and found that each of these trusts had 'problematic cultures' but in different ways. Goodwin asserts that culture is complex and evolving but she did identify similarities. The CQC (2019) *Learning from Deaths* report stresses the impact of culture, *"…there needs to be a culture where staff, patients and leaders all feel able to speak up and work collaboratively to learn"* (p15). The issue of NSFT having an unsafe culture and not being a learning organisation has been raised over and again in reports, staff surveys, board papers, and the media. For example, the CQC full Inspection report (28th April 2022) states:

> *"Whilst positive changes in leadership and culture had occurred, we found safety of services remained a concern because leaders lacked oversight and did not respond at pace which had led to services such as acute admission services and child and adolescent mental health services not making improvements quickly enough"* (p18).

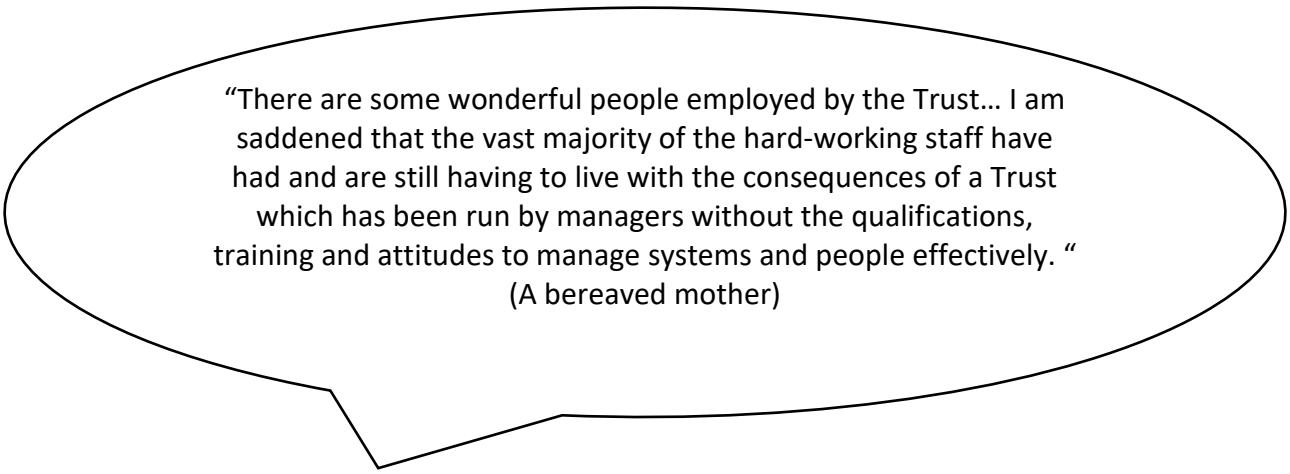
And, in the September 2022 board papers, the 2021 staff survey data was presented. It highlighted multiple issues with the culture of the organisation, for example:

"*The data available shows that bullying and harassment is taking place within the Trust and this includes instances of a lack of respect and unhealthy behaviours from colleagues, managers and service users. Although not everyone exhibits these behaviours, and there is evidence of a downward trend, the scale of the problem suggests that it is still widely tolerated*" (p 44).

Consequently, 69.6% of staff reported not feeling safe or confident to "*raise unsafe clinical practice*" (p139 and 158). When compared to other trusts NSFT performs significantly poorly and the table which compares the top and bottom 5 scores presented on page 144 of the board papers show large discrepancies:

"Of real concern in this year's staff survey results is the significant decrease in the percentage of respondents that feel the trust acts on concerns raised by service users or that secure to raise concerns about clinical practice. Not only are these scores being most declined, but they also feature in the bottom 5 scores and are significantly lower than the national average" (p145).

Bereaved families and campaigners observe all too often the toxic culture and they sometimes hesitate to make justified complaints because they do not want front-line staff blamed for system failings.



We wonder if staff felt able to raise their concerns? If not, this is a feature of 'organisational silence' – where people know the truth about certain issues but feel unable to speak out and therefore within the organisation 'very little' is said (Jones and Kelly, 2013).

With so many people working hard within and outside of NSFT to improve the culture and to set conditions where it is easier to do the right thing, it is concerning that these embedded problems with mortality data have been revealed. We wonder if this reflects habitual, rather than critically reflective, behaviours from some key individuals who have a strong unconscious bias. We noticed that in an outstanding trust Sheffield Health and Social Care NHS Foundation Trust they set board agendas with a standing item of reflecting on unconscious bias and any preferences that influence decisions. Our bias means we are sensitive to deaths associated to NSFT and associated recurring themes. We acknowledge this

and recognise that a counter-balance from a wider systemic perspective is needed. However, from the outside we would question if the whole system has succumbed to an unconscious bias of unquestioningly trusting the data and the decision making about including and categorising deaths. By the 'whole system' we feel NHSE has a significant role to play in this. We think that routinely asking the question, at every level, "how might unconscious bias be influencing how we gather, interpret and use mortality data?" would be prudent.

Transparency

Throughout their report, what Grant Thornton present could be described as a lack of transparency. There is ample evidence that the documentation presented to the board obscures the mortality data. In turn, the public, external stakeholders, and monitoring bodies remain ignorant of how many have lost their lives. As citizens, it is very difficult to gain access to mortality data nationally because the systems keep changing and often data is not accessible to us. The lack of challenge from ICBs, the CQC, and NHS England about missing, inaccurate, or confusing data leads us to question whether obscuring mortality data is a failure of wider system governance.

The failure to be aware of and respond to alarms being raised has parallels with the Mid Staffordshire scandal. The report into that inquiry stated that rather than knowingly contributing or condoning poor practice it was more likely those in the system:

> *"… were not being sufficiently sensitive to signs of which they were aware with regard to their implications for patient safety and the delivery of fundamental standards of care"* (Francis report, 2013 point 71).

An observable indicator of NSFT's lack of transparency is the way investigations and reviews are mentioned in board papers but there is no published subsequent exploration by or accountability to the board. For example, in the September 2021 board papers it states that NSFT had commissioned an independent review of its response to a number of unexpected deaths within Children, Families and Young People's (CFYP) services. As members of the public, we are unable to access any report arising from this review, neither can we see the full findings reported in board papers. In September 2021's Board minutes the following is reported from the Quality Assurance Committee (25th August 2021):

> *CFYP External Review*
>
> *"The Trust had commissioned an independent review of its response to a number of unexpected deaths during the Covid pandemic, in addition to the usual Serious Incident process. The Committee discussed the learning and were assured that the Trust had responded well to the review and recommendations for improvements. Most are completed and the Quality Committee will continue to monitor the remaining. The right leadership was now in place within the CFYP teams following recruitment, training and coaching programmes and an oversight assurance group was being established for ongoing scrutiny and assurance".*

All we can see from the minutes is that "*the Board noted all reports*" which does not give an indication about whether the Board actually saw any details regarding, or findings from, the review into this cluster of deaths. Patient deaths are the most serious NHS 'never' events and

it is not acceptable for investigations into unexpected deaths to be held behind closed doors and for findings not to be accessible.

Not reporting back on reviews into deaths has a long history at NSFT. Verita (2016) cited examples of reports into deaths that the board did not follow up:

- March 2012 - the director of nursing was asked to look at an increase in unexpected deaths in the community. No further updates or actions were minuted (Verita, page 53).

- December 2013 – A Community serious incidents resulting in death -working party report (The working Party Report) into 20 unexpected deaths in the community *was* presented to the board (which Verita say was an exception). The board minuted there had been learning points but not what these lessons were or who was responsible for overseeing any learning or practice changes (Verita, pages 55 -56). It is of note that this report was conducted internally and its findings were largely positive and inconsistent with Verita's findings on a number of points.

- February 2014 – The director of nursing reported to the board they would be investigating 38 deaths across Norfolk Recovery Partnership. The findings were not fed back to the board but they were presented to the service governance committee (Verita, page 56). Verita say *"We would have expected the report to be discussed at board level given that the findings were to contribute to the service improvement plan and be used for quality monitoring"* (page 58).

- March 2014- Private board minutes state that West Norfolk CCG were commissioning an external review into deaths in the community but it was September before there was agreement to share with the public board and it was *"unclear if the report was circulated to the board"* and the *"minutes suggest that detailed discussion of the final outputs of this review were limited"* (Verita, page 58).

This lack of transparency meant we have been unable to access all the information that should have been available to us. For example, Emma Corlett put in a Freedom of Information request asking for Dr Peter Jeffries report into 20 unexpected deaths in 2014. At the end of the statutory timeframe NSFT informed her that they cannot find this.

In the 2022/23 Annual Report we found this: *"In September 2022, NHS England's Intensive Support Team completed a review of serious incident governance from care groups to the Trust Board. Their recommendations and the actions we have taken as a result are summarised in the table on the following page.[7]"* As an example of poor transparency, we are not entirely sure what this means. We think this is the external review referred to by Grant Thornton (p43). We are curious about why this report was neither mentioned in previous board papers or published.

It is disappointing that the trust and monitoring bodies continue to conduct reviews into deaths without reporting back in outward facing forums. We wonder why this is and also to

[7] NSFT Annual Quality Account 2022-23 pg. 83

what extent findings are shared with staff across the organisation so they can learn and change.

NSFT is not unique in commissioning reviews into deaths that seem to lead to further reviews without actions being implemented. Setting this in context, across the NHS there is a habit of repeating inquiries into the same issues without this leading to learning and, more importantly, change. Each of these is viewed in isolation rather than as part of a wider whole (over time within an organisation or across trusts) *"… seeing each inquiry as a repeat of the last carries the risk of missing opportunities to learn more specific lessons arising from the different inquiries"* (Goodwin, 2019 p 208). Even when reviews lead to patient safety alerts trusts can be slow to comply and implement actions and some will 'forget' what they should be doing (Cousins, 2020). There seems to be organisational, systemic and structural amnesia which is compounded by changes in personnel. Reading Grant Thornton's report, we felt that we had seen and heard all this before. We suggest that NHS England, the Department for Health and Social Care and our government have, over many decades, enabled and perpetuated this practice of reviews and inquiries that do not lead to accountability and improvement.

Duty of Candour

> *"… for all the fine words printed and spoken about candour, and willingness to remedy wrongs, there lurks within the system an institutional instinct which, under pressure, will prefer concealment, formulaic responses and avoidance of public criticism."* (Francis, 2013)

This statutory Duty of Candour (DoC) is *"now seen as a crucial, underpinning aspect of a safe, open and transparent culture"* (CQC, 2021). Certainly, NSFT has committed in its policies to exercising a DoC. However, if they do not know who has died under their care and management, they will not know which families to it exercise it to.

Bereaved relatives would find it more credible when they witness openness, transparency and candour in the way the trust were to present all their shortcomings for public scrutiny. One could argue that those preparing mortality data for internal and external scrutiny need to exercise a duty of candour.

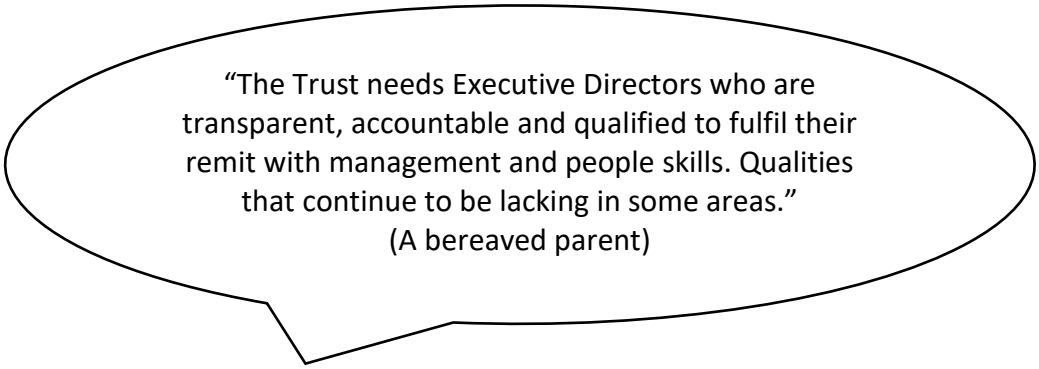
Accountability

In this section we will consider issues of internal and external accountability. Whilst NSFT must, in our view, accept responsibility for its inadequate recording and reporting processes, the wider system should also be held accountable. Had the national problems in mortality data been addressed, national consistent criteria and processes set, and commissioners, monitoring, and regulatory bodies performed due diligence, then these issues would have been picked up and addressed years ago. Sir Robert Francis cites similar system failings:

> *"When examining what went wrong in the case of a systems failure … the temptation of offering up scapegoats is a dangerous one which must be resisted. To do this would be to create the fiction that the behaviour of one person, a small group of people, would have made all the difference … There was a combination of factors, of deficiencies throughout the complexity that is the NHS, which produced the vacuum*

in which the running of the Trust was allowed to deteriorate" (Francis report, 2013 point 110).

However, INQUEST (2016) say that disciplinary action is not robust enough (p5) and when there is action, *"too often blame is focussed on junior level staff with insufficient action on corporate level…"* (p13).



The concepts of blame and censure are often conflated. Kelsey (2017) suggests that professionals and organisations *should* be blamed if they have made errors because they should be held accountable and take responsibility, however, they should not be harshly criticised for actions made in good faith or due to *"unavoidable human or systemic error"* (p51). A 'just culture' rather than a 'blame culture' recognises that harms are rarely down to individuals and that a restorative approach can underpin learning and remedial action (Cribb et al, 2021). There needs to be accountability in the context of the system as a whole because it is hard to class the errors in mortality data as entirely unavoidable given the repeated concerns raised or the responsibility of scrutineers to notice and address.

The bereaved families no longer have faith in the 'learning lessons' rhetoric. Many of those we represent *do* want individuals held accountable, perhaps because some of the same individuals repeatedly act in ways that are unacceptable to those left behind. There are only so many times they can hear the same assurances from the same people, about the same things, and believe them.

We too have brought our concerns to different people's attention and they have thanked us for it but continued without change. Rather than apportioning blame, we want to see a restoration of public and staff confidence via honesty, some demonstrable change, and a focus on repairing the damage arising from poor mortality data. This can only be achieved through greater transparency and genuine co-production.

Over the last decade, many people, organisations, quangos, and initiatives have come and gone but some things remain persistently problematic. There is the potential for parts of the system to try and slough off responsibility or even start blaming each other as a response to the findings in the report. This will only lead to further inertia. We have already observed this phenomenon in the delay between Grant Thornton completing their report in February and publication at the end of June which we are told is due to checking for 'factual accuracy'. We question why this checking process took longer than compiling the report. From the information available to us, we believe the delay was in part due to organisations within the system defending their positions. This has to stop.

We observed this again when NSFT's CEO deflected blame for NSFT's poor mortality data on to GPs and partners in media reports. The whole system needs to stop looking for the things it wants to disown and start looking for the things it should collectively own and urgently address.

Internal leadership and governance issues at NSFT

The April 2022 CQC report states:

> *"Leaders operated governance processes throughout the service and with partner organisations. However, our findings from our core service inspections identified governance processes in place failed to identify or address all risks leading to significant patient safety concerns"* (P25).

The NQB lays down standards and expectations for those responsible for leadership and governance with regards to mortality.

> *"Mortality governance should be a key priority for Trust boards. Executives and nonexecutive directors should have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge"* (NQB, 2017 p8).

The role of non-executive directors includes:

> *"Understand the process: ensure the processes in place are robust and can withstand external scrutiny, by providing challenge and support. For example, be curious about the accuracy of data and understand how it is generated; who is generating it, how are they doing this, is the approach consistent across the Trust …"* (NQB guidance p 24).

In addition, they should ensure that: *"…information presented in board papers is fit for publication i.e. it is meaningful, accurate, timely, proportionate and supports improvement*" (NQB p25). From the evidence presented in the Grant Thornton report and our search for triangulating evidence it seems the non-executive directors and the Council of Governors have not been performing some of their fundamental duties.

More curiosity and challenge is required

> *"Whilst data is presented in board reports there is limited evidence of interrogation into the data on either a routine or areas of concern basis."* (GT report p35)

A lack of curiosity and challenge from the board around mortality figures is a long-standing problem. In 2016, the Verita report stated that although unexpected deaths were routinely reported to the board there was *"…little evidence in board minutes of action beyond this to explore themes or lessons"* Verita, p 11). They recommended *"…more detailed discussion at board meetings about unexpected deaths to ensure that learning is being applied across the trust".* Grant Thornton's report provides detailed evidence that demonstrates mortality governance is still not a priority for NSFT's board. The board reports contain minimal evidence

of interrogation of data to investigate peaks in mortality or understand themes in the wider data.

Verita (2016) recommendation 7 (page 19) states: *"The trust board should develop its role beyond monitoring unexpected deaths"* and it lists 6 points relating to learning and outcomes including - *"seeking assurance that learning flows from 'ward to board' and back".* It is clear from Grant Thornton's report that 7 years later this is still an issue.

To change this embedded behaviour will, in our opinion, require more than the introduction of a new dashboard or renaming a committee. It requires someone with sufficient understanding of the trust's processes and personnel, who has a willingness to explore why this is such a deep-rooted problem and the courage to challenge and to undertake robust and regular reviews. A study, that looked at how hospital boards implemented the recommendations of the Francis report, concluded that a *"restless board"* that *"seeks constantly to find out more, benchmark itself, do better, and check on prior concerns and actions"* is needed (Smith and Mannion, 2018). Our observations over the last decade, and the evidence we present in this report, are not reflective of a 'restless board'.

The Healthy NHS Board Principles for Good Governance (2013) highlight the key role in scrutinising patient safety. *"Effective scrutiny relies primarily on the provision of clear, comprehensible summary information to the board"* (Verita, 2016, page 53). The concerns Verita raised in 2016 about the board's lack of examination and challenge on mortality data mirror Grant Thornton's findings in a way that is deeply concerning. Nothing seems to have changed.

> "*Unexpected deaths are routinely reported to the board but the board minutes suggest little discussion about them takes place*" (Verita, page 62).

Our examination of board papers over the last decade shows a long-standing acceptance of the numbers presented, even though the methodology and the 'ball park' figures fluctuate wildly, without this generating deeper discussion, monitoring, or learning. Questions that still need to be answered are:

- The trust made commitments to Verita about its plans to address these issues but these did not bring about the necessary change, why didn't this happen?
- Why has poor practice around mortality been allowed to continue through successive board memberships?
- What needs to happen for the board to substantially change in their attitudes and behaviours towards mortality?
- If there are any positive changes, how will they be sustained?
- How will the public know that mortality data and scrutiny is accurate and being used for learning?

Verita reviewed NSFT board papers from 2012 -2015 to examine board oversight of unexpected deaths. We have examined all the board papers since. Therefore, we are confident that although there have been many changes, and significant fluctuations in quality, the acceptance of poor quality mortality data and limited scrutiny of deaths associated with

the trust is consistent. Nearly every report we looked at was riddled with anomalies that should have alerted readers to the way data is presented, even in some cases manipulated.

For example, In NSFT's 2022 Annual Report they state: "*There are 101 cases where cause of death is known to be by patient safety incident"* (p59). In the following paragraph, it states that of 190 deaths with no known cause: *"101 are potentially safety incidents…".* Three paragraphs later, the report says: *"There were no cases of a patient death during this reporting period which was judged to be more likely than not due to problems in the care provided to the patient".* It is worth noting that in this reporting period April 2021 – March 2022 the Coroner issued 5 Prevention of Future Deaths Reports: Terence Tuttle, Joshua Sahota, Mary Bush, Sheila Steggles, and Theo Brennan-Hulme.

In 2022, a bereaved mother from the above cohort came with us to meet MPs to express our concerns over the deaths and the way NSFT seemed to have lost count. Her utter devastation about her son's avoidable death was heart-rending to witness. It is simply untrue that no patients died due to problems in the care provided to the patient. An unquantifiable number died, some of whom will have been due to unsafe care. The PFDs bear witness to that. The arrogance and abdication of responsibility that sits behind inadequate mortality data, and the minimising of statistics reported publicly, is unacceptable and it disrespects those who have died and their families.

The Council of Governors public papers, including meeting minutes, do not demonstrate any evidence of detailed discussions or exploration of data in relation to mortality. The October 2022 papers contain comments about too many lives lost and asking for assurance. However, there is no forensic analysis or evidence of holding to account. Similarly, the questions asked by governors at the public board do not demonstrate understanding of the board papers of the issues that they raise in relation to mortality and the corresponding data. The Governor Improvement Plan has a specific section on improving the way they hold to account but, sadly, the actions which underpin this would not result in more robust challenge or analysis.

Overall, we feel that the Board of Directors and the Council of Governors show a low level of 'situational awareness' about mortality at the trust. Situational awareness is defined as *"knowing what is going on around you"* and a loss of it is *"thought to be fundamental to many types of human error"* (Kelsey, 2017 p 133). We wonder if governance on mortality is poor because people are too reliant on, or accepting of, those responsible for gathering, recording and presenting data over the last decade. There has not been sufficient curiosity or challenge or awareness of what is going on, why this matters, and what needs to happen.

Mortality data is over-shadowed by patient safety data

Grant Thornton's report identifies that the board reports focus on patient safety incidents and inpatient deaths and our examination of board papers corroborates this. In recent board papers there are 'risk registers' but mortality is overshadowed by patient safety. NSFT link their risk register to 'risk appetites'. It would seem there has been little appetite to explore and address the risks posed by mortality data management. This is consistent with a general low level of interrogation of mortality information by the board. *"Board reports reviewed as part of this report contain minimal evidence of interrogation of data to investigate peaks in mortality or understand areas of interest in the wider data"* (GT report p32). If the board and governors do not have the capability or capacity to understand what is being presented to

them, they cannot effectively challenge. We, and other campaigners, could spot anomalies and, with our appetite to check and challenge, we have raised this regularly.

However, the CQC do not share our concerns:

> *"Since the last inspection the trust had progressed work to improve the availability, quality and presentation of data. The performance function was being strengthened and had been moved from the finance to the operations team. The trust had worked with NHS England to refresh the use of statistical process control to present data so it clearly showed trends over time for the Integrated Quality and Performance Board report and other Board papers; and to strengthen the dashboards used for care groups"* (CQC 2023, p20).

Looking at the last 7 months board papers, it is difficult to see the impact of the input of NHS England, who have been supporting the trust since September 2022 to present mortality data, because the January and April 2023 papers continue to contain minimal and confusing mortality data. As previously mentioned, there continues to be changes in methodology. The May 2023 papers contain no mortality data at all with the exception of reporting that there had been no Prevention of Future Death reports.

No clear lines of accountability

Through Grant Thornton's report a thread of complex and unclear lines of accountability, with regards to the gathering, recording and reporting of mortality data, is evident.

> *"The Trust's oversight over the end-to-end process of mortality reporting requires improvement and there are inadequate controls to ensure the data reported accurately reflects the service's understanding of their patients"* (GT report p42).

In their 2023 inspection report, the CQC stated:

> *"The non-executive directors worked together attending more than just their main sub-committee of the Board to ensure issues that extended across more than 1 committee were considered in a joined-up manner"* (CQC Page 11).

We question the CQC's judgement on how joined up mortality governance is because their views are at odds with Grant Thornton's findings. They suggest the way sub-committees work together is complex and at times unaligned: *"The governance over mortality reporting at the Trust is complicated and straddles a number of corporate functions*" (GT report p42) and the trust has used similar but different names for committees which adds to the confusion. In fact, the Trust do have a number of similar but different names for committees. For example, the 'patient safety incident group' and the 'patient safety incidents and mortality review group' and these seem to continually morph into similar sounding groups and sub groups. Grant Thornton wrote:

> *"Internally, whilst there is a documented line for reporting through sub-committees into the board, members of staff interviewed by Grant Thornton reflected that they felt processes were not clear"* (GT report p32).

The complex web of committees that are presented as a flow chart in Appendix I (GT report p59) graphically illustrate how confusing the oversight and governance of mortality data is. It reminds us of the 'pit of inaction' (Aldridge cited in Aldridge and Corlett, 2023) which graphically shows the way sub-committees can becoming a self-perpetuating cycle of investigation, delegation, reporting back highlights, and generating reports that no one reads.

It is not clear how the board are meeting their responsibilities but there is a helpful list of who is accountable for mortality data at NSFT with the "*overall responsibility for policy implementation"* sitting with the CEO (GT report p42). From the CQC report it looks as though community deaths have been the responsibility of the finance director. NSFT had reassured the CQC that governance of mortality data was moved away from finance to clinical directors. In the action plan in Grant Thornton's report (pages 10-16) the Chief Finance Officer as the Executive Lead for 7 of the 16 recommendations. Some of these actions do not seem to be about finance but about training, data, data sharing and other things which would appear to be outside the remit of a Finance Director. This does not sit well with bereaved relatives.

The CQC say that having a *"specific person, at a reasonably high level in the trust, is key to driving the work forwards"* (CQC, 2019 p 13) and that good practice includes the appointment of a medical examiner (p16). Grant Thornton describe how plans to appoint a medical examiner are in place to oversee mortality data. However, NSFT's Learning from Deaths Policy (last updated via a full review in January 2023) lists 'Medical Examiner' in the list of roles and responsibilities for the board and details the medical examiner's duties (NSFT, p4). May's 2023 board papers mention the *"introduction of the Medical Examiner system" (*p154). We are genuinely puzzled – does NSFT have a medical examiner or not?

Lack of oversight and action from regulatory and monitoring bodies

> *"We weren't able to identify any trust that demonstrated good practice across all aspects of identifying, reviewing and investigating deaths, and ensuring that learning is implemented" (*CQC, 2017).

We are not in a position to establish if any trusts are demonstrating good practice now. It is unclear how the Department of Health and Social Care are discharging their duties to ensure the whole system is functioning effectively with regard to identifying patient deaths and using this data to underpin patient safety.

Something that concerns us is the almost invisibility of mortality within the trust's BAFs (Board Assurance Framework) that are presented to the board and externally to evidence risks and improvements. For example, in March 2023's BAF the only reference to mortality is in relation to suicide awareness and in May 2023's BAF there is no mention of mortality, other than 'learning from deaths' being an action and a vague reference to 'unexpected deaths' being an outcome indicator. We are surprised that there is not a category on mortality. This oversight sends a message to bereaved relatives that deaths are not important to NSFT or the wider system.

Throughout the hierarchical structure of the NHS, organisations have their risk registers and Board Assurance Frameworks (or their equivalent). We are perplexed that mortality data and

monitoring death rates at NSFT do not seem to feature in these. Neither can we find any form of scrutiny of mortality in either of the ICB's published board papers. This reflects a wider system failing in our opinion.

"Families express a lot of anger about the inadequate role of the CQC…" (INQUEST 2016, p12). Bereaved families are angry with the organisations responsible for regulation and scrutiny because they feel concerns are repeatedly raised about mortality and ignored and therefore problems continue. Bereaved families are left feeling that, at best, no one cares about the deaths of people with mental illness and, at worst, that this is state-sanctioned 'deathmaking' as defined by Wolfensberger.

" It's eugenics of the 21st Century because we don't want the mentally ill in our communities"
(A bereaved sister)

Integrated Care Boards

The NQB outlines the role of commissioners in managing mortalities:

> *"Commissioners should use information from providers from across all deaths, including serious incidents, mortality reviews and other monitoring, to inform their commissioning of services"* (NQB 2017 p22).
>
> *"Commissioners are accountable for quality assuring the robustness of providers' systems so that providers develop and implement effective actions to reduce the risk of avoidable deaths, including improvements when problems in the delivery of care within and between providers are identified"* (NQB 2017 p23).

For the majority of the last decade Clinical Commissioning Groups (CCGs) rather than the ICBs were responsible. In Norfolk and Suffolk there were several CCGs. Investigation into mortality was undertaken in small geographical areas which meant that oversight of NSFT as a whole was more difficult. The inception of the ICBs offers the opportunity to do things differently, particularly if they work together, and get to grips with mental health related mortality in order to commission the most effective services.

We agree with Grant Thornton that there are opportunities to learn from their review and for NSFT to work with their partners to understand the underlying issues that contribute to deaths (GT report p40). The ICBs will need to coordinate how they respond to the issues raised by Grant Thornton. *"The ICB should support the trust to ensure appropriate plans and resources are in place… and to hold the Trust to account for the plans it sets"* (GT report p44). Three areas that Grant Thornton identified for learning and information sharing were: physical health, public health and inequalities, and service access and availability.

Grant Thornton go on to set out recommendations about the areas the ICBs should focus on when supporting NSFT (p40). These are: senior oversight, data quality and monitoring, documentation, and information security.

We suggest that the ICBs need to work with Public Health to explore in depth mental health related mortality data. There must be discrepancies that should be raising alarm. Some questions the ICBs might want to explore include:

- How many people are dying due to suicide, drug/alcohol related deaths, with serious mental illnesses who are not under the care of NSFT? How does this compare to national figures and might it reflect gaps in services?
- Are there clusters of deaths in particular areas and how does this correlate to NSFT's mortality data?
- Are there specific issues such as deaths on waiting lists or following discharge that might be addressed via commissioning?
- How might all partners in the system improve their information sharing and understanding of cause of death when a patient dies?
- How might analysis of mortality data be used to identify and learn from themes? For example, where deaths occur in the gap between GPs and NSFT.

The ICB non-executive directors have an important role to play in pushing back to NHSE, the CQC and Department of Health and Social Care to make the necessary policy changes to ensure that going forward deaths are accounted for and scrutinised, mortality data is accurate, reliable and supports learning and improvement, and that they produce updated guidance.

We do not believe that point 15 of the action plan (p15), *"establish a clear improvement plan to address the issues identified in this report, and report progress to a [NSFT] board committee"* is robust enough. We implore the ICBs to take a more active role in ensuring this (of the multiple improvement plans relating to NSFT) is implemented.

Care Quality Commission

The CQC highlighted the scale and depth of poor recording and reporting of mortality data nationally (CQC, 2017). They made a number of recommendations which specifically cited mental health: *"CQC will continue to be actively involved in translating these recommendations into actions..."* (CQC, 2017 p11). They went on to state the: *"CQC will also review how learning from death is documented in inspection reports"* (p11). This aligns to the National Quality Board England *National Guidance Learning from Deaths* (2017) which states:

> *"The Care Quality Commission will strengthen its assessment of providers learning from deaths including the management and processes to review and investigate deaths and engage families and carers in relation to these processes"* (NQB, 2017 p7).

In 2019, the CQC reported on how trusts were progressing the learning from deaths agenda since the NQB guidelines were introduced. They undertook case studies for 3 well led trusts. One of which was Norfolk Community Health and Care NHS Trust (NCH&C) who were at that time rated 'outstanding' (CQC, 2019 pages 23-24). By 2018, NCH&C already had processes in place where deaths were all reviewed by a doctor and senior nurse to decide which deaths to escalate. They undertook thematic reviews of all deaths quarterly to look for learning and further review. Unlike NSFT, who do not have clinically-led categorising of deaths and have processes that seem to minimise how many deaths they want to own, NCH&C were actively

seeking to review more deaths because they did not wish to miss the learning opportunities. This is a good example of a trust with a healthy learning culture. We are aware that NCH&C lost their outstanding CQC rating and we have no information about the way they currently handle their mortality data. However, we feel the Norfolk and Waveney ICB are well placed to comment on this with a view to deciding if NSFT could benefit from learning from NCH&C.

The enablers and barriers to good practice detailed by the CQC (2019, p9) are all issues that have been raised in inspections of NSFT. Therefore, we would have expected the CQC to anticipate NSFT might not be performing well with regard to mortality. Since 2016, the CQC have routinely inspected NSFT 5 times plus many inspections of individual services. In 3 out 5 they mention mortality /death. The chronology of CQC comments on mortality present a stark and concerning picture:

2016: They found a number of incidents across the trust that had not led to learning these had resulted in the Verita investigation.

2017: they said "…*ensure that the recommendations of the* [Verita] *report into unexpected deaths at the trust are fully implemented and learnt from*". And, in the 'Are services safe?' section, they say "…*the* [Verita] *report made 13 recommendations, including that there needed to be more detailed and informed discussion at board meetings about unexpected deaths and more cohesive governance structures to ensure that learning was being applied across the trust*". And in the 'Are services well led?' section: "*We judged that there was a lack of grip around some serious issues that had been identified over the past two inspections … we were particularly concerned that the information and learning from deaths within the trust had not been given adequate focus. Despite several reports there was a lack of traction within the trust to affect change in practices based on findings from the learning following these serious incidents".* This could epitomise Grant Thornton's findings 7 years later.

2022: Within discussion about mortality and patient safety it states: "*The board and senior staff expressed confidence in the quality of the data and welcomed challenge*". And, "*Effective systems were in place to identify and learn from unanticipated deaths*". We note the term 'unanticipated' is used here which is different from the terms used and cited by Grant Thornton

2023: In their most recent inspection, there is zero mention of mortality or zero mention of death. This is disappointing because we would have hoped the CQC would be more robust in checking that NSFT had actually done what they said and, if so that they had sustained any changes. This is particularly disconcerting because they were inspecting at the same time as Grant Thornton were conducting their audit of mortality.

It is of note that the CQC do not report over consistent date ranges, or use consistent terminology, across their reports (see Appendix 4). We would deduce that they are drawing on NSFT's chaotic and flawed data. If there is to be any hope of the CQC holding NSFT to account there has to be consistency in the way both NSFT and the CQC report mortality.

The 2017 NQB guidance (p52) states:

> *"Inspectors will use new key lines of enquiry in relation to safety and governance, set out in the Care Quality Commission's assessment framework, to assess learning from deaths, collect evidence and identify good practice. Where specific concerns are identified, the Care Quality Commission can use its powers to take action with individual providers and will report its findings of good and poor progress in individual inspection reports or national publications to help encourage improvement"* (NQB 2017 P52).

And

> *"As the revised inspection regime of the Care Quality Commission will assess providers' ability to learn from deaths as a key component of high quality care, work to address this will be factored into NHS Improvement's work to support providers in achieving good or outstanding Care Quality Commission care ratings. Regional teams will work with providers, their commissioners and NHS England to identify areas where improvements can be made and the strategies which can help deliver the change required."*

We are concerned that despite their responsibilities to inspect and identify issues the CQC seem to have largely missed the flaws in the way mortality data is gathered and reported on. The following quotes below, from page 6 of the CQC full inspection of NSFT (15th January 2020), raise some concerns about level of CQC scrutiny because it contrasts with Grant Thornton's findings:

> "*The trust had improved its approach to learning from and managing serious incidents as a result of feedback from families and staff. Trust committees and the trust board had sight of incident data. The trust took proactive steps to address themes identified and improve ways to share learning across services. A new serious incident scrutiny panel and serious incident team had been created to report findings from investigations to the board. The trust recognised there was still work to be done to embed and improve this process further".*

And

> *"The trust collected reliable data and analysed it. This was a significant improvement from the last inspection. Staff across most services could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Staff submitted data or notifications to external organisations as required. New ways of monitoring and addressing waiting lists had been implemented with evidence that many lists had reduced. This meant leaders were able to understand what was happening in their organisation and act when needed*."

However, sometimes the CQC did make observations that align with Grant Thornton's findings. For example, in their 22nd January 2021 report they state:

> *"The trust had six serious incidents resulting in the death of a patient between January and September 2020 with a further death reported the week prior to inspection. Staff in both Great Yarmouth and Waveney and West Suffolk teams told us that they did not routinely receive feedback about the outcomes or learning from incidents" (*p3).

This raises a 'so what' question. If NSFT were collecting reliable data in 2020, but the CQC didn't check if the improvements were sustained in 2021, then the NSFT pattern of improving for only short time periods went unchallenged. The repeated relapsing of improvements is a feature of NSFT's in and out of 'special measures. Therefore, it was even more imperative for CQC to check back on their concerns in every subsequent inspection.

National Quality Board

Most trusts follow the NQB (2017) mortality guidance on mortality and the Mazar's (2015) report but there *"…is no single national document which offers a clear framework and supporting terminology…"* (p19). The NQB have not updated guidance since 2017 which is concerning given the scale of problems with mortality data they and others document. The NQB is part of NHS England.

NHS England

Within the layers of bureaucracy, that caused or perpetuated the conditions that have led to NSFT being able to get into, and seemingly unable to get out of, such a serious muddle with mortality data, NHSE play a significant role. There is an abundance of evidence from numerous reports into deaths across the NHS in the last decade that issues such as no agreed definitions or processes and insufficient monitoring or challenge of mortality data they collect (including data that is not submitted as required) to support our opinion that NHSE are providing weak leadership.

The 2022/23 guidance from NHSE in respect of how trusts should present annual reports has zero mention of mortality or Prevention of Future Death reports. Given that patient safety and learning from incidents is stated as a priority for NHSE, it is somewhat curious that they appear to feel it unimportant enough to be included in annual Quality Accounts. [8]

Trusts, particularly those like NSFT who are in and out of special measures, require strong consistent guidance and support. NHSE need to model what good looks like and set the conditions for trusts to know what they need to do and how they should do it. They should provide ongoing support and challenge to ensure improvements are both made and sustained. From our perspective mortality is not prioritised by NHSE and their example does not inspire confidence or support trusts to do the right things. The intervention of government and the Department for Health and Social Care to demand coherent and coordinated policies that applies across the NHS is long overdue.

In their 2019 Patient Safety Strategy NHSE state:

> *"We are changing the underlying taxonomy of the data we collect, so it is better suited to learning, more appropriate for analysis and more user-friendly to people making reports. We are balancing reducing the time it takes to input information with*

[8] NHS Foundation Trust Annual Reporting Manual 2022-23

collecting data that provides insight about the issues we need to record and what might be done to improve safety" (p23).

It seems to us critical that mortality data is included in these changes in ways that illuminate rather than minimise who is dying and why, and to make it impossible for NHS mortality data to be distilled into statistics that exclude too many deaths. Whilst we understand, and agree with, an approach of serious incident review quality over quantity, we question NHSE's solution to the problem of trusts being overwhelmed by the numbers of deaths and consequently unable to keep up with investigating them, being to only investigate a sample. Surely, what is needed is to concentrate on reducing mortality so that the numbers dying and requiring review are more manageable? In our opinion, this reflects the normalising of patient deaths rather than a determination to reduce mortality.

NHS England's website says that they ask themselves questions to evaluate the quality of data, these relate to consistency, accuracy, timeliness, efficiency, validity and completeness. Given how many issues Grant Thornton uncovered, we wonder how effectively NHS England had been asking questions about the quality of mortality data generated by NSFT.

Something we find hard to understand is the way NSFT, and other trusts, can report to NHSE statistics that should raise concerns, or even not report their data at all, but this is seemingly not noticed or addressed. We wonder if anyone reads annual reports or looks at NRLS figures to critically analyse mortality data within them. This seems consistent with the 'deaf effect' which is when decision makers and those holding power do not do not hear (by ignoring or over-ruling) 'bad news' and they carry on with a 'failing course of action' (Cuellar,2009 cited in Jones and Kelly, 2013).The bereaved families feel unheard and unheeded, not just by NSFT but by NHSE and the wider system, through their deafening silence.

We looked at the Annual Reports that the trust submitted to NHS England and been shocked by some of the data presented within them that seems to have been accepted without question. We compared the sections on mortality in the last two annual reports:

April 2021- March 2022	**April 2022 -March 2023**
1929 people died within 6 months of contact with NSFT.	2864 people died within 6 months of contact with NSFT
The 'substantial increase' over last 12 months reflected the "impact of COVID 19. NB: The reported peak in deaths January 2021 in NSFT's data.	No mention or explanation of the increase in deaths (an additional 935). NB: No quarter is as low as the highest quarter the previous year.
Of those deaths - 23 patient safety investigations and 12 structured judgement reviews	15 deaths where coroner has ruled 'suicide' or 'took own life'. 12 patient safety investigations relating to deaths and 12 structured judgement reviews. 5 thematic reviews and 16 'after action reviews'.
	Key theme from reviews '*gaps in access to service delivery'.*
94% deaths are 'natural causes'.	No percentage given for 'natural causes'

Other than age and gender, no mention in demographic breakdown of ethnicity or protected characteristics	Other than age and gender, no mention in demographic breakdown of ethnicity or protected characteristics
No mention of Prevention of Future Deaths reports. NB: There were 5 on Ministry of Justice website for this period	There have been 3 Prevention of Deaths reports. NB: There are 3 on Ministry of Justice website for this period.
	No mention of Grant Thornton's mortality review. Comment about working towards appointment of a medical examiner officer

Please note: We have not had time to fully analyse the 2022/23 Annual Report because it was late being published (3rd July 2023). We do note there is significantly more detail about mortality than usual however it still does not tell bereaved families and the public what they want to know.

NHS Digital have made a number of national recommendations about the reporting of mortality data (2020). It would help trusts to do the right thing if the processes were set out clearly from above and the recommended improvements were made.

In Grant Thornton's report they stated that NHS England had conducted an external review of patient safety and learning from deaths and mortality. However, it was not clear when this happened, why, and what else they recommended (p43). On page 43 (GT report) it states:

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

We are very concerned that the Patient Safety Review group had 'lost sight' of mortality. We can see that from recent board papers there does seem to be more detail and focus on patient safety and on inpatient deaths and we can see that different sub-committees are responsible. However, the patient safety team review some deaths (which are reported to NRLS) and the patient safety team are responsible for overseeing that all deaths are reported on the incident reporting system (NSFT, 2023 p 7). NSFT state in their Annual Report 2022 that NRLS figures are only deaths by suspected suicide which are reported to the system. They, correctly, state that the figures reported to the Strategic Executive Information System (which allows users to report and view, depending on access rights, serious untoward incidents) figures will be different and include all forms of unexpected death.

We are finding it hard to conclude governance is strong not poor from the evidence within Grant Thornton's report. We recognise that inpatient deaths might be more accurate because the fundamentals of the data journey are more likely to be correct

It states in the Grant Thornton report that:

> *"The Trust has been working with NHS England since September 2022 to improve its processes, particularly in relation to mortality … The recommendations from this report will support improvement by providing focus and clarity on issues impacting on data recording"* (p5).

It is not clear what this is referring to. We wonder if it is the *Better Tomorrow* quality improvement plan referred to on page 8 of Grant Thornton's report.

Better Tomorrow

The Grant Thornton report makes some statements about the *Better Tomorrow* initiative and how this will be a key part of improving mortality data quality. However, this is not backed up with any detail. We welcome this support for NSFT, which we assume might be part of the sector 4 intensive recovery support plans.

It is quite difficult for those external to the NHS to get any information about the *Better Tomorrow* initiative. Therefore, to assist lay readers of our response, we will summarise their aims. Our understanding of the *Better Tomorrow* project is that the focus is on *"learning from deaths, learning for lives"* and using mortality data to inform improvement. They state that *"mortality metrics are only smoke signals to be understood in a wider context"* and that data should be considered by the whole system. *Better Tomorrow* best practice requires:

- ICBs to work closely with partners to share information and learning by sharing intelligence to identify themes and opportunities to prevent future deaths. We are therefore curious about how the ICBs are involved in *Better Tomorrow's* work with NSFT and what the resulting improvements are.

- Board level leadership that is consistent, uses mortality data to inform care, considers data capture and accuracy, seeks gaps in information, understands trust methodologies, and work with other trusts and partners.

The *Better Tomorrow* project does seem to be exploring more meaningful ways of mental health trusts categorising and presenting mortality data. From the information available to us, it looks like *Better Tomorrow*'s focus is on using mortality data to identify spikes in mortality, to steer investigation and learning, rather than in the data capture and quality per se. We can see from Grant Thornton's report that NSFT are planning to use Seagry consultancy to help with this aspect.

We cannot find any information suggesting that *Better Tomorrow* will be recommending consistent definitions and approaches across trusts which is disappointing and potentially ineffective. Without a consistent approach it will remain impossible to compare trusts on a like for like basis.

Until the May 2023 Board papers were released, we did not have any information about *Better Tomorrow* input at NSFT. However, this is just a single point without explanation. We checked board papers back to September 2021 and could not find mention of NHS England undertaking this work. In the April 2023 board papers it states that there had been a deep

dive review of Trust learning from deaths during quarter 2 of 2022/23 and the Better Tomorrow Quality Planning process complete during quarter 4. However, we have been unable to find any mention of these in the board papers between March 2022 and April 2023.

We do not share Grant Thornton's optimism that *Better Tomorrow* will in itself be able to prompt the level of change required to address the difficulties in mortality data at NSFT which we believe reflects a deep organisational and system malaise. Additionally, whatever the *Better Tomorrow* plans are to focus on the "process of reviewing deaths" (p8) will be limited in their effectiveness and usefulness because, as we outlined in the data journey section, not all deaths are included or categorised correctly. If the raw data at the beginning is incorrect then it can never represent a true picture however well it is analysed and presented.

National Recording and Learning System (NRLS)

Over the last few years we have been tracking the mortality data that NSFT submit nationally that is available to us. Caroline Aldridge shared with Grant Thornton that there was missing data for NSFT on the NRLS website in some months. These included missing data from April - September 2017 and April 2019 to January 2022. On 1st July we checked NRLS and found no data had been uploaded for 6 of the previous 12 months. The last two are January, and February 2023 but the others are March, June, July and December 2022.

By comparison, Sheffield Health and Social Care NHS Foundation Trust has reported deaths for every month during the same time period except December 2022 and East London NHS Foundation Trust has reported deaths for every month during the time period.

In their April 2022 report, the CQC state: *"The trust [NSFT] was rated 'worst' for consistency of reporting to the National Reporting and Learning System (October 2018 to– March 2019), which showed a downward trend when compared to the previous period"* which leads us to wonder if, despite having this highlighted, NSFT had continued to be inconsistent reporters. Had we time, we would compare this to other trusts to see whether they upload in a timely way. It is a concern to us that this omission went seemingly unnoticed or challenged by Non-executive directors, Governors and commissioners. We are wondering if the data was added retrospectively as a result of the issue of missing data being flagged up by Grant Thornton. If so, we feel this should have been made explicitly clear.

We noticed that there was a steady increase in NSFT's 6 monthly reported deaths to NRLS from single figures in 2014/15 to 25-35 each 6 months in 2016 - March 2019. Then, following the gaps where no data was recorded things revert to mainly single figures or even zero. We cannot find any explanation for this, which might be because we only have public access. Something else we noticed is the way NRLS figures changed over time on their webpage which is very hard to keep track of. We feel that it is important that any under-reporting to NRLS is investigated and explained. Again, we are curious why no one seemed to have noticed or challenged these things.

There was no mention of NRLS in the report. This is interesting and of concern because it is often the NRLS figures (which are a small sub-sample of the deaths attributable to the trust) that are often quoted in board papers. It raises questions about why this key information relating to mortality data has been omitted from this mortality review. Did Grant Thornton

fail to look at this as part of the review, or did they look and decide it was not relevant? In either case this brings in to question the thoroughness of this audit.

NHS improvement[9] has repeatedly and clearly stated that *"regular and timely reporting to the NRLS will help reduce the likelihood of your organisation being flagged as potentially under-reporting".* They further state that *"deaths and severe harms should be reported within two working days".* It is clear NSFT frequently falls well short of this standard. For example, NHS Improvement data shows that during the period October 2018 to March 2019 50% of NSFT incidents were reported after 145 days, and 5% after 190 days. In fact, the best that they have achieved in recent years is April 2016-September 2016 when 50% of incidents were reported after 28 days, and 5% after 51 days.

We are curious why NHSE are not more proactive in exploring data quality and bias because they know it is an issue:

> *"Patient safety incident data in general is prone to reporting error and bias and NRLS data is no exception to this. Error and bias will affect the number, type and temporality of reported incidents and how the data is interpreted. Users must also remember that as the number of incidents reported reflects reporting culture rather than the definitive number of patient safety incidents occurring"* (NHS England, 2018b p16).

This seems even more important when a trust is rated 'inadequate' or 'requires improvement'.

NHS Improvement remind NHS Trusts that the thresholds for under-reporting are unlikely to be triggered by being a 'safer' trust; therefore a red '*potential under-reporting' indicator should be investigated and issues relating to your local reporting processes and data explored*". So, the warning signs to NSFT and commissioners were there in plain sight. We have neither the time nor resources to find every single notification and submission on this issue, but a quick search easily found 3 submissions that were flagged 'red'. At best, they reported 97.4 incidents per 1000 bed days (April-September 2017) and by October 2019-March 2020 this had reduced to 65.88 incidents per 1000 bed days and this was flagged as a red risk for potential under-reporting.

The distillation by design of mortality data is a feature of the data presented by NRLS. Only those deaths that have a serious incident review are included. This naturally reflects the individual and subjective processes and cultures of trusts who decide this. Therefore, NRLS data has never matched the data within the trust's annual quality reports that are published by NHSE. This anomaly needs to be addressed as it misleads the public. We feel that nationally mortality data should reflect the gross number of deaths.

[9] NHS Improvement send notifications to trusts regarding how they are meeting key performance indicators and flagging any potential risks in 'How to understand and improve your patient safety incident report to the National Reporting and Learning System (NRLS)'.

Independent scrutiny

As well as the organisations mentioned in Grant Thornton's report who are responsible for scrutinising NSFT, there are other statutory or voluntary organisations who have a role in calling NSFT to account.

Local Authority Health and Scrutiny Committees (HOSCs)

According to the Suffolk County Council website - "*The Health Scrutiny Committee is responsible for scrutinising wellbeing and health services across the county*."

And:

> "*The Norfolk Health Overview and Scrutiny Committee considers all matters relating to the needs, health and health related services of the population of Norfolk. It scrutinises services that have an impact on the health of Norfolk's citizens and challenges the outcomes of interventions designed to support the health of Norfolk people*."

Throughout the last decade concerns about patient safety and deaths have been brought before Norfolk's HOSC. They have attempted to call NSFT to account and to drill down into concerns. However, what Grant Thornton's report reveals is that they, like all external bodies, will not have accurate and reliable data to inform them.

Emma Corlett has been a member, or substitute member, of NHOSC since 2013. She has reviewed the minutes of every Health Scrutiny Committee meeting that NSFT and commissioners responsible for mental health have reported to since 2013. She has also reviewed the NHSOC briefings that are circulated to committee members between meetings.

While some of the scrutiny has been around the broader safety and culture issues as identified in the NHS staff survey and CQC inspection reports, the minutes relating to mortality provide further evidence of a system that has not and is not consistently or accurately collating or analysing information.

It also evident that assurance has been provided to Councillors at committee when there is an absence of objective evidence to support those assurances. Many of the problems and themes identified in the Grant Thornton audit are issues that NSFT and the wider system claim to have addressed or to already have good governance and oversight arrangements in place.

Where appropriate we have viewed the video footage to ensure for factual accuracy. In September 2022 the Deputy CEO in responded to question about death numbers and why all of the recommendations of the Verita review not been implemented. She said:

> *"I'm going to give some push back. It's not that we don't know the rates. It's that there is a disagreement with the rates. The agreement is therefore that NSFT will be party to an independent review of mortality data. The ToR, the commissioning is happening by the ICBs and we will supply the information requested. We are not attempting to interfere with the ToR or findings of that review. So that's the situation. It's not that we don't know, it's that there is a difference of opinion so we are taking a different approach and this review will provide a single version of the truth on deaths in our trust".*

The part of the question about why Verita recommendations had not been implemented remained unanswered.

What is shocking is how many times the HOSC have asked specific questions about recurring issues (deaths, waiting lists, unsafe discharges, poor systems etc) and been assured by NSFT that changes have been made or planned. And for those assurances to be proven false. Other, more general assurances relating to the demand on local mental health services and capacity to meet that demand have been made. Again, we cannot find objective evidence to support those assurances or any meaningful action by the wider system to address those issues when assurances proved false. These system-wide demand and capacity problems should have acted as a further major alarm to the wider system because of their very obvious risk to safety. This does beg the question of who follows things up and where the accountability lies. It feels like there is a system wide amnesia that asks the questions but promptly forgets to check.

We have been unable to find any scrutiny of NSFT by the Suffolk HOSC of any concerns relating to mortality or number of deaths. We would like to see Suffolk HOSC adopt a similar approach to scrutinising NSFT as Norfolk HOSC. The issue of mortality is very important and we feel the HOSCs should work together in regularly questioning and challenging on deaths associated with NSFT and the ICBs in terms of mental health related deaths across our counties that might be a result of gaps in services. We would like the HOSCs to be persistent in following up the issues raised by Grant Thornton's report and our response.

Healthwatch

The functions of local Healthwatch are: to gather and represent the views of people who use services and share these with commissioners and scrutineers; make recommendations about service improvements; promote the involvement of people with lived experience within all levels of the health system; feed user views into Healthwatch England and advise them and the CQC about areas of concern.

In response to the Verita report in 2016, Andy Yacoub, Healthwatch Suffolk CEO, said:

> "*The figures reported by the BBC appear shocking and we urge the Trust to take immediate steps to implement the recommendations outlined in the Verita report. With improved internal reporting, we would hope that the reasons for the increased numbers of unexpected deaths could be better understood, with clear remedial actions taken wherever possible … We will be making enquiries of the Trust to monitor its progress towards implementing the learning from this report and the experiences of service users and their families.*"

We have been unable to find any reports after this date which demonstrate the monitoring of NSFT's progress on this or in relation to mortality or unexpected deaths. Given their proactive approach to improving services it was surprising that they were not involved in the Grant Thornton SoR or interviewed as a key stakeholder.

Healthwatch Suffolk issued a statement following the publication of Grant Thornton's report which was critical of the findings, the action plan, and the way it had been produced. Andy Yacoub, CEO at Healthwatch Suffolk said this on social media:

> *"In my mind, an audit report (and the accompanying news releases) of this magnitude, sensitivity, and importance of the one the mortality, published earlier this week, is of less interest than:*

(a) What lies behind it (it was conceived, commissioned and produced without the involvement or knowledge of, people with lived experience; and
(b) the immediate and future impacts from the action plan (also produced without the input of people with lived experience) and its 16 recommendations i.e. outcomes

We completely agree.

There is no mention of the mortality review on Healthwatch Norfolk's website and we are not aware of them issuing any statements. We have been unable to find any reports or statements in relation to the Verita report, mortality or unexpected deaths on the Healthwatch Norfolk website. We note, without conclusion, the differences between Norfolk and Suffolk Healthwatch organisations.

Campaign to Save Norfolk and Suffolk Mental Health Services (the Campaign)
Since its inception in 2013, the Campaign have raised concerns about patient deaths at NSFT via its website and through letters to the trust, the CQC, NHSE&I, MPs. and others. They have also repeatedly raised the poor quality of data presented in board papers that at times render the content meaningless. We could cite numerous documents where the things highlighted by Grant Thornton have been previously raised by campaigners. This review by Grant Thornton arose as a direct result of campaigners presenting their concerns about the deaths and the way NSFT seemed to have lost count of these to a group of interested MPs in London in July 2022. Something has gone seriously adrift when campaigners need to flag up deaths because the system fails to notice what is in front of them or heed the warnings of concerned citizens and frontline staff.

Suffolk User Forum (SUF)
The functions of SUF include: gathering people's feedback and enabling an active user voice in the commissioning and delivery of mental health services, facilitating coproduction, and influencing decision making, valuing lived experience as an essential resource for service improvement. SUF receive core funding from the Mental Health Pooled Fund, to be a strategic partner with Suffolk County Council and NHS commissioners to ensure that the voices of people with mental health and wellbeing needs are at the heart of service planning, delivery, improvements and commissioning.

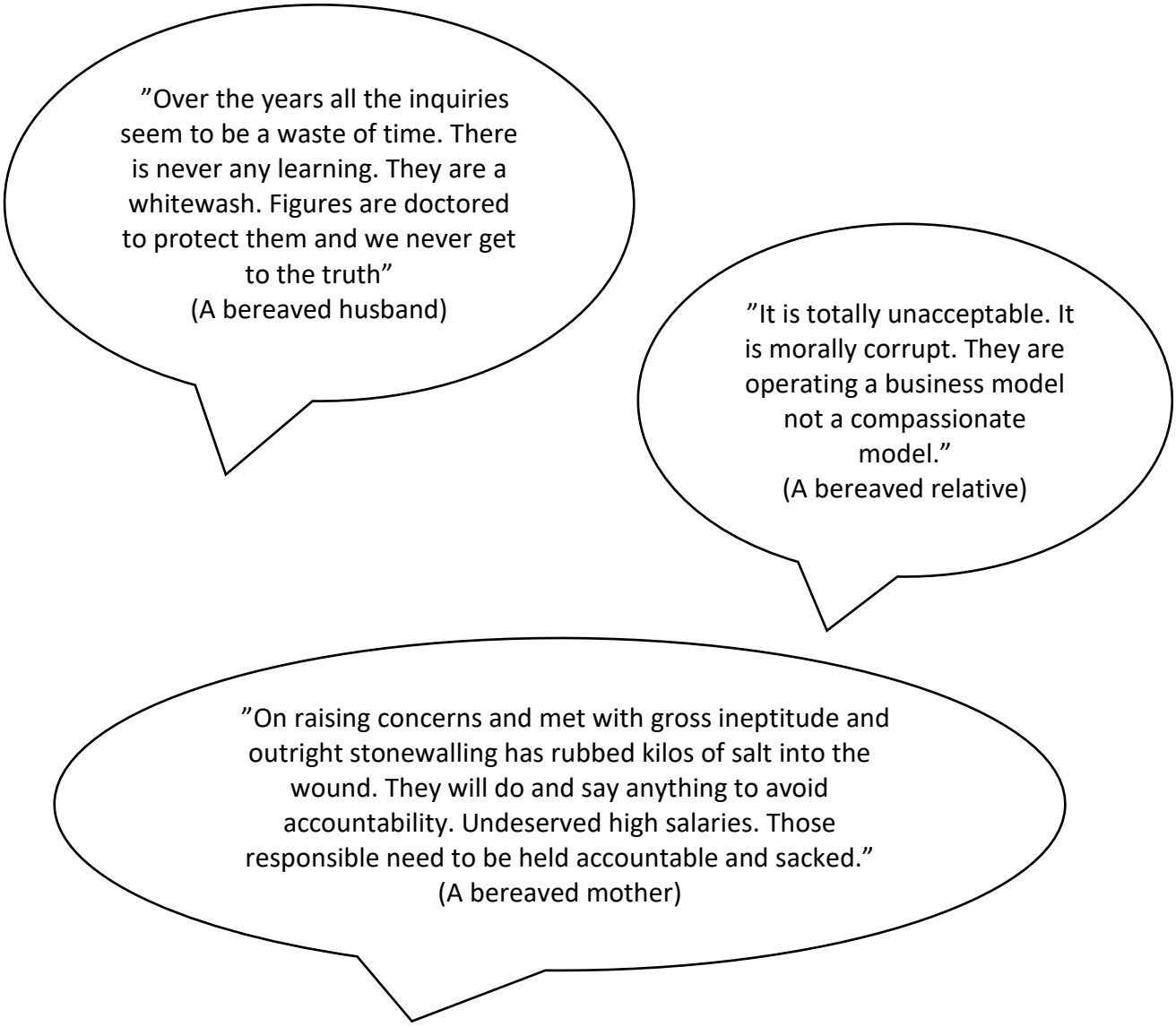
We were unable to find any explicit sections in feedback reports on the SUF website which provides experiences related to mortality, or any form of challenge to the system about mortality. This appeared to indicate that SUF are not aware of any of the issues cited in this report and would appear to be a gap in their role as strategic partners. However, SUF were quick to issue a statement supporting NSFT's challenge to the media about perceived misreporting of the Grant Thornton report. This was disappointing and left us wondering if their impartiality has been compromised.

Why the findings in the mortality review matter

In this section, we consider some of the concerns arising from Grant Thornton's findings. The poor mortality data might be contributing to deaths because without themes and trends being identified and analysed, no remedial or reparative action can be taken. NSFT and the wider system have a duty to acknowledge and address these things.

Bereaved families' view

The impact on bereaved families who read Grant Thornton's report will be powerful and painful because the contents are shocking and show disrespect to service-users who lose their lives. Every life lost **must** matter. Bereaved families typically want there to be learning from a death of a loved one because it might prevent similar deaths. It is unlikely learning can occur if deaths are not even accounted for and the reasons why they have died are understood.



Healthcare Safety Investigation Branch Inspection (HSIB)

In our opinion, the issues are serious enough to merit a Healthcare Safety Investigation Branch investigation. The HSIB decide whether to investigate based on three criteria - impact, risk, and learning potential. We believe that people dying under the care and management of a trust and clinical staff not having mortality data to use to learn from and prevent further deaths demonstrates impact, risk and potential for learning.

In terms of satisfying the HSIB criteria for a national investigation, we know from similar issues in Essex and from the lack of national guidance on mortality recording and reporting that this

is likely to be a national issue. In Essex they have struggled to identify how many inpatient deaths there have been over a 20-year period, currently this stands at around 2,000[10]. From the Grant Thornton report it seems that NSFT would find it even harder to identify how many inpatient deaths there have been.

The HSIB recently undertook a national investigation around assessing risk in mental health that was called by a relative which is relevant to the issue Grant Thornton raised about numbers who die within one month of an appointment. We feel that unsafe discharges indicated by the statistics presented by Grant Thornton merits a similar level of investigation. We will be sending a copy of our response to the HSIB and asking them to investigate. We would like to see the wider system do the right thing and support our request for the HSIB to investigate.

In October 2023 HSIB will officially become the Health Services Safety Investigations Body (HSSIB). The HSSIB will have increased powers and will become a fully independent non-departmental public body, commonly known as an arm's length body (ALB), of the DHSC.

Are the issues so serious that the Health and Safety Executive (HSE) should be called in?
With Grant Thornton being unable to definitively say how many people have died, and why, it is impossible to determine how many deaths were avoidable. The report states repeatedly that the mortality data quality is so low that it cannot be used for learning. This feels like a health and safety issue on a corporate scale.

An example, and there may be others, where the lack of scrutiny, learning and action from mortality data has contributed to deaths is inpatient deaths by fixed point ligature. The CQC flagged these up as a risk in all their inspections and at times flagging up that they were repeatedly identifying the same ligature points because the necessary remedial action had not taken place. In April 2022, the CQC once again raised the issue in their full inspection report: *"The trust did not ensure staff were aware of ligature assessments or mitigated or removed ligature points effectively to maintain patient safety"* (p3). In January's 2023 board papers there was yet another discussion and plan to remedy fixed ligature points. In the same papers a death by 'fixed point ligature' is mentioned. In February 2023, NSFT's Chair's report to the performance and finance committee states that "*ligature removal was underway"*. In May 2023's Board Assurance Framework on the addressing of ligature points risks on wards is described as work in progress. The theme since 2015 seems to be identification of ligature points, followed by plans and some action, but never completion of the work. There is a precedent of the HSE prosecuting a trust for failing to remove the known risks of ligature points on a ward and further deaths occurring. It would be prudent for the ICBs and/or CQC to ask the Health and Safety Executive to offer a view of whether this merits investigation.

Under-assessing risk is an issue that has come up in Prevention of Future Deaths reports and media accounts of inquests. We also wonder if the 1953 patients who died within 1 month of discharge in a 42-month period (potentially evidencing unsafe discharges) would also meet the HSE threshold (Figures from GT report p38).

[10] https://www.medscape.co.uk/viewarticle/number-deaths-be-investigated-mental-health-inquiry-rises-2023a10000qx?src=WNL_ukmdpls_230114_mscpedit_gen&uac=459011MV&impID=5083353&faf=1&sso=true

Comparison with other trusts and localities

How NSFT compares to other trusts

In 2016, Verita highlighted similar difficulties regarding mortality data and they gave a credible and clear rationale about why the data was unreliable. However, they did some in-depth analysis to draw comparisons by looking at particular aspects. We do not have the resources to replicate their methodology.

Identifying excess deaths

The SoR the ICBs issued to Grant Thornton (point v) states: *"Considering if there is any appropriate mechanism for establishing 'excess deaths' as context to crude mortality…".* This fundamental question remains largely unanswered in Grant Thornton's report. However, they do make a number of references about why making comparisons with other trusts and national data is important but difficult given the quality of NSFT's mortality data.

We have picked some indicators that Verita used to give an insight into the current situation. Please bear in mind that any comparison will be skewed because NSFT's raw data is fundamentally flawed.

- In 2019, ONS statistics cited Norfolk as having the fastest increase in suicide rates in the country. This was despite the suicide prevention initiatives that had started since the Verita report.
- Deaths due to drugs and alcohol: The Verita report discussed how the 'unexpected deaths' at NSFT seemed higher because unlike some trusts they offered a drug and alcohol service. This narrative was one that had been used by NSFT for some time. In 2013 the then Director of Nursing told the EDP *"the majority of deaths were of patients using [NSFT] drug and alcohol services"*[11]. Chief Executive Michael Scott told NHOSC on 16 September 2016 *"deaths due to drugs and alcohol misuse made up for approximately 30% of suicidal and unexpected deaths reported by NSFT".* In April 2018, drug and alcohol services were out-sourced and if this reasoning was correct, deaths attributable to the trust should have dropped. They did not. Having a dual diagnosis increases the risk of dying and the Verita report cited people (particularly men) as being the most likely to die. We know from media reports into inquests that drug or alcohol related deaths often cite 'long history of mental health problems' or 'known to mental health services'.

We looked at data produced by partner agencies within Norfolk and Suffolk to see their statistics on mental health.

- Norfolk County Council's, *How does health vary by place Norfolk* (2022) report draws on ONS Health Index to compare aspects of health that are better or worse compared to England. Their graph (p14) illustrates that 'mental health' is markedly worse but overall deaths (for any health reason) are a bit better. However, 'avoidable deaths and early deaths from all causes' (which are likely to include some mental health related deaths) are in the worst fifth in King's Lynn, Norwich, Thetford, Hemsby and Great Yarmouth, and the second worst fifth in some other areas of Norfolk.
- In 2019, the Norfolk's Clinical Commissioning Group reported on physical health and severe mental illness (Great Yarmouth and Waveney et al CCGs, 2019). They state that

11

two thirds of the population with a serious mental illness living in Norfolk and Waveney STP are dying from physical illnesses that can be prevented.

From triangulating data to national statistics, we can see NSFT have higher death rates in some respects but, thankfully, not alarmingly so.

Lack of learning from data

The never-ending stream of promises to bereaved families and others about learning lessons have been repeatedly broken. We believe that if sufficient care and attention had been paid to the mortality data, and due diligence been undertaken by those responsible for monitoring, scrutinising, and calling to account, there could have been learning that would have supported action and prevented some deaths.

NHS England states:

> "*Quality data plays a role in improving services and decision making, as well as being able to identify trends and patterns, draw comparisons, predict future events and outcomes, and evaluate services*" (www.nhsengland.nhs.uk).

On their website. NSFT have publicised their 2021 Safety Strategy[12] which states that: *"We will continue to embed, maintain and improve structures, processes and roles that enhance safety. A continual focus on the person, and human stories related to safety …"* (p3) and a core component is *"Systems that enable identification, monitoring, escalation, oversight and mitigation of risks from ward to board"* (p3). However, mortality data and learning from deaths are not mentioned within the strategy, with the exception of 'unexpected deaths' being one of the outcome measures. Fundamental flaws in this strategy are the implicit assumptions that the structures and processes are sound and that the data can be relied upon.

Grant Thornton highlight that NSFT's mortality data is not conducive to learning because there is no clear conversion from mortality statistics to understanding care: *"There is limited evidence of community death themes or learning beyond the expected and unexpected categorisation of death stage"* (GT report p35). As this categorisation is poor in first place it is questionable how useful any learning would be.

> *"During the review two senior clinical leaders stated that members of the Trust's clinical staff have limited faith in their data and do not use or analyse it in a structured manner"* (GT report p37).

This means that the data does not do what staff want or need it to do. Frankly, if the data does not provide clinicians with what they need to inform their practice it is of limited use.

Using, or rather not using, mortality data for learning is a longstanding problem. The Verita report cited NSFT as ranking 223/230 trusts in the Learning from mistakes league table. They stated *"…our work tends to reinforce this conclusion, in view of whole board examination of learning from unexpected deaths"* (Verita p 61). As far as we can see no further league tables

[12] https://www.nsft.nhs.uk/download.cfm?doc=docm93jijm4n1964.pdf&ver=3065

were produced by the Department of Health and Social Care so we were unable to track whether NSFT improved or deteriorated using this measure.

We are very concerned about how learning from deaths and tracking the implementation of recommendations from PFDs is managed at NSFT. We know from campaigners Freedom of Information (FOI) requests to NSFT that the trust might be struggling to keep tabs of who was issued an FOI let alone the recommendations. The first FOI requesting PFDs was returned but a PFD missing from 2014. A more recent follow up FOI response had a name on the list that, as far as we can tell, did not receive a PFD (this is a data protection breach).

Significantly, current and past Learning from Deaths policies do not make any mention of PFDs. This omission is concerning because PFD recommendations are learning points. A purpose of PFDs is to answer key questions: How did this person die? Was it a death that could have been prevented? What lessons can we learn? Are there things that can be done so that similar deaths can be avoided? (The Law and Policy Blog, 2023).

"There is little wider point in coroners conducting their inquiries and making recommendations if nothing comes of the lessons that have been identified." However, the lack of follow up, implementation of recommendations, and monitoring of those, is a national problem - *"In essence, the lack of any body (and, indeed, anybody) being responsible for monitoring what happens to coroners' recommendations robs the coronial system of any wider efficacy*" (The Law and Policy Blog, 2023).

It is as if, within the patient safety and mortality systems at NSFT, they have lost sight of PFDs. If so, this is appalling.

We note in Grant Thornton's report that NSFT *"attends public health and inequalities forums"* (p37). In our opinion, attendance is not sufficient. It is engagement, and acting upon what has been heard and learnt from partners, that matters. This is particularly true in an era of Teams meetings where logging in can constitute attendance. We can see no evidence in Grant Thornton's report of any outcomes or impact of NSFT's attendance and therefore do not accept that it is reasonable to cite it as evidence of how they are addressing the fundamental flaws in their processes.

A lack of learning is a national issue. The Parliamentary and Health Service Ombudsman (2014) reviewed the quality of complaints and investigations into avoidable harm. They say: *"…learning from investigations appears to be trapped in high level meetings…"* and learning across organisations is reliant on *"goodwill and personalities"* and *"cross organisational learning tends to be led by the willing few rather than something that is widespread practice across the NHS"* (p8). We are curious about where within NSFT the data and any learning is trapped.

Within the Grant Thornton report it is clear that the data collected does not have enough specificity to be used to identify and address themes. We already knew this because we had spotted a theme from Prevention of Future Deaths reports and media articles on inquests that people were dying on NSFT's waiting lists. Dying while waiting for services is a theme of Caroline Aldridge's book about her son who died waiting for an appointment, *He Died Waiting*

*(*2020), and the book she co-edited with Emma Corlett, *They Died Waiting* (2023), which is a collection of other people's lived experiences.

Over the last few years, the Norfolk and Suffolk campaigners have put in a number of Freedom of Information request to NSFT regarding deaths. The majority of these were refused. On 13th December 2021 they put in an FOI for NSFT to provide the numbers of 'unexpected deaths' between 2019 to 2021 (including those on waiting lists). This was refused under Section 22 with a rationale that all the information would be in a paper being written by Dr Dalton about Mortality and Learning from Deaths and that the trust had checked that all the information requested in the FOI would be in the report. The published report did not contain information about waiting lists. In February 2022 campaigners requested the missing information and were told this would be responded to but a fee might be payable. To date this information has not been provided. Having read Grant Thornton's report it seems likely that the reason the information about deaths on waiting lists (which would be vital information) was not provided is that NSFT do not gather, or if they do cannot retrieve, this information.

The CQC has repeatedly criticised the trust for its management of waiting lists. In terms of learning and using data to improve services it would be helpful that any improved systems captured this data.

There are several references in Grant Thornton's report that suggest a lack of analysis and learning which means that further investigation is needed because the data has revealed serious issues. We shall explore four of these in the next section.

Covid masking deaths

Grant Thornton describe how NSFT attempted to evaluate the impact of Covid-19 on their mortality figures, the Trust *"…reached the conclusion that 'people who were in contact with NSFT's services were disproportionately affected, compared to the whole population [of Norfolk and Suffolk]",* however, the analysis did not adequately explore the reasons (p35). This is an example of the way not just NSFT but the wider system, are not interrogating mortality data to explore trends.

We looked at NSFT's Board Assurance Framework: On 28th January 2021, they identify the risk of *"…loss of life in service users, carers and staff…"* due to Covid but there is no mention in the controls, assurances and actions sections that states how they are recording these deaths and what would be indicators of the risk increasing (point 4.3).

Compounding the issues surrounding the spike in deaths in January 2021 (discussed on pages 33 and 35 of GT report) is the categorisation of deaths. Grant Thornton suggest that deaths from Covid may have been categorised as 'Natural- non-specific cause' and that Covid might not have been captured as a cause of death. Some deaths during the pandemic were connected to Covid, but not from having the disease. For example, we discovered in board papers that there had been a cluster of deaths in Children Families and Young People services that merited a review.

Unsafe discharges

On 8th and 22nd November 2022, we, and others, met with the ICBs, NSFT, and NHSE to share our concerns about the safety and effectiveness of NSFT. One of the issues we raised was unsafe discharges. We know from deaths reported in the media and from our observations that this is a recurring theme. Similarly, there have been Prevention of Future Deaths reports about unsafe discharges. Unsafe discharges are a longstanding problem at NSFT. 'Discharge with insufficient care package' was one of the top 5 causes of complaint reported in NSFT's 2022 Annual Report. Deaths following discharge are very difficult for bereaved relatives to accept.

"When NSFT are there to support those with mental health to continue life, I find it perplexing that the service does not keep a close eye on the mortality rate of those under their care and within a period of time of discharge. How can the service know it's effectiveness if it is not seeking to understand how those with mental health issues are responding to the treatment/care plans they are given?"
(A bereaved mother)

The Verita (2016) report highlighted serious shortcomings with discharges (p43) and in "*a few cases"* the poor practice they highlighted *"…were considered to have contributed to or caused the unexpected death"* (p43). Verita (who reviewed 126 serious incident reports) found examples of poor practice around discharges (page 43). These included: no 'proper' discharge plan; discharge without care plan, CPA or updated risk assessment; limited or no liaison with GPs; discharge from CRHT without face-to-face meeting with the service-user; unclear rationale for discharge; and no crisis plan in place. These issues have featured repeatedly in Prevention of Future Death reports and media reports of inquests. It is devastating for bereaved families who have subsequently lost their loved ones to know that the trust had been informed of these failings but continued with unsafe discharge practice. What the Grant Thornton report demonstrates is that a barrier to learning from deaths in these circumstances is the poor quality mortality data that does not even provide reliable and accurate basic information on deaths.

In their Annual Report 2022, NSFT state they use tools to "*alert for 'red flag' concerns such as recent discharge from a mental health unit or contact with crisis services".* Given Grant Thornton's findings and the number of deaths we observe, it seems this system is not effective enough. Grant Thornton's analysis indicates that there might be links between discharges and deaths but cannot elucidate due to the quality of the mortality data. We agree.

Grant Thornton describe less clarity about community/out-of-hospital deaths. This might reflect that under NQB guidelines reporting inpatient deaths are mandatory but community

deaths are not. This is a national problem and community deaths commonly do not have "*any notification or appropriate investigation or inquest"* (INQUEST, 2016 p3).

We are concerned about the 278 patients whose date of death and discharge are the same (GT report p38). There is no clarity in Grant Thornton's report about what this means. It could be that 278 patients were discharged then died on the same day (which would be horrific), or that the death notification triggered being discharged, or a mix of both. In a statement correcting the media for inaccurately reporting this figure, an explanation was given that was ambiguously worded and seems to imply all 278 were discharged on date of death as an administrative process. We were not convinced. It is deeply worrying that there does not seem to be a way of clarifying this.

Grant Thornton flag up the high numbers of deaths within one month of discharge (p38). In the period April 2019 – September 2022:

> *"1953 patients whose death is considered under the management and care of the Trust the date of death is within one month of discharge … Given the large number of patients who die within a month of discharge from the Trust's services, more work is needed to understand this cohort. Having an accurate cause of death will be crucial so the Trust can understand if it could have acted differently…"* (GT report p38).

The difficulty in a piece of work exploring this cohort is that NSFT do not know the causes of death for many of their patients. Nevertheless, we believe that a robust attempt should be made to interrogate this data.

On page 39 (GT report) it states that 37% of deaths (some 3261 people) between April 2019 and September 2022 had a *"discharge date recorded after the date of death"*. If so, 63% (5552 people) of those who died did so following their discharge from services. This means 8813 people died in this 3.5 year period.

The issue of identifying when patients who are discharged from services die, is a national issue*:*

> *"There is no consistent process or method for NHS trusts to record when recent patients die after they have been discharged from the care of the service, either from an inpatient service or from receiving services in the community"* (CQC, 2016 p9).

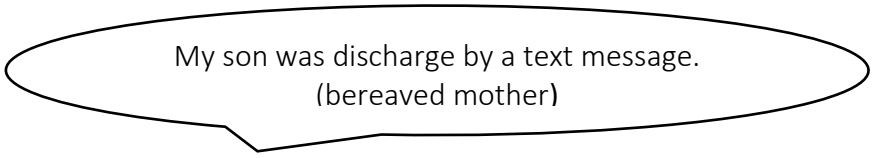
We are curious about why nobody in the system has noticed or addressed deaths following discharge from services because so many are publicly reported. Anecdotally, we know these kinds of deaths relentlessly occur and in recent weeks we have been told of several such deaths.

Lack of follow-up of at-risk patients

The chart on page 38 [Figure 5] indicates that of approximately 5,400 patients who died in the 41 month period examined, almost 2000 died within one month of discharge. Grant Thornton state that "more work is needed to understand this cohort, ensure this data is accurate and act on any learning". We assert that this could indicate a lack of oversight and follow-up of at-risk patients by the Trust, and any further work around this cohort should have

robust oversight by the ICBs. It was equally concerning that almost 7% of deaths in the cohort examined had "not been seen for a number of years", with 2% "where the patient had not been seen for over 2 years". This is a clear example of the Trust not even being able to accurately identify patients for inclusion by its own stated criteria (under the care of or within six months of discharge). It is currently impossible to determine how many of those deaths were people who had in fact been discharged from services and their records not updated accordingly, and how many were of people who still required further clinical input but had 'slipped through the net'.

We have been given examples by people using services and bereaved families of people languishing in services but not actually being seen during prolonged gaps between one care co-ordinator leaving and being reallocated to another, or of being discharged after months of not being seen with no discussion or face to face clinical assessment.



It is our sense that particularly in adult and youth community teams' caseloads were overwhelming and there was not good oversight of those 'team held' cases where a member of staff left their job and there was simply no-one to allocate their care to. For example, the CQC found objective evidence of wholesale removal of 300 young people from awaiting allocation lists for non-clinical reasons within Youth Services[13].

We know from inquests and media reports that inadequate risk assessments have led to many deaths. Two recent examples are Alan Hunter (2020) and Faisal Mohammed (Rowan) Al-Dossary (2021).

Despite many months of checking the report for factual accuracy the data and discussion about dates of death and discharge it is impossible to penetrate the ambiguity. Although we know much of the data is meaningless, this stark information must be further assessed, analysed and acted upon.

The police are often involved in mental health related deaths because they attend and investigate. In Zoe Billingham's (former HM Inspector of Constabulary) foreword to the HMI CFRS (2018) report *Policing and mental health: picking up the pieces*, she describes how it is often the police who are called on when there is a mental health crisis. We notice that within the literature, processes, policies, and information about deaths connected to the NHS there is almost no mention of how the police might provide or use mortality data. With the new mental health collaboratives being stood up in Norfolk and Suffolk, it might make sense to include the police in action plans. We would hope that with her understanding of managing mental health risk from both a police and mental health trust perspective, Zoe Billingham is well placed to build connections. Critical to this will be having accurate mortality data. Adding to the urgency of establishing accurate NSFT attributable death data is the news that the

13 https://www.edp24.co.uk/news/local-council/20750426.mental-health-trust-admits-discharge-300-young-people-waiting-list-decision/

Metropolitan Police will soon be refusing to attend mental health emergencies.[14] Subsequently, his strategy was adopted in Norfolk and Suffolk. It will be extremely difficult to identify any excess deaths that could occur because the baseline data is flawed.

The importance of coroners

Across NHS trusts:

> *"There remains too much subjectivity in the system and too much room for error, for example, highlighted by revelations that large numbers of mental health deaths are not being reported to coroners. We simply don't know how many deaths are going below the radar"* (INQUEST 2016 p4).

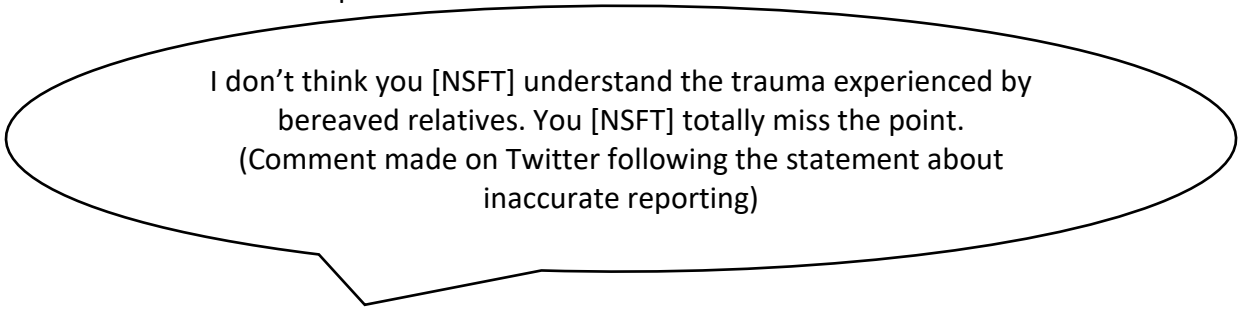
Grant Thornton do not specify the processes by which NSFT are reporting deaths to the coroners, although by implication it is likely some might be missed.

Grant Thornton did not comment of how NSFT record and report on Prevention of Future Deaths reports issued by coroners. From the evidence presented by Grant Thornton about mortality data we cannot assume that there are good processes in place for this. We would like assurance that there is an effective system for managing and using this data for learning and that oversight from NSFT's board and the ICBs will be much stronger.

Harm upon harm

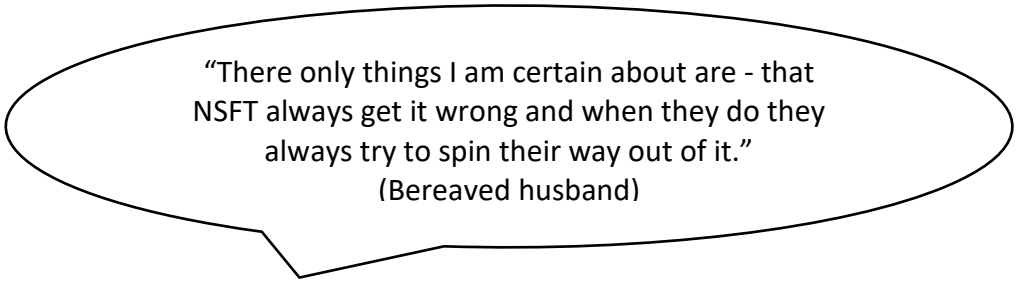
We have been appalled by NSFT's responses following the publication of the report. The toll on bereaved has been immense. It was not helped by a communications team who acted without compassion or thought for the families. The swiftness with which they issued subsequent statements (which were not shared with us in advance so we could warn families) has exacerbated their grief and trauma. If ever there was a time when NSFT needed to be understanding, absorb criticism, supportive and gentle it was in the immediate period after publishing such an emotionally-loaded and devastating report. What was communicated to families was that statements from the CEO and Chair were tightly scripted and the statements were all designed to try and make things look better than they are. It is difficult to find words to adequately express how families felt.

Rather than reassure, the issuing of definitive death numbers and tetchy statements correcting the media for quoting verbatim the report, confirms that NSFT still do not seem to grasp their data is fundamentally flawed and that they continue to manipulate statistics in a misguided attempt to minimise how many deaths there have been. There is an irony in NSFT seizing on an opportunity to criticise others for inaccurate recording. The inappropriateness of this was obvious to the public.



[14] https://www.bbc.co.uk/news/uk-65741824

The dangers of certainty



It is well recognised in health and social care that professionals and organisations certainty is unlikely due to the nuances and complexities of working with people. Indeed, in the field of social work certainty and unsafe practice are considered as 'bed fellows'. The key to embrace working with uncertainty by being critically reflective and seeking to understand context (Fook,2016). Fook asserts we need to accept and manage uncertainty because:

> "*One of the major dilemmas posed for modern current practice is the difficulty of acting effectively, through using learning from past experience, when the new situations we encounter are unpredictable and uncertain"* (p190).

What we have observed over the last decade is leaders at NSFT declare certainties whilst presiding over chaos. There seems a lack of critical reflection and an integral arrogance that fails to fully comprehend both the seriousness of failings, or the impossibility of simple and/or certain remedies. Therefore, we were not impressed to hear the Deputy CEO talk at NHOSC of finding a 'single version of the truth' with regards to death numbers. We knew that even in an outstanding trust this would be impossible because the national guidance and criteria being changeable and unclear. Every part of the mortality data processes rely, in some part, on humans making a judgement or taking appropriate actions.

Even in the face of the evidence presented in the Grant Thornton report, NSFT persisted in the belief they could be certain of some of their data. In their statement in response to the mortality review on 28th June 2023, the CEO states:

> *"We have certainty on the number of deaths related to incidents and suicides; firstly, because they correlate with and are verified by the coroners' data; secondly, because they correlate with real-time recording by local authority public health teams, and thirdly, because Grant Thornton have found strong governance around the recording and reporting of all patient safety incident deaths and suicides."*

We would counter:

Firstly, that there is evidence that there is variation between coroners about where the thresholds are for this (Gunnell et al, 2013). In 2020, the standard of proof (from beyond reasonable doubt to a balance of probabilities) for ruling a death as suicide was changed[15] so

[15] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/changeinthestandardofproofusedbycoronersandtheimpactonsuicidedeathregistrationsdatainenglandandwales/2020-12-08

looking retrospectively across 5 years means that it will be difficult to compare between years. Despite the change, within NSFT's catchment area the different coroners are more or less likely to come to this conclusion and/or issue a PFD. For example, one of the Norfolk coroners is known to sum up by describing the act by which someone died by their own actions but qualifies this by saying *"we cannot know"* their intent to die.

Secondly, real time recording is contemporaneous and it includes suicides and suspected suicides. So, by design, data will be uncertain because it will keep changing as investigations uncover more information.

Thirdly, as detailed in the data journey section, if not every death is captured in the first place the numbers can never be 100% correct however well patient safety incidents are investigated.

We know enough to know we could never be certain of the death statistics. We were never seeking certainty or a single truth. We were seeking honesty and transparency about the processes and methodologies alongside consistent published data so we could, as concerned citizens, make informed judgements about how many people might be dying due to poor care and why.

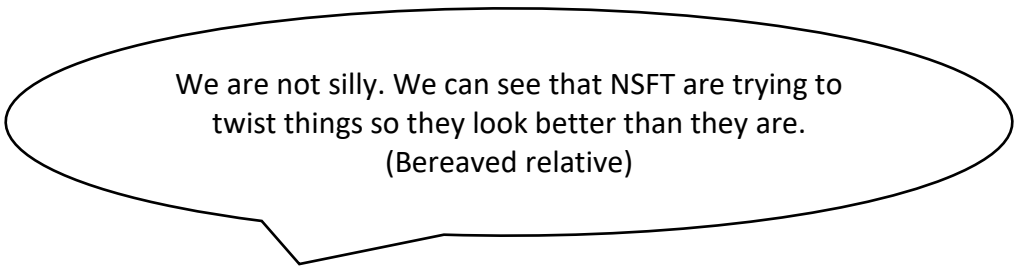
One thing is certain, those who have lost their lives are forever gone. There are thousands of bereaved families across Norfolk and Suffolk who live a version of a single the truth every day: Their loved ones are dead.

The myth of a duty of care to the public

In NSFT's statement by the CEO issued in response to Grant Thornton's report he states:

> *"We have a duty of care to our public and service users and so it is important for us today to dispel misunderstandings and assumptions that 'all deaths of those known to NSFT' equate to deaths related to poor care."*

He goes on to cite that of the 11,379 deaths, 271 were suicides and *"not all of these necessarily equate to poor care".* This seems a disingenuous response to the mortality review and, rather than offer a duty of care, it further upset those who were concerned about the death statistics.



We sometimes feel that people underestimate our understanding of mortality data. We are not silly women and we see straight through poorly conceived deflections.

We looked at the latest coroner's statistics[16] to set NSFT's mortality data in context. The issuing of PFDS was up 7% nationally but there are wide variations across the county. There are more PFDs issued in Norfolk than Suffolk (for all trusts). Coroner verdicts of 'natural causes' are up 10%. NSFT's natural causes deaths have gone from 54% to 94% since 2019 which seems disproportionate and merits investigation.

We suggest that exercising a duty of care to the public and dispelling myths should be founded on honesty.

Manipulation of mortality data

Grant Thornton's report, coupled with information provided by the CEO in media interviews, could not make it clearer that NSFT's data is 'chaotic', has gaps which means they are struggling to know how many have died, and that it is unreliable and inaccurate. Instead of admitting they have lost count of their dead, NSFT rather unwisely decided to publish some figures for the last 5 years alongside Grant Thornton's report (Appendix 3). This ill-judged decision was cited as evidence of how they are improving their transparency. Indeed, the Chair shared the link to the data within a chain of tweets promising that she will *"act and put things right"* saying *"I hope you can see that we have not tried to hide, or obfuscate, its [the report] findings".* The concerns we have regarding the newly published data are:

- Any data produced about the deaths in the last five years will be incorrect because of the basic errors in data collection outlined by Grant Thornton. NSFT do not seem to have grasped this key point.

- The decision to cover 5 years rather than the same period as Grant Thornton reported on or the 9 years that the disputed 1000 deaths related to further confuses people and makes like-for-like comparisons impossible.

- The descriptors in the table relating to these figures are ambiguously worded and even people, such as ourselves and journalists, who are familiar with mortality data struggled to understand what they meant. The use of bafflegab is not improved transparency. Plain English should be used.

- The choice of which data to be 'transparent' about are particular subsets rather than complete data sets. This gives the public the impression that things might not be so bad. For example: patient safety incident related deaths (but only those investigated); the number of prevention of future deaths (PFD) reports (but only those where the person died *and* the inquest concluded with a PFD within the 5 years; the number of suicides and 'took own life' coroner conclusions (thus excluding those who died by their own actions but their intent to die was not established); the number of suicides and 'took their own lives' coroner conclusions for inpatient deaths (thus excluding all the other inpatient deaths). We shall expand on some of these points below.

- We note that for PFDs NSFT chose to use date of death rather than date of inquest but for suicides they used date of inquest. NSFT's Chair wrote, "*We also commit to*

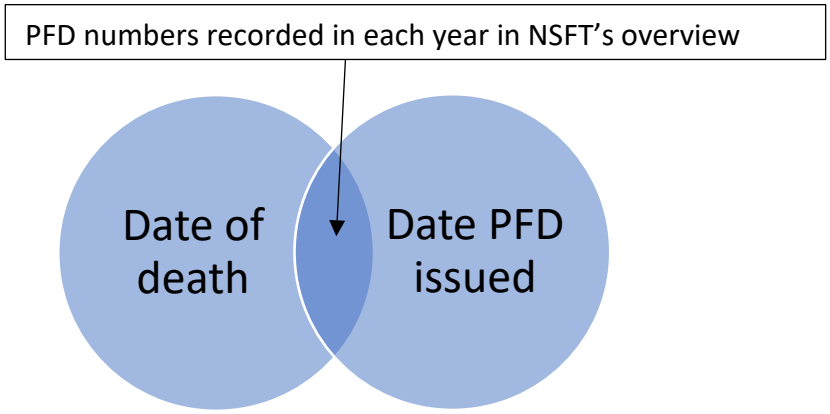
[16] https://www.gov.uk/government/statistics/coroners-statistics-2022/coroners-statistics-2022-england-and-wales#statisticians-comment

publishing a consistent set of information for the public…" The data published within this single document does not use consistent criteria.

- Grant Thornton criticised NSFT for its frequent changes of methodology without explanation, the trust committed to consistency, but the report was not a day old before they changed their methodology over a key indicator relating to mortality.

- Something that had been consistent and relatively reliable over the last decade in NSFT's data, was how they presented PFDs in their board papers and annual reports. Invariably they publish these under the date the coroner issued the PFD. This is consistent with the way PFDs are recorded on the Ministry of Justice Website and by other trusts. There have been 21 PFDs issued in the last 5 years. The figures published on 28.6.23 say 13 - these are placed under year of death. It took 2 of us 2 hours to go back into each PFD to check the dates and work out how NSFT had arrived at 13 PFDs. Whoever collated the data seems to be finding this difficult too. They have made an error (the transposing of the numbers for 2018/19 and 2020/21). By using criteria that requires both the death, and the PFD to fall within the 5 years, the trust have made it appear that there were 8 fewer PFDs in this time period. For ease, we have created at visual aid to understanding what this means:

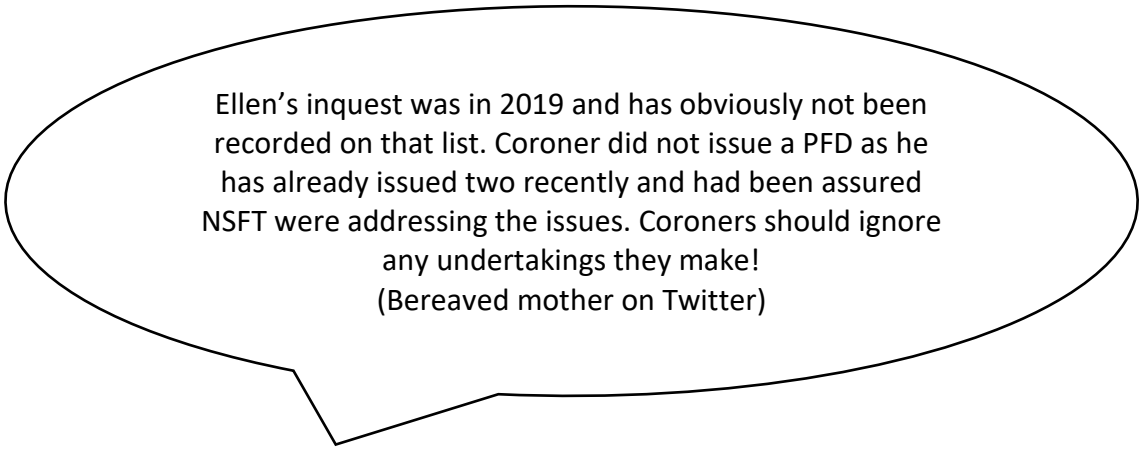
Figure 3: Diagram showing which PFDs are recorded in the Overview of NSFT's mortality data for the past 5 years.



Our interpretation of this is based on the information we have been provided with. This change in methodology means is that someone will need to die **and** have their inquest conclude (with the issuing of a PFD) within the same financial year (April-March) to be included in the trust's PFD figures in their table. Most deaths that result in PFDs are those where inquests are likely to be delayed due to adjournments. Even straightforward inquests usually occur some months after the death. Furthermore, the PFD figures will keep changing because we do not know if any PFDs will be issued for those who have died whose inquests have not concluded yet. This means the data will need to be added retrospectively to the figures published this week. It will incredibly difficult to keep track of these figures. This is not transparency.

We are not clear whether they intend to use this new methodology in their annual accounts going forward though from the 2022/23 Annual Report it seems NSFT have reverted to

reporting PFDS under in the year they were received. If they do use the, date of death and date of PFD it would mean that if someone dies in January to March of one year and there is zero chance that any PFD issued at their inquest in subsequent years would be included. If we have not fully understood or explained clearly enough how PFD data is being manipulated. This reflects how something that was easy to keep track of has been made very complicated.



- PFDs are an important part of mortality data and we were surprised this was omitted from Grant Thornton's report. They are not representative of deaths due to failings in care because often NSFT say they have already made the necessary changes, or the coroner has recently issued a PFD for similar issues, so the coroner does not issue one. The inclusion in NSFT's response to the report suggests they were looking for the smallest number of deaths to accept responsibility for (21). Showing a dexterity with statistics, that seems largely absent from their mortality data processes, they were able to present this as 13. This is a blatant misrepresentation.

- We noticed that one of the key responses to the report was a focus on suicides. The trust reassured critics that they know about **all** these deaths. By conflating suicides with other mental health deaths, they effectively exclude all the other deaths they are responsible for. For example, several of their recent PFDs have not been for suicides but for other serious failings in care such as Eliot Harris whose death was ruled unascertained. Either, NSFT do not understand that suicide deaths are not the only form of mental health death (which would be alarming) or, they do know but are deliberately focussing on a subset to present themselves in a better light.

- One area of concern for us is the number of impatient deaths we read about but have no data for. If NSFT wished to be transparent it would have been helpful to publish inpatient death numbers. Presumably, this is one data set they should have no difficulty identifying. Instead, by the use of some weasel wording, they chose to publish only inpatient deaths where the coroner had ruled suicide or took own life. This is a small subset and to those not familiar with the data it looks like there have been little or no inpatient deaths. The data presented does not even cover all of NSFT's inpatient deaths where the trust were issued with a PFD. There were 2 PFDs issued for inpatients in 2021/22 and 3 in 2022/23.

NSFT's communications messages

These consistently set a wrong tone and have caused offense and further distress to bereaved families. The usual platitudes about this being about people not data were presented but they lacked sincerity. Some weak apologies were made for the poor processes - *"We are deeply sorry that we have not previously had systems and processes to record and report mortality data as we should"* (NSFT Chair). This implies that the systems and processes currently used will be correct. However, it is clear from recent board papers that the mortality data recording is still opaque and incomplete. And, from the action plan it is abundantly clear that work to address mortality data issues has not, or only just, started. Any apology for the distress caused or for any potential lack of learning was totally missing. The clever choice of words such as 'previously' are classic deflection techniques from owning responsibility. The CEO's interviews were disastrous and his deflection onto GPs and partners has really angered people.

The report spent 5 months being checked for accuracy yet the final report was full of inconsistencies and ambiguously worded statements. So, it was no surprise to us that the media, who had only a short time to read and understand the report night not grasp the nuances of the data within it. Instead of focussing their time and energy on putting their own house in order, or working on reparation and rebuilding public trust, or supporting bereaved relatives (some of whom are their staff), NSFT decided to issue a statement about the way the media had correctly quoted but not adequately explained the 278 people whose death and discharge are the same day. As if this was not bad enough, in quoting Grant Thornton's report in their statement they skipped two paragraphs that might have presented the trust in a poor light. This is not transparency it is gaslighting.

To top all the above, NSFT contacts and 'comms,' who are connected to Caroline on Twitter and usually keen to join in with any of her 'good news' tweets, ignored any critical tweets or those that showed she was distressed. Instead they decided to jump in on the Chair's tweets to correct Caroline about the PFD discrepancy. This has not gone unnoticed by others and it exemplifies how NSFT are maintaining an arrogant and insensitive position.

Different messages for different audiences

We understand that briefings need to be tailored to different audiences. However, we feel that the briefings were disingenuous and, in some cases, caused harm.

At the media briefing the CEO and Chair both said that people (implication being the campaigners, bereaved relatives and public) would need help to understand the data because the terms unexpected deaths is being confused with avoidable deaths. When questioned the CEO said they could not comment on campaigners 1000 deaths claim because NSFT did not know where we got our data from. For clarity – Caroline told NSFT, both ICBs, and Grant Thornton that NSFT had been conflating terms and she provided all the working out for 2,600 deaths complete with links to NSFT's own published data. She was clear that the data was unreliable because of the many changes in methodology and terminology used by NSFT over the previous decade. The following day, in our briefing it was all care and concern for our wellbeing and thanking us for our work on mortality data. This dissonance was triggering for Caroline.

At the staff 'Hear to Listen' briefing the CEO commented on the way the media were reporting 'inaccurately' and 'liked a headline', forgetting that some of the staff listening to, or hearing

about this, found the minimisation upsetting. There was no appreciation in the staff briefing that some staff are themselves bereaved relatives or that they might have lost patients they care about.

Wider system's communications messages

These are weak and minimal. The impression given is that by keeping their heads down, commissioners, monitoring and regulatory bodies, can keep the focus on NSFT and absolve themselves from owning their part in this mess. The message from the wider system seems to be 'say little and wait for it to blow over'. This is not good enough. And, we are not going to let this blow over.

The impact on bereaved relatives

There does not seem to have been any insight by NSFT or the ICBs about the likely impact on bereaved relatives when Grant Thornton's report was published. The report should have had a trigger warning on the front along with contact details of who to contact if you think you might be affected by anything in it. There are people asking: "Has my relative been included in NSFT's figures?" There is no helpline number for them to contact.

There should have been an action plan in place and clear signposting for sources of support. As far as we are aware, partner agencies who might have people turning to them for help did not have advance notice of the report so that they could prepare for any aftermath.

We have all, but particularly Caroline, had distressed people contacting us via any means they can because there is no support for them. This includes members of NSFT's staff who felt unable to work and totally unsupported. A general feeling of how can they continue 'working for truth twisters' (this is our polite paraphrasing). Likewise, bereaved people who are involved in working with NSFT to improve things have been left wondering if they are naïve and have been used in tokenistic ways. Did nobody think beyond learning their carefully worded 'comms' lines and consider taking some responsibility for the fallout?

The damage to confidence and trust is huge. Any clumsy attempts to be seen to do the right thing now could be counter-productive and further traumatise people. The ICBs and NSFT need to urgently look at co-producing a reparation plan.

The sound of silence

We have worked diligently, and we hope respectfully, with senior leaders at NSFT and the ICBs to raise concerns. We had felt optimistic that, after years of failed attempts, the system was listening to us and respecting our understanding of the deep-seated problems at NSFT. We felt we had built some trusting relationships with key people. On the run up to the publication of Grant Thornton's report, the authenticity of these relationships was tested. We know who contacted us and offered support and care and who was silent (or offered minimal, tokenistic comments). It has been profoundly disappointing and re-traumatising. .

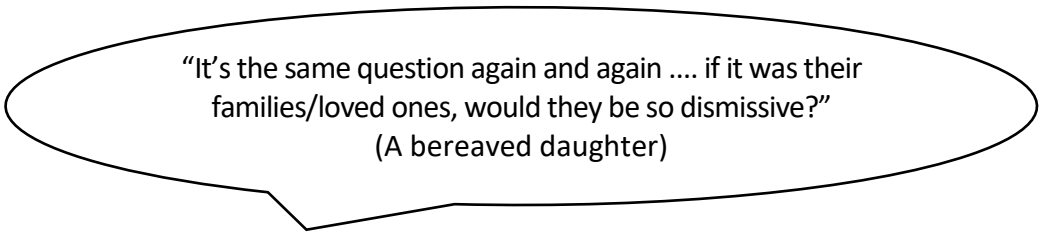
> *"Many organisations send out the message -verbally or non-verbally – that falling into line is the safest way to hold on to our jobs and further our careers"* (Rahman, 2019 p129).

We know that within the system there are those in senior positions who know that things are wrong but they remain silent. They might hold positions of responsibility but they lack the courage (or perhaps the moral fibre) to speak out. Vitullo (cited in Sicora,2017) says that leaders need to be reflexive, brave, authentic, able to listen, and open to others' opinions. We suggest that in Norfolk and Suffolk they need to find their 'everyday courage' that is *"required for health professionals who work in an environment of high complexity, responsibility and uncertainty…"* (Myers, 2019 p 29). What is needed now is for others to speak out and break the silence.

We are whistle-blowers who have stood up many times to try and get the system to notice that, among other things, mortality recording and reporting is in disarray. Caroline and Emma know only too well the impact that whistle-blowing about NSFT has had on their careers. Whistle-blowing takes courage and it is exhausting. We will not stop until things have improved.

Actions required

Bereaved families reading Grant Thornton's report do so with their hearts. They will be wondering if their loved one was included in the figures or whether their deaths have been discounted. They will inevitably look at the numbers presented and feel incredibly sad to know so many other families have experienced the agony of losing someone to a premature and maybe avoidable death. They might justifiably be very angry that this has happened.



We invite people reading our response to pause for a moment and imagine someone they care about has died under the care and treatment of NSFT and think about how they would feel.

A public apology

First and foremost, NSFT need to issue a public apology that clearly and frankly says that:

- they cannot say with any confidence how many people under their care and management have died or why
- they unreservedly apologise for the distress caused to bereaved families (including some who are staff members or governors) for the distress caused by the content of the report and how publication was handled
- they unreservedly apologise that bereaved families had to beg for mortality statistics and their warnings were not listened to
- they unreservedly apologise that the report was not co-produced with bereaved people
- they unreservedly apologise that the action plan has not been not co-produced with bereaved people

- they unreservedly apologise for the lack of sensitivity and compassion shown by not preparing bereaved people for the publication of the report
- they unreservedly apologise for the lack of provision to support following publication
- they apologise for the insensitive and disingenuous behaviours of the communication team and the CEO in their public interactions

Any apology should include plans for reparation.

We are not making recommendations because successive reports (such as Verita and the CQC) and investigations have made recommendations that have not been actioned. We feel the seriousness of losing patients, in both the sense of patient deaths and in losing people from the data, means that it is time to act swiftly and wisely.

Working with bereaved families

We asked some bereaved families what actions they wanted to see:

" CHANGE CHANGE CHANGE and listening. And working together"
(A bereaved sister)

"I want the CQC to go back in and re-evaluate their own findings with this new information. I want NSFT to be so ashamed of their behaviour and structure that they beg to have conversations with those that can aid the organisation to grow and do it promptly without losing another day!"
(A bereaved mother)

"We were not listened to before the deaths, and nothing changed afterwards. Working WITH families has to be the way forward"
(A bereaved relative)

From this point forwards we would like assurance that every death will be properly accounted for. Each bereaved family needs their loss fully acknowledging and to know how their loved one's death features in NSFT's mortality data and learning.

NSFT told Norfolk HOSC on 8th September 2022 that the terms of reference for Grant Thornton's review had not been co-produced but bereaved families would be included in discussions around mortality numbers. We believe this is essential.

Bereaved relatives are the service-user with regard to anything following patient deaths. By proxy they are the voice of the person who was under the trust's care. There is research evidence to show that useful patient safety information is missed if service-users and carers are not involved in co-producing interventions arising from concerns about mental health services, however, operationalising this and incorporating at service-level can be difficult (Berzins et al, 2018). One of Berzins et al's findings is: "*the need to co-design methods for the systematic and routine gathering of information about the safety of care and care services"* (p6). They cite a service-user thus: *"If patient safety is seen as the sole preserve of professionals they are partially sighted. They are missing a vital part of the picture" (*p5).

In a large study into patient safety, that looked at the correlation between concerns raised by patients and their families and mortality rates in hospitals, Reader and Gillespie (2021) concluded that: "… *nonemployee stakeholders may provide alternative and independent source of data on safety in contexts where they observe and/or experience unsafe employee behaviours"* (p448) and they propose that 'holistic analysis' of safety and mortality requires viewing service-users and their families as important 'stakeholders in safety'. We suggest that bereaved families and campaigners (as independent observers and experts by experience), including ourselves, have been raising concerns (often via complaint processes) and have raised red flags which have been repeatedly ignored. We could see that something was seriously amiss in the way NSFT was gathering and reporting on mortality. A paradigm shift within the entire system is long overdue and we believe it is essential to include bereaved relatives as stakeholders in safety within every aspect relating to mortality and patient safety.

Bereaved families should be involved in all the steps moving forwards from Grant Thornton's report. We think bereaved families should help the ICBs to create an easy read version of Grant Thornton's report. This would benefit not just those with a learning difficulty or others who might struggle to comprehend the complex issues and technical language but also those within the system who do not seem to understand what the key findings are. It would have been helpful if the executive summary had bullet-pointed the key points. Representatives should be included in the formulation of action plans, and in monitoring progress against that plan.

NSFT already has a 'learning from deaths' policy that is unequivocal about the importance of involving and working transparently with bereaved families. Indeed, this has been in place since 2017. It cannot be okay that these conversations are still necessary 6 years later. We do feel that inviting Caroline Aldridge in to lead on a project exploring how NSFT works with and supports bereaved families was a positive move. It gives us hope that within NSFT there are people who genuinely see the need to behave better when patients die.

We believe NSFT has squandered an opportunity to build bridges with bereaved relatives by following through on promises that the mortality review would be independent and establish a 'single truth' about how many loved ones are forever gone. Root and branch change is needed if the longstanding problems with mortality data are to be overcome. To achieve this

NSFT needs to involve a range of bereaved relatives in every aspect of their work on mortality data and learning from deaths. The policies need to be converted to reality.

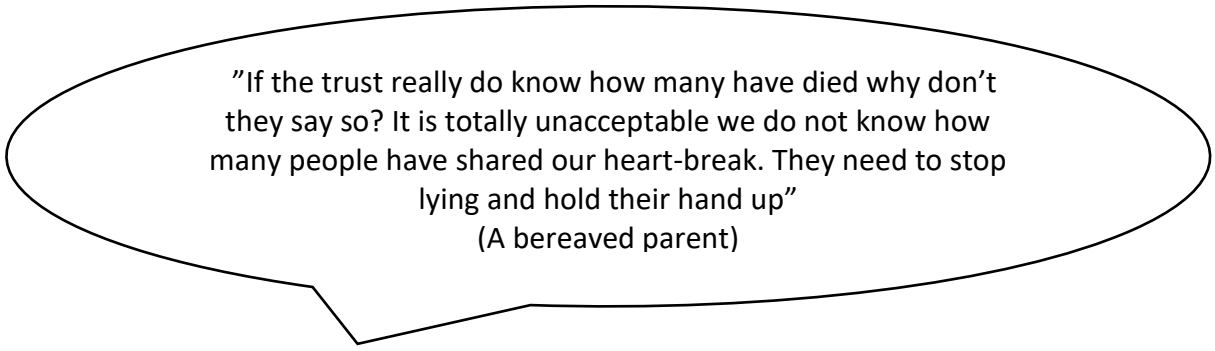
Establishing how many have died

It is almost a year since we went to London and met with MPs. We would not have said NSFT had lost count of their dead and that their mortality data was inconsistent unless we were 100% sure of this. We want to know how the decision was made for the requirement for Grant Thornton to verify the numbers was removed. We would draw your attention back to the first thing in the SoR which says: *"Verification of the number of deaths associated with care or treatment at NSFT per year…"* and to the statement made by the trust's deputy CEO to Norfolk HOSC.

In the period running up to publication, we have been told from more than one source that Grant Thornton were *not* asked to establish how many have died. We were not surprised because we knew this would be impossible given the way NSFT manage their mortality data (as evidenced by the contradictory numbers they have placed in the public domain). However, we feel there needs to be transparency about Grant Thornton not providing this data. It is really concerning that a firm of auditors say the data is not verifiable but the trust go on to publish death statistics.

Therefore, it seems reasonable to ask questions about how the Grant Thornton audit/review was conducted, particularly what occurred during the factual accuracy checking period. In a letter to campaigners (Appendix 2) the two ICBs state clearly how the review would be conducted under auditing processes and standards. This was confirmed by the Chair of Norfolk and Waveney ICB in our briefing.

It is disappointing that Grant Thornton were not able to do this because NHS data should enable trusts to establish how many of their patients have died. This seems a basic thing. That they could not, reflects the severity of NSFT's issues with mortality data. Instead of dropping the requirement to establish numbers it would have been more candid to own the impossibility of this.



We genuinely had hoped when this mortality review was commissioned, that NSFT and the two ICBs were committed to investigating how many patients had died and to explore the processes that had led to this. We are left feeling that they arrogantly believed we were wrong and that they were doing this with an aim of proving that so that bereaved relatives and campaigners could be disregarded and silenced. It shows a closed and defensive culture

that is rigidly continuing with behaviours that are unsafe. It is unsafe for an NHS trust to be unwilling or unable to identify their patient deaths and use this to inform safer practice.

Clearly, from the bereaved families' viewpoint, NSFT need to admit that they have lost count of how many of those under their care have died. Anything less is an insult to those who have lost loved ones and who realised this was the case long ago. Not establishing how many have died means the scale of loss goes unacknowledged. The raw data within the Grant Thornton report provides unequivocal evidence that the scale of deaths is worse than we imagined. There needs to be an acknowledgement of the seriousness of this and full ownership of this failing. However, we accept a line might need to be drawn under this because time and resources are better spent trying to remedy things than squabbling over numbers.

We want to see a credible and transparent plan, with resources from the wider system, to determine whether it is possible to identify a number. If not, there needs to be accountability for this shocking situation. We accept that it may not be possible to ever identify how many have died, and we want the focus to be on moving forwards with accurate data, but neither do we want this glossed over. All those involved in this sorry mess need to be seen to be accountable.

There needs to be a full stop to the current, poor quality, mortality data so that going forward all deaths are correctly identified, categorised, and reported. There has already been years of drift, with people doing what they have always done. Even since Grant Thornton have completed their report the drift has continued due to the inexplicable delay in publication and agreeing an action plan. This cannot continue because all the time more people become bereaved and are suffer iatrogenic harm by the NSFT's processes.

Critique of Grant Thornton's action plan

A criticism of Grant Thornton's report is that there is insufficient granular detail that shows exactly what has gone wrong and which would inform what needs to happen to resolve things. Interestingly, the recommendations and action plan provide clues about things that they found that are less clear in the report itself.

There are 16 recommendations that cover the following areas/operational groups (p9):

- 1 - 4 Data- which focusses on the technical management to be completed by business intelligence and related teams
- 5 – 8 Reporting - the process of producing internal/external reports, dashboards etc.
- 9 -11 Clinical engagement – engaging with clinical staff in use and production of mortality data
- 12 - 13 Partnership working- The Trust in the lead supported by the ICBs and partner organisations
- 14 – 16 Governance – oversight and controls over mortality data and reporting

There are key recommendations missing from the action plan, which can be drawn from the findings of the report. The action plan is inconsistent with information provided in the report itself in some areas and generally the recommendations do not reflect the severity of the report findings. For example, there is nothing to address the issue of not being able to establish how many people have died or recognising the high numbers cited within Grant

Thornton's report and seeking to reduce these (not via data manipulation but by prevention of deaths).

There are some notable omissions in the recommendations and subsequent action plan:

- There is nothing that acknowledges the impact of inadequate mortality data reporting and recording, and the inability to establish how many have died, on bereaved relatives reading Grant Thornton's reports. Indeed, bereaved relatives or any regret about patient deaths are missing from the report itself. This dehumanisation has rendered patients who have died and their families invisible within the data and the recommendations/action plan.
- There is nothing in the plan about reparation for the damage this report will have on bereaved families who will be upset by the report contents.
- Likewise, the impact on staff who have been attempting to protect life without good quality data to inform them is missing or the staff responsible for the creation of shoddy data who have done so in good faith under instruction, is missing.
- Any form of co-production is absent from the recommendations.
- There is nothing in the action plan that indicates any transparency such as making information about methodology, processes and the data publicly available so external stakeholders can scrutinise and flag up concerns.
- The plan contains minimal information about the difficulties with reporting to NHS England and again NRLS is omitted.
- There is nothing in the action plan to follow up on areas of unsafe practice that Grant Thornton's report brought into question – insufficient risk assessments and unsafe discharges.
- Although there are multiple mentions of things that might be presented to the board there is nothing that addresses the issues of inadequate overall governance including scrutiny of the data and curiosity about mortality in the action plan.
- There is also nothing in the action plan which properly covers the accountability of the ICBS or CQC or NHSE. With their roles absent how is there going to be any oversight or account both for them in relation to NSFT completing the action plan and of them in terms of their failures that led to this?

Of note in the action plan is a lack of urgency to address issues. In the action plan 9 of 16 recommendations are rated high (completion by August 2023), 6 are medium (completion November 2023), and 1 is low (completion 2024). This will be more than a year after Grant Thornton completed their audit. We know from previous reviews that recommendations might not ever be implemented.

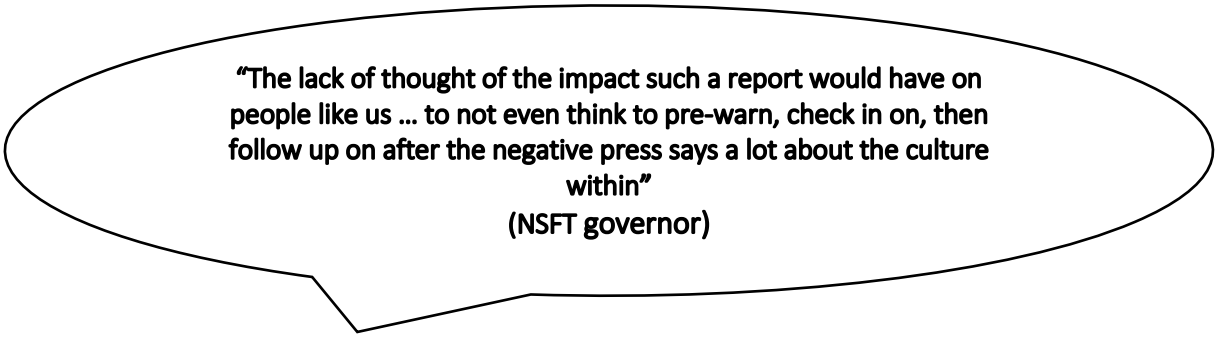
In setting the priority levels for meeting the recommendations in the action plan consideration has not been given to the priorities bereaved families, service-users and carers would want. Had the plan been co-produced it is more likely that it would hold patients at the centre and consider those forever gone or left behind.

The action plan needs reviewing to re-focus oversight and governance from the finance director to clinical staff. However, we acknowledge that the mortality statistics are complicated and maybe only the finance director has sufficient mathematical expertise to understand it. Nevertheless, we are concerned about how many of the actions will be overseen by the chief finance or digital officers. We would like assurance that in addressing

the errors Grant Thornton uncovered, the solution does not replicate the root of the problem. One of which was non-clinical staff categorising deaths.

The action plan cites the formation of Learning from Deaths Forums for both ICBs, which we welcome providing they have efficacy. We are aware that Norfolk and Waveney have stood one up but we are unsure whether Suffolk and North East Essex are planning their own or whether they will join Norfolk and Waveney. Whichever, the ICBs need to include people with lived experience on these. These need to be people who hold the corporate memory and have sufficient understanding of the issues to act as 'canaries in the mine' because they are attuned to signs of deaths or learning (or lack of) taking place. This report will provide essential background reading for the Learning from Deaths Forums.

We have been critical of NSFT's Council of Governors (CoG) for their lack of challenge regarding deaths at NSFT. However, we have become aware that this might be due to a culture that involves governors in a tokenistic way. The papers for their meetings seem to be glossy information and/or retrospectively giving information. A good example of this is the way the CoG were involved with the Mortality Review. Despite having governors who are bereaved relatives (both of whom are open about this and advocates for change), the governors were not forewarned about Grant Thornton's findings. Indeed, they were briefed and provided with the report to read *after* MPs, the media, and campaigners.



We are aware that governors with lived experience found the CoG briefing shocking and upsetting. It is symptomatic of the culture at NSFT towards bereaved people that support was not put in place for any governors before or after the publication. We are left wondering if NSFT have a tokenistic view of their CoG. And, whether the organisation is mature enough to work safely with people with lived experience of mental health related bereavement. Yet we know there are insightful and sensitive individuals with the right skills working for NSFT.

We welcome the creation of a Mortality Team at NSFT and the recognition they need to resource this if they are going to have capacity to meet demand. Going by their recently published figures, this team will need to screen around 50 deaths per week and follow up where appropriate. We are aware 2 leads have been appointed with a team being recruited over the next few months. We have a number of questions about these plans: How long will it be before the team has sufficient staff to be effective? What are the plans for co-production and/or the appointment of people with lived experience? How will this interface with the many other teams and committees at NSFT who undertake related tasks? Who will have the senior oversight? Who is creating their work plan and who will be quality assuring them?

We have observed the formation, amalgamation and disbanding of many posts and committees relating to mortality over the last decade. Our questions would be: How will it be different this time? How will the mortality team be sustained? How will the mortality team interface with bereaved relatives, the wider system and the public? Our experiences lead us to question whether the team will actually ever become fully formed let alone deliver on its goals.

Have both ICBs got an action plan to oversee and monitor mortality issues at NSFT? If so, is this a joint plan? If not, why not?

The new mental health collaboratives will have a vital part to play in any plans to move forward with accurate and reliable mortality data and any actions relating to deaths attributable to NSFT. They are invisible with the action plan. This needs addressing promptly.

As far as we are aware, the action plan has not been co-produced with system partners and key stakeholders, which is a missed opportunity, and furthermore, does not meet NSFT's own publicly expressed commitments to co-production. Recommendation 12 – "*Establish links with primary care networks to explore opportunities to improve the completeness of the Trust's mortality data (including cause of death) supported and enabled by the ICB"* (p14). How this will be achieved when point 12:1 states – *"This recommendation will be shared with the ICBs through dissemination of this report and to be added as an agenda item on ICB Learning from Deaths Forums where/when in place".* This indicates that the ICBs were not fully involved in creating partnership working sections of the action plan. We would hope that the ICB's Learning from Deaths Forums are going to be co-produced with bereaved relatives. Perhaps the absence of learning from deaths forums thus far might in and of itself partially explain how the problems with mortality data at NSFT might have become so entrenched.

It is worrying that several of the action plan points do not match things raised in the report. Or, if they are in the report, they are presented in a way that does not correlate to the level of priority in the action plan. For example: Standard Operating Procedures (SOPs) need creating; human error eliminated; a coherent mortality data pathway created; a tool to capture missing demographic information developed; processes for categorising deaths and establishing cause clarified; and policies updating. Their inclusion in actions tells us that these things were not already happening.

There is nothing in the action plan to address the issue of culture and consider what conditions at NSFT enabled these problems with mortality data to happen and continue for so long. This means there is nothing in this plan that inspires confidence that the underlying issues of the ways the organisation and individuals behave has changed.

A credible and concrete action plan

We would like to see an action plan that is co-produced between NSFT, the ICBs, NHSE, and, crucially, bereaved families. We would like to see some of the actions we suggest included in it.

We are concerned that this situation has been drifting for years and there seems to be no sense of urgency to sort this mess out. It is seven years since the Verita report, a whole year since campaigners raised the issue, and five months since Grant Thornton completed their

report. Five months in which 'checking for factual accuracy' has led to a report that has errors and curious inconsistencies in it. Five more months of drift and the status quo. It is reasonable to question whether the procrastination was about factual accuracy or an attempt to avoid publication.

Get the basics right
We need to see a transparent and accountable process that means there is an effective end-to-end mortality data journey. We note NSFT's aspirations for excellence but we want to see them get the basics right and a 'good enough' foundation first. Anything built on rotten foundations will collapse. We have seen this whenever there has been scrutiny of mortality figures – once the glossy top layer is turned over, what lies beneath is not palatable.

It is positive that NSFT are an early innovator of the new Patient Safety Incident Response Plan (PSIRP) and that the aims of this approach are co-produced. On their website it states that NSFT aims to be *"in the top quarter of mental health trusts for quality and safety by 2023"*. We are half way through 2023 and it feels we are further away from this than ever.

Swift and wise response to avoid drift
Given the length of time from the completion of the GT report to publication, both NSFT and the wider system should be able to demonstrate that they have reflected on the contents and their timescales for improvement works show pace and appropriate drive to improve.

Oversight of the action plan
The plan needs to be credible and concrete. There needs to be sufficient detail about what, how, who and when and with monitoring and checking built in. There is still a sense that NSFT are 'marking their own homework'. We believe that the action plan needs to be overseen by the Department of Health and Social Care. There monitoring and oversight needs to be publicly available and published on a monthly basis in order for bereaved families to be able to track tangible progress and that any improvements are sustained.

Robust oversight and management by local and national bodies
Whilst there has been previous system-wide oversight and assurance groups with local and national memberships in response to inadequate CQC ratings, these have failed to provide robust oversight and management of improvements within NSFT. As such, there needs to be innovative and challenging oversight and management of the action plan by local and national bodies. It will not be acceptable to keep mortality data processes and outputs internal and to simply issue statements saying progress is being made. Bereaved families and the public need to see evidence.

How will NSFT work with their partners
NSFT's action plan needs to more clearly show how they will work collaboratively with system partners to ensure that the data journey is accurate and to reflect the importance of ensuring that all available data is obtained for this to be affective.

Review of the Verita report

On 16th September 2016 NSFT's CEO answered questions about the Verita report to Norfolk HOSC. He said that *"all of the recommendations made are already, or will be acted upon"* and he presented an action plan that cited 8 of 16 recommendations were complete. He gave

assurance that NSFT undertook: *"regular analysis of our data and testing for trends and actions that would prevent further deaths".* It is clear from Grant Thornton's report that this is unlikely, given the quality of the raw data, to have happened. Witnesses to HOSC said that unexpected deaths were not discussed in any detail at board meetings because the quality and safety committee held regular meetings to review deaths and we know that the board showing minimal interest in deaths and relying on subcommittees is remains problem. In the same meeting, it was discussed that NHS England had asked NSFT to *"consider the appropriateness of closing an investigation when the cause of death is unknown.* This seems disturbingly similar to the issue raised by Grant Thornton of deaths with no known cause being categorised as 'natural'. It raises the question: "What did NHSE do to assure themselves? We wonder if they raised the concern but did not following up on NSFT's commitments to change.

Recommendation 2 of the 2016 Verita report states:
"The patient safety team should ensure that all unexpected deaths are treated like any other SI in respect of applying the statutory requirements of duty of candour" (p 18) and that this should happen within 3 months. Therefore, Grant Thornton's findings that patient safety and mortality are still treated differently is concerning. We are curious about why this is and what the barriers to change are.

Having looked carefully at the Verita report we have noticed a number of their recommendations do not seem to have been implemented. We will never know what difference it might have made to patient deaths or NSFT's mortality data gathering and use. Nevertheless, we would like someone to review Verita's recommendations and where actions remain outstanding a plan is put in place to implement them. This would need following up to see if this actually happens. There cannot be a repeat of 2016 where promises are made but the changes do not happen.

Questions that need answering

As we have evidenced above, here remain some serious questions that need addressing:

How has mortality data been allowed to be so poor for so long at NSFT?
How will those responsible be held to account?
How can the public be assured that mortality data in future will be accurate?
What does this mean for patient safety?
What else might be happening?
Who will ensure that any improvements are made and sustained?
Who will be overseeing the implementation of the action plan?
What will happen next?

The protracted process of publishing Grant Thornton's report led to questioning from bereaved families and campaigners about why and whether the report has been 'watered down' in the interim. Campaigners challenged this and were assured in writing by the Chairs and CEOs of both ICBs that this had not happened.

"Self-interest and ineptitude at Executive level and a failure to listen and act. Result: systems not fit for purpose."
(A bereaved parent)

We anticipate that the trust will use the gap between Grant Thornton reporting and publication to support claims that they have already made the necessary changes. For example, the creation of Learning from Deaths Forums. The empty rhetoric of changes already being made and tokenistic actions have been repeated in responses to reports on deaths (such as the Verita report), at inquests, or in Prevention of Future Deaths, before. We suggest that the evidence we have presented shows that the problems with mortality are deep-rooted and longstanding. Therefore, even if changes have been made they probably will not be sustained. Additionally, we would question how we or anyone else in the system would know. The only way of knowing this would be if what Grant Thornton looked at was reviewed every 6 months to check for changes and quality control. This needs to be undertaken by people who have sufficient independence, skills, and willingness to challenge.

Wider system accountability

Full scrutiny and accountability for the mortality data

The ICBs, Norfolk and Suffolk Healthwatch, HOSCs and Mental Health collaboratives to monitor the effectiveness and accuracy of NSFT's mortality data and ensure appropriate chains of accountability are in place and will be sustained. The CQC need to ensure that they perform their duties within inspections to examine and challenge mortality data and take action if required.

NHSE need to act on the national issues:

> *"Among the most disheartening features of the post-Francis NHS are recurrent organisational catastrophes … the repeated failure to identify promptly and intervene effectively in the worst of these events, linked to a persistent lack of valid and reliable measures …the NHS's ongoing difficulty in tackling problems of culture and behaviour …the disproportionate representation of vulnerable groups in these disasters …Failure to listen to the voices of patients and carers is a recurrent theme of investigations and avoidable harm – and one that the system seems incapable of heeding"* (Martin, Stanford and Dixon-Wood, 2023).

The above quote resonates with bereaved relatives whose warnings have been ignored and for whom the worst has happened. Grant Thornton's report articulates what they already surmised – that there is a lack of reliable data, problems with the trust culture, and a failure to heed and respond to errors.

NHSE are the overseeing body for NHS digital, NRLS, Better Tomorrow and the NQB. They need to own their failings in determining consistent guidance and systems, monitoring trust mortality figures. They need to set some national definitions, and ways of gathering and

reporting data so that accountability and comparison between trusts is possible. They should be noticing and responding to red flags of mortality spikes and their current processes are demonstrably not fit for purpose.

Transparency about the Better Tomorrow initiative
There needs to be clarity about the scope of *Better Tomorrow's* work with NSFT and the wider system. It is not okay for this important work to be hidden within websites that the public cannot access or for board papers to omit information about this.

Use of this report by system partners
Extensive work that has gone into preparing our response and we hold a system memory. We suspect the 'system' will wish to drop Grant Thornton's report into the pit of inaction and expect the bereaved families to move on. However, we believe this will only lead to more deaths and it is time to do things differently. Invitations from system partners to discuss and review how they will use the findings to improve the commissioning and accountability of services are welcome.

Healthcare Safety Investigations Branch
A copy of this report is being sent to the Healthcare Safety Investigations Branch with a request for them to carry out an investigation into mortality data and processes. Wider system partners need to overtly support this.

Government intervention

MPs and local councillors in Norfolk and Suffolk have been made aware of the concerns around mortality being a system-wide problem over the last decade by campaigners. They have too easily taken the word of the system over the testimonies of bereaved families and campaigners. The exception being Clive Lewis, who has raised several questions in Parliament. More recently our other MPs, Duncan Baker and Tom Hunt, have listened and started to question and challenge platitudes about improvements. We are grateful for their persistence. There have been multiple ministers responsible for health and mental health during this time and they have shown minimal interest even when their own constituents have been affected. In our view, there needs be a strengthening of Parliamentary reporting processes to assist monitoring of NHS trusts mortalities. All the region's MPs and responsible ministers need to work together to ensure improvements are made and sustained.

A statutory independent public inquiry
Grant Thornton say: *"There may be matters, other than those noted on the Report, which might be relevant in the context of the Purpose and which wider scope assessment might uncover"* (p3). We suggest that the issues exposed by this report justify wider and deeper exploration because this relates to deaths and patient safety. We would like to see concrete evidence that the gaps in data and understanding surrounding mortality data is further assessed.

However, we feel that the issues are not just NSFT's failures but symptomatic of a longstanding national problem as evidenced by the CQC *Learning, candour and accountability* report (2017) and the NQB *National guidance on learning from deaths* (2017) and the serious issues with mortality data in Essex. For comparison, Essex has a population of c1.3m and 2000 deaths over a 20-year period. Norfolk and Suffolk have a combined population of neatly 1.7m

and a high but unquantifiable number of deaths. We support both the Essex families and Norfolk and Suffolk campaigners in their calls for statutory independent public inquiries. The Essex MPs who did not believe the bereaved families or advocate for them had to make public apologies. It is disappointing that only 2 MPs attended NSFT's briefing on Grant Thornton's review. This sends a message to their constituents that they are not interested.

The Essex families got their statutory public inquiry on the same day the mortality review was published. They know their inpatient death numbers, we do not. We respectfully suggest that the Secretary of State might want to consider holding a national public inquiry into how mental health trusts gather, report on and, crucially, use mortality data for learning and to prevent deaths.

Active involvement of those in government
Concerns about deaths associated with NSFT, and inadequate practice, have been raised consistently over the last decade. We are grateful to those MPs who have actively involved themselves in calling NSFT to account. However, we feel this serious situation has gone on for too long and it is time for the Department of Health and Social Care, our regions MPs and the Minister for Mental health to be proactive in further exploring what has gone wrong and in ensuring the problems are remedied in a sustainable way.

Meeting with the Minister for Mental Health
We would like the opportunity to meet with our region's MPs and the Minister to discuss Grant Thornton's report and our response. We would like to be part of co-producing any solutions.

Conclusion

We feel we hold the organisational and system memory relating to NSFT's mortality rates and processes. Our view and knowledge is not definitive or complete but we believe it is important and could be helpful to those trying to rectify the problems. One reason for writing such a detailed response is to share our wisdom in the hope of supporting positive change. We would suggest that careful reading of, and reflection on, this report should form an essential for anyone delivering, commissioning, and monitoring mortality recording and reporting. It will be of interest to anyone wishing to understand what Grant Thornton's report and NSFT's responses mean.

The Francis report (2013) identified *"…numerous warning signs which cumulatively, and in some cases singly could or should have alerted the system to problems developing at the Trust"*. We believe that we, along with campaigners, hold the memory of NSFT.

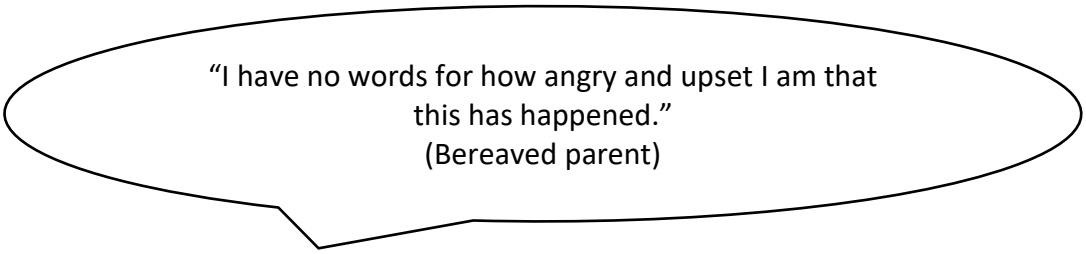
> *"Local scrutiny committees and public involvement groups detected no systemic failings. In the end, the truth was uncovered in part by attention to the true implications of [the Mid Staffordshire General Hospital NHS Trust] mortality rates, but mainly because of the persistent complaints made by a very determined group of patients and those close to them. This group wanted to know why their loved ones had been failed so badly.*" (Francis Report, 2013 Point 1)

If we three ordinary women could see what was going on and challenge it, why couldn't those who are actually responsible? It shouldn't be necessary for bereaved relatives to raise

concerns about things happening in plain sight, or for us to make the referral to the HSIB. There is a system who are responsible for holding to account and who should have intervened years ago.

We acknowledge the limitations of our information and the complexity of the issues. We might be naïve in some respects but our views hold the validity of being experts by experience who have perhaps looked more closely at mortality across a decade than some of those within the system. Our persistence and depth of scrutiny should not be under-estimated because we are motivated by exposure to the devastating consequences of patient deaths.

We recognise that in places this report is emotive. We feel that for the system to acknowledge what is wrong and to embrace change people need to connect to what this means to those who have lost their loved ones. We also feel that any anger bereaved families feel is understandable and justified. Indeed, everyone within the system should feel outraged that people are dying and their deaths are not even being accounted for properly. This is outrageous and it should prompt rapid and decisive change.



We cannot overstate how angry and distressed many bereaved relatives are about the way NSFT have handled the deaths. The findings of the Grant Thornton report offer no reassurance just confirmation that bereaved relatives and campaigners were correct about the chaotic and disrespectful way mortality data is gathered and presented. We are speaking for many bereaved relatives and service-users and carers who fear the death of a loved one may occur. We are determined and persistent and want to know why people's loved ones have been failed by the system. Not because we are vexatious or we enjoy complaining but because too many people have died and by incorporating our knowledge with the issues raised by Grant Thornton there is an opportunity for the system to change and improve.

To reiterate, the Trust's data governance over mortality data is poor and there are no effective controls to ensure the data is reported accurately and reflects the services understanding of patients. Mortality data recording and reporting does not meet the quality expected by NHS England (2018).

Many bereaved relatives perceive NSFT's approach to recording and reporting mortality data as casual and disinterested. They deserve better. Likewise, the public needs assurance that the poor practice surrounding mortality data will stop. Bereaved families should be able to understand mortality process so they can make sense of where their loved one sits within the data if they wish. Those who have died deserve their deaths to be treated with diligence, respect, curiosity, and candour.

NSFT ‘did not recognise’ that there had been over a 1,000 deaths over a nine-year period. They were right because there were indeed many more. We do not think NSFT ‘already knew’ or that Grant Thornton were able to establish a ‘single truth’. We do not think it is acceptable that a review that set out to establish how many deaths there had been at NSFT side-stepped this issue. We can fully understand why Grant Thornton were unable to answer this question but they should have explained clearly the impossibility of this in the context of NSFT’s poor mortality recording. The recording of deaths does not reliably and accurately capture all deaths and the data is incomplete, poorly categorised, lacking in validity and integrity. Therefore, NSFT do not know how many of their patients have died.

It is shocking that NSFT do not seem to know that they don’t know or if they do know they would not step forward with an answer to the question: How many of their patients have died since 2014? We have shown that from the data presented in the Grant Thornton report the numbers are meaningless. Even the best-case scenario is several thousand in the last decade. Each one is a life ended prematurely, someone forever gone, and a death that should not go unnoticed. We will never know how many of these deaths are attributable to the trust due to their data processes. **That is the scandal. No one knows how many have died. There is no way of finding out. This has happened in plain sight of those with a public duty to make mental health services safe.**

Information about report authors

Preparing this report has taken an emotional and physical toll on us. Many hundreds of hours of researching and writing in what should be our leisure time. Emotionally, it has been very difficult delving into the evidence and engaging with traumatically bereaved people. We do this because someone must speak out for those forever gone. We hope our efforts will lead to positive change.

We are three individuals who campaign for safer mental health services and advocate for bereaved families and those trying to access services. We have prepared this report in good faith from information that is available to us. We acknowledge that our analysis might have been different if we had access to the information Grant Thornton did. We have done this on a voluntary basis and we do not represent any organisation that we are, or have, been employed by. Although we have each of us supported the work of the Norfolk and Suffolk Campaign to Save Mental Health Services (the Campaign) in different ways, we have written this report in an independent capacity. Our affiliations with bereaved relatives and advocacy for improved mental health services is far wider than the campaign and indeed many bereaved relatives and families struggling to keep loved ones alive would not wish to be associated with campaigning. We will be sharing this report with the Campaign as an integral stakeholder and anticipate they will formulate their own response to the Grant Thornton report and our response. For clarity we summarise our interests and affiliations below.

Lead authors

Caroline Aldridge is a bereaved mother, mental health campaigner, and social worker from north Norfolk. She is author of *He Died Waiting: Learning the lessons – a bereaved mother's view of mental health services* (2020) and co-author of *They Died Waiting: The crisis in mental health – stories of loss and stories of hope* (Aldridge and Corlett, 2023). Caroline gave evidence to the 2016 Verita report. She is a former member of the Norfolk and Suffolk Mental Health Campaign and a patron of Mental Health Time for Action. Caroline advocates for bereaved people on a voluntary basis. Caroline is an independent trainer and public and patient advisor, her clients include NSFT, Norfolk and Waveney ICB and Suffolk and North Essex ICB. Currently, Caroline is an external project lead for NSFT assisting them to explore how they support their bereaved relatives. She is also chair of an informal group, *Remembering Together*, which aims to improve support for people bereaved due to mental illness.

Anne Humphrys

Anne was a teacher for the best part of 20 years and has two adult children, both of whom have mental health issues. During her children's teenage years, Anne wrote a popular blog about the experiences of mental health care. She has worked both locally and nationally to improve her area's education, social care and health services and co-authored some of the MindEd for families mental health resources. She is a former adviser to the Campaign to Save Mental Health Services in Norfolk and Suffolk. Anne is now an independent advocate for families in the fields of mental health and special educational needs and disabilities and supports young people and their families across the country as a continuation of her work to improve services for adults and young people. She is also carer for her sister who has early onset Alzheimer's and a complex history of trauma which has given her experience in the field of mental health services for older age adults. Anne also lost her brother-in-law through suicide and has represented her sister through the serious incident, complaint and inquest processes as part of this.

Co-author: Emma Corlett

Emma is a Labour Norfolk County Councillor in Norwich and has been a member or substitute member of Norfolk Health Overview and Scrutiny Panel since 2013. She was the Norfolk Member Champion for Mental Health (a non party-political role) from 2013 until the role was deleted in 2021. She was previously Vice Chair of Children's Services Committee and Chaired an in-depth cross-party scrutiny working group on the mental health of children and young people in Norfolk in 2016/2017. Emma worked as a mental health nurse at Norfolk and Suffolk NHS Foundation Trust for seventeen years until 2016. She was a UNISON trade union workplace representative for much of her time at NSFT and was a founder member of The Campaign To Save Mental Health Services In Norfolk And Suffolk.

Emma has advocated for, and supported numerous bereaved relatives over the last decade. She has set up a local charity that does grass-roots work, this includes a community café that aims to tackle the social determinants of poor mental health.

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Appendices

Appendix 1: Letter via email to Norfolk and Waveney and Suffolk and North Essex ICB chairs and CEOs on 9.5.2023.

Dear Zoe, Tracy, Patricia, Ed and Will,

We are writing regarding the Mortality Review to express our concern and disappointment that this has not yet been published.

We know that the initial report was completed and with yourselves in February and that you were waiting for any factual accuracy changes.

We were notified that Norfolk and Waveney ICB stated it would be published in April. NSFT then responded to questions during their public board meeting of the same month, that it would be published in May.

We now understand that there is no publication date and NSFT are saying the decision lies with the ICBs.

Given that the period for factual accuracy checking is long since over, we are deeply concerned about the continued delay and we are fast heading towards the system having had the report for longer than Grant Thornton took to do the work. We are also approaching a year since we travelled to Westminster to meet with MPs and the Minister to raise our concerns.

We would like to ask you to confirm the following:
1) the reasons for the delay
2) the date the report will be published and available to the public
3) the date on which the factual accuracy period ended

We are sure you can appreciate that this does not provide assurance to ourselves, service users, carers and members of the public that the process has been one of transparency or that the system is concerned about the findings of the report. We have long stated that NSFT have no idea about the number of people who have died and people continue to lose their lives and, therefore, the findings of the report are required urgently.

We have collated death numbers and raised concerns about them since the inception of the campaign. In April 2022 we knew the figure to be in excess of 1000 deaths. NSFT refuted this and further research from public documents found over 2600. We also found discrepancies in the figures reported in different official documents. We were under the impression that, as a system, you wanted to provide some clarity in a swift and transparent manner. The continued delays only serve to raise concerns that there is something much more sinister going on with potential collusion across the system to prevent the report being published.

Yours sincerely,
The Campaign to Save Mental Health Services

Appendix 2: Letter from Norfolk and Waveney and Suffolk and North Essex ICB chairs and CEOs replying to the Campaign on 30th May 2023.

Dear colleagues

Thank you for your letter. We understand that the factual accuracy check was completed on Friday, 26 May.

In terms of the number of drafts of the report, there was an original draft produced that was used to assess for factual accuracy. During the checking process, individual facts were checked for accuracy, but a whole new draft of the report was not created when each point was resolved. Once all the factual accuracy matters were agreed, another draft of the report was produced for approval.

It is of course standard practice for an audit like this to go through a factual accuracy check between the auditor and the organisation being audited. It is also standard practice for an action plan to be completed alongside an audit report, and we understand NSFT's action plan will be finalised shortly. When the report and the action plan are both ready, they will be combined to produce the final report, which will be shared with the ICBs and published.

On your final question, we would not and have not watered down the report. Only by understanding a challenge can it be solved, so it is vital we have a full and clear understanding of the situation. We are assured by Grant Thornton that as an experienced, certified and independent auditor, that the process for checking the factual accuracy of the report has complied with the standards expected.

Kind regards

Patricia, Will, Tracey and Ed

Rt Hon Patricia Hewitt Chair NHS Norfolk and Waveney ICB
Tracey Bleakley Chief Executive NHS Norfolk and Waveney ICB
William Pope NHS Suffolk and North East Essex ICB
Ed Garratt Chair Chief Executive NHS Suffolk and North East Essex ICB

Appendix 3: Overview of NSFT mortality data for the past five years

	2018/19	2019/20	2020/21	2021/22	2022/23	Total
Total number of deaths overall from any cause including natural deaths[1] This represents all people who had been cared for as an inpatient and/or known to our community services and who had died whilst under our care or within six months of being discharged. It is important to note that these deaths include deaths from natural causes and don't equate to deaths relating to poor care.	585	2,343	2,951	2,636	2,864	11,379
Total patient safety incident related deaths[2] Number of patient safety incident related deaths investigated. However, it should be noted that following investigation not all these necessarily equate to poor care.	100 Breakdown: 100 - community	82 Breakdown: 76 - community 6 - inpatient	54 Breakdown: 40 - community 14 - inpatient	23 Breakdown: 21 - community 2 - inpatient	12 Breakdown: 9 - community 3 - inpatient	271
Total number of prevention of future death reports received by the Trust This is where the coroner has identified there has been learning for the Trust relating to an individual's care. This data relates to PFDs received within the five-year period, relating to deaths within the five-year period, but the figures are allocated to the year when the report was received and not when the individual died.	1	2	2	5	3	13

Total suicide and 'took own life' conclusions by the coroner of people known to our community services or within six months of their discharge Suicides are multifactorial and do not necessarily relate to poor care. This data relates to individuals who sadly died in this fiveyear period, but the figures are allocated to the dates the coroner inquest took place and not to the year the individual died.	53	53	72	66	15	259
Total suicide and 'took own life' conclusions by the coroner of people under the care of our inpatient services This data relates to individuals who sadly died in this five-year period, but the figures are allocated to the dates the coroner inquest took place and not to the year the individual died.	0	4	1	0	0	5

[1] After 2019/20, access to data from the NHS Spine (a shared data source amongst NHS organisations) allowed the Trust to collect much more data than previously, especially mortality data relating to people who died within six months of discharge from the Trust's care. This explains the rise in numbers between 2018/19 and 2019/20 and subsequent years.

[2] From 1 January 2021, NSFT became an 'early adopter' of the new national Patient Safety Incident Response Framework, which was introduced in a phased way. In the past deaths were considered under the old National Serious Incident Framework and reported through the national system. The new Patient Safety Incident Framework allows for the application of a range of system-based approaches to learning and all deaths are considered as part of a tiered range of reviews according to the Trust priorities, under the Trust Patient Safety Incident Response Plan. This means that a smaller number of deaths than previously are reported on the national system. All deaths are screened, and where appropriate, receive a form of review, such as a Screening Tool, After Action Review, or Safety Incident Review. This difference in approach and type of review limits direct comparisons across the five-year period. The national Patient Safety Incident Framework was rolled out across all NHS organisations from August 2022.

Appendix 4: Care Quality Commission Figures for Routine Inspection Reports

	April 2015 to September 2015	15th January 2015 and 12th March 2016	Since April 2016	During 2015/16	Between April 2012 and December 2015	Between 2012 & 2016	Between 1 April 2016 and 31 March 2017	Between 1 April 2017 and 31 May 2017	October 2018 to March 2019	Between May 2021 to July 2021	Between November 2019 to May 2021	PFDs	Since October 2020
2016 Inspection Report	8,803 incidents reported to NRLS 31 incidents categorised as death 8 resulted in severe harm	215 serious incidents which required further investigation. The majority of these were 'unexpected or avoidable death' at 152 incidents. The majority of	trust confirmed that there had been 55 deaths since April 2016 which were under investigation.	Overall, the trust had improved its reporting rates and had been a good reporter of incidents during 2015/16 when compared to trusts of a similar size.	there had been 686 deaths 405 of these incidents were investigated as serious incidents, as they were not due to natural causes.								

	in the highest 25% of reporters of incidents Trust reported 77% of no harm incidents compared to the national average of 62%	deaths had occurred in community adult services at 61. The majority of inpatient deaths had occurred in acute services at six incidents.		It was noted that the overall rates of severe and moderate incidents decreased during the reporting period.	620 in the community 51inpatient units. 14 had been detained at the time of their death. Overall, it was found that the trust's root cause analysis investigation process met								

					national requirements but improvements were needed to procedures following a death and the actions taken following the investigation.								
2017 inspection report						The trust had also undertaken an internal clinical review of	Reported 9,414 incidents to the NRLS. 48 incidents	27 deaths					

						deaths considered to be due to suicide or as a consequence of self-harm between 2012 and March 2016. The internal report found that the majority of people were under the care of a community or crisis services at the time of or just prior to their	categorised as death six had resulted in severe harm. When benchmarked, the trust was in the highest 25% of reported incidents when compared with similar trusts. reported 78% of no harm incidents which was above the national average.						

						death. Around a fifth of people were awaiting assessment or treatment. A fifth of people had been discharged from a ward for less than six months. The majority had a history of previous attempts, many within three months of their death.	Trust data showed there were 242 serious incidents which required further investigation. The majority of these were 'unexpected or avoidable death' at 184 incidents. 74 community deaths. 22 had occurred						

						However, in some cases there was no risk assessment or care coordinator in place. Approximately half did not have a crisis plan in place. During this inspection we looked in detail at these reviews and the actions the trust had taken. We found	in crisis services. The majority of inpatient deaths had occurred in older people's wards at 17 incidents. 191 incidents related to 'apparent /actual/suspected self-inflicted harm'						

						that work had begun on all required actions, but further work was needed to ensure that there were not missed opportunities.							
2018 inspection report													
2020 inspection report													
2022 inspection report									The trust was rated 'worse'	Between May 2021 to July 2021, mortality	Five coroners' reports were	The trust had received one	the trust had had five

									for consistency of reporting to the National Reporting and Learning System (October 2018 to– March 2019), which showed a downward trend when compared to the previou	rates had recovered to pre-pandemic figures. In the previous three months, August to October 2021, in total 133 people died within six months of contact with trust services. 71 (53%) of those people identified as male and 62 (47%) as female. The mean	submitted to the trust for deaths between November 2019 to May 2021. A further death was currently with the coroner.	prevention of future deaths notification in this reporting period, in July 2021.	deaths in detention, of which all the patients were on unescorted leave.

									s period. There were 115 unexpected or potentially avoidable deaths reported to Strategic Executive Information System (STEIS) from 1 September 2019 to 30 Septem	age of those who died was 67 years. This was slightly younger than had been the trend over the preceding 18 months, 70 years. The ethnicity of the person who died was recorded in 72% of these cases. In all but two cases the person			

									ber 2021.	who died was of a white background, all but six of whom were British. 15 people who were in contact with trust services are thought likely to have taken their own lives in the previous three months. This was not a significant change			

										from the number of people who had taken their own lives over the previous three years. Ten of these 15 people were men and five were women. These people were aged between 18 and 85 years of age, mean 48 years, median 46 years.			

										Where the person's ethnicity had been recorded, all identified as White and British. In all instances where a person takes their own life, the trust carried out an investigation following the principles of root cause analysis to			

										identify changes in local and trust wide practice which might lead to improvements in care and treatment.			
2023 report	0 mention of mortality 0 mention of death												

NHS
Suffolk and North East Essex
Integrated Care Board

Integrated Care Board meeting held on 23 May 2023 at Endeavour House, 8 Russell Road, Ipswich and live streamed for members of the public.

PRESENT:

Prof. Will Pope	Integrated Care Board (Chair)
Kirsten Alderson	Partner Member, Voluntary Community and Social Enterprise (VCSE)
Craig Black	Provider Partner Member – Acute
Steve Clarke	Non-Executive, Finance and Audit
Tanya Curry	Non-Executive, People, Remuneration and Diversity
Ed Garratt	ICB Chief Executive
Stuart Keeble	Suffolk County Council
Howard Martin	ICB Director of Finance
Phanuel Mutumburi	Non-Executive Member, Quality and Safety (Interim)
Nick Hulme	Provider Partner Member – Community
Dr Andrew Kelso	ICB Medical Director
Lisa Nobes	ICB Director of Nursing
Dr Nick Rayner	Partner Member Primary Care Suffolk
Stuart Richardson	Provider Partner Member - Mental Health

REGULAR ATTENDEES:

Maddie Baker-Woods	Director Ipswich and East Suffolk Alliance
Susannah Howard	Integrated Care Partnership Director
Paul Gibara	ICB Director of Performance and Improvement
Amanda Lyes	ICB Director of People and Workforce
Laura Taylor-Green	Director North-East Essex Alliance

OBSERVERS:

Andy Yacoub	Healthwatch, Suffolk

IN ATTENDANCE:

Tom Brown	Green Light Trust
Jo Mael	Corporate Governance Manager (Minutes)
Simon Morgan	Head of Communications

23/051 NOTIFICATION OF ANY QUESTIONS FROM MEMBERS OF THE PUBLIC FOR RESPONSE AT THE APPROPRIATE TIME ON THE AGENDA.

The Chair advised that no questions had been received prior to the meeting.

23/052 WELCOME AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting, and apologies for absence were received from:

Dr Freda Bhatti	Partner Member Primary Care Essex
Sue Cook	Partner Member Suffolk County Council
Dr Ewen Cameron	Provider Partner Member – Acute
Steve Feast	Non-Executive Member, Quality and Safety
Patrick Warren-Higgs	Partner Member Essex County Council

Unconfirmed

Richard Watson	ICB Director of Strategy and Transformation
Peter Wightman	Director West Suffolk Alliance

Other Regular Attendees:

Edward Creasy	Ipswich and East Suffolk Alliance Chair
Cllr Andrew Reid	Integrated Care Partnership Chair, Suffolk

Observers:

Sam Glover	Healthwatch, Essex

The Chair advised that today was the last Board meeting for Steve Clarke, Non-Executive Member for Finance and Audit and Patrick Warren-Higgs, Partner Member Essex County Council. Both were thanked for their contribution to the SNEE ICB Board and wished well for the future.

23/053 DECLARATIONS OF INTEREST AND HOSPITALITY AND GIFTS

No declarations were received.

23/054 MINUTES OF THE PREVIOUS ICB BOARD MEETING HELD IN PUBLIC ON 24 JANUARY 2023.

The ICB Board approved the minutes of its meeting held in public on 21 March 2023 as a correct record**.**

23/055 MATTERS ARISING FROM THE ICB BOARD MEETING OF 21 MARCH 2023 AND REVIEW OF OUTSTANDING ACTIONS.

There were no matters arising and the action log was reviewed and updated.

23/056 GENERAL UPDATE TO INCLUDE UPDATE ON INDUSTRIAL ACTION

The ICB's Chief Executive reported;

- Thanks to colleagues for their support to mitigate risk during the recent periods of industrial action. The BMA had announced further Junior Doctor strikes from 14-17 June.
- Congratulations were extended to the stroke team at West Suffolk NHS Foundation Trust as following a recent audit programme the Trust had been highlighted as giving the highest quality care within the UK in the last quarter and had achieved an 'A' rating every quarter for the last five years.
- A community hub had been launched at Constantine House, Ipswich which brought together community teams, EEAST and 111 providers to, where appropriate, facilitate community support for patients rather than them being conveyed to hospital. The hub reflected closer partnership working and Neill Moloney was thanked for his contribution to the work.
- Reverse job fairs had taken place in Colchester and Ipswich and were planned in West Suffolk that provided an inclusive approach to employment and supported those with learning disabilities and autism. The fairs were reverse in that potential employers visited candidates rather than the other way around and they had been successful and were an innovative approach.
- Amanda Pritchard. Chief Executive of NHS England had recently visited Ipswich Hospital to showcase the work at ESNEFT and open the breast care centre. Meetings had been held with System leaders to discuss planning, finances, waiting list recovery and outpatient reforms and how to accelerate transformation and ambulance performance. There had been positive appraisal of the System.

Unconfirmed

- The ICP was organising an Expo event on 7 July 2023 at Wherstead Park which people were welcome to attend. The theme would be to value every voice in health and care.
- The Chief Executive had earlier chaired a conference on the Care Technology Campus at the University of Essex at which there had been good attendance and the health and social care sector, and industry were keen to progress. It was anticipated that, when appropriate, the Board would receive a future presentation with regard to the testing of new care technology innovations within SNEE and neighbouring systems.
- As a result of recent local elections new Cabinets were being formed and the ICB looked forward to working with them going forward.

The Board received and noted the update.

23/057 IPSWICH AND EAST SUFFOLK ALLIANCE UPDATE: SUPPORTING 'HIGH INTENSITY USERS' WITH THE GREEN LIGHT TRUST

Tom Brown from the Green Light Trust was welcomed to the meeting and proceeded to give a presentation with key points highlighted being;

The Green Light Trust supported those who were the most marginalised and disadvantaged in society and used the natural environment to engage. It targeted those with the highest needs, who were often the most frequent users of statutory services, especially health services.

The Trust was present in Norfolk and Suffolk. Participant Engagement Coordinators directly built a relationship with the individual which endured throughout support. Needs were addressed through purposeful activity with Green Light Trust and/or other organisations. The Trust worked alongside health partners to manage risk and support clinical needs with an aim to reduce dependency and higher needs as they progressed through the Trust's support; reduce the cost of supporting high-cost individuals across the system and to create system capacity by redirecting use of services in third sector activity.

The presentation went on to outline the pathway model and provide detail of examples of impact.

Comments included;

The presentation was welcomed and highlighted what could be achieved if thought was given to working differently as the initiative was life changing. There was challenge to the Board as the work could be relevant, and provide benefit, to many people across the area.

It would be interesting to explore what models might look like for other long-term conditions where public trust had been lost.

The work was an example of where recurrent investment in the voluntary sector had been successful and there was a need to scale up such initiatives and do more to reap benefit.

Having queried whether there were any barriers to access of the service, it was reported that the Green Light Trust had tried to maintain open access to its programmes although with funding via health individuals were being referred. Ideally there would be an established pathway with people able to access the Trust without barrier of assessment. The largest barrier at present was capacity which was dictated by funding. Recurrent funding was key and it was important to get other organisations to deliver as part of the pathway. Transport could be a barrier to access in rural areas.

Unconfirmed

It was queried whether there was potential for the model of care to be affiliated with other organisations in order to enter the prevention space. The Trust did support organisations that worked alongside it and would like to be able to model a way of working that included greater integration with statutory services.

It was suggested that evaluation via the evolving population health management data set might be of benefit and **it was agreed** that the ICB's Director of Nursing, Medical Director, and Partner Members for Suffolk County Council and Mental Health would discuss the use of datasets outside of the meeting.

In response to questioning the Board was informed that within areas such as Ipswich the poorest areas were often the least green areas and there was a need to attempt to influence planning.

The importance of relationships with statutory sector partners other community organisations was recognised.

The Board noted the presentation **and thanked** Tom for his informative presentation which highlighted the work of the Green Light Trust.

23/058 SOUTHEND, ESSEX, THURROCK MENTAL HEALTH STRATEGY COLLABORATIVE

The report provided an update on the development of Southend Essex and Thurrock Mental Health Strategy from 2023 to 2028.

Over the past nine months we had worked with partners across Southend, Essex, and Thurrock (SET), supported by an external consultancy, Tricordant, to:

- Understand the population needs around mental health informed by the Essex Joint Strategic Needs Assessment (JSNA), national and local data and extensive engagement with local professionals, partners and service users.
- Respond to the identified needs within the context of national policy and local ICP strategies through developing a revised 'all age' strategy building on the 2017 version.
- Explore options for working together to support implementation of the strategy.
- Develop supporting enabler and implementation plans.

Key issues were detailed in Section 2 of the report and patient and public involvement in Section 3.

Once agreed by all partners:

a) The Southend, Essex and Thurrock All-Age MH Strategy would be published and shared with the public and partners.
b) The Southend, Essex and Thurrock All-Age MH Strategy Implementation Group would be formally established and would develop a work programme and supporting working arrangements.
c) Regular (six monthly) reports on strategy implementation progress would be produced for each partner.

The Board:

1) **Endorsed** the Southend Essex and Thurrock All-Age Mental Health Strategy, recognising it had been the product of extensive engagement and input from across a diverse range of stakeholders and partners.

Unconfirmed

2) **Agreed and supported** the establishment of the Southend, Essex and Thurrock All-Age Mental Health Strategy Implementation Group, recognising it had been the product of extensive engagement and discussion with partners.

3) **Noted** it would receive regular updates on progress with implementation of the strategy and development of collaborative working arrangements.

23/059 SUFFOLK AND NORTH-EAST ESSEX (SNEE) JOINT FORWARD PLAN (JFP)

As mandated by the Health and Care Act 2022, ICBs and partner NHS Trusts/Foundation Trusts must prepare a five-year Joint Forward Plan (JFP) in collaboration with local Health and Wellbeing Boards (HWBs). The JFP described how Suffolk and North-East Essex Integrated Care Board (SNEE ICB), and its partner trusts intended to arrange and provide NHS services to meet its population's physical and mental health needs and how it would work with partners across the Integrated Care System to achieve that. That included consideration for the delivery of universal NHS commitments and addressing the ICS's four core purposes.

National guidance stated that JFPs must be reviewed and updated or confirmed annually before the start of each financial year. NHSE shared guidance on the development of JFPs with ICBs on 24 December 2022.

The SNEE Joint Forward Plan for 2023-2028 was appended to the report for approval. Engagement that had taken place in respect of the plan was detailed in Section 3 of the report. Once approved, the JFP would be formally published during early June 2023 and thereafter would be refreshed on an annual basis which would include a stocktake of how far we had achieved the priorities set out within the plan.

The Board approved the SNEE ICB Joint Forward Plan (JFP) 2023-2028 as appended to the report.

23/060 DIGITAL AND CARE TECHNOLOGY SERVICES

The national success of the Cassius project and other care technology solutions across the ICS raised pertinent questions about how digital innovations were coordinated across the health and care sectors in the ICS. A review of current practice was jointly commissioned by the ICB, Essex County Council (ECC) and Suffolk County Council (SCC), to be led by SCC on behalf of both local authorities. The report summarised the outcome of that review with key issues including:

Governance needed to give accountability and uniformity at a strategic level, while allowing for ownership and delivery at place. Dedicated resources and capacity to support and facilitate digital change were critical to the right delivery and outcomes – but those were not always present in digital initiatives across SNEE. Accessing clinical and user/practice expertise around digital change initiatives could be challenging, as there was little or limited dedicated capacity in the system.

Multiple digital initiatives existed across the system, delivering innovative practice and good benefits to people and pathways. Those were not all aligned and there was a risk of duplication in both functionality as well as funding support.

The care market was an incredibly important part of the system that we need to work with to achieve best outcomes for people, as well as to maximise capacity to meet needs for everyone. The system might not hold a shared view on its aspiration around the care market, which included the care market itself. There was limited or little opportunity to influence or guide the Department of Health and Social Care (DHSC) strategy to enable the ICB to deliver at place level.

Unconfirmed

The report highlighted the following seven key points that acted as signposts to feed into the next phase of the work and set out a timetable and description of how those recommendations would be delivered.

1. *Establish our conceptual strategic priorities for Digital Data and Technology (DDaT)*
   Agree our high-level ICB DDaT priorities for the next 3-5 years together with a supporting (shared) investment plan and publish widely. All system partners should be 'bought into' the ICB DDaT vision, the concept of our DDaT plan and see those as the North star for decision making.
2. *Streamline governance*
   Develop and agree a system-wide and consistent approach to all DDaT initiatives and how they are signed off.
3. *Rationalise our programmes of work*
   Review all current initiatives against the current landscape to decide which should continue, which should be postponed, and which should now cease or go into business as usual based on our priorities and agreed areas of focus.
4. *Curate a DDaT programme activity list*
   A system-wide view of all digital programmes above a certain threshold should exist centrally as a DDaT programme directory and reference point.
5. *Develop more tangible stakeholder involvement*
   Encourage and develop clinical and patient networks/communities of practice.
6. *Develop DDaT skills*
   Embed digital expertise and knowledge to develop the whole workforce.
7. *Involve the care market more*
   Align care and community providers with the overall DDaT strategy with support from central resources to maximise the adoption and use of technology at scale.

Comments included:

It was queried where we pick up on digital maturity and austerity for people using our services and sought to ensure that people were not left behind. The Board was informed that the Strategic Digital Investment and Assurance Committee (SDIAC) looked at the ethics of digital innovations in health and had started to articulate what ethics looked like. There was a recognised gap and need to be aware that access to digital solutions was challenging. A recent digital assessment had highlighted that the System was better than the national average.

The Health and Inequalities Prevention Board had highlighted the need to ensure side by side conversations across the System, Healthwatch and other system groups and wider forums. Were we maximising opportunity across the System to tackle digital exclusion? Digital exclusion would feature on the agenda for a future planned workshop.

Mention of the voluntary sector with regard to the work was welcomed and, if included, and the sharing of data considered it would become apparent as to how well the voluntary sector could contribute to work. One thing holding the voluntary sector back was being able to present information in ways that the statutory sector could understand. The Department of Health and Social Care had invested money in the development of technology in social care and pilots and it was felt that those pilots should include exploration of support to the voluntary sector and potential benefit. **The ICB's Medical Director agreed** to take the issue forward.

Having made progress with regard to an impact assessment of the digital programme, it was suggested that the System challenge itself to carry out a review as to how it was doing. The **ICB's Medical Director and ICP Director agreed** to take the matter forward.

The Board noted the report **and endorsed** the direction of travel.

Unconfirmed

23/061 SUFFOLK AND NORTH-EAST ESSEX INTEGRATED CARE PARTNERSHIP (ICP) UPDATE

The report provided a brief update on the current work of the Suffolk and North-East Essex ICP.

Key issues discussed at the last ICP meeting held in April 2023 were set out in Section 2 of the report.

The report went on to provide information on further development of the Integrated Care Strategy; the 'Can Do Health and Care' Expo event to be held on 7 July 2023 at Wherstead Park together with other System Learning and 'Thinking Differently Together' Events, and patient and public involvement.

The ICS website set out how colleagues had got involved with partnership and it was pleasing to note that the Health Service Journal had taken time to look at every ICS across the country and the work of its ICPs with SNEE having been ranked top in the country.

The Board noted the content of the report.

23/062 SUFFOLK AND NORTH-EAST ESSEX (SNEE) ICB FINANCIAL PLAN AND BUDGETS 2023/24

The ICB's Director of Finance introduced a report which set out the ICB's Financial Plan and Budgets for 2023/24. The report provided detailed information on the System Plan, the ICB Plan and budget allocation and delegation.

Key points highlighted included;

The 'system' was defined as NHS partner Trusts and the ICB within our system control total; East Suffolk and North Essex Foundation Trust (ESNEFT), West Suffolk Foundation Trust (WSFT), East of England Ambulance Service NHS Trust (EEAST), and the Integrated Care Board (ICB).

The system had submitted a balanced financial plan to NHS England on 4 May 2023.

That was unchanged from the previous submission on 30th March 2023 as the system had already made a significant improvement from the £59m deficit in the draft plan on 23 February 2023.

Delivery of the plan would be challenging with particular focus needed on improving the total £52m underlying deficit position across all partner organisations.

WSFT was planning for a deficit position of £2.7m after receipt of £7m of non-recurrent funding from system partners.

The ICB was planning for a surplus position of £2.7m, EEAST and ESNEFT were planning for a break-even position.

The ICB Finance Committee had played a key role and continued to monitor the situation closely.

<u>ICB Finance plan</u>

The ICB had total funding allocations of £2.08bn, which included an allocation for running costs of £18.8m

The ICB submitted a financial plan with a surplus of £2.6m to NHS England on 4 May 2023, which was after the provision of £6.1m of non-recurrent financial support to WSFT.

Unconfirmed

That was a significant improvement from the £13.5m deficit in the draft plan on 23 February 2023.

The ICB had planned for a surplus position in order to offset the deficit at WSFT and ensure the system could submit a balanced financial plan.

The ICB had met its key statutory duties - was compliant with the Mental Health Investment Standard growth target of 7.1%, met the requirement to stay within the running costs limit for 23/24 and required £13.5m of efficiency delivery (3.1% of influenceable expenditure).

The ICB had approved £12m of its £13.5m Cost Improvement Programme (CIP) and had another £4m of plans drafted or scoped.

There were risks associated to delivery of the plan with the largest being unplanned inflation and delivery of the CIP. The ICB had set aside a reasonable level of contingency and would monitor the situation closely going forward.

Comments included;

The team were congratulated on the work carried out to deliver a collective break-even position. The need to focus on CIP and not management cost reduction going forward was emphasized and recognised.

The whole System needed to have the same robust approach to CIP. In response to questioning the Board was informed that the ICB had set up a process with regard to Equality Impact Assessments although it required further work.

The ICB's Chief Executive advised that if NHS organisations kept financial discipline they could then invest in models such as the Green Light Trust and other community initiatives.

The Board:

1) **Approved** the financial plan for the ICB as presented, and;

2) **Noted the work still required to:**

- Formally approve Budget Delegations to Directors and Committees
- Deliver the required Cost Improvement Programme target on a recurrent basis.
- Mitigate remaining risks.
- Work with system partners towards a sustainable underlying financial position.

23/063 INTEGRATED CARE BOARD PERFORMANCE REPORT

The Board was in receipt of the Integrated Care Board Performance Report with key points highlighted including;

- With regards to performance there was nothing to escalate to the Board.
- The national team had visited with regad to elective recovery and had reported SNEE as a mature system which was good news.
- Tiering was to be a new form of national assessment – Tier 1 was for organisations or systems that required national support, Tier 2 for those that required regional support, and Tier 3 for those that were self-managing and had robust plans in place. As set out within the report the SNEE System had a couple of providers within Tiers 1 and 2.
- The quality performance review was detailed in Section 2 of the report.
- Operational delivery – the ICB had recently published its performance matrix and plan and key performance indicators had been set.

Unconfirmed

- At the previous Board meeting there had been discussion with regard to communications and further narrative was now included within the report as to what the System was doing well and what was not going quite so well. The ICB Team had reached out to Healthwatch colleagues and welcomed their input.

Quality

The ICB's Quality Committee had recently agreed an accountability framework which would provide quality assurance at system level and if felt appropriate it could be presented to a future Board meeting.

Safety – it was felt by the ICB's Medical Director that organisational culture was the strongest predictor of a safe culture. The NHS staff survey had identified that 49% of respondents were not confident organisations would address safety concerns and 42% had not felt confident enough to raise concerns. Those figures did not take into account primary and social care. There was a need for the Board to be aware of that feedback as it formed the main area of work going forward.

The Board received and noted the report.

23/064 BOARD ASSURANCE FRAMEWORK (BAF)

The Director of People and Workforce presented the most recent Board Assurance Framework (BAF).

The BAF Board Development Session held on 18 April 2023 resulted in some changes to the current BAF. One of the key recommendations from the session was to reduce the number of risks to a minimum hence some risks had been merged and individual Provider risks removed. The BAF should now contain only the top strategic risks.

Most Provider risks were now system risks and others had been transferred to directorate risks registers to be managed there. There was to be increased focus on assurance and risks now contained less text and were more succinct.

Importantly, the Audit Committee regarded Board assurance as one of its most important functions and as such, the BAF would be a substantive item on future agendas.

Internal Audit had recommended that we had a greater focus on Risk Appetite. In order that we continued to use our current 4T process in addition to the inclusion of a Risk Appetite for each identified risk included in the BAF, the developed Risk Appetite matrix would be included in the Risk Management Policy and Organisational Framework. That was approved at the April 2023 Audit Committee.

Key issues were detailed within Section 2 of the report.

The aim was that in July 2023 the Board would be presented with an updated refreshed risk framework which incorporated the Board Opportunity Framework.

Having looked at the broader role of sharing information across partners and key areas there was intention to build a suite of dashboards that could be shared with broader ICP partners and provide a view of system assurance issues.

The ICB's Director of Nursing advised that Risk 21 with regard to five special education schools in NEE not having access to school nursing had been transferred to the Essex SEND Partnership Board and hence the Essex County Council risk register.

Unconfirmed

The Board noted and approved the BAF as presented **subject to** amendment to Risk 21 as notified

23/065 READING THE SIGNALS, MATERNITY AND NEONATAL SERVICES IN EAST KENT

The ICB Board was asked to receive the report following correspondence from NHS England. The purpose of the report was to share the key recommendations and learning from the Independent Inquiry into the maternity and neo-natal services provided in East Kent and for the Board to consider the Independent Inquiry recommendations and NHS England's request as of 10 October 2022.

The Independent Inquiry into the maternity and neonatal services provided in East Kent was published on 19 October 2022. The investigation reviewed the maternity and neonatal services provided at two hospital sites within East Kent Hospitals University NHS Foundation Trust between the years 2009 and 2022.

On 10 October 2022, NHS England wrote to trust Chief Executives and Chairs, ICB Chief Executives and Chairs, and the Chair of the Local Maternity and Neonatal System (LMNS).

'We expect every Trust and ICB to review the findings of this report at its next public board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals'.

The report went on to detail the findings of the Inquiry and maternity assurance processes within SNEE ICS.

Comments included;

Having noted comments within feedback from the NHS staff survey associated to staff confidence in bringing forward issues with regard to quality, it was queried whether we knew the position within maternity services. The Board was informed that the NHS staff survey was used to inform. The Care Quality Commission recent assessment which had included the interview of staff had not raised any concerns. The figure reported would be spread and there was continued work to do within ESNEFT which would focus on the culture within maternity services and survey in order to better understand the safety culture.

The Board was informed that ESNEFT held granular information by site, division and clinical group which could be made available.

It was highlighted that those who experienced the worst outcomes were often those less likely to engage and there was a need to facilitate the voice of those people. The System had been nationally recognised for its work in that area and had also commissioned a youth education service that worked with young mothers, and a Roma advocate to support that section of the community through the ante-natal process. Pre-terms birth within the Roma community had reduced since the advocate had been in place. The ante-natal education model would be one universal offer and need to have ambassadors working with communities.

It was important to look at system level data rather than individual providers. There was a need to drill into feedback from the staff survey to see if System level information for maternity was available.

It was highlighted that the SNEE maternity programme had risen to challenge of engagement. Short term funding had been made available and organisations should not forget the importance of learning to address inequalities.

The Board felt assured from information within the report and:

Unconfirmed

1) **Noted** the request made by NHS England in its letter from 10 October 2022.
2) **Noted** East Suffolk and North Essex NHS Foundation Trust (ESNEFT) and West Suffolk Hospital (WSH) had presented their review of maternity and neonatal care against the recommendations to their trust boards as per the NHS England letter of 10 October 2022.
3) **Considered** the recommendations from the Independent Inquiry and the process in place to meet those recommendations.
4) **Noted** that ESNEFT maternity service Care Quality Commission report was published 5 May 2023 and was rated 'requires improvement' for the safe and effective domains.

23/066 ICB GOVERNANCE SELF-ASSESSMENT

ICBs had specific features and flexibilities within their governance arrangements, reflective of their role in bringing local NHS organisations together to plan how to meet the healthcare needs of their population and to work with local government and other partners to improve population health outcomes. It was for individual ICBs to decide how to use those decision-making features and flexibilities to best achieve their goals.

NHS England now expected ICBs to conduct periodic self-assessment of those arrangements – including a process for gathering and acting upon 360-degree feedback from partners – to help identify opportunities to strengthen relationships and collaboration and optimise decision-making and implementation within the context of partnership.

The self-assessments were intended to inform the work of the ICB to ensure decision-making arrangements remained effective as the ICS evolved and that they were best enabling integrated, system-based working and in turn, improvements in care and outcomes for the local population.

It was considered particularly relevant for ICBs to review their partnership governance arrangements this year following a period of establishment and transition, the development of the first Joint Forward Plan and further delegation of functions from NHS England. As such, it was expected that the ICB self-assessment process would commence from Q3 2023-24 although dates were flexible in order to meet the needs of individual organisations.

The report went on to outline key issues, suggested areas of self-assessment focus, the development process, next steps and proposed timeline.

Comments included;

It was mentioned that June 2023 felt early to be able to assess how well the Board was working. It was important to make the assessment real and test in real time. The Board was on a journey of maturing and September 2023 would be an appropriate time to embrace the concept of a maturing board and review how it had dealt with the assessment.

There was opportunity to also look at Care Quality Commission and NICE statements and their impact with regard to the domains.

Other areas included how the ICB worked with system framework assessments, the quality of discussion and robustness of conversation and how to measure the diversity of conversations.

It was suggested that completion of the NHSE quality development toolkit might contribute to discussion. The quality of the ICS required balance of new and old power and consideration should be taken as to how we felt, relationships and working together. As we were coming up to the Board's first anniversary it was important to check how we are feeling.

The Board noted the outline of the NHS England ICB self-assessment requirement and next steps and timeline.

Unconfirmed

23/067 APPOINTMENT OF A FOURTH NON-EXECUTIVE MEMBER (NEM)

The report sought endorsement of a decision made by the Remuneration and Human Resources Committee to approve the appointment of a fourth Non-Executive Member.

At its meeting held on 27 September 2022, the ICB Board had agreed that the number of Non-Executive Members (NEMs) should be increased to four, that decision having been based upon a detailed report around Board capacity and diversity.

Recruitment to the additional NEM position was initiated in April 2023 with it being reported for noting to the Remuneration and Human Resources Committee on 2 May 2023.

In view of the cost savings currently being identified, the Chair of the Remuneration and Human Resources Committee requested than an options appraisal be undertaken, prior to appointment of a fourth NEM, to ascertain whether there were other possibilities to address the capacity issue. The various options considered were set out in Section 4 of the report.

The options appraisal was considered by the Remuneration and HR Committee via a virtual meeting with members approving the original decision of the Board to appointment a fourth NEM. As such, it was recommended that the Board be asked to endorse the decision of the Remuneration and Human Resources Committee and again approve the appointment of a fourth NEM.

The Board was informed that discussion at the Remuneration and HR Committee had centred around the ICB being an outlier and what actions should be taken in light of the challenging environment and need to reduce running costs. The need for appropriate and correct communications had been emphasized.

It was queried how the report sat with the previous paper regarding self-assessment and governance of the board. There was a need to reflect on whether the independent voice was being heard enough.

The Board subsequently re-affirmed its previous approval of the appointment of a fourth Non-Executive Board Member.

23/068 POLICIES FOR APPROVAL

The Board was in receipt of the following policies that had been recommended for approval by the ICB's Remuneration and HR Committee at a meeting held on 7 March 2023 and virtual meeting held on 5 April 2023, the Audit Committee at a meeting held on 13 April 2023, and Quality Committee held on 11 May 2023.

Policies and recommendations as follows:

1. Dealing with concerns around conduct – (Remuneration and HR Committee 7 March 2023)
2. Domestic Abuse Policy – (Remuneration and HR Committee 7 March 2023)
3. Agile Worker Policy – (Remuneration and HR Committee 7 March 2023)
4. Social Media Policy – (Remuneration and HR Committee 7 March 2023)
5. Fit and Proper Person Policy – (Remuneration and HR Committee virtual meeting 5 April 2023)
6. Continuing Healthcare One to One Policy – (Audit Committee 13 April 2023)
7. Norfolk and Suffolk NHS Continuing Healthcare Joint Working Policy – (Quality Committee 11 May 2023)

Unconfirmed

Having queried whether such policies should be brought to the Board for approval and whether it was more appropriate for sub-Committees to sign them off, **it was agreed** to review the terms of reference of various committees in respect of the approval of policies.

It was noted that the Equality, Diversity and Inclusion workplan would be coming back to the Board and would include a commitment to review policies. There was a need to ensure the correct checks and balances were in place.

The importance of facilitating staff networks to challenge and review policies was emphasized.

The fact that different NHS organisations had different policies was questioned and it was felt there was need to pursue the development of ICB policies for use across the System. It was noted that any progress in that area would be dependent on support from leaders at the acute Trusts in order to facilitate.

The Board approved the policies as presented.

23/069 DECLARATIONS OF INTEREST

The Board was presented with the current SNEE ICB Declarations of Interest register following the April 2023 request. The register provided a public record of relevant and material interests declared by members of the Integrated Care Board, its sub-committees, and decision-making staff. Also attached to the report was the current Gifts and Hospitality Register.

The ICB Board was asked to review the register and consider whether any action was required prior to it being placed on the SNEE ICB website.

The Board noted and reviewed the current SNEE ICB Declaration of Interest Register as attached to the report **and agreed** its publication.

23/070 COMMITTEE MINUTES AND HIGHLIGHT REPORTS

The Board received and noted minutes and highlight reports from the following ICB Sub Committees*:*

a) **Audit Committee**
The unconfirmed minutes of a meeting held on 13 April 2023.

b) **Remuneration and HR Committee**
Decision notice from a virtual (email) meeting held on 5 April 2023, the unconfirmed minutes of a meeting held on 2 May 2023, and decision notice from a virtual (email) meeting held on 9 May 2023.

The Committee Chair reported that discussion had centred on culture and moral and how it felt for staff; focus on industrial action and system response; and robust discussion with regard to the non-executive additional role.

c) **Finance Committee**
The minutes of meetings held on 14 March and 11 April 2023

d) **People Committee**
The unconfirmed minutes of a meeting held on 19 April 2023

e) **People and Communities Committee**
The minutes of meetings held on 1 March 2023 and 5 April 2023

Unconfirmed

f) **Estates Committee**
Highlight report from March and April 2023 meetings.

The Board was informed that the Estates Infrastructure Strategy would be presented to a future Board meeting.

23/071 ATTENDANCE LOG

The Board received and noted the current attendance log.

23/072 ANY OTHER BUSINESS

1) **Non-Executive Recruitment** – there was a need to ensure the recruitment process was done in the most effective way to obtain diversity.

2) Once again, the thanked Steve Clarke, Non-Executive Member for Finance and Audit and Patrick Warren-Higgs, Partner Member Essex County Council for their contribution to the SNEE ICB Board and wished them well for the future.

23/073 DATE AND TIME OF NEXT MEETING

Scheduled Dates:

20 June 2023 – Extraordinary meeting.
25 July 2023

23/074 QUESTIONS FROM THE PUBLIC – MAXIMUM 10 MINUTES

The following questions were received:

Question from Ms B Robinson

Health Inequalities sub-committee referenced in 5 year Forward Plan

As a priority condition with national identified significant unmet needs (ME and CFS), ICBs had been tasked by NICE to develop a delivery plan which SNEE had done. With priority listing within the SNEE ICS 5 year Forward Plan, would co-producers for the ME service be invited to be part of the above sub-committee?

1. What were the Terms of Reference for this sub-committee please?
2. Who had been appointed to date and when were meetings scheduled?

Response:

The ICB's Chief Executive agreed that a written response would be provided outside of the meeting.

Question from Cllr Michael Nimmney

Following questions put at a previous Board meeting the Ipswich and East Suffolk Alliance Director had met with three patient participation groups in Felixstowe to respond to questions with regard to local population growth and use of CIL funding.

The local population was anticipated to increase by 10,000 over the next local plan period and surgeries were already over-subscribed. Having investigated the use of CIL monies associated to the Poppyfields site it seemed that 60% had been allocated for pre-primary school and primary school provision which did not leave much for secondary education,

Unconfirmed

health, highways, sports etc. It was queried how East Suffolk District Council had set a levy that had resulted in Felixstowe receiving the least of all of the sub districts with regard to CIL monies to meet primary care needs within the community. It was queried whether CCGs had had separate S106 agreements? and what was being done to ensure people that lived in Felixstowe were getting the health care they deserved.

Response:

Detailed work was currently being carried out to understand demand and what was forecasted and as previously advised, an interim report would be available in June 2023. There had also been conversations with regard to engagement with the local community and the seeking of views on need. There was also ongoing dialogue with Estates and East Suffolk District Council, together with engagement with the League of Friends and colleagues at ESNEFT. Whilst not able to answer all questions, assurance was provided that the work was ongoing and further information with regard to the findings and next steps would be made available when known.

Mr Nimmney reported concern that CIL was least for Felixstowe and questioned what the Board could do. Having queried whether any future report could address those issues, the Ipswich and East Suffolk Alliance Director reported that S106 was one source of funding. It should be recognised that as ICB capital resources were challenged there was a need to prioritise, and contribution from local authority partners would be important.

Question from Mr Michael Taylor

Having listened to the item on digital inclusion, it was important that there was recognition that a proportion of the population did not adopt it and the need to be inclusive was emphasized. Digital links between local authorities and the NHS were important and it would be interesting to understand the link between primary and secondary care and its effect on the outpatient waiting list. Was there a programme to get digital applied in primary care to drive down waiting lists within the acutes?

The ICB's Medical Director agreed to provide a written response to Mr Taylor outside of the meeting.

It was important that although it was digital first, it should not be digital only and a non-digital option should also be available. It was important to have links between primary care and the acute hospital so that information could be seen in whatever area of the health system you were in so that people had all the information available before making referral. A lot more work was required to facilitate good community based information.

Unconfirmed

NHS
Suffolk and North East Essex
Integrated Care Board

Integrated Care Board 'Extraordinary' meeting held on 20 June 2023 held via MS Teams and live streamed for members of the public.

Unconfirmed

PRESENT:

Prof. Will Pope	Integrated Care Board (Chair)
Dr Ewen Cameron	Provider Partner Member – Acute
Sue Cook	Partner Member Suffolk County Council
Peter Devlin	Partner Member Essex County Council
Geoff Dobson	Non-Executive, Finance and Audit (Interim)
Ed Garratt	ICB Chief Executive
Howard Martin	ICB Director of Finance
Nick Hulme	Provider Partner Member – Community
Dr Andrew Kelso	ICB Medical Director
Dr Nick Rayner	Partner Member Primary Care Suffolk
Stuart Richardson	Provider Partner Member - Mental Health

REGULAR ATTENDEES:

Paul Gibara	ICB Director of Performance and Improvement
Amanda Lyes	ICB Director of People and Workforce
Laura Taylor-Green	Director North-East Essex Alliance
Cllr Andrew Reid	Integrated Care Partnership Chair, Suffolk
Richard Watson	ICB Director of Strategy and Transformation
Peter Wightman	Director West Suffolk Alliance

OBSERVERS:

Sam Glover	Healthwatch, Essex

IN ATTENDANCE:

Jo Mael	Corporate Governance Manager (Minutes)
Simon Morgan	Head of Communications

23/075 NOTIFICATION OF ANY QUESTIONS FROM MEMBERS OF THE PUBLIC FOR RESPONSE AT THE APPROPRIATE TIME ON THE AGENDA.

The Chair advised that two questions had been received prior to the meeting, which would be progressed in the final agenda item.

23/076 WELCOME AND APOLOGIES FOR ABSENCE

The Chair welcomed Geoff Dobson and Peter Devlin to the meeting, and apologies for absence were received from:

Kirsten Alderson	Partner Member, Voluntary Community and Social Enterprise (VCSE)
Dr Freda Bhatti	Partner Member Primary Care Essex
Tanya Curry	Non-Executive, People, Remuneration and Diversity
Steve Feast	Non-Executive Member, Quality and Safety
Phanuel Mutumburi	Non-Executive Member, Quality and Safety (Interim)
Lisa Nobes	ICB Director of Nursing

Other Regular Attendees:

Maddie Baker-Woods Director Ipswich and East Suffolk Alliance
Susannah Howard Integrated Care Partnership Director

Observers:

Edward Creasy Ipswich and East Suffolk Alliance Chair
Andy Yacoub Healthwatch, Suffolk

23/077 DECLARATIONS OF INTEREST AND HOSPITALITY AND GIFTS

No declarations were received.

23/078 2021-22 CCGs ANNUAL REPORTS AND ACCOUNTS

The NHS Suffolk and North-East Essex ICB (SNEE ICB) was the successor body to NHS Ipswich and East Suffolk CCG, NHS North-East Essex CCG and NHS West Suffolk CCG (the SNEE CCGs). In its capacity as successor body, the Board of SNEE ICB had the authority to approve the SNEE CCGs Annual Reports and Accounts, for any outstanding periods before their demise.

The 2021-22 Annual Reports and Accounts of the three SNEE CCGs had been presented to the SNEE ICB Audit Committee on 13 April 2023. That resulted in a recommendation to the SNEE ICB Board that the Annual Reports and Accounts were considered for approval. The ICB Board approved the Annual Reports and Accounts at a part 2 'private' Board meeting on 23 May 2023.

The SNEE CCGs 2021-22 Annual Reports and Accounts should have been approved by the national deadline of 22 June 2022 (prior to the establishment of the ICB). That deadline was not achieved due to issues surrounding an irregular payment, that related to an exit package, of which part should have been disclosed as a special payment. The SNEE CCGs applied for retrospective approval of the special payment, but that approval was not granted by HM Treasury.

HM Treasury communicated that it would not provide retrospective approval of the special payment in November 2022. Unfortunately, due to resourcing issues, BDO (the CCGs external auditor) were unable to complete the SNEE CCGs audits until March 2023.

BDO had issued an unqualified audit opinion on the financial statements of all three CCGs. However, due to the unapproved special payment, BDO had issued a qualification of the regularity opinions of all three CCGs, to reflect the breach of statutory regularity duty. Because of that, BDO had also issued a separate s30 Referral Letter to the Secretary of State for each CCG. The actual date opinions were issued was 2 June 2023 (NHS Ipswich and East Suffolk CCG) and 7 June 2023 (NHS North-East Essex CCG and NHS West Suffolk CCG).

Further details of the outcome of the SNEE CCGs audits were included in the attached Joint Auditor's Annual Report.

The Board noted the 2021-22 Annual Report and Accounts for the three demised SNEE CCGs **and thanked** the ICB's Finance Team for their work in producing the documentation.

23/079 SNEE INTEGRATED CARE BOARD (ICB) BUDGETS 2023/24

The Board was in receipt of a report which set out the ICB budgets for 2023/24.

Unconfirmed

The financial plan had been approved by the Board on 23 May 2023. The associated budgets including those to be delegated to committees were now submitted to the Board for approval. The proposed budgets had been reviewed by the Executive Committee and the Finance Committee and were net of the Cost Improvement Programme (CIP) approved by the Financial Recovery and Sustainability Group as of 7 June 2023.

The Board:

1) **Approved** the proposed budgets including director budgetary responsibility as presented.
2) Approved the budgets to be delegated to committees and any relevant delegation to sub-groups as presented.

23/080 ANY OTHER BUSINESS

The Board congratulated Ed Garratt on award of an OBE in the recent Kings Honours List which was a credit to him and his leadership within the system.

Ed thanked the Board for its support and said that he was both humbled and proud to receive the award which was reflective of the great partnership working and leadership within the whole system.

23/081 DATE AND TIME OF NEXT MEETING

Scheduled Dates:

25 July 2023

23/082 QUESTIONS FROM THE PUBLIC – MAXIMUM 10 MINUTES

The following questions were received from Mr Anthony Dooley:

Question 1:

Given your acknowledgment of the reduction in funding allocated to the ICS from what was originally proposed, and other financial reductions such as was planned to promote walking and cycling what do you anticipate will be the impact on services within the 5 areas you claim to wish for improvements for our population?

Response:

It is true that the financial position of this system is financially pressured as is common across the NHS. However, none of our saving programmes are targeted at seeking reductions in health prevention spending, in fact we have been able to secure some £3.9m of funding towards the aim of reducing health inequalities in our populations.

Question 2:

Could you indicate how much of the budget will go towards payments for past Private Finance Initiatives, in the current financial year, and how that compares with previous financial years? Also, if the current new build at Ipswich Hospital is being financed through a PFI arrangement what will the cost implications be for this and future financial years? What is the cost of the new build, and what will be the actual cost at the end of the PFI term?

Response:

Unconfirmed

The SNEE system has a very low current and historic utilisation of PFI, totalling only £1m. No new build proposal in this system will be funded from PFI. The Chief Executive of ESNEFT reiterated that there had only been one instance of PFI at Ipswich Hospital which was reviewed each year. All subsequent new builds at both Ipswich and Colchester hospitals had been subject to treasury finance and not PFI.

No further questions had been received from the public during the meeting.

Unconfirmed

NHS
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ICB BOARD
ACTION LOG: 23 May 2023 (Updated)

MINUTE	AGENDA ITEM	ACTION	RESPONSIBILITY OF:	TIMESCALE/UPDATE
Meeting of: 24 January 2023				
23/022	Policy Endorsement	It was suggested that attempt be made to align policies across the System where appropriate. It was explained that these were legacy policies but going forward it was recognised there was a need to better align policies and the ICB's Director of People and Workforce agreed to take the suggestion forward via the People Committee.	Amanda Lyes	17/4/23 - This was raised at the People Committee on the 15 February 2023 and was agreed that further conversations were needed via the System HRD forum. This is ongoing and as policies are developed/reviewed good practice from partners will be taken into account to help shape.
Meeting of: 21 March 2023				
23/035	Suffolk and North-East Essex (SNEE) Alliances – Focus on West Suffolk Alliance - Physical Activity Pathways And Health	Co-location was recognised as a significant opportunity for the whole system especially as the primary care estate was constrained. The ICB's Director of People and Workforce agreed to take the issue forward for consideration by the ICB Estates Committee. prior to providing report back to a future Board Development Session.	Amanda Lyes	On Estates Committee Forward Plan for May 2023 - **Complete**
23/037	Integrated Performance Report	1) The ICB's Director of Performance Improvement agreed to take the issue of ensuring that patients waited well via the Elective Recovery Committee.	Paul Gibara	**Complete**
Meeting of: 23 May 2023				
23/057	Ipswich and East Suffolk Alliance Update: Supporting 'High Intensity Users' With The Green Light Trust	It was suggested that evaluation via the evolving population health management data set might be of benefit, and it was agreed that the ICB's Director of Nursing, Medical Director, and Partner Members for Suffolk County Council and Mental Health would discuss the use of datasets outside of the meeting.	Lisa Nobes/Andrew Kelso/Stuart Keeble/Stuart Richardson	June 2023
23/060	Digital and Care Technology Services	1) The Department of Health and Social Care had invested money in the development of technology in social care and pilots and it was felt that those pilots should include exploration of support to the voluntary sector and potential benefit. The ICB's Medical Director agreed to take the issue forward.	Andrew Kelso	**Complete**

MINUTE	AGENDA ITEM	ACTION	RESPONSIBILITY OF:	TIMESCALE/UPDATE
		2) Having made progress with regard to an impact assessment of the digital programme, it was suggested that the System challenge itself to carry out a review as to how it was doing. The ICB's Medical Director and ICP Director agreed to take the matter forward.	Andrew Kelso/Susannah Howard	
23/068	Policies for Approval	Having queried whether such policies should be brought to the Board for approval and whether it was more appropriate for sub-Committees to sign them off, it was agreed to review the terms of reference of various committees in respect of the approval of policies.	Amanda Lyes	Quality and Remuneration and HR Committee TOR to be amended in respect of approval of policies - **Complete**
23/074	Questions from the Public	<u>Question from Mr Michael Taylor</u> Having listened to the item on digital inclusion, it was important that there was recognition that a proportion of the population did not adopt it and the need to be inclusive was emphasized. Digital links between local authorities and the NHS were important and it would be interesting to understand the link between primary and secondary care and its effect on the outpatient waiting list. Was there a programme to get digital applied in primary care to drive down waiting lists within the acutes? The ICB's Medical Director agreed to provide a written response to Mr Taylor outside of the meeting.	Andrew Kelso	Response sent to Mr Taylor 7 July 2023 - **Complete**

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ICB BOARD

Agenda Item No.	**08**
Reference No.	**ICB 23-47**
Date.	**25 July 2023**

Title	**Improving Access to Dentistry**
Lead Director	Howard Martin, Director of Finance
Author(s)	Lizzie Mapplebeck, Associate Director of Strategic Change & Greg Brown, Senior Performance Improvement Manager
Purpose	For Information

Recommendation:

It is recommended that the ICB note the content of this report.

1. Introduction

1.1 Oral health is a key aspect of general health and wellbeing, with good oral health being linked to good quality of life. Oral health directly affects an individual's quality of life.

1.2 There have been longstanding issues with NHS dental access including NHS routine dental care and urgent dental care. This problem has been amplified by the current COVID-19 pandemic.

1.3 The pain experienced with dental problems such as toothache or abscess can be considerable, intractable and distressing, and might lead sufferers to extreme measures to address pain if urgent dental care is not available. Examples include DIY dentistry and overdoses of paracetamol, which in turn increases pressure on urgent and emergency care. There are also wider societal impacts and costs that arise when people cannot access urgent care, such as increased demands and pressures placed on the wider health care system such as accident and emergency and primary care services.

1.4 There are 172 dental practices in North East Essex and 114 dental practices in Suffolk; however, 397,000 residents are not able to access a dentist in a 15-minute walk and 98,000 residents are not able to access a dentist by public transport in 30 minutes.

1.5 Several large Suffolk and North East Essex dental practices have closed or have transferred to largely private practices and many general dental practices are not taking new NHS patients. The historic payment rate for Units of Dental Activity is low in SNEE and therefore the market is shrinking. Dentists are less keen on being partners and many now prefer salaried employment. Previous NHS procurements had therefore shown a limited response from the local dental market.

1.6 From a population perspective, 31% of the Suffolk and North East Essex population unsuccessfully tried to get an appointment in the last two years, 9% more in comparison to the rest of England.

1.7 Suffolk and North East Essex Integrated Care Board (SNEE ICB) received delegated authority from NHS England (NHSE) on 1st April 2023 to commission dental services. In preparation for the delegation and since delegation, SNEE ICB have been working with local providers, Public Health Suffolk, Public Health Essex and in partnership with the University of Suffolk, University of Essex, regional dentists, Health Education England, NHS England and local MPs to develop solutions to the present oral health crisis in the short, medium and longer term. The approach has followed the NHS England dental priorities, which encourage the need for reform and a focus on tackling health inequalities:

- To reduce oral health inequalities and improve oral health in children under the age of five
- Flexible commissioning
- To oversee national dental access and address area of weakest dental provision
- To ensure a consistent and fair approach to contract performance management is applied nationally to dental contracts
- Dental contract reform

As a system, we wanted to create a new service grounded in education and preventative care:

- We wanted to take a unique, innovative approach to increasing NHS capacity by growing and upskilling the local dental workforce through education and training
- We wanted mandatory services with a focus on prevention as well as treatment

- We wanted a 'NHS only' focus (no private treatment allowed) with all profits reinvested in improving oral health
- We wanted a focus on skills development within the wider dental workforce utilising full scope of practice of dental care professionals

1.8 We believe that education and continuing professional development are key incentives for recruiting and retaining our workforce.

1.9 This report updates the Suffolk and North East Essex Integrated Care Board on a new NHS dental commissioning contract which was recently approved for implementation on 12 July 2023. The programme will contribute to the SNEE ICB vision for dentistry: *Routine and urgent NHS dental care is available to all who want or need it in Suffolk and North East Essex.*

2. New Dental Contract Award

2.1 On 12 July 2023, and following a procurement process, the SNEE ICB Board approved the award of an innovative, nationally unique model to start to address the dental crisis by simultaneously increasing access to NHS dental treatment and increasing and upskilling the local dental workforce through education and training.

2.2 The contract 'SNEE NHS Primary Care Dentistry supporting Dental Workforce Training and Education' will provide an NHS only service (no private practice) to the population (both adults and children) of SNEE ICB to address oral health needs with a focus on prevention. The service will utilise a skilled multidisciplinary team, covering all proper and necessary dental care and treatment.

2.3 The dental training and education element (commissioned separately by Health Education England (HEE)) includes offers around post graduate educational opportunities as well as wider training opportunities for newly qualified dentists alongside training of dental nurses, therapists and hygienists.

2.4 The contract is for five years in the first instance with the option available to both parties to extend for up to a further two years by mutual agreement. The contract value is £2,200,000 per year which will provide ten fully equipped dental surgery units providing of 5,200 sessions per year which equates to 18,000 hours of dental appointments in year one and then increasing further as we move to a seven days' service.

2.5 The contract does not use Units of Dental Activity (UDAs) as the metric for payment. It is widely accepted that the UDA model is not fit for purpose, this has been clearly cited in the current, ongoing Parliamentary Dental Enquiry. For the 60 years that NHS dentistry has been in existence, many argue that the focus of the service has been mainly on treatment rather than prevention or quality.

2.6 Rather, the contract value is based on sessions. This will not only pay fairly for dental treatment but also reward quality and preventative dentistry and promote good oral health, offering a patient pathway built around prevention, high-quality treatment and continuing care. Because of the long-term impact of dental disease, making provision for its prevention is good for the patient and the commissioner, minimising the long-term damage to oral health and its cost.

2.7 The service will provide a choice of appointments, including evenings and weekends as well as weekday daytime access. There will be at least 50 appointments each week for unscheduled care for patients not currently undergoing a course of treatment with the service but who require urgent treatment, these patients will be triaged by 111.

2.8 A percentage of appointments will be made available to patients undertaking treatment for Rheumatology, Oncology or Cardiology in our local acute Hospitals and patients residing in local care homes.

2.9 The service will look to provide the opportunity for overseas dentists currently residing in England to practice under supervision alongside completing the Overseas Registration Examination (ORE). The General Dental Council (GDC) require the provider to have 'institution' status to host overseas dentists. Currently only the acute trusts across Suffolk and North East Essex have this status; however, locally we hope to see national policy change to expand this to universities.

The procurement process and timeline are as follows:

January 2023: The ICB Executive Committee were presented a set of options. The option selected was to commission a nationally unique solution to the dental access challenge by simultaneously increasing access to NHS dental treatment and increasing and upskilling the local dental workforce through education and training. The approval of this option provided authorisation for the development of the detailed service specification and procurement options
6 March 2023: The SNEE ICB Executive Committee approved the detailed service specification. At this point three procurement options were presented to the Executive Committee for commissioning the service specification, the Executive Committee agreed to proceed with Option b: to issue a Prior Information Notice (PIN)
9 March 2023: The PIN was published on the .gov portal
31 March 2023: The PIN closed on 31st March 2023, running for a total of 19 calendar days. In total three organisations expressed an interest in providing the services. Following discussions with each of the organisations that expressed an interest, only one confirmed they would be able to deliver the service specification
1 April 2023: SNEE ICB receives delegated authority to commission dental services
18 April 2023: A Voluntary Ex Ante Transparency (VEAT) Notice was issued to notify all potential suppliers / providers of the ICBs intention to award the contract to the University of Suffolk Dental Community interest (pending Board approval). The VEAT Notice was open to challenge for 10 days
28 April 2023: VEAT closed. No challenges were received
12 July 2023: ICB Board approved the award of the contract

2.10 The contract has been awarded to the University of Suffolk Dental Community Interest Company and will be based on Ipswich Waterfront. The social enterprise model will ensure that all profits are reinvested to improve local oral health and will place emphasis on generating social value. The new service is planned to open to the public in December 2023.

3. Recommendation

3.1 It is recommended the ICB Board note the content of this report and the progress being made to improve access to NHS dental services in SNEE, with the new service to be based in Central Ipswich, an area of significant economic deprivation.

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ICB BOARD

Agenda Item No.	**09**
Reference No.	**ICB 23-48**
Date.	**25th July 2023**

Title	**Developing People led approaches to Health and Wellbeing**
Lead Director	Laura Taylor-Green, North East Essex Alliance Director
Author(s)	Ben Hughes, Head of Wellbeing and Public Health: Safer Essex, Health and Justice, Risk Behaviours
Purpose	To receive a presentation about the innovative people and communities led approach to commissioning in Essex

Recommendation:

To note the presentation

ECC Wellbeing, Public Health and Communities

Developing People Led Approaches to Health and Wellbeing

Empowering communities to make the change

Ben Hughes. Head of Wellbeing and Public Health, ECC.

Essex County Council

Just one example – but what an example!

- From a recognition that we needed to put people at the heart of decision making
- Created the **Essex Recovery Foundation** - Charitably Incorporated Organisation
- A Board comprising people with lived and living experience
- Chaired by “A Man in Recovery”
- Recovery Advisory Committee
- Jointly chairing Essex Joint Commissioning Group and Lived Experience Lead on SET Drug and Alcohol Partnership Board
- Commissioned the recent Needs Assessment – supported by peer research training
- Taking a dynamic long term view of needs assessment
- In their own words

“Take a brave and radical approach to commissioning”

The Community's 5-Year Framework

THE CYCLE OF GROWTH AND CHANGE:

This is an ongoing process that will develop over the next five years.



That Brave and Radical Approach to Commissioning

AIM #2: TAKE A BRAVE AND RADICAL APPROACH TO COMMISSIONING

We aim to transform the commissioning process and ensure that the recovery community influence key decisions around commissioning services, with support from Essex County Council.

INFLUENCING LIFE-CHANGING SERVICES

Actions

- Create a new commissioning process led by the recovery community
- Be transparent about the commissioning process for addiction services
- Award contracts based on evidence and community support
- Ensure that all involved feel confident and empowered to participate in the commissioning processes

Outcomes

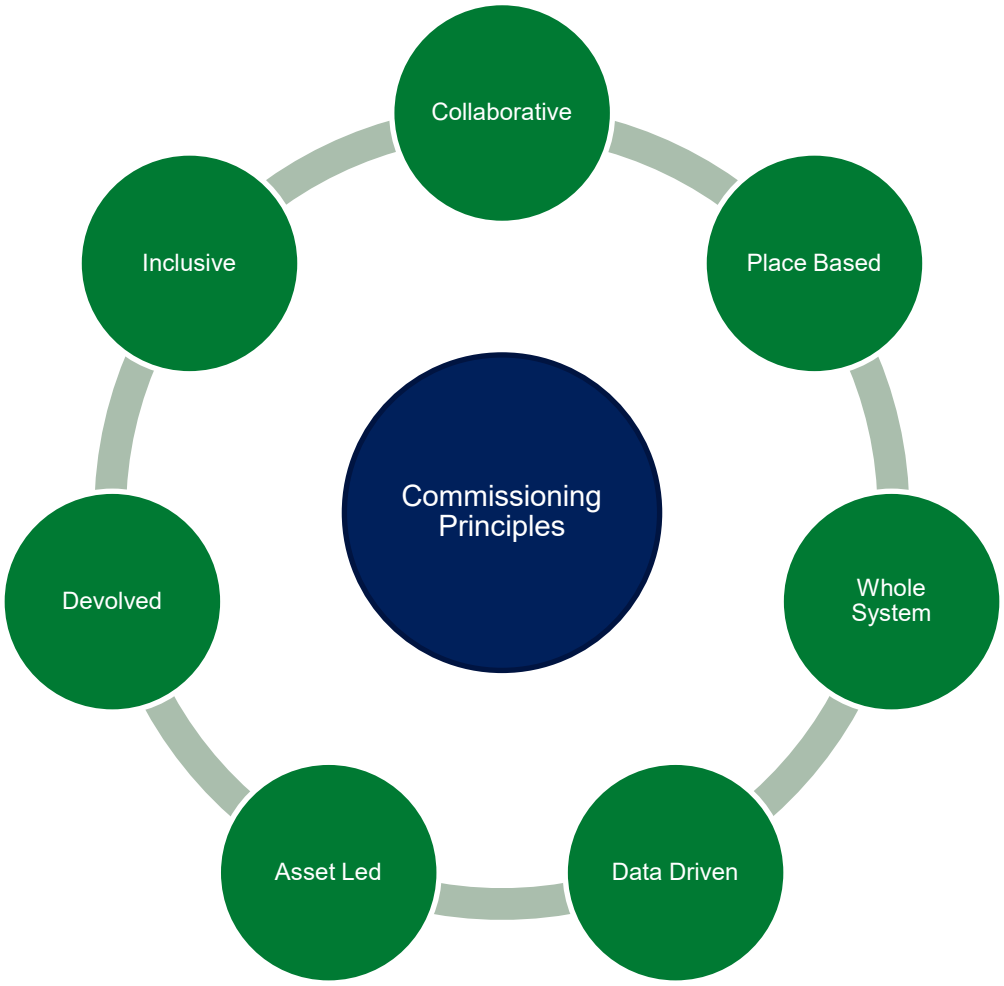
- Clear and transparent processes
- Revolutionised commissioning of services
- Influence national government decisions surrounding drug and alcohol addiction
- Essex to be recognised for innovation

So much more than……

- ……Engagement
- ……Consultation
- ……Involvement
- The Community will be in control and take the lead
    - They will lead the co-design, co-production and system development that is actually commissioning
    - With support from ECC Public Health as the “CSU”
    - In partnership

Embedding Lessons Learnt into future commissioning

Identified a core set of principles to underpin future commissioning decisions with community partners.



The Principles in Practice

These principles are applied when developing outcomes based specifications for future commissioned services e.g. Voluntary and Sector Infrastructure Review

Principle	In Practice
Collaborative	Enabling the voice of communities, service users and the wider Voluntary and Community Sector in service design and delivery
Inclusive	Seeking engagement with under-represented groups and diverse communities to supporting them to play a part in decisions that affect them
Devolved	Actively promote the transfer, management and protection of decision making, funding, power and assets and services to communities.
Asset Led	Encourage and enable communities to develop local solutions using local assets. Adopting a ABCD approach, to have the greatest long-term impact.
Place Based	Meeting people where they are and understanding their aims and ambitions, needs, issues, connections and relationship that drive a place.
Whole System	Driven by those best placed and suitably skilled to support outcomes. Build individual organisational capabilities and tackle structural inequalities.
Data/Evidence Driven	Utilise locally expressed need as data and evidence to prioritise resources on places and people experiencing highest need – **proportionate universalism**.

Embedding across North East Essex

- As a way of working
- In this particular arena – AND others
- Moving Forwards
    - ERF Community Leads working with others in the Alliance
    - Sharing experiences of co-producing
    - Building Lived and Living Experience capacity
    - Services “By and For”

NHS
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ICB BOARD

Agenda Item No.	**10**
Reference No.	**ICB 23-49**
Date.	**25 July 2023**

Title	**All Age Autism Outreach Service**
Lead Director	Lisa Nobes, Director of Nursing
Author(s)	George Martin, Learning Disability Health Equalities Commissioner, Essex County Council
Purpose	Approval

Recommendation:

Approval to engage the provider market ahead of the future procurement of the service.

1. Background

1.1 The All Age Autism Outreach Service will aim to reduce the number of avoidable admissions of autistic people to tier 4 and inpatient services as a result of their autism not being understood.

1.2 The Learning Disability and Autism Health Equality Programme receives funding from NHSE to boost community delivery on behalf the Collaborative Partnership (TCP) across Southend Essex and Thurrock. Two amounts in the Service Development Fund were identified to develop a health service for autistic adults and children/young people. Further funding for a crisis response service for autistic children/young people was bid for and added to this project.

1.3 The service will provide support to autistic individuals of all ages, across the Transforming Care Partnership footprint of Southend, Essex, and Thurrock, and will be anchored upon the upcoming all age Dynamic Support Register (DSR - also being developed by the LDHE team).

1.4 Engagement with individuals with Lived Experience has begun and learning from this will inform the development of the Service Specification.

1.5 Due to the niche nature of the service, it would be beneficial for commissioners to engage the market well ahead of any future procurement, to assess interest in the service, gain feedback from the market regarding the type of support provided, and to give the market enough time to initiate conversations around potential partnerships.

1.6 There is no requirement for the ICS to fund at this point. However at the end of the 4 year contract of this service the NHSE development funding will cease. During the lifetime of the contract evidence and options for funding will be brought to LD HE Board for members of the Collaborative Partnership to consider future funding.

2. Key Issues

2.1 Across the Southend, Essex and Thurrock TCP, a key deficit reported by autistic people, and their families, is that community services did not understand the impact of their autism on how they experienced the world or how they processed information. Whilst there are various services in place for individuals with learning disabilities, autistic individuals are not supported well by the local health and social care system.

2.2 Across the TCP, we have too many Children & Young People in Tier 4 inpatient beds. National targets mandate that the TCP should have no more than 5 children and young people in a Tier 4 inpatient setting at any one time. Between 2019 and 2021, the TCP has held anywhere between 6 and 14 CYP inpatients. Of these, approximately 80% were autistic without an associated learning disability diagnosis. Since 2022, the number of inpatients has remained between 6 and 10 and the proportion of those with autism has risen to 95%. Many of these received a diagnosis of Autism following admission. As of June 2023, there were 79 CYP on the DSR, 67 of which have a diagnosis of autism, without a learning disability.

2.3 Wider engagement with social care and mental health services is taking place to better understand the demand for this service from autistic adults. There is currently no Dynamic Support Register that identifies autistic adults at risk of admission to inpatient services, however the LDHE have recently begun work to develop an all age DSR, which will capture children and adults at risk of any form of institutionalisation who have an autism or learning disability diagnosis.

2.4 The LDHE programme has recruited an ‘Autism Clinical Specialist’ to deliver an in house pilot, supporting the discharge of autistic CYP currently in tier 4 services, and to reduce the

risk of admission for those autistic CYP current rag rated as red on the DSR. A project team has been mobilised to oversee the in house pilot and the procurement of the service.

2.5 A procurement strategy has been developed for this service, and a recommendation has been made to undertake market engagement via online 'Live' event(s), provided for by Attain, to realise the following benefits within Option A below.

2.6 The Section 75 and/or Collaborative Agreement to which all partners are signatories may be used to enable the LDA Health Equalities Team (Formerly Transforming Care) to hold the contract on behalf of all partners.

2.7 The procurement of this service and the funding from SDF and CYP Medium Term Plan Fund has already been endorsed by all Partners through the LDA Health Equality Board.

Option A	**Benefits**	**Risks**
Approval to proceed with market engagement ***Recommended***	Allows commissioners to inform the market of our intentions in relation to this service, and provide information about the Specification Provides potential bidders with a greater understanding of how the procurement process will work and the procurement rules. Allows commissioners to assess interest capacity and capability from the market in the procurement of this service, and promote the forthcoming opportunity to capture as wide and diverse market as possible Allows commissioners to gain feedback from the market on the service, perhaps highlighting alternatives that had not been previously considered. Offers potential bidders for the service the opportunity to better understand our intentions for the service, resulting in better quality bids. Offers potential bidders the time and opportunity to explore potential partnerships with other bidders.	If the commissioners decide to not undertake a procurement for the service for any reason in the future (as a result of information gleamed during engagement or for any other reason which is at its discretion to do so), but then decide to undertake any other form of contract award (for example a direct award to a single entity) there is a risk that the engagement event will have created competition and stimulated the market which may mean they are potentially more likely to question any decision not to procure, potentially leading to a legal challenge. This may have a negative impact on our relationships with the market. This risk only materialises through non-compliance with the Public Contract Regulations 2015 (the Regulations).
Option B	**Benefits**	**Risks**
Do not approve to proceed with market engagement ***Not Recommended***	Time/resource can be focussed elsewhere.	The market is not prepared for a future procurement, potentially resulting in a small number of bids. The market is not clear on what the AOS is intending to deliver, resulting in poor quality bids or an increased number of clarifications. The ICB has not informed its

		procurement strategy and approach on an appropriate evidence base. The procurement may proceed with the agreement of other ICS in the partnership, leaving an inconsistent offer across the footprint of the Collaborative Partnership

There are no immediate resource implications for Suffolk and Northeast Essex ICB.

2.8 Funding for the service has been secured from NHSE and the LDHE Service Development Fund. Commissioning of the service will be led by the LDHE team, and contracts, finance, and procurement support from Mid and South Essex ICB.

2.9 Sustainability of the service beyond the life of the MTP and SDF funding will need to be considered and will be factored into the evaluation of the service

3. Patient and Public Engagement

3.1 Engagement has recently begun with autistic people or all ages, their families, and carers to inform the redesign of the service specification.

3.2 This has been coordinated in partnership with the Essex Family Forum (acting on behalf of the three family forums of Southend, Essex, and Thurrock), the Multi Schools Council, the Southend, Essex and Thurrock keyworker service and the Southend, Essex, and Thurrock adults Autism Navigation Service, as well as via a number of individuals known to the commissioning team who have contributed to previous engagement activity, and with a number of autism and neurodiversity specialist charities and voluntary organisations.

4. Recommendation

4.1 Conducting market engagement is positively encouraged within the Regulations, because it leads to high quality bids that are more aligned with commissioner's needs. To ensure a fair, equal, and non-discriminatory process, in accordance with the Regulations, the market engagement event(s) will be advertised in the UK's e-Notification Platform, Find a Tender Service, as well as Contracts Finder, available to all potential bidders to access the documentation. Any local advertisement in online forums or through networks will not be published until the national advert is published. All interested parties will be treated fairly and given an equal opportunity to participate in the event(s), with access to the same information. The information shared at the market engagement event will be shared in the tender pack for the subsequent procurement process to ensure all potential bidders receive the same information.

4.2 Approve commissioners to engage the provider market ahead of the future procurement of the service.

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ICB BOARD

Agenda Item No.	**11**
Reference No.	**ICB 23-50**
Date.	**25 July 2023**

Title	**Improving uptake, experience and outcomes of Learning Disability Annual Health Checks**
Lead Director	Ed Garratt, ICB Chief Executive
Author(s)	Ed Garratt and Wendy Scott, ICB Associate Director for Nursing Learning Disabilities and Autism
Purpose	To note

Recommendation:

To prioritise the ambition to improve the uptake, experience and outcomes of annual health checks (and action plans) for people with a learning disability in Suffolk and North-East Essex (SNEE).

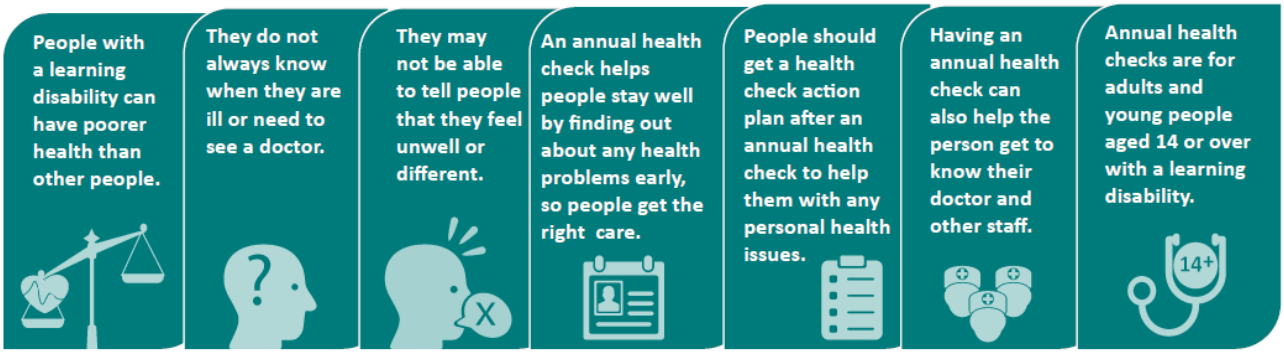
1. Background

1.1 People with a learning disability have a significantly lower life expectancy than the average population. Every year, people with a learning disability die sooner than they should. Only 37% of people with a learning disability live beyond 65. For the general population that statistic is 85%, a marked difference.

1.2 Learning from Lives and Deaths – People with learning disabilities and autistic people (formerly known as LeDeR – Learning from deaths review programme) show that the most common cause of death is a respiratory condition and SNEE is no exception. The SNEE ICB learning from Lives and Deaths annual report is due to published early summer 2023 for 2022/23.

1.3 People with a learning disability may be unaware of the medical implications of symptoms they experience, or they may have difficulty communicating their symptoms so as a result they are often less likely to report them or act on them. To address this major health inequality a national Learning Disability Annual health check service, delivered by general practice under a Directed Enhanced Service, was introduced in 2008.

1.4 Annual health checks enable health action plans to support improvements in health and wellbeing and (potentially) life expectancy by identifying preventable conditions (often non-complex issues). A summary of their importance is below:



1.5 The NHS Long Term Plan set an ambition that by 2023/24, at least 75% of people aged 14 or over with a learning disability will have had an annual health check. In 2022/23 SNEE benchmarked positively against the national standard of 75% of health checks being completed by achieving 82.5% (local data), which represented a 10% improvement on 2021/22. However, we would like to improve our performance further and set the standard nationally.

1.6 This has been chosen as a key priority for the NHS in the East of England and I am sponsoring this work.

2. Key Issues

2.1 We focus at NHS board level on achieving 75% - but not on the remaining % of people without an annual health check.

2.2 The number of health action plans following a health check is recorded. We must focus on the action plan % matching the annual health check total – nationally they are 9.8% less.

2.3 The number of health checks and action plans completed will only count if the quality of them is good.

2.4 We must also focus on the quality of workforce development, such as the Oliver McGowan training.

3. Approach to Patient Experience and Quality

3.1 In SNEE we aim to develop a culture of 'Ask, Listen, Do' in the way professionals work with service users. This approach is embedded in policies from the NHS England Learning Disability and Autism programme and is part of the NHS Standard Contract 2023/24. It means doing things differently so people who have a learning disability or autistic people get their right to high quality, safe care, and equal access to services. We want people, their families and staff to be truly listened to and have their concerns acted on.

3.2 In SNEE we have created a 'My Health Focus Group' (organised ICB and ACE Anglia) and co-chaired with a person with a learning disability. It follows the principles of 'Ask, Listen, Do'. The group's aim is to improve patient experience and coproduction. Members of the group are peer workers who have worked with three GP surgeries as quality checkers for "GP friendly" pilot. They find out which areas require improvement and praise good practice.

3.3 The Group has recently coproduced a patient experience survey for annual health checks and health action plans as well as an awareness poster. Funding received from NHS England has enabled an assistant psychologist to be recruited to deep dive the GP registers, understand the cohort who do not have an annual health check, and develop a physical health dynamic support register for those most as risk. The annual health check peer educator programme has continued with extension into local special schools for those 14 years plus. They have also been raising awareness and providing social prescribing training.

3.4 The Group have been shortlisted for a Health Service Journal patient safety award for 2023 as the learning disabilities initiative of the year.

3.5 The Group have three outcomes that they are focused on improving:

Outcome 1: **Awareness and Training**

I/We statement	KPI	Is it…**measurable?**
		Quantitative:
"I want professionals to be appropriately trained and have the right skills to understand and support me."	**100%** of service users feel that professionals are appropriately trained and have the right skills to understand and support them.	• **All** staff receive their mandatory training (Oliver McGowan) • **All** providers need to evidence how they are working towards or meeting the Learning Disability Improvement Standards for NHS Trusts. • 00% reduction in provider complaints (all alliance partners). Analysis of key themes of complaints and action plan to address common issues. • Family and Friend Test. • 00% of workforce that have attended LISTEN training. • 00% of workforce that have attended THRIVE training.
		Qualitative:
"I want my circle of support* to be supported so they can continue to look to after me"	**100%** of the circle of support feel supported to continue looking after service user.	• Provide evidence of how feedback is responded to (positive or negative) and provide details of changes that have been put into place. • Audits carried out by people with lived experience and their circle of support. • Service user feedback. • Workforce feedback. • Provide evidence of co-production with Alliance partners, user-led organisations and the voluntary and community sector. • Evidence how people with lived experience and their circle of support are involved in training. • Staff being made aware of advocacy provision. • 'What to Expect' standards: agreed and made in co-production, a series of publications/videos to communicate the kind of service(s) people are expected to receive. • People with lived experience and their circle of support involved in **all** aspects of recruitment • Evidence how stories from people with lived experience and their circle of support are used to change practice and improve services. • Evidence how people with lived experience and their circle of support are supported to keep their personal information up to date and not have to repeat their story.
"I feel listened to"	**100%** of service users and their circle of support feel that they are listened to.	

Outcome 2: **Communication & Information**

I/We statement	KPI	Is it…**measurable?**

"I need support to let others know how I'm feeling or to explain my issues."
 	
"I expect to be treated with respect & compassion. Dependant on my needs at the time of using services."
 	
"Information is shared so I only need to tell my story once."
 	
"I need access to information that is in a format that I understand and when I need it."
 	
"My circle of support and I are able to access information easily and when we need it"
	100% of people felt supported in explaining how they were feeling.
	
	100% of people feel that they were treated with respect and compassion.
	
	100% of service users feel that they build on their story and not repeat it.
	
	100% of service users feel that they have access to information that is in the right format for them.
		Quantitative:
		• **All** staff receive their mandatory training (Oliver McGowan)
		• **All** NSFT staff aware and using the NSFT RA Toolkit
		• **All** providers need to evidence how they are working towards or meeting the:
		  o Learning Disability Improvement Standards for NHS Trusts.
		  o Accessible Information Standards
		  o Equality Act
		• Audits undertaken by experts by experience - Commissioning a local organisation to work with Experts By Experience (people with a learning disability and / or autism) to work with provider to carry out quality audits?
		• 00% reduction in provider complaints (all alliance partners). Analysis of key themes of complaints and action plan to address common issues.
		• 00% reduction in DNAs.
		Qualitative:
		• What to expect standards agreed and made in co-production, a series of publications/videos to communicate the kind of service(s) people are expected to receive.
		• Co-produced service user feedback mechanisms - Commissioning regular mechanisms to receive ongoing feedback from service users and their circle of support.
		• Service user feedback
		• Workforce feedback
		• Provide evidence of co-production with Alliance partners, user-led organisations and the voluntary and community sector.
		• Provide evidence of working with LD strategy and partnership boards and associated meetings

Outcome 3: **Reasonable Adjustments**

I/We statement	KPI	Is it…**measurable?**

"I want reasonable adjustments in place so that I can be seen in mainstream services."
 	
We expect individuals to be treated with respect, compassion. Not just once – every single time."
 	
"I want to be able to use a communication device, or accessible communication methods if I need to."
	100% of service users feel that reasonable adjustments were put into place when being seen.
	
	100% of service users were able to use a communication device or accessible communication method if required.
		Quantitative:
		• **All** staff receive their mandatory training (Oliver McGowan)
		• **All** NSFT staff aware and using the NSFT RA Toolkit
		• **All** providers need to evidence how they are working towards or meeting the:
		  o Learning Disability Improvement Standards for NHS Trusts.
		  o Accessible Information Standards
		  o Equality Act
		Qualitative:
		• Provide evidence of co-production with Alliance partners, user-led organisations and the voluntary and community sector.
		• Service user feedback
		• Workforce feedback
		• Co-produced service user feedback mechanisms - Commissioning regular mechanisms to receive ongoing feedback from service users and their circle of support.

4. Recommendations

1) Suffolk and North East Essex perform relatively well in this area and we thank our primary care teams for their excellent work. But we want to improve and set the standard nationally given the obvious health inequalities in this patient cohort.

2) Board support for annual health checks to be a key metric to prioritise within the ICB with sponsorship from the Chief Executive Officer.

3) Progress on the completion of annual health checks and health action plans in 2023/24 is reported quarterly to the Board so that we maintain oversight of progress. This should include updates on the quality improvement initiatives being led locally.

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ICB BOARD

Agenda Item No.	**12**
Reference No.	**ICB 23-51**
Date.	**25 July 2023**

Title	**Suffolk & North-East Essex Integrated Care Partnership (ICP) Update**
Lead Director	Susannah Howard, Integrated Care Partnership (ICP) Director
Author(s)	Susannah Howard, Integrated Care Partnership (ICP) Director
Purpose	Update

Recommendation:

Members of the NHS Suffolk and North-East Essex ICB Board are asked to note this brief general update report on the work of the ICP.

1. Background

1.1 This report provides a brief general update on the current work of the Suffolk and North East Essex ICP.

2. Key Issues

a. ICP Meetings Held in June and July 2023

Key items discussed at the meetings of the held in June and July 2023 are summarised below. Papers and minutes of meetings are available on the ICS website HERE:

/

ICP Committee Meeting – Friday 9 June 2023 Chair: Cllr. John Spence, Chair – Essex Health and Wellbeing Board	
NHS Suffolk and North East Essex ICB – Joint Forward Plan (JFP)	The ICP approved the NHS ICB Joint Forward Plan
Focus on Enabling the VCFSE Sector to be Equal Partners in the ICS • *'Thinking Differently Together' about….* The Essential Role of the VCFSE Sector in Health and Care • *System Learning* 'A Community Powered NHS: with New Local' • ICS VCFSE Quality Development Tool • ICS VCFSE Resilience Charter	Kirsten Alderson, Chair of the ICS VCFSE Assembly led the presentation of a series of reports of work in the ICS focused on enabling the VCFSE sector to be equal partners in the ICS. The ICP approved the revised ICS VCFSE Resilience Charter (see below).
Community Ambition Programme 2021 – 2023 - including the Task and Finish Group	The ICP received a detailed report about the background, achievements and learning from this NHS Charities Together funded programme and the outputs of the Task & Finish Group agreed by the Committee in March 2023 to explore opportunities for the projects to continue to build on their achievements and progress in a sustainable way.
SNEE ICS Leaders Awayday - System Learning from Winter 2022/23	The ICP discussed a detailed report of the recent awayday including next steps (see below).
Refreshing ESNEFT Clinical Strategy	The ICP received a presentation from Dr. Shane Gordon at ESNEFT on the work underway to refresh the ESNEFT clinical strategy.
EXPO2023: Friday 7 July 2023	Susannah Howard, ICP Director provided an update for ICP members on preparations for EXPO2023.
ICP Committee Meeting – Friday 7 July 2023 Chair: Cllr. Andrew Reid, Chair – Suffolk Health and Wellbeing Board	
People at the heart of Care: Our strategic ambition for adult social care in Suffolk	Presentation by Elissa Rospigliosi, Assistant Director, Strategy & Change – Suffolk County Council. The ICP discussed and endorsed the strategic ambition.
Reflections from 'Can Do Health and Care' Expo2023	A discussion about reflections from the event taking place that day led by Susannah Howard, ICP Director. Also see below.

b. ICS System Learning from Winter Pressures 2022/23

On Friday 12 May 2023 over 70 leaders from across the Suffolk and North East Essex ICS attended an ICS Leaders Awayday to look at **ICS System Learning from Winter Pressures 2022/23**. The event included more than 20 speakers including frontline clinicians, patients and the public and leaders from across the NHS, social care, public health and the VCFSE sector. A comprehensive report from the event has been produced which is attached and is also available as a 'flipbook' on the ICS website HERE. This includes written accounts of each of the presentations, reflections following the day and also a summary of key points captured using the 'Three Horizons Thinking' model. The event explored a broad range of areas where action might be taken within the ICS using a data and experience driven approach to both mitigate short term pressures and ensure that to move to more viable long term solutions.

The event has already prompted a range of subsequent conversations and discussions including:

- Incorporation into the SNEE UEC One Plan led by the NHS ICB. This will have 8 workstreams each with an Executive level SRO and identified benefits, timelines and success measures.
- Subsequent reflections from some ICS leaders at Healthwatch, Suffolk Public Health and ESNEFT captured within the report
- Feedback into the WSFT recover plan specifically on strategic coherence for plans- both bottom up and top down, ensuring joint working between UCR services and frailty and ward process improvements.
- Further exploration of the concept of a mental health urgent care centre shared by EPUT from Basildon
- Suggested consideration of the report as part of planning for use of the Better Care Fund in Suffolk.

Wider partners have also proposed that there should be:

- focused work to ensure that admission avoidance is properly valued and quantified when making winter funding investment decisions and evaluating services/interventions
- more opportunity for non-NHS partners to contribute to winter plans and to apply for funding at an earlier stage.
- clarity about how Alliances will be asked to act on learning from the event.
- further work to strengthen and embed a culture of research and innovation in the ICS as proposed in the recent report from the Hewitt Review
- involvement of more third sector organisations in discussions

The report was considered by the Suffolk and North East Essex ICP Committee at their meeting on Friday 9 June 2023. At the meeting the committee approved the report of the ICS system leaders awayday, agreed to share the report of the report with their relevant organisational boards and/or system groups to inform planning for future system pressures and agreed to report on the output of these discussions by the end of July 2023 for collation into a system wide action plan for the ICS for consideration by the ICP committee in August or September 2023.

c. 'Can Do Health and Care' EXPO2023 – Friday 7 July 2023, Wherstead Park

'Can Do Health and Care' Expo is the main annual event for the ICP and a key date in the diary for everyone involved in health and care across Suffolk and North East Essex. The theme for 'Can Do Health and Care' Expo 2023 was 'The Future is Now: Time to Value Every Voice in Health and Care'.

The event took place on Friday 7 July 2023 and was attended by around 1,000 delegates from across the Suffolk and North-East Essex ICS. More than 140 exhibitors took part across

six exhibition zones as well as keynote presentations, workshops, demonstrations and discussions. The final event programme is available on the ICS website HERE.

The six exhibition zones were:

- Valuing Lived Experience Zone
- Communities Zone
- Social Care Zone
- Heritage and Culture Zone
- Research and Innovation Zone
- Central Square

The day began with an Event Launch in the Atrium at Wherstead Park featured a number of keynote speakers including Health Minister Will Quince MP, Paulette Lewis MBE from the Caribbean Nurses and Midwives Association (UK) and Jordan from the Suffolk SEND Young Person's Network. The Event Launch ended with a 'snow storm' of messages on the theme of *'What matters to you?'* conducted by Nick Hulme, Chief Executive of ESNEFT.
A special edition of the ICP newsletter containing a report and photos from the event is available HERE.

d. Suffolk and North East Essex ICS VCFSE Resilience Charter

A key highlight of the day at Expo2023 was the official signing of the Suffolk and North East Essex ICS VCFSE Resilience Charter. The charter was signed in person by numerous VCFSE sector leaders alongside Will Pope and Ed Garratt on behalf of NHS Suffolk and North East Essex ICB, Cllr. Andrew Reid on behalf of Suffolk County Council and Lucy Wightman on behalf of Essex County Council.

The charter was originally drafted by VCFSE sector partners in 2021 and set out a number of commitments and principles for wider system partners to work to that was underpinned by an ethos of collaboration, sustainable funding, co-production and shared resources. Whilst the principles of the Charter were widely accepted by system partners, challenges with adopting the commitments were identified, largely owing to the complexity of the ICS system whereby commitments such as embedding co-production, reducing overlap, and removing unnecessary bureaucracy, whilst agreed in principle, in practice have been harder to achieve. So, to agree a Charter that the whole system agreed to and could be adopted by all partners across all sectors in the system, the Charter was revisited to refine and co-produce a new Charter that recognises the diversity of the VCFSE sector and will enable it to work with and be recognised as a key partner within the ICS.

Over 100 people from across the system contributed to the co-design of the revised Resilience Charter Principles, which included task and finish groups to explore five priority areas: *Sustainable Funding, *Co-Production, *Quality and Monitoring, *Resilience and Capacity and *Trust and Culture. The groups helped to develop the eight new principles and made recommendations for the system to progress to ensure that the principles are embedded by all partners. The Charter and Principles were approved by the ICP Committee in June 2023.

3. Patient and Public Engagement

3.1 As an ICP we continue to work closely with Healthwatch and wider members of the public. Information about how to 'Get Involved' in the work of the ICP is available on the ICS website together with written reports of our work.
Get Involved - Suffolk & North East Essex Integrated Care System (sneeics.org.uk)

4. Recommendation

4.1 The NHS Suffolk and North-East Essex ICB Board is asked to note this brief general update report on the work of the ICP.

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ICB BOARD

Agenda Item No.	**13**
Reference No.	**ICB 23-52**
Date.	**25 July 2023**

Title	**Suffolk and North-East Essex Finance Report**
Lead Director	Howard Martin, ICB Director of Finance
Author(s)	Howard Martin, ICB Director of Finance
Purpose	To present the ICB finance report for Month 02 2023/24

Recommendation:

The Board is asked to note the report.

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NHS Suffolk and North East Essex ICB Finance Report

Month 02 2023/24

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ICB Report

Month 02 2023/24

ICB Key Financial Metrics Month 02 2023/24

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	Month 02	Forecast	
Surplus / Deficit	G	G	At this early stage of the year forecast position remains on plan for a £2.6m surplus
Efficiency Delivery	R	G	Efficiency forecast is at 100% of the £13.5m target. The majority of the year to date shortfall reported is due to unavailability of prescribing data.
Running Costs Limit	G	G	The forecast is an underspend against of £2m against the annual limit.
Mental Health Investment Standard	G	G	The forecast is for achievement of the £158.9m target.
Net Risk	G	G	At this early stage there has been no change to the net risk position reported in the financial plan.

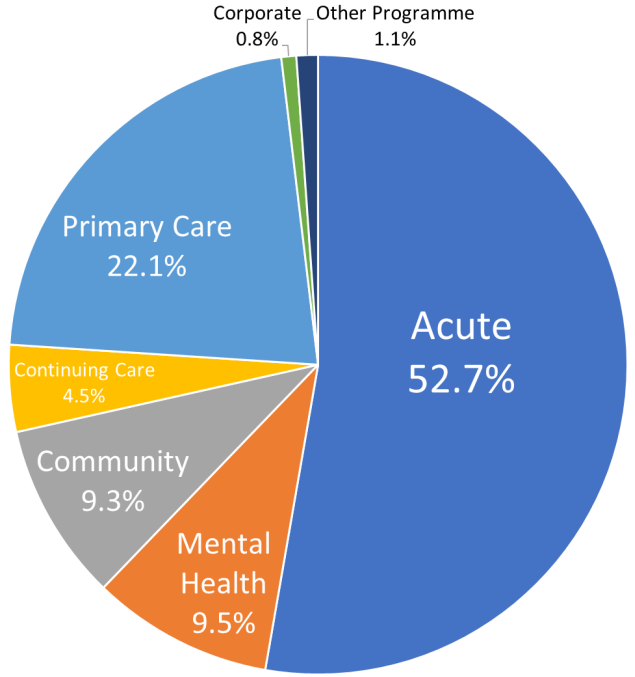
G On plan

A Adverse variance to plan within manageable tolerance

R Adverse variance to plan above manageable tolerance/risk to financial duties

Annual Funding & Expenditure by Category

Funding Type	23/24 M02 £m
Core Programme	1,862.9
Delegated Commissioning	269.8
Running Costs	18.8
Total	**2,151.6**
Plan Surplus/(Deficit)	2.6
Forecast Surplus/(Deficit)	2.6



ICB Summary Position at Month 02 2023/24

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The ICB has reported on plan for Month 02 with a £0.4m surplus year to date and £2.6m forecast surplus.

Areas of expenditure to note are:

- Prescribing -national data was not available for reporting so reported on budget. This will be a key risk area through the year.
- Continuing Care – Uplift negotiations are still ongoing with providers and therefore increased costs were not fully reported in month 02.
- Mental Health – Out of Area placement costs in North East Essex continue to rise, impacting on funding available for other investments.
- Delegated Pharmacy, Optom, Dental – Reported on plan for month 02 as services are in transition from NHS England.
- Corporate – Vacancy rates continue to rise pending restructure to meet 30% reduction target.

Category	1 Apr 23 to 31 May 23 YTD			Forecast to 31 Mar 24		
	Budget £m	Actual £m	Variance £m	Budget £m	Forecast £m	Variance £m
Revenue Resource Limit (in year)	358.7	358.7	0.0	2,151.6	2,151.6	0.0
TOTAL REVENUE RESOURCE LIMIT	**358.7**	**358.7**	**0.0**	**2,151.6**	**2,151.6**	**0.0**
Acute	187.3	188.0	(0.7)	1,123.5	1,123.5	0.0
Mental Health	33.9	34.1	(0.1)	203.6	203.6	(0.0)
Community Health Services	32.8	33.0	(0.2)	196.6	196.6	0.0
Continuing Care	16.2	15.7	0.6	97.3	97.3	0.0
Primary Care	35.1	35.0	0.1	210.2	210.2	0.0
Delegated GP	32.1	32.1	(0.0)	192.7	192.7	0.0
Delegated Pharmacy, Optom, Dental	14.0	13.8	0.2	84.1	84.1	0.0
Corporate	2.8	2.5	0.3	17.0	16.8	0.3
Other Programme	4.0	4.2	(0.2)	23.9	24.2	(0.3)
TOTAL EXPENDITURE	**358.3**	**358.3**	**0.0**	**2,148.9**	**2,148.9**	**(0.0)**
IN YEAR SURPLUS/ (DEFICIT)	**0.4**	**0.4**	0.0	**2.6**	**2.6**	**0.0**

Committee Delegated Budgets Month 02 2023/24

NHS
Suffolk and
North East Essex

Currently there is limited data available to report an accurate financial position.

This means that the majority of spend has been reported in line with budget for year-end forecasts and year to date positions. This will evolve as the year develops.

Acute – The budget is planned to be fully utilised in each Alliance by the end of the financial year as part of Seasonal Resilience plans.

Community –The majority of expenditure is on fixed contracts and therefore limited variance is expected.

Mental Health – Overall very small variance to date with the largest adverse variance being Out of Area placement costs in North East Essex.

Primary Care - Prescribing has been forecast to plan for the year to date and full year position as Month 01 data is yet to be received.

Delegated GP – Information on significant variable payments such as QOF achievement for 2022/23 and IIF will be published over the next 2 months and will inform the position.

Category	1 Apr 23 to 31 May 23 YTD			Forecast to 31 Mar 24		
	Budget £m	Actual £m	Variance £m	Budget £m	Forecast £m	Variance £m
Acute	0.3	0.2	0.1	1.8	1.8	0.0
Community Health Services	13.0	13.0	(0.0)	79.3	79.3	0.0
Primary Care	11.7	11.7	0.0	70.4	70.4	0.0
Delegated GP	12.7	12.7	0.0	76.4	76.4	0.0
Ipswich & East Alliance	**37.8**	**37.7**	**0.1**	**227.9**	**227.9**	**0.0**
Acute	0.1	0.1	0.0	0.7	0.7	0.0
Community Health Services	11.5	11.5	0.0	68.8	68.8	0.0
Mental Health	12.4	12.5	(0.1)	74.1	74.1	0.0
Primary Care	12.8	12.8	0.0	76.8	76.8	0.0
Delegated GP	10.8	10.8	0.0	65.0	65.0	0.0
North East Essex Alliance	**47.6**	**47.7**	**(0.1)**	**285.5**	**285.5**	**0.0**
Acute	0.2	0.1	0.1	1.0	1.0	0.0
Community Health Services	8.0	8.0	(0.0)	46.9	46.8	0.0
Primary Care	9.3	9.2	0.0	55.5	55.5	0.0
Delegated GP	8.5	8.5	0.0	51.3	51.3	0.0
West Suffolk Alliance	**26.0**	**25.9**	**0.1**	**154.7**	**154.6**	**0.0**
Delegated Pharmacy, Optom, Dental	14.0	13.8	0.2	84.1	84.1	0.0
Alliance Committees	**14.0**	**13.8**	**0.2**	**84.1**	**84.1**	**0.0**
Mental Health	33.9	34.1	(0.1)	203.6	203.6	(0.0)
Suffolk Mental Health Collaborative	**33.9**	**34.1**	**(0.1)**	**203.6**	**203.6**	**(0.0)**
Total Delegated	**159.3**	**159.1**	**0.2**	**955.8**	**955.7**	**0.0**

Efficiency Summary Month 02

NHS
Suffolk and
North East Essex

	£,000
Annual Plan	13,500
YTD Plan	2,250
YTD Actual	1,179
YTD Variance	(1,071)
Forecast value	13,500
Forecast Variance	(0)

YTD Actual, Annual Plan £,000 and YTD Plan



Recurrent / Non-Recurrent	YTD Plan £,000	YTD Actual £,000	YTD Variance £,000	Annual Plan £,000	Forecast value £,000	Forecast Variance £,000
Non-recurrent	155	4	(150)	927	927	(0)
Recurrent	2,095	1,175	(921)	12,573	12,573	(0)
Total	**2,250**	**1,179**	**(1,071)**	**13,500**	**13,500**	**(0)**

Directorate	YTD Plan £,000	YTD Actual £,000	YTD Variance £,000	Annual Plan £,000	Forecast value £,000	Forecast Variance £,000
Director of Nursing	652	652	(0)	3,912	3,912	(0)
Alliance Director NEE	417	71	(346)	2,502	2,502	(0)
Alliance Director IES	412	60	(352)	2,471	2,471	(0)
Alliance Director WS	293	70	(223)	1,759	1,759	(0)
Unidentified	150		(150)	903	903	(0)
Director of Perf Improvement	113	113	(0)	681	681	(0)
Director of Workforce	105	105	(0)	632	632	(0)
Director of Finance	54	54	(0)	321	321	(0)
DCEO, Strategy & Transformation	28	28	(0)	165	165	(0)
Medical Director	26	26	(0)	155	155	(0)
Alliance Directors	0		(0)	0	0	(0)
Total	**2,250**	**1,179**	**(1,071)**	**13,500**	**13,500**	**(0)**

It is very early in the financial year and national data delays have impacted reporting. Based on the positive progress made through the Financial Recovery and Sustainability Group the forecast for the year remains on plan.

At month 02 we have reported under delivery of £1m but still forecasting to remain on plan by the end of the year.
The key drivers of the are:

- Prescribing - £0.9m due to unavailability of data at the time of reporting.
- Unidentified - £0.2m. This is expected to move to nil due to approval of further efficiency schemes.

NHS
Suffolk and
North East Essex

System Report

Month 02 2023/24

System Summary

Suffolk and North East Essex

System Revenue

Organisation	Surplus / (Deficit) - Adjusted Financial Position							
	Plan YTD £000	Actual YTD £000	Variance YTD £000	Variance YTD %	Plan Year Ending £000	Forecast Year Ending £000	Variance Year Ending £000	Variance Year Ending %
Suffolk And North East Essex ICB	442	442	0	0.0%	2,649	2,649	(0)	(0.0%)
East Of England Ambulance Service NHS Trust	42	47	5	0.0%	51	51	-	0.0%
East Suffolk And North Essex NHS Foundation Trust	(1,782)	(1,682)	101	0.1%	-	-	-	0.0%
West Suffolk NHS Foundation Trust	(1,024)	(1,411)	(387)	(0.6%)	(2,700)	(2,700)	-	0.0%
ICS Total	(2,323)	(2,604)	(281)	(0.1%)	(0)	(0)	(0)	(0.0%)

The system reported a deficit of £2.6m at month 02, which is an adverse variance of £0.3m to plan.

At the date of this report submission the draft values for month 3 shows the WSFT has deteriorated further to £2.3m off plan due to efficiency slippage, costs of industrial action and other pressures.

Efficiency slippage is not limited to WSFT, with £4.0m achievement reported against a system target of £8.2m at month 02.

All organisations are forecasting to return to plan (system break-even) by 31 March 2024.

System unmitigated financial risk is unchanged (at £46.8m) from the figure submitted as the final plan on 4th May 2023. Risk was reviewed by all organisations in the course of the month.

The ICS is currently forecasting an overspend on system capital. Additional RAAC expenditure of £2.5m is not recognised in a revised plan for WSFT. In addition, organisations were encouraged to identify projects to spend up to 105% of system capital. All organisations are forecasting an 'on-plan' position at this stage, resulting in a forecast overspend of £4.4m.

System Risk

Gross Risk	Net Risk	Net Risk % allocation	Movement from prior month
(84.3)	(46.8)	2.2%	46.8

System Capital Allocation

	Capital allocation	Variance to allocation	Forecast variance %
Providers	59.8	(4.4)	(7.3%)
ICB	2.0	2.0	100.0%
System	61.8	(2.4)	(3.8%)

Underlying Position

NHS
Suffolk and North East Essex

Organisation	Plan Submission 4 May	M02	*Change to Plan*	*Underlying Surplus/Deficit as % of Plan Revenue*
	£000s	£000s	*£000s*	*%*
SNEE ICB	(7,753)	(6,329)	***1,424***	-0.3%
ESNEFT	(15,428)	(22,092)	***(6,664)***	-2.2%
WSFT	(15,400)	(30,447)	***(15,047)***	-8.4%
EEAST	(13,390)	(13,390)	***0***	-3.1%
SNEE System	**(51,971)**	**(72,258)**	**(20,287)**	

The system undertook a local exercise to review organisations underlying exit positions into 24/25.

Whilst it is still very early in the year to assess recurrent impacts there was a £20m deterioration from the planning submission to a £72m underlying deficit.

The key driver for this was an increase in the forecasted non recurrent efficiency delivery and reliance on other non recurrent measures.

The deterioration of the WSFT position within a short period of time is of significant concern at this stage of the year.

	SNEE ICB	ESNEFT	WSFT	EEAST	Total
	£000's	£000's	£000's	£000's	£000's
Plan Surplus / (Deficit)	**2,649**	**0**	**(2,700)**	**51**	**0**
Non Recurrent					
Income	(96,967)	(1,993)	(1,921)	0	(100,881)
Expenditure	85,202	(10,346)	(20,100)	(10,441)	44,316
Full Year Effect					
Income	0	0	(1,033)	0	(1,033)
Expenditure	2,787	(9,753)	(4,693)	(3,000)	(14,659)
Underlying Surplus / (Deficit)	**(6,329)**	**(22,092)**	**(30,447)**	**(13,390)**	**(72,258)**
Remove Non Recurrent:					
Income	(96,967)	(1,993)	(1,921)	0	**(100,881)**
Allocation	(96,967)				(96,967)
Operating income from patient care activities	0	0	(1,921)		(1,921)
Other operating income	0	(1,993)	0		(1,993)
Expenditure	85,202	(10,346)	(20,100)	(10,441)	**44,316**
Employee expenses		1,385			1,385
Operating expenses (excluding employee expenses included above)	93,480	1,022			94,502
Non Recurrent Efficiency Delivery	(3,900)	(12,752)	(5,100)	(10,441)	(32,193)
Non Recurrent measures i.e. balance sheet	(4,378)		(15,000)		(19,378)
Full Year Effect Adjustments	2,787	(9,753)	(5,726)	(3,000)	(15,692)
Income	0	0	(1,033)	0	**(1,033)**
Operating income from patient care activities			(1,033)		(1,033)
Other operating income					0
Expenditure	2,787	(9,753)	(4,693)	(3,000)	**(14,659)**
Employee expenses		(8,553)	(5,300)		(13,853)
Operating expenses (excluding employee expenses included above)	(700)	(1,200)		(3,000)	(4,900)
Other adjustments to get to adjusted financial performance			607		607
Adjust for Full Year Effect Efficiency Delivery	3,487				3,487

System Financial Self-Assessment

NHS
Suffolk and
North East Essex

In order to support systems in addressing the financial issues such as inflation, pay increases post covid challenges NHS England has distributed more funding into local allocations than ever before and has advised there are no central reserves to cover any local deficits in 23/24.

It is therefore imperative for systems to deliver on financial plans and statutory duty to break even.

The system has a limited amount of time to ensure robust measures are in place to deliver the financial plan and take any local remedial action, before further regional and national scrutiny results in direct intervention.

The purpose of the self assessment is to undertake a high level desk top assessment using hard and soft evidence of each organisations:

- financial performance,
- capability and capacity.

Where this concludes a lack of confidence in the ability of an organisation(s) to:

- deliver in year planned financial performance or
- deliver an improved underlying financial position to the extent it puts the delivery of future years plans at risk,

the Finance Committee is recommended to trigger local interventions.

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Overall Assessment & Recommendations

NHS Suffolk and North East Essex

RAG	Plan	Actual YTD	Actual FOT	Efficiency YTD	Efficiency FOT	M02 Underlying %	Underlying Change	HfMA	Internal Audit	Resourcing	Senior Engagement
G	Break even or better	Plan or Better	Plan or Better	> 80%	> 80%	Surplus	Improving	Score >	Substantial Assurance		
A	na	na	na	> 50%	> 50%	Deficit <3%	No Material Change		Reasonable Assurance		
R	Deficit	Adverse Variance	Adverse Variance	< 50%	< 50%	Deficit >3%	Material Deterioration	Score<	Limited/no assurance		

Organisation	Plan	Actual YTD	Actual FOT	Efficiency YTD	Efficiency FOT	M02 Underlying Postion %	Underlying Postion Change	HfMA	Internal Audit	Resourcing	Senior Engagement
SNEE ICB	G	G	G	A	G	A	G				
EEAST	G	G	G	A	G	R	A				
ESNEFT	G	G	G	R	A	A	R				
WSFT	R	R	G	R	R	R	R				

The table brings together a basic RAG rating of the information reviewed in order to provide an overview of each organisation in the system. Once information in the blank sections has been submitted and reviewed these will be incorporated into an updated self assessment.

SNEE ICB – The ICB needs to continue improvements in efficiency delivery and recurrent efficiency in particular to improve the underlying position. The internal processes and governance give confidence that this being addressed at this stage.

EEAST – The underlying position is concerning and there is an urgent need for clarity over the impact of the national capacity funding.

ESNEFT – The deterioration in efficiency forecast has also impacted the underlying position. The Trust has advised it is already addressing this and the internal processes and governance, track record of efficiency delivery gives a degree of confidence at this stage.

WSFT - It is clear from this overview that all information is indicating significant financial performance issues at WSFT which appear to be worsening and these will impact on this financial year and future years. This will require immediate action alongside the development of a multi year programme to address the financial sustainability of the organisation. Information on resourcing issues in the Trust means it is unlikely the Trust currently has the internal capacity to deliver this and it will therefore need to be clear on what external support is needed from the system for greatest impact.

NHS
Suffolk and
North East Essex
Integrated Care Board

ICB BOARD

Agenda Item No.	**14**
Reference No.	**ICB 23-53**
Date.	**25 July 2023**

Title	**Integrated Care Board Performance Report**
Lead Director	Paul Gibara, ICB Director of Performance Improvement
Author(s)	Executive
Purpose	To present the ICB Integrated Performance Report
Recommendation: To note the report.	

Suffolk and North East Essex Integrated Care Board Performance report
July 2023

System Oversight Assurance Committee 11th July 2023

Several subject areas were discussed at this month Committee to seek assurance:

- Performance Dashboard.
  - Nhse planning submission letter
  - End of year Assessment
- Neurodevelopmental services for children
- Outcome of review work Cancer performance
- Maternity – LMNS priorities – 3 year plan
- Quality update with three escalations relating to:
  - mortality,
  - regulatory assessment and
  - A&E performance / patient safety
- Outpatient transformation system approach
- Unscheduled Care Coordination Hub
- Industrial Action – preparation and impact.

The committee have not escalated any issues to the Integrated Care Board at this point

SNEE operational plan submission

The ICB received a letter from Clare Panniker 28th June 2023, Regional Director for NHS England acknowledging Suffolk and North East Essex (SNEE) ICB final system operating plan for 2023/24 and setting out next steps. Requesting that our boards were made cognisant of this letter. (see enclosed letter)

The letter reminded us that our priorities were framed around three tasks:

1. *Recovery of our core services*
2. *Setting of ambition to deliver NHS long term plan*
3. *Transforming of services.*

Whilst the letter recognises the intense pressure the system has been under it sets key priorities which will form part of ongoing reviews:

- *Emergency care*
- *Elective recovery with a particular focus on 65 weeks, outpatient transformation and productivity.*
- *Cancer with focus on Faster diagnosis*
- *Diagnostic recovery with a focus on digital histopathology.*
- *Mental health*
- *Workforce with focus on recruitment, retention and primary care.*
- *Finance with focus on efficiency and preparedness for 23/24 plans*

23/24 Planning & Priorities

Area	Metric	Data Source	Month	Current Value	Target (23/24)	Variation	Assurance	LPL	Mean	UPL
Urgent and emergency care	A&E 4 Hour Waiting Times	National Monthly Reporting	Apr-23	75.2%	76%			69.1%	76.6%	84.1%
Urgent and emergency care	Ambulance response times - C2 Mean	EEAST	May-23	00:36:31	00:30:00			00:12:10	00:55:42	01:39:14
Urgent and emergency care	G&A Bed Occupancy	Local Daily Trust Report	Jul-23	94.9%	92%			92.0%	94.6%	97.2%
Urgent and emergency care	Ambulance handover delays	EEAST	Jun-23	80.0%	95%			61.8%	77.4%	93.1%
Urgent and emergency care	12 hour waits in ED	Local Trust Report	Jun-23	1,384 (6.6%)	2%			1.22%	5.79%	10.4%
Community health services	UCR Referrals in 2 hours	CSDS	May-23	74.3%	70%			54.8%	68.4%	82.1%
Primary care	Number of general practice appointments	NHS Digital	Apr-23	435,516	644,482			361,877	488,589	615,301
Primary care	Improve units of dental activity	NHS Oversight Framework	Mar-23	95.0%				27.0%	61.8%	96.6%
Elective care	65 weeks wait	National RTT	Apr-23	1,351					1,860	
Elective care	Elective Day Case	Faster SUS	May-23	12,254	12,255			8,756	11,108	13,459
Elective care	Elective Ordinary	Faster SUS	May-23	1,635	1,623			1,225	1,607	1,988
Elective care	First outpatients	Faster SUS	May-23	31,949	29,708			19,293	29,862	40,431
Elective care	Follow up outpatients	Faster SUS	May-23	58,581	40,582			37,489	52,493	67,496
Elective care	First outpatients - procedures	Faster SUS	May-23	5,878	6,889			3,388	5,196	7,004
Elective care	Follow up outpatients - procedures	Faster SUS	May-23	10,443	9,879			7,217	9,873	12,529
Cancer	62+ day waiting list	Trust Local PTL	Jun-23	540	323			651	740	828
Cancer	28 day faster diagnosis	National CWT	Apr-23	67.4%	75%			58.4%	65.0%	71.6%
Cancer	Increased first cancer treatments	National CWT	Apr-23	458				363	538	713
Diagnostics	Diagnostic Tests within 6 weeks	DM01	Apr-23	77.4%	84.7%				74.4%	
Diagnostics	Diagnostic Tests	DM01	Apr-23	28,272	20,833			21,835	27,615	33,394
Maternity	Stillbirth rate (per 1,000)	Civil Registration of Births	Mar-23	0.00				-3.04	3.75	10.5
Maternity	Neonatal mortality rate (per 1,000)	Civil Registration of Deaths	Mar-23	5.52				-5.63	2.97	11.6
Mental health	CYP accessing MH services	MH Core Data Pack	Mar-23	12,085	14,266			11,247	11,792	12,337
Mental health	IAPT Access (rolling qtr)	MH Core Data Pack	Mar-23	2,395	6,852			1,555	2,178	2,800
Mental health	Community MH services access (older adults/SMI)	MH Core Data Pack	Mar-23	5,175	7,778			5,576	5,767	5,959
Mental health	Inapproriate OOA placement bed days	MH Core Data Pack	Mar-23	1,465	106			462	787	1,113
Mental health	Dementia diagnosis rate	NHS Digital	Apr-23	59.4%	66.7%				60.2%	
Mental health	Perinatal Access - YTD	MH Core Data Pack	Mar-23	1,015	1,570			879	946	1,014
People with a learning disability and autistic people	LD health checks	NHS Digital	Apr-23	3.9%	75%				35.3%	
People with a learning disability and autistic people	Adult IP - Suffolk TCPs (Rate per mil)	FutureNHS	May-23	23.3	30				21.1	
People with a learning disability and autistic people	Adult IP - Essex TCPs (Rate per mil)	FutureNHS	May-23	23.2	30				23.2	
People with a learning disability and autistic people	U18s IP - Suffolk TCPs (Rate per mil)	FutureNHS	May-23	15.3	15				15.3	
People with a learning disability and autistic people	U18s IP - Essex TCPs (Rate per mil)	FutureNHS	May-23	17.0	15				20.1	
Prevention and health inequalities	Patients with hypertension treated to NICE guidance	NHS Oversight Framework	Mar-22	64.4%	77%				63.7%	
Prevention and health inequalities	CVD - Lipid lowering therapies	NHS Oversight Framework	Dec-22	55.6%	60%				53.3%	

Annual Assessment NHS England

Under the terms of the Act, NHS England is required to undertake a performance assessment of each ICB in respect of each financial year and to publish a summary of these assessments.

NHS England » Annual assessment of integrated care boards 2022-23: supporting guidance

Outcome and timetable

- The inaugural annual assessment for 2022/23 will take the form of a letter from the relevant NHS England Regional Director to the ICB Chair in response to the ICB's first annual report and accounts. The annual assessment will:
- summarise areas where NHS England believes that the ICB has demonstrated good or outstanding practice as well as areas of challenge
- detail any support needs that have been identified over the course of the year, any support or intervention that has been implemented in response, and a summary of the ICB's progress towards any agreed improvement goals.
- Annual assessments for 2022/23 will be completed and the outcome shared with ICB Chairs by the end of July 2023. The assessment will not include an overall rating of ICB performance.
-
- NHS England is required under the terms of the Act to summarise the outcomes of all annual assessments and will include this summary within its own annual report and accounts.

Assessment approach and process

- This guidance sets out how the annual assessments will be conducted, including the specific Key Lines of Enquiry (KLOEs) that NHS England will use when making its assessment.
- The assessment approach for 2022/23 has been developed with ICBs to minimise additional burden and meet the specific requirements set out in the Act. The assessment will therefore draw, wherever possible, on existing processes and information, reducing bureaucracy and avoiding duplication. Assessments will be underpinned by three main sources of evidence:
- The ICB's own **Annual report and accounts**
- The outcomes of **routine discussions** between NHS England and ICBs held over the course of the year
- **Feedback** from key system partners.

Performance Summary

NHS
Suffolk and North East Essex
Integrated Care Board

Key Theme		Areas of improvement	Areas requiring further work
	Urgent and emergency care	Community based urgent care response has been improving since May 2022. Most patients have a response in under two hours which exceeds the national expectation.	Since last summer, waiting times for accident and emergency have increased and patients have waited longer for ambulances, although both are moving closer towards national target
	Elective (planned) care	82% of patients are now waiting less than 6 weeks for diagnostic imaging and tests which is a significant (10%) increase on March 2022.	The longest waits (over 18 months) which built up during Covid for planned hospital treatment reduced by over 500 patients but a small number of patients are still waiting more than 18 months from referral for treatment. We are aiming to reduce the maximum wait to 15 months by March 2024.
	Cancer care	The number of patients awaiting cancer treatment for more than 62 days was at its lowest in two years.	
	Primary care	Dental activity (appointments and treatments) has risen since May 2022.	Dental activity (appointments and treatments) is not yet back to pre-pandemic levels, although Mar-23 is showing the highest activity since then.
	Mental health	The number of children and young people able to receive mental health care has increased significantly since March 2022. The number of people able to receive mental health care before and after birth (perinatal period) has increased significantly. The number of people with learning disabilities who have an annual health check in 22/23 was well above the national target of 75% (79.8%)	Overall, fewer adults are currently receiving community mental health care. We are reviewing the causes of this and will develop an action plan in response. Out of area placements for mental health care are increasing – we are working with our local providers to reduce these.

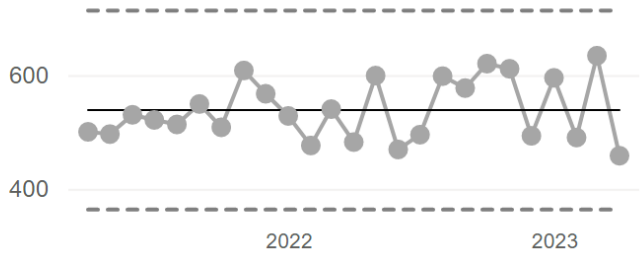
Cancer

NHS
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Integrated Care Board

Issues & Root Cause

Key focus has been 62 day backlog recovery for 22/23, with SNEE now having the lowest backlog in the region of 7.8% resulting in 488 patients waiting over 62 days for their first treatment. The focus for 23/24 will be the recovery of the 75% faster diagnosis standard, with the Q1 expectation 67.5%, SNEE's currently 68.6%. With the most challenged pathways skin and colorectal.

Patients Treated for Cancer



Apr-23

First cancer treatments are currently **458** for this month

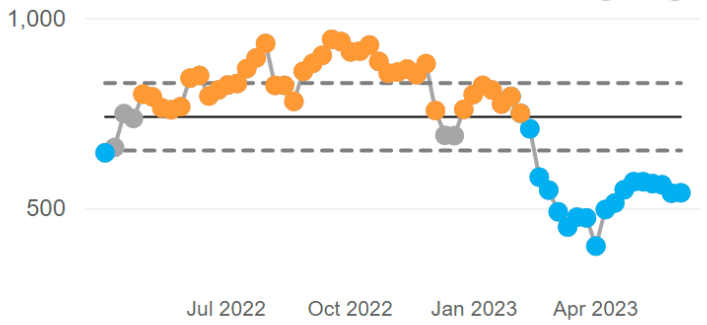
62+ Day Cancer Waits

w/e 04-Jun-23

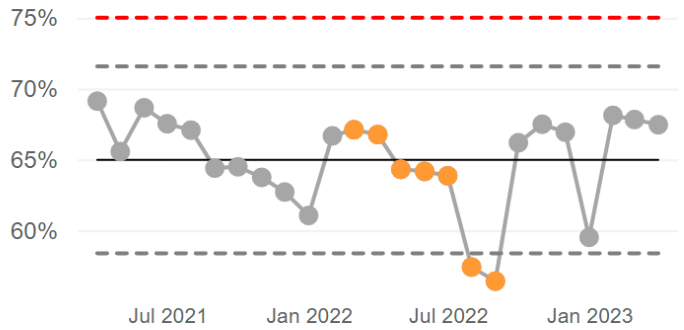
540 ESNEFT/WSFT patients are currently on the waiting list who have been waiting more than 62 days

374	at ESNEFT	8.7%	of all waiters
166	at WSFT	10.1%	of all waiters

62+ day waiting list: Cancer

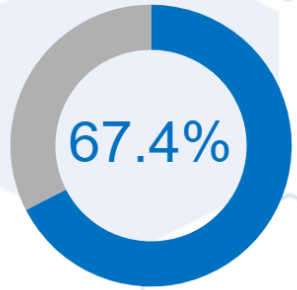


28 Day Faster Cancer Diagnosis



Apr-23

Proportion of ESNEFT/WSFT patients meeting the faster cancer diagnosis standard



Recovery Actions

Recovery trajectories for the 62 day and 75% faster diagnosis standard have been submitted to the national team. Weekly backlog data is submitted to the national team and reviewed, with priority specialties identified.

Cancer & Rapid Diagnostics

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
62+ day waiting list	Reduction of waiting list to pre-pandemic levels by Mar 2023	Trust Local PTL	Jun-23	●	323	374	540		
62+ day waiting list - over 104 days		Trust Local PTL	Jun-23	○			129		
Increased first cancer treatments	Reduce shortfall	National CWT	Apr-23	●			458		
28 day faster diagnosis	75% by Mar 23	National CWT	Apr-23	●	75.0%	64.4%	67.4%		
31 day wait diagnosis to treatment	Improve performance	National CWT	Apr-23	○	96.0%		94.1%		
Patients treated within 62 days	Improve performance	National CWT	Apr-23	○	85.0%		68.4%		
Screening uptake - Cervical (25-49)	Maintain and restore cancer screening programmes	NHS Digital	Dec-22	●			72.3%		
Screening uptake - Cervical (50-64)	Maintain and restore cancer screening programmes	NHS Digital	Dec-22	●			77.4%		
Screening uptake - Breast (50-70)	Maintain and restore cancer screening programmes	PHE - Fingertips	Mar-22	●			67.8%		
Screening uptake - Bowel (60-74)	Maintain and restore cancer screening programmes	PHE - Fingertips	Mar-22	●			73.7%		
Early stage diagnosis	75% by 2028		Sep-22	●			59.3%		

Key performance issues & root cause summary

We remain focussed on reducing the 62 day wait backlog across the ICB. We finished 22/23 with the lowest backlog level in the region at 7.8% of the overall waiting list waiting more than 62 days. Our focus in 23/24 remains on further reducing the 62 day backlog as well as achievement of the 75%Faster Diagnosis Standard (FDS) for which we are currently ahead of the Quarter One trajectory. The main focus areas are skin and colorectal to enable us to achieve the end of year standard at 75%.

Key performance recovery actions

The ICB has agreed recovery trajectories for our two key national cancer standards - 62 day backlog and FDS achievement. Actions plans are in place at Trust and aggregated ICB level which are monitored through the ICS Cancer Operational Group and the ICS Cancer Committee.

Cancer & Rapid Diagnostics Committee

Narrative submitted: 28/06/2023

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

* Additional Cancer Service development funding has been agreed by the national team. Spending priorities has been agreed with the wider cancer team
* Cancer delivery plan to be completed for 2023/24 and signed off by national team, with service development funding released
* The targeted lung health check pathway has had a soft launch, with a full rollout planned but slightly delayed due to loss of programme manager
* Bowel Cancer screening pathway now live in Beacon House for our homeless population
* TLHC pathway live in SNEE
* B/C for prehab taken to ops group – asked to return in August with more local data
* PCFU funding gap plugged with SDF until sustainable funding stream identified

Key actvities planned for the next 2 months

* Recruit two additional transformation leads to support the delivery of the cancer programme, both to be hosted at WSFT, adverts out next week
* SBRI funding awarded to SNEE to deliver Cytoprime2 a new Cytosponge pilot within the community setting, plan to live date June 2023
* SBRI funding awarded to SNEE to deliver a community skin pathway, utilising AI technology, plan go live summer 2023.
* Improving the Cancer Journey ambitions have been developed, MIA developed in partnership with MacMillan to further support the workstream with the resource required.
* Review SDF funding and repurpose to other schemes if not utilised in the correct timeframes, end of Qtr 1 Review

We have learned this and need to share...

We have learnt, to develop a function to support the communication between partners as a continuous discussion, therefore we are going to further develop our let's talk SNEE platform. Our phycological support questionnaire and communication has been well received.

We need help with..

* Transformation capacity within providers to support implementing deliverables from the cancer programme. Our Cancer Radiology lead in ESNEFT has returned to their substantive role, resulting in risks to programme delivery
* Awaiting the decision on the clinical lead review and the status of our cancer GP Leads

Key Issues

*Within the system we have a shortage of specialist roles, including Consultant radiologists and Specialty Consultants, Oncologists (Ipswich) this results in vacancies and high locum workforce.
* 28-day Faster Diagnosis 70% achievement under NHSE Review and National Team - regular reporting required.
* Loss of key clinical support will cause impact on programme

Key Risks

* Sustainability of transformation support within the providers, supporting delivery of the cancer programme, these roles can conflict with operational pressures
* Cancer project delivery reliant on the support of GP Clinical Leads - awaiting outcome of review
* Non-Site specific pathways for lower GI - maintaining clinic capacity and optimising the usage of these pathways

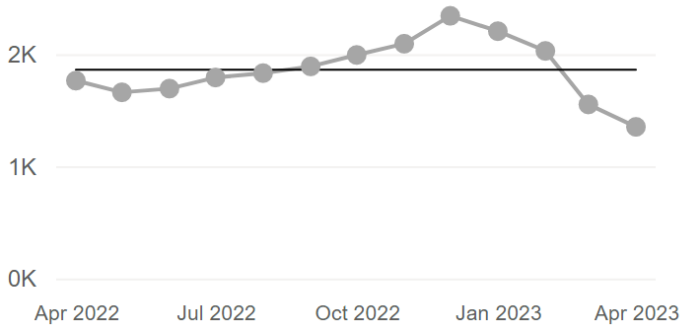
Elective Care & Diagnostics

NHS Suffolk and North East Essex Integrated Care Board

Issues & Root Cause

78 week breaches reduced from 259 to 195 in May 2023. There are still two significant groups of patients who were 'capacity' breaches (as opposed to patient choice or clinically complex exclusions): General Surgery patients at ESNEFT (insufficient internal and outsourced capacity) and Urogynaecology (small sub-specialty where no external capacity available) patients at WSFT. ESNEFT have been placed in Tier 1 (national support) and WSFT Tier 2 (regional support) for 65 week recovery.
Activity out-turn appears to be falling but this looks like a counting change - BI are reviewing. Productivity improvements are being seen in theatre utilisation, daycase rates, advice and guidance and patient initiated follow up use.
Diagnostic performance at ESNEFT remains strong. WSFT saw improvements in many areas in May 2023 (most notably endoscopy waits improved) but still has major challenges to recover MRI and endoscopy waiting times.

RTT - 65 weeks waits



Apr-23

There are currently **1,351**

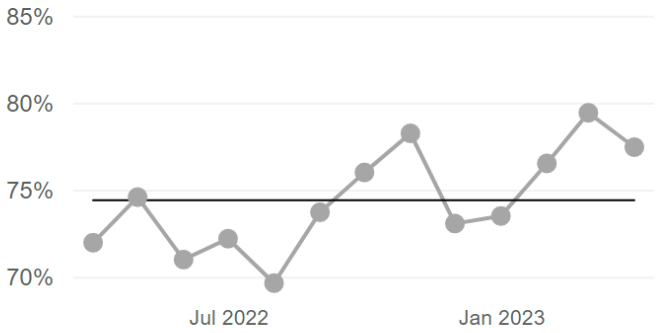
ESNEFT/WSFT patients who have been waiting more than 65 weeks to start treatment

Recovery Actions

Recovery plans are in place for all areas to bring waits down to 65 weeks. ESNEFT have reduction trajectories for all speciailties and are aiming to reach 65 weeks earlier then MArch 2024 where possible. WSFT are exploring insourcing options for urogynaecology and regional support from NHS England and are on track in all other areas. The focus on increasing productivity and throughput will continue into 2023/24 as we look to meet the challenge of reducing waiting times to a maximum of 65 weeks.
A clinically led, pan-SNEE, outpatient programme is being scoped and will commence imminently.
There will be continue to be a specific focus on general surgery in addition to the established groups on musculoskeletal and ophthalmology services.
WSFT continue the outsourcing of endoscopy to InHealth in Ipswich.

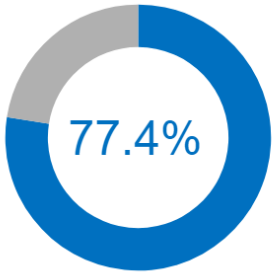
MetricName	Date	Actual	Var.	LPL	Mean	UPL
Elective Day Case	May-23	12,254		8,756	11,108	13,459
Elective Ordinary	May-23	1,635		1,225	1,607	1,988
First outpatients	May-23	31,949		19,293	29,862	40,431
Follow up outpatients	May-23	58,581		37,489	52,493	67,496
First outpatients - procedures	May-23	5,878		3,388	5,196	7,004
Follow up outpatients - procedures	May-23	10,443		7,217	9,873	12,529

Diagnostic Tests within 6 weeks

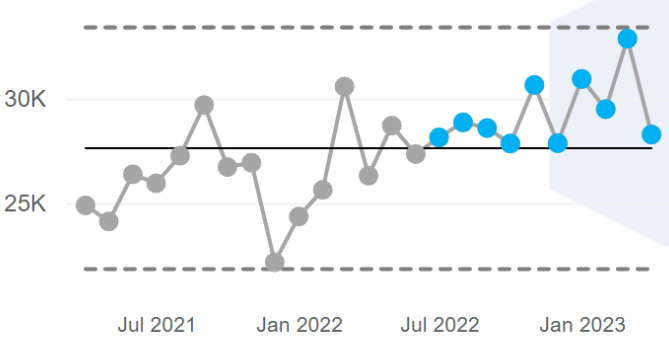


Apr-23

Proportion of ESNEFT/WSFT patients waiting less than 6 weeks (target 95%)



Diagnostic Tests



Apr-23

Diagnostic tests are currently **28,272** for this month

Strategic Programmes, Elective Care and Diagnostics

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
RTT Admitted Pathways	110% of 19/20 baseline	National RTT	Apr-23	○			2,391		
RTT Non-Admitted Pathways	110% of 19/20 baseline	National RTT	Apr-23	○			14,803		
104 weeks wait	0 by 31 Jul 2022	National RTT	Apr-23	●			9	L	F
78 weeks wait	0 by 31 Mar 2023	National RTT	Apr-23	●			259	L	F
52 weeks wait	Reduction on Apr 22 baseline	National RTT	Apr-23	●			5,249	H	F
Diagnostic Tests	Increase diagnostic capacity to 120% of pre-pandemic activity	DM01	Apr-23	●			28,272	H	
Elective Day Case		Faster SUS	May-23	○			12,236		
Elective Ordinary		Faster SUS	May-23	○			1,632		
First outpatients - F2F		Faster SUS	May-23	○			36,030		
Follow up outpatients - F2F	25% reduction in outpatient follow-ups by 2023	Faster SUS	May-23	●			62,431		
First outpatients - Virtual		Faster SUS	May-23	○			5,420		
Follow up outpatients - Virtual	25% reduction in outpatient follow-ups by 2023	Faster SUS	May-23	●			20,306		

Key performance issues & root cause summary

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Strategic Programmes, Elective and Diagnostics Committee (1 of 2)

Narrative submitted: 26/06/2023

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

ESNEFT continue to meet with the national elective recovery team and intensive support team and are implementing improvement actions. WSFT are exploring mulitple potential solutions to their urogynaecology capacity shortfall.
Getting It Right First Time (GIRFT) and High Volume Low Volume Complexity (HVLC) work continues.
The Elective Care Programme Board - a forum where the system's two trusts share best practice from their respective improvement programmes, noted good progress in outpatient productivity, theatre utilisation, reducing the length of stay and increasing cases per list.
An outpatient programme sub-group is being scoped.
Outsourcing of endoscopy from WSFT to the independent sector is ongoing and waits are beginning to fall.

Key actvities planned for the next 2 months

ESNEFT expect to clear all non-choice/non-complex 78 week waits in July 2023 (delayed from June due to Industrial Action).
WSFT will be meeting with NHS England's medical directorate to explore alternative capacity solutions to the shortfall they have in the Urogynaecology sub-specialty. Insourcing scoping continues.
Productivity, throughput, outsourcing and insourcing projects will continue throughout 2023/24. There will be a specific focus on outpatients as that's where the majority of waiting list growth is currently occuring.
As part of the ICB restructure proposals we are reviewing roles and responsibilities relating to elective care.
The elective teams are preparing for their third GIRFT/HVLC visit which will include cancer.

We have learned this and need to share...

Acute trusts have shared their elective programmes and are looking to align as much as possible. The ICB will also seek to align resource so that programmes consider the full pathways from self-care through to treatment.

We need help with..

Mutual aid continues to be sought for Urogynacology at WSFT and Oral Maxillo-Facial Services at ESNEFT.

Key Issues

Our key issues are: staffing availability and industrial action resulting in cancellations; availability of mutual aid for some of our hard-pressed specialties and sub-specialties; capacity for the growing number of 'priority' programmes coming from NHS England.

Key Risks

Our key risks are: ongoing and heightening industrial action, absence of sufficient funding to increase capacity; insufficient beds to meet demands of UEC and elective programmes; staff resilience; escalating cancer demand; clinical and managerial capacity to service change programmes.

Strategic Programmes, Elective and Diagnostics Committee (2 of 2)

Narrative submitted: 28/06/2023

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

Lipid specification & contract governance nearly completed for NEE Community Service
L2b Neuro Rehab beds VEAT notice(procurement) no challenges, can complete waiver & issue contract
Working with GP Fed on AF health inequalities project. Service spec completed
Catalyst Project 6 month review HUB contract signed with Livability, recruitment due to start. Options appraisal shared with project group for delivery pathways.
Diabetes "Paths to Remission" (T2DR) prospectus completed & returned to NHSEI Evaluation for NDPP3 (diabetes prevention procurement) completed.
13 practices moved to Eclipse Reporting
CVD: Inclisiran CLF bid written & returned to NHSEI, awaiting decision. Letters to top 6 practices sent inviting to join Blood Pressure Optimisation project
SNEE ICS spirometry investment approved & agreed to extend until Mar 24
Sentinel plus pilot - 1st patient focus group in NEE with NHSE exploring experiences of inhaler switching and education.

Key actvities planned for the next 2 months

Lipid clinic NEE complete spec sign off, lipid governance, reporting and KPIs
L2b complete contract for block beds & progress AQP for procurement
AF health inequalities project delivery to start
6 month review, patient engagement for review, assessment tool and invitation process, engage with IES pathway to revise
Review SSNAP action plans with trusts for new data, plus their NOCIP action plan
Undertake SNEE Diabetes review. Continue work on Healthy Hearts Together LES. Complete contracts for Healthy Hearts Together providers
WS home ACR testing. Support SNEE wide Diabetes pump formulary project
24/25 Forward planning options: spirometry community, long covid, ME&CFS services
Discuss winter planning options with respiratory committee & liaise with BI team to review A&E, outpatient activity & last year's ARI hub data.

We have learned this and need to share...

We need help with..

* Diabetes options appraisal for SNEE
* Winter plans for respiratory services

Key Issues

* Shortage of IES Diabetes consultants affecting treatment lead-times
* Risk of not being able to fund Diabetes LES for 23/24 for West Suffolk

Key Risks

* Recruitment for 6 month reviews for the Catalyst project may impact on service delivery to achieve 60% by March 2024 (current position @20%)
* Spirometry funding non recurrent to end of March, business case for sustainable model to be developed that is affordable and location of the service needs to be further explored

Urgent & Emergency Care

NHS Suffolk and North East Essex Integrated Care Board

Issues & Root Cause

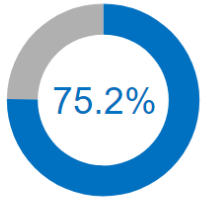
Ambulance response times remain above expected for both C1 & C2 priority categories, however this has been improving since Jan-23, with response times in Apr/May-23 at their fastest since Jun-21

Response times are no longer being reported by EEAST at sub-ICB level, so all measures are for SNEE ICB only

The % of ambulance handovers in 30 mins remains below the target of 95%, but at 85.9% has continued to show a significant improvement in May-23

The number waiting over 12 hours in ED is now within the SPC control limits and has shown significant improvement since Mar-23, with 6.4% currently waiting over 12 hours, compared to the target of 2%

A&E 4 Hour Waits



Apr-23

Proportion of ESNEFT patients waiting in A&E for less than 4 hours

WSFT currently not reporting against this metric

G&A Bed Occupancy



02-Jul-23

94.93% of G&A beds are currently occupied in ESNEFT/WSFT

97.24% at Colchester Hospital

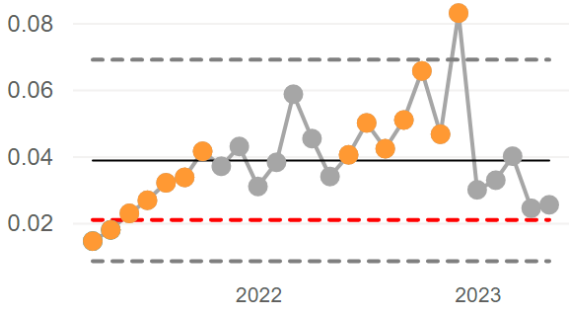
95.02% at Ipswich Hospital

92.07% at West Suffolk Hospital

Recovery Actions

Significant pressure remains across the UEC system. Demand & Capacity work has been undertaken (linked to national funding) with a number of schemes being implemented to support flow. This should improve the ED performance and support improved patient arrival to handover performance.

Ambulance Cat 2 Responses



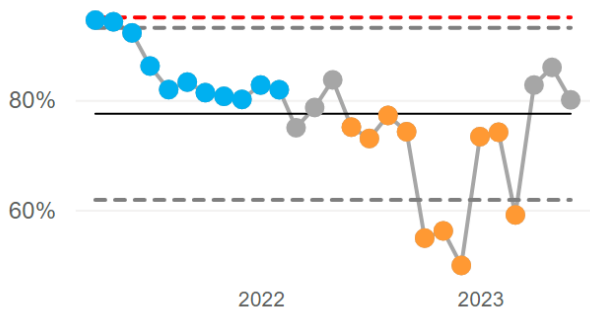


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May-23

Mean category 2 ambulance response time (target 30 mins)

Ambulance Handover Delays

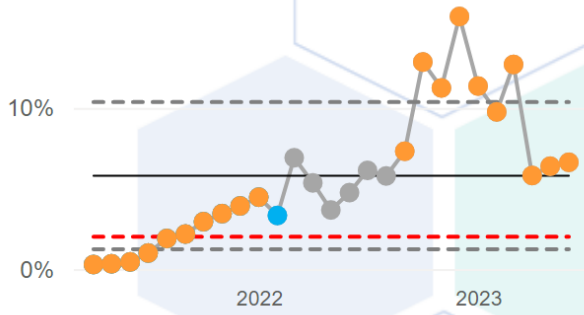


Jun-23

Handovers within 30 mins (target 95%)

80.0%

ED 12 Hour Waits



Jun-23

Reduce towards 0 with no more than 2%

1,384 (6.6%)

Urgent & Emergency Care

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
Ambulance response times - C1 Mean	7 mins	EEAST	May-23				00:09:08		
Ambulance response times - C1 90th percentile	15 mins	EEAST	May-23				00:17:38		
Ambulance response times - C2 Mean	18 mins	EEAST	May-23				00:36:31		
Ambulance response times - C2 90th percentile	40 mins	EEAST	May-23				01:15:39		
Ambulance handover delays	95% within 30 mins	EEAST	Jun-23				80.0%		
A&E Attendances - Type 1&2		Faster SUS	May-23				20,282		
12 hour waits in ED	Reduce towards 0 and no more than 2%	Local Trust Report	Jun-23				1,384 (6.6%)		
NEL Spells		Faster SUS	May-23				8,884		

Key performance issues & root cause summary

Ambulance response times remain above expected for both C1 & C2 priority categories, however this has been improving since Jan-23, with response times in Apr/May-23 at their fastest since Jun-21

Response times are no longer being reported by EEAST at sub-ICB level, so all measures are for SNEE ICB only

The % of ambulance handovers in 30 mins remains below the target of 95%, but at 85.9% has continued to show a significant improvement in May-23

The number waiting over 12 hours in ED is now within the SPC control limits and has shown significant improvement since Mar-23, with 6.4% currently waiting over 12 hours, compared to the target of 2%

Key performance recovery actions

Significant pressure remains across the UEC system. Demand & Capacity work has been undertaken (linked to national funding) with a number of schemes being implemented to support flow. This should improve the ED performance and support improved patient arrival to handover performance.

Urgent & Emergency Care Committee

Narrative submitted: 15/06/2023

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

The SNEE One plan workstreams have been designated SRO's and are continuing to formulating milestones, timelines, outcome measures and resouricng requirements.

SNEE Operational Delivery Group holds the governance for the monitoring of the UEC recovery trajectories and actions on behalf of the UECC. This group is now holding a monthly assurance meeting joined by NHSE UEC group.

The system contiunued to manage the various rounds of industrial action with no significant incidences.

The Unscheduled Care Coordination hub (UCCH) (formerly known as the Community Hub), began phase 1 on 12 April and continues to 'test and learn' with phase 1 being extended to 31 July

Key actvities planned for the next 2 months

To assign the operational lead to the one plan workstreams, with refinement of the actions as the plans develop.

Robustly monitor UEC perfomance against the planned trajectories. Deep dive planned for C2 response times and ESNEFT (IHT) ED delivery. peer to peer reviews of ED at ESNEFT sites (WSFT completed)

BCF / Discharge fund plans towards 2025 are due for submission on the 28th of June
National teams developing the minimum viable product required for System control Rooms which is expected to be published in June. .

The financing the UCCH into Phase 2 is currently being explored through the Finance Information Group (FIG)

We have learned this and need to share...

SNEE UEC Operational delivery Group (ODG) new format and structure has been well received

The newly reported 4 hour ED standard at WSFT has had a very positive start and reporting above planned trajectory with positive impact on 12 hr standard

WS had a DH visit to review their Transfer of Care Hub and ECIST are working with ESNEFT on sharing their discharge processes for national best practice

We need help with..

Executive support is needed in order to agree and provide visabilty of key live metrics in real time.

Executive support to gain an understanding of any additional funds for seasonal planning so that we can ensure that it is maximise.

Key Issues

Significant pressures on ability to provide UEC services, with further potential IA having a significant impact. Awaiting the ballot outcome from Consultants due 27 June.

Focus on UEC performance metrics from regional and national teams. Challenges will be ED 4 hour performance; reducing lost hours due to arrival to handover delays; C2 - 30 min response and 12 hour waits.

Key Risks

Challenged UEC performance - particularly C2
On-going and possible escalating industrial action, especially consultants as planning for this will be extremely challenging.
Workforce fatigue
Seasonal planning funding uncertainty

Maternity & Neonatal

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
Preterm Births (<37 weeks) 12 month rolling rate	<=6%	RPQOG	Apr-23	○			8.20%	H	F
Preterm Births (<37 weeks) monthly rate	<=6%	RPQOG	Apr-23	○			7.70%		?
3rd & 4th degree tear - singleton vaginal delivery	<=2.5%	RPQOG	Apr-23	○			0.90%		?
3rd & 4th degree tear - instrumental delivery	<=6.3%	RPQOG	Apr-23	○			9.35%		?
Massive Obstetric Haemorrhage = 1500 mls - Vaginal delivery	<=3.3%	RPQOG	Apr-23	○			2.70%		?
Massive Obstetric Haemorrhage = 1500 mls - C-section	<=4.5%	RPQOG	Apr-23	○			4.26%		?
Stillbirth Rate (per 1,000)		Civil Registration of Births	Jan-23	●			6.47		
Neonatal Mortality Rate (per 1,000)		Civil Registration of Deaths	Jan-23	●			1.29		
Smoking at time of delivery	<=6%	RPQOG	Apr-23	○			8.50%		F

Key performance issues & root cause summary

Performance metrics currently reported from combined local reports for ESNEFT and WSFT. Known DQ issues with ESNEFT's submission to the national Maternity Services Data Set (MSDS). When rectified, reporting will switch to national flows, and will provide more detail behind some of these metrics. Variation seen in stillbirth & NND but overall remain static whereas national ambition of 50% reduction before 2025. % of women smoking at time of delivery has reduced and now below national target of 6% - due to new smokefree pathway. This should now start to reduce the number of preterm births (slight reduction seen this month), however preterm births remain higher than national benchmark.

Key performance recovery actions

Data Quality - ESNEFT to resolve data quality issues. LMNS returned digital midwife to Trust to increase capacity and pace. Stillbirth & NND - Root cause is still under investigation, ESNEFT have completed a 4 yr mortality review, awaiting release to LMNS. Preterm - New pathway developed by clinical workstream, agreed by LMNS Strategic Group in May 23.

**there is a known lag in the completeness of both births and deaths monthly data, so these figures are likely to change on refresh*

Maternity Committee

Narrative submitted: 30/06/2023

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

Independent Senior Advocate role recruited, planning start date and criteria for referral.
Programme plan and allocation of resources finalised
LMNS website in final construction phase
Gap analysis against 3 Year Delivery Plan, Saving Babies Lives, and CNST, and agreeing assurance and sign off processes
Review of Band 6 coaching session
Commencing business case production for community ambassador schemes to continue beyond March 24
Commenced review of 6 week GP check
Review of three stillbirth deaths at WSFT

Key actvities planned for the next 2 months

Finalise antenatal education specification and commence procurement
LMNS Strategic Group to agree workplan for 23/24 and funding allocation
Commence pelvic health MDT clinic review
Continue to Rollout preterm birth pathway
Shared learning event with buddy LMNS (delayed due to Dr strike)
Commenced LMNS wide discussions on data quaility improvement plan to ensure accurate reporting of outcomes for 3YDP

We have learned this and need to share...

Whilst preterm births, stillbriths and neonatal deaths are static, we have discovered that the rate of late miscarriages has decreased. We are developing a hypothesis that due to preterm birth clinics the number of late miscarriages are decreasing. Babies may survive when previously they might have been miscarried but the baby is not able to be born at term. We will explore this at the next preterm workstream.

We need help with..

To ensure that any rebates received from Clinical Negligence Scheme for Trusts are reinvested into maternity services as national requirement.
To focus on data quality within all maternity and neonatal services as NHSE will be extracting data from these as their main source of quality and safety indicators.

Key Issues

1. Ipswich hospital remain national outlier for term admissions to neonatal unit
2. MSDS not accurate re ESNEFT data, unable to create reliable SPC's or complete historical analysis to identify trends and impacts of any QI measures, therefore dependent on ESNEFT to provide data required. This puts pressure on ESNEFT BI team.
3. Both Trusts having difficulty with full MDT ward rounds, 12 hours apart
4. Ipswich Hospital national outlier for term admissions to neonatal unit
5. LMNS regional outliers for preterm birth, PPH

Key Risks

1. Stillbirth and neonatal mortality rates not reducing as per national ambition risks ICB not achieving national ambition
2. NEWTT trigger tool in ESNEFT to be implemented.
3. Neonatal development follow-up checks below national benchmarks in all units may result in later diagnosis of NDD or developmental delay

Mental Health

NHS
Suffolk and North East Essex
Integrated Care Board

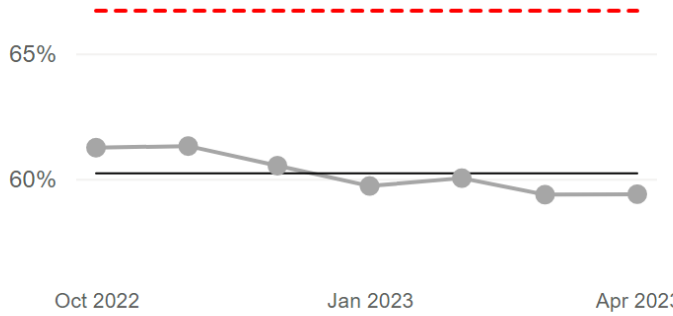
Issues & Root Cause

Access to community MH services has been decreasing steadily since Dec-21, with actvity since Jun-22 falling below the SPC control limits

The number of out of area bed days have been increasing continually since Jun-22, with numbers now considerably higher than the peak in Apr-21.

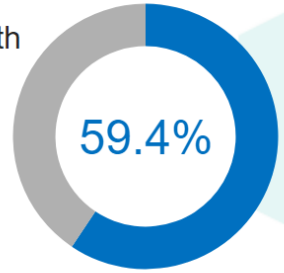
Dementia diagnosis rates appear to show a distinct drop from Dec-22, but this is largely as a result of a change in methodology and corrections in the data published by NHS Digital.

Dementia Diagnosis Rate



Apr-23

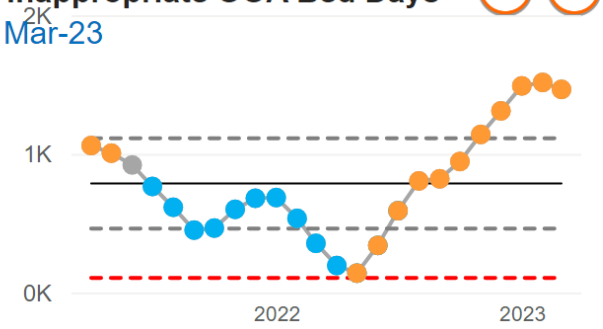
% diagnosed with dementia compared to estimated prevalence (target 66.7%)



MetricName	Date	Actual	Var.	LPL	Mean	UPL
CYP accessing MH services	Mar-23	12,085		11,247	11,792	12,337
IAPT Access (rolling qtr)	Mar-23	2,395		1,555	2,178	2,800
Community MH services access (older adults/SMI)	Mar-23	5,175		5,576	5,767	5,959
Perinatal Access - YTD	Mar-23	1,015		879	946	1,014

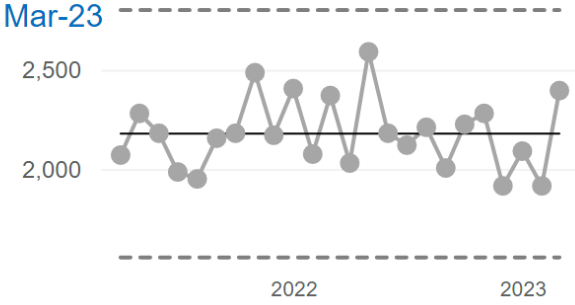
Inappropriate OOA Bed Days

Mar-23



IAPT Access

Mar-23



Recovery Actions

Access to psychological therapies is challenging nationally due to reduced availability of trained staff. Targets are reduced nationally for 23/4 in recognition of this. Work continues with Xyla to reduce 90 day waits in EPUT utilising temporary staff to bolster capacity. Waits between 1st and 2nd treatment are gradually reducing, though still exceeding the 10% national target and recovery plans are in place.

Out of area beds are increasing predominantly in NEE and this continues to be monitored.

Waiting lost growth remains of a concern in NSFT, targeted actions remain in place, challenges are persisting due to growth in demand

Mental Health

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
SMI full annual physical health checks		MH Core Data Pack	Mar-23	●	5,563		5,026		
NHS Talking Therapies Access		MH Core Data Pack	Mar-23	●	2,380		2,395		
NHS Talking Therapies Recovery Rate		MH Core Data Pack	Mar-23	○			52.0%		
Community MH services access (older adults/SMI)		MH Core Data Pack	Mar-23	●			5,175		
Inapproriate OOA placement bed days		MH Core Data Pack	Mar-23	●			1,465		
Dementia diagnosis rate		NHS Digital	Apr-23	○	66.7%	61.0%	59.4%		
Perinatal Access - Rolling 12 Mths		MH Core Data Pack	Mar-23	○			1,015		
EIP - Waiting Times	Treament within 2 weeks of referral	MH Core Data Pack	Mar-23	○			96.0%		

Key performance issues & root cause summary

Access to community MH services has been decreasing steadily since Dec-21, with actvity since Jun-22 falling below the SPC control limits

The number of out of area bed days have been increasing continually since Jun-22, with numbers now considerably higher than the peak in Apr-21.

Dementia diagnosis rates appear to show a distinct drop from Dec-22, but this is largely as a result of a change in methodology and corrections in the data published by NHS Digital.

Key performance recovery actions

Access to psychological therapies is challenging nationally due to reduced availability of trained staff. Targets are reduced nationally for 23/4 in recognition of this. Work continues with Xyla to reduce 90 day waits in EPUT utilising temporary staff to bolster capacity. Waits between 1st and 2nd treatment are gradually reducing, though still exceeding the 10% national target and recovery plans are in place.

Out of area beds are increasing predominantly in NEE and this continues to be monitored.

Waiting lost growth remains of a concern in NSFT, targeted actions remain in place, challenges are persisting due to growth in demand

Mental Health Committees (Suffolk & North East Essex)

Narrative submitted: 28/06/2023

NHS
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Key activities completed in the previous 2 months

SNEE
- Suffolk Mental Health Collaborative launched on 20.04.2023. Second collaborative workshop held on 26.05.2023 to consider structure, shared priorities and culture.
- Joint working NEE Head of Mental Health Service Change post started on 01.06.23 with supporting system wide priorities in development. Pan Essex discussion underway with ICB's and ECC on better working together. Suffolk Head of Mental Health Service Change post in development across ICB/NSFT/SCC.
- Eating Disorders Suffolk Deep Dive held on 17.05.2023 ICB Medical Director supporting with NHSE and clinical leads identified from acute and MH Trust.
- Early Intervention in Psychosis- NSFT achieved Level 3 and EPUT Level 2.
- Southend Essex and Thurrock (SET) MH Strategy- agreed by ICB Board in June 2023.

Key actvities planned for the next 2 months

SNEE
- Suffolk Mental Health and Emotional Wellbeing Strategy 2019-29 to be refreshed as now four years old; to consider a refreshed JSNA (Public Health), inequalities and shared system priorities.
- Suffolk Public Health Mental Health Prevention Strategy- to be taken through the collaborative in June to support a broad conversation on early intervention and prevention.
- Police: Right Care Right Person system conversation underway with police colleagues.
- Suffolk ASD and ADHD meeting to agree service model and associated waiting list initiative.
- Suffolk Talking Therapies (IAPT) Service discussion underway with NSFT to agree deliverables for 1 year contract until 30.09.24 and procurement.
- Suffolk Community Model Finalisation of MH PCN ARRS roles with supporting MOU.

We have learned this and need to share...

SNEE: At May 2023 dementia diagnosis rate for England 63%. SNEE ICB is at 59.23% (NEE:64.95%; I&E:57.45%; WS:54.53%). Plan in place to deliver 66.7% by 31.10.24. Discussion continues on WS Memory Assessment capacity.
SMI Physical Health Checks at Q4 2022/23: IES 75.1% (increase from 65.8% in Q3); WS 66.9% (increase from 53.8% in Q3) and NEE 66.1%. Highest in East of England ICB's.

We need help with..

SNEE
Request Alliance support in developing relationships with district and borough colleagues in respect of housing agenda and broader community wellbeing conversations.
We seek views on the development of our Mental Health Collaboratives to ensure that they will deliver for our local populations.
Seek opportunities to join up mental health services with our physical health programmes of work.

Key Issues

Increasing demand for MH services in light of covid pandemic and cost of living crisis.
Recruitment and retention of workforce challenges.
NSFT and EPUT CQC outcomes. ICB will continue to work with both Trusts to support associated improvement/recovery plans.

Key Risks

EPUT Public Inquiry announcement-June 2023.
EPUT CQC visit and outcome- Final CQC Report expected.
NSFT- release of Norfolk and Suffolk FT report on recording, processing and reporting of mortality data (commissioned by SNEE & N&W ICB's).
System financial challenges could create the conditions for silo working and inhibit organisations from integrated working.

Children & Young People

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
CYP accessing MH services		MH Core Data Pack	Mar-23		12,583		12,085		
CYP Eating Disorders - Routine	Treatment within 4 weeks of referral	MH Core Data Pack	Mar-23		95.0%		85.2%		
CYP Eating Disorders - Urgent	Treatment within 1 week of referral	MH Core Data Pack	Mar-23		95.0%		59.4%		

Key performance issues & root cause summary

Key performance recovery actions

Children & Young People Committees (Suffolk & North East Essex)

Narrative submitted: 28/06/2023

NHS
Suffolk and North East Essex
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Key activities completed in the previous 2 months

1 VCSE CAMHS Admission avoidance for Kooth now live. Other Providers already in place
2 ARFID draft business case is being shared with families for co-production of future pathway
3 Development of new VCSE package for CYP eating disorders, agreed implementation by September 2023
4 Suffolk Therapies - working with SCC to include as co-commissioner
5 NEE Community Paediatric, supporting the ongoing transition between providers
6 NEE MHSTs procurement bids received
7 Implementation of NEE PCN MH practitioners programme.
8 CYP Crisis Peripatetic Team funding agreed to extend and recurrent ICB funding obtained

Key actvities planned for the next 2 months

1 NDD implementing outcomes from SNEE deep dive
2 MH for 0-5 being developed for SNEE
3 Embedding steering group for Acute and Community paediatric services review
4 Suffolk PCN CYP workers pilot options being developed
5 ARFID pathways business case to be presented in July
6 NEE MHST Procurement progress, moderation July
7 Mobilisation of NEE PCN MH practitioner pilot and CYP accessing support.
8 Suffolk SEND review expected soon
9 NEE counsellors in PCNs working to align pathways and reporting consistency
10 Finalise Suffolk therapies contract & reporting arrangements with SCC
11 WS developing the education representation within Start Well framework
12 Development of service review to transfer early intervention services from NSFT to SCC
13 NDD deep dive outputs presented to July SOAC

We have learned this and need to share...

1 Importance of co-production in transformation, vital to embody across ICS. Input from service users builds engagement and improvement
2 CYP working being further embedded in alliances frameworks is supporting join up and preventing duplication
3 Mapping of MH crisis in Suffolk has demonstrated complexity & hand offs within current pathways that must be reviewed, look to map NEE provision

We need help with..

1 Ensuring both NDD pathways continue to be raised across the system, support and engagement from system partners on deep dive.
2 Education leadership being more engaged and more equitable offer to all our schools.
3 Continued system working to ensure we can support CYP effectively to 'Wait Well' whilst waiting for assessment and treatment.

Key Issues

1 Residual waiting lists for autism/ADHD diagnostic services. Looking at options for investment, additional focus on backlog of cases with Barnardo's
2 Recruitment is ongoing system challenge
3 Continuing high level of demand for emotional health & wellbeing services
4 Key staff changes within ESNEFT children's services will result in need to establish & build new working relationships

Key Risks

1 Lack of financial support for non-mental health investment
2 Staffing resource to support Transformation programmes
3 Identification of resource to support current demands on service
4 CYP not able to access support quickly causing escalation in some cases to crisis or more complex needs
5 Significant demand for ASD/ADHD assessments and backlog of referrals with co-ordination function

Learning Disabilities & Autism

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
LD health checks		NHS Digital	Apr-23		75.0%	6.5%	3.9%		
Adult Inpatients - Suffolk TCP (Rate per million)		NHS England	Apr-23		28		21.52		
U18s Inpatients - Suffolk TCP (Rate per million)		NHS England	Apr-23		15		15.30		
Adult Inpatients - Essex TCP (Rate per million)		NHS England	Apr-23				23.17		
U18s Inpatients - Essex TCP (Rate per million)		NHS England	Apr-23				19.49		
Flu Vaccination Uptake		CQRS	Mar-23				82.0%		

Key performance issues & root cause summary

The annual health check data received from NHSE/Digital is not refreshed and so any changes that practices may make are not captured. For most, these changes will be insignificant (one or two checks), however a small number of practices have completed significantly more checks than what the data is suggesting. Conversations are underway with the Business Intelligence team, who can access a more accurate source of data (CQRS). The ICB will be able to use this when reviewing our practice level activity.

Key performance recovery actions (NEE)

Practices are supported with regular comms, coding issues, info on funding sources, best practice models and available resources etc. Some PCN group training taking place with specialist LD nursing team. Evidence of PCN working. A dedicated LDHC support area for primary care health professionals is being set up on the ICB website to support actions from the LeDeR report.

Key performance recovery actions (Suffolk)

The deep dive project which is underway is allowing a granular view into the LD registers. This is enabling the LD liaison team to follow up, explore and understand the story at an individual level, providing the necessary support to improve access and enable delivery of the annual health checks and provide targeted interventions to reduce risks. Themes are beginning to be understood as to why individuals are not attending or declining their annual health check and support.

Learning Disabilities & Autism Committee (Suffolk)

Narrative submitted: 30/06/2023

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Key activities completed in the previous 2 months

Oliver McGowan Day 2 lead facilitators training was held on 13th and 14th June. Identified lead facilitators from social care providers were in attendance.
Third party providers will begin to deliver the Tier 1 online training to staff in the ICB. The ICB lead trainer delivered Day 1 of the 3 day experts with experience Autism training to the third party providers for T2
Weekly implementation meetings are being held with new Step up Step Down service provider to ensure a timely start date.
Work has been progressing on a ASD/ADHD adult assessment and diagnosis pathway with system partners and people with lived experience.
The My Health Focus Group has been shortlisted for a Health Service Journal Patient Safety Award 2023 as the Learning Disabilities Initiative of the year

Key actvities planned for the next 2 months

The ICB will be having a stand at the Expo to promote the Oliver McGowen Training and
The next My Health Focus Group will be held live at the Expo 23 at Wherstead Park Ipswich on the 7th July.
The ICB continues to work with system partners and people with lived experience to develop the Suffolk All Age Autism Strategy and Partnership led by 31Ten Consulting.
The ICB lead trainer will deliver Day 3 of the 3 day experts with experience training to the third party providers for T2 in August
SNEE LeDeR annual report for 22/23 will be finalised and published.

We have learned this and need to share...

We now have the workforce in place to rollout the train the trainer model for the Oliver McGowan Training. We need to share that our experts with experience require us, as an ICB, as a safe space to practice delivering initially the tier 1 1 hour online training.

We need help with..

Continue emphasis with practices on the importance of completing LD annual healthchecks and Health Action Plans for people with a learning disability.
To ensure that invitations to annual healthchecks are being sent throughout the year by practices and not completed as traditionally in quarter 4.

Key Issues

No issues to be raised.

Key Risks

Healthchecks – young people not having a LD code are not being identified to be added to the LD register and are therefore not receiving an annual healthcheck
ASD waiting lists are long and demand is not being met.

Learning Disabilities & Autism Committee (North East Essex)

Narrative submitted: 30/06/2023

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Suffolk and North East Essex
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Key activities completed in the previous 2 months

Worked with Suffolk colleagues and BI Team to clarify discrepancies in 22-23 year end performance data with NHSE. NHSE data will stand.
Richard Mboma now onboarded to assist with LDHC quality work in NEE. SNEE wide project initiated to set up a dedicated LDHC support area for primary care health professionals on the ICB website to support actions from the LeDeR report. Partnership working with the Herts Parts specialist LD nursing team to co-ordinate improvement activities.

Key actvities planned for the next 2 months

Contribute to new SNEE wide LDHC steering group to share, learn and co-ordinate.
Investigate further how NEE can adopt best practice models that employ co-ordinator roles to support LD patients to receive their LDHCs.
Review LD register sizes against national benchmarking to investigate if any practices have lower than expected lists and any follow-up actions.
Continue supporting with sharing resources, coding issues, funding sources and communicating best practice models etc
Continue developing the LDHC area on the ICB website, as above
Quality Lead to utilise LDHC performance data as part of Quality visits, and offer recommendations as necessary. Visits will monitor and inform on reasonable adjustments for LD patients, to ensure a reduction in service inequalities.

We have learned this and need to share...

The COLTE partnership did 2 things differently to acheive better results with NHSE funding than other Essex scheme participants. They offered weekend appointments and employed a dedicated delivery co-ordinator.
The Essex LeDeR report highlighted significant deaths from pneumonia related illnesses, that NHS Pneumonia vaccinations are available and practices should consider doing LD health checks with pneumonia jabs in the Autumn.

We need help with..

- Getting practices to gradually shift doing their LD health checks, from mostly towards the end of the year, to spreading them more evenly throughout the year.
- Whilst the IIF funding encourages PCNs as a whole to achieve LDHCs, there is currently no mechanism to make individual practices complete the health checks.
- resources to support HAP quality analysis and improvement

Key Issues

- Many practices leaving most of the LDHCs until the last 2 quarters.
- Lack of understanding within ICB of GP clinical systems and ability to help practices resolve coding issues.
- Performance data does not tell us whether people who did not receive a health check last year have received one this year or not.
- Lack of project resource in NEE to support quality initiatives/improvements

Key Risks

- Some hard to reach patients may not be receiving a health check on a rolling basis. We do not have the data to monitor/manage this, so there may be patients with worsening conditions who are not being monitored.
- LD patients not proactively monitored, are at higher risk of exacerbating conditions, leading to unplanned care incidents, greater demand on carers, poor quality of health/patient experience.

Quality

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
Summary Hospital Mortality Index rate - ESNEFT	SHMI banding = 2, 'as expected' (1, 'higher than expected')	NHS Digital	Dec-22				1.0780 (2)		
Summary Hospital Mortality Index rate - WSFT	SHMI banding = 2, 'as expected' (1, 'higher than expected')	NHS Digital	Dec-22				0.9800 (2)		
CQC rating - ESNEFT		CQC	Jan-20				Requires improvement		
CQC rating - WSFT		CQC	Jan-20				Requires improvement		
CQC rating - NSFT		CQC	Feb-23				Requires improvement		
Safety culture in NHS - raise concerns (ESNEFT)		NHS Staff Survey	Mar-22				66.3%		
Safety culture in NHS - raise concerns (WSFT)		NHS Staff Survey	Mar-22				69.0%		
MRSA rate (current month)		GOV.UK	Apr-23		0		0		
C Diff rate (current year - cummulative)		GOV.UK	Apr-23		150		8		
E-coli rate (current year - cummulative)		GOV.UK	Apr-23		147		15		

Key performance issues & root cause summary

The mortality index for ESNEFT fell back to expected levels in the rolling 12 months up to Dec-22. The rate for WSFT continues to rise, significantly so for Dec-22 reporting. Both remain as expected however (SHMI Banding 2)

Both Trusts were rated as overall requiring improvement in Jan-20. ESNEFT required improvement in the responsive and safe domains, but was rated good for being caring, effective and well-led. WSFT were rated good for being caring and effective, but required improvement in all other domains

There were 0 MRSA breaches in Apr-23. C. diff and E. coli are monitored against an annual cumulative threshold based on infection rates for the 12 months up to Nov-21. The thresholds have been set at 150 C.diff cases and 147 E.coli cases for 23/24.

Key performance recovery actions

NSFT CQC rating: ICB executives fully engaged in improvement work within NSFT, as well as triangulating at regional level with colleagues from N&W ICB. Evidence groups underway with ICB commitment. Re-inspection expected September 2022.
MRSA: All MRSA cases investigated at provider level with oversight from ICB IPC team. PIRs underway, performance on timely completion improving, and resulting actions are followed through. IPC inspections have identified further areas for improvement (cleaning) and are working with providers to implement them.

Quality Committee

Narrative submitted: 29/06/2023

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Key activities completed in the previous 2 months

The Quality Committee convened on the 11 May 2023.
The new Quality Dashboard was discussed and agreed.
Reports were presented from the Medicines Optimisation Committee; MH & LDA Services; Safeguarding.
Updates to CQC Action Plans were presented by ESNEFT and NSFT.
The Quality Model Framework was discussed and agreed.
Norfolk and Suffolk NHS Continuing Healthcare Joint Working Policy was presented to the committee.
A risk summit meeting was held on the 15 Jun to discuss our current Quality risks and agree a way forward to present Quality risk and what they should include.

Key actvities planned for the next 2 months

The next Quality Committee will be held on the 13 July 2023.

The next Development Session will be held on the 10 Aug 2023.
Discussion to be had on Health Inequalities within the system.

We have learned this and need to share...

Recognition of local authorities' dual responsibility for quality assurance and statutory responsibility for safeguarding.

It was important that the flow of information was open and honest.

The importance of looking at data, listening to soft intelligence, having strong governance in place and opportunity to appraise.

Pressure on ED's continues across the ICS.

We need help with..

Assurance for learning from deaths for all of the health sector, including primary care.

There was recognition that the Quality Dashboard was very health focused and that more work was required in conjunction with local authorities to explore how client satisfaction information might be included.

Key Issues

The impact of Cost of Living issues.
Refugee and Asylum Seeker issues.
CQC Ratings for WSHFT, NSFT, EPUT & EEAST.
CYP access to Tier 4 Beds.
Dementia is excluded from MH D2A pathways.
Demand v. Capacity.
Access to Dentistry Services.

Key Risks

EEAST delays and off loading waits.
Access to all services.
Special Schools in NEE do not have access to the Universal School Nursing Service.
Refugees and Asylum Seekers unable to access Primary Care.
Access to MH placement via the Emergency Department.
Eating Disorder Services.

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Executive Summary

Mortality and Learning from Deaths remains an important focal point across the ICB. Internal and external reviews of Mortality and how this is reported demonstrate that whilst some assurance is given within our acute providers, further system collaboration and integration is required by our ICB and Mental Health.

Emergency and Acute care remain challenged but strong system collaboration and trialling of new pathways to ensure the correct system partner is responding to patients at the right time continue. This includes initiatives to reduce ambulance wait times and increase response times to all ambulance categories, in particular C21 and C2

Quality within the Emergency Department is high on our agenda and system collaboration with ICB, Acute and Mental Health providers has commenced to shape a defined group of UEC Quality metrics, to include the 4hr Emergency Department standard as a quality marker.

Shared definition of Quality

- **Safety** - No Serious Safety Concerns were noted at Quality Committee
- **Experience** - Care Quality Commission action plan updates were received from providers with evidence of appropriate management and executive oversight being noted.
- **Effectiveness** - The Quality Committee was in receipt of the current quality dashboard. The inclusion of satisfaction and survey information was welcomed, and the Committee was informed that local authorities carried out surveys for carers which might be able to be linked into the dashboard. Whilst the information was interesting, it was felt that regarding patient safety incidents it would be beneficial to look at the rate of incident reporting and level of harm from incidents reported
- **Well Led –** The Quality Committee received quality and safety updates from alliances and system partners. Presentation of the Quality Model Framework: The quality assurance framework had been developed in conjunction with ICB System Partners and aligned to the current approach of partnership working and system assurance. The importance of looking at data, listening to soft intelligence, having strong governance in place and opportunity to appraise were emphasised and there was excitement within the committee towards taking the work forward.
- **Use of Resources** – Estates, Digital and Financial planning have not been considered by the Quality Committee, but assurance is provided in separate reporting.

Quality Update – UEC Dashboard

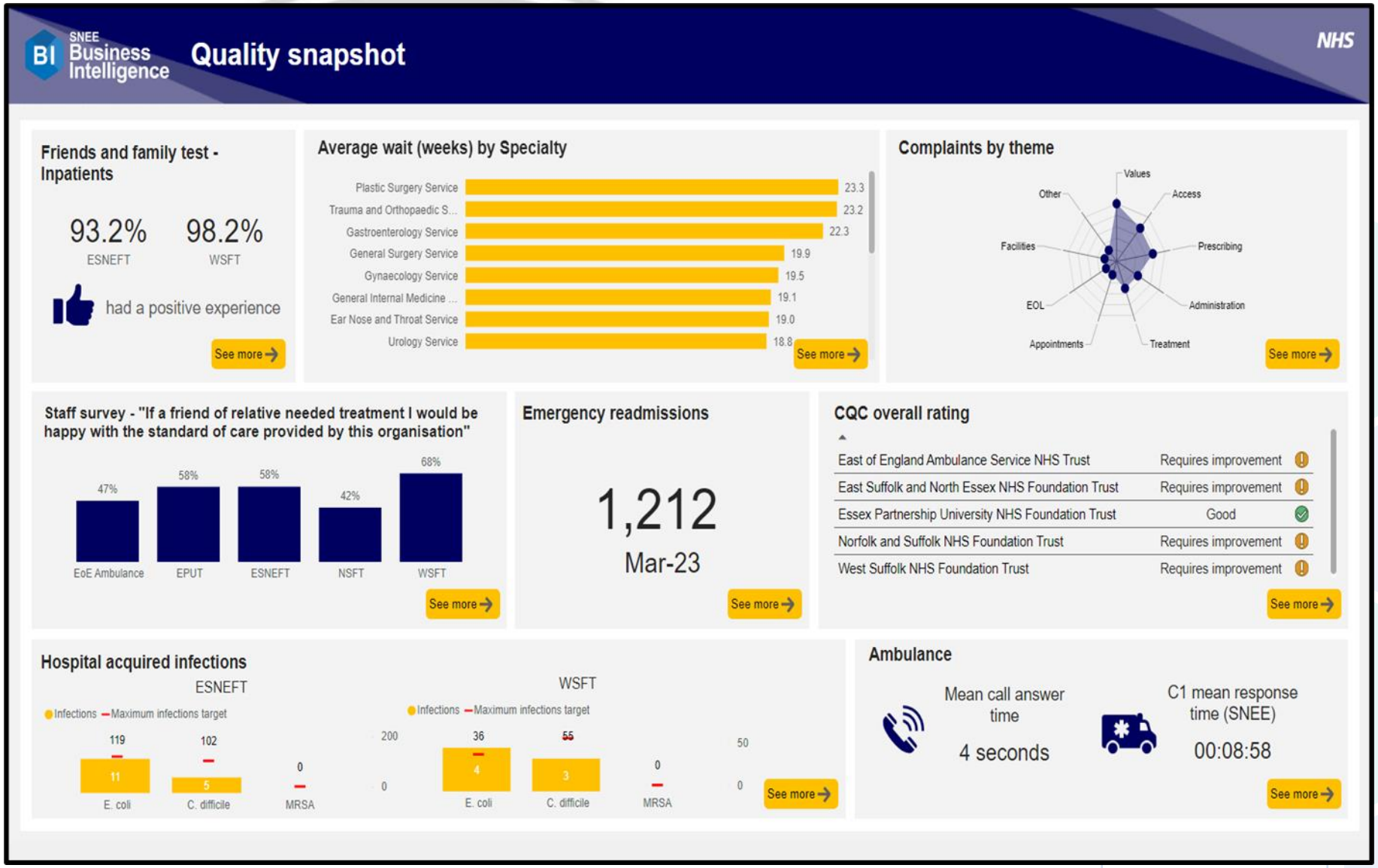
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Quality Snapshot

The Quality snapshot presents a view of the latest health data from 8 key focus areas including patient and staff experiences and waiting times. In depth focus is available in deeper pages. Information is drawn from existing shared datasets.

Long waiting times for secondary care remains a quality concern, also reflected in complaints content. Staff working in the NHS in SNEE have mixed views regarding the quality of service they can provide.

Infection Control challenges are discussed in more detail in the report



Quality Update – UEC Dashboard

Suffolk and North East Essex Integrated Care Board

Infection Prevention Control

With reference to the Power BI Quality snapshot, the style in which the IPC data is currently displayed requires further formatting. We are addressing this with the Power BI team and expect to present a clear and current representation of IPC data moving forward. In collaboration with our acute providers a SNEE wide 5-year plan to support a downward trend in all reportable infections and incidence of outbreaks has been agreed. ESNEFT made progress towards achieving a downward trend in each infection category other than C Diff (2 over trajectory) in the 22/23 reporting period. West Suffolk Foundation Trust saw a challenging year 22/23 reporting period with infection rates increasing across all categories, with exception of C Diff, whereby the Trust achieved within trajectory. WSFT continue work towards improving infection rates both in hospital and in community settings through post infection reviews with increased engagement from ward and clinical teams. Feedback and learning is shared with clinical staff. Antibiotic use has received particular focus to ensure prolonged use of antibiotics is monitored and ceased.

Ambulance Response Times

Ambulance response times are an important measure of high-quality care. Demand in C2 ambulances has reduced, although this is marginal. C2 calls are currently down from > 1hr to >30 mins, but further reduction is needed. A deep dive is underway in collaboration with EEAST, Acute Trusts and ICB and results are awaited to establish themes for further action towards further improving C2 waits.

Equally, work continues towards improving C1 response times through 'Access to Stack' the focus of which is to improve outcomes for patients via interventions from urgent care response teams for C3-5 calls. By alleviating up stream pressure and reducing numbers of patients often conveyed to hospital when they can be cared for in the community (e.g. fallers who sustain no injuries but need help) it is anticipated that ambulances can also be released, thereby improving response times to all calls in particular C1 and C2 priority calls.

Escalations from Quality Committee

NHS
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Escalation QC - 1

Mortality and Learning from Deaths

Standardised measures of mortality (SHMI) remain within normal limits at both ESNEFT and WSFT. An internal summary of Mortality and Learning from Deaths conducted in April 2023 has indicated that partial assurance can be provided based upon the information available.

Since the last QC meeting, a report of mortality data recording has been published by SNEE and N&W ICBs. It has not possible to provide assurance over the mortality data reported at NSFT. ICS support will be necessary to improve the quality of data available to the trust.

Escalation QC - 2

Regulatory Assessments

CQC ratings have improved across the ICS with NSFT being rated as Requires Improvement on 24th February 2023. Within EPUT, Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units was rated as Inadequate by the CQC on 3rd April 2023, but this did not influence the overall rating for the trust, which remains Good.

We await publication of the formal CQC report expected 12th July which will encompass outcomes from the well lead inspection that took place earlier this year.

Escalation QC - 3

4 hr Standard as Quality Metric

Pressures on EDs continues across SNEE. A report published by RCEM, demonstrates how there is an increased mortality rate among patients who experience delays in admission to an inpatient bed from the emergency department.

Published evidence shows that the standardised mortality rate increases from 5 hours after the patient's time of arrival at the ED[1]. The increasing effect of long stays in the ED before inpatient admission can be measured and represented as a number needed to harm metric: after 6–8 hours, there is one extra death for every 82 patients delayed.

1. : Jones S, Moulton C, Swift S, et al. Emerg Med J. doi:10.1136/ emermed-2021-211572

Alliance - Ipswich & East Suffolk

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
UCR Referrals in 2 hours	0.7	CSDS	May-23				80.9%		
Hospital discharge to usual place of residence		SUS	May-23				97.0%		
GP appointments per 10k weighted pop		NHS Digital	Apr-23				4,027		
Experience of making a GP appointment - Good		GP Patient Survey	Apr-22				67.6%		
Antibiotic Items/STAR-PU	0.871 or below	PrescQIPP	Mar-23		0.871		1.039		
Co-amoxiclav, Cephalosporins & Quinolones	Broad spectrum antibiotics - 10% or below	PrescQIPP	Mar-23		10.0%		7.51%		
All 8 diabetes care processes		Eclipse	Jun-23				53.75%		
Supported through NHS diabetes prevention programme		Eclipse	May-23				2,267		
Referrals to NHS weight mgmt services per 100k pop		NHS Oversight Framework	Mar-23				45.8		
Seasonal flu vaccination (over 65s)		CQRS	Mar-23				95.2%		
MMR 2 doses (5 year olds)		GOV.UK	Dec-22				91.53%		

Key performance issues & root cause summary

The reported UCR % is well above the target of 70% in September. DQ work remains on-going to ascertain whether the currenlty reported UCR % is accurate

Those who had a good experience of making a GP appointment is considerably higher than the 56% reported nationally and the highest in SNEE

In regards to reducing antibiotic usage, the number of items per STAR-PU remains above the target of 0.871 and the prescribing of broad spectrum antibiotics are well below the 10% Target

Key performance recovery actions

8 Care Processes – 18 practices are now uploading their data regularly. Getting the next generation of practices onboard will require the publication of the new DM LES which remains an issue due to capacity.

We do not yet have the latest dataset regarding the IES NDPP referral contribution so remains at 37.9% (of 40% planned - this data is cumulative since the start of the current contract (Dec 20). Speaking with the Engagement Lead am told the referrals for May / June remain high.

The antibiotic formulary has now been ratified and published on the SNEE ICB website. Communication has gone out to colleagues in primary care, community pharmacy and hospital colleagues across the system informing them of the updates and changes to the formulary. We are working with colleagues to develop a centralise dashboard for antibiotic prescribing data in primary care using PowerBI. In addition we are currently in the process of reviewing the programmes of work for the upcoming year.

Ipswich & East Suffolk Alliance Committee

Narrative submitted: 27/06/2023

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

- Primary care – Focus on core service delivery and access planning
- Medicines Management – Communications sent to qualifying PCNs about available atrial fibrillation Detect, Protect and Perfect schemes to support Edoxaban project.
- Personalised Care – Connect linking closer to PHM data, Be Well domain development, New cohort began the outdoor wellbeing experience, discussions around holistic approach to oral care.
- Transformation – Focus on INT development, Alliance planning
- Publication of IES Alliance Annual Report

Key actvities planned for the next 2 months

- Publication of the IES Alliance Delivery Plan
- Implementation of domain working
- Primary Care – MDT approach to the review of the analysis for Felixstowe and surrounding areas, Support development of new PCN in Ipswich (Wolsey), Practice GP Contract reissue project, Agree priorities for secondary care and primary care interface
- Medicines Management – Continue the development of a joint ICS formulary
- Personalised Care – Development of social prescribing strategy, development of easy read resources.

We have learned this and need to share...

- Population Health Management data combined with the INT One Team development programme is able to target planning and action with integrated resources.

We need help with..

- Lack of IT/screens for ARRS staff
- Funding to support PHM interventions/alternative offers for care outside of statutory services eg VCFSE

Key Issues

- Current Price Concessions and Category M adjustments are resulting in significant cost pressures, impacting the GP prescribing budget.
- Current capacity issues within primary care significantly limit their ability to undertake programmes of work recommended by the Medicines optimisation team
- Increased demand for social prescribing

Key Risks

- Fixed Term contracts for Integration Partnership Managers cease in February/March 2024

Alliance - North East Essex

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
UCR Referrals in 2 hours	0.7	CSDS	May-23				50.0%		
Hospital discharge to usual place of residence		SUS	May-23				95.7%		
GP appointments per 10k weighted pop		NHS Digital	Apr-23				3,968		
Experience of making a GP appointment - Good		GP Patient Survey	Apr-22				57.0%		
Antibiotic Items/STAR-PU	0.871 or below	PrescQIPP	Mar-23		0.871		1.126		
Co-amoxiclav, Cephalosporins & Quinolones	Broad spectrum antibiotics - 10% or below	PrescQIPP	Mar-23		10.0%		7.89%		
All 8 diabetes care processes		Eclipse	Jun-23				70.87%		
Supported through NHS diabetes prevention programme		Eclipse	May-23				2,258		
Referrals to NHS weight mgmt services per 100k pop		NHS Oversight Framework	Mar-23				11.3		
Seasonal flu vaccination (over 65s)		CQRS	Mar-23				89.9%		
MMR 2 doses (5 year olds)		GOV.UK	Dec-22				89.72%		

Key performance issues & root cause summary

ESNEFT has reported data quality issues on CSDS, which may be affecting performance figures. This is being actively looked at. Prior to CSDS the response was generally around the 80% mark but since the introduction of CSDS performance has dropped to be constantly in the 50 – 60% bracket for 2 hour response.

Other issues impacting performance include referrals coming into the service that do not need a 2 hour response but still need an urgent response (within 4 hours) and referrals coming in from the discharge pathway that are delayed with transport to get the patient home.

Key performance recovery actions

The team are looking at resolving data quality issues in CSDS submissions and reporting, which has been affecting UCRS performance figures.

Further information may need to be shared with referrers to ensure only referrals requiring a 2 hour response are sent to UCRS and to ensure patients not suitable for UCRS are signposted to more appropriate services.

Transport delays are being discussed with the NEE transport provider to improve timeliness of discharge.

North East Essex Alliance Committee

Narrative submitted: 28/06/2023

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

Feel Well Domain Spotlight Report
- An overview of progress to date was shared with particular focus on men being picked up as a cross cutting theme concerning suicide prevention moving forward. Was recommended work continues in aligning the Feel Well and Die Well domains regarding bereavement support for those affected by suicide, with the next Alliance Committee to receive an update on the Start Well approach to emotional health and wellbeing.

Culture Awareness Work - end of funding evaluation report shared with the Committee, outlining recommendations including how we continue to hear the voices of those who may not regularly engage with groups moving forward.

NEE Alliance Committee terms of reference were shared with requests for a small working group to set up to support the review these as part of the ongoing Governance review.

Key actvities planned for the next 2 months

NEE Carers Network - Commitment To Carers Pledge to be presented to Committee
Start Well Domain Spotlight to be received by the Committee
Alliance Local Delivery Plan first draft to be presented
Alliance Committee Terms of Reference to be reviewed by the Committee
Alliance Executive Group Highlight report to be shared
Alliance Quality Group Highlight report to be shared
Information to be shared on Developing a Sustainable Funding Model to Support Victims of Sexual Abuse and Violence in Essex
Frailty framework launch to be shared.
Update on the digital, access and support team work to be shared with Committee.

We have learned this and need to share...

Having the opportunity for an external lense of the progress of the Alliance through the LGA has been helpful in realigning our work programmes and ensuring we are focusing on the key elements to support the delivery of our priorities.
The key outcomes from our Alliance development workshops have helped to shape and drive forward our refreshed Alliance Delivery plan with particular focus on our Neighbourhood and NICS model.

We need help with..

No new requests of SOAC.

Key Issues

Sustained operational pressures placing competing demands on domain leads and Alliance partners.

Key Risks

No key risks to escalate.

Alliance - West Suffolk

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
UCR Referrals in 2 hours	0.7	CSDS	May-23				93.0%		
Hospital discharge to usual place of residence		SUS	May-23				96.4%		
GP appointments per 10k weighted pop		NHS Digital	Apr-23				4,051		
Experience of making a GP appointment - Good		GP Patient Survey	Apr-22				59.7%		
Antibiotic Items/STAR-PU	0.871 or below	PrescQIPP	Mar-23		0.871		1.137		
Co-amoxiclav, Cephalosporins & Quinolones	Broad spectrum antibiotics - 10% or below	PrescQIPP	Mar-23		10.0%		9.18%		
All 8 diabetes care processes		Eclipse	Jun-23				52.53%		
Supported through NHS diabetes prevention programme		Eclipse	May-23				1,639		
Referrals to NHS weight mgmt services per 100k pop		NHS Oversight Framework	Mar-23				15.6		
Seasonal flu vaccination (over 65s)		CQRS	Mar-23				89.5%		
MMR 2 doses (5 year olds)		GOV.UK	Dec-22				94.01%		

Key performance issues & root cause summary

The reported UCR % is significantly above the target of 70%. DQ work remains on-going to ascertain whether the currently reported UCR % is accurate Antibiotic usage has been rising steadily and the number of items per STAR-PU is higher than the target of 0.871. The trend is similar to other systems regionally. However, the prescribing of broad spectrum antibiotics remains below the 10% Target.
Diabetes metrics (people on the prevention programme and the 8 care processes) are both improving.

Key performance recovery actions

Antibiotic improvement: Antibiotic formulary updated, finalised and communicated; recurrent UTI guidelines being updated; purple book for use with care homes being updated; structured medication review covering antibiotic use for UTI, Acne and COPD; joint working with WSFT to review inappropriate antibiotic usage; Clostridium difficile Post Infection Review with infection prevention & control nurse; improved intelligence reporting for practices in place; establishing a SNEE Antimicrobial Stewardship working group (with representative from med opt teams, infection prevention & control, LPC, LMC, PCNs, primary and secondary care nursing) to help with the delivery of training using the TARGET antibiotics toolkit.
Diabetes programme looking at practice level data and targeting support.

West Suffolk Alliance Committee

Narrative submitted: 26/06/2023

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

Alliance delivery plan - agreed by Committee (May) and supported from WSFT Board
National discharge funds - plans agreed.
Memory clinic business case - supported (subject to future funding)
ACS strategy - Received and discussed
Healthy behaviours - plan received, discussed and supported
Medicines optimisation - budgets set using new standard ICB/NHSE methodology. Agreed and communicated prescribing incentive scheme. All meetings with 7 high spending practices complete
Primary Care - GP education event held including focus on paediatrics and primary care strategy; approved transformation bids for all PCNs

Key actvities planned for the next 2 months

Alliance delivery plan - implemntation including highlight reporting method, evaluationconfirming work with partners to agree alignment of plans
Health inequalities- Clarify approach with Public Health and through emerging Inequalities Committee
Age well: System integrated reablement modelling; implement schemes funded from discharge programme
Be Well: further prepare for health behaviours transition
Premises: plan Haverhill health centre reopening; PCNs complete premises stocktakes
Data and Digital: Learn from “waiting well” and build into PHM programme; Complete initial evaluation for 1st phase of Cassius+
Medicines optimisation: recruit to B5 vacancy and seek interface pharmacist with WSFT.
Primary care: support practices to implement access & capacity and PC recovery plan

We have learned this and need to share...

Alliance delivery plan process
Distributed leadership model has been successful but takes time and is a process of development
This has brought Education closer to the heart of the plan

We need help with..

Primary care premises - National framework and funding problem

Reflections on sytem working with primary care
- LMC has notified withdrawal of Bury PCN from mental health ARRs
- WS PCNs have withdrawn from AHPS providing MSH ARRs
(suffolk-wide review planned september)

Key Issues

Industrial action
Sustained operational pressures
Impact of ICB staff running costs
Resources to deliver ADP
Ensuring transition with retirement of experienced west suffolk transformation lead

Key Risks

NA

Workforce

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
Leadership culture - staff survey (ESNEFT)	Score out of 10	NHS Staff Survey	Mar-22				6.77		
Leadership culture - staff survey (WSFT)	Score out of 10	NHS Staff Survey	Mar-22				6.81		
CQC well-led rating - ESNEFT		CQC	Jan-20				Good		
CQC well-led rating - WSFT		CQC	Jan-20				Requires improvement		
Engagement - staff survey (ESNEFT)	Score out of 10	NHS Staff Survey	Mar-22				6.64		
Engagement - staff survey (WSFT)	Score out of 10	NHS Staff Survey	Mar-22				6.88		
Bullying and harrassment (never experienced) - staff survey (ESNEFT)		NHS Staff Survey	Mar-22				78.6%		
Bullying and harrassment (never experienced) - staff survey (WSFT)		NHS Staff Survey	Mar-22				81.1%		
FTE GPs per 10k weighted pts		NHS Digital	May-23				5.1		
Direct pt care staff per 10k weighted pts		NHS Digital	May-23				5.6		

Key performance issues & root cause summary

The latest results from the NHS staff survey show that in regards to compassionate leadership both ESNEFT and WSFT staff responses were broadly in line with the national average, with WSFT matching the 6.8 (out of 10) sub-score and ESNEFT only just below

In relation to staff engagement, both Trusts reported similarly to the national average of 6.8 (out of 10), with WSFT above the average and ESNEFT just below

There are 3 survey questions in relation to bullying and harrassment, from patients, from managers and from colleagues. The metric score shown is the average of these 3 percentages

Key performance recovery actions

On going engagement with system partners
Linking with East of England Leadership Academy/ Looking at the system leadership programme
Utilising national staff survey engagement schemes
Developing Health and Wellbeing strategy and action plan
Continuing to develop the Training hub recruitment and retention programmes

Workforce Committee

Narrative submitted: 02/05/2023

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

The focus over the past 2 months has been on the 2023/24 Operational Plan. Work has been on-going with the workforce planners/leads acorss our NHS providers to ensure the workforce submission is not only submitted but also aligns with submissions from activity and finance colleagues. In addition to the operational planning, the workforce team has been supporting the resilience team with the Industrial Action (both nursing and jnr doctors). The following areas have also been taken forward - Reservists, HCSW recrutiment, Education governance and CPD investment.

Key actvities planned for the next 2 months

The focus for the next two months will be: concluding the Operational Planning, agreeing key areas from the Operational Plans (exploring recovery areas such as Cancer & Diagnostic), review the first 6mths of the Reservists, amend and take forward. Establish the Educational Governance Group, continue to support workforce areas e.g End of Life Care, Frailty. Establish key system priority interventions such as retention hub, supply programme incl. Health and Care Academies focus

We have learned this and need to share...

Importance of collaboration especially during the industrial action.

We need help with..

Alignment of the workforce interventions with the other enabling functions and with transformation plans to ensure triangulation with activity/performance and finance

Key Issues

The ongoing challenges of retention and industrial action which incl. the cancelled elective care appointments and impact on workforce and recovery plans

Key Risks

The workforce risks across the system still maintain with pressures associated with retention, resilience and burnout. 'Attraction' to health and care roles appears to be challenging with lower numbers entering key academic roles

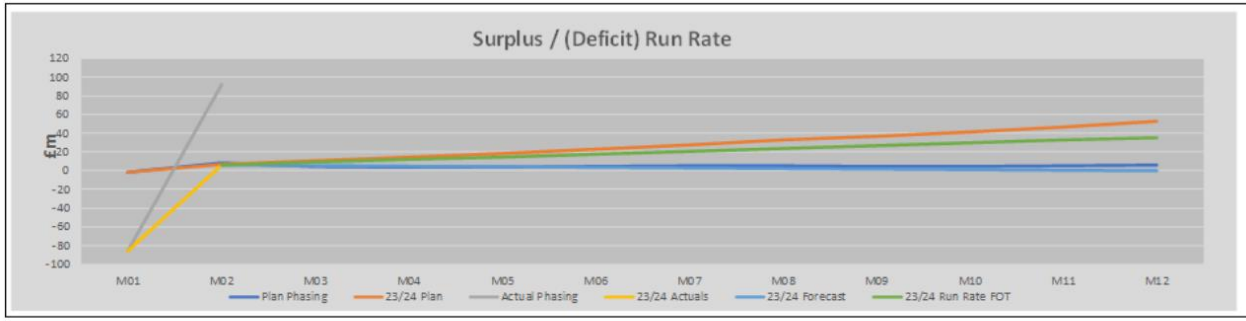
SNEE Business Intelligence

NHS

Finance - SNEE ICB System Dashboard (Month 2)

Surplus / (Deficit) - Adjusted Financial Position

	YTD Surplus / (Deficit)				Full Year Forecast Surplus / (Deficit)			
	Plan	Actual	Variance		Plan	Forecast	Variance	
	£m	£m	£m	%	£m	£m	£m	%
Suffolk And North East Essex ICB	0.4	0.4	0.0	0.0%	2.6	2.6	(0.0)	(0.0%)
Providers	(2.8)	(3.0)	(0.3)	10.2%	(2.6)	(2.6)	-	0.0%
ICS Total	(2.3)	(2.6)	(0.3)	12.1%	(0.0)	(0.0)	(0.0)	88011211.9%



System I&E Summary

	Plan	Actual	Variance		Plan	Forecast	Variance	
	YTD	YTD	YTD	YTD	Year Ending	Year Ending	Year Ending	Year Ending
	£m	£m	£m	%	£m	£m	£m	%
System Revenue Resource Limit	- 359				- 2,152			
ICB Net Expenditure								
Acute Services	187.3	188.0	(0.7)	(0.4%)	1,123.5	1,123.5	-	0.0%
Mental Health Services	33.9	34.1	(0.1)	(0.4%)	203.6	203.6	(0.0)	(0.0%)
Community Health Services	32.8	33.0	(0.2)	(0.6%)	196.6	196.6	0.0	0.0%
Continuing Care Services	16.2	15.7	0.6	3.5%	97.3	97.3	-	0.0%
Primary Care Services	35.1	35.0	0.1	0.2%	210.2	210.2	-	0.0%
Other Commissioned Services	1.9	1.9	(0.1)	(3.1%)	11.3	11.8	(0.5)	(4.6%)
Other Programme Services	0.6	0.6	0.0	5.7%	3.7	4.0	(0.3)	(8.2%)
Reserves / Contingencies	1.5	1.6	(0.2)	(10.8%)	8.9	8.4	0.5	5.9%
Delegated Primary Care Commissioning	46.1	45.9	0.2	0.5%	276.7	276.7	-	0.0%
ICB Running Costs	2.8	2.5	0.3	12.0%	17.0	16.8	0.3	1.5%
Total ICB Net Expenditure	358.3	358.3	0.0	0.0%	2,148.9	2,148.9	(0.0)	(0.0%)
ICS Providers I&E - Adjusted Financial Performance								
Income	(295.2)	(298.9)	3.7	(1.3%)	(1,787.2)	(1,787.2)	-	0.0%
Pay	193.5	196.2	(2.7)	(1.4%)	1,167.8	1,167.8	-	0.0%
Non-Pay	100.5	102.6	(2.2)	(2.2%)	598.2	598.2	0.0	0.0%
Non Operating Items (exc gains on disposal)	4.0	3.1	0.9	21.9%	23.9	23.9	(0.0)	(0.0%)
TOTAL Provider Surplus/(Deficit)	(2.8)	(3.0)	(0.3)	10.2%	(2.6)	(2.6)	-	0.0%
TOTAL ICS Surplus/(Deficit)	(2.3)	(2.6)	(0.3)	12.1%	-	(0.0)	(0.0)	0.0%

System Risk

Gross Risk	Net Risk	Net Risk % allocation	Movement from prior month
(84.3)	(46.8)	2.2%	46.8

Mental Health Investment Standard

Target MHIS Spend 2023/24	FOT 2023/24	Excess / Shortfall in 2023/24 MHIS Delivery %	MHIS Achieved in 2023/24?
158.9	159.0	0.0%	Y

System Efficiencies



	YTD	FOT
System efficiency % of allocation	(1.1%)	(2.3%)
ICB efficiency % of allocation	0.3%	0.6%
Provider efficiency % of gross operating Expenses	2.6%	7.3%

	ICB	Providers
Unidentified efficiency %	0.0%	1.8%
High risk %	29.0%	18.9%
Medium risk %	29.0%	47.4%
Low risk %	42.0%	33.7%

System Agency Expenditure

Cap	YTD spend	YTD % of Cap	FOT	FOT % of Cap
33,996.0	-	0.0%	-	0.0%



System Capital Allocation

	Capital allocation	Variance to allocation	Forecast variance %
Providers	59.8	(4.4)	(7.3%)
ICB	2.0	2.0	100.0%
System	61.8	(2.4)	(3.8%)

Cash

	Prior Year	Year to Date	Forecast
Providers	112.7	96.7	112.3
ICB			
System	112.7	96.7	112.3

Number of organisations missing BPPC target

		Providers	ICB
Current Month	Non NHS	3	
	NHS	3	
	Total	3	
Prior Month	Non NHS	-	
	NHS	-	
	Total	-	

Finance

System Financial Position: Narrative Month 2

- The 2023/24 SOAC reports are based on a revised monthly system financial reporting tool. Further developments in system financial reporting can be expected in 2023/24. This approach significantly reduces the resource required each month for its production.
- The system is reporting a YTD deficit of £2.604m, an adverse variance of £0.281m on a planned deficit of £2.323m. The plan is in deficit in the early stages of the year due to the phasing of efficiency schemes and ESNEFT proceeding at risk with EPR projects that will likely be funded later in the financial year, creating a balancing surplus.
- The adverse variance is attributable to WSFT and is caused primarily by efficiency plan slippage. Slippage is not limited to WSFT, with £4.0m delivered against a system target of £8.2m at month 2.
- All organisations are forecasting to return to plan (system break-even) by 31 March 2024.
- System unmitigated financial risk is unchanged (at £46.8m) from the figure submitted as the final plan on 4th May 2023. Risk was reviewed by all organisations in the course of the month.
- The ICS is forecasting delivery of the mental health investment standard.
- The ICS is currently forecasting an overspend on system capital. Additional RAAC expenditure of £2.5m is not recognised in a revised plan for WSFT. In addition, organisations were encouraged to identify projects to spend up to 105% of system capital. All organisations are forecasting an 'on-plan' position at this stage, resulting in a forecast overspend of £4.4m.
- The system cash position is being monitored. Cash balances are forecast to be adequate. Measures to chart the change/trend in cash position have been recommended for inclusion in the national finance dashboard.
- Data relating to the agency expenditure cap and ICB capital spend should be ignored at this stage. There are data extraction errors that have been reported to the national team.

Suffolk and North East Essex Integrated Care Board

ICB BOARD

Agenda Item No.	**15**
Reference No.	**ICB 23-54a**
Date.	**25 July 2023**

Title	**Board Assurance Framework**
Lead Director	Amanda Lyes (Director of Workforce and People)
Author(s)	Tony Buckle (Risk Manager)
Purpose	To approve the Board Assurance Framework

Recommendation:

The ICB Board is asked to approve the Board Assurance Framework for July 2023.

1. Background

1.1 Content of the BAF document is reviewed by the Executive Committee (EC) every month and by the Board, Quality and Audit Committees at each of its meetings. All BAF updates have been received and are up to date.
As agreed with the Directors, the BAF document is available for examination with this report.

2. Key Issues

2.2 A brief overview of the amendments is included in separate table along with this report.

2.3 The BAF Board Development Session held on 18 April resulted in some changes to the current BAF. One of the key recommendations from the session is to reduce the number of risks to a minimum hence we have merged many risks and removed individual Provider ones. The BAF should contain the top strategic risks only; there are now 10 active risks.

2.4 Most Provider risks are now system risks and others have been transferred to directorate risks registers to be managed there (these are the greyed out risks). More focus is to be on assurance. It has been asked that the risks contain less text and be more succinct.

2.5 Importantly, the Audit Committee regard Board assurance as one of its most important functions and as such, the BAF will be a substantive item on future agendas.

3. Recommendation

3.1 The ICB Board is requested to review the BAF document.

4. Risk Registers

4.1 A summary table of the top directorate risks accompanies this report.

Suffolk and North-East Essex BAF

Risk No and Owner	Risk description and actions update
System A&E Risk 1 Paul Gibara	*The ICB continues to be under significant pressure and whilst benchmarks well against other regional systems it continues to fail several established standards.* **Current risk rating 16.** **July 2023 update.** Position at W/E 18/06 for ED 4 hour was WSFT 72.5% and ESNEFT 72.57%. 12 hour performance remains at 4% of attends although we have seen reduced delays. June has been challenging for patient handover at ESNEFT sites with a deep dive underway to identify actions to improve. C2 response times have also struggled in June, and we are off trajectory to deliver 30 minutes - deep dive also underway.
System RTT Risk 3 Paul Gibara	*System is not meeting Constitutional Referral to treatment Target of 18 weeks.* **Current risk rating 16.** **July 2023 update.** The system aims to clear by 78 week waits (due to capacity) by July (delayed due to industrial action). However, there is likely to a residual cohort of urogynaecology patients at WSFT (regional solution being sought).
NSFT CQC Risk 8 Lisa Nobes/Richard Watson	*Statutory Duty to ensure patient safety within commissioned services: The Trust inability to demonstrate appropriate safety standards throughout it services present significant patient safety risks to the population of Suffolk.* **Current risk rating 20** **July 2023 action points.** **NSFT -** MATS business case presented to West Suffolk Alliance in May 2023- pending further conversation on affordability. ADHD pathway design/demand & capacity analysis due to be completed by June 23. Eating Disorders (Adult) deep dive took place with NSFT and system partners to discuss service challenges and relationships on 17.05. Action plan worked up. **CYP** - We are now starting to see the impact of the mitigating measures in place however remain concerned about the waiting lists for treatment. Recommend reducing the current risk to 12 as the risk is less likely. **EPUT** - Currently awaiting updated Action Plan.
Access to Primary Care Risk 10 Maddie Baker-Woods Peter Wightman Laura Taylor-Green	*Reduction in access to, experience of and outcomes in primary care due to capacity, demand, constraints (workload; workforce; digital and estates).* **Current risk rating 16.** **July 2023 no further update to below.** Working with LMC and practices to establish new contract requirements. NHSE have completed the review of cloud based telephony (CBT). PCNs producing Capacity and Access Payment (CAP) by 30 June to evidence improvement against 3 key areas. Working through the timeline for recovery: empower patients, implement modern general practice, build capacity and cut bureaucracy.
Cyber Security Risk 11 Andrew Kelso	*Potential impact of cyber security incident could lead to wide scale IT system outages, meaning no access to patient records, e-dispensing services etc.* **Current risk rating 15** **July 2023 update** MFA (Multi-Factor Authentication) will be enabled across all SNEE domain logons by 30th June. MFA uses AI (Artificial Intelligence) to calculate the risk and then challenge. Cyber Essentials plus accreditation work will pick up again in July.
Provider Workforce Risk 12 Amanda Lyes	*Workforce challenges across the system.* **Current risk rating 20** **July 2023 update.** A new draft system Workforce risk has been written focussing on three themes: Grow the Workforce, Working Differently and Productively and Compassionate and Inclusive Culture. This was presented at the People Committee in June 2023.
EEAST Quality/Performance Risk 16 Ed Garratt	*EEAST is not meeting performance targets against ambulance response categories.* **Current risk rating 20** **July 2023 no further update to below.** Improving handover delays and C2 performances seen although not achieved target. Handover plan total hours agreed with regulator, systems aware of individual targets to achieve overall trajectory. C2 plan for 23/24 has been submitted to NHSE showing plan to achieve <30min cat 2 average target.
System Cancer Standards Risk 19 Richard Watson	*System not meeting the outcomes within the NHS constitution in regard to cancer standards.* **Current risk rating 16** **July 2023 update** 62 day trajectories published for 23/24 as @ June 2023 ESNEFT 276 currently 303 and WSFT 93 currently 121. New FDS recovery trajectories have been published for 23/24 with Q1 67.5%, SNEE are

	currently 67.8%. ESNEFT LGI PTL is currently 61%. Remains a risk to recovery. Skin pathway delayed at WSFT, with 60% of their backlog, skin patients. Tertiary referrals quality teams looking to mitigate. ESNEFT are tier 2 in elective which has resulted in cancer submissions. SNEE were highlighted by the national team due to FDS performance and the response has been submitted in May 2023.
Financial targets Risk 25 Howard Martin	*Failure to meet statutory ICB financial targets.* **Current risk rating 15.** **July 2023 update.** The programme plan has been baselined and features all activities required to achieve the development and issuing of the Consultation Pack and all tasks required post consultation. All activities are on track. The 9.6m non pay has completed first review and will be fully complete and savings calculated by 07/06 (FRSG), including estates and IT. SNEE is applying (via a Business Case) to NHSE to launch Voluntary Redundancy scheme to launch early August. This means Consultation planned for 17/07 has been paused and is now planned for 04/10. All VR documents and processes are on track - the Plan has been updated to reflect the change in direction.
Consequences of climate change Risk 29 Amanda Lyes	*Consequences of climate change on the health and healthcare services of the SNEE population.* **Current risk rating 16.** **July 2023 update.** Sustainability Impact Assessment (SIA) has had soft launch and pilot. Feedback being collated to modify template and final draft for hard launch.

Suffolk and North East Essex ICB Board Assurance Framework: Version Control

NHS
Suffolk and North East Essex
Integrated Care Board

Month	Version	Reviewed By	Summary of Changes
01 January 2023	6	Executive Committee 09/01/2023	Approved
01 February 2023	7	6 Feb Exec Comm 16 Feb Audit Committee	Approved
01 March 2023	8	6 March Exec Comm 21 March ICB Board	Approved
01 April 2023	9	3 April Exec Comm 13 April Audit Committee	Approved
01 May 2023	10	9 May Exec Comm 23 May ICB Board	Approved
01 June 2023	11	5 June 2023 8 June Audit Committee	

Suffolk and North East Essex ICB Board Assurance Framework: Overview

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The Suffolk and North East Essex Integrated Care Board Assurance Framework (BAF hereafter) provides the NHS Suffolk and North East Essex Integrated Care Board (ICB) with a simple but comprehensive method for the effective and focused management of risk. Through the BAF the ICB Board gains assurance that risks are being appropriately managed throughout the organisation.

The BAF identifies which of the organisation's strategic objectives may be at risk because of inadequacies in the operation of controls, or where the ICB has insufficient assurance. At the same time, it encompasses the control of risk, provides structured assurances about where risks are being managed and ensures that objectives are being delivered. This allows the ICB Board to determine how to make the most efficient use of resources and address the issues identified to improve the quality and safety of care. The BAF also brings together all the evidence required to support the Annual Governance Statement.

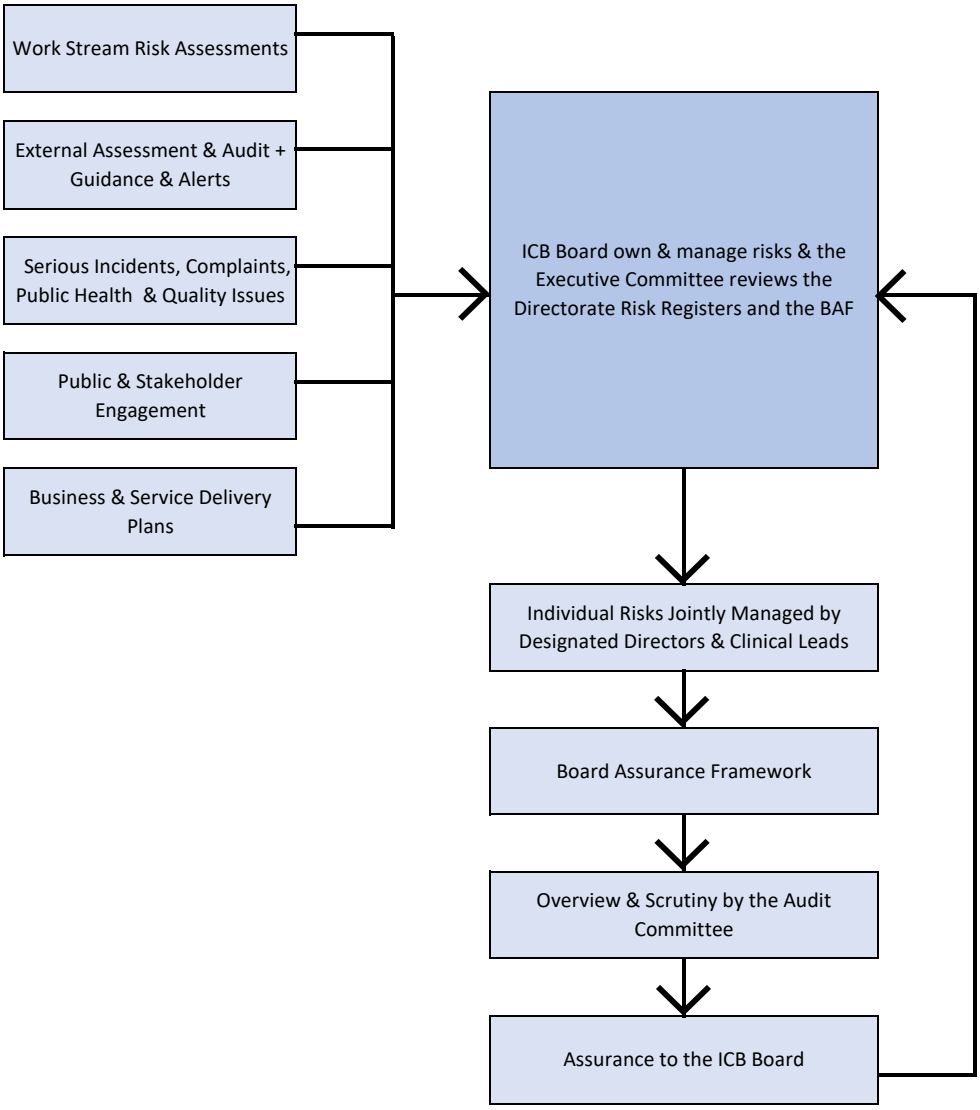
The BAF should be a working document and will be updated regularly by the Executive Management Team, monitored by the Audit Committee and reported to the ICB Board at each of its meetings. The BAF is linked to the Directorate Risk Register's, the content of which is also provided for review by the Executive Management Team. A flow chart setting out how risks are identified and managed is set out on the Risk Identification and Management tab.

In order to ensure consistency in the risk assessment process, the likelihood and consequences of all risks on the Risk Register are assessed against the former National Patient Safety Agency (NPSA) 5X5 risk matrix and those scoring 15 and above and are of strategic concern migrate to the BAF and thereby inform the ICB Board agenda. Once added to the BAF, a risk should remain in place until its RAG rating has been mitigated to a score of 1-6 when it is considered manageable and therefore no longer a strategic concern.

The 5X5 risk matrix and subsequent red, amber, green (RAG) score identify the level at which identified risks will be managed within the organisation. It also assigns priorities for remedial action and determines whether risks are to be accepted based on the colour bandings and risk ratings. In terms of evaluation of effectiveness, the RAG rating system is also used to present how well the agreed controls are operating.

Suffolk and North East Essex ICB Board Assurance Framework: Risk Identification & Management

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Risk Scoring Matrix

The subsequent red, amber, green (RAG) scores identify the level at which identified risks will be managed within the organisation. It also assigns priorities for remedial action and determines whether risks are to be accepted on the basis of the colour bandings and risk ratings. In terms of evaluation of effectiveness, the RAG rating system is also used to present how well the agreed controls are operating within the Risk Appetite classifications:

		Likelihood				
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
Consequence	1 Negligible	1	2	3	4	5
	2 Minor	2	4	6	8	10
	3 Moderate	3	6	9	12	15
	4 Major	4	8	12	16	20
	5 Severe	5	10	15	20	25

In order to determine the likely consequence arising from an identified risk and using the 5X5 matrix:
- Define the risk explicitly in terms of the adverse consequence or consequences that might arise
- Use the table below for examples, by risk domains, to determine the consequence score relevant to the risk identified

	Consequence score (severity levels) and example of descriptions				
	1	2	3	4	5
Risk Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Severe**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality / complaints / audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption	Loss/interruption of >1 hour	Loss/interruption of >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
Environmental impact	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment

Risk Appetite

For all risks that have been agreed and then assessed and rated, an action plan should be drawn up containing the actions that will be taken, with timescales, in order to either totally eliminate the risk or to reduce its consequences to a level that the ICB is prepared to accept.
It is useful to consider the 'Four T's' when considering the management of risks:

Tolerate	Where the ICB accepts the risk and lives with it
Treat	Where the ICB takes action to reduce the risk
Transfer	Where the ICB lets someone else carry the risk such as by passing the responsibility for the risk to a contractor
Terminate	Where the ICB feels that the risk is too great and does not continue with the activity giving rise to it

Suffolk and North East Essex ICB Board Assurance Framework **MERGED WITH RISK 8**

Risk 9 NSFT Performance

Detail				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls Established	Assurance of Controls	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
	Richard Watson	The worsened performance of mental health services provided by NSFT causes poor patient outcomes and reduced quality of services provided. Cause Capacity insufficient to meet the rising demand for services and resolve the backlogs created. Effect Poor patient experience and heightened safety risks.	Poor performance against a number of performance indicatorsy, driven by: • Demand over plan for many services • Workforce gaps across services and challenge to fill key posts • System gaps particulary within primary care MH support	4	4	16	National standards scrutinised by NHS E/I. ICB teams working closely with NSFT counterparts to identify root causes of problems through: -SNEE ICB MH monthly MDT meetings providing overview of MH performance. -Monthly joint quality/ performance meetings (QCPM) between NSFT and ICB. - Monthly NSFT/ICB Director to Director meetings for escalation -NSFT Improvement Board	Reporting through the Suffolk MH Committee and SNEE ICB Board Director attendance at Trust Finance/Business Investment Committee. SNEE ICB Board agreed in March 2023 to establish the Suffolk System MH Collaborative from April 2023 with delegated authority from the ICB Board.	Treat/High	4	5	20	Same	Amber	April 2023 update: -Mental Health Committees overseeing recovery plans on a county basis. Options appraisal for ADHD presented to ICB Deputy Chief Executive on 21/03/23 - action plan agreed. -Suffolk system taking forward the development of a Mental Health Collaborative to go live from 01.04.23. ICB Board approved establishement of collaborative on 22/03/23	1. Suffolk system MH Collaborative Launch 2. Service Review for CYP MH Services completed 3. Service review for Adults Community MH model and business case finalised 4. Additional services commissioned through MH Commissioning Framework completed	1. April 2023 2. April 2023 3. April 2023 4. March 2023
			National standards: 1. Early intervention in psychosis (14 days referral to treatment) 2. Eating disorder (1-week urgent referral to treatment) 3. Eating disorder (4-week routine referral to treatment)				Additonal capacity sought from other providers, including the VCSE	Mental Heath Commissioning Framework Contracts put into place with other organisations and monitored				20		- Significant reform programme in place across four priority areas: Crisis, Commumity, Children and Young People and Learning Disabilities & Autism.	5. Plans being developed in partnership with NSFT to commission some external short term capacity to reduce ADHD waiting list backlog	5. March 2023

			Local standards: 4. Emergency referrals (4 hours referral to assessment) 5. Routine referrals (28 days referral to assessment) 6. Referral to treatment (15 weeks) 7. Children's emotional wellbeing hub (10 days referral to discharge) 8. Increasing waiting times for ADHD assessment and treatment				Additional investment into NSFT to support increasing workforce numbers	NSFT QCPM and Suffolk MH Committee. SNEE Workforce MH Group established with suporting 23/24 plan.								
			CQC rating as 'requires improvement' in February 2023				Development of Suffolk MH Collaborative and service review	Programme Plan and oversight through the Suffolk MH Committee								
							Development of demand and capacity plans for MH services with linked investment plans	NSFT Improvement Board and Suffolk MH Committee								

Suffolk and North East Essex ICB Board Assurance Framework

Risk 13 SNEE System Covid Outbreak RISK CLOSED

				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls	Assurance Methods	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
ICB Quality Committee	Lisa Nobes	The consequences of the Covid-19 pandemic on the SNEE system. **Cause** The impact of a widespread Epidemic on the ICB will see an increase in demand on all commissioned services. **Effect** The ICB could see significant changes to establish ways of working. The ICB may have absenteeism as staff self-isolate / ill over the period of the outbreak.	Increased risk of fraud from Covid-19 related claims. The ICB may have absenteeism as staff self-isolate / ill over the period of the outbreak. The ICB could see significant changes to establish ways of working.	4	5	20	Business continuity plan in use. SNEE incident room established. SNEE operational and tactical meetings stood up and down dependant on waves.	SNEE Covid-19 Incident room staffed on rota basis. Virtual support from Primary Care / Care homes / Communications and IPC teams.	Treat/High	4	5	20	Same	Green	**June 2023 update.** Risk closed. WHO has decided to end the global emergency status for COVID-19		
			The impact of a widespread Epidemic on the ICB will see an increase in demand on all commissioned services.				Response to Covid managed at ICS, Alliance and LRF levels and will step up and down linked to covid waves for recovery actions to be managed.	Business continuity plans in full operational use.					20				
			Patient & Public access to a significant number of NHS services has been disrupted due to Covid 19 pandemic with an increased demand on all commissioned services.				Daily tracking of case numbers in place. On-going liaison with Local Resilience Forums (currently stood down). ICB staff working virtually where possible and controls in place at office locations.	Alliance Operational Group overseeing local recovery planning related to community and urgent care services.									
							LCFS distributed warnings re Covid related fraud and passed to relevant finance staff. Invoice checking in place, where there are changes to these they do not relate to new suppliers and all items will be reconciled as required.											

Suffolk and North East Essex ICB Board Assurance Framework

Risk 14 WSFT RAAC **TRANSFERRED TO DIRECTORATE RISK REGISTER**

				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls	Assurance Methods	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
	Paul Gibara	WSFT have identified and alerted the ICB to risks associated with the Trusts Reinforced Autoclaved Aerated Concrete (RAAC) infrastructure. **Cause** Hospital built from RAAC planks. **Effect** Risk of shear failure in buildings made from RAAC planks.	May 2019 Standing Committee on Structural Safety (SCOSS) alert identified a risk of shear failure in buildings made from RAAC planks.	3	5	20	WSFT have established a significant surveyance program/remedial plan to ensure safety of patients, visitors and staff are met. ICB is required to ensure WSFT who are legal owners of estate and provider of services give assurance as to the safety of services.	The ICB has established a RAAC Risk Committee independently chaired to ensure that the ICB undertakes all necessary actions required to provide assurance to mitigate risks. These include:	rate/Signif	3	4	12	Same	Green	**March 2023 no further update.** 1. Meetings ongoing between structural expert and trust engineers on end bearing work. 2. ICB has requested Trust decision process document from Trust. 3. DAB Beachcroft asked WSFT to provide document scoping SWECO work.		
			Dust released from a plank failure is likely which will require decontamination of those affected. What is currently not known is the quantity of dust that may be released.				The ICB developed a governance structure to monitor the level of assurance together with a set of measures to assess and give the ability to respond to any adverse changes and consequence of the risks identified.	• Emergency preparedness • Alternative service provision • Internal WSFT governance and remedial works • New hospital build • Quality and physical environment. • Exercise programme at Trust, System and Regional Levels. • Attendance of WSFT to ICB Risk committee for regular updates and assurance.				12				

							WSFT internal expert leadership team in place. System has developed initial plans which will be reviewed. The ICB has worked with Region to ensure regional/local plans are aligned.												

Suffolk and North East Essex ICB Board Assurance Framework

Risk 17 CYP Access to mental health **MERGED WITH RISK 8**

				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls Established	Assurance of Controls	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
ICB Quality Committee	Lisa Nobes	CYP are unable to access MH therapy and treatment. As a result, YP have been admitted into paediatric wards in acute hospitals across the ICS. This creates a risk to staff, patients and families on these wards. **Cause** CYP are unable to access MH therapy and treatment due to capacity issues. **Effect** YP have been admitted into paediatric wards in acute hospitals across the ICS. This creates a risk to staff, patients, and families on these wards.	1. Availability of Tier 4 Beds 2. Blocking of Paediatric Beds 3. Safety of CYP 4. Safety of other Patients 5. Safety of Staff 6. Safety of Families / Visitors / Carers 7. FWB of Staff 8. Increased Complaints 9. Adverse Publicity	4	5	20	1.local CYP MH providers regular calls with provider collaborative to review capacity for admissions 2. Introduction of risk matrix (et to be seen and confirmed) by CYP NHSE provider collaborative to review requests for admission 3. ICB Escalation and flow management in acute hospitals 4. ICB financial support to provide care input for YP in acute settings where and seeking regular oversight to all admissions 5. Regular reporting and escalation through QSAF/ NEE QC/ ICB CYP MDT 6. Regular system calls for CYP with involvement of all partners and ICB to manage clinical risk, share information and plan delivery of care	Involvement of the ICB Board. Regular reports to statutory committees. Previous JLT Assurance Board for CCG Closure. Chaired by EG.	Treat/High	4	4	16	Same 16	Green	**April 2023 update.** No further update following review. Local Protocol for managing, escalating need in acutes in place. Review taking place based on practice-based evidence across CYP system agencies and led by ICB through a Task and Finish Group considering development of “place of safety” locally Dynamic Support Register for CYP with LD and/or A in place for proactive and support and monitoring where CYP at risk of admission SCC leading on a forum where cases of concern locally across care, education and health are reviewed for proactive support and monitoring Potential funding being accessed to improve/provide better environments for CYP with acutes needs. Peripatetic offer is now in place. Applied for Medium term funding to extend pilot offer and CATAT hosted by NSFT.		03/04/2023

Suffolk and North East Essex ICB Board Assurance Framework

Risk 18 Clacton Hospital Redevelopment **TRANSFERRED TO DIRECTORATE RISK REGISTER**

				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls Established	Assurance of Controls	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
	Amanda Lyes	Delay in progressing the Clacton Hospital site redevelopment in accordance with the original bid criteria and stated spend profile could result in withdrawal of STP capital for the project. **Cause** Insufficient finance for hospital redevelopment/ business case not submitted in accordance with the required timeframe. **Effect** Building will not be fit for purpose for future model of services, including Primary, Community and Acute care as per the original STP bid.	If significant monies are not obtained through the bidding process for the STP Capital, the primary care estate in Clacton will not be fit for purpose for the future model of primary care, or for UTC and other community services.	4	4	16	Controls over quality, performance, reputational and financial risk: Programme governance established with project board, which includes representation from NHSE via SEA. NHSE Regional team engaged in early page turns of business case to ensure correct content and context provided. Wider master planning taking place to look at options beyond phase one project and ensure maximum efficiencies are implemented. NHSE to explore potential of site ownership from NHS PS to a NHS Provider organisation which may reduce costs of the scheme. Full business case being developed at risk to reduce overall programme.		Treat/High	5	4	20	Same 20	Amber	**April 2023 update.** Business case developed is now being led by ESNEFT in accordance with ICB partners including ESNEFT, EPUT, Primary Care (Ranworth PCN) and NHS Property services. A 'flexible' development control plan has been drafted which would allow delivery of the primary aims of the original STP bid, to support estate requirements and the model of care for General Practice, Urgent Treatment and Elective (Outpatient services). A plan has been developed to prepare a suite of business cases to maximise on any existing or future funding opportunities available via Primary Care, Urgent or Elective Funding. Funding secured to move forward designs and detailed capital		01/12/2023

Suffolk and North East Essex ICB Board Assurance Framework

Risk 20 EPUT ligature points **MERGED WITH RISK 8**

				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls Established	Assurance of Controls	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
ICB Quality Committee	Lisa Nobes	Patient safety risk in relation to Fixed Ligature Points and clinical governance of EPUT Ligature process. **Cause** Inappropriate management and or inappropriate mitigation of risk of fixed ligature points. **Effect** Patient serious harm or death.	Patient serious harm of death as a result of inappropriate management and or inappropriate mitigation of risk of fixed ligature points.	3	5	15	Robust ligature assessment process that aligns with Trust policy. No reported Serious Incidents in relation to Patient Harm due to fixed ligature points.	Quality Assurance Visits NHSE/I Mental Health Task Force	Treat/High	3	5	15	Same 15	Green	**April 2023 update**: No further update following review. No ligature deaths in reporting period. Datix data held within EPUT suggests increase in number of non-anchored ligature attempts on wards, particularly amongst females. Action plan not yet available. Keep watching brief and raise through Essex Quality Collaborative QCPM meetings.		30/09/2023

Suffolk and North East Essex ICB Board Assurance Framework

Risk 21 NEE Special Schools **TRANSFERRED TO DIRECTORATE RISK REGISTER**

				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls	Assurance Methods	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
ICB Quality Committee	Lisa Nobes	The 5 Special schools across NEE do not have access to the Universal School Nursing commissioned offer and as such, the healthy Child Programme. **Cause** There is variable or no commissioned special school nursing support within these schools. **Effect** Young people do not receive the Universal Offer which impacts on their health and wellbeing.	All pupils attending these schools have an Education Health and Care Plan. There is variable or no commissioned special school nursing service supporting these schools.	4	4	16	Raised as a risk at SEND Health Subgroup. Raised at Essex SEND Health Improvement board. DCO team to meet with headteacher to offer ongoing support. Audit of 20% of Langham Oaks EHCP's to identify Health needs and provision.	Minutes of meetings. Action Plan for Langham Oaks. Audit results 08/21 NEE Health Sub- group Minutes.	Treat/High	4	4	16	Same	Green	**April 2023 update:** No further update following review. 1.That there is a Specialist Community Paediatric/Nursing offer from ESNEFT to all NEE special schools. The need for this offer is largely within two of these schools where pupils have complex physical health needs. The further three schools are SEMH schools. 2.All schools have been contacted to support with training requirements for health needs however uptake of this offer is limited. ECC are fully aware and have been provided with a chronology of engagement where there may be high needs but schools have not engaged. We are continuing to progress these discussions and work with ECC. 3.There is a universal School Nursing offer commissioned for Essex provided by HCRG but not for special schools across Essex, including NEE. There is a variable offer across other ICB's with additional commissioning by West Essex to enhance the offer. 4.A full update on current situation will be presented at next SEND Partnership Board and joint commissioning group from an NEE perspective 5.We will be working with Public Health who commission the universal School Nursing offer to work towards a solution. 6. ESNEFT have raised a concern about the Health needs of children being met in a specific special school which has been shared with ECC. A sample audit of IHCP's to identify the required level of need and how this is being met		03/04/2023
			There may not currently be health representation at safeguarding meetings for these students. Young people currently not offered health consultation in 'drop-in sessions' or sexual health and relationship advice.				Working with LA colleagues to scope the extent of health provision detailed in EHCP plans. Liaising with key health providers to Map provision historically and to re-establish links.					16				
			Consequences are that young people do not receive the Universal School Nursing Service which impacts on their health and wellbeing.				NELFT to offer regular consultation with Langham Oaks and offer support as required. DCO team to meet with headteacher to offer ongoing support.									

Suffolk and North East Essex ICB Board Assurance Framework

Risk 22 Covid Public Patient Access **MERGED WITH RISK 13**

NHS Suffolk and North East Essex Integrated Care Board

				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls Established	Assurance of Controls	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
ICB Quality Committee	Lisa Nobes	Patient & Public access to a significant number of NHS services has been disrupted due to Covid 19 pandemic with an increased demand on all commissioned services. **Cause** NHS service disruption due to pandemic. **Effect** Patients will present with late symptoms or not at all with worsening outcomes for both acute and longer-term conditions.	Risk that patients will present with late symptoms or not at all with worsening outcomes for both acute and longer-term conditions.	3	5	15	Clear local/national communications that NHS services are open. Online options for consultations rolled out across primary and secondary care.	Activity Reporting via Contract meetings, F/P Tactical Cell information and Feedback. BI team data reporting regarding referrals.	Treat/High	5	3	15	Same	Amber	**March 2023:** No further update on below. Messaging to patients, public and professionals around service changes and NHS is open for urgent care other than Covid19 at national and local level. Cancer promotions underway re early checks with primary care teams. Support to services caring for vulnerable groups enhanced, staff redeployed to alternative care settings and support with a focus on supporting UCRS for admission avoidance. Increased demand across CYP ad Adult MH services, with focus on supporting delivery of services including suicide prevention across Alliance Partners including Police and Fire Services, and other services. Focus on Ambulance handover delays and ED performance at Alliance and SNEE Tactical Meetings. Support to hospital discharge flow with ECC and partners working together. National Cancer campaign amplified on previous CCG comms. Primary care focused on recovery and returning to BAU referrals to return to normal level.		
			Risk to increased mortality due to both Covid and Non Covid presentations. Increased risk of fraud from Covid related claims.				Virtual content and support networks set up by providers for all ages with support of voluntary services.	Monitoring of virtual appointments for the Acute via the elective care programme board. PH reporting on excess death reporting. Virtual support from Primary Care / Care homes / Communications and IPC teams.					15				
							Response to Covid managed at ICS, Alliance and LRF levels and will step up and down linked to covid waves for recovery actions to be managed.	Board Oversight. Alliance Operational Group overseeing local recovery planning related to community and urgent care services.									
							Business continuity plan in use. SNEE incident room established. SNEE operational and tactical meetings stood up and down dependant on waves.										
							Local Outbreak Management Plan. Tracking of case numbers in place. LRF stood down both TCG & SCG meetings but will stand up again as needed.										

Suffolk and North East Essex ICB Board Assurance Framework

Risk 24 Dementia Environment **TRANSFERRED TO DIRECTORATE RISK REGISTER**

NHS Suffolk and North East Essex Integrated Care Board

				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls	Assurance Methods	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
ICB Quality Committee	Lisa Nobes	Dementia is excluded from MH D2A pathways. **Cause** Dementia is excluded from MH D2A pathways. **Effect** There is a risk of Serious Physical and/or Psychological Harm to Patients with Dementia whilst remaining in the wrong environment.	The D2A assessment process is undertaken when individuals are in heightened states of distress due to the environmental triggers.	5	4	20	There are regular patient flow meetings involving both NSFT & ACS to discuss barriers to discharge. There are individually funded packages of D2A for this cohort, which alleviates some pressure but is done on a SPOT purchase approach.	ICB Quality Committee. ICB MH Transformation team aware.	Treat/High	4	4	16	Same	Green	**April 2023 update:** No further update following review. A business proposal has been shared with the MH Transformation team for Step Up and Step Down.		30/09/2023
			There is a risk of Serious Physical and/or Psychological Harm to Patients with Dementia whilst remaining in the wrong environment.				Consideration for extending the use of Wickham House with additional resources is currently being explored. Transformation MH team within ICB are sighted upon this issue.						16				

Suffolk and North East Essex ICB Board Assurance Framework

RISK CLOSED **Risk 26 Primary care access to Afghan nationals, asylum seekers, and refugees**

NHS Suffolk and North East Essex Integrated Care Board

				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls Established	Assurance of Controls	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
ICB Board	Andrew Kelso	Reduction in access to, experience of and outcomes in primary care due to capacity. **Cause** Home office policy to stand up sites at short notice to reduce the backlog of people held at receiving/holding sites for people entering the country. **Effect** High expectation of local health services to respond to the needs of hotel residents. The scale and complexity of cases leading to impact of demand and capacity for primary care contractors already under pressure within existing resources.	Delay in patients being registered Reputational risk of ICB for perceptions of lack of access	4	5	20	Commissioned service (Enhanced Assessments). Commissioned Service (GP open access).	ICB governance followed inc. due diligence. Contract variation and contracting.	Treat	2	3	6	Same	Green	**March 2023 update.** Nearly all residents have been registered with GP Practice, confirmation of exact numbers awaited Public Health have met with provider to provide reassurance that infection control measures are robust within hotel Risk largely mitigated by current measures, but requires ongoing monitoring and may increase in future should further hotels be commissioned. **RISK CLOSED**	Vaccination bus to visit hotel to support	31/01/2023
			Health and wellbeing of primary care staff, increased workforce pressures				Local working groups with system partners. Clinical and governance processes underpin preferred models.	Engagement with primary care via ICB GP lead and LMC					6		Continue to register & support refugees as they arrive & manage their health needs	Ongoing
			Opportunity costs of enhanced investment redirected from other budget areas				Meetings with Hotel to monitor emerging risks for mitigation and review. Additional support commissioned from voluntary sector e.g Colchester Refugee Action.									
			Where patients not registered risk of duplicate records by supporting providers													
			Lack of workforce to be deployed to preferred model.													

Suffolk and North East Essex ICB Board Assurance Framework

Risk 27 PODs Finance and Operations REMOVED

NHS Suffolk and North East Essex Integrated Care Board

				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls	Assurance Methods	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
Aliance Committees	Maddie Baker-Woods	SNEE ICB will receive delegated authority for Pharmacy, Optometry and Dental (POD) services on 01/04/23. There are a number of areas that pose a risk to the ICB, namely finance and operations. **Cause** NHSE are yet to provide SNEE ICB with clear processes for a number of areas and clear breakdowns of finance. **Effect** The limited information means SNEE ICB are unable to fully assess the financial and operational impact of the delegation.	Lack of clarity regarding complaints processes which are being part delegated.	3	4	12	Attending the weekly Complaints T&F group - Led by Sophie Martin	Quality Committee and POD Working Group	Treat/High	3	3	9	Same	Green	**April 2023 update.** Financial plan reviewed with NHSE showing a balanced position for 23/24. Risk on pharmacy overspend but mitigated by a regional contingency held by NHSE.		
			No detailed financial plan has been shared (only high level received).				Attending the weekly finance T&F group - Led by Deputy Finance Director	Finance Committee					9				
			Access to key systems not yet granted (eDEN and Compass), needed for day one.				Requested and awaiting outcome	POD Working Group									
			DPIA not yet completed by region.				Been escalated and IG Lead aware	POD Working Group									
			Potential resource funding gap of circa £500k				Gaps will be around Finance, Complaints and Quality - yet to be quantified.	POD Working Group									

Suffolk and North East Essex ICB Board Assurance Framework

Risk 28: 30% reduction in ICB running costs **MERGED WITH RISK 25**

NHS Suffolk and North East Essex Integrated Care Board

				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls Established	Assurance of Controls	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
ICB People Committee	Amanda Lyes	The financial recovery programme will lead to a degree of uncertainty with stakeholders and staff. The programme might not achieve financial goals whilst ensuring mandate, retention of key staff, timing, staff morale due to proper change management.	Financial cost reduction targets not met.	3	5	15	Directors managing process and allocating new cost frameworks to functions.	Programme team and design steering group weekly monitoring.	Treat/High	2	3	6		Green			
			Stakeholder and partner confidence drops.														
			Organisation design not thorough in leveraging synergies or optimisation of roles.														
			Change management project does not manage the change.				Stakeholder engagement planned to ensure alignment, assurance of services and ability to feed into programme.	Feedback channel to directorates.									
			Staff not involed in in design.				Organisation Design Steering Group established to co-ordinate and manage.	Organisation Design Steering group regulating and monitoring weekly.									
			Communication is inadequate to ensure buy in and alignment to goals.				Change management plan developed.	Organisation Design Steering group regulating and monitoring weekly.									
			Proccesses are not integrated to the new structure.				Process to include each team in desig with individual feedback channels. A finance and organisation design staff reference group formed to broaden involvement and feedback.	Organisation Design Steering group regulating and monitoring weekly.									
			Staff morale at risk.				Comprenesive communication plan developed.	Communication group monitoring and ensuring flow of information and communication.									
			Union relationships break down.				Programme Director appointed to ensure co-ordination of projects, alignment of functional efforts and integration of processes.	Steering group monitoring weekly.									

							Line manager capacity building and support programme. Staff support clinics. Health & wellbeing support programme available.	Organisation Design steering group regulating and monitoring weekly.										
							Union engagement ensured through regular engagements, feedback and information sharing.	Organisation design steering group monitoring monthly.										

Risk no	Risk title	Risk owner
1	System A&E	Paul Gibara
3	System RTT	Paul Gibara
8	System Mental Health (was NSFT CQC)	Lisa Nobes
10	Access to Primary Care	Alliance Directors
11	Cyber Security	Andrew Kelso
12	Provider Workforce	Amanda Lyes
16	EEAST	Ed Garratt / James Waites
19	System Cancer Standards	Richard Watson
25	Finance statutory targets	Howard Martin
29	Consequences of climate change	Amanda Lyes

Suffolk and North East Essex ICB Board Assurance Framework

NHS Suffolk and North East Essex Integrated Care Board

Risk 1 SYSTEM A&E

Detail				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls	Assurance Methods	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
Urgent and Emergency Care Committee	Paul Gibara	The ICB continues to be under significant pressure whilst benchmarks well against other regional systems it continues to fail several well established standards namely 4hr wait 12 hour delay (new standard) Ambulance off load delays Ambulance response times **Cause** - demand to the department Insufficient flow through the department Delays to discharge medically fit patient's **Effect** - poor patient experience and heightened safety risk.	Compounding these difficulties remains the prevelance of Covid 19. Workforce and bed occupancy relating to system flow and operational delivery plans exceed 19/20 activity thresholds for elective recovery.	4	4	16	Daily system operational system flow meetings to support effective use of available capacity. Routine weekend planning and on call arrangements. Admission avoidance schemes aimed at reducing ambulance conveyancing. Improvement trajectories aligned to 'Oneplan' actions with monthly monitoring	Performance dashboard established together with live data feed to monitor system pressures and support appropriate actions. Tactical reviews of system performance and actions UECC oversight of system risk, performance and programme development SOAC oversight of performance and risks Regional oversight of performance and risks	Treat/High	4	4	16	Same 16	Amber	**July 2023 update:** Position at W/E 18/06 for ED 4 hour was WSFT 72.5% and ESNEFT 72.57%. 12 hour performance remains at 4% of attends although we have seen reduced delays. June has been challenging for patient handover at ESNEFT sites with a deep dive underway to identiify actions to improve. C2 response times have also struggled in June and we are off trajectory to deliver 30 minutes - deep dive also underway.		

Suffolk and North East Essex ICB Board Assurance Framework

NHS Suffolk and North East Essex Integrated Care Board

Risk 3 SYSTEM RTT

Detail				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls	Assurance Methods	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
Strategic Programmes and Elective & Diagnostics Committee	Paul Gibara	System is not meeting Constitutional Referral to treatment Target of 18 weeks. Patients are not receiving care within expected standards. This is a national issue underpinned by Covid-19 pandemic. **Cause** Backlog built up during the pandemic when treatment slowed. Insufficient capacity to treat the incoming demand and backlog. **Effect** Poor patient experience and heightened safety risk	Covid 19 has led to a backlog and continues to provide challenges, namely ; Reduced outpatient capacity. Theatre throughput for routine electives activity. Diagnostic capacity back up and running but is restricted in certain areas due to Covid restrictions. Whilst number of long waiting patients are reducing as planned, we are seeing an increased level of patients waiting over 52 weeks. Much effort has been diverted to reviewing and ensuring patients waiting long period of time are monitored so as to mitigate risk associated with long waits.	4	4	16	Recovery is overseen by the Strategic Programme and Elective recovery committee. Committee supported by a joint operational delivery group between WSFT and ESNEFT. The system has established plans aimed at reducing patients waiting for a long time over 78 weeks and patients requiring urgent treatment. Mutual aid across organisations is in place with conversation extending into regional support. Weekly review of performance against plan. Focus on productivity and efficiency across waiting list management, theatre utilisation and outpatient.	ICB attend/active part of Elective Care Programme Board. Long waits and overall length of wait are both on downward trend although mutual aid support to WSFT (system long waiters) has affected over last few months. ICB monitoring new targets in 22/23 operational targets.	Treat/High	4	4	16	Same 16	Amber	**July 2023 update:** The system aims to clear by 78 week waits (due to capacity) by July (delayed due to industrial action). However, there is likely to a residual cohort of urogynaecology patients at WSFT (regional solution being sought). ESNEFT receiving national tier 1 support, WSFT receiving tier 2 regional support.	Clear remaining 78 week waits. (High risk - see narrative) Tier 1 and Tier 2 action plans being devloped for delivery by end of year	30/07/2023 30/12/2023

Suffolk and North East Essex ICB Board Assurance Framework

Risk 8 System Mental Health

Detail				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls	Assurance Methods	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Completition
ICB Quality Committee	Lisa Nobes/Richard Watson	The inability to demonstrate appropriate safety standards throughout mental health services. These present significant patient safety risks to the population of SNEE. **Cause** The inability to demonstrate appropriate safety standards throughout the services. **Effect** Significant patient safety risks to the population of SNEE.	**NSFT -** Statutory Duty to ensure patient safety within commissioned services: The Trust inability to demonstrate appropriate safety standards throughout it services present significant patient safety risks to the population of Suffolk. The worsened performance of mental health services provided by NSFT causes poor patient outcomes and reduced quality of services provided.	4	5	20	**NSFT -** Quality assurance process initiated jointly with NSFT to review every service line. Monthly meetings to review / challenge quality performance. Quality dashboard. Attendance at monthly stakeholder assurance meetings led by NHS Improvement / CQC.	**NSFT** - Improvements to patient safety and experience noted through QA process. Demonstrated improvement against contractual key performance indicators evidenced through quality dashboard escalation of issues via Contract Quality Performance Review (CQPR) meetings.	Treat/High	4	5	20	Same	Green	**July 2023 update.** NSFT - Discussions ongoing to agree plans to address areas with highest waiting lists: ADHD/MATS. Following recent CQC inspection there has been an improvement performance. The Trust is now rated as requires improvement. CYP - Local Protocol for managing, escalating need in acutes in place. Review taking place based on practice-based evidence across CYP system agencies and led by ICB through a T&F Group considering development of "place of safety" locally and the development of "cases of concern" system oversight group for early support and intervention. Dynamic Support Register for CYP with LD and/or A in place for proactive and support and monitoring where CYP at risk of admission. ICB funded Short Breaks for CYP with LD and/or A and mental health needs commissioning due to be available Sept 2023. SCC leading on a forum where cases of concern locally across care, education and health are reviewed for proactive support. Potential funding being accessed to improve/provide better environments for CYP with acutes needs. Peripatetic offer is now in place and being evaluated – positive feedback from system and longer term funding has been applied for, decision pending. Applied for Medium term funding to extend pilot offer and CATAT hosted by NSFT. Three additional	NSFT - MATS business case presented to West Suffolk Alliance in May 2023- pending further conversation on affordability. ADHD pathway design/demand & capacity analysis due to be completed by June 23. Eating Disorders (Adult) deep dive took place with NSFT and system partners to discuss service challenges and relationships on 17.05. Action plan worked up.	30/09/2023
			CYP - CYP are unable to access MH therapy and treatment. As a result, YP have been admitted into paediatric wards in acute hospitals across the ICS. This creates a risk to staff, patients and families on these wards.				**CYP** - ICB Escalation and flow management in acute hospitals. Regular reporting and escalation through QSAF/ NEE QC/ ICB CYP MDT. Regular system calls for CYP with involvement of all partners and ICB to manage clinical risk, share information and plan delivery of care	**CYP** - Involvement of the ICB Board. Regular reports to statutory committees.					20		CYP - We are now starting to see the impact of the mitigating measures in place however remain concerned about the waiting lists for treatment. Recommend reduing the current risk to 12 as the risk is less likely.	
			EPUT - Patient safety risk in relation to Fixed Ligature Points and clinical governance of EPUT Ligature process.				**EPUT** - Robust ligature assessment process that aligns with Trust policy. No reported Serious Incidents in relation to Patient Harm due to fixed ligature points.	**EPUT** - Quality Assurance Visits NHSE/I Mental Health Task Force							EPUT - Currently awaiting updated Action Plan.	

Suffolk and North East Essex ICB Board Assurance Framework

Risk 10 Access to Primary Care

Detail				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls	Assurance Methods	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
	Alliance Directors	Reduction in access to, experience of and outcomes in primary care due to capacity, demand, constraints (workload; workforce; digital and estates). **Causes** Workforce – recruitment Inability to recruit or retain GPs Reduction in partners to take on liability Stress leading to high turnover Reduction in clinical sessions to protect from burnout Reduction in trainees IT pressures Availability of hardware and changing systems Lack of system alignment Financial Partner liabilities (estates, employment and single partners) Wage growth and inflation including energy prices System pressure Movement of unfunded workload Reduction in carers Lack of dental capacity Increased waiting times for elective care **Effect** Potential quality of outcomes for patients. Increased workforce issues remain challenging and exacerbated by estate issues and workload pressures	Waiting resulting in deterioration (delay in accessing appointments (first and follow up). Further reduction in GP numbers. Increased referral to acute diagnostic and/or planned care services. Increased attendance at A&E Adverse impact on continuity of care and daily acute demand pressures Increased pressure on 111 and Pharmacy services	4	4	16	Development of Primary Medical Care Task Force -forward strategy and plan towards new models of care including safe working levels Recruitment and retention programmes (clinical and non clinical) including ARRS roles Workload management models. Development of PCN estates plan and delivery of new digital support. Delivery Plan for Recovering Access to Primary Care released May 23. Aim to cover the 8am rush, 4 key areas identified.	Primary Care Commissioning Groups Training Hub Operational Support (PM meetings / PCN CD and PCN Business Manage Meetings) Alliance clinical leads meetings (weekly).	Treat/High	4	4	16	Same 16	Green	**July 2023 no further update to below:** Working with LMC and practices to establish new contract requirements. NHSE have completed the review of cloud based telephony (CBT). PCNs producing Capacity and Access Payment (CAP) by 30 June to evidence improvement against 3 key areas. Working through the timeline for recovery: empower patients, implement modern general practice, build capacity and cut bureaucracy.	Timeline for each area	30/06/2023

Suffolk and North East Essex ICB Board Assurance Framework

Risk 11 Cyber Security

NHS Suffolk and North East Essex Integrated Care Board

Detail				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls	Assurance Methods	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
	Andrew Kelso	Potential impact of cyber security incident could lead to wide scale IT system outages, meaning no access to patient records, e-dispensing services etc. **Cause** Cyber security attack. **Effect** Wide scale IT system outages, meaning no access to patient records, e-dispensing services etc	National requirements have increased, in respect of the need to achieve cyber essentials + accreditation. No national funding has been identified specifically for cyber security work to mitigate against the increased risk, and the increased requirements.	4	5	20	Cyber Essentials Plus accreditation moving to scoping phase. Additional ETTF funds have been successful to implement a NAC solution, details being worked up with NEL. W10 rollout 99.95% complete. Handful of remaining W10 PCs will be decommissioned in service transition, they remain supported.	External Audit. Internal audit complete. Monthly SLA provider meetings. Monthly service review provider meetings. CE+ certification will include annual pen test and vulnerability scans. Monthly Joint Digital and IT Services Board. Audit Committee review. SNEE ICB will be working towards Cyber Essentials plus accreditation which invoves vulnerability scans/Pen tests	Treat/High	3	5	15	Same	Amber	**July 2023 update:** MFA (Multi-Factor Authentication) will be enable across all SNEE domain logons by 30th June . MFA uses AI (Artificial Intelligence) to calculate the risk and then challenge. Cyber Essentials plus accreditation work will pick up again in July.		
			No access to systems – would require frontline services to fully enact Business Continuity and Disaster Recovery procedures. Potential for lack of access to relevant IT skills and insight to develop a recovery plan (dependent on type of attack). Restoration of services complex, would involve multiple vendors and take a significant period of time				OKTA has been replaced with native Microsoft MFA. Ensure that backups, restore mechanisms and online defences are working as BAU, monthly reporting and live dashboards. NEL have team to keep up to date with latest threat and mitigation information.	MFA is now active so a log on from an unexpected location will be treated by the system as a threat. All backups are now cloud based and data is located in more than one datacentre. Restoration of services is now easier to mnage and control. Once NEE is onboarded SNEE will have full autonomy in the event of a disaster.					15				

Suffolk and North East Essex ICB Board Assurance Framework

Risk 12 Provider Workforce

				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls	Assurance Methods	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
ICB People Committee	Amanda Lyes	Workforce challenges across the system. **Cause** Supply Sustainability Support to staff **Effect** Leading to risks to patient safety, care and delivery of services.	Supply: Current and future workforce supply. Sustain: Current and future workforce profile Sustaining safe quality staffing Retaining the current workforce.	4	5	20	SNEE People Committee established to implement the system People Plan and associated initiatives. Working transformation, performance improvement, quality and finance to create pathway led workforce strategies	IES, NEE and WS Local Workforce Transformation groups, PC WIG and GPCC reporting to SNEE People Committee. Working groups to address topic specific challenges e.g. retention, 50K nursing, H&WB.	Treat/High	4	5	20	Same	Green	**July 2023 update:** A new draft system Workforce risk has been written focussing on three themes: Grow the Workforce, Working Differently and Productively and Compassionate and Inclusive Culture. This was presented at the People Committee in June 2023. The operational plan is as an opportunity to refocus the system workforce team. At a system level workforce needs to: • Drive transformation • Reduce the gap between capacity and demand • Increase productivity and activity within the workforce financial envelope The SNEE ICS has multiple pathway plans and models. By looking at each pathway's operational plan and drawing up key lines of enquiry we will be better able to create a future workforce state and combine and co-ordinate	Pathway Workforce strategies and plans created, creating a future model	01/12/2023
			Support: re-energise the workforce(wellbeing/work-life balance/ flexibility right equipment/functionality/estate.					Workforce Intelligence & Planning. Workforce workshops for challenged pathways.					20			People committee sub groups of the people to be reiewed	01/09/2023
																Assurance dashboard to be created and aligned with performance improvement	01/09/2023
																On going conversations with stakeholders	01/09/2023

Suffolk and North East Essex ICB Board Assurance Framework

Risk 16 EEAST Performance and Quality

				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls	Assurance Methods	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
	Ed Garratt	EEAST is not acheiving national performance targets. **Cause** Capacity constraints, productivity issues around abstraction rates and to some degree handover at hospital delays **Effect** There has been a trend increase in SIs arising from delays in response. Continued high pressure on staff in patient facing positions resulting in relatively high sickness rates and high vacancy rates	New leadership team in place, some new to the sector/roles. A+E handover delays impacting capacity. Delays in responding causing patient safety risks particulalry in Category 1 and 2 calls.	5	5	25	Bi-Monthly Oversight & Assurance meeting. (Regulator and Lead Commissioner at Chief Exec level). Fortnightly Improvement update meetings (Regulator Lead, Commissioner and Provider PI)	Reviews of EEAST Operational Improvement and workforce plan updates at OSM and OSG.	Treat/High	5	4	20	Same	Red	**July 2023 no further update to below.** Improving handover delays and C2 performances seen although not achieved target. Handover plan total hours agreed with regulator, systems aware of individual targets to achieve overall trajectory. C2 plan for 23/24 has been submitted to NHSE showing plan to acheive <30min cat 2 average target.		
			The level of PFSH available to deploy on the road is unable to meet capacity and is below 2019/2020 ISR plan. Sickness levels and abstraction rates are high in the sector and is contibuting to lower levels of PFSHs main causes of this. 23/24 recuitment plan, staff ready on the road behind plan although pipeline okay.				Monthly quality and performance meetings held locally at ICS level. ICS/Alliance UEC System meetings. Weekly SI report circulated by Trust to commissioners	Clinical review of serious incidents through SI panel. Clinical review of serious incidents through SI panel. Local EEAST improvement plans monitored.					20				
							Handover hours target for systems has now been agreed with regulator	Escalation to Exec Quality & Safeguarding, QSAF, Quality and Scrutiny Committees.									

Suffolk and North East Essex ICB Board Assurance Framework

Risk 19 System Cancer Standards

				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls	Assurance Methods	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
	Richard Watson	System not meeting the cancer related standards within the NHS constitution leading to worsening patient outcomes and quality of services. **Cause** Capacity insufficient to meet the rising demand for services and resolve the backlogs created. **Effect** Poor patient experience and heightened safety risks.	• Clinical risk of patients not being seen in appropriate timescales • Risk of deteriorating patient outcomes and experience due to long waits. • Risk of breaching constitutional obligations. • Risk of increasing patient harm both physically and mentally due to being on Cancer pathway for extended period of time.	4	4	16	National standards scrutinised by ICB and NHS Cancer Alliance. -SNEE Cancer Ops Group monthly meetings providing overview of Cancer performance. -Monthly joint quality/ performance meetings (QCPM) between ESNEFT and ICB and WSFT and ICB. -SNEE ICS Cancer Committee (bi-monthly)	Local cancer programmes and performance reports up into: 1. SOAC and through to the ICB Board 2. Regional Cancer Alliance Board Time Matters Board. ICS Cancer Ops Group and through the ICS Cancer Committee.	Treat/High	4	4	16	Same	Green	**July 2023 update** 62 day trajectories piblished for 23/24 as @ June 2023 ESNEFT 276 currently 303 and WSFT 93 currently 121 New FDS recovery trajectories have been published for 23/24 with Q1 67.5%, SNEE are currently 67.8%. ESNEFT LGI PTL is currently 61%. Remains a risk to recovery. Skin pathway delayed at WSFT, with 60% of their backlog, skin patients. Tertiary referrals quality teams looking to mitatigate. ESNEFT are tier 2 in elective which has resulted in cancer submissions. SNEE were highlighted by the national team due to FDS performance and the responce has been submitted in May 2023.	Recovery Plans in place for 62 backlog and 62 day performance and 28 FDS recovery.	01/04/2024
							Weekly specialty reporting and cancer focused ESNEFT and WSFT PTLs in place. Recovery Plans development and in place down to specialty level within ESNEFT and WSFT.						16				

Suffolk and North East Essex ICB Board Assurance Framework

Risk 25 Failure to meet financial targets

NHS Suffolk and North East Essex Integrated Care Board

				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls	Assurance Methods	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
ICB Finance Committee	Howard Martin	Failure to meet statutory ICB financial targets to: - At least break even. - Ensure both capital and revenue resources do not exceed the limit set by NHS England. - Ensure expenditure on running costs does not exceed the limit set by NHS England. **Cause** Insufficient funding, ineffective controls, or ineffective cost improvement to meet statutory targets. **Effect** Non delivery of financial planning targets and/or delivery of statutory duty will result in a loss of autonomy and credibility for the system. This will materialise as restrictions on investments and challenging disinvestment decisions for example.	Prescribing price inflation. Non NHS contract inflation. Pressure on CHC pricing. Delivery of efficiency target. Cost of waiting list recovery.	3	5	15	ICB Finance Committee, ICB FRSG, and Financial Improvement Group in place to ensure scrutiny of delivery of efficiency programme.	Internal audit of key financial controls. Internal audit against HfMA Financial Sustainability Checklist.	Treat/High	3	5	15	Same	Amber	**July 2023 update.** The programme plan has been baselined and features all activities required to achieve the development and issuing of the Consultation Pack and all tasks required post consultation. All activties are on track. The 9.6m non pay has completed first review and will be fully complete and savings calculated by 07/06 (FRSG), inlcuding estates and IT. SNEE is applying (via a Business Case) to NHSE to launch Voluntary Redundancy scheme to launch early August. This means Consultation planned for 17/07 has been paused and is now planned for 04/10. All VR documents and processes are on track - the Plan has been updated to reflect the change in direction.	Consultation Pack issued	04/10/2023
			Additional cost of Urgent and Emergency Care pressures. Innefective commissioning of dicharge capacity funding. Cost of supporting organisations in financial distress.				Clear internal expenditure controls in place to ensure spend is only authorised within limits and funding available. Inflationary pressures reserves established.	ICB Finance Committee and Financial Recovery and Sustainability Group scrutiny of financial position and efficiency delivery. Monthly director budget scrutiny meetings. Alliance Committees scrutiny of financial position for delegated budgets.					15			Non pay review complete	07/06/2023
			The Running Cost Reduction Programme (reduction of 30% running costs, both pay and non-pay) will lead to a degree of uncertainty with stakeholders and staff. The programme might not achieve the required 30% running cost reduction whilst ensuring mandate, retention of key staff, timing, staff morale due to the pace of change and the requirement to reduce costs.				All fully populated, detailed programme plan has been developed to define critical tasks and milestones to achieve both the non pay element (review of 9.6m) and the pay element (restructure).	A number of groups have been established to support and assure the programme (Working Group, Staff Refernce Group and Steering Group) Executive Committee hold ultimate decision making authority. Non-pay reduction feeds into FRSG.								Launch of VR process.	10/08/2023

Suffolk and North East Essex ICB Board Assurance Framework

Risk 29 Consequences of climate change

				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls	Assurance Methods	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
Estates Committee	Amanda Lyes	Consequences of climate change on the health and healthcare services of the SNEE population.	Risk to health and social care service delivery. Patients and staff suffering ill health due to an increase in adverse weather. Unusable healthcare premises due to adverse weather events. Poor air quality.	4	4	16	ICB Green Plan. Multi agency planning by LRF's.	ICS Board approval. LRF Executive Boards.	Tolerate/ Significant	4	4	16	Same		**July 2023 update** Sustainability Impact Assessment (SIA) has had soft lanuch and pilot**.** Fedback being collated to modify template and final draft for hard launch.	1.The NHS Estates Net Zero Carbon Delivery Plan sets out the actions that the various organisations within the NHS should be delivering over the next five years. These are included in Appendix J. These actions have been shared with all organisations in SNEE and form the basis of the SNEE action plan.	01/12/2028
													16			2.Further review this risk following LRF Community Risk Register updates following the update to the National Strategic Risk Assessment (NSRA).	01/09/2023

Directorate Risk Register summary of top risks

Date: June 2023

Department	Risk Description / consequences	Current controls / assurance	RAG	Actions with status	Completion date	Responsible person
1. Corporate Services	Clacton Hospital redevelopment	Controls over quality, performance, reputational and financial risk: Programme governance established with project board, which includes representation from NHSE via SEA.	**20**	Following a review of BAF risks this risk is now back on the directorate risk register. Business case developed is now being led by ESNEFT in accordance with ICB partners including ESNEFT, EPUT, Primary Care (Ranworth PCN) and NHS Property services.	1 Dec 2023	Amanda Lyes
2. Corporate Services	Lack of single tenancy.	NEE staff are reliant of Suffolk colleagues to assist.	**16**	IT working towards end June early July 2023 for completion.	July 2023	Amanda Lyes
	Risk Description / consequences	**Current controls / assurance**	**RAG**	**Actions with status**	**Completion date**	**Responsible person**
1. COO Ipswich & East and West	A practice in IES have encountered significant GP staffing issues which may impact on their ability to see patients in a timely manner	ICB is working with local practices and the current provider to develop a plan to deal with this issue.	**12**	Work on the way with the practice in respect of building project. Staffing issues have stabilised	Ongoing	Caroline Procter
	Risk Description / consequences	**Current controls / assurance**	**RAG**	**Actions with status**	**Completion date**	**Responsible person**
1. Performance Improvement	Suffolk CYP Community services There have been longstanding concerns around the waiting times for autism spectrum disorder assessment & diagnosis for CYP up to 11 yrs. The pandemic has exacerbated waiting times. >400 CYP are waiting over 12 months for an autism assessment vs NICE guidance which is assessment/diagnosis within 6 months	A progress summary paper was shared by the trust in April 2022 and several areas of concern have been identified. Concerns have been shared with the trust and a meeting has been scheduled for 27 April to discuss the concerns. Concerns were raised at the April Community contract meeting and on-going discussions with the trust will be supported by colleagues from clinical quality and transformation. Concerns will be summarised at the CYP MDT in April to understand any other mitigation options. There is currently limited assurance that WSFT has implemented the service restoration plan.	**16**	Waiting list restoration plan developed and ICB investment agreed in October 2021. Restoration plan implemented by WSFT. A progress summary paper was shared by the trust in April 2022 and several areas of concern have been identified. These concerns have been shared with the trust Families have been provided with information/signposted to support resources. Additional resources due to be available from summer 2021 following the completion of the NDD procurement.	No end date	Nicola Brunning

				Service has contacted all families to support signposting.		
2. Performance Improvement	Pandemic Disease Hazard: On both the Suffolk and Essex Community Risk Registers Pandemic Influenza is the highest noted. During an outbreak we could see significant staff shortages from the ICB and provider organisations, disruption to supply chains. Changes in both local and national priorities for NHS Care that will translate in to changes within teams to deliver them. Consequences include inability to provide services, temporary loss of staff (through sickness/ caring for relatives), permanent loss of staff. Inability to discharge from hospitals due to lack of care facilities (inclusive of domiciliary care, residential and nursing homes). Increase in deaths likely to create significant pressure on hospital mortuaries and wider fatality management services (funeral homes etc). Impacts of the pandemic linked to changes in elective programs (both urgent and non-urgent) will involve a recovery plan, while potentially mitigating subsequent pandemic waves. Any prophylaxis or vaccination program will also add a huge demand on NHS services.	UKHSA monitoring for potential outbreaks. Resilience Forum Pandemic Plans. Resilience Forum Mass Fatality and excess death plans. ICB Business Continuity Plan, ICB Emergency Response Plan, Provider business continuity plans. NHS EPRR Core Standards process.	**15**	Annual ICB Business Continuity exercise. Annual flu vaccination campaign.	01/04/2024	Chris Chapman
3. Performance Improvement	Practice Plus Group are unable to deliver the 20 second response target for 111 The risk is that patients with urgent needs are delayed or missed due to the longer than standard waits.	Regular monitoring and action meetings are in place, Director Level conversations occurring.	**16**	Additional funding for Think 111 First given to PPG. Regular System Escalation conversations occurring	September 2023	Greg Brown

	Risk Description / consequences	Current controls / assurance	RAG	Actions with status	Completion date	Responsible person
1. Nursing	Dementia is excluded from MH D2A pathways. The D2A assessment process is undertaken when individuals are in heightened states of distress due to the environmental triggers. There is a risk of Serious Physical and/or Psychological Harm to Patients with Dementia whilst remaining in the wrong environment.	There are regular patient flow meetings involving both NSFT & ACS to discuss barriers to discharge. There are individually funded packages of D2A for this cohort, which alleviates some pressure but is done on a SPOT purchase approach. Consideration for extending the use of Wickham House with additional resources is currently being explored. Transformation MH team within ICB are sighted upon this issue.	**16**	No further update.	September 2023	Wendy Scott
2. Nursing	The 5 Special schools across NEE do not have access to the Universal School Nursing commissioned offer and as such, the healthy Child Programme.	Raised as a risk at SEND Health Subgroup. Raised at Essex SEND Health Improvement board. DCO team to meet with headteacher to offer ongoing support. Audit of 20% of Langham Oaks EHCP's to identify Health needs and provision. Working with LA colleagues to scope the extent of health provision detailed in EHCP plans. Liaising with key health providers to Map provision historically and to re-establish links. NELFT to offer regular consultation with Langham Oaks and offer support as required. DCO team to meet with headteacher to offer ongoing support.	**16**	July 2023 Update: ECC to raise as a SEND system wide risk within the Partnership as it lies with Public Health. Recommend closure on the ICB Quality Risk Register.	September 2023	Kathryn Searle
	Risk Description / consequences	**Current controls / assurance**	**RAG**	**Actions with status**	**Completion date**	**Responsible person**
1. Transformation	Failure to achieve national Dementia diagnosis target for WS of 67% in line with the Prime Minister's Challenge on Dementia 2020. Length from referral to diagnosis currently c. 6 months with	System recovery funding in place with both diagnostic services as well as support agencies which also pick up pre-diagnosis. Recovery plan in place with projected achievement of 66.7% come March 2023 Current attainment for locality 56.7% at January 23	**9**	**Update:** West Suffolk Memory Assessment service business case derived with demand and capacity modelling to clear backlogs and sustain an MSNAP accredited service. Pending ICB finance prioritisation process.	March 2023 Update: Trajectory in the process of review following NHS Digital amending	Rob Chandler

	scanning across the locality being a key issue for delays.				prevalence calculations	
	Risk Description / consequences	**Current controls / assurance**	**RAG**	**Actions with status**	**Completion date**	**Responsible person**
1. NEE – Meds Mgmt	NICE issued updated guidance relating to the monitoring of blood glucose monitoring in all patients (adults and children; type 1 and 2 diabetes mellitus) on 31st March 2022. A significant and substantial impact on both Alliance and ICB medicines and devices budgets.	Joint ICB task and finish group is working on pathways and list of approved cost-effective options for CGMs.	**9**	Pathway completed by task and finish group, led by ICB Diabetes lead Pharmacist, agreement has been reached by all from clinical leads in ESNEFT, WSFT and NEEDS. ICB executive team has approved funding.	31 March 2023	Olubusola Daramola
2. NEE – Meds Mgmt	Minimising health inequalities by creating a SNEE wide insulin pump formulary with all patients being subject to common Approval criteria. NEE supports an insulin pump formulary based on lower acquisition cost options in the market, while Suffolk does not have a formulary. This creates a disparity and increases cost pressure in NEE with patients on the border or transferred to NEE from Suffolk.	Joint ICB task and finish group is working on a joint ICS-wide approval process and insulin pump formulary which takes into account a forecast of increase in use and a budget impact assessment, in view of the current financial recovery position without a negative impact on patient outcomes.	**15**	Pathway completed by task and finish group, led by ICB Diabetes lead Pharmacist, final agreement required from clinical leads in ESNEFT and NEEDS.	31 March 2023	Olubusola Daramola

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ICB BOARD

Agenda Item No.	**15**
Reference No.	**ICB 23-54b**
Date.	**25 July 2023**

Title	**Redesigned Board Assurance Framework (BAF)**
Lead Director	Amanda Lyes (Director of Workforce and People)
Author(s)	Colin Boakes – Independent Governance Advisor
Purpose	To note and approve the redesigned BAF format

Recommendation:

The ICB Board is asked to approve the redesigned BAF format.

1. Background

1.1 Further to discussions regarding the ICB BAF at previous Board and Audit Committee meetings and subsequently a Board Development Session earlier in the year, it has now been redesigned and an example of the format proposed for the future is presented for discussion and hopeful approval.

1.2 The redesign process has taken account of the issues and concerns raised at these meetings.

1.3 Once approved, the complete BAF will be converted into the new format ready for presentation at the September and subsequent meetings of the Board and Audit Committee.

2. Key Issues

2.1 The BAF is intended to provide the organisation with a simple but comprehensive method for the effective and focused management of the principal risks that may impede the ICB in meeting its objectives and statutory obligations.

2.2 The BAF therefore serves as the key document to assure the Board that effective risk management is firmly embedded across the organisation.

2.3 Further to the earlier discussions, it was acknowledged that the format of the BAF document needed to be addressed in order to promote a system wide approach to risk management, more clearly set out where ownership and responsibility for the component risks rests and enhance the assurance elements through the sharing of underpinning system data.

2.4 A prime aim of the redesign was to ensure that there are clear lines of sight between the Board governance responsibilities, accountability of the Executive Directors and the assurance activities of the Board's governance committees.

2.5 It was acknowledged that the previous columnar design of the BAF had outlived its usefulness and the new design therefore moves entirely away from that model into a format which we believe will be easier to complete, update and understand, not only for the Board and staff, but also the public given that it is a public facing document presented at Board meetings.

2.6 An example of the new format for the existing BAF Risk 12 regarding system workforce is attached.

2.7 In order to promote a system wide approach to risk management going forward is the inclusion of relevant ICS system outcome measures and the SNEE system workforce report is attached which aims to underpin the controls and assurances contained in the BAF for this particular risk. Similar data, where available, will be used to underpin other risks within the BAF.

2.8 Again to promote a system wide approach, we have worked with the ICP Research, Information and Analysis Lead to coordinate relevant system outcome measures into the BAF where possible.

2.9 Likewise, the redesign includes sections for alignment of the BAF risks with the ICB departmental risk registers from which they arise and also to system partner BAFs although this element will require further work and discussion with partners.

2.10 A primary purpose of the of the BAF is also to identify controls and assurances in relation to the ICBs principal risks. As such, the redesign includes an aggregated assurance rating which measures the level of assurance in place and demonstrates the controls being relied upon to manage each risk and where gaps in such assurance may exist.

2.11 With the development of a Board Opportunities Framework (BOF) in parallel with the BAF, where opportunities exist, the risks and consequent opportunities will be aligned.

2.12 As part of the approach to develop the BAF format iteratively, focus has also been placed on developing an Executive summary as another new stand alone segment of the BAF which sets out the current strategics risk ratings together with their current aggregated assurance ratings.

2.13 At a recent Audit Committee meeting, there was concern expressed that so many of the strategic risks within the BAF are red RAG rated. However, further to the merger of a number of risks to promote a system wide approach, the number of BAF risks overall has been reduced and given they are those of most concern are likely to still have a red severe rating.

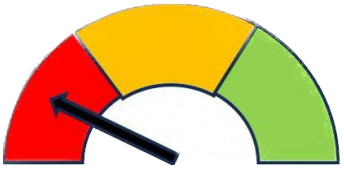
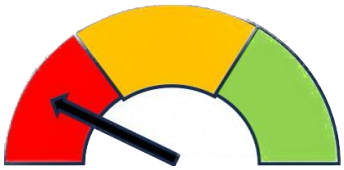
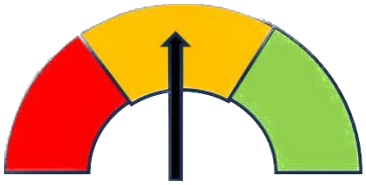
2.14 Whilst the redesign has taken on board issues raised across a range of meetings, it should be recognised that this is simply a new format. The content, as ever, remains the most important element of the BAF but we trust that the revised format will facilitate improved completion and updating while also moving further to a system wide approach to risk management.

3. Recommendation

3.1 The Board is requested to review the example redesigned BAF and accompanying documents and approve the new format.

Strategic Risk Number: 12	**Description:** Workforce challenges across the system

Risk due to:	**Impact(s) arising from the risk:**
1. Workforce Growth: attraction and supply of staff across a range of disciplines & professions to meet demand and capacity. **2.** Sustainability – Retention of experienced staff and newly qualified with a focus on work-life balance.	**1.** Inability to meet patient demand and capacity targets **2.** Concerns for patient safety **3.** Ability to sustain current & future workforce **4.** Cost pressures due to skill mix

Aligned to ICB Higher Ambitions:	All are relevant	
 **Original Risk Rating** **4 x 5 = 20**	 **Risk Rating This Month** **4 x 5 = 20**	 **Target Risk Rating** **12 or below**
Risk Appetite: (see matrix)	**HIGH**	**TREAT**
Last Review Dates:	**Executive Committee:** 10 July 2023	**Board:** 23 May 2023
Responsible Executive Director:	Amanda Lyes – Director of Workforce & People	
Responsible Committee:	ICB People Committee	
Relevant Directorate Risk Register entries:	Workforce Risk register – work currently in progress	
System Partner Aligned Risks:	ESNEFT, WSFT, NSFT, EPUFT, Primary Care EEAST Suffolk County Council (Adult and CYP Social care): Alliance X3 Partners	

Current Controls (what do we have in place to mitigate the risk)	**Gaps in Controls** (which of the controls are not effectively mitigating the risk or are not operating effectively)	**Assurance Methods** (how do we know the controls are working)	**Gaps in Assurances** (which of the controls are not able to provide us with assurance)
1. SNEE People Plan & associated activities **2.** Alliance local Workforce Transformation activities **3.** Programmes to address specific challenges **4.** Workforce planning and transformation – workshops for challenging pathways	**1.** SNEE People plan needs to be refreshed and updated (currently in development) to include recently published NHS Long Term People Plan. **2.** West Suffolk Alliance plans are underway. Scoping with NEE and IES Alliance workforce challenges and plans to address.	**1.** Reports to SNEE People Committee **2.** ICS Anchor Summary data **3.** Sharing of data & intelligence with partner organisations **4.** Creating KPI's and a Workforce Dashboard to become part of SOAC reporting.	**1.** The underlying problem of staff supply across both the system & more widely across the national health and social care remains
Current Aggregated Assurance Rating:		**ADEQUATE**	

Assurance Rating	Details
SUBSTANTIAL	The scope of Assurances noted on the current BAF demonstrate that the Controls are effectively managing the Risk.
ADEQUATE	There are a full range of Assurances in place and no material issues have been identified with the effectiveness of Controls. Assurances are reflecting the need to fully embed the Controls
LIMITED	Either some of the Assurances noted on the current BAF demonstrate that the Controls in place are not effectively managing the Risk and action is required to address and / or there are gaps in assurance
NONE	No assurance can be taken / is available that the Controls relied upon are working. Action needs to be taken to address to improve Controls and Assurance provided

Actions Being Taken to Improve Assurances:	Implementation Dates:
1. Re-energise the workforce through improved wellbeing, work-life balance, flexibility, availability of tools to do jobs, functionality & improved estates	Ongoing
2. People Committee sub-groups being reviewed	01/09/2023
3. Assurance dashboard being created & aligned with performance improvement	01/09/2023
4. Ongoing conversations with stakeholders	01/09/2023
5. Pathway workforce strategies & plans created for future models	01/12/2023
Link to Relevant ICS System Outcome Measures (see attached):	Workforce
Reference to Board Opportunities Framework (BOF)	Addressing workforce supply means that we need to address skill mix and transformation opportunities within pathways that could lead to better WAU efficiency and productivity.

Executive Director Update on Actions to Date

A new draft system Workforce risk has been written focussing on three themes: Grow the Workforce, Working Differently and Productively and Compassionate and Inclusive Culture. This was presented at the People Committee in June 2023. The operational plan is as an opportunity to refocus the system workforce team.
At a system level workforce needs to:

- Drive transformation
- Reduce the gap between capacity and demand
- Increase productivity and activity within the workforce financial envelope

The SNEE ICS has multiple pathway plans and models. By looking at each pathway's operational plan and drawing up key lines of enquiry we will be better able to create a future workforce state and combine and co-ordinate each pathway's workforce to create a coherent workforce strategy and plan for the entire system.

BAF SUMMARY DASHBOARD	Current Aggregated Assurance Rating	Current RAG Rating
Strategic Risk 1: System Accident & Emergency Services - The ICB continues to be under significant pressure whilst benchmarks well against other regional systems it continues to fail several well established standards	LIMITED	SEVERE
Strategic Risk 3: System Referral to Treatment (RTT) - System is not meeting Constitutional Referral to treatment Target of 18 weeks. Patients are therefore not receiving care within expected standards.	LIMITED	SEVERE
Strategic Risk 8: System Mental Health Services - The inability to demonstrate appropriate safety standards throughout mental health services. These present significant patient safety risks to the population of Suffolk and North East Essex.	LIMITED	SEVERE
Strategic Risk 10: Access to Primary Care - Reduction in access to, experience of and outcomes in primary care due to capacity, demand, constraints (workload; workforce; digital and estates).	ADEQUATE	SEVERE
Strategic Risk 11: Cyber Security - Potential impact of cyber security incident could lead to wide scale IT system outages, meaning no access to patient records, e-dispensing services etc	ADEQUATE	SEVERE
Strategic Risk 12: Provider Workforce - Workforce challenges across the system.	ADEQUATE	SEVERE
Strategic Risk 16: EEAST Performance & Quality - EEAST is not achieving national performance targets.	LIMITED	SEVERE
Strategic Risk 19: System Cancer Standards - System not meeting the cancer related standards within the NHS constitution leading to worsening patient outcomes and quality of services.	ADEQUATE	SEVERE

Strategic Risk 25: Finance - Fail to manage our finances effectively and deliver value for money to ensure the long-term sustainability of care provision	SUBSTANTIAL	SEVERE
Strategic Risk 29: Consequences of Climate Change - Risk to health and social care service delivery.	ADEQUATE	SEVERE

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Suffolk and North-East Essex Strategic System Workforce

Giles Turner, Head of Workforce Intelligence and Planning & Graham Seward, Head of Workforce Transformation

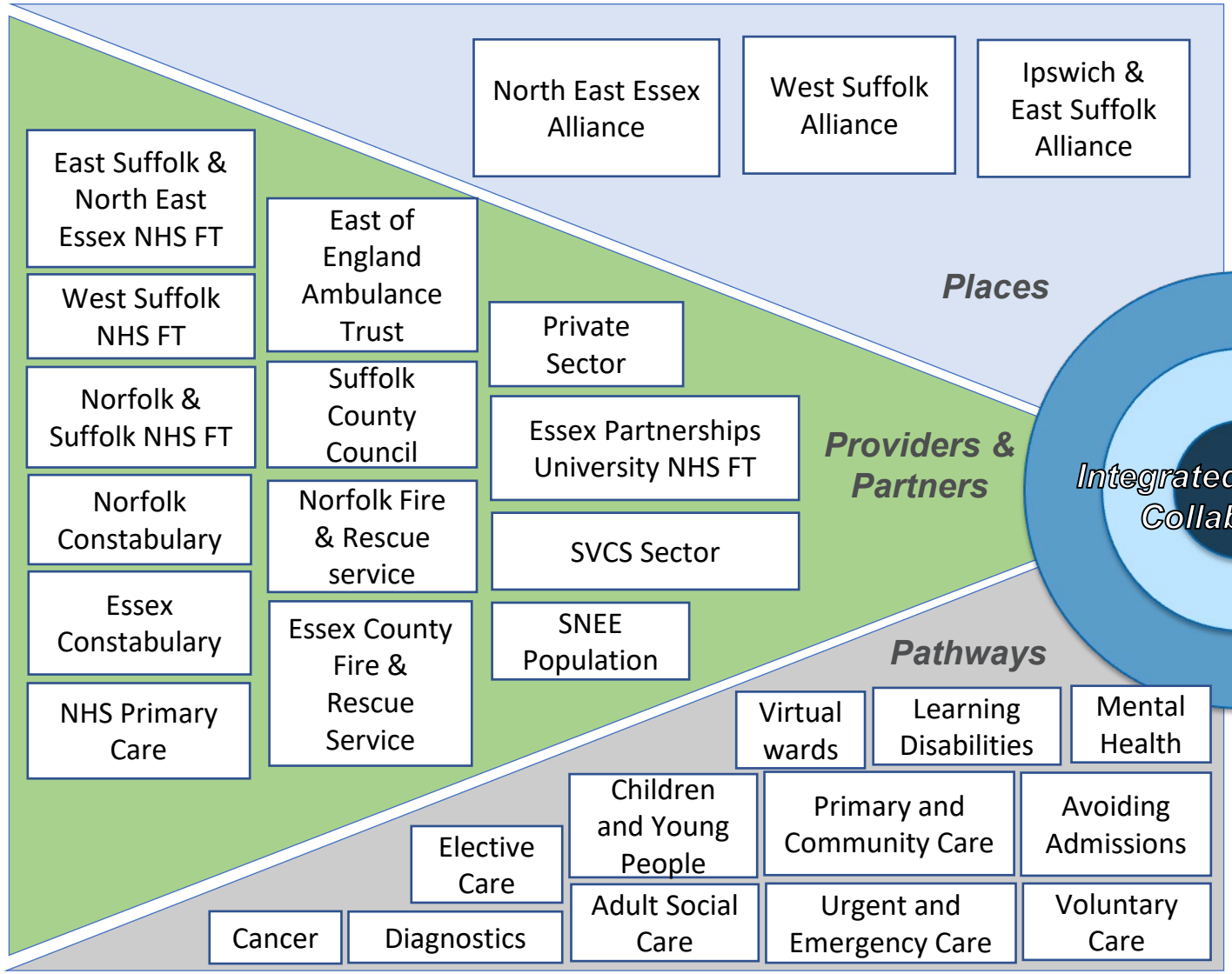
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Summary

Suffolk and North East Essex Integrated Care Board

Priorities

- ICB Statutory Duties
- Joint Forward Plan
- Long Term NHS WF Plan
- National People Plan
- Fuller Report
- NHS system workforce priorities

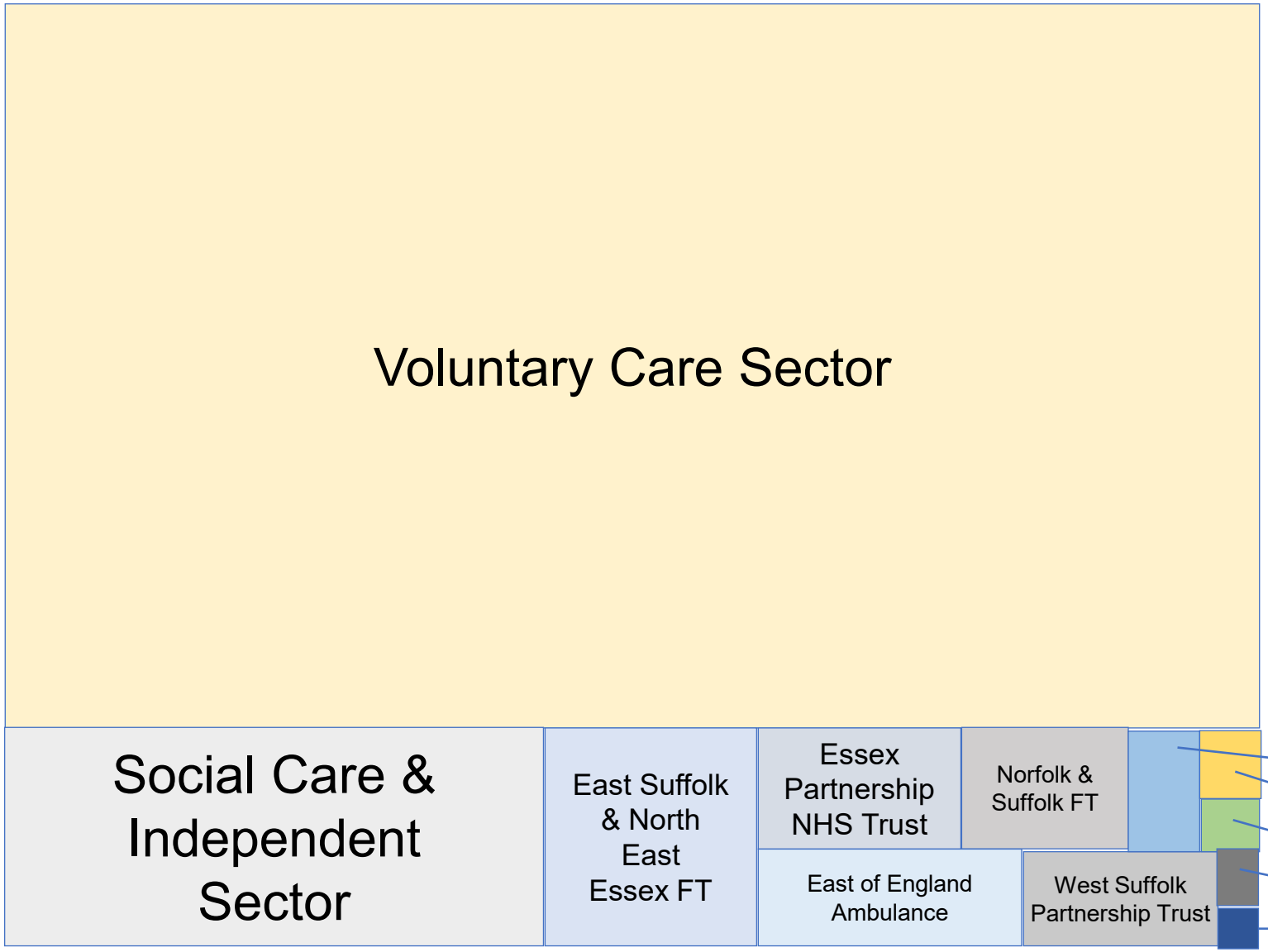


Programmes

- Growing the workforce
- Working Differently And Productively
- In a compassionate and inclusive culture

Who We Are: Our Workforce (our people)

Suffolk and North East Essex Integrated Care Board



The SNEE ICS workforce consists of approximately 270,173 people, who work for hundreds of different employer. This includes over **200,000** unpaid regular volunteers!

We need to understand the workforce beyond the silo of health and the important intricate interactions of workforce that affect system, pathway and provide

EAST OF ENGLAND Workforce, Training and Education – our purpose, objectives and key deliverables

Workforce Training and Education Directorate Mission statement

Ensuring the NHS in England has a **sufficient and inclusive workforce** with the knowledge, skills, values and behaviours to deliver **compassionate high-quality health and care** to the people it serves.

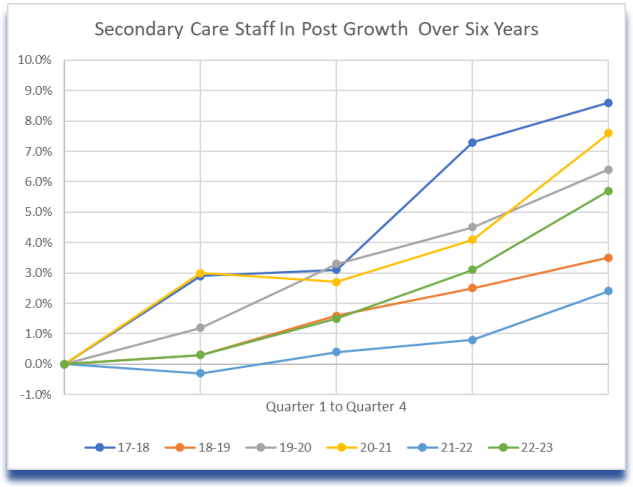
Aims	Growing the workforce	Working differently and productively	In a compassionate and inclusive culture
Objectives 2023/24	1. Increase the number of qualified healthcare professionals available to work in the NHS, that reflects local need. 2. Recruit more staff, domestically and internationally, to respond to local need and reduce NHS vacancy rates. 3. Improve the quality of healthcare education and training and reduce course leaving rates in 2023/24.	1. Review and reform education and training to better meet patient and student needs. 2. Optimise the use of digital technology, research, knowledge and innovation to help increase the time to care. 3. Ensure all systems have a robust view of how future workforce supply can be developed to meet workforce demands based on service delivery and available finance to 2025/26.	1. Improve NHS leadership, talent and management practices 2. Improve staff engagement, experience and retention by embedding the right culture. 3. Ensure equality, diversity and inclusion of all NHS staff
Key Deliverables 2023/24	**1.1** With regions deliver the 2023/24 METIP plan for medics, and clinical professions and develop Clinical Placement Management System. **1.2** Develop and deliver an implementation plan to accompany the new Educator Workforce Strategy to create a sustainable supply of clinical educators. **1.3** Develop more flexible routes into training such as apprenticeships that will help to grow and diversify the talent pool. 2.1 Implement the global health workforce strategy. **2.2** Deliver NHS LTP/LTWP priorities including N50k and domestic workforce plans for Mental Health, Cancer and Diagnostics and UEC and Primary Care recovery plans. **3.1** Develop and implement a new Quality Management system. **3.2** Using the NHSE Intensive Support Framework undertake three thematic reviews. **3.3** Expand engagement with the National Education and Training Survey (NETS) in October 2023 to all learners.	**1.1** Expand trailblazer learner cohorts to enhance the generalist skills of postgraduate doctors. **1.2** Implementation of the reformed initial training programmes for pharmacists and maximising opportunities offered by skill-mix and up-skilling across all pharmacy professions. **1.3** Improve the efficacy and flexibility of the medical education training system to better support doctors in training. **1.4** Increase the number of adult nurses and midwifery students on blended learning degrees. **2.1** Develop a national Learning Hub to promote the growth of our educational resources and learning opportunities. **2.2** Implement flexible working practices and flexible deployment of staff across organisational boundaries using digital solutions (e-rostering, e-job planning, digital staff passport). **2.3** Deliver workforce productivity diagnostic across all trusts to address service level productivity gaps. **3.1** Create national resources and guidance to support ICB capabilities on workforce redesign and transformation, maximising the new ways of working opportunities offered by up-skilling, enhanced, advanced and consultant practice. **3.2** Assure integrated WT&E planning at system, region and national level across place, pathway and programmes.	1.1 Deliver the recommendations in the Messenger review and develop collaborative leadership across health and social care. **1.2** Identify, track and support clinical leaders towards business-critical leadership roles to ensure strong measurable leadership in key roles to demonstrate quality improvement across systems. **1.3** Implement the Kark recommendations and the Fit and Proper Persons (FPP) test. **2.1** Systematically deliver of all elements of the People Promise (in line with planning guidance). **2.2** Provide national leadership and support national interventions to improve health and wellbeing. **3.1** Roll out of the 5yr NHS EDI Improvement Plan (23-28) and development of national policy for protected characteristics other than race and disability. **3.2** Implement national and regional Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) action plans.
Performance Enablers	(i) Develop Strategic Human Resource Management; (ii) Deliver a balanced budget; (iii) Strengthen relationships with key partners; (iv) Leverage digital capability; (v) Integrate planning in line with our Operating Framework.		

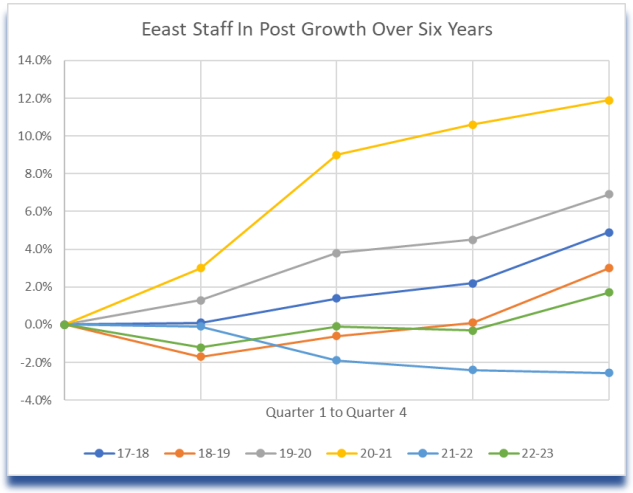
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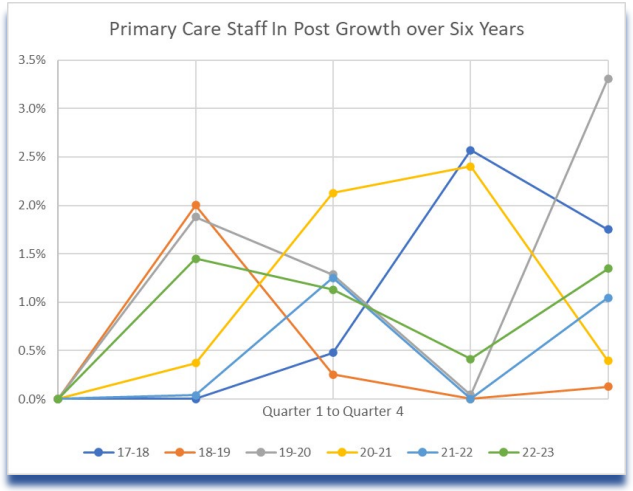
Growing the Workforce

Six Year FTE Growth Trends in SNEE Systems

Suffolk and North East Essex Integrated Care Board







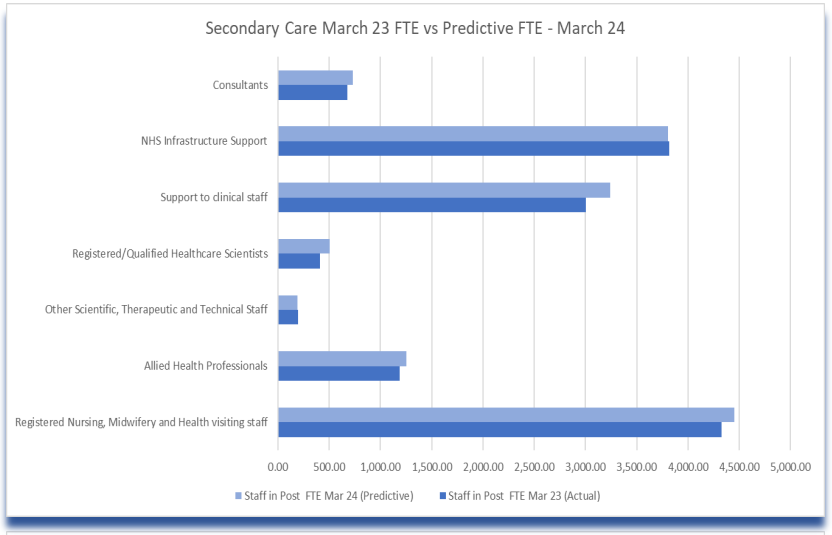
Social Care

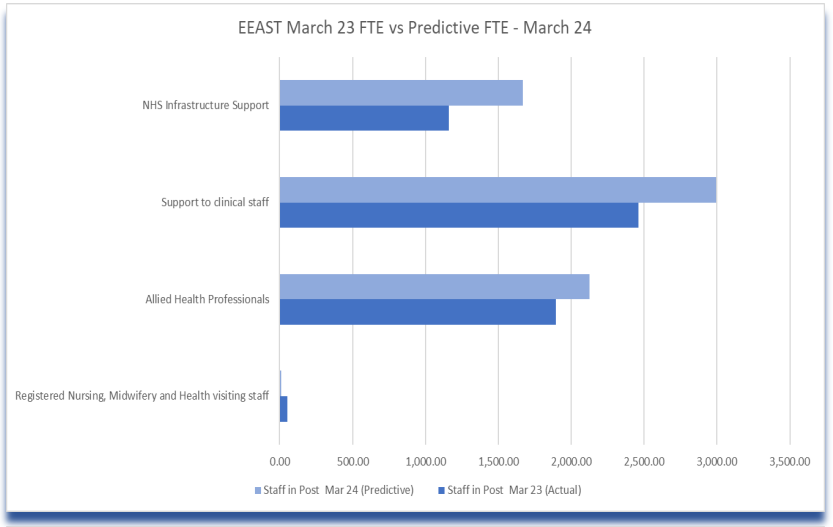


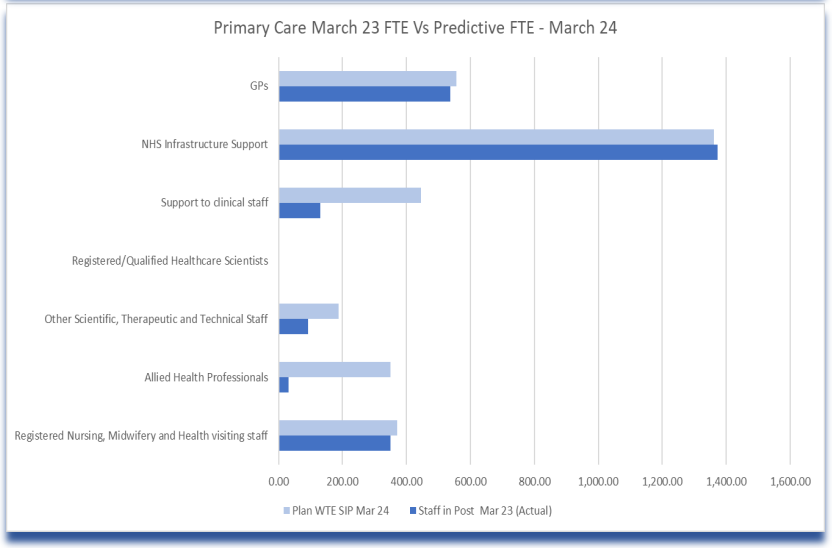
- The charts shows annual cumulative growth in SIP numbers by month each year.
- The system staff in post (SIP) numbers (excluding social care) grew on average by 4% per year over the last 6 years.
- When comparing trends between the three sectors, the is no clear shared trend. This was point to system wide discussion over collaborative communication in recruitment, to explore keeping high quality candidates within the SNEE system.
- During the last financial year (22/23) the system saw 4.8% growth.
- Most of SIP growth happens during the second half of the year when we recruit newly qualified graduates.
- Primary care shows that growth is not stable with steep declines in year.
- For EEAST 21-22 although appears outlier rapid growth in 20-21 will have affected this. In 22-23 there was a normalisation of trend data.
- Secondary care steady growth over six years (the spike in 20-21 and slower growth in 21-22 is to be obstructed).

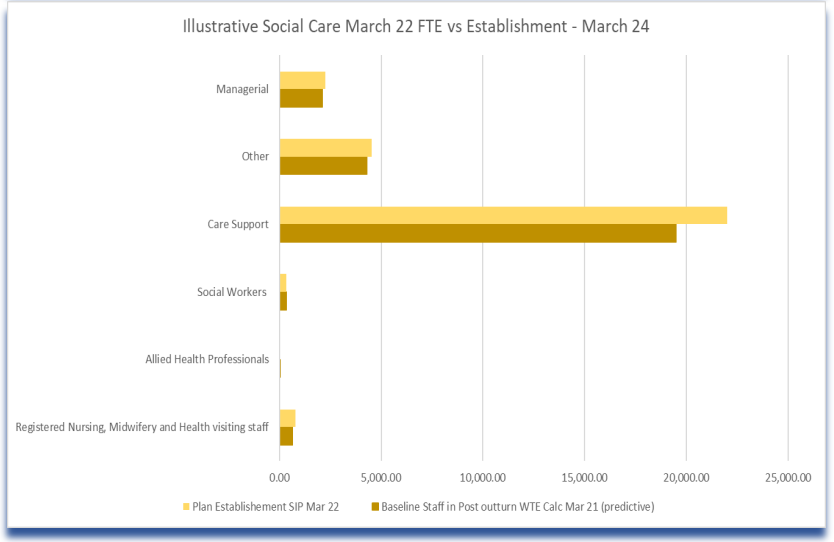
Actual Staff in Post gap against Predicted Staff In Post March 2024

Suffolk and North East Essex Integrated Care Board









- The charts shows current staff in post numbers against predicted staff in post numbers for March 24.
- There is currently 5492.16 gap between actual staff in post in March 2023 against the predicted staff in post in March 2024.
- Care Support Workers (HCA's, AHP support etc…) account for 65.3% of the growth in the system 23/24 with a current 3587.61 fte gap.
- Allied Health Professionals (AHP's) make up 11.8% of the predicted growth within the system for 23/24 with a current 650.46 fte gap. It is important to note that PCN's/ practices outsource some of their physiotherapy interventions, this needs to be explored further, puts points to being less of a gap that currently expected.
- Within Secondary Care, Registered Nursing and Midwifery accounts for 22.2% of growth at 124 fte current gap.

System Workforce Education And Training Supply

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SNEE Business Intelligence

SNEE ICB Rolling 12 Month Total Training Hours

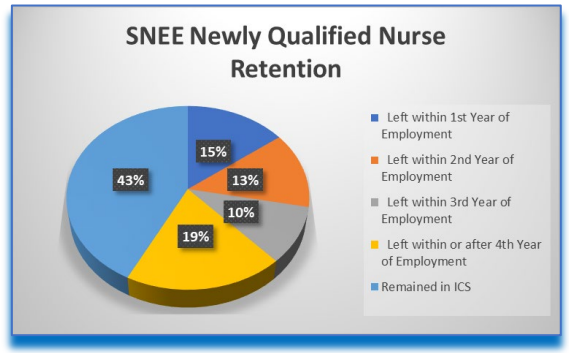
Fiscal Year: 2022-23

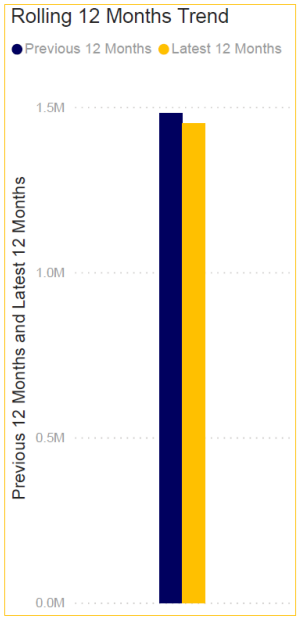
Quota: Feb Quota

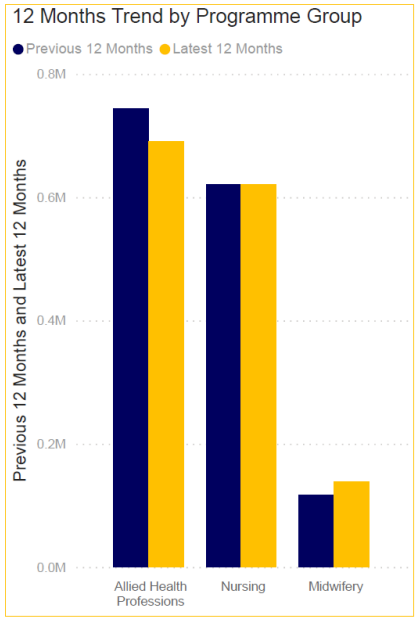
Latest 12 Months Rolling Total Hours	Previous 12 Months Rolling Total Hours	12 Months Rolling Variance
1,450.1K	1,482.3K	-32.2K

Programme Group
- Select all
- Allied Health Professions
- Midwifery
- Nursing

Placement Type
- Select all
- NHS
- Non-NHS







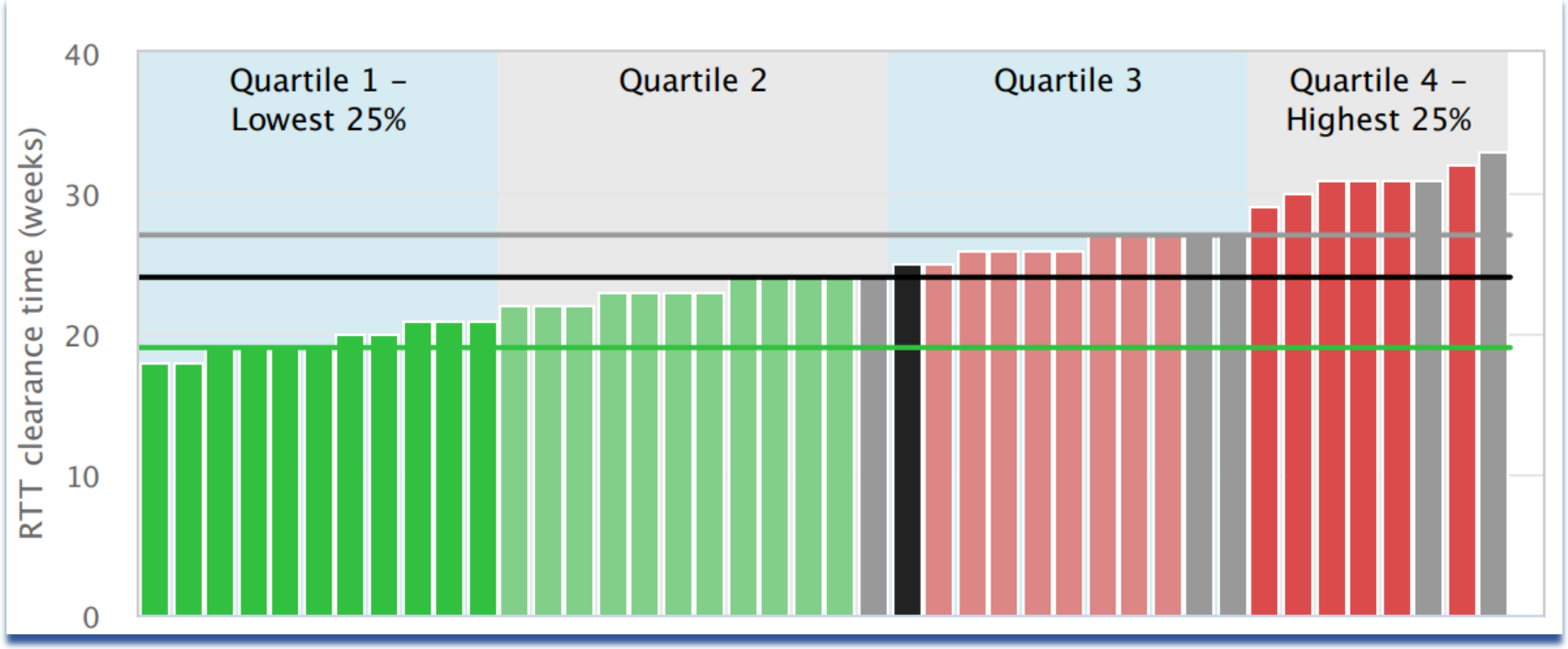
- Within four years of employment 57% of newly qualified nurses leave the SNEE system.
- Of the newly qualified nurses that leave the SNEE system 46% leave the NHS.
- We are seeing a rolling variance in hours committed to training programmes. This is particularly prevalent in AHP professions.

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Working differently and productively

Referral to Treatment SNEE System Benchmark

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System value	Peer median	System median
Quartile 3	Quartile 3	
25 Weeks	27 Weeks	24 Weeks

This slide shows for the system:

- The number of weeks it would take to clear current waiting list at current capacity. Clearance times can be interpreted as follows:

  < 8 weeks: 18 weeks performance (all but) guaranteed

  8 – 10 weeks: ideal list size. 'Normal' elective care management will assure delivery

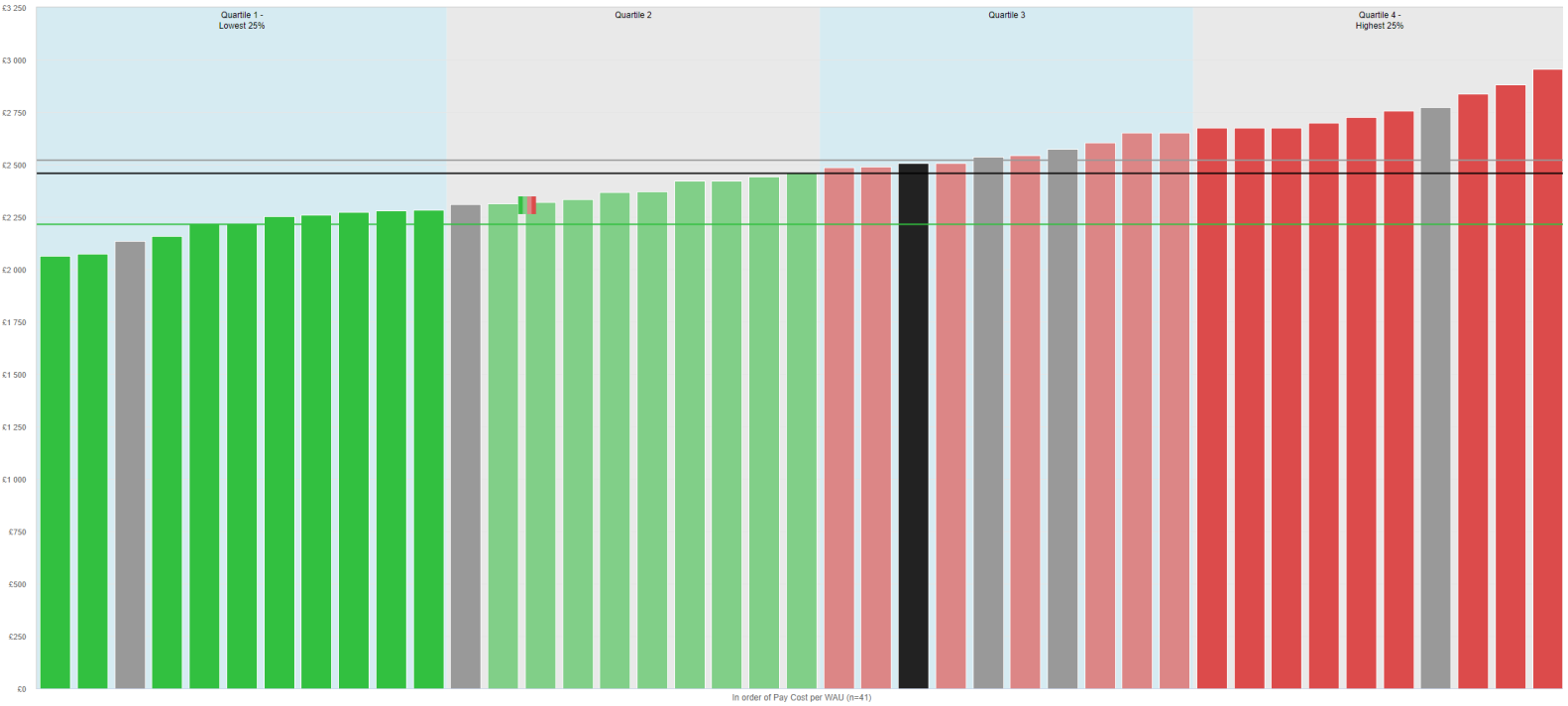
  10 – 12 weeks: list is too big for assured delivery of the standard. Exceptional management action is required to achieve 92% >

  12 weeks: Referral to Treatment (RTT) standard (all but) impossible to deliver.

- This metric has been highlighted because 2 of the 3 most recent results show deterioration.

Productivity: Pay Cost

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System value Quartile 3

£2,506

Peer median Quartile 3

£2,521

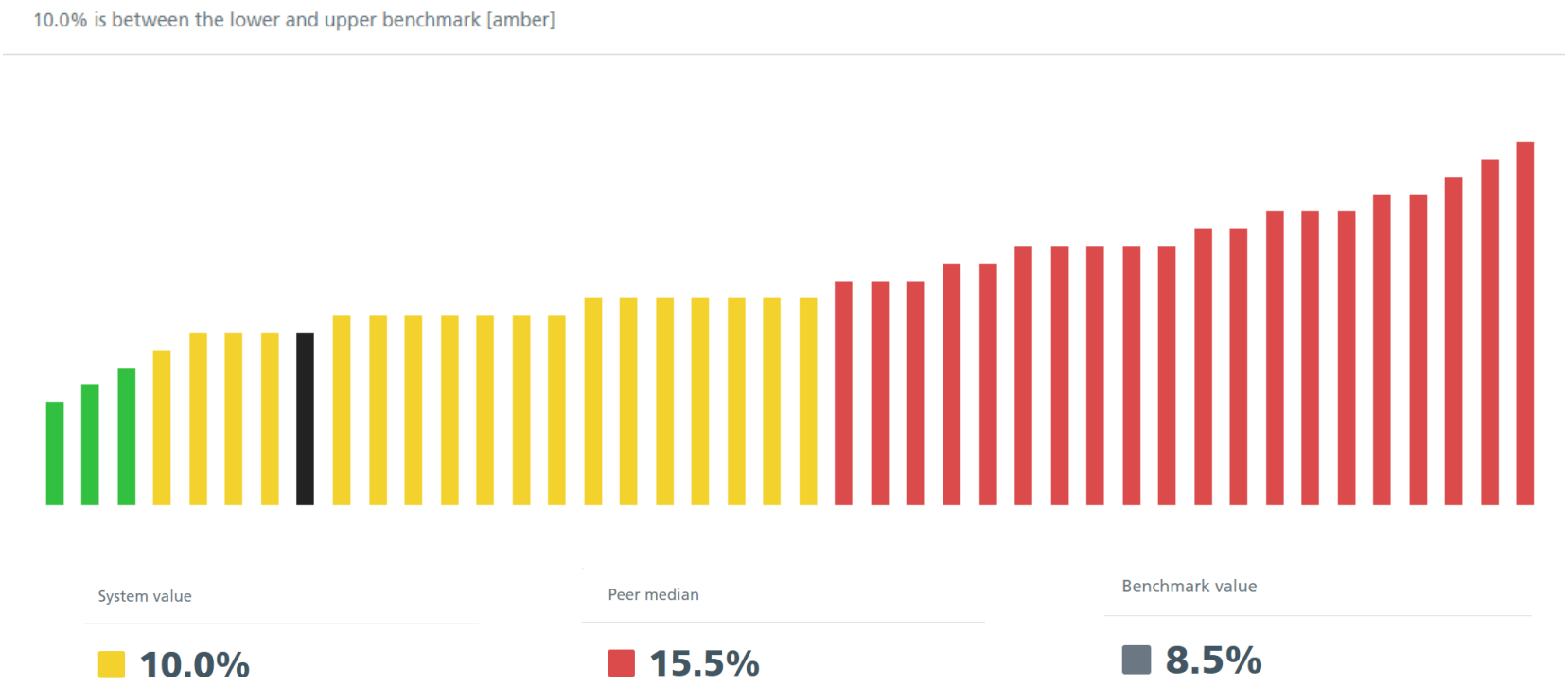
System median

£2,458

- This slide shows how an organisation's costs compare to the amount of output (WAUs produced). It is possible to break the cost per WAU down into the various cost components (e.g. pay vs non-pay, or medicines cost per WAU) to provide a more detailed indication of where a organisation appears to be more or less productive than its peers.
- This information can help organisations identify those areas of expenditure where they differ most from their peers, and help determine which interventions or activities are most likely to lead to improvements in productivity. When looking at the breakdown in cost per WAU, each element should not be viewed in isolation. High costs in one area of expenditure may be justified as they help reduce expenditure in other areas. The overall cost per WAU (i.e. considering all areas of expenditure) is the most important metric, and excess costs in one area of spend are likely to only be an issue if they appear to be resulting in a high overall cost per WAU.
- The higher than national average pay cost per WAU suggests the SNEE system spends more on staff per unit of activity. The cost per WAU indicators should be used to benchmark relative efficiency - i.e. to make comparisons between similar organisations within one financial year.

Overall Temporary Staff Spend as a % of Total Spend

Suffolk and North East Essex Integrated Care Board



This slide is intended to highlight to the system where they may be spending more on temporary staffing than others and should consider reducing the usage of temporary staffing as a whole, if possible.

Temporary staffing costs ideally should be kept to a minimum and the benchmark figures are set at the following values:

Green: 0 – 8.5%

Amber: 8.5 – 12%

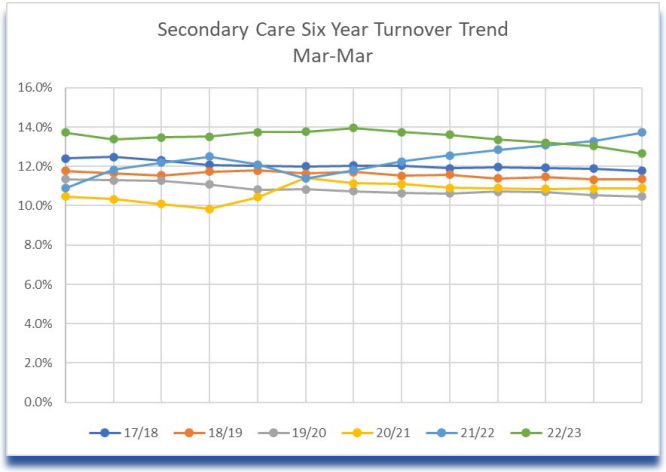
Red: More than 12%

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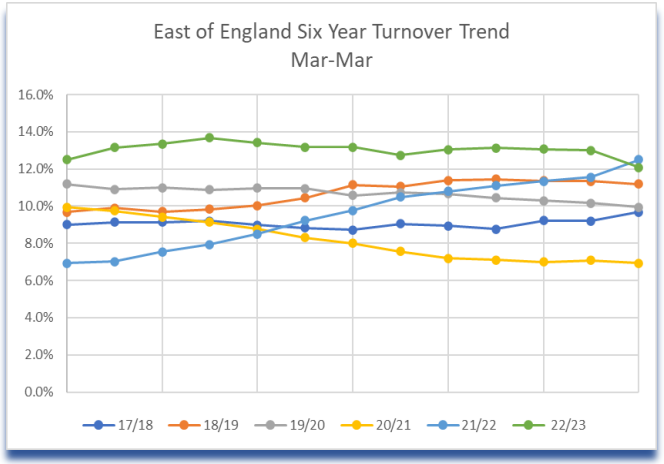
In a Compassionate and Inclusive Culture

Six Year Turnover Trends in SNEE Systems

Suffolk and North East Essex Integrated Care Board

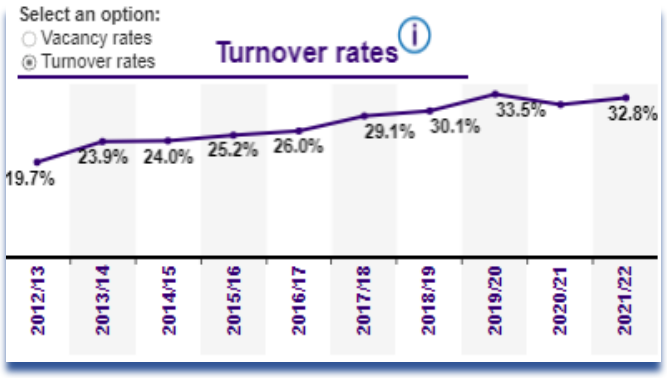


Primary Care



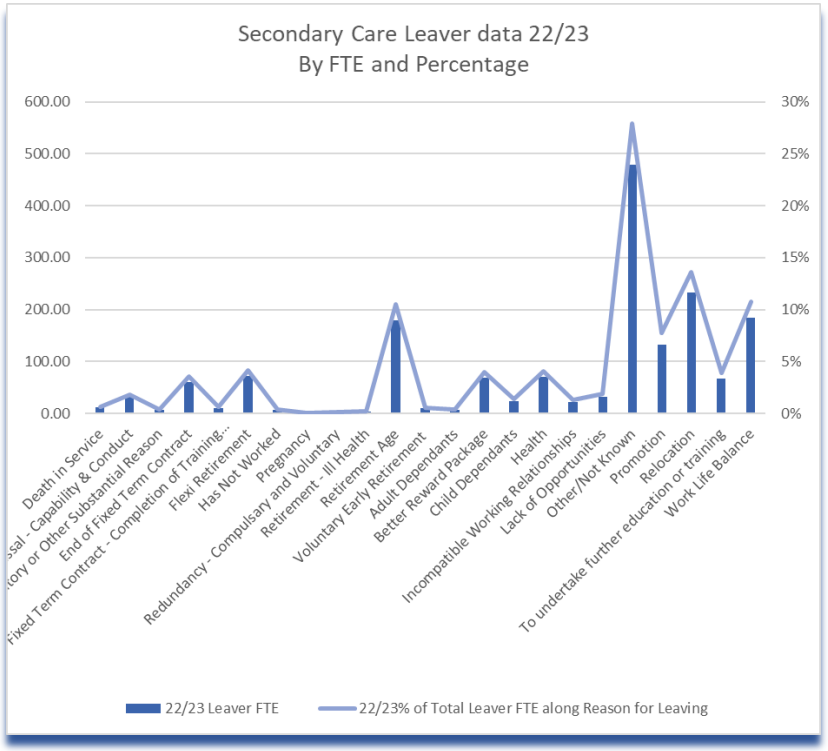
Social Care

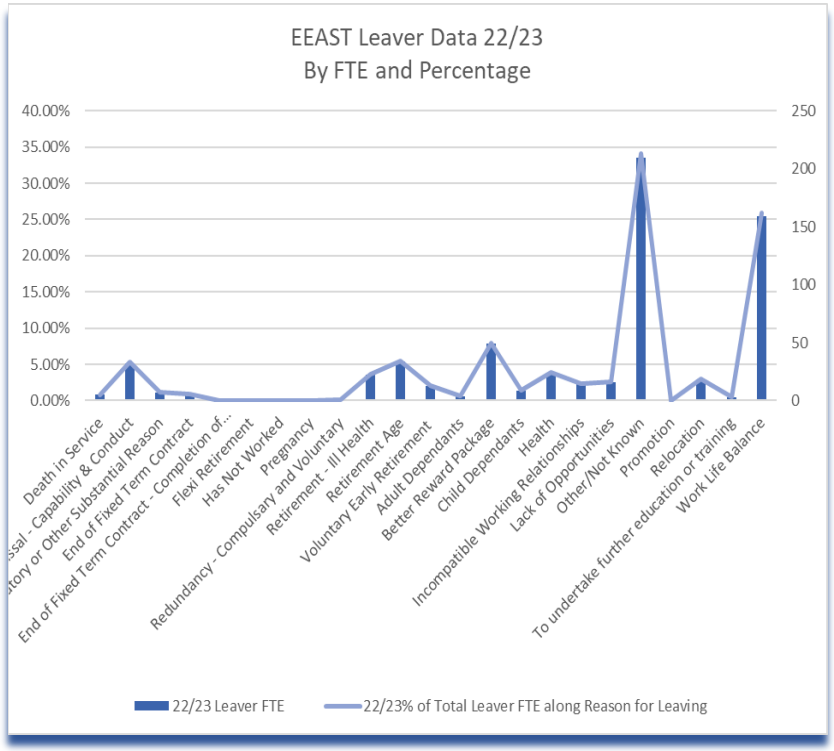




- The charts shows annual rolling turnover for the past six years. Social care is illustrative but based on data available for 21/22.
- Although within secondary care and the ambulance service Turnover reached a six-year high in mid 22/23 we saw a downwards trajectory in turnover in the last quarter, which is continuing in quarter one 23/24.
- The 22/23 should also been seen in the context of the below average turnover trend in the last quarter of 19/20 and throughout 20/21. The is a clear collation that staff stayed within the NHS to help during the pandemic and staring leaving mid 22/23 when the pandemic had been controlled.

Retention Trends In the NHS





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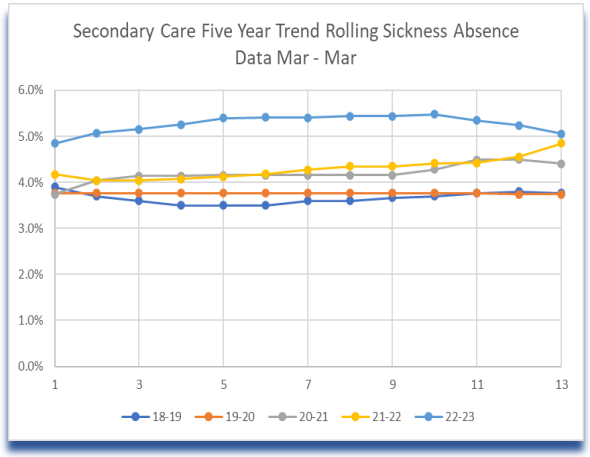
- This slide shows: Reasons staff gave for leaving the organisation and the staff survey measure of staff members want to change their job.
- Key area of data quality identified as high percentage of reasons given are other/not known.
- Work life balance is a key issue in why staff are leaving.
- Further investigation needs to be undertaken into the high percentage of staff relocating within secondary care.

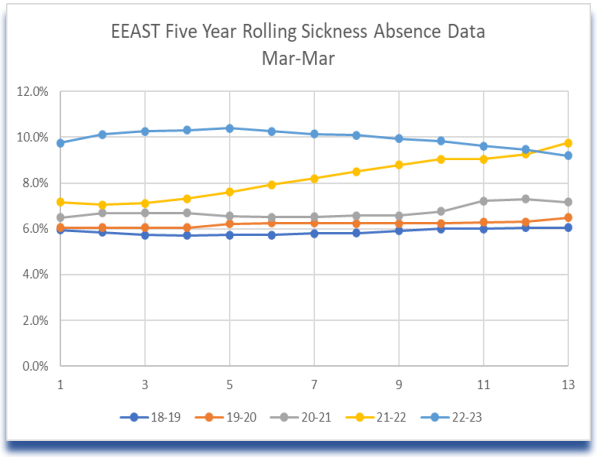
I am thinking of leaving the Organisation

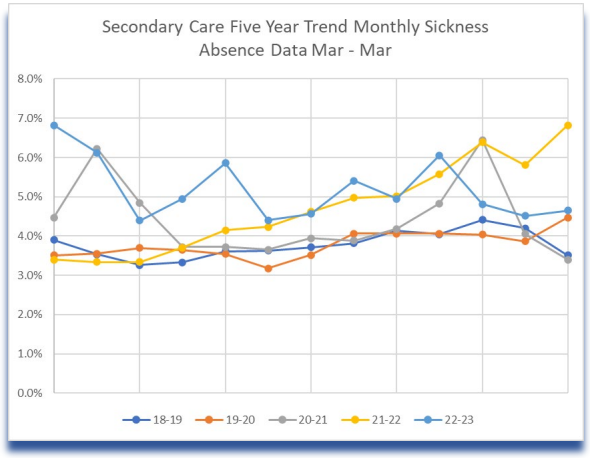
WSFT	National Median	ESNEFT	EEAST
Provider value: Quartile 2	Provider median	Provider value: Quartile 3	Provider value: Quartile 4
14.9%	16.1%	17.1%	27.8%

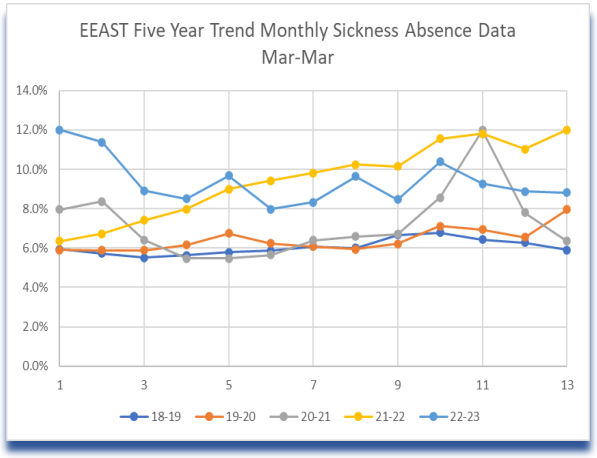
Five Year Sickness Absence Trends in the NHS

Suffolk and North East Essex Integrated Care Board





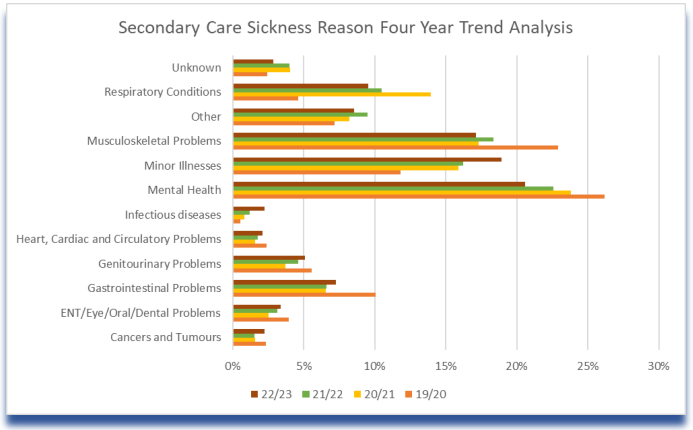


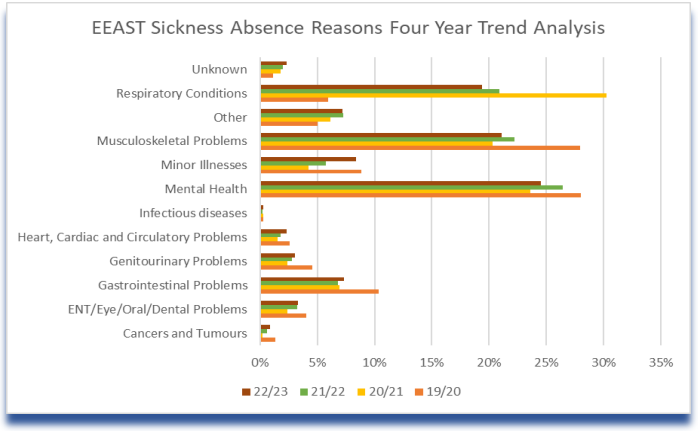


- The charts shows both rolling sickness absence for the past five years and monthly sickness absence trend. Rolling sickness absence gives a more reliable over all view of sickness absence year in year, monthly sickness absence allows us to analysis seasonal variation.
- It should be noted that Eeast has historically higher levels of sickness than secondary care.
- Rolling sickness absence in both secondary care and EEast follow a similar curvature in terms of sickness absence levels, with clear pre-covid variations. There is a downwards trend in sickness absence but a return to pre-covids levels will take longer tan 23/24.
- The sickness absence monthly trend data points to seasonal spikes in July and January .

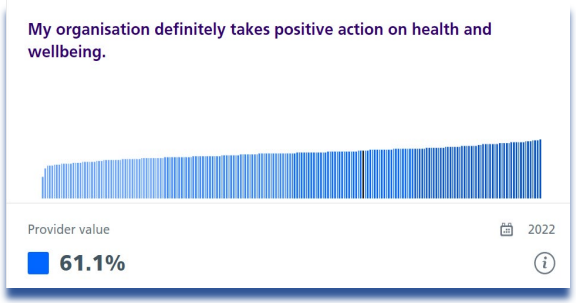
Health and Wellbeing Trends in the NHS

Suffolk and North East Essex Integrated Care Board

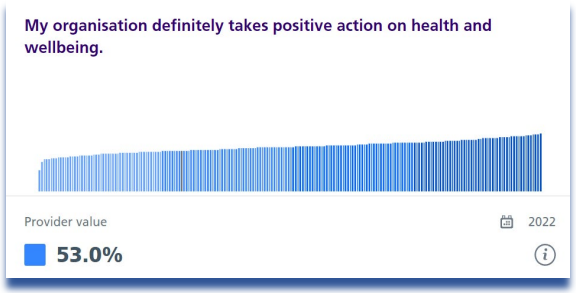




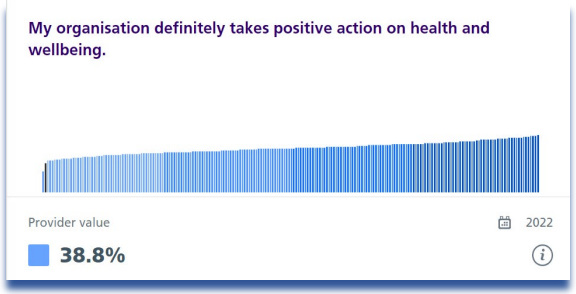
WSFT



ESNEFT



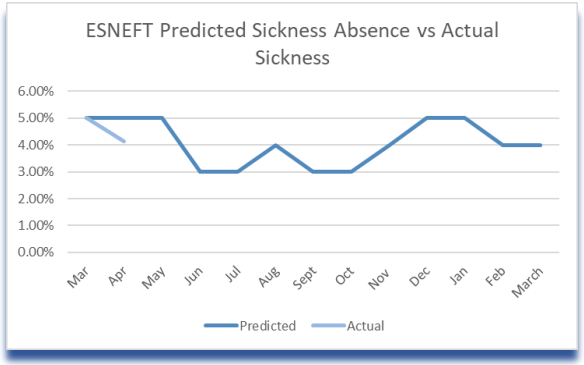
EEAST

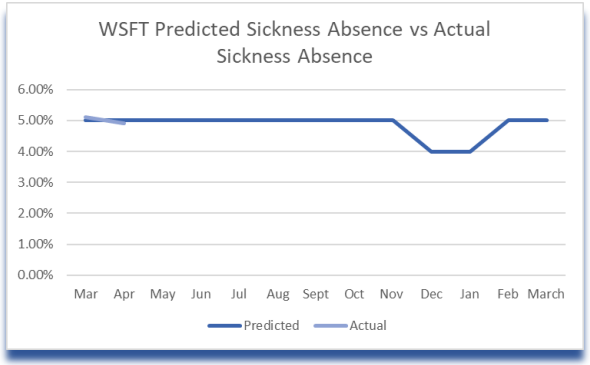


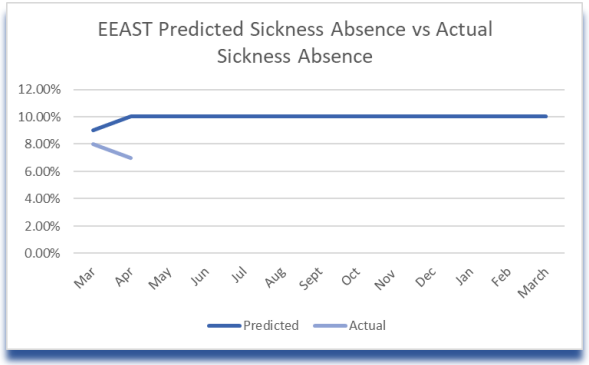
- This slide shows four-year sickness absence trends within Secondary Care and East of England Ambulance Service and staff survey results on staff perceptions of health and wellbeing within their organisation.
- Further analysis needs to be undertaken of sickness absence reasons particularly the improvement in mental health related sickness absence but higher minor illness.
- West Suffolk is seen a positive outlier in terms of staff perceptions of the wellbeing initatives they have undertaken.

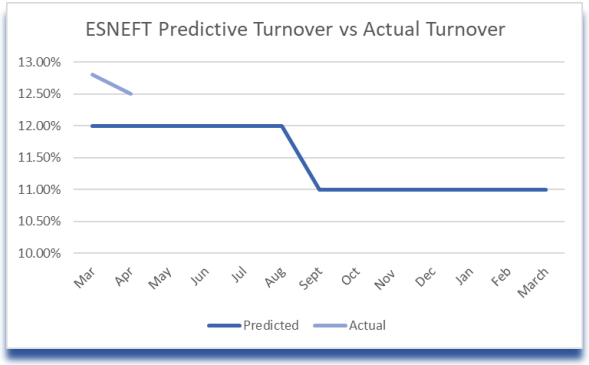
NHSE Key Performance Indicators

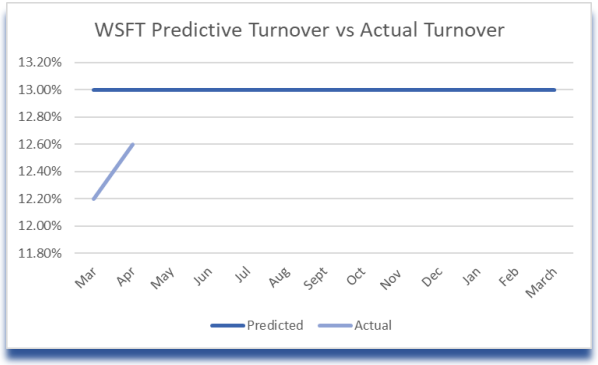
Suffolk and North East Essex Integrated Care Board

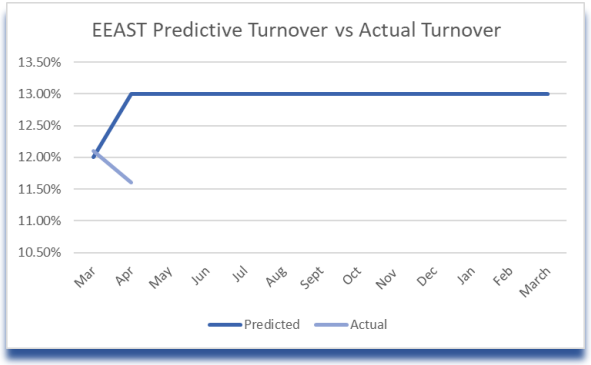












- This slide shows actual sickness and turnover against the KPI predictive targets, organisations set themselves in the NHS Operational Plan .
- Currently there is only two months data March 23 and April 23 against which to measure so we cannot draw any accurate analysis until the end of June to look at quarter one.

NHS Equity And Inclusion Benchmark Summary March 2023

Suffolk and North East Essex Integrated Care Board

SNEE System



West Suffolk Foundation Trust



East Suffolk and North-East Essex



East Ambulance Service



- These graphs show the percentage of measures within the Equity and Inclusion Cultural Element on the Culture and Outcomes Dashboard which is above the national median.
- Equity and Inclusion helps us to explore and understand aspects of organisational culture including: equity, positive diversity and comprehensive inclusion for all.
- The SNEE system needs to aim for a higher percentage as it indicates the need for a stronger cultural element for the system. The stronger the cultural elements overall, the more likely the organisation will be described as having a compassionate and inclusive culture through collective leadership.

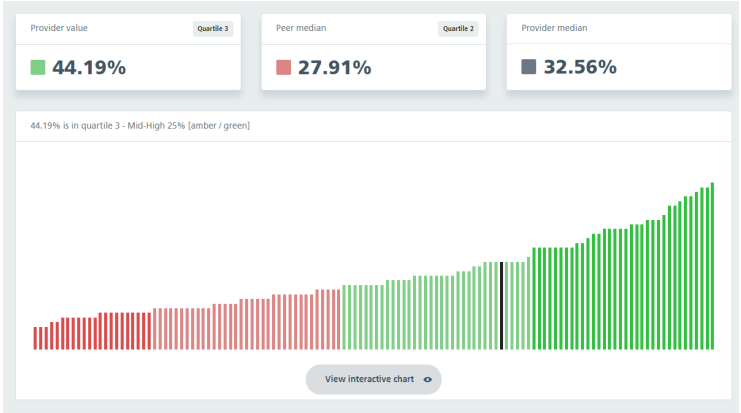
NHS Support and Compassion Summary March 2023

Suffolk and North East Essex Integrated Care Board

SNEE System



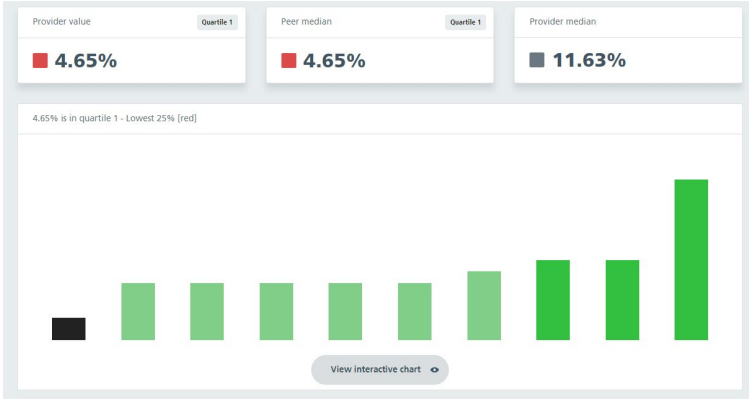
West Suffolk Foundation Trust



East Suffolk and North-East Essex



East Ambulance Service



- These graphs show the percentage of measures within he Support and Compassion Cultural Element on the Culture and Outcomes Dashboard which is above the national median.
- Support and Compassion helps us to explore and understand aspects of organisational culture incl. support, compassion and psychological safety for all patients and staff.
- The SNEE system needs to aim for a higher percentage as it indicates the need for a stronger cultural element for the system. The stronger the cultural elements overall, the more likely the organisation will be described as having a compassionate and inclusive culture through collective leadership.
- WSFT is a clear positive outlier

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ICB BOARD

Agenda Item No.	**16**
Reference No.	**ICB 23-55**
Date.	**25 July 2023**

Title	**Pharmacy, Optometry and Dentistry – Highlight Report**
Lead Director	Maddie Baker-Woods, Ipswich and East Suffolk Alliance Director
Author(s)	Elizabeth Moloney (Deputy Director Strategic Change) Greg Brown (Senior Performance Improvement Manager)
Purpose	To ensure the Board's awareness of material transformation, risks and mitigations relating to pharmacy, optometry and dentistry in the Suffolk and North East Essex Integrated Care System (SNEE ICS).

Recommendation:

The ICB Board is asked to note this briefing and be advised a strategic briefing will be presented to its meeting in September regarding status of pharmacy in the ICS and recommendations for local action.

1. Background

1.1 In April '23, NHS England delegated commissioning of pharmacy, optometry and dentistry to ICBs. The SNEE ICB discharges this responsibility through a small team, leveraging contract management expertise from a team – resource shared by the six East of England ICBs that is hosted by Herts and West Essex ICB. This is the first highlight report to the ICB Board since commissioning arrangements were delegated.

2. Key Issues

1.2 Material transformation activity, risks and mitigations are summarised below:

Pharmacy

1.3 **Health and Social Care Committee** – The ICB has submitted written evidence to two inquiries commissioned by the Health and Social Care Committee. A summary of the evidence together with recommendations for local actions by the SNEE ICB will be provided to the ICB Board in September. An overview of the scope of the inquiries is provided below and reflects the ICB's commitment to influence the strategic direction of the sector.

a) Health and Social Care Committee's Independent Expert Panel in their evaluation of the Government's commitments in the area of pharmacy in England. As context, the Health and Social Care Committee has established and commissioned a politically impartial panel of experts to conduct an evaluation – independently of the Committee – of the Government's commitments in the area of pharmacy, nine Government commitments across five policy areas including community pharmacy, integrated care, hospital pharmacy, workforce education and training, and extended services. The ICB's evidence developed in collaboration with system partners has been published and is available here.

b) Health and Social Care Committee's pharmacy inquiry. The inquiry is exploring issues impacting different types of pharmacy, with a particular focus on community, primary care and hospital pharmacy services. It will assess the current status of pharmacy in England and consider what the future of pharmacy could look like. Furthermore, it will focus on addressing current challenges, particularly around the funding model, digital infrastructure and workforce recruitment, training and retention. Looking to the future, the inquiry will consider what innovations could have the biggest impact and what action needs to be taken now to ensure the potential of pharmacy is realised. The ICB's evidence, developed in collaboration with system partners, was submitted on 6th July and is expected to be published here.

1.4 **C19 Treatment Pathway Redesign** - As the NHS continues to move from a pandemic to an endemic response to COVID-19 infections, NHS England (NHSE) has delegated commissioning of community access to existing and new COVID-19 treatments to ICBs. As part of the ICB's committed to transition services into routine pathways, the pathway was redesigned with the support of a multi-partner task and finish group. On the 27 June, the service transition to one wholly delivered by ESNEFT and WSFT acute hospitals to one that is now supported by primary and secondary care providers. In so doing, oral anti-viral treatments are now available from commissioned community pharmacy providers, improving local access to the service and reducing demand on Trusts. In addition, for the first time, the ICB has adopted PharmOutcomes[1] as part of our commitment to digital integration enabling streamlined service delivery and improved assurance of excellent

[1] PharmOutcomes is an established and trusted IT solution that support integrated care with a proven track record of meeting the service requirements and managing claims effectively for community pharmacies.

patient care. With the infrastructure now in place, the opportunity to expand use of the platform for the benefit of other services is available - evidence of our commitment to local transformation that supports community pharmacies.

1.5 **Primary Care Recovery Plan** – The ICB continues to work with a broad range of providers and Local Pharmaceutical Committee representatives to optimise the integration of community pharmacy in support of the Primary Care Recovery Plan (PCRP). In particular, effort is focused on improved access (inc. direct GP referrals) to hypertension, oral contraceptive and the future common conditions services.

1.6 **Financial Delegation** – Whilst delegation of commissioning responsibilities from NHSE to the ICB has been smooth, the ICB has experienced challenges regarding financial delegation. This particularly relates to understanding and accessing the practical mechanisms to enable transfer of funds from the ICB to community pharmacy providers – much of which is managed through national infrastructure such as NHS Shared Business Services (NHSSBS). The ICB is grateful to the HWE-hosted contract management team for their advice and support and have escalated concerns to NHS East of England given the fundamental role funding plays in enabling service transformation.

1.7 **Streamlining Commissioning** – The ICB welcomes the opportunity to continue to work with County Councils to explore opportunities to streamline and adopt a standardised approach to the commissioning of services from community pharmacy providers. As identified by Suffolk LPC, different mechanisms used by public sector commissioners increases bureaucracy and limits interoperability – the opportunity to move to an approach based upon the NHS standard contract has been identified by the LPC as desirable. The approach adopted by Essex County Council in partnership with their local ICBs presents a model the SNEE ICB could learn from.

Optometry

1.8 **Minor Eye Care/Urgent/Community Services** - Through the ICB Strategic Programme's Elective & Diagnostics Group, activity is ongoing to enable re-procurement of the Minor Eye Care/Urgent/Community Services (MECs+). The intent is to ensure equitable access to provision, particularly in north east Essex, through a new ICS-wide contracted service. Work is ongoing to develop a business case to be presented to the ICB's Executive Committee for approval by the end of 2023.

1.9 **Hydroxychloroquine retinal screening** – Hydroxychloroquine (HCQ) is usually prescribed by a Specialist Consultant in Rheumatology and occasionally Dermatology. Patients who receive the medication for 5 years or more require annual retinal screening (OCT) to detect early signs of increased damage to the retina (retinal toxicity). The ICB is working with primary and secondary care providers together with the Suffolk Local Optimal Committee (LOC) to explore options to ensure equitable access to the service across the ICS, particularly in west Suffolk. Work is ongoing to develop a business case to be presented to the ICB's Executive Committee for approval.

Dental

1.10 Prevention – The ICB has invested in Oral Health Promotion in a range of areas to help address the current issues in dental care. We are supporting schools, homeless and transient populations, children and young people and care home residents across SNEE. We are doing this in collaboration with Public Health Suffolk and Public Health Essex to increase awareness of oral health. These schemes went live in 2023 and will continue into early 2024 and are already having a positive impact with hundreds of school children already having opportunities to have supervised toothbrushing in school. There are also a

number of opportunities that are being explored on how we can link this work with the wider healthier lifestyles work that is being undertaken by partners across SNEE.

1.11 **Primary Care Access –** Access to all dental services remains a key priority and issue for the ICB. A number of procurements are planned which, subject to approval, aim to expand service provision across Suffolk and North East Essex. A number of discussions are ongoing with current providers to use flexible commissioning and variations to current contracts to improve the pipeline of dentists into Suffolk and Northeast Essex, alongside improving urgent care access.

1.12 **Orthodontic Waiting Lists** – The ICB is undertaking a review of orthodontic waiting lists, to understand the current service wait times. A further paper will be submitted to the ICB Executive about a non-recurrent programme for reducing waiting times for orthodontics.

1.13 **Community and Specialist (LD/Anxiety/wheelchair/bariatric dentistry) Waiting lists. –** The ICB is working with providers, but currently waiting lists for these services are up to 12 months in North east Essex, and in Suffolk are also increasing from the previous waiting times. A review of these providers is being undertaken to look at what support we can offer to reduce waiting times.

3. Patient and Public Engagement

3.1 The ICB continues to co-produce services with partners and the public to ensure provision meets local population need.

4. Recommendation

4.1 The ICB Board is asked to note this briefing and be advised a strategic briefing will be presented to its meeting in September regarding status of pharmacy in the ICS and recommendations for local action.

NHS
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North East Essex
Integrated Care Board

ICB BOARD

Agenda Item No.	**17**
Reference No.	**ICB 23-56**
Date.	**25 July 2023**

Title	**One Year Review of the ICB Constitution**
Lead Director	Amanda Lyes (Director of Workforce and People)
Author(s)	Colin Boakes – Independent Governance Advisor
Purpose	Review of the ICB Constitution
Recommendation: The ICB Board is asked to note the review the ICB Constitution.	

1. Background

1.1 The Board endorsed the ICB Constitution at its inaugural meeting on 1 July 2022, the former Clinical Commissioning Groups (CCGs) having previously approved the document. This was in accordance with the Health and Care Act 2022 which stated that the CCGs must propose to NHS England the Constitution for the first Integrated Care Board (ICB) to be established for the ICB area of Suffolk and North East Essex.

1.2 Some six months after establishment of the ICB, it was considered an opportune moment for Board Members to review the Constitution and if appropriate, suggest any necessary amendments. This was discussed at the Board meeting in January 2023 with members requested to provide any feedback and/or suggested amendments within the following two weeks. At the Board meeting in March 2023, it was noted that the ICB Constitution remained unchanged but would be reviewed again, one year after the ICB establishment, in July 2023.

2. Key Issues

2.1 Since the interim review carried out earlier in the year there have been some minor amendments to the Constitution, these being necessary to facilitate the appointment of a fourth NEM to the Board.

2.2 Further to discussion at the May meeting of the Board where the appointment of a fourth NEM was agreed, the request to increase the establishment together with the necessary amendments to the Constitution were put to NHS England for approval, together with supporting evidence which included the report to the Board, the Board and Remuneration and Human Resources Committee minutes, together with an equality impact assessment.

2.3 NHS England subsequently approved the establishment increase and changes to the Constitution on 15 June 2023 with the new version now uploaded to the ICB website.

2.4 A copy of the Amended Constitution is attached with the amendments at points 2.2.3(f), 3.11 and 3.11.1, highlighted in red for ease of reference.

2.5 In accordance with the initial approval and endorsement and subsequent interim review, the Constitution is now subject to a further review one year since establishment of the ICB. Again, Board Members are requested to reflect on the document and provide any comments or feedback by **8 August 2023**, this being two weeks after the date of the July Board meeting.

2.6 However, it should again be reiterated that within the power given to NHS England by each ICB Constitution (which is a mandatory provision in all ICB Constitutions pursuant to the Act) to make amendments, they expect to use that power only in exceptional circumstances. As such, any suggested amendments would need to be substantial and comply with the specific requirements of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2022) and that the proposed changes are otherwise appropriate.

2.7 As ICB Constitutions can therefore only be amended in very limited circumstances, it is suggested that for the future, it will only be brought back to the Board for review when the ICB wishes to make a substantive change, as in the case of increasing the NEM establishment, or that there have been amendments mandated by NHS England.

3. Recommendation

3.1 The Board is requested to note the foregoing report, review the ICB Constitution and provide any comments or feedback by 8 August 2023.

NHS
Suffolk and
North East Essex
Integrated Care Board

Suffolk and North East Essex Integrated Care Board

CONSTITUTION

VERSION CONTROL

Version	Date Approved by the ICB	Effective Date
V1.0	1 July 2022	1 July 2022
V2.0	22 November 2022	22 November 2022
V3.0		

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1. Introduction

1.1 Background/ Foreword

1.1.1 NHS England has set out the following as the four core purposes of ICSs:

a) improve outcomes in population health and healthcare
b) tackle inequalities in outcomes, experience and access
c) enhance productivity and value for money
d) help the NHS support broader social and economic development.

1.1.2 The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

a) improving the health of children and young people
b) supporting people to stay well and independent
c) acting sooner to help those with preventable conditions
d) supporting those with long-term conditions or mental health issues
e) caring for those with multiple needs as populations age
f) getting the best from collective resources so people get care as quickly as possible.

1.1.3 Suffolk and North East Essex Integrated Care Board (the ICB) brings together partners responsible for planning and delivering health and care across Suffolk and North East Essex to ensure shared leadership and joint action to improve the health and wellbeing of the one million people who live locally.

1.1.4 ICBs are central to the NHS Long Term Plan and have a key role in ensuring joint working across the NHS and Local Authorities to make shared commissioning decisions together with providers on how to use resources, design services and improve population health.

1.1.5 The ICB will enable communities to continue to shape priorities and release the assets which contribute to their wellbeing, care and health, within a common set of standards which reduce unnecessary variations in performance and outcomes. By working with people in our communities the ICB will develop trust and understanding with stakeholders about what matters.

1.1.6 Integrated care systems are partnerships of health and care organisations, local government and the voluntary sector. They exist to improve population health, tackle health inequalities, enhance productivity and help the NHS support broader social and economic development. Each ICS is comprised of an Integrated Care Board working with an Integrated Care Partnership committee formed jointly with local authority partners.

1.1.7 The ICP is required to produce an integrated care strategy and the ICB and local authorities are required by law to have regard to the ICPs strategy when making decisions, commissioning and delivering services.

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS Suffolk and North East Essex Integrated Care Board ("the ICB").

1.3 Area Covered by the Integrated Care Board

1.3.1 The area covered by the ICB is coterminous with and includes the District of Babergh, Borough of Colchester, Borough of Ipswich, District of Mid Suffolk, District of Tendring and the District of West Suffolk. The area also includes part of the District of East Suffolk as per the following LSOAs: (E01030201, E01030219, E01030222, E01030154, E01030172, E01030173, E01030174, E01030176, E01030186, E01030208, E01030209, E01030210, E01030212, E01030152, E01030153, E01030187, E01030188, E01030189, E01030193, E01030194, E01030195, E01030220, E01030175, E01030200, E01030221, E01030199, E01033443, E01033445, E01033446, E01033448, E01033449, E01030155, E01030185, E01030203, E01030211, E01030179, E01030180, E01030183, E01030184, E01030207, E01030181, E01030190, E01030191, E01030192, E01030198, E01033442, E01033444, E01033447, E01030196, E01030197, E01030204, E01030205, E01030206, E01030171, E01030214, E01030215, E01030216, E01030217, E01030218, E01030158, E01030159, E01030164, E01030166, E01033450, E01030160, E01030161, E01030168, E01030169, E01030170, E01030162, E01030163, E01030165, E01030167)

1.4 Statutory Framework

1.4.1 The ICB is established by order made by NHS England under powers in the 2006 Act.

1.4.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its constitution (section 14Z29). This Constitution is published at www.suffolkandnortheastessex.icb.nhs.uk

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory

duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act);
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
c) Duties in relation children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014)
d) Adult safeguarding and carers (the Care Act 2014)
e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35); and
f) Information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000).
g) Provisions of the Civil Contingencies Act 2004

1.4.6 The ICB is subject to an annual assessment of its performance by NHS England which is also required to publish a report containing a summary of the results of its assessment.

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under:
a) section 14Z34 (improvement in quality of services)
b) section 14Z35 (reducing inequalities)
c) section 14Z38 (obtaining appropriate advice)
d) section 14Z40 (duty in respect of research)
e) section 14Z43 (duty to have regard to effect of decisions)
f) section 14Z45 (public involvement and consultation)
g) sections 223GB to 223N (financial duties), and
h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61).

1.5 Status of this Constitution

1.5.1 The ICB was established on 1 July 2022 by The Integrated Care Boards (Establishment) Order 2022, which made provision for its Constitution by reference to this document.

1.5.2 This Constitution must be reviewed and maintained in line with any agreements with, and requirements of, NHS England set out in writing at establishment.

1.5.3 Changes to this Constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:

a) where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; and
b) where NHS England varies the Constitution of its own initiative, (other than on application by the ICB).

1.6.2 The procedure for proposal and agreement of variations to the Constitution is as follows:

a) The Chief Executive may periodically propose amendments to the Constitution which shall be considered and approved by the ICB prior to making an application to vary the Constitution to NHS England
b) Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

1.6.3 Before any amendments can be approved under Clause 1.6.2, above, the proposed amendments must be provided to all relevant respondents with a period of twenty-one days from the date the amendments are sent in which they can respond with any comments on the amendments. Any comments provided must be submitted to the Board in writing before the meeting at which the amendments proposed are to be considered.

1.7 Related Documents

1.7.1 This Constitution is also supported by a number of documents that provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to the Constitution and form part of it for the purpose of clause 1.6 and the ICB's legal duty to have a Constitution:

a) Standing orders – which set out the arrangements and procedures to be used for meetings and the processes to appoint the ICB committees.

1.7.3 The following do not form part of the Constitution but are required to be published:

a) The Scheme of Reservation and Delegation (SoRD) - sets out those decisions that are reserved to the board of the ICB and those decisions that

have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to to whom functions and decisions have been delegated to.

b) **Functions and Decision Map** - a high-level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision Map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

c) **Standing Financial Instructions** – which set out the arrangements for managing the ICB's financial affairs.

d) **The ICB Governance Handbook** – this brings together all the ICB's governance documents so it is easy for interested people to navigate. It includes:

- The above documents a) to c)
- Terms of reference for all committees and sub-committees of the Board that exercise ICB functions
- Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act
- Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act
- The up to date list of eligible providers of primary medical services under clause 3.6.2

e) **Key policy documents** – which should be included in the Governance Handbook or linked to it - including:

- Standards of Business Conduct Policy
- Conflicts of interest policy and procedures
- Policy for public involvement and engagement

2 Composition of the Board of the ICB

2.1 Background

2.1.1 This part of the Constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in section 3.

2.1.2 Further information about the individuals who fulfil these roles can be found on our website www.suffolkandnortheastessex.icb.nhs.uk

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this Constitution as "the board" and members of the ICB are referred to as "board members") consists of:

a) a Chair
b) a Chief Executive
c) at least three Ordinary Members.

2.1.4 The membership of the ICB (the board) shall meet as a unitary board and shall be collectively accountable for the performance of the ICB's functions.

2.1.5 NHS England Policy requires the ICB to appoint the following additional Ordinary Members:

a) three Executive Members, namely:
   - Director of Finance
   - Medical Director
   - Director of Nursing
b) At least two non-executive members

2.1.6 The ordinary members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are nominated by the following and appointed in accordance with the procedures set out in Section 3 below**:**

- NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description
- the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description
- the local authorities that are responsible for providing social care and whose area coincides with or includes the whole or any part of the ICB's area.

2.1.7 While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board, they are not to act as delegates of those sectors.

2.2 Board Membership

2.2.1 The ICB has seven Partner Members, as follows**:**

a) Two members who bring the perspective of the acute and community sector
b) One member who brings the perspective of the mental health sector
c) Two members who bring the perspective of the primary care sector
d) Two members from the upper tier local authorities whose area coincides with, or includes the whole or any part of, the ICB's area

2.2.2 The ICB has appointed the following further Ordinary Members to the board:

a) Non-Executive Member
b) Member representing the VCSE sector

2.2.3 The Board is therefore composed of the following members:

a) Chair
b) Chief Executive
c) Three Partner Members NHS and Foundation Trusts
d) Two Partner Members Primary Medical Services
e) Two Partner Members Local Authorities
f) Four Non-Executive Members
g) Director of Finance
h) Medical Director
i) Director of Nursing
j) One Member for the VCSE sector

2.2.4 The Chair will exercise their function to approve the appointment of the Ordinary Members with a view to ensuring that at least one of the Ordinary Members will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

2.2.5 The board will keep under review the skills, knowledge and experience that it considers necessary for members of the board to possess (when taken together) for the board effectively to carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.

2.3 Regular participants and observers at board meetings

2.3.1 The board may invite specified individuals to be Participants or Observers at its meetings to inform its decision-making and the discharge of its functions as it sees fit.

2.3.2 Participants will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair, to ask questions and address the meeting but may not vote.

2.3.3 The board will regularly invite the following individuals to attend any or all of its meetings as regular participants:

a) Director: North East Essex Alliance
b) Director: Ipswich and East Suffolk Alliance
c) Director: West Suffolk Alliance
d) Director of People and Workforce
e) Director of Strategy and Transformation
f) Director of Performance and Improvement
g) Integrated Care Partnership Co-Chair – Suffolk County Council

h) Integrated Care Partnership Co-Chair – Essex County Council
i) Integrated Care Partnership Director

2.3.4 Observers will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may not address the meeting and may not vote.

2.3.5 The board will regularly invite a number of observers to attend any or all of its meetings, to include Healthwatch Suffolk and Healthwatch Essex together with Lay representatives from the North East Essex, Ipswich and East Suffolk and West Suffolk Alliances.

2.3.6 Participants and/or observers may be asked to leave the meeting by the Chair in the event that the board passes a resolution to exclude the public as per the standing orders.

3 Appointments process for the board

3.1 Eligibility criteria for board membership

3.1.1 Each member of the ICB must:

a) Comply with the criteria of the "fit and proper person test"
b) Be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles)
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification
d) Familiarise themselves with the eligibility and ineligibility requirements, confirming their eligibility prior to appointment and immediately notifying the Chair of the ICB of a change of circumstances that may render them no longer eligible

3.2 Disqualification criteria for board membership

3.2.1 A Member of Parliament.

3.2.2 A person whose appointment as a board member (''the candidate') is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement in the private healthcare sector or otherwise

3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted:

a) in the United Kingdom of any offence, or

b) outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, Part 13 of the Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

3.2.5 A person who has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.

3.2.6 A person whose term of appointment as the Chair, a Member, a Director or a Governor of a Health Service Body, has been terminated on the grounds:

a) that it was not in the interests of, or conducive to the good management of, the Health Service Body or of the health service that the person should continue to hold that office
b) that the person failed, without reasonable cause, to attend any meeting of that Health Service Body for three successive meetings,
c) that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest, or
d) of misbehaviour, misconduct or failure to carry out the person's duties.

3.2.7 A Health Care Professional or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was:

a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated
b) the person's erasure from such a register, where the person has not been restored to the register
c) a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded, or
d) a decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:

a) a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or
b) an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

3.2.9 A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

3.2.10 A person who has at any time been removed, or is suspended, from the management or control of a body under:

a) section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities), or
b) section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State for Health and Social Care.

3.3.2 In addition to criteria specified at 3.1, this member must fulfil the following additional eligibility criteria:

a) The Chair will be independent.

3.3.3 Individuals will not be eligible if:

a) They hold a role in another health and care organisation within the ICB area
b) Any of the disqualification criteria set out in 3.2 apply.

3.3.4 The term of office for the Chair will be 3 years and the total number of terms a Chair may serve is 3 terms. The maximum term of 9 years is in place to ensure ongoing independence.

3.4 Chief Executive

3.4.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.

3.4.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England

3.4.3 The Chief Executive must fulfil the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act
b) Meets the ICB leadership competency domains
c) Meets the requirements of the role function and specification that the Board shall approve and including:
    (i) Executive health care experience
    (ii) Substantial experience of operating at board level and as a CEO leading across complex, regulated environment. A track record of navigating the media and political stakeholders
    (iii) Extensive knowledge of the health, care and local government landscape and an understanding of the social determinants of public health
    (iv) Sound understanding of strategic financial planning, oversight and control of significant public funds
    (v) Communication skills which engender community confidence, strong collaborations and partnerships
    (vi) Strong critical thinking and strategic problem-solving skills

3.4.4 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) Subject to clause 3.4.3(a), they hold any other employment or executive role

3.5 Partner Members – NHS trusts and foundation trusts

3.5.1 These Partner Members are jointly nominated by the NHS trusts and/or foundation trusts that provide services for the purposes of the health service within the ICB's area and meet the forward plan condition or (if the forward plan condition is not met) the level of services provided condition:

a) East Suffolk and North Essex NHS Foundation Trust
b) West Suffolk NHS Foundation Trust
c) Norfolk and Suffolk NHS Foundation Trust
d) Essex Partnership University NHS Foundation Trust
e) East of England Ambulance Service NHS Trust

3.5.2 These members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be the Chief Executive Officer or another Executive Director of one of the NHS trusts or foundation trusts within the ICB's area
b) Meet any other criteria set out in NHS England guidance or supporting legislation
c) Meet the requirements of the role specification for the post
d) One member shall have specific knowledge, skills and experience of the provision of acute services

e) One member shall have specific knowledge, skills and experience of the provision of community services
f) One member shall have specific knowledge, skills and experience of the provision of mental health services.

3.5.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) Any other disqualification criteria prescribed through NHS England guidance or supporting legislation apply
c) A conflict of interest is evident, as determined by the Chair or the ICB Board appointment panel, which results in the individual being unable to fulfil the role.

3.5.4 These members will be appointed by the Chief Executive subject to the approval of the Chair in accordance with the process set out at 3.5.5 below.

3.5.5 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation listed at 3.5.1 a) to e) will be invited to make up to two nominations each per role (one Partner Member role for acute, one Partner Member role for community, and one Partner Member role for mental health)
- The nomination of an individual must be seconded by one other eligible organisation outside the nominated individual's own eligible organisation
- Eligible organisations may nominate individuals from their own organisation or another organisation
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within five working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they do not agree the list, the nomination process will be re-run until a majority acceptance is reached on the nominations put forward.

b) Assessment, selection and appointment subject to approval of the Chair under c):
- The full list of nominees will be considered by a panel convened by the Chief Executive
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.5.2 and 3.5.3
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval:
- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b)

3.5.6 The term of office for these Partner Members will be 3 years and the total number of terms they may serve is 3 terms.

3.6 Partner Members - Providers of Primary Medical Services.

3.6.1 These Partner Members are jointly nominated by providers of primary medical services for the purposes of the health service within the ICB's area, and that are primary medical services contract holders responsible for the provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility.

3.6.2 The list of identified eligible providers of primary medical services for this purpose is published as part of the Governance Handbook. The list will be kept up to date but does not form part of the Constitution.

3.6.3 These members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Is a partner or salaried GP working in a GP practice within the ICB geographical area and included on the Medical Performer List
b) Is a Practice Manager or Healthcare Professional working within the ICB geographical area
c) Is actively engaged in the work of the ICS at place
d) As a commitment to the ICB, this member shall work for a minimum one session per week
e) Meets the requirements of the role specification for the post
f) Collectively provide different perspectives of the Suffolk and North East Essex populations.

3.6.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) They are a GP working predominantly in the out-of-hours service
c) A conflict of interest is evident, as determined by the Chair or the ICB Board appointments panel, which results in the individual being unable to fulfil the role.

3.6.5 These member(s) will be appointed by the Chief Executive subject to the approval of the Chair in accordance with the process set out at 3.6.6 below.

3.6.6 The appointment process will be as follows:

a) Joint Nomination:

- When a vacancy arises, each eligible organisation described at 3.6.1 and listed in the Governance Handbook will be invited to make up to two nominations each per role
- The nomination of an individual must be seconded by one other eligible organisation outside the nominated individual's own eligible organisation
- Eligible organisations may nominate individuals from their own organisation or another organisation

- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals with a failure to confirm within five working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they do not agree the list, the nomination process will be re-run until a majority acceptance is reached on the nominations put forward.

b) Assessment, selection and appointment subject to approval of the Chair under c):
   - The full list of nominees will be considered by a panel convened by the Chief Executive
   - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.6.3 and 3.6.4
   - In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval:
   - The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b)

3.6.7 The term of office for this Partner Member(s) will be 3 years and the total number of terms they may serve is 3 terms.

3.7 Partner Members - local authorities

3.7.1 These Partner Members are jointly nominated by the local authorities whose areas coincide with, or include the whole or any part of, the ICB's area. Those local authorities are:

a) Suffolk County Council
b) Essex County Council

3.7.2 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be the Chief Executive or hold a relevant Executive level role of one of the bodies listed at 3.7.1
b) Meets the requirements of the role specification for the post
c) Collectively provide different perspectives of the Suffolk and Essex populations.

3.7.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) Any other disqualification criteria prescribed through NHS England guidance or supporting legislation apply
c) A conflict of interest is evident, as determined by the Chair or the ICB Board appointment panel, which results in the individual being unable to fulfil the role.

3.7.4 These members will be appointed by the Chief Executive subject to the approval of the Chair in accordance with the process set out at 3.7.5 below.

3.7.5 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation listed at 3.7.1 will be invited to make up to one nomination each per role
- Eligible organisations may nominate individuals from their own organisation or another organisation
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals with a failure to confirm within five working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they do not agree the list, the nomination process will be re-run until a majority acceptance is reached on the nominations put forward.

b) Assessment, selection and appointment Subject to approval of the Chair under c):
- The full list of nominees will be considered by a panel convened by the Chief Executive
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.7.2 and 3.7.3
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's Approval:
- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b)

3.7.6 The term of office for this Partner Member will be 3 years and the total number of terms they may serve is 3 terms.

3.8 Medical Director

3.8.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Medical Practitioner
c) Meets the ICB leadership competency domains
d) Meets the requirements of the role specification for the post.

3.8.2 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply

3.8.3 This member will be appointed by the Chief Executive subject to the approval of the Chair

3.9 Director of Nursing

3.9.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act
b) Be a Registered Nurse
c) Meets the ICB leadership competency domains
d) Meets the requirements of the role specification for the post.

3.9.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) They do not maintain a current Nursing and Midwifery Council (NMC) registration.

3.9.3 This member will be appointed by the Chief Executive subject to the approval of the Chair.

3.10 Director of Finance

3.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Is a qualified accountant with full membership of a recognised accountancy qualification awarding body
c) Meets the ICB leadership competency domains
d) Meets the requirements of the role specification for the post.

3.10.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) They do not maintain the necessary professional qualification requirements.

3.10.3 This member will be appointed by the Chief Executive subject to the approval of the Chair.

3.11 Four Non-executive Members

3.11.1 The ICB will appoint four Non-executive Members

3.11.2 The appointment process for these members will include local advertising via established channels. Interviews will be conducted by a panel comprising

members of the Board. These members will be appointed by the board subject to the approval of the Chair.

3.11.3 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Not be an employee of the ICB or a person seconded to the ICB
b) Not hold a role in another health and care organisation in the ICS area
c) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee
d) One should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration and Human Resources Committee
e) One should have general knowledge, skills and experience in quality and safety that makes them suitable for the role
f) Must live or work within the area of the ICB.

3.11.4 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) They hold a role in another health and care organisation within the ICB area

3.11.5 The term of office for a Non-executive Member will be 3 years and the total number of terms an individual may serve is 3 terms after which they will no longer be eligible for re-appointment.

3.11.6 Initial appointments may be for a shorter period in order to avoid all Non-executive Members retiring at once. Thereafter, new appointees will ordinarily retire on the date that the individual they replaced was due to retire in order to provide continuity.

3.11.7 Subject to satisfactory appraisal the Chair may approve the re-appointment of a Non-executive Member up to the maximum number of terms permitted for their role.

3.12 Other Board Members – Member for Voluntary, Community and Social Enterprise (VCSE)

3.12.1 This member represents the VCSE Assembly.

3.12.2 This member must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be the Chief Executive Officer or another Executive Director/Officer of one of the VCSE organisations within the ICB's area.

3.12.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.12.4 The appointment process will be as follows:

a) The nomination will be received from the VCSE Assembly.

3.12.5 This member will be appointed by the ICB Chief Executive subject to the approval of the Chair.

3.12.6 The term of office for this Member will be 3 years and the total number of terms they may serve is 3 terms.

3.13 Board Members: Removal from Office

3.13.1 Arrangements for the removal from office of board members is subject to the term of appointment, and application of the relevant ICB policies and procedures.

3.13.2 With the exception of the Chair, board members shall be removed from office if any of the following occurs:

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance
b) If they fail to attend a minimum of 75% of the meetings to which they are invited unless agreed with the Chair in extenuating circumstances
c) If they are deemed to not meet the expected standards of performance at their annual appraisal
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise
e) Are deemed to have failed to uphold the Nolan Principles of Public Life
f) Are subject to disciplinary proceedings by a regulator or professional body

3.13.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.13.2 apply.

3.13.4 Executive Directors (including the Chief Executive) will cease to be board members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

3.13.5 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State.

3.13.6 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:

a) terminate the appointment of the ICB's Chief Executive; and
b) direct the Chair of the ICB as to which individual to appoint as a replacement and on what terms.

3.14 Terms of Appointment of Board Members

3.14.1 With the exception of the Chair and Non-executive Members, arrangements for remuneration and any allowances will be agreed by the Remuneration and Human Resources Committee in line with the ICB remuneration policy and any other relevant policies published at www.suffolkandnortheastessex.icb.nhs.uk or any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England. Remuneration for Non-executive Members will be set by a Non-executive Member Remuneration Panel.

3.14.2 Other terms of appointment will be determined by the Remuneration and Human Resources Committee.

3.14.3 Terms of appointment of the Chair will be determined by NHS England.

3.15 Specific Arrangements for appointment of Ordinary Members made at establishment

3.15.1 Individuals may be identified as “designate Ordinary Members” prior to the ICB being established.

3.15.2 Relevant nomination procedures for Partner Members in advance of establishment are deemed to be valid so long as they are undertaken in full and in accordance with the provisions of 3.5 to 3.7.

3.15.3 Any appointment and assessment processes undertaken in advance of establishment to identify designate Ordinary Members should follow, as far as possible, the processes set out in section 3.5-3.12 of this constitution. However, a modified process, agreed by the Chair, will be considered valid.

3.15.4 On the day of establishment, a committee consisting of the Chair, Chief Executive and an HR representative will appoint the Ordinary Members who are expected to all be individuals who have been identified as designate appointees prior to ICB establishment and the Chair will approve those appointments.

3.15.5 For the avoidance of doubt, this clause is valid only in relation to the appointments of the initial Ordinary Members and all appointments post establishment will be made in accordance with clauses 3.5 to 3.12.

4 Arrangements for the exercise of our functions

4.1 Good Governance

4.1.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Seven Principles of Public Life (the Nolan Principles) and any governance guidance issued by NHS England. These include but are not limited to:

a) The highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business
b) The Good Governance Standard for Public Services
c) The seven key principles of the NHS Constitution
d) The Equality Act 2010
e) The Standards for Members of NHS Boards and Governing Bodies in England

4.1.2 The ICB has agreed a code of conduct and behaviours which sets out the expected behaviours that members of the board and its committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB code of conduct and behaviours is published in the governance handbook.

4.2 General

4.2.1 The ICB will:

a) comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations
b) comply with directions issued by the Secretary of State for Health and Social Care
c) comply with directions issued by NHS England
d) have regard to statutory guidance including that issued by NHS England
e) take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England
f) respond to reports and recommendations made by local Healthwatch organisations within the ICB area

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with (a)-(f) above, documenting them as necessary in this Constitution, its governance handbook and other relevant policies and procedures as appropriate.

4.3 Authority to Act

4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:
a) any of its members or employees
b) a committee or sub-committee of the ICB

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS Trust, NHS Foundation Trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act the board must authorise the arrangement, which must be described as appropriate in the SoRD.

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a Scheme of Reservation and Delegation (SoRD) which is published in full in the ICB Governance Handbook

4.4.2 Only the board may agree the SoRD and amendments to the SoRD may only be approved by the board.

4.4.3 The SoRD sets out:

a) those functions that are reserved to the board;
b) those functions that have been delegated to an individual or to committees and sub-committees
c) those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act.

4.4.4 The ICB remains accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to the board for the exercise of their delegated functions.

4.5 Functions and Decision Map

4.5.1 The ICB has prepared a Functions and Decision Map which sets out at a high level its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decision Map is published at www.suffolkandnortheastessex.icb.nhs.uk

4.5.3 The map includes:

a) Key functions reserved to the board of the ICB
b) Commissioning functions delegated to committees and individuals.

c) Commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body;
d) functions delegated to the ICB (for example, from NHS England).

4.6 Committees and sub-committees

4.6.1 The ICB may appoint committees and arrange for its functions to be exercised by such committees. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees.

4.6.2 All committees and sub-committees are listed in the SoRD.

4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference agreed by the Board. All terms of reference are published in the Governance Handbook.

4.6.4 The board remains accountable for all functions, including those that it has delegated to committees and subcommittees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub committees that fulfil delegated functions of the ICB, will be required to:
a) Submit regular decision and assurance reports to the board
b) Submit minutes of committee meetings to the board
c) Ensure that the committee Chair or designated deputy attends meetings of the board as necessary
d) Comply with internal audit findings and committee effectiveness reviews.

4.6.5 Any committee or sub-committee established in accordance with clause 4.6 may consist of or include persons who are not ICB Members or employees.

4.6.6 All members of committees and sub-committees that exercise the ICB commissioning functions will be approved by the Chair. The Chair will not approve an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

4.6.7 All members of committees and sub-committees are required to act in accordance with this Constitution including the Standing Orders as well as the Standing Financial Instructions and any other relevant ICB policy.

4.6.8 The following committees will be maintained:
a) **Audit Committee:** This committee is accountable to the board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.

The Audit Committee will be chaired by a Non-executive Member (other than the Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters.

b) **Remuneration and Human Resources Committee:** This committee is accountable to the board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.

The Remuneration and Human Resources Committee will be chaired by a Non-executive Member other than the Chair or the Chair of Audit Committee.

4.6.9 The terms of reference for each of the above committees are published in the Governance Handbook.

4.6.10 The board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further information about these committees, including terms of reference, are published in the Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 4.3.2 the ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

4.7.2 All delegations made under these arrangements are set out in the ICB Scheme of Reservation and Delegation and included in the Functions and Decision Map.

4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the board.

4.7.4 The board remains accountable for all the ICB's functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation arrangements, summaries of which will be published in the ICB's Governance Handbook.

4.7.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

5 Procedures for making decisions

5.1 Standing Orders

5.1.1 The ICB has agreed a set of standing orders which describe the processes that are employed to undertake its business. They include procedures for:

- conducting the business of the ICB
- the procedures to be followed during meetings; and
- the process to delegate functions.

5.1.2 The Standing Orders apply to all committees and sub-committees of the ICB unless specified otherwise in terms of reference which have been agreed by the board.

5.1.3 A full copy of the Standing Orders is included in Appendix 2 and form part of this Constitution.

5.2 Standing Financial Instructions (SFIs)

5.2.1 The ICB has agreed a set of Standing Financial Instructions (SFIs) which include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFIs are published in the ICB Governance Handbook.

6 Arrangements for conflicts of interest management and standards of business conduct

6.1 Conflicts of Interest

6.1.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest, including registers of interest which are published on the ICB's website.

6.1.3 All board, committee and sub-committee members, and employees of the ICB, will comply with the ICB policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

6.1.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of

interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution and the Standards of Business Conduct and Conflicts of Interest Policy.

6.1.6 The ICB has appointed the Audit Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:

a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest
b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest
c) Support the rigorous application of conflicts of interest principles and policies
d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation
e) Provide advice on minimising the risks of conflicts of interest.

6.2 Principles

6.2.1 In discharging its functions, the ICB will abide by the following principles:

a) acting in good faith and in the interests of the ICB
b) following the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles);
c) compliance with the standards set out in the Professional Standards Authority guidance - Standards for Members of NHS Boards and Governing Bodies in England; and
d) comply with the ICB's Standards of Business Conduct and Conflicts of Interest Policy, including the requirements set out in the policy for managing conflicts of interest, which is available on the ICB's website and will be made available on request.

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

a) Members of the ICB
b) Members of the board's committees and sub-committees
c) Its employees

6.3.2 In accordance with section 14Z30(2) of the 2006 Act, registers of interest are published on the ICB website www.suffolkandnortheastessex.icb.nhs.uk

6.3.3 All relevant persons as per 6.1.3 and 6.1.5 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the registers as per 6.3.1

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually.

6.3.7 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.

6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of business conduct

6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:

a) act in good faith and in the interests of the ICB
b) follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles)
c) comply with the ICB's Standards of Business Conduct and Conflicts of Interest Policy, and any requirements set out in the policy for managing conflicts of interest.

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct and Conflicts of Interest Policy.

7 Arrangements for ensuring Accountability and Transparency

7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 12(2) of Schedule 1B to the 2006 Act.

7.2 Principles

7.2.1 The ICB will demonstrate its accountability to its members, local people, stakeholders and NHS England in a number of ways, including by being open and transparent.

7.2.2 In addition to statutory requirements, the CCG will demonstrate its accountability by publishing a range of documents and information on its website at www.suffolkandnortheastessex.icb.nhs.uk

7.3 Meetings and publications

7.3.1 Board meetings, and committees composed entirely of board members or which include all board members, will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

7.3.2 Papers and minutes of all meetings held in public will be published.

7.3.3 Annual accounts will be externally audited and published.

7.3.4 A clear complaints process will be published.

7.3.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

7.3.6 Information will be provided to NHS England as required.

7.3.7 The Constitution and Governance Handbook will be published as well as other key documents including but not limited to:

a) Standards of Business Conduct and Conflicts of Interest Policy and procedures
b) Registers of interests
c) Key policies

7.3.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. The plan will explain how the ICB proposes to discharge its duties under:

- sections 14Z34 to 14Z45 (general duties of integrated care boards),and
- sections 223GB and 223N (financial duties).

And

a) proposed steps to implement the Suffolk and North East Essex joint local health and wellbeing strategy.

7.4 Scrutiny and Decision Making

7.4.1 At least three Non-executive Members will be appointed to the board including the Chair; and all of the board and committee members will comply with the Seven Principles of Public Life (the Nolan Principles) and meet the criteria described in the fit and proper person test.

7.4.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

7.4.3 The ICB will comply with the requirements of the NHS Provider Selection Regime including:

a) Complying with existing procurement rules until the provider selection regime comes into effect
b) Ensuring appropriate governance structures and arrangements are in place to deal with any provider selection challenges which may arise.
c) Retaining evidence to underpin the proper exercise of the ICB's responsibilities for arranging healthcare
d) Publishing intentions for arranging relevant healthcare services in advance
e) Publishing contracts awarded and retaining records of decision making
f) Ensuring audit arrangements are capable of examining the decisions made

7.4.4 The ICB will comply with local authority health overview and scrutiny requirements.

7.5 Annual Report

7.5.1 The ICB will publish an Annual Report in accordance with any guidance published by NHS England; and that sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report must in particular:

a) explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards)
b) review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan)
c) review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under

section 13SA(1) (views about how functions relating to inequalities information should be exercised) and

d) review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007

8 Arrangements for Determining the Terms and Conditions of Employees

8.1.1 The ICB may appoint employees, pay them remuneration and allowances as it determines, and appoint staff on such terms and conditions as it determines.

8.1.2 The board has established a Remuneration and Human Resources Committee which is chaired by a Non-executive member other than the Chair or Audit Chair.

8.1.3 The membership of the Remuneration and Human Resources Committee is determined by the board. No employees may be a member of the Remuneration Committee, but the board ensures that the Remuneration Committee has access to appropriate advice by:

a) A senior representative for HR, and the Chief Executive, attending in an advisory capacity. It is acknowledged that HR advice should be sought to assist the Committee in reaching decisions and it would be expected for the HR representative to be present throughout the meeting unless the majority of the Committee and the Chair considered otherwise

b) Other Directors or Senior Managers invited to attend as appropriate.

8.1.4 The board may appoint independent members or advisers to the Remuneration Committee who are not members of the board.

8.1.5 The main purpose of the Remuneration and Human Resources Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act.

8.1.6 The duties of the Remuneration and Human Resources Committee are set out in detail in its terms of reference, which in summary are to confirm the ICB Pay Policy, including adoption of any pay frameworks for all employees including senior managers/directors (including board members) and non-executive directors. The full terms of reference are included in the ICB Governance Handbook.

8.1.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

9 Arrangements for Public Involvement

9.1.1 In line with section 14Z45(2) of the 2006 Act the ICB has made arrangements to secure that individuals to whom services that are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and

their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

a) the planning of the commissioning arrangements by the ICB
b) the development and consideration of proposals by the ICB for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them, and
c) decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.1.2 In line with section 14Z54 of the 2006 Act, the ICB has made arrangements to consult the local population on its system plan, following best practice for the conduct of public consultations published by HM Government.

9.1.3 The ICB has adopted the 10 principles set out by NHS England for working with people and communities:

a) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS
b) Start engagement early when developing plans, and feed back to people and communities how it has influenced activities and decisions
c) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect
d) Build relationships with excluded groups – especially those affected by inequalities
e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners
f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust
g) Use community development approaches that empower people and communities, making connections to social action
h) Use co-production, insight and engagement to achieve accountable health and care services
i) Co-produce and redesign services and tackle system priorities in partnership with people and communities
j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

9.1.4 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

Appendix 1: Definitions of terms used in this Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022
Integrated Care Board (ICB)	A body corporate with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act
ICB board	Members of the ICB
Chair of the ICB Board	The individual appointed to act as chair of the ICB board
Chief Executive	An individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act, appointed by NHS England, with responsibility for ensuring the ICB complies with its obligations under: sections 14Q and 14R of the 2006 Act, sections 223H to 223J of the 2006 Act, paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006, and any other provision of the 2006 Act specified in a document published by the Board for that purpose; exercises their functions in a way which provides good value for money.
Director of Finance	A qualified accountant employed by the ICB with responsibility for financial strategy, financial management and financial governance and who is a member of the ICB Board.
Area	The geographical area that the ICB has responsibility for, as defined in part 2 of this Constitution.
Committee	A committee created and appointed by the ICB board.
Sub-committee	A committee created and appointed by and reporting to a committee.
Integrated Care Partnership (ICP)	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area

	coincides with or falls wholly or partly within the ICB's area.
Place-based partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.
Ordinary Member	The board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 having been nominated by the following: • NHS trusts and foundation trusts that provide services within the ICB's area and are of a prescribed description • The primary medical services (general practice) providers within the area of the ICB and are of a prescribed description • The local authorities that are responsible for providing social care and whose areas coincide with or include the whole or any part of the ICB's area.
Health Service Body	Health Service Body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.
Professional Standards Authority	An independent body accountable to the UK Parliament which help Parliament monitor and improve the protection of the public. Published *Standards for Members of NHS Boards and Governing Bodies in England* in 2013
NHS England	The body which leads the NHS in England
Health Care Professional	An individual who is a member of a profession regulated by a body mentioned in Section 25(3) of the National Health Service Reform and Health Care Professions Act 2002

Appendix 2: Standing Orders

1. Introduction

1.1 These Standing Orders have been drawn up to regulate the proceedings of the Suffolk and North East Essex Integrated Care Board so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's Constitution.

2. Amendment and review

2.1. The Standing Orders are effective from 1 July 2022.

2.2. Standing Orders will be reviewed on an annual basis or sooner if required.

2.3. Amendments to these Standing Orders will be made as per clause number 1.6 in the constitution which sets out the procedure for making amendments to the Constitution and its constituent parts.

2.4. All changes to these Standing Orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the Constitution has been approved.

3. Interpretation, application and compliance

3.1. Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 1.

3.2. These Standing Orders apply to all meetings of the board, including its committees and sub-committees unless otherwise stated. All references to board are inclusive of committees and sub-committees unless otherwise stated.

3.3. All members of the board, members of committees and sub-committees and all employees, should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4. In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the Independent Governance Adviser, will provide a settled view which shall be final.

3.5. All members of the board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

3.6. If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the board for action or ratification and the Audit Committee for review.

4. Meetings of the Integrated Care Board

4.1. Calling Board Meetings

4.1.1 Meetings of the board of the ICB shall be held at regular intervals at such times and places as the ICB may determine.

4.1.2 In normal circumstances, each member of the Board will be given not less than one month's notice in writing of any meeting to be held. However:

a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.

b) One third of the members of the Board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the board specifying the matters to be considered at the meeting.

c) In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

4.1.3 A public notice of the time and place of meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4 The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

4.2 Chair of a meeting

4.2.1 The Chair of the ICB shall preside over meetings of the board.

4.2.2 If the Chair is absent, or is disqualified from participating by a conflict of interest, the Deputy Chair, if present, shall preside.

4.2.3 If both the Chair and Deputy Chair are absent, or are disqualified from participating, then a member of the Board shall be chosen by the members present, or by a majority of them, and shall preside.

4.2.4 The board shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3 Agenda, supporting papers and business to be transacted

4.3.1 The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.

4.3.2 Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the board at least five calendar days before the meeting.

4.3.3 Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website at www.suffolkandnortheastessex.icb.nhs.uk

4.4 Petitions

4.4.1 Where a valid petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the board in accordance with the ICB policy as published in the Governance Handbook.

4.5 Nominated Deputies

4.5.1 With the permission of the person presiding over the meeting, the Executive Directors and the Partner Members of the board may nominate a deputy to attend a meeting of the board that they are unable to attend. The deputy may speak and vote on their behalf if authorised to do so in advance.

4.5.2 The decision of person presiding over the meeting regarding authorisation of nominated deputies is final.

4.5.3 If a member of the ICB is unable to attend two consecutive meetings, other than as the result of illness or other exceptional circumstance, the member will be asked to meet with the Chair

4.6 Virtual attendance at meetings

4.6.1 The board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means when necessary, unless the terms of reference prohibit this.

4.7 Quorum

4.7.1 The quorum for meetings of the board will be 50% of its members, including:

a) The Chair or nominated deputy
b) Either the Chief Executive or the Director of Finance
c) Either the Medical Director or the Director of Nursing
d) At least one further Non-executive Member
e) At least two Partner Members

4.7.2 For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.

b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

4.7.3 For all committees and sub-committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.

4.8 Vacancies and Defects in Appointment

4.8.1 The validity of any act of the ICB is not affected by any vacancy among members or by any defect in the appointment of any member.

4.8.2 In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:

a) Vacant roles will not be included in the total number.

4.9 Decision making

4.9.1 The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.9.2 Generally, it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

a) All members of the board who are present at the meeting will be eligible to cast one vote each.

b) Under no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.

c) For the sake of clarity, any additional participants and observers (as detailed within Section 2.1 of the Constitution) will not have voting rights.

d) A resolution will be passed if more votes are cast for the resolution than against it.

e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.

f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

4.9.3 Where helpful the board may draw on third party support to assist them in resolving any disputes, such as peer review or support from NHS England.

Urgent decisions

4.9.4 In the case urgent decisions and extraordinary circumstances, every attempt will be made for the board to meet virtually. Where this is not possible the following will apply:

4.9.5 The powers which are reserved or delegated to the board, may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees) subject to every effort having made to consult with as many members as possible in the given circumstances.

4.9.6 The exercise of such powers shall be reported to the next formal meeting of the Board for formal ratification and the Audit Committee for oversight.

4.10 Minutes

4.10.1 The names and roles of all members present shall be recorded in the minutes of the meetings.

4.10.2 The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.

4.10.3 No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4 Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11 Admission of public and the press

4.11.1 In accordance with Public Bodies (Admission to Meetings) Act 1960, all meetings of the board and all meetings of committees which are comprised of entirely board members or all board members, at which public functions are exercised will be open to the public.

4.11.2 The board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3 The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board business shall be conducted without interruption and disruption.

4.11.4 As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time), the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

4.11.5 Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the board.

5 Suspension of Standing Orders

5.1 In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least two other members,

5.2 A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.

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ICB BOARD

Agenda Item No.	**17**
Reference No.	**ICB 23-56a**
Date.	**25 July 2023**

Title	**Remuneration and HR Committee and Quality Committee Revised Terms of Reference.**
Lead Director	Amanda Lyes, ICB Director of People and Workforce
Author(s)	Colin Boakes, Governance Advisor
Purpose	To approve revised terms of reference for the Remuneration and HR Committee and Quality Committee – changes in respect of delegated responsibility from the Board for approval of relevant policies.

Recommendation:

Further to recommendations by the Board at its meeting in May 2023, the Board is now requested to approve the attached terms of reference for the Remuneration and HR Committee and Quality Committee which have been revised to allow for approval of relevant policies at those committees. The amendments are highlighted in red for ease of reference.

The changes to the terms of reference were agreed by Remuneration and HR Committee on 6 June 2023 and Quality Committee on 13 July 2023.

NHS
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Integrated Care Board

Remuneration and Human Resources Committee Terms of Reference

NHS Suffolk and North-East Essex Integrated Care Board

1. Purpose

1.1 The Remuneration Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution. The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary, to confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including board members) and non-executive directors.

1.2 These terms of reference, which are published on the ICB website as an appendix to its Constitution, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Authority

The Remuneration Committee is authorised by the Board to:

2.1 Investigate any activity within its terms of reference

2.2 Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference.

2.3 Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice.

2.4 Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's Constitution, standing orders and SoRD but may /not delegate any decisions to such groups.

2.5 For the avoidance of doubt, in the event of any conflict, the ICB's Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference.

3. Remit and Responsibilities of the Committee

For the Chief Executive, Directors and other Very Senior Managers:

3.1 Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars

3.2 Determine arrangements for termination of employment and other contractual terms and non-contractual terms.

For all staff:

3.3 Determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change)

3.4 Oversee contractual arrangements.

3.5 Determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.

3.6 The Committee shall review as required, the Chief Executive's performance.

3.7 The Committee shall establish arrangements for monitoring and evaluating the performance of individual senior officers and managers, as approved by the ICB Board.

3.8 The Committee shall advise on and oversee contractual arrangements for staff by developing policies ~~for recommendation to the Board~~, to ensure an equitable and consistent approach.

3.9 The Committee shall receive and approve HR, Organisational Development and Learning and Development policies and procedures.

3.10 The Committee shall receive and approve reports and have oversight of the work of the Health and Safety Committee.

3.11 The Committee shall receive the minutes of any sub-groups that may be formed and receive and approve reports on Organisational Development and Learning and Development.

3.12 By reference to the Board Assurance Framework, the Committee shall monitor allocated risks and satisfy itself and assure the Audit Committee that the mitigating actions proposed for each allocated risk are reasonable and that each mitigating action is being undertaken.

3.13 In making its recommendations the Committee will take into account:

- Provisions of any national guidance and arrangements
- Relevant legislation (in particular anti-discrimination and equal pay legislation)
- Best practice and affordability
- Employee relations and relevant staffing matters within the Integrated Care Board
- Remuneration levels elsewhere within the NHS and other relevant labour markets
- Trends and development in non-pay benefits and terms and conditions
- Organisational performance
- Auditor requirements
- Existing terms and conditions of service
- Statutory health and safety legislation and best practice

3.14 The Committee will retain the right to place specific reports, on an exception basis and with the agreement of the Chair, in a closed agenda whereby the content of the report and subsequent discussion, will not be accessed under the Freedom of Information Act 2000. Reports placed in a closed agenda will be returned to the Board Secretary or nominated deputy at the meeting for shredding. Committee members will be responsible for deleting the relevant electronic records from their own computer systems.

4. Relationship with the ICB Board

4.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

4.2 The Chair of the Committee in consultation with colleagues on the Committee and senior officers of the ICB will make decisions that are required urgently.

4.3 The Committee has delegated powers from the ICB Board for the approval of all Human Resources policies and procedures and issues that may impact on the terms and conditions of employment for all staff, for instance lease cars and travel policies.

4.4 The Committee shall ensure that all such policies are reviewed and updated as necessary and that a repository of these is maintained on the ICB intranet.

4.5 The Committee has delegated powers from the ICB Board for all matters of health and safety.

4.6 Formal minutes shall be kept of the proceedings which will be submitted to the ICB Board.

4.7 The Committee will submit copies of its minutes and a report to the Board following each of its meetings. Where minutes and reports identify individuals, they will not be made public and will be presented at a meeting of the Board in private session. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.

4.8 The Chair of the Committee shall draw to the attention of the ICB Board any issues that require disclosure in a specific report to the full Board or require executive action.

4.9 The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

5. Membership of the Committee

5.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

5.2 The Board will appoint no fewer than three members of the Committee including two independent members of the Board. Other members of the Committee need not be members of the board, but they may be.

5.3 The Chair of the Audit Committee may not be a member of the Remuneration Committee.

5.4 The Chair of the Board may be a member of the Committee but may not be appointed as the Chair.

5.5 When determining the membership of the Committee, active consideration will be made to diversity and equality.

Chair and Vice Chair

5.6 In accordance with the constitution, the Committee will be chaired by an independent non-executive member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

5.7 Committee members may appoint a Vice Chair from amongst the members.

5.8 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting.

5.9 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

Attendees

5.10 Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

5.11 Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:

- The ICB's most senior HR Advisor or their nominated deputy
- Director of Finance or their nominated deputy
- Finance Department Observer
- Chief Executive or their nominated deputy

5.12 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

5.13 No individual should be present during any discussion relating to:

- Any aspect of their own pay
- Any aspect of the pay of others when it has an impact on them.

6. Secretary and Administration

The Committee shall be supported with a secretariat function which will ensure that:

6.1 The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.

6.2 Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.

6.3 Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.

6.4 The Chair is supported to prepare and deliver reports to the Board.

6.5 The Committee is updated on pertinent issues/ areas of interest/ policy developments.

6.6 Action points are taken forward between meetings.

7. Meeting Quoracy and Decisions

7.1 The Committee will meet in private.

7.2 The Committee will meet at least twice each year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

7.3 The Board, Chair or Chief Executive may ask the Remuneration Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

7.4 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Quorum

7.5 For a meeting to be quorate a minimum of two of the non-executive members is required, including the Chair or Vice Chair.

7.6 If any member of the Committee has been disqualified from participating on item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

7.7 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision Making and Voting

7.8 Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

7.9 Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

7.10 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

7.11 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

8. Conduct of the Committee

Benchmarking and Guidance

8.1 The Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

ICB Values

8.2 Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

8.3 Members of, and those attending, the Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality, Diversity and Inclusion

8.4 Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

9. Review

9.1 The Committee will review on an annual basis its own performance and effectiveness including membership and terms of reference. The ICB Board will approve any resulting changes to the terms of reference or membership.

Initial Approval:	1st July 2022
Last Review and Approval:	June 2023
Next Review:	July 2024

NHS
Suffolk and
North East Essex
Integrated Care Board

Quality Committee Terms of Reference

NHS Suffolk and North-East Essex Integrated Care Board

1. Purpose

1.1 The Quality Committee is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution. The Committee's main purpose is to provide the ICB with assurance that is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2021. This includes reducing inequalities in the quality of care.

1.2 The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care.

1.3 The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

2. Authority

2.1 The Quality Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

2.2 The Quality Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

3. Remit and Responsibilities

The Quality Committee will:

3.1 Be assured that there are robust processes in place for the effective management of quality.

3.2 Scrutinise structures in place to support quality planning, control and improvement, to be assured that the structures operate effectively, and timely action is taken to address areas of concern.

3.3 Agree and put forward the key quality priorities that are included within the ICB strategy/annual plan, including priorities to address variation/inequalities in care.

3.4 Oversee and monitor delivery of the ICB key statutory requirements.

3.5 Review and monitor those risks on the BAF and Quality Risk Register which relate to quality, and high-risk operational risks which could impact on care. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner.

3.6 Oversee and scrutinise the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSEI and other regulatory bodies / external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained.

3.7 Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites.

3.8 Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes.

3.9 Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place, this includes reviewing patient experience data.

3.10 Receive assurance that the ICB identifies lessons learned from all relevant sources, including incidents, never events, complaints and claims and ensures that learning is disseminated and embedded.

3.11 Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and PFD reports).

3.12 To be assured that people and communities are systematically and effectively involved as equal partners in quality activities.

3.13 Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children.

3.14 Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control.

3.15 Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity working in partnership with people and communities.

3.16 Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety.

3.17 Have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Quality Committee (e.g. Alliance Quality Groups, Alliance Engagement forums, Infection Prevention and Control, Safeguarding Boards / Hubs, people and communities committee of the ICB etc.).

3.18 Review and approve all relevant quality and clinical policies.

3.19 Ensure that all such policies are reviewed and updated as necessary and that a repository of these is maintained on the ICB intranet.

4. Relationship with the ICB Board

4.1 The Quality Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

4.2 The Quality Committee has delegated powers from the ICB Board as delegated in these Terms of Reference as determined by the ICB Board.

4.3 Formal minutes shall be kept of the proceedings which will be submitted to the ICB Board.

5. Membership

5.1 The Quality Committee members shall be appointed by the Board in accordance with the ICB Constitution.

5.2 Partners will ensure that the membership of the Quality Committee is diverse.
~~When determining the membership of the Quality Committee, active consideration will be made to diversity and equality.~~

5.3 The membership compromises of:

- Non-Executive Member (Chair)

- ICB Director of Nursing
- ICB Medical Director
- Local Authority Directors
- Alliance representatives
- Provider representatives
- Healthwatch Suffolk and Healthwatch Essex
- At least two lay members with lived experience (People and Communities Group and Patient Safety Partner)
- Other representatives where required

Chair and Vice Chair

5.4 The Quality Committee will be chaired by a Non-Executive Member

5.5 The Quality Committee members may appoint a Vice Chair from amongst the members.

5.6 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

5.7 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

Attendees

5.8 Only members of the Quality Committee have the right to attend Quality Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Quality Committee.

5.9 When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

5.10 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

6. Secretary and Administration

The Quality Committee shall be supported with a secretariat function which will ensure that:

6.1 The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.

6.2 Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.

6.3 Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.

6.4 The Chair is supported to prepare and deliver reports to the Board

6.5 The Quality Committee is updated on pertinent issues/ areas of interest/ policy developments.

6.6 Action points are taken forward between meetings.

7. Meeting Quoracy and Decision

7.1 For a meeting to be quorate there will be a minimum attendance of two Board Members comprising either the Non-Executive Member, Director of Nursing or Medical Director, together with one provider representative, one Local Authority representative and at least one other representative.

7.2 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

7.3 Where members are unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf.

Decision Making, Voting and Frequency

7.4 Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

7.5 Decisions will be taken in according with the Standing Orders. The Quality Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

7.6 Only members of the Quality Committee may vote. Each member is allowed one vote and a simple majority will be conclusive on any matter.

7.7 Where there is a split vote, with no clear majority, the Chair of the Quality Committee will hold the casting vote.

7.8 The exception to this will be Healthwatch Suffolk and Healthwatch Essex. The impartiality and independence of Healthwatch organisations is critical to their role. Therefore, it has been agreed mutually that they will not have voting membership on the group. They will be fully involved and collaborate within the partnership, but without voting rights.

7.9 The Quality Committee will convene bi-monthly, rotating via each of the ICB Alliance main offices.

8. Conduct of the Quality Committee

Benchmarking and Guidance

8.1 The Quality Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

ICB Values

8.2 Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

8.3 Members of, and those attending, the Quality Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality, Diversity and Inclusion

8.4 Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

Declarations of Interest

8.5 All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

9. Review

9.1 The Quality Committee will review on an annual basis its own performance and effectiveness including membership and terms of reference. The ICB Board will approve any resulting changes to the terms of reference or membership.

Initial Approval:	01 July 2022
Last Review and Approval:	June 2023
Next Review:	July 2024

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ICB BOARD

Agenda Item No.	**18**
Reference No.	**ICB 23-57b**
Date.	**25 July 2023**

Title	**Finance Committee Revised Terms of Reference**
Lead Director	Howard Martin – ICB Director of Finance
Author(s)	Howard Martin – ICB Director of Finance
Purpose	Review amended Terms of Reference post conclusion of the 2023/24 planning round. It was agreed by system partners that the Finance Committee would have an enhanced role in making recommendations to the ICB where system partners had adverse movements to financial plans, and/or did not improve underlying financial positions.

Recommendation:

The Board is asked to:

Approve the amended Finance Committee Terms of Reference post conclusion of the 2023/24 planning round.

It was agreed by system partners that the Finance Committee would have an enhanced role in making recommendations to the ICB where system partners had adverse movements to financial plans, and/or did not improve underlying financial positions.

These Terms of Reference were approved at the Part 1A (System) Finance Committee on the 13 June 2023.

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Financial Performance Committee Terms of Reference

NHS Suffolk and North-East Essex Integrated Care Board

(DRAFT VERSION FOR CONSIDERATION JULY, 2023)

1 Purpose

The Financial Performance Committee is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

Its main purpose is to contribute to the overall delivery of the ICS objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan. This includes:

- Financial performance of NHS organisations within the formal ICS footprint (system control total) (part 1a)
- Financial management of the Integrated Care Board (part 1b)

2 Authority

The Financial Performance Committee is authorised by the Board to:

Investigate any activity within its terms of reference

Scrutiny of progress of improvements in recurrent underlying financial positions for all formal NHS ICS partners. The Committee can recommend to the ICB Board the triggering of remedial actions in the event that forecasts deviate from plan or no progress is made in improving the current year and recurrent underlying position. Authority for triggering that action will be via the ICB Board based on that recommendation.

Commented [HM1]: Recommendation 1: change in authority

Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference

Invite any partner Finance Committee Chair to join a meeting.

Commission any reports it deems necessary to help fulfil its obligations

Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice

Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, Standing Orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups.

Authorise expenditure on behalf of the ICB Board up to the value set out in the scheme of delegation.

3 Remit and Responsibilities

The Committee will have a part 1a meeting which considers system financial issues, and separate part 1b meeting which considers issues specific to the internal management of the ICB. The committee's duties are as follows:

Part 1a

System financial management framework

To set strategic financial framework for ICB and ICS partners where appropriate

To develop the system financial planning processes to be used to make recommendations to the Board on the system financial plan in line with the strategy and national guidance.

To gain a better understanding of whole system finances and interdependencies between, for example, health and social care.

Commented [HM2]: Amendment 2

to assure the development of a medium- and long-term financial plan which demonstrates ongoing value and sustainability

Commented [HM3]: Amendment 3: moved up from 'financial monitoring information'

Scrutiny of progress of improvements in recurrent underlying financial positions for all formal NHS ICS partners. The Committee can recommend to the ICB Board the triggering of remedial actions in the event that forecasts deviate from plan or no progress is made in improving the recurrent underlying position. Authority for triggering that action will be via the ICB Board based on that recommendation.

To ensure health and social inequalities are taken into account in financial decision-making

Resource allocation (revenue)

to develop an approach to distribute resource allocations through commissioning and direct allocation to drive agreed change based on the ICS strategy

to advise on the process regarding the deployment and monitoring the impact of system wide transformation funding

to work with ICS partners to identify and allocate resources where appropriate to address finance and performance related issues that may arise

to work with ICS partners to consider major investment/disinvestment business cases for material service change or efficiency schemes and to agree a process for sign off.

National framework

to advise the ICB and ICS partners on any changes to NHS and non-NHS funding regimes and consider how the funding available to the ICS can be best used within the system to achieve the best outcomes for the local population

to oversee national system level financial returns

to ensure the required preparatory work is scheduled to meet national planning timelines

Financial monitoring information

to articulate the financial position and financial impacts (both short and long-term) to support decision-making

to work with ICS partners towards common approaches across the system such as financial reporting, estimates and judgements

to work with ICS partners, including their non-executive members, to seek assurance over the financial performance from system bodies

to oversee the development of financial, activity and workforce modelling to support the system wide priority areas

to ensure the system develops an understanding of where costs sit across a system, including its cost drivers and the impact of service changes

to ensure appropriate information is available to enable the system to manage financial issues, risks and opportunities across the ICS

to ensure visibility and reporting of system financial and associated risks as part of the overall review of system finances

Financial Performance

to oversee the management of the system financial target

to agree key outcomes to assess delivery of the system wide financial strategy

to monitor and report to the ICB, and to the Integrated Care Partnership as required, the overall financial performance against national and local metrics, highlighting areas of concern

to monitor and report to the ICB key service performance which should be taken into account in assessing the financial position

System efficiencies

to ensure system efficiencies are identified and monitored across ICS partners, in particular opportunities at system level where the scale of the ICS partners together and the ability to work across organisations can be leveraged

to ensure financial resources are used in an efficient way to deliver the objectives of the ICS

to review exception reports on any material breaches of the delivery of agreed efficiency plan including the adequacy of proposed remedial action plans

Communication

to co-ordinate and manage communications on financial governance with stakeholders internally and externally

to develop an approach with partners, including the Integrated Care Partnership, to ensure the relationships between cost, performance, quality and environmental sustainability are understood

People

to ensure an ICS wide finance staff development strategy is in place to ensure excellence by attracting and retaining the best finance talent

Capital

to seek assurance that the system capital strategy and associated plan properly balances clinical, strategic and affordability drivers

to ensure effective oversight of future prioritisation and capital funding bids

to monitor the system capital programme against the capital envelope and take action to ensure that it is appropriately and completely used

to gain assurance that short, medium and long term commitments are built into the overall system capital plan

Part 1b – Internal ICB finances

to ensure development of a reporting framework for the ICB (using the chart of accounts devised by NHS England and the integrated single financial environment (ISFE))

to oversee the management of the ICB's own financial targets.

to oversee the development of the ICB financial strategy and agree key outcomes to assess delivery

to ensure that suitable financial policies and procedures are in place for the ICB to comply with relevant regulatory, legal and code of conduct requirements

to approve expenditure within the committee's delegated limit, as listed in the Scheme of Reservation and Delegation.

4 Accountability and Reporting

The Financial Performance Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

Formal minutes shall be recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

The Chair will draw to the attention of the Board any issues that require disclosure to the Board or require the Board to take action.

The Committee will provide an annual report to the Board to describe how it has fulfilled its terms of reference and give details on progress and a summary of key achievements in the delivery of its responsibilities.

5 Membership

The Financial Performance Committee members shall be appointed by the Board in accordance with the ICB Constitution.

When determining the membership of the Financial Performance Committee active consideration will be made to diversity and equality. Members of the committee may be co-opted to ensure diversity of thinking in decision making.

The board will appoint no fewer than four members of the Committee including one who is an Independent Non-Executive Member of the Board. Other members of the committee need not be members of the board but may be.

Members should possess between them knowledge, skills, and experience in:

- Accounting
- Risk management
- And technical or specialist issues pertinent to the business of the committee

Core membership for Part 1a and Part1b includes:

Part 1a – System Financial Management Framework

- Independent Chair - The chair will be selected to ensure that the Audit Committee and the Finance Committee are chaired by different members
- Non-Executive Member (ICB Appointed)
- Up to 2 Non-Executive Directors (Nominated by Provider Partners)
- Primary Care ICB Board representative
- Suffolk and North-East Essex ICB Director of Finance
- Suffolk and North-East Essex ICB Director of Performance Improvement
- ESNEFT Director of Finance
- WSFT Director of Finance
- EEAST Director of Finance
- NSFT Director of Finance (non-voting member)*
- EPUT Director of Finance (non-voting member)*
- Section 151 Officer, Suffolk County Council (non-voting member)
- Section 151 Officer, Essex County Council (non-voting member)
- Suffolk and North-East Essex ICB Director of Operational Finance (non-voting member unless deputising for the Director of Finance)

* Mental health representation and logistics to be agreed at the start of each meeting.

Part 1b – Internal ICB Finances

- Independent Chair - The chair will be selected to ensure that the Audit Committee and the Finance Committee are chaired by different members
- Non-Executive Member (ICB Finance and Audit)
- Primary Care ICB Board representative
- Suffolk and North-East Essex ICB Director of Finance
- Suffolk and North-East Essex ICB Director of Performance Improvement
- Suffolk and North-East Essex ICB Deputy Director of Finance (non-voting member unless deputising for the Director of Finance)

Commented [HM4]: Amendment 4: increasing the number of provider NEDs to 2

- ICB Alliance Directors

Other Directors of the ICB will be expected to attend part 1b when required to report on significant expenditure areas within the ICB.

Other appropriate representatives from system partners may be invited or may request to attend in agreement with the chair.

Members are expected to attend at least 75% of meetings held each year to ensure consistency.

Where a member is unable to attend, efforts should be made to ensure that a suitable representative attends, as nominated by the member and agreed by the Chair.

Chair and Vice Chair

In accordance with the constitution, the Committee will be chaired by an Independent Non-Executive Member of the Board appointed on account of their specific knowledge, skills and experience making them suitable to chair the Committee.

The Financial Performance Committee members may appoint a Vice Chair from amongst the members.

In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

Attendees

Only members of the Financial Performance Committee have the right to attend meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the committee. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with discussions on any particular matter.

The Chair may ask any or all of those who normally attend, but are not members, to withdraw to facilitate open and frank discussion on particular matters.

The Chair and the Chief Executive of the ICB may also be invited to attend one meeting a year in order to gain an understanding of the committee's operations.

6 Frequency, Secretary and Administration

The Financial Performance Committee shall meet monthly.

Commented [HM5]: Amendment 5: Change frequency to monthly.

The Financial Performance Committee shall be supported with a secretariat function, which will ensure that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead

- Records of members' appointments and renewal dates and the Committee is prompted to renew membership and identify new members where necessary
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
- The Chair is supported to prepare and deliver reports to the Board
- The Financial Performance Committee is updated on pertinent issues/ areas of interest/ policy developments
- Action points are taken forward between meetings and progress against those is monitored
- Attendance of those invited to each meeting is monitored and the Chair is made aware as soon as possible of those meetings that do not meet the minimum quoracy requirements

7 Meetings, Quoracy and Decision

The Committee will ordinarily be held in person or via video conference. However, meetings may be conducted on a 'virtual' basis through the use of email or teleconference communication if necessary.

The Committee may meet 'in common' with other Finance Committees where the Committee deems this appropriate. However, when meeting in common, the committee will have the ability to take its own decisions that might differ from those of the other committee(s) and regardless of any arrangements permitting decisions to be made following discussions by the committees in common, each Committee retains individual accountability for any decisions taken on behalf of organisation: a consensus decision will only be binding if each individual committee consents to that decision.

For a meeting to be quorate a minimum of 50% of the voting members is required, including the Chair or Vice Chair and the ICB Director of Finance (or nominated deputy). Given the differing membership of part a and part b, the members required to reach a quorum for part a and part b may be different.

If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum for that item.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision Making and Voting

Decisions will be taken in according with the Standing Orders. The Financial Performance Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Financial Performance Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Financial Performance Committee will hold the casting vote.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other

electronic communication. Where such action has been taken between meetings, then these will be reported to the next meeting.

8 Conduct of the Financial Performance Committee

Benchmarking and Guidance

The Financial Performance Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

Conflict of Interest

In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to the NHS guidance on managing conflicts of interest.

All conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Chair and submitted to the Board. If a conflict of interest arises, the Chair may require the affected member to withdraw at the relevant point, refrain from voting in any votes on the particular matter, or taking part in discussions at the point, depending on the Chair's view of the best way to manage this conflict of interest.

ICB Values

Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

Members must agree that this overrides all individual or organisational self-interest. Members will be expected to abide by the duty to collaborate and the principles set out by the ICS.

Members of, and those attending, the Financial Performance Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality, Diversity and Inclusion

Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make. They should also consider whether any new resource allocation achieves positive change around inclusion, equality and diversity.

9 Review

The Financial Performance Committee will review on an annual basis its own performance and effectiveness including membership and terms of reference. The ICB Board will approve any resulting changes to the terms of reference or membership.

Initial Approval:	1 July 2022 (ICB Board)

Last Review and Approval:	25 July 2023
Next Review:	July 2024

NHS
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North East Essex
Integrated Care Board

ICB BOARD

Agenda Item No.	**19**
Reference No.	**ICB 23-58**
Date.	**25 July 2023**

Title	**Health Inequalities and Prevention Committee Terms of Reference**
Lead Director	Laura Taylor-Green, North-East Essex Alliance Director
Author(s)	Laura Taylor-Green, North-East Essex Alliance Director Stuart Keeble, Director of Public Health, Suffolk County Council
Purpose	Approval

Recommendation:

- To review and approve the Health Inequalities and Prevention Committee Terms of Reference
- For the Board to approve delegation of decision-making associated with the allocated health inequalities funding to the Health Inequalities and Prevention Committee.

1. Background

- The Health Inequalities and Prevention Committee (HIPC) is a sub-committee of the Suffolk and North- East Essex Integrated Care Board (SNEE ICB). The terms of reference have been developed following the agreement by the SNEE ICB to support the establishment of the HIPC in January 2023.

2. Key Issues

- The HIPC terms of reference have been developed through contribution of various members of the ICB including the executive team and the HIPC committee membership.

- These terms of reference are recognised as being iterative due to the nature of this being a new committee with these terms of reference coming back to this committee for review next year.

- The SNEE ICB has given delegation to the HIPC to be the decision-making committee for the health inequalities funding.

3. Patient and Public Engagement

- Patient and public engagement will be facilitated through established forums and mechanisms.

- The HIPC committee and ICP sub-committee will work with local communities to coproduce plans, projects and approaches whenever possible as described previously in the paper to this Board in January and will further be worked through at committee meeting and via the operational sub-group.

4. Recommendation

- To approve the terms of reference of the HIPC

Suffolk and North East Essex Integrated Care Board

NHS Suffolk and North East Essex Integrated Care Board

Health Inequalities and Prevention Committee

Terms of Reference

1. Overview

1.1 Health inequalities are unfair and preventable differences in health and wellbeing across the population, and between different groups within society that are influenced by a variety of factors. These inequalities are evident for some populations and communities living in Suffolk and North East Essex (SNEE) and addressing health inequalities is a key priority for the SNEE Integrated Care System (ICS).

1.2 Across our geography, different causes contribute to the difference in life expectancy between our most deprived and least deprived communities. Leading causes of preventable death include circulatory conditions, cancer, respiratory conditions. There are also higher rates of suicide specifically in North East Essex.

1.3 Health inequalities can manifest themselves as differences in access, experience and outcomes amongst these different geographical communities and communities of interest.

1.4 Several underlying risk factors are implicated in the causation of specific conditions or diseases for example tobacco, high blood pressure, obesity, diabetes, physical inactivity, excess alcohol use and high low-density lipoproteins (bad cholesterol). Suicide is a complex issue associated with multiple risk factors. Focused action to address the risk factors associated with these preventable issues will reduce health inequalities. A population health approach focused on prevention, targeting areas where we have the strongest evidence for inequalities is therefore important

1.5 A population health approach aims to improve physical and mental health outcomes across the population, while reducing health inequalities. This approach considers these wider influencing factors that drive health inequalities whilst recognising the need to work with communities and across partner agencies taking a 'whole system approach' and an understanding that addressing health inequalities is 'everyone's business' and should be incorporated in the decision making of every Board and Committee of the ICB.

1.6 The Health Inequalities and Prevention Committee will therefore be guided by seven key principles:

1. Reducing health inequalities by levelling up is core business for everyone
2. Matching resources to identified need
3. Being data, intelligence and insight informed
4. Working through community centered, co-produced approaches
5. Targeting focused efforts addressing Core20 Plus 5 and associated influences
6. Maximising our collective community assets
7. Ensuring all commissioned services and communication are inclusive

2 Purpose

2.1 The overarching purpose of the Health Inequalities and Prevention Committee (HIPC) is to influence, coordinate and monitor action across the ICB that will reduce health

inequalities in access, experience, and outcomes amongst SNEE population with a particular focus on the proximal influences of these.

2.2 The HIPC will also advocate for, and promote action, across the ICB on the prevention agenda- 'prevention first' approach.

2.3 The HIPC is established by the ICB as a formal Committee of the Board as part of its overall governance processes.

2.4 Effective action to address health inequalities requires a whole- system approach, with targeted prevention work focusing on Core20PLUS5, and using data, insight, and Population Health Management (PHM) as an enabler. To facilitate this, the HIPC exists to:

a) Establish a shared understanding of what is meant by health inequalities, with a particular focus on differences in access, experience and outcomes and the proximal drivers of these across key stakeholders and our population and communicate this effectively.

b) Understand the lived experience of local people and communities, using this insight to champion, evidence and advocate for addressing health inequalities. This will be through the various mechanisms and approaches existing within the ICB to engage with our communities so to ensure that we reflect the needs of our communities so to ensure we are inclusive and have diverse views.

c) Identify areas of focus/priority that use insight, intelligence and quantitative evidence and agree these with key stakeholders and communities ensuring that these are communicated and considered by other boards and committees of the ICB and the ICP.

d) Develop evidence-based plans based on the areas of focus/priority that aim at reducing health inequalities by focusing on prevention, utilising community assets and building community resilience.

e) Make recommendations to inform wider health inequalities strategy development, priority setting and resource allocation,

f) Work with the ICP Equality and Prevention Sub-Committee (EPSC) to ensure co-ordination, maximising use of resource and reducing duplication of work

g) Work with the Population Health Management Strategic Group and Operational Delivery Group, both of which will report to the HIPC.

h) To ensure that ICB work on health inequalities and prevention is captured and provided to NHS England as required.

3. Remit and Responsibilities

3.1 The HIPC will:

a) Provide a focal point and strategic leadership on health inequalities with a particular focus on difference in access, experience and outcomes and embedding prevention across the ICB.

b) Take a lead responsibility for the development and oversight of delivery of the Core20PLUS5 for adults and children and young people.

c) Influence ICB resources and priorities (including those of other Boards and Committees of the ICB) to ensure a focus on reducing health inequalities and prevention

d) Have delegated responsibility for the distribution of and oversight of the health inequalities funding to support the inequalities agenda.

e) Use data-led approaches driven by PHM to inform and drive collective action on health inequalities and to evaluate the impact on outcomes through its subgroup structure.

f) Support more systematic approaches to health inequalities and prevention across the ICB. This could include embedding a 'Health Inequalities in all Policies' approach.

g) Support the ICB in understanding the broad dimensions of health inequalities between population groups i.e., socio-economic groups and deprivation, protected characteristics in the Equality Duty, geography, and vulnerable groups across the ICB.

4. Provide guidance to ICB long-term condition committees work programmes to ensure actions include a focus on prevention and reduce health inequalities.

5. Authority

4.1 The HIPC is a formal committee of the ICB.

4.2 The HIPC holds only those powers as delegated in these Terms of Reference and determined and agreed by the ICB Board.

5. Relationship with the ICB Board

5.1 The HIPC is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

5.2 The HIPC may have delegated powers from the ICB Board as determined by the Board.

5.3 Formal minutes, together with an action and decisions log, shall be kept of the proceedings.

6. Membership

6.1. Membership of the HIPC includes:

a) ICB Chief Executive
b) ICB Director of Strategy & Transformation/Deputy Chief Executive
c) ICB Medical Director
d) ICB Director of Nursing
e) ICB Non-Executive Member
f) ICP Director
g) SNEE Alliance Directors

h) Suffolk County Council – Director of Public Health
i) Suffolk County Council – Adult & Children's Services Representatives(s)
j) Essex County Council – Director of Public Health
k) Essex County Council – Adult & Children's Services Representatives(s)
l) Healthwatch Suffolk Representative
m) Healthwatch Essex Representative
n) 2 VCFSE Representatives
o) Acute Sector Representatives
p) Community Sector Representative
q) Acute Mental Health Trust Representatives
r) 2 Primary Care Representatives
s) SNEE PHM Lead
t) Office of Health Inequalities and Disparities Representative (regional level)

7. Chair

7.1 The HIPC will be chaired by the Director of Public Health for Suffolk.

7.2 In the absence of the Chair, the nominated vice-chair will chair the meeting.

7.3 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

8. Attendees

8.1 Only designated members have the right to attend meetings of the HIPC, but relevant subject matter leads will be invited to attend to present papers for discussion and be in attendance for that agenda item only.

8.2 In the absence of a named member, a deputy of their choosing may be nominated to represent them at the meeting.

8. Administration

8.1 The HIPC shall be supported by the ICB, to ensure that:

a) Meetings are timetabled and agreed in advance
b) The agenda and papers are prepared and distributed, three days in advance of each meeting having been agreed by the Chair
c) Minutes are taken and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept
d) A record of attendance is kept
e) Members are updated on pertinent issues/ areas of interest/ policy developments
f) Action points are taken forward between meetings
g) A forward plan of agenda items is in place

9. Quorum

9.1. For a meeting to be quorate there will be a minimum of 8 Members:

a) 2 ICB Directors
b) 1 Suffolk County Council Representative

c) 1 Essex County Council Representative
d) 1 Alliance Directors
e) 1 VCFSE Representative
f) 1 Provider Sector (Acute, Community, Mental Health) Representative
g) 1 Primary Care Representative

9.2 If a quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

10. Decision Making and Meeting Frequency

10.1 Decisions will be guided by national NHS policy and best practice, whilst ensuring proper regard to wider influences such as national consistency.

10.2 The HIPC will ordinarily reach conclusions by consensus. Where there is no clear majority, the Chair will hold the casting vote.

10.3 The HIPC will convene every two months.

10.4 Meetings may be held virtually, in person or hybrid.

10.5 The submission of information to NHS England on work by this committee on behalf of the system shall be agreed by the Chair and named system SRO if the timing of meetings does not allow for this to be discussed within the HIPC prior to submission.

11. Conduct of the Committee

11.1 **ICB Values**

a) Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

b) Members, and those attending, shall behave in accordance with the ICB's Standards of Business Conduct Policy.

12. Equality, Diversity and Inclusion

12.1 Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make and in particular, the impact of health inequalities.

13. Declarations of Interest

13.1 All members, and those in attendance, must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

14. Patient and Public Engagement

14.1 Patient and public engagement will be facilitated through established forums and mechanisms including that of the ICP.

14.2 The HIPC will work with local communities to coproduce plans, projects and approaches whenever possible.

15. Review

15.1. These Terms of Reference will be reviewed on an annual basis.

Date Approved:	July 2023
Next Review:	July 2024

NHS
Suffolk and North East Essex
Integrated Care Board

ICB BOARD

Agenda Item No.	**20**
Reference No.	**ICB 23-59**
Date.	**25 July 2023**

Title	**Suffolk Mental Health Collaborative – Terms of Reference**
Lead Director	Richard Watson, Deputy Chief Executive and Director of Strategy and Transformation
Author(s)	Andy Vowles
Purpose	For decision

Recommendation:

The Board is asked to:

- Approve the Terms of Reference for the Suffolk Mental Health Collaborative Committee
- Note that the Audit Committee approved the draft Terms of Reference for the Suffolk Mental Health Collaborative Committee at its June meeting.

1. Background

1.1 In March 2023 the ICB Board approved a detailed paper[1] that proposed the establishment of the Suffolk Mental Health Collaborative. Since then, the Boards of WSFT, ESNEFT, NSFT and the Cabinet of Suffolk County Council have all approved similar papers.

1.2 The establishment of the Collaborative was the culmination of a detailed design process that involved partners from across the Suffolk system. The main driver for establishing the Collaborative is a shared commitment from all partners to fundamentally change the way that the Suffolk system plans, resources and delivers mental health services in order to improve outcomes for local people. Specifically, the aims are to:

- Create a single forum at which all relevant partners can take decisions on all aspects of mental health
- Develop and agree shared system-wide mental health priorities
- Develop a single, integrated Suffolk mental health delivery programme
- Increasingly align and consolidate resources

1.3 The Collaborative has at its centre a formal Committee. This Committee is the forum at which partners will take decisions on behalf of its constituent statutory bodies, including the ICB.

1.4 At its meeting in March, the ICB agreed to delegate responsibility for relevant ICB mental health budgets to the Collaborative from July 2023, subject to the final approval of the Committee's Terms of Reference.

1.5 The final draft Terms of Reference of the Collaborative Committee are attached at Annex 1.

1.6 This draft was considered and approved by the ICB Audit Committee at its meeting on 15 June 2023.

2. Key Issues

2.1 In order for the Collaborative to operate effectively and fulfil its objective of enabling partners to collectively take decisions about all aspects of mental health in a single place, it is vital that all relevant resources and decisions are delegated into the Collaborative.

2.2 In the case of the ICB, this is best achieved by establishing the Collaborative Committee as a formal Committee of the ICB.. This arrangement enables relevant ICB mental health budgets (set out at Annex 1 of the Terms of Reference) to be delegated to the Committee. This change was approved by the ICB Board in March 2023.

2.3 At this point, delegation of decision making and resources by other (non ICB) partners – such as the County Council - has been achieved through the seniority of its membership.

2.4 Once the Terms of Reference are approved by the ICB Board, full delegation of relevant ICB mental health resources and decisions will commence. The ICB's Scheme of Reservation and Delegation (SoRD) has been amended to reflect this change.

[1] https://suffolkandnortheastessex.icb.nhs.uk/wp-content/uploads/2023/03/23-03-21-ICB-P1-Agenda-Complete-Set.pdf

3. Patient and Public Engagement

3.1 The Collaborative has been developed with extensive contributions from existing patient, user and carer groups, including:

- Healthwatch Suffolk
- Suffolk Mind
- Suffolk User Forum
- Suffolk Family Carers

3.2 The ICB People and Communities team has also been strongly engaged in the development work, including considering how the proposed Collaborative might in future link into the ICB People and Communities Committee.

3.3 One of the key supporting groups for the Collaborative is the proposed Lived Experience Forum, which will have a vital role in ensuring that the views or service users and carers are core to the work of the Collaborative.

4. Recommendation

4.1 The Board is asked to:

- Approve the Terms of Reference for the Suffolk Mental Health Collaborative Committee
- Note that the Audit Committee approved the draft Terms of Reference for the Suffolk Mental Health Collaborative Committee at its June meeting

ANNEX 1

Suffolk Mental Health Collaborative Committee

Terms of Reference

FINAL DRAFT V1.6

July 2023

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2 Purpose

The Suffolk Mental Health Collaborative is the mechanism through which all relevant partners have agreed to come together to ensure there is a collective approach to the planning, resourcing and delivery of the full range of mental health services in Suffolk.

The Suffolk Mental Health Collaborative Committee (this Committee) sits at the heart of the Collaborative, and is supported by all relevant partners across Suffolk. Its purpose is to act as the principal decision making forum for the wider Collaborative.

The Collaborative Committee is established as a Committee of the Suffolk and North East Essex Integrated Care Board (SNEE ICB), to support and enable the delegation of the ICB's mental health commissioning functions and resources into the collaborative.

3 Authority

The Suffolk Mental Health Collaborative Committee is authorised by all partners to take decisions on all relevant aspects of mental health in Suffolk, including:

- Leading the delivery of the Suffolk Mental Health and Wellbeing Strategy (2019-2029) and its associated outcomes
- Overseeing the delivery of the NHSE Long Term Plan as it relates to mental health and the Suffolk mental health element of the SNEE Joint Forward Plan (JFP)
- Promoting co-production so that the voice of people who use services, as well as their families and carers, are able to fully contribute to service design and delivery
- Developing, agreeing and implementing new models of care and service delivery that align with the Suffolk Mental Health and Wellbeing Strategy
- Making best use of the collective financial resources available to the Suffolk system (the "Suffolk Mental Health Pound"), including ensuring that the system remains within agreed allocations / budgets
- Ensuring services are evidence based, appropriately targeted to need and are of the highest possible quality
- Ensuring that all partners contribute to narrowing health inequalities through the work led by and decisions taken by the Collaborative.

As a Committee of the ICB, the Mental Health Collaborative Committee has delegated responsibility for the ICB's mental health commissioning functions and for the budgets set out at Annex 1.

For the avoidance of doubt, the other statutory partners in the Collaborative have not at this point formally delegated their own duties or functions into this Committee. However, to ensure that the Collaborative Committee can operate effectively as a system decision making forum, membership of the Committee is at a sufficiently senior level that each member will, in general, be able to take decisions on behalf of the organisation(s) they represent.

The Mental Health Collaborative Committee may, where appropriate, delegate responsibility for the discharge of some functions to the West Suffolk and Ipswich and East Suffolk Alliances.

4 Remit and Responsibilities

The Suffolk Mental Health Collaborative Committee is responsible for:

- Delivering the Suffolk Mental Health and Emotional Wellbeing Strategy, 2019-2029 and the Suffolk mental health element of the SNEE Joint Forward Plan
- Ensuring there are arrangements in place to deliver appropriate mental health services to people of all ages, including children and young people, adults and older people
- Ensuring there are arrangements in place to provide a comprehensive range of mental health support and provision to the people of Suffolk, from prevention and building resilience through to more specialist secondary care
- Ensuring that the 7 Suffolk health inequalities commitments are fully embedded in and factored into the planning of every aspect of the Collaborative's work:
    - Reducing health inequalities by levelling up is core business for everybody
    - We will match resources to need
    - We are data informed and evidence based
    - We will do this work through community centred approaches and co-production
    - We target our efforts through a Core 20 Plus 5[2] and prevention frame
    - We use our position as community anchors to tackle the 'causes of the causes'
    - Our services and communication are digitally inclusive
- Agreeing annual priorities and financial proposals for mental health
- Taking decisions on how to deploy the available financial resources of all partners (the "Suffolk Pound") in order to deliver the best possible outcomes for local people
- Ensuring that the Committee is complemented by an appropriate range of supporting groups within the wider Collaborative (Annex 2)
- Overseeing delivery of the NHSE Long Term Plan (January 2019) as it relates to mental health
- Working collaboratively with the Ipswich and East Suffolk and West Suffolk Alliances to support local mental health service transformation
- Ensuring that the approach taken by all elements of the Collaborative is one of co-production with patients, carers, public, and key stakeholders
- Receiving programme delivery and supporting group updates as appropriate
- Establishing time-limited task and finish groups as required
- Receiving and approving programme plans, business cases and specifications/models of care as required

[2] Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement

- Reviewing risks to delivery and ensuring these are managed and escalated as appropriate

For the avoidance of doubt, the following service areas are not with the scope of the Collaborative Committee, as there are effective alternative partnership structures already in place:

- Specialist mental health provision which is led by the East of England mental health collaborative

- Learning disabilities and autism, including neurodevelopmental disorders (NDD)

5 Waveney

The Suffolk Mental Health Collaborative Committee has different roles and responsibilities to those outlined in Sections 3 and 4 in relation to Waveney, reflecting the fact that this part of the County of Suffolk falls within a neighbouring Integrated Care Board (Norfolk and Waveney).

For Children and Young People's mental health services, the Suffolk Mental Health Collaborative Committee has the authority, remit and responsibility (outlined in Sections 3 and 4 above) to take decisions within the County footprint. In order to enable Waveney to be included in this county-based approach, the following are required:

- A named representative of the Norfolk and Waveney ICB will be a member of the Suffolk Mental Health Collaborative Committee (this could be a shared role between the Great Yarmouth and Waveney Place and the Norfolk and Waveney ICB Executive).
- The named representative has delegated authority from the Norfolk and Waveney ICB to take decisions about NHS funded mental health services for Children and Young People in Waveney, to ensure that services are integrated and, as far as is possible and desirable, consistent across the county
- The named representative of Norfolk and Waveney ICB retains a right of veto over decisions specific to children and young people's mental health services in Waveney, and reserves the right to refer relevant decisions to the Norfolk and Waveney ICB for ratification if of a material or reputational nature. It is anticipated that this is only likely to be necessary in exceptional circumstances.

Decisions about NHS funded mental health services for adults and older people in Waveney that are the responsibility of Norfolk and Waveney ICB are not within the scope of the Suffolk Mental Health Collaborative. As the Norfolk and Waveney Adult Mental Health Collaborative develops, its attendance will likely include representatives from Suffolk County Council in order to promote and enable service integration.

These arrangements will be kept under review.

6 Relationship with the Integrated Care Boards

As a formal Committee of the Board, one of the principal lines of accountability for the Suffolk Mental Health Collaborative Committee is to the SNEE ICB:

1.1 The Collaborative Committee is accountable to the SNEE ICB for the NHS functions and resources delegated to it, and shall report to the Board on how it is discharging its responsibilities. The delivery of the Mental Health Investment Standard, and related

financial reports will also continue to be reported (but not accountable to) to the ICB Finance Committee

1.2 The Suffolk Mental Health Collaborative Committee has delegated powers from the SNEE ICB Board for the commissioning of mental health services in Suffolk in accordance with the SNEE ICB Scheme of Reservation and Delegation (SoRD) and per the budgets set out in Annex 1

- Formal minutes shall be kept of the meetings of the Suffolk Mental Health Committee which will be submitted to the SNEE ICB Board.

Similarly, the senior officer or officers representing Norfolk and Waveney ICB on the Suffolk Collaborative Committee is directly accountable to that ICB for decisions on Children and Young People's NHS funded mental health provision on Waveney.

7 Membership

The members of the Suffolk Mental Health Collaborative Committee shall be agreed by the relevant partners. Members must be of sufficient seniority to take decisions on behalf of their organisations (as set out in Section 3)

When determining the membership of the Suffolk Mental Health Collaborative Committee, active consideration will be given to diversity and equality.

The membership of the Group is as follows:

- Senior Responsible Officers (SROs) and Chair/Convenor:
  - Richard Watson, Deputy Chief Executive, SNEE ICB
- Suffolk and North East Essex ICB:
  - Quality and Safety Lead: Lisa Nobes/Andrew Kelso
  - Director of Finance: or nominated deputy: Howard Martin
  - Clinical Leads: Dr Roz Tandy & Dr Lulu Preston
- Norfolk and Waveney ICB:
  - Director of Mental Health Transformation: Jossy Pike
- Suffolk Alliances:
  - West Suffolk Alliance Director: Peter Wightman
  - Ipswich and East Suffolk Alliance Director: Maddie Baker-Woods
- Norfolk and Suffolk NHS Foundation Trust (NSFT)
  - Chief Executive: Stuart Richardson
  - Chief Operating Officer: Thandie Matambanadzo
  - Medical Director: Dr Alex Lewis
  - Director of Strategy and Partnerships: Kathryn Ellis
- Suffolk County Council:
  - Executive Director, People Services: Sue Cook
  - Corporate Director for Children and Young People: Allan Cadzow
  - Director of Adult and Community Services: Georgia Chimbani

- Director of Public Health: Stuart Keeble

- East Suffolk and North Essex Foundation Trust:
  - TBC
- West Suffolk Hospital NHS Foundation Trust
  - Chief Executive: Ewen Cameron
- Healthwatch Suffolk
  - Chief Executive Officer: Andy Yacoub
- Suffolk Mental Health & Emotional Wellbeing Focus Group
  - Jayne Stevens, Chief Executive, Suffolk User Forum
  - Jenna Keenan
- Primary Care Networks
  - Dr Ruth Bushaway
- Suffolk GP Federation
  - Chief Executive: David Pannell
- Voluntary, community and social enterprise:
  - Chief Executive Suffolk Mind: Jon Neal[3]
- NHS England:
  - Regional Head of Mental Health: Helen Hardy

[3] Jon Neal was nominated to be the representative of the VCFSE sector on the Committee by the Suffolk VCFSE Health and Wellbeing Network

Members are expected to attend to represent their organisations. In the unlikely event that they are not able to attend, a deputy must be nominated who has delegated authority to enable decisions to be agreed.

Programme team members and other partners will be invited to attend themed agendas to report key activities as required.

Chair and Vice Chair

Members have agreed that in its initial phase, the Collaborative will be chaired by the Deputy Chief Executive of the ICB, Richard Watson. Vice Chair(s) will be identified by the Committee at its first meeting.

Attendees

Only members of the Suffolk Mental Health Collaborative have the right to attend meetings, but the Chair/Convenor may invite relevant staff to join as necessary in accordance with the business of the Committee.

8 Secretary and Administration

The Suffolk Mental Health Collaborative Committee shall be supported with a secretariat function which will include ensuring that:

The agenda and papers are prepared and distributed have been agreed by the Chair with the support of the relevant lead. Papers will be issued no later than 4 working days before scheduled meetings.

Agenda items should take the form of electronic papers; those submitting agenda items are responsible for ensuring that the information provided is of sufficient granularity to enable a full discussion at meetings. Papers will be tabled only in exceptional circumstances.

The SNEE ICS Transformation Team will service the meeting.

Minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept

The Suffolk Mental Health Collaborative Committee is updated on pertinent issues/ areas of interest/ policy developments

- Papers can be shared with organisations with the caveat, that discretion be applied to sensitive or confidential items.

9 Meeting Quoracy and Decision making

Meetings will initially take place every 6 weeks. For a meeting to be quorate, a minimum of half the members must be present, and these must include the Deputy Chief Executive or the Director of Finance of the ICB (or nominated deputies), plus at least one clinical member.

As a Committee of the ICB Board, only the votes of ICB Officers are legally able to contribute towards the count. However, in the spirit of and in line with the principles of the Committee the votes of all members will be taken and recorded for the minutes, to ensure transparency and fair representation in the record.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision Making and Voting

The Suffolk Mental Health Collaborative Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

In the event of a dispute, the matter will be referred to an appropriate system forum (e.g. ICB Board or Health and Wellbeing Board) for resolution.

Decisions will be taken in according with each partner's Standing Orders.

If required, each member has one vote and a majority will in general be used to determine the decision of the Committee on any given matter, subject to the status of ICB members, set out above. An exception to this is for matters that relate purely to the population of Waveney, as set out in Section 5, above.

As outlined in Section 3, the Group has decision making authority via the sovereign status of its membership. However decisions of a material, i.e. financial or reputational nature may require sign-off outside the meeting itself.

Conflict of Interest

The Committee is a mixed group of service funders ('commissioners') and organisations that deliver services ('providers'). As such, there is the potential for conflicts of interest to arise.

The overall approach to managing conflicts of interest will be as set out in the ICB Standards of Business Conduct and Conflicts of Interest Policy[4]. In summary, this sets out the following:

- Declaring and minuting any conflict of interest
- Where the Chair has a conflict of interest, another non-conflicted member must chair that part of the meeting
- Any individuals with a conflict of interest may be required to not attend the meeting or the relevant part of the meeting
- If appropriate, ensuring that any individual with a conflict of interest do not receive papers or minutes pertaining to the relevant item
- If appropriate, allowing an individual with a conflict of interest to participate in the discussion about the relevant item, but requiring them to leave when a decision is taken

If there is a lack of clarity or a disagreement about the most appropriate way of managing a conflict of interest, advice will be sought from the ICB Commissioning Governance Process Group.

These arrangements for managing conflicts of interest will be reviewed after four meetings, in the light of experience. A summary of how any conflicts (or potential conflicts) are managed in meetings will be included in reports to the ICB Board and to other partners.

[4] https://suffolkandnortheastessex.icb.nhs.uk/about-us/our-policies/#h-nhs-suffolk-and-north-east-essex-icb-governance-handbook-1

10 Conduct of the Suffolk Mental Health Collaborative Committee

Values

Members will be expected to conduct business in line with its agreed values.

Members of, and those attending, the Suffolk Mental Health Collaborative Committee shall behave in accordance with each organisation's constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality, Diversity and Inclusion

Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

11 Review

The Suffolk Mental Health Collaborative Committee will review on an annual basis its own performance and effectiveness including membership and terms of reference. Partners' Boards will approve any resulting changes to the terms of reference or membership.

Date Approved:	
Next Review:	

Date:

Date Agreed:

Review Date: Annually from the date agreed, with earlier reviews for conflicts of interest (section 9)

Annex 1

Delegation of ICB Budgets

The Board of the ICB has agreed, in establishing the Collaborative Committee, to delegate responsibility for the following budgets:

Cost centres formally delegated to the MH collaborative		
Cost Centre Name	**Detailed Description**	**Total £'000**
ADHD	ADHD Non Contract Activity	167
AMBULANCE RESPONSE SERVICES	Ambulance Joint Response Service	429
COMMUNITY A NOT BED-BASED NOT PLACEMENTS	VCSE Community Contracts Other MH Community schemes	3,778
COMMUNITY B SUPPORTED HOUSING SERVICES	Supported Housing spend	875
CYP MENTAL HEALTH (EXC LD)	Various CYP contracts	2,180
DEMENTIA	Dementia Shared Care costs Dementia Together Contract	1,158
LOCAL NHS ACUTE MH & REHAB IP SERVICES ADULT	MH Services from EPUT	62
MENTAL HEALTH ACT	MH Shared Care Section 12 payments	5,111
MENTAL HEALTH NCA	MH NCA	195
MENTAL HEALTH PLACEMENTS IN HOSPITALS	MH Placements	1,394
MENTAL HEALTH SDF/NON RECURRENT FUNDS	Service Development Funding	8,667
MENTAL HEALTH SERVICES OTHER	MH Audit Fees	21
PERINATAL MH (COMMUNITY)	MH Perinatal	108
SUICIDE PREVENTION	Suicide Prevention	311
		24,459

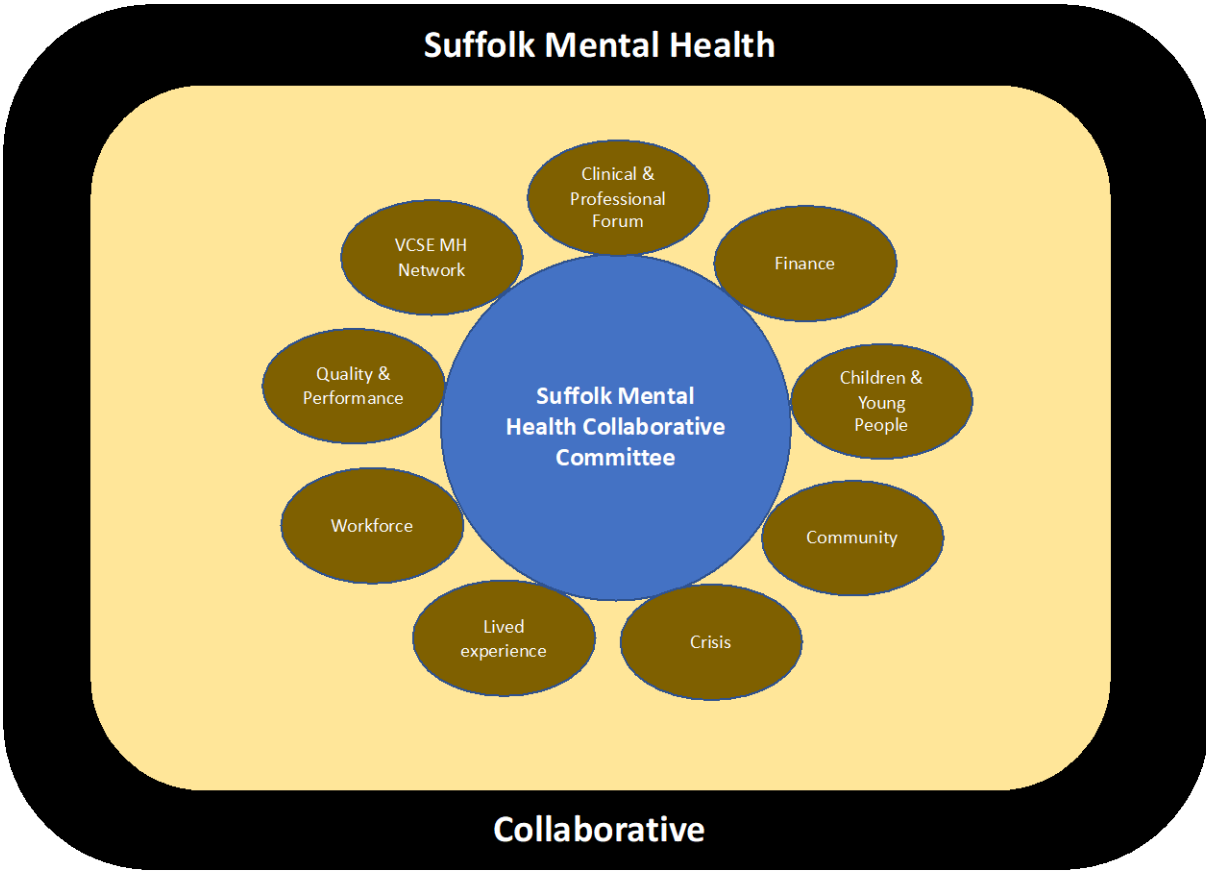
Cost centres formally delegated in part to the MH collaborative with some specific exclusions *		
Cost Centre Name	**Detailed Description**	**Total £'000**
MENTAL HEALTH CONTRACTS	NSFT Contract	94,855
		94,855

**** For investment decisions relating LD & Autism included within the Mental Health Contracts the delegation still resides with the Alliance.***

Cost centres which are not formally delegated to the MH collaborative Delegation still resides with the Alliance		
Cost Centre Name	**Detailed Description**	**Total £'000**
LD & AUTISM SDF/NON RECURRENT FUNDS	Service Development Funding	2,145
LD AND AUTISM	LD Placements LD Shared Care LD Admission Avoidance scheme	6,920
		9,065
		128,379

Annex 2

Supporting Groups within the Suffolk Mental Health Collaborative



NHS
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ICB BOARD

Agenda Item No.	**21**
Reference No.	**ICB 23-60**
Date.	**25 July 2023**

Title	**Committee Minutes and Highlight Reports**
Lead Director	Amanda Lyes, Director of Corporate Services and System Infrastructure
Author(s)	Jo Mael, Corporate Governance Manager
Purpose	**Minutes and Highlight Reports:** ***To receive*** *minutes and highlight reports from the following ICB Sub Committees.* **a) Audit Committee** *The unconfirmed minutes of a meeting held on 15 June 2023* **b) Remuneration and HR Committee** *The minutes of a meeting held on 6 June 2023, extraordinary meeting held on 16 June 2023, and meeting held on 4 July 2023* **c) Finance Committee** *The minutes of meetings held on 9 May and 13 June 2023* **d) Quality Committee** *The minutes of a meeting held on 11 May 2023.* **e) People Committee** *The unconfirmed minutes of a meeting held on 21 June 2023* **f) People and Communities Committee** *The minutes of a meeting held on 3 May 2023 and 7 June 2023* **g) Estates Committee** *Highlight report from May 2023 meeting.* **h) Strategic Digital Investment and Assurance Committee** *A summary of minutes of a meeting held on 5 May 2023*

Recommendation:
To receive the minutes and highlight reports as attached to the report whilst noting that 'unconfirmed' minutes remain subject to change by the relevant Committee/Group.

NHS
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Unconfirmed Minutes of a Meeting of the SNEE ICB Audit Committee held on 15 June 2023

PRESENT:

Geoff Dobson (Chair)	GD	Non-Executive Member, Finance and Audit (Interim)
Phanuel Mutumburi	PM	Non-Executive Member, Quality and Safety (Interim)

IN ATTENDANCE:

Ben Askew	BA	ICB Head of Workforce
Lisa Blake	LB	External Audit, BDO
Janine Combrinck	JC	External Audit, BDO
Paul Cook	PC	ICB Information Governance Lead
Nick Fanning	NF	RSM, Internal Audit
Mark Game	MG	ICB Deputy Director of Finance
Tshiamo Hlatshwayo	TH	External Audit, BDO
Mark Kidd	MK	Local Counter Fraud Specialist (LCFS)
Amanda Lyes	AL	ICB Director of People and Workforce
Howard Martin	HM	ICB Director of Finance
James Thompson	JT	ICB Finance Team
Richard Watson	RW	ICB Director of Strategy and Transformation
Jo Mael (Minutes)	JM	ICB Corporate Governance Manager

23/032 WELCOME AND APOLOGIES FOR ABSENCE

Geoff Dobson introduced himself as interim Chair and then welcomed all to the meeting. Apologies for absence were received from:

Chris Armitt, ICB Director of Operational Finance
Tanya Curry, Non-Executive Member, People, Remuneration and Diversity
Colin Boakes, ICB Governance Advisor
Liz Wright, RSM Internal Audit

23/033 DECLARATIONS OF INTEREST

The Committee noted the register of interests. There were no declarations in relation to the agenda items and the meeting was confirmed as quorate.

23/034 MINUTES OF THE PREVIOUS MEETING

The minutes of the SNEE ICB Audit Committee meeting held on 13 April 2023 **were approved** as correct record.

23/035 MATTERS ARISING AND REVIEW OF ACTION LOG

There were no matters arising from the previous meeting and the action log was reviewed and updated.

(The Chair advised that agenda item 9 (Suffolk Mental Health Collaborative Terms

of Reference) would be taken first)

23/036 SUFFOLK MENTAL HEALTH COLLABORATIVE TERMS OF REFERENCE

In March 2023 the ICB Board approved a detailed paper that proposed the establishment of the Suffolk Mental Health Collaborative. Since then, the Boards of WSFT, ESNEFT, NSFT and the Cabinet of Suffolk County Council had each approved similar papers.

The formal approval of the papers to establish the Collaborative was the culmination of a detailed design process that involved partners from across the Suffolk system. The main driver for establishing the Collaborative was a shared commitment from all partners to fundamentally change the way that the Suffolk system plans, resources and delivers mental health services in order to improve outcomes for local people. Specifically, the aims are to:

- Create a single forum at which all partners can take decisions on all aspects of mental health.
- Develop and agree shared system-wide mental health priorities.
- Develop a single, integrated Suffolk mental health delivery programme.
- Increasingly align and consolidate resources.

The Collaborative had at its centre a formal Committee. That Committee was the forum at which partners would take decisions on behalf of its constituent statutory bodies, including the ICB.

At its meeting in March, the ICB agreed to delegate responsibility for relevant mental health budgets to the Collaborative from July 2023, subject to the final approval of the Committee's Terms of Reference.

The draft Terms of Reference of the Collaborative Committee were attached at Annex 1 and key issues were set out in Section 2 of the report.

The ICB's Director of Finance reported that whilst it was not the Audit Committee's role to approve the terms of reference it had been felt appropriate to present them as it signified a different way of working and provided the Audit Committee with opportunity to comment. Approval of the terms of reference would be sought by the SNEE ICB Board on 25 July 2023. It would be interesting to see how potential conflicts of interest were managed going forward and a regular report to the Audit Committee might be thought appropriate.

Comments included:

With regard to membership of the Committee, it was queried whether there had been discussion with regard to inclusion of the Police representative. The Committee was informed that, although not on the Suffolk Mental Health Collaborative, there was Police representation on the Crisis sub-group. Live conversations were taking place and workshops anticipated over the summer months.

It was explained that whilst at present the ICB was the only organisation delegating budgets it was hoped that might change going forward. Within NEE there was a group operating across Southend, Essex and Thurrock which, although similar, was not a collaborative. A North-East Essex Mental Health Committee had been established with sign off via the Executive Committee.

The Committee was pleased that conflicts of interest would be reviewed after four

meetings, and it was suggested it might be helpful for the Audit Committee to receive a case study as to how conflicts were being dealt with going forward. It was noted that the process should not be dis-similar to that already in place for the ICB Board.

The Committee:

1) **Noted** the decision of the ICB Board to establish the Suffolk Mental Health Collaborative

2) **Agreed** the Terms of Reference for the Suffolk Mental Health Collaborative Committee

3) **Noted** that the Terms of Reference would be presented for final approval to the July 2023 ICB Board.

23/037 AUDIT COMMITTEE BRIEFING ON MATTERS OF INTEREST OR STRATEGY

The ICB's Director of Finance reported:

- Focus remained on addressing the required 30% reduction of running costs. Progress was positive although remained challenging with important decisions expected in the next few weeks.

- The ICB's Cost Improvement Programme was progressing well with good work on non-pay and solid plans with regard to continuing healthcare and medicines management.

- With regard to System wide finances, WSFT had posted a small year to date deficit which was early in the year. It was felt that there could be larger deficits within other Eastern region ICBs.

- A system framework was being developed through the ICB's Finance Committee to strengthen communication and prevent the need for remedial action should partners go off the financial plan.

- A junior doctors strike was currently taking place and the ongoing action would have an impact on 2023/24 plans and the need to reduce the elective backlog. Discussions were ongoing with Suffolk Police with regard to its announcement that it would be ceasing attendance at emergency mental health calls.

- A staff briefing with regard to the running cost reduction programme was scheduled to take place on 19 June 2023, together with a further briefing for line managers.

- Interviews were scheduled at the end of July 2023 for recruitment to Non-Executive Board Member vacancies.

In response to questioning it was confirmed that the running cost reduction was to be achieved by March 2025. The ICB was seeking to address running costs in one phase.

The Committee noted the update.

23/038 DRAFT ICB ANNUAL REPORT AND ACCOUNTS FOR THE NINE MONTHS ENDING 31 MARCH 2023.

The ICB had produced its first Annual Report and Accounts covering the nine-month period from its inception (1 July 2022) to 31 March 2023. The draft version was submitted to NHS England in line with the national deadline of 27 April 2023. The

deadline for submission of the audited version was 30 June 2023.

The Committee was informed that the report would have been presented earlier but the audit had been delayed to the 1 July 2023. The ICB's External Auditors, BDO were currently auditing accounts for the three CCGs which were not expected to be completed by the 30 June 2023 deadline. It was anticipated that the ICB Audit would commence in July 2023. Concern was expressed at the current pace of the audit and its resourcing.

The External Auditors reported that although when presenting the CCG audit plan, it had been envisaged that the audit could be completed by the 30 June 2023, that had not subsequently been the case due to the resignation of an Audit Senior. Additional resource had now been identified and it was hoped that the field work could be finished in mid-July for an end of July 2023 sign off. It was anticipated that the ICB audit would commence in July with sign off in August 2023.

The Chair advised that he had some comments with regard to the documentation that he would feed back to the Finance Team outside of the meeting.

Having queried a non-recurrent provision as set out within the report, it was clarified that it was due to liability associated with vacant estate.

In response to a query with regard to vacancies and running costs information contained within the report, the Committee was informed that the information was skewed with regard to where costs sat and had not been by design.

The Committee noted the draft ICB Annual Report and Accounts for the nine months ending 31 March 2023 and the issues surrounding the timeliness of the audit of both the ICB and the predecessor CCGs as set out within the report. Those involved in producing the documentation **were thanked** for their efforts.

23/039 2021/22 MENTAL HEALTH INVESTMENT STANDARD AUDIT.

All Clinical Commissioning Groups (CCGs), and now Integrated Care Boards (ICBs), were required to increase their spending on Mental Health Services each year by a greater proportion than their overall increase in programme budget allocation for that year. The spend on the qualifying Mental Health Services was then subject to an independent reasonable assurance review, as carried out by BDO for the 2021/22 financial year.

The work regarding the Mental Health Investment Standard Audits for the financial year 2021/22 for Ipswich and East Suffolk CCG, West Suffolk CCG and North-East Essex CCG had drawn to a close.

The audit results report detailed that all three CCGs had been deemed compliant for 2021/22, thus achieving the required level of spend on Mental Health Services as required by NHS England.

The three CCGs were required to publish the results of the audits and their compliance on the Suffolk and North-East Essex ICB (ICB) website.

The Committee noted the Letters of Representation and Compliance Statements for the three CCGs.

23/040 EXTERNAL AUDIT

The Committee was in receipt of the following reports:

a) Progress Update on the Audit of the CCG Accounts for the 3 months ending 30

There was nothing to add to that reported under Minute 23/038 above.

b) Mental Health Investment Standard Audit Results

The Committee received the Mental Health Investment Standard Audit Results.

The auditors were satisfied that each CCG had met its MHIS target for the year and its Statement of Compliance had been properly prepared in all material respects.

In 2019/20 the auditors had qualified the reasonable assurance reviews on each of the three CCGs on the basis that continuing healthcare (CHC) expenditure included in MHIS spend included patients with learning disabilities, behaviour disorders, dementia and elderly mental illness. NHS England's MHIS guidance required expenditure on learning disabilities and dementia, including elderly mental-health related costs, to be excluded from qualifying mental health expenditure in preparing the Statement of Compliance. The CCGs' systems did not allow for separate coding of CHC expenditure on dementia or separate coding where a patient with a primary mental health diagnosis also had another secondary diagnosis. NHS England did not require MHIS reasonable assurance reviews to be carried out for 2020/21.

For 2021/22, the CCGs had estimated the elements to be excluded from CHC spend for the purposes of the MHIS, based on the information in the continuing healthcare systems, and the sample testing had not identified any errors. Therefore, the auditors had not repeated the qualification reported in the CCGs' 2019/20 MHIS reviews.

Overall it had been a good result with only one issue relating to the prescribing of multi-use drugs identified, as detailed in the report.

Statements of compliance and reasonable assurance would need to be published and confirmation form NHSE with regard to the publication date was awaited.

2022/23 reviews would cover one statement of compliance but refer to three part year CCGs and ICB remaining months.

The Finance Team were thanked for their help to complete the reviews.

The Committee noted the reports.

23/041 INTERNAL AUDIT

The Committee was in receipt of the Internal Audit Progress Report and individual audit reports, with comment as follows:

Internal Audit Progress Report

The report provided an update on work completed since the previous meeting. Key points included:

There were four final reports completed which had been included within the agenda pack.
Conflict of interest and risk management phase 2 audit reports were currently in draft.

There were currently 18 open actions and 10 were overdue. Six actions related to the core HR controls review for which the Committee was to receive a further report later on the agenda. The first two reviews for 2023/24 had been scheduled and the ICB was ahead of the curve re delivery.

Having queried the inclusion of actions from the Childrens Continuing Healthcare audit, the Committee was informed that actions were included on the schedule once the report had been presented and any outstanding actions would be regularly reported as part of the regular actions outstanding reports.

The Committee was informed that External Audit would use the HR work to assess value for money arrangements for 2022/23. Due to the 2021/22 weakness with regard to special payments it would look at implementations of recommendations which dependent on timing could be included within the narrative regarding weaknesses of the system.

Internal Audit Reports:

a) **Governance Phase 2** – Substantial assurance, only one action.

b) **Primary Care Commissioning** – Substantial assurance, two minor actions.

c) **Childrens CHC** – Partial assurance opinion – key outcomes were for the ICB to finalise guidance with regard to process, which included informing parents and carers of decisions in a timely manner and defining roles and responsibilities in the service specification with Suffolk County Council. Progress on actions would be reported back within the regular outstanding actions report.

d) **Data Security and Protection Toolkit** – a number of actions had been agreed. It should be noted that delivery was in line with the NHS Digital framework and subject to the second year of the enhanced DSP reporting framework which required that 113 items be evidenced to meet the requirements. At the time of the audit the ICB had had two separate ICT providers and it was not an outlier with regard to other organisations.

The Committee noted the reports.

23/042 HUMAN RESOURCES AUDIT UPDATE

An audit review had been carried out of mandatory training and the governance mechanism in place around redundancies and exit payments as part of the approved internal audit plan for 2022/23. The review enabled management to take assurance on the effectiveness of controls in place to ensure HR systems and processes are operating efficiently. It was noted that the sample testing for the redundancy element pre-dated the ICB transition but, as requested by ICB management, was included as part of the scope of the review.

Key issues and management actions identified from the review were detailed in Section 2 of the report.

Comments included:

Having queried whether the ICB mandated core training for everyone or whether it was specific to roles, the Committee was informed that there were 10/12 core mandated courses with some staff required to do higher levels of safeguarding or LD training due to their roles. There was also additional training for the Executive team.

Staff were thanked for their progress in addressing the audit actions and production of a detailed action plan.

The Committee noted the report.

23/043 LOCAL COUNTER FRAUD SPECIALIST (LCFS)

The Committee was in receipt of the Counter Fraud Annual Report for 2022/23. Key points highlighted included:

Compliance with the Government Functional Standard 013: Counter Fraud – the return had been positive with an overall 'green' rating. There had been one 'amber' rating and the return had been submitted by the deadline of 31 May 2023.

Having queried investigation activity, the Committee was informed that the total brought forward had been three and they had been included within the eight reported.

The Committee noted the Counter Fraud Annual Report for 2022/23 as presented.

(Agenda item 14 (Approvals Process for ICB Exit and Severance Payments) was taken next)

23/044 APPROVALS PROCESS FOR ICB EXIT AND SEVERANCE PAYMENTS

A recent audit by NHS England had highlighted that nationally, consistent oversight of approvals for ICB exit and severance payments had not always been attained.

From April 2023, the East of England Workforce Training and Education (WT&E) Team would be responsible for coordinating regional and national approvals for all ICB exit and severance payments. In order to support that, new guidance was published, and a copy was attached to the report.

Key issues were outlined in Section 2 of the report.

Assurance was provided that the ICB was aware of relevant timelines and had mapped them though the Remuneration and HR Committee meeting dates.

It was queried whether, as with waivers of competitive tendering, the Committee should have sight of terminations and exits on a regular basis for assurance. **The ICB's Director of People and Workforce agreed** to take the matter forward for consideration.

The Committee noted the NHS England, East of England Region Guidance on ICB Exit and Severance Payments.

23/045 INFORMATION GOVERNANCE UPDATE AND APPROVAL OF THE DATA PROTECTION BY DESIGN AND DEFAULT PROTOCOL

The report provided an update on;

- organisational compliance with legislative and regulatory requirements relating to the handling of information, including compliance with the Data Protection Act (2018), UK GDPR and the Freedom of Information Act (2000),
- compliance with the Data Security and Protection Toolkit (DSPT) and provided assurance of ongoing improvement in relation to managing risks to information, and
- an update on any development plans, current projects or forthcoming projects the Information Governance Team was involved in or planning during 2023/24.

Providing the report to the Committee was part of the Information Governance Team's work plan to make sure the ICB was aware of any risks, decisions and/or actions needed to ensure compliance with the Information Governance agenda.

Key issues were detailed in Section 2 of the report and included;

Back in 2021, Scan House was procured by Suffolk Primary Care (SPC) with additional money provided by the CCG to start digitising Lloyd George Patient Records. Earlier in May 23 the digital team had received an informal notification from an ex-employee that Scan House Solutions Ltd had gone into administration. The digitisation was approximately 2/3rds complete at the point of that news. There were circa 165,000 paper records from 17 GP Practices across Suffolk being held by Scan House with an estimated 90-100k of those also held electronically. The ICB needed to secure the records, both physical and electronic as a matter of urgency to ensure impacted GP surgeries could comply with an SARs (Subject Access Requests) that might come in from patients or other organisations and also to ensure the patient had access to a full patient medical record. Work was underway to ensure that everything was retrieved from Scan House by the end of June 2023.

The Committee was also being asked to approve the:

1) Data Protection by Design and Default Protocol - the UKGDPR required ICB's to put in place appropriate technical and organisational measures to implement the data protection principles and safeguard individual rights. The Data Protection by Design & Default protocol documented the processes we as an organisation go through. It had been approved by the ICB IG Steering Group in March 2023.
2) Data Quality Policy
3) IT Security Policy
4) Network Security Policy
5) Log Retention Policy

Comments included:

In response to questioning it was explained that policies would normally go through the Information Governance Steering Group normally with IT policies seen by the IT team before being presented. The policies are then presented to the Audit Committee for approval.

The Committee noted the report **and approved** the following protocols and policies as appended to the report:

1) Data Protection by Design and Default Protocol
2) Data Quality Policy
3) IT Security Policy
4) Network Security Policy
5) Log Retention Policy

23/046 BOARD ASSURANCE FRAMEWORK (BAF)

The BAF document was reviewed by the Executive Committee (EC) every month and by the Board, and Audit Committees at each of its meetings.

A brief overview of the amendments was set out within the report.

It was highlighted that the report was slightly different to previous ones as it now incorporated feedback from a recent Board Development workshop. There was increased focus on strategic risk, with some risks having been consolidated and others re-directed to directorate risk registers for management.

Further work would take place on the BAF in conjunction with the ICP to seek to incorporate risks prior to a complete overhaul of the BAF for presentation to the ICB Board in July 2023. As highlighted at a recent Board meeting by Healthwatch, Board opportunities would also be included.

The Chair advised that he felt the document was still lacking with regard to providing clarity and also contained a lot of acronyms and a lot of 'red' risks. It was also queried whether the merging of risks was appropriate. **The ICB's Director of People and Workforce agreed** to take the comments back to the Executive Team for consideration.

The Audit Committee reviewed and approved the Board Assurance Framework as presented.

23/047 GOVERNANCE LOGS

Waivers

The Committee received the following waivers of competitive tendering.

ICB 020	Primary Care Careers' Applicant Tracking System: Eploy
ICB 021	Optum Population Health Intelligence Suite
ICB 022	Softcat PLC for VDI
ICB 023	Livability Icanho contract extension 01 April 2023 – 31 March 2024
ICB 024	Dedicated Triage Service – Personalised Care Programme to support people with complex needs
ICB 025	Supported Self-Management – Personalised Care Programme to support people with complex needs
ICB 026	Homeward Bound Service

The ICB's Director of Finance reported that it had been noted that the waivers were signed by a variety of Directors and recognised the need to clarify the sign off procedure in order to ensure consistency going forward by a review of the SORD. There was also a need to ensure that the documentation was consistent and had been updated since the CCG.

In response to questioning it was confirmed that a waiver log was maintained.

Hospitality and Gifts Register

The Committee received the current hospitality and gifts register for review.

Having noted that two of the declarations involved travel, it was confirmed that there had been no cost to the ICB.

It was suggested and agreed that the declaration form be amended to identify the date of declaration to ensure that it was prior to take up of any hospitality.

The Committee noted the waivers of competitive tendering and hospitality, and gifts register as presented.

23/048 POLICIES/DOCUMENTS FOR APPROVAL

No policies had been received for approval other than those approved under Agenda item 13 (Information Governance)

23/049 ANY OTHER BUSINESS

No items of other business were received.

23/050 DATE AND TIME OF NEXT MEETING

The next meeting was scheduled to take place on 14 September 2023. The Director of Finance reported that it was intended to facilitate face-to-face meetings going forward with hybrid facilities.

It was noted that an exceptional meeting might also be required in the interim period in order to receive and sign off the CCGs and ICB accounts.

The Chair thanked everyone for their contribution.

NHS
Suffolk and
North East Essex
Integrated Care Board

Minutes of a meeting of the SNEE Integrated Care Board Remuneration and HR Committee held at 0900 hrs on 6 June 2023

PRESENT:

Phanuel Mutumburi	Non-Executive Member, Quality and Safety - Interim
Prof. Will Pope	ICB Chair

IN ATTENDANCE:

Ben Askew	ICB Head of Workforce
Amanda Lyes	ICB Director of People and Workforce
Jo Mael	ICB Corporate Governance Manager
Lizzie Mapplebeck	ICB Programme Director
Howard Martin	ICB Director of Finance
John Noble	ICB Deputy Director of People and Workforce

23/020 APOLOGIES FOR ABSENCE

Apologies for absence were received from;

Tanya Curry Non-Executive Member, People, Remuneration and Diversity (Chair)

23/021 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and introductions were made.

23/022 DECLARATIONS OF INTEREST

No declarations of interest were received.

23/023 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 2 May 2023 **were approved** as a correct record.

23/024 MATTERS ARISING AND REVIEW OF ACTION LOG

There were no matters arising and the action log was reviewed and updated with comment as follows:

23/015 – Financial Recovery Programme – Expo Event – whilst the reason for continuing with the event was noted, **the Committee requested** that the ICB's Director of People and Workforce liaise with the Head of Communications to ensure there was appropriate messaging surrounding the event.

23/025 DELEGATION OF PHARMACY, OPTOMETRY AND DENTISTRY (POD) – PROGRAMME CLOSURE DOCUMENT

The Committee was in receipt of the programme closure document with regard to the delegation of POD services. Key points highlighted included;

- Six members of NHSE staff had been TUPEd across to the ICB and were now embedded within the organisation, operating efficiently and there were no concerns.
- Whilst there had been one issue associated to complaints and a lack of clarity with regards to the shadow complaints process, that had now been resolved. A resulting issue was the receipt of archived complaints and the TUPE across of complaints staff. One member of the complaint staff was due to be TUPEd across on 4 July 2023.
- A lessons learnt document had been included within the report.

The importance of continuing to monitor the programme going forward was emphasized.

The Committee noted the report **and thanked** everyone involved in the process for their hard work.

23/026 FINANCIAL RECOVERY PROGRAMME 2023/24

The Running Cost Reduction Programme had launched on time and was being managed within the governance framework recommended in the previous report to the Committee.

Progress on the programme was detailed within Section 2 of the report with key points highlighted being:

- The good governance framework had been applied to the programme and the Steering Group met fortnightly with its outcomes reported to the Executive Committee. The Steering Group meetings were held between Financial Recovery Group meetings which was working well.
- Progress detailed within Section 3 of the report included a well-informed project plan which was continually reviewed.
- The SOAR exercise had also been included and its outcomes had been fed into directorate conversations.
- Consultation and engagement were strong, and Trade Unions were involved in the Steering Group and there was a Staff Reference and Redesign Group with a membership of 40+ members of staff where concepts, ideas and thoughts were shared. The last meeting had resulted in the receipt of good feedback which had been fed back to directors.
- A change communications plan had been signed off by the Steering Group and was now being activated. A newsletter had been circulated last Friday and virtual staff briefings continued to be held with the next scheduled on 19 June 2023. Staff briefings were to be enhanced by the facilitation of line manager briefings prior to the main briefing.
- Risks and mitigations were identified in the report.
- Alongside a staff support programme and health and wellbeing support, a 'Leading Through Change Programme' was to be launched which would take place over six dates to support line managers. To date 45 managers had signed up.

The ICB's Director of People and Workforce reported that whilst working through the programme and preparing for staff consultation on 17 July 2023, the ICB had been informed by NHSE regional office within the last 10 days that it would now support any system that wished to apply to the national team for a voluntary redundancy scheme. At a meeting held last week there seemed to be interest from all Systems to put a business case forward for such a scheme although the SNEE Director team had not yet reached a conclusion.

At a meeting to be held on 12 June 2023 the Executive Team would discuss emerging post structures and proposed savings prior to deciding whether to pursue a voluntary redundancy scheme. If it was decided to go ahead a report would be prepared for the Committee to consider and any resulting decision would be included within a business case for submission to NHSE's regional team by 5 July 2023 and from region to the national team by 25 July 2023. As yet it was unknown when any decision by the national team might be communicated although assumption was being made that would not be until the end of July 2023. As a result of the change, it might be necessary to pause the consultation to run the voluntary redundancy scheme.

Comments included:

Having queried whether the voluntary redundancy scheme could be run alongside the consultation, it was reported that whilst it could run in parallel more thought was required as it could be difficult to consult on posts that the organisation wished to remove from the organisation.

It was suggested that any 'extraordinary' Remuneration and HR Committee be held as a Teams meeting rather than via email to ensure there was opportunity to talk through issues. It was also important to be mindful of potential conflicts of interest regarding Executives making decisions where there was potential for financial benefit. It was important to formalise the Committee's role in approving what the business case looked like.

The Chair advised that when previously looking at the process and challenges for staff it had been recognised that the ICB would be looking at a reduced workforce at the end of process and it was queried what priorities and workload might look like for staff going forward.

The Committee was informed that it was part of the design phase to work through what the new organisation might look like and how things could be done differently. In terms of the longer timeline there was a need to factor in organisational development as it was recognised that it would be a different organisation, with a different function. It was important that the work was overlaid with the organisational development plan and strategy.

The Committee was informed that an Equality Impact Assessment was being produced which would look at the whole system.

There was some concern regarding issues that might arise if staff that the ICB wished to retain sought voluntary redundancy. It was noted that the ICB could only affect issues within its control, and it was not in control of action taken by neighbouring systems which could have a significant impact.

The Committee noted the report **and requested** that an 'Extraordinary' meeting be scheduled for week commencing 12 June 2023, with future agenda items being entitled 'Running Cost Reduction Programme.

23/027 UPDATE ON HR AUDIT

An audit review had been carried out of mandatory training and the governance mechanism in place around redundancies and exit payments as part of the approved internal audit plan for 2022/23. The review enabled management to take assurance on the effectiveness of controls in place to ensure HR systems and processes are operating efficiently. It was noted that the sample testing for the redundancy element pre-dated the ICB transition but, as requested by ICB management, was included as part of the scope of the review.

Key issues and management actions identified from the review were detailed in Section 2 of the report.

Comments included:

Having queried the reporting back mechanism it was explained that a report was circulated to the ICB's Executive Committee monthly which included update of the dashboard. To seek improvement of performance, mandatory training was to be discussed at regular directorate meetings which were incorporated within the new business partnership model.

The importance of regular update to the Committee was emphasized and it was suggested that it also might be beneficial to receive audit report information if feasible.

The Committee noted the report **and requested** that it receive quarterly updates.

23/028 REVISED TERMS OF REFERENCE

The Committee was in receipt of revised terms of reference for approval. The terms of reference had been revised to allow for the approval of human resources policies and procedures.

The Committee approved the revised terms of reference as presented **and recommended** them for endorsement by the ICB Board.

23/029 ANY OTHER BUSINESS AND REFLECTION

No items of other business were received.

23/030 DATES OF FUTURE MEETINGS

4 July 2023

NHS
Suffolk and
North East Essex
Integrated Care Board

Minutes of a meeting of the SNEE Integrated Care Board Remuneration and HR Committee held at 1400 hrs on 16 June 2023

PRESENT:

Phanuel Mutumburi	Non-Executive Member, Quality and Safety - Interim
Prof. Will Pope	ICB Chair

IN ATTENDANCE:

Ben Askew	ICB Head of Workforce
Amanda Lyes	ICB Director of People and Workforce
Jo Mael	ICB Corporate Governance Manager
Howard Martin	ICB Director of Finance

23/031 APOLOGIES FOR ABSENCE

Apologies for absence were received from:

Tanya Curry, Non-Executive Member, People, Remuneration and Diversity (Chair)

23/032 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and introductions were made.

23/033 DECLARATIONS OF INTEREST

Amanda Lyes and Howard Martin both declared an interest in the agenda item as Directors of the ICB. They remained in the meeting to present the report.

23/034 RUNNING COST REDUCTION PROGRAMME VOLUNTARY REDUNDANCY PROPOSAL.

NHS England had set a target reduction in ICB running cost allowances, which would be subject to a 30% real terms reduction per ICB by 2025/26, with at least 20% of that to be delivered in 2024/25. To deliver the reduction SNEE ICB had created a Running Cost Reduction Programme, the programme had two distinct elements, namely Pay and Non-Pay.

The SNEE ICB Executive team had acknowledged that to achieve the running cost reduction directive of 30%, alongside a review of the non-pay budgets, the ICB would be required to review its current structures. The restructuring presented SNEE ICB with an opportunity to reduce pay costs and create a leaner and more effective organisation structure for the future whilst ensuring all statutory functions were safely delivered.

The ICB directors were currently in the process of designing the organisational structures. The reduction in pay costs would require a process to reduce overall staffing numbers and there were two main options to achieve that, Voluntary Redundancy (VR) and Compulsory Redundancy (CR).
ICB staff had enquired about redundancy options, specifically in relation to VR. The ICB Executive had been encouraged by region to consider VR as an alternative to CR.

SNEE ICB was seeking approval to run a VR scheme as it would provide SNEE ICB with the opportunity to rebalance the roles and skills to achieve the pay cost reduction whilst maintaining good motivation and morale.

There was no difference in calculations for voluntary and compulsory redundancy payments,
(i.e., VR paid at 1 month salary for every year of continuous service up to a maximum of 24 years' service to be capped at £80k annually (i.e., maximum payment would be £160k). Section 2 of the report went on to detail terms and conditions and consider risks.

Having queried why the NHSE regional office had changed its mind with regard to facilitation of a voluntary redundancy scheme, it was explained that it had been seeking confirmation from the national team that it was supportive before making a commitment.

There was currently a £2m gap and it was felt appropriate by the Executive Team to seek approval to run a VR scheme.

If approved, it was envisaged that the ICB Board would be recommended to endorse the approval on 20 June 2023 prior to a proposal being put to NHSE by July 2023. The proposal would then be presented to the national team for consideration at a meeting to be held on 25 July 2023. No definitive timescale had been received with regard to decision making although it was thought a decision might be available one week after the panel sat.

It was highlighted that the key issue going forward would be the timeline as if it got to August and October with no decision made it would be a concern.

It was noted however, that should the ICB decide to proceed with compulsory redundancy it would be subject to a similar process with similar timescales.

Having queried the process should the voluntary redundancy scheme not be approved it was explained that the ICB would need to return to look at compulsory redundancy. If entering into a voluntary redundancy scheme there would be a need to review its effect on the running cost reduction once applications had been received and then take a view as the required length of consultation that might be required.

There was concern that key staff might opt for voluntary redundancy and it was questioned whether anything could be done to prevent that. The Committee was informed that it would be mitigated via the design of the voluntary redundancy package which would need to be carefully managed in respect of communication. While all staff would be invited to apply, it would be important not to promise approval. The Panel would need to consider applications carefully and the criteria under which they were to be evaluated should be shared with staff. Criteria could restrict applications from those with a professional registration or those on fixed term contracts that had not done more than two years' service.

Some minor amendments to the documentation were suggested as follows:

- That the recommendation be revised to state that the Committee was approving the voluntary redundancy scheme and recommending that the SNEE ICB Board endorse the approval at its meeting on 20 June 2023.

- That the word 'and' be removed from the third line on Page 2 in relation to notice period as it was superfluous.

- That the voluntary redundancy amount for Agenda for change staff within Section 2 be amended to £150k.

- Page 3 – section 2.3 'positive' had been spelt wrongly and in section 2.4 the second

bullet point should be revised to read ‘at risk’ and the fourth bullet point to change ‘ember’ to ‘member’.

- Section 2.6 – table on risks – to include a risk associated to the morale of staff that apply for voluntary redundancy and are not granted it.

- Page 5 – Executive summary – third bullet point to be amended to read ‘requires a 30% reduction’.

- Page 9 – where appendices were listed there should be an Appx D which would be the endorsement of the Board on 20 June 2023.

- Page 10 - Appx B – the diagram should be revised so that ‘why’ was before ‘what’ and consideration of the narrative being altered so indicate national direction.

It was questioned whether there was any indication of the cost of the scheme. The Committee was informed that a provision of £1.4m had been set aside which was based on average pay cost and previous intelligence. There was currently a £2m gap and any cost would be non-recurrent.

In response it was reported that until conclusion of the scheme it would not be known who might apply. Voluntary redundancy did not mean that posts had to cease and the challenge going forward might be how to recruit to posts from within current resources which could be an opportunity or risk.

After discussion it was concluded that a P2 SNEE ICB Board meeting would be scheduled to take place on 20 June 2023.

The Committee recommended that the SNEE ICB Board endorse:

1) **Approval** of the voluntary redundancy application to the Executive Human Resources Sub-Committee (EHRSC) and the associated tasks and milestones.

2) **Approval** of the pausing of the compulsory redundancy consultation.

23/035 ANY OTHER BUSINESS AND REFLECTION

No items of other business were received.

23/036 DATES OF FUTURE MEETINGS

4 July 2023

NHS
Suffolk and
North East Essex
Integrated Care Board

Minutes of a meeting of the SNEE Integrated Care Board Remuneration and HR Committee held at 0900 hrs on 4 July 2023

PRESENT:

Tanya Curry	Non-Executive Member, People, Remuneration and Diversity (Chair)
Phanuel Mutumburi	Non-Executive Member, Quality and Safety - Interim
Prof. Will Pope	ICB Chair

IN ATTENDANCE:

Ben Askew	ICB Head of Workforce
Jo Mael	ICB Corporate Governance Manager
Howard Martin	ICB Director of Finance
John Noble	ICB Head of Human Resources

23/037 APOLOGIES FOR ABSENCE

Apologies for absence were received from:

Amanda Lyes, ICB Director of People and Workforce

23/038 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and introductions were made.

23/039 DECLARATIONS OF INTEREST

No declarations of interest were received.

23/040 MINUTES OF THE PREVIOUS MEETING

The minutes of the meetings held on 6 and 16 June 2023 **were approved** as correct records.

23/041 MATTERS ARISING AND REVIEW OF ACTION LOG

There were no matters arising and the action log was reviewed and updated.

23/042 RUNNING COST REDUCTION PROGRAMME UPDATE.

NHS England had set a target reduction in ICB running cost allowances, which would be subject to a 30% real terms reduction per ICB by 2025/26, with at least 20% of that to be delivered in 2024/25. To deliver the reduction SNEE ICB had created a Running Cost Reduction Programme, the programme had two distinct elements, namely pay and non-pay.

To date, a review of both pay and non-pay costs had reduced the gap to £1.4m, more detail was provided within the report. The report also went on to outline the voluntary redundancy proposal timeline and to set out estate options together with outlining risks.

The Director of Finance reported that the ICB had received confirmation of receipt of

additional £800k of recurrent funding in respect of the pay uplift, which although had been partially offset by £300k of additional cost, had reduced the gap from £2m to £1.4m.

There was a reasonable case to allow for a vacancy factor of 3%, although that would require a change of working practice. Currently budgets were assigned to Directors with any underspends being retained by directorates, going forward there would be a need to monitor the situation more closely and for underspends to be held centrally.

Comments included:

In response to questioning, the Director of Finance clarified that the additional pay uplift funding was recurrent. Challenges associated to the reorganisation, with regard to capacity and competence were recognised, together with the need for the Board to monitor the situation carefully going forward.

Reassurance was sought on the ICB's ability to achieve the required pay and non-pay budget reduction. The Committee was informed that a new draft structure had been developed and was costed on a regular basis. With regards to non-pay, it was noted that there were some further actions required and that estate costs would be a key factor. The work was being led well and did not have to be delivered in 2023/24.

With regard to the estate options set out within the report, the pursuance of Option 5 to retain a base within all three areas was welcomed.

Having queried whether the staff working group would be consulted on the estate options, the Committee was informed that a consultation exercise was about to commence on estate as mentioned in the most recent staff briefing. With regard as to whether staff would have the option to be homeworkers, it was explained that there was no appetite to alter contracts and a more flexible approach was preferred.

The benefit of completing an Equality Impact Assessment (EIA) at an early stage to aid decision making was highlighted. The Committee was informed that previously work on the EIA had been associated to compulsory redundancy and that due to a recent shift of focus to voluntary redundancy and estate issues there was a need to revise the EIA and that work was currently taking place. There was recognition of its importance.

The Committee was advised that the next key piece of work would be development and presentation of the terms by which an application for voluntary redundancy would be accepted. Key criteria for any application would be the need to demonstrate a return on investment and other aspects. Reports were currently being prepared for review by the Executive Committee, Trade Unions and Staff Reference Group. It was anticipated that a report would be presented to the 1 August 2023 Remuneration and HR Committee.

The need to ensure that the Executive Committee saw the report prior to the Staff Reference Group was emphasized.

The Chair highlighted that there might be a requirement to move the Remuneration and HR Committee due to member's leave commitments. **The ICB's Head of Workforce agreed** to reconsider the timescales and facilitate a change of diary date if required.

The Committee noted the report.

23/043 LOSSES AND EXIT PAYMENT: HR OVERSIGHT GROUP

The Committee was in receipt of a report which sought approval of the formation of an ICB HR Oversight Group who would provide assurance on compliance across HR policy and in line with the ICB Losses and Special Payment guidelines. The HR Oversight Group remit would also cover:

- Assurance for job evaluation outcomes
- Starting salaries
- Management of fixed-term appointments

Key issues were detailed in Section 2 and proposed controls and assurance in Section 3 of the report.

The HR Oversight Group would meet monthly and include a range of senior leaders across the ICB. Terms of reference were to be developed and agreed and would be presented at the next scheduled meeting.

Approvals for 'Exit and Severance Payments' would be unchanged as would the existing reporting and oversight of ICB 'Losses and Special Payments'.

The activity of the HR Oversight Group would report to the Remuneration and HR Committee.

Comments included:

Having noted the report, it was queried whether, in such circumstances as highlighted, the member of staff might be asked to carry out another task during the notice period. In response it was reported that in the specific incident reported the role had been project specific and had redundancy potential.

Given previous experience it was asked whether there was a need for the auditors to review the process prior to its implementation. Internal audit provided an opportunity to run the process past auditors and embark on an audit to test processes. It was recognised that terms of reference for the Group would need to come to the Committee for approval. When considering establishment of the Group there was a need to ensure that it would facilitate the rigour required, otherwise thought should perhaps be given to making existing HR processes more robust.

Having queried the present process it was explained that managers were alerted six months in advance of a contract finishing and risks highlighted re continuous service. HR then worked with the manager to deliver notice at the appropriate time.

It was suggested that the Group might also look at other processes such as the rebanding of job roles and review of starting salaries. Individual managers had previously had a lot of discretion and there might be a need for wider education work to be carried out.

A key element to consider was 'what was the most effective control to put in place that reduces the risk'.

In response to a question, it was confirmed that the organisation was required to give notice if staff were on fixed term contracts.

As a result of the discussion, whilst the **Committee was supportive** of the approach, **it requested** that further work take place to review the requirement for the ICB HR Oversight Group prior to any terms of reference being presented for approval.

23/044 ANY OTHER BUSINESS AND REFLECTION

No items of other business were received.

23/045 DATES OF FUTURE MEETINGS

25 July 2023
1 August 2023 – as discussed above, this date might change.

NHS
Suffolk and North East Essex
Integrated Care Board

Meeting of the SNEE ICB Finance Committee Part 1A - System Finances held on 09 May 2023

PRESENT:

Edward Creasy	EC	Interim Chair
Craig Black	CB	WSFT Representative
Adrian Marr	AM	ESNEFT Representative
Howard Martin	HM	ICB Director of Finance
Kevin Smith	KS	EEAST Representative
Louise Aynsley	LA	Suffolk County Council (Part)
Trevor Smith	TS	EPUT Representative

IN ATTENDANCE:

Keith Wood	KW	ICB/ESNEFT
Jo Mael	JM	Corporate Governance Manager (Minutes)

23/042 WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting and apologies for absence were received from;

Chris Armitt	CA	ICB Deputy Director of Finance
Steve Clarke	SC	ICB Board Non-Executive Member
Paul Gibara	PG	ICB Director of Performance Improvement
Mark Millar	MM	Provider Non-Executive
Dr Nick Rayner	NR	ICB Board Primary Care Representative
Jason Hollidge/Kathryn Walsh	JH/KW	NSFT Representative

23/043 DECLARATIONS OF INTEREST

No declarations of interest were received.

23/044 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting of the ICB Finance Committee held on 11 April 2023 **were approved** as a correct record.

23/045 MATTERS ARISING AND REVIEW OF ACTION LOG

There were no matters arising and the action log was reviewed and updated.

23/046 ICS FINANCE REPORT

The Committee was in receipt of the system finance report with key highlights being;

- SNEE hosted NHS organisations collectively delivered a revenue surplus of £0.128m against a submitted plan figure of £0.008m.
- Within the overall system figure each organisation reported a surplus, ranging from £0.007m to £0.057m.

- SNEE exceeded its adjusted system capital target by £2.680m. That was approximately £1m higher than the figure anticipated by Regulators. Capital outturn performance would need to be aggregated at National level before it could be determined whether the overspend had any implications (ie a small reduction in capital plans in 2023/24). The overspend was caused primarily by the decision by WSFT to proceed at risk ordering diagnostic equipment in the expectation, supported by Regulators, that additional capital would be available. No further allocation was made.
- The wider definition of capital, that included System Transformation Plan and Targeted Investment Fund capital was underspent, with ESNEFT having successfully negotiated the transfer of £30m of that resource to 2023/24 to accommodate delays caused by global supply chain issues.
- 2022/23 financial delivery risks were limited to any items identified by audit, and the potential clawback of an element (up to £2m) of the capital overspend noted above.
- NHSE did not require the completion of financial monitoring returns for month one (on which that dashboard was based). Consequently, the next finance dashboard would be prepared for month two.
- At the time of reporting year-end updates were not available from the County Councils. Figures used throughout the report were based on the forecast position at month 11. The overspends at the year-end would be resourced by transfers from reserves.

The Committee was informed that since circulation of the report information with regard to Essex County Council (ECC) had been revised. ECC was now reporting a draft deficit of £543k compared to the £1.56m reported.

It was suggested that discussion should focus on Cost Improvement Plans (CIP), capital overspend, and whether revision to the report might be required for 2023/24.

Comments included;

It was highlighted that CIP information was not included within the report and those attending were invited to provide a brief verbal update.

The Committee was informed that national reporting methods were currently being redesigned and therefore, going forward, there was a need to be careful not to duplicate the provision of information. Once the national approach was known it would be shared with Members and if anything was missing there was opportunity to revise the regular Committee report.

It was queried whether it might be beneficial for the Committee to receive information on what was happening within other Systems in order to gain a strategic context, although recognised that provision of such information would be subject to timing.

It was highlighted that the provider efficiency report had too many zeros in it to be useful, and noted that agency criteria changes were expected for 2023/24 which would need to be incorporated.

West Suffolk NHS Foundation Trust (WSFT) was currently going through a process of CIP report design and the need to look at what was presented to each Board/Committee was recognised.

ICBs had been invited to join a national roadshow with NHSE and the roadshow for the Eastern region had been held on 27 April 2023. All those that had helped with the preparation for the roadshow were thanked for their contribution. Overall, the ICB had been well received as a System and a key message was that view should not be taken for granted as it was aligned to a balanced plan.

<u>CIP updates</u>:

ICB – the ICB had a CIP of £13.5m with currently £11m approved. Bi-weekly Financial Recovery Group meetings were being held and it was hoped that another £600k would be approved shortly with a further £3m scoped. Approximately £3m of the CIP was rated as low risk with another £7m rated as 'amber' aligned to prescribing and CHC. The largest risk was associated to CHC holding the line on the pay uplift. Current work involved review of non-pay options and focus on Estates and digital solutions. There was expectation of £600k-800k of non-pay solutions with the largest aspect coming from estate at Aspen

House, Colchester. Non-recurrent and recurrent required further clarification and it was anticipated there would be more recurrent cost improvement in the next financial year.

ESNEFT – divisions had been asked to carry forward anything not achieved on a recurrent basis into the new year and add 1% on top. On top of non-cash release activity there was approximately 2%. As a result of divisional review and from cash release, there was potential for £15m which equated to 60% from divisions and other from productivity. Addressing CIP was work in progress with the end of the May 2023 being the crucial date.

WSFT – a CIP of 70-75% had been identified. It was explained that funding had been allocated for growth in activity to divisions and therefore if productivity improved it could be used for CIP to make cash releasing. Focus within divisions was on improved throughput or increased theatre efficiency. The aim was to update the Board sub-Committee in may prior to sharing information with the ICB Committee in June 2023.

EEAST – the Trust had a CIP programme of £13.6m of which a third had been identified. Much of the CIP related to thematic schemes with pay off in 2024/25 although some were expected in 2023/24. A key area of focus was the reduction of sickness. The next report to the Committee would be provided in June 2023 although headlines from the Trust's Board report could be supplied in May 2023. CIP meetings were held monthly and sub-group meetings fortnightly with the Chief Executive having attended the last meeting to reinforce the message. The organisations performance improvement plan focused on operational performance and there was a desire to link it to the CIP.

EPUT – £22.9m efficiencies were planned which was circa 4-4.5% for the organisation. Recurrency of CIPs was key. £6m was non-recurrent which resulted in an underlying issue going forward. Approximately 80% of the CIP had been identified but there was a further push to identify other schemes. There had been reasonable pick up by care units. 2023/24 would be challenging and would require more centralised grip and control of corporate areas.

Having recognised there were different methodologies with regard to the Elective Recovery Fund, it was felt that there might be benefit from sharing those differences to feed into the CIP discussions.

The Committee noted the report **and welcomed** further information at its June 2023 meeting.

23/047 SNEE ICS FINANCIAL PLANNING 2023/24

The Committee felt that the item had already been discussed under minute 23/046 above and therefore the report was **noted**.

(Louise Aynsley left the meeting)

23/048 NEWMARKET ELECTIVE SURGICAL UNIT

The Committee was in receipt of the business case for development of a multi-specialty Elective Surgical Unit at Newmarket Hospital, consisting of a 32-bed inpatient ward and two laminar flow theatres.

Key points highlighted included:

The Bid had been submitted after a four-day request for capital bids and it was recognised that further work on the financial aspect was required. West Suffolk NHS Foundation Trust (WSFT) was holding meetings to work through the consequences for its divisions. The key issue for the Trust was that it was short of capacity and had been feeling the operational impact of that for the past 12 months. There was no ability to put in additional capacity on the current West Suffolk site hence the need to find somewhere else with the most logical site being Newmarket.

The ICS had received a presentation the previous week at which it was highlighted that the revenue consequences of between £4m to £5m looked unaffordable. The bid was

supported by the ICB subject to further work to determine value for money and that it would not adversely impact the underlying deficit of the Trust. There were two elements associated to cost, with one being the cost of running the theatre and ward at Newmarket and the other being the cost of creating backfill space to provide additional emergency capacity. When the plan had been put together the Trust had looked at additional income being received in respect of additional activity and had facilitated additional budget to divisions. The cost of providing additional medical activity had been envisaged to be covered by growth of additional activity. The real cost was depreciation of PDC which was a genuine increase in cost to the System and needed to be paid for through efficiency improvement which required work through. The relevant division felt it could demonstrate increased efficiency via improved planning although that was yet to be evidenced and required further talk through with colleagues. The ICS had emphasized the need to demonstrate that the finances added up.

Whilst recognising that the bid had been prepared quickly and there was more work to do on the finances, comments were welcomed:

There was concern with regard to the revenue implications of the programme. The £400k cost for 2023/24 had been included in current plans, with 2024/25 being an issue going forward.

With regard to PDC, it was suggested that funding from Region could be available and it might be worth opening discussions with NHSE. ESNEFT's endoscopy bid had been approved within 6-7 weeks. It was queried why laminar flow was required and whether there was a possible saving there. With regard to revenue funding which it was presumed would come from fair shares growth, it was queried whether Cambridgeshire had any impact on flow etc or whether there was more capacity that could be used to reduce capital outlay.

The Committee was informed that the Trust had not been allowed to factor backlog into the new hospital programme, although there would be a backlog issue that would need to be addressed. At present there was desire to make the facility as flexible as possible which was the reason for pursuing laminar flow. Discussion with Cambridgeshire with regard to possible use of the Newmarket facility and also discussions with Region with regard to PDC and depreciation would be explored.

The need to ensure that any solution was designed in partnership with ESNEFT in order to facilitate a System solution was emphasized. It was suggested that the seven-day average length of stay did not feel like a high volume, low cost activity. The ability to staff and backfill the unit would be key, particularly with regard to clinicians and the complexity of extending to another location.

Length of stay was one area to be further investigated along with flexibility of the new facility. It was reported that the Trust when moving to its new site would be retaining its current Day Surgery Unit although it would need refurbishment. As such capacity was required whilst it was being refurbished and a flexibly designed unit at Newmarket could provide that opportunity. The ability to staff the unit was of concern although the Trust's turnover rate had recently declined and there was good work taking place across the ICS to address workforce.

It was suggested that it might be of benefit to consider any lessons learnt from the development of Braintree community hospital which would have a £18m deficit next financial year. The net additional cost was related to capital charges with the rest being activity. There was a need to deliver activity anyway and consideration was required as to the extent at which capacity delivered more efficiency. The team had already spoken with those involved with Braintree and were aware of the issues. In terms of use of a site distanced from the main base, as the scheme had been initiated from clinicians and surgeons it was hoped it was starting from a place of good engagement.

It was felt that the issue had raised a question as to how the System wished to go about assuring itself in future with regard to such schemes. There was concern that the need to make decisions within short timeframes did not allow for proper governance. The submission had gone off with ICS support but caveated with the need to demonstrate a review of the costs. A lot of the enabling work had already been completed.

The ICB's Director of Finance agreed to seek to clarify governance going forward.

In the event that there was any suggestion of under-utilisation then it would be stripped out of capacity into the new facility so that the overall System could absorb it going forward.

The Committee was assured that whilst more work would be carried out on the finances, what had been submitted was consistent with the requirements. Should the finances not be robust it would be for the WSFT Board or ICB Board to make a decision on the way forward.

The Committee noted the report and the Chair advised that the Committee was concerned to ensure that relevant work was carried out in order to clarify that revenue costs could be afforded by the System. It was felt that unnecessary tight time pressure had been put on the Trust to submit the bid. It was noted that further work was required as a System to get as much understanding geographically and cooperatively to ascertain the best way forward and that more information would be received once there was greater clarification with regard to finances.

23/049 CHAIR SUMMARY

The Chair advised that financial targets had been achieved as expected for 2022/23 although 2023/24 remained challenging. There was more work required to enhance reporting and incorporate CIP information for an overall System overview.

23/050 ANY OTHER BUSINESS

The Committee's lack of diversity was highlighted and presented as a consideration for its future development.

23/051 DATE OF NEXT MEETING

13 June 2023

NHS
Suffolk and
North East Essex
Integrated Care Board

Meeting of the SNEE ICB Finance Committee Part 1B - ICB Finances held on 09 May 2023

PRESENT:

Edward Creasy	EC	Interim Chair

IN ATTENDANCE:

Jo Mael	JM	Corporate Governance Manager (Minutes)

(As the meeting was inquorate, it did not go ahead. The agenda pack had been circulated with most papers being for note. The minutes of the previous meeting held on 11 April 2023 would be added to the agenda of the June meeting for approval)

NHS
Suffolk and
North East Essex
Integrated Care Board

Meeting of the SNEE ICB Finance Committee Part 1A - System Finances held on 13 June 2023

PRESENT:

Edward Creasy	EC	Interim Chair
Craig Black	CB	WSFT Representative
Paul Gibara	PG	ICB Director of Performance Improvement
Adrian Marr	AM	ESNEFT Representative
Howard Martin	HM	ICB Director of Finance
Mark Millar	MM	Provider Non-Executive
Kevin Smith	KS	EEAST Representative
Lauren Gable	LG	EPUT Representative

IN ATTENDANCE:

Keith Wood	KW	ICB/ESNEFT
Kathy Wilton	KWi	(Minutes)

23/052 WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting and apologies for absence were received from.

Dr Nick Rayner	NR	ICB Board Primary Care Representative
Chris Armitt	CA	ICB Deputy Director of Finance
Jason Hollidge	JH	NSFT Representative

23/053 DECLARATIONS OF INTEREST

No declarations of interest were received.

23/054 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting of the ICB Finance Committee held on 9 May 2023 **were approved** as a correct record.

23/055 MATTERS ARISING AND REVIEW OF ACTION LOG

There were no matters arising and the action log was reviewed and updated.

23/056 ESSEX COUNTY COUNCIL BUDGET 2023/24 AND SOCIAL CARE

The Committee was in receipt of the Essex County Council Budget 2023/24 and Investments for Social Care.

Key points highlighted included:

Essex County Council Budget for 2023/24 is £1.2billion shown as a net revenue budget because it gives the funding requirement from both central government funding and for locally raised Council tax and business rates.

The gross budget includes specific grants which get offset and social care is not a free service so contributions from service users would be part of the income in the net budget. The budget for adult social care and public health is just over £500 million for 23/24.

Learning Disabilities is the biggest cohort cost at £240m net, with older people at £121m which includes investment from the Better Care Fund, which will offset that, and also Older People contribute more towards cost of care than working age adults.

The budget includes savings of £36m for the year with £16m savings specifically for the Adult Social Care division.

The change of budget from 22/23 to 23/24 has been increased by £36m net, which is the 2% adult social care precept each of 1% of Council tax is about £8m so they have funded £21m to make up the £36m gap.

There is new funding available of £21.6m currently sitting in the Adult Social Care transformation reserve while decisions are made as to how that will be deployed this year and a paper going to Cabinets in July to set that out.

The two main areas of spend are residential care and domiciliary care and support including supported living.

New funding this year firstly for the Adult Social Care Discharge Fund (£1.6m growth, £5.6m total) which was received last minute at the end of last year between Local Authorities and ICB's. Secondly the Market Sustainability & Improvement Fund (£9.9m growth, 13.9m total) and thirdly the Social Care Grant (£31.6m growth).

Care Market Uplifts 2023/24 not above standard inflationary uplift for residential care but have increased the minimum rate for older placements to move to a closer parity. Have increased nursing rates by 20% and by using spot purchasing and encouraging more providers to work to improve the quality and access to those homes.

ASC £16m Savings for 23/24 will go into full year effect next year; Meaningful Lives Matter in its 3rd year also Connect programme. Seen good benefits and financial benefits from use of care technology and will see more opportunities beyond this in social care and health.

Comments included:

A suggestion was made that investment has been in growth of capability and quality and not so much in volume: and therefore demand may be suppressed so not offering better pay rates to attract better staffing.

The Committee was informed that the care workforce has a bigger vacancy factor than the NHS workforce, so they are trying to attract more people into that sector by improving rates. However, often they are working with private companies where they don't have ability to dictate what rates they pay. It was recognised this is an issue but investment into the home care market has seen an improvement in the provision of long-term care in the domiciliary care market.

It was queried how the impact of these initiatives are measured to determine underlying growth and the authorities' ability to respond effectively. There was a question as to whether some of the additional funding is being used to invest in additional capacity or to fund the savings programme.

It was explained that the budget had been set first and then ways were found to make savings before the funding target was set in the Autumn. Ways were found to set the inflation margin a bit tighter- by changing the policy on who would be offered an uplift; it was only offered to framework providers, something not done before.

It was recognised that the impact analysis was vital, and the Committee would welcome regular reporting of a performance pack demonstrating the impact of these significant investments.

The Committee was informed that there are some dashboards in existence, and they have met with Suffolk to align some reporting and they are committed to make this happen.
It was recognised that this evaluation work is in progress in Suffolk but is different in Essex. Conversations have been held with the Alliances and they are working to get a joint agreement on the plan comparable to the Better Care Fund which is a joint plan with joint governance.

It was noted that on the slide deck some of the pay uplifts are 12% or a bit higher in some cases; the ICB is trying to hold these down to around 7.6% and this is causing some tension so this should be noted as a system and financial pressures risk.

It was reported that a framework for homecare with NEE is not provided although a framework for nursing care is available. This is for historical reasons, and the framework is up for renewal in 2025 ; it was agreed there should be a common framework.

The Committee noted the report and **welcomed** further information on the impact analysis and how the new funds are being utilised throughout the year.

23/057 FINANCE COMMITTEE TERMS OF REFERENCE

The Committee was in receipt of the updated Terms of Reference with key changes highlighted:

- The key changes are as a result of the system agreement between the Chief Executives and Directors of Finance in March which outlined that the Finance Committee would have an enhanced role in system remediation in the event that a partner went off plan.
- Expanding the NED representation from one to two.
- The meetings become more face to face with some having a hybrid option.

A request was made to reflect the ToR more in the forward work plan for this Committee, with focus on key areas.

It was queried how we escalate to Board and whether it should go through SOAC and the Oversight Committee as this is now part of NHSE and the regulators.

The Committee **agreed** the key changes:

- That the Finance Committee would have an enhanced role in the system in the event that a partner went off plan and it was **agreed** to bring a paper to the July meeting which would outline the practical and effective processes that would be followed in order to fulfil this role.
- That the NED representation on the committee would be increased to two Neds'
- That the meetings would take place face to face where possible with hybrid options.

23/058 2023/24 SYSTEM EFFICIENCY SAVINGS: UPDATE

The Committee was in receipt of the System Efficiency Savings Plans for 2023/24.

It was reported that this is the first look at the efficiency savings plans without having a year-to-date position available to us at the time, so instead it focuses on the governance arrangements around the plans as they stand, with a limited preview of the plans where they have been worked up in more details. These are shown within separate documents.

Comments included:

It was highlighted that there is a lot of variety in the reports, and we should be considering standardising the presentation.

The Committee were informed that the Regional Productivity Group is producing a standardised format for systems to report through, and our aim will be to utilise this as an organisation to capture the information. However, we are trying to avoid creating an extra layer of information demand, thus not replicating the situation of last year when we were reporting on around 600 CIP schemes.

It was noted that this provides an opportunity for the system to adopt a set of principles to increase productivity efficiency across the Alliances and how this is brought together across so that providers can collectively make improvements in the way that money is spent .

This was supported as an opportunity for discussion across divisions to learn from each other and discuss improvements which will hopefully lead to improved clinical and service to service discussions and better outcomes.

The Committee noted the report and agreed an **Action** to seek a degree of standardisation on CIP progress which would allow for each organisation to compare its progress against what others are doing

23/059 RISK AND REVISION OF BAF ENTRY

The Chair advised that this report has been deferred to the July meeting

23/060 CHAIR SUMMARY

The Chair advised that this had been a very good meeting in terms of working through the purpose of this committee;to make sure that we see and can advise when things are going wrong and find constructive and effective solutions to bring back on track. In terms of cost improvements, we can work together to create genuine improvements across the whole system, and we will bring back more detail to a future meeting for discussion.

It was noted that we are now going through the process to recruit a permanent Chair of this committee with interviews expected to be completed by end of July with a start in August or September. If anyone has any recommendations for a person who would be good for this role, please contact Howard directly.

23/061 DATE OF NEXT MEETING

11 July 2023

NHS
Suffolk and
North East Essex
Integrated Care Board

Meeting of the SNEE ICB Finance Committee Part 1B - ICB Finances held on 13 June 2023

PRESENT:

Edward Creasy	EC	Interim Chair
Paul Gibara	PG	ICB Director of Performance Improvement
Howard Martin	HM	ICB Director of Finance

IN ATTENDANCE:

Kathy Wilton	KW	(Minutes)

23/018 WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting.

Apologies for absence were noted from;

Dr Nick Rayner	NR	ICB Board Primary Care Representative
Chris Armitt	CA	ICB Deputy Director of Finance

23/019 DECLARATIONS OF INTEREST

No declarations of interest were received.

23/020 MINUTES OF THE PREVIOUS MEETING

The minutes of meetings of the ICB Finance Committee Part 1b held on 11 April 2023 and 9 May 2023 were reviewed **and agreed** as a correct record.

23/021 MATTERS ARISING AND REVIEW OF ACTION LOG

There were no matters arising and the action log was complete.

23/022 SNEE ICB BUDGETS 2023/24

The Committee was in receipt of the SNEE ICB Budgets 2023/24

The Committee Agreed and noted that the delegation of budgets had been to Scrutiny Committee.

23/023 ICB COST IMPROVEMENT PROGRAMME

The Committee was in receipt of the ICB Cost Improvement Programme.

The Committee noted the report and **welcomed** that the program was going well and had produced a strong set of plans with a drive on non-pay items. However, they noted an additional risk in the short term as Liz Moloney was now taking on additional responsibilities which could mean her focus on this programme being diverted.

23/024 CHAIR SUMMARY

This had been set out in the previous meeting

23/025 DATE OF NEXT MEETING

11 July 2023

NHS
Suffolk and North East Essex
Integrated Care Board

Minutes of a meeting of the ICB Quality Committee held on 11 May 2023

PRESENT:

Phanuel Mutumburi	Acting ICB Board Non-Executive Member (Chair)
Sarra Bargent	Ipswich and East Suffolk Alliance Representative
Victoria Baster	ICB Associate Director of Nursing, Urgent and Elective Care
Jackie Bland	North-East Essex Alliance Representative
Richard Cracknell	Suffolk County Council, Asst Director of Public Health & Communities (Part)
Simon Froud	Essex County Council (ECC) Representative (Part)
Samantha Glover	Healthwatch, Essex
Natalie Hammond	Essex Partnership University NHS Foundation Trust (EPUT)
Dr Andrew Kelso	ICB Medical Director
Paul Molyneux	West Suffolk NHS Foundation Trust (WSFT) Representative (Part)
Giles Thorpe	East Suffolk and North Essex NHS Foundation Trust (ESNEFT)

IN ATTENDANCE:

Joe Allen	ICB Head of Patient Safety
Ganesh Baliah	ICS Strategic AHP Workforce Lead, Suffolk and North-East Essex ICS
Laura Bowen	ICB Business Intelligence Team
Vicki Briggs	ICB Continuing Healthcare Team
Elizabeth Hogg	ICB Locality Clinical Manager
Cindie Dunkling	ICB Designated Nurse for Safeguarding Children
Anisha Sharma and Vanessa Lodge	ICB Senior Interface Pharmacist, ESNEFT, Ipswich and East Suffolk Alliance North-East Essex Alliance Independent Consultant
Lee Toner	LPS Programme Lead
Stephen Woods	Governance and Clinical Risk Manager
Jo Mael	Corporate Governance Manager (Minutes)

23/037 INTRODUCTION, APOLOGIES AND QUORACY

The Chair welcomed everyone to the meeting and apologies for absence were noted from;

Sue Cook	Suffolk County Council (SCC) Representative
Lisa Nobes	ICB Director of Nursing
Rebecca Thompson	Practice Plus Group Representative
Andy Yacoub	Healthwatch, Suffolk

The meeting was noted as quorate.

23/038 DECLARATIONS OF INTEREST

No declarations of interest were received.

23/039 ANY SERIOUS SAFETY CONCERNS NOT ON THE AGENDA?

No items were notified.

23/040 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting of the ICB Quality Committee held on 9 March 2023 **were approved** as a correct record.

What is the data telling us?

23/041 QUALITY DASHBOARD

The Quality Committee was in receipt of the current quality dashboard. The Quality Committee had established a working group to populate the dashboard and finalise the template. It was important to be able to provide assurance to the ICB of early warning signs. Whilst the importance of data was recognised there was also a need to take account of patient feedback and soft intelligence. Healthwatch received a lot of information and provided guidance via in-depth stories across a range of subjects.

The Committee was asked to review the format of the dashboard which provided opportunity to discuss what had been working well and to draw out strengths within the System.

There was recognition that the dashboard was very health focused and that more work was required in conjunction with local authorities to explore how client satisfaction information might be included.

Comments included:

The inclusion of satisfaction and survey information was welcomed, and the Committee was informed that local authorities carried out surveys for carers which might be able to be linked into the dashboard. **Richard Cracknell agreed** to investigate the provision of satisfaction information from Suffolk County Council.

It was noted that EPUT information had been omitted and would be included in future presentations. Having queried where information was obtained from, it was explained that it came from provider data sets, government information, staff surveys and friends and family test data.

Whilst the information was interesting, it was felt that with regard to patient safety incidents it might be more beneficial to look at the rate of incident reporting and level of harm from incidents reported.

From a local authority perspective, it was highlighted that all information was reviewed by the Care Quality Commission in order to performance manage and therefore there was perhaps a need to be careful about how the data was used from a quality and performance management perspective.

It was felt that it was not the role of the Committee to do performance management but to gain assurance that risks were being identified and suitably managed to facilitate improvement.

There was a need to link system wide risks and ensure they were aligned to strategy.

The importance of coming together as a System to review best practice and facilitate learning was emphasized.

Having queried where population health management work sat, it was explained that it was separate at present. Quality touched everything but needed to see relevant data from other work and members of the quality team were working in all workstreams.

Workforce remained the largest risk and there was a need to work closely with the ICB's People Committee, although that Committee was focussed on more strategic issues such

as future planning and workforce issues that were driving quality should continue to be raised here.

The ICB's Medical Director agreed to discuss closer working in respect of population health management and workforce within the Executive team and report back.

The Committee noted the report.

23/042 SNEE QUALITY GROUP

No report for the May 2023 meeting.

23/043 QUALITY RISK REGISTER

The ICB Quality Risk Register was presented for the Committee to note risks contained within the ICB's Board Assurance Framework (BAF) and to approve those on the Quality risk register.

All risks had been reviewed and updated in April 2023, with key points being;

- *CNO-001, 009 & 032 – Mental Health related risks on the BAF* - the risks were being incorporated into a System Wide Risk on Mental Health
- *CNO-002 – Covid 19 related risks on the BAF* - the risk was being incorporated into a System Wide Risk on Covid 19
    - *CNO-004 - Safety concerns regarding maternity services across the ICS Specific concerns relate to staffing* - the risk had been transferred to the LMNS Risk Register.
    - *CNO-008 - The existing DOLS legislation will be replaced by the LPS legislation* - the risk to the ICB of non-compliance to legislation for LPS Code had changed due to announcement by DOHSC on 5th April 2023 that implementation would be in delayed beyond the life of Parliament. Current Deprivation of Liberty Safeguards would remain an important system for authorising deprivation of liberty in line with the Mental Capacity Act 2005. Ongoing MCA and DoLs processes across the ICB would remain in place and that would ensure MCA and DoLs would be supported in accordance with national, regional and local requirements. Closure of risk recommended to ICB Quality Committee

The ICB's Medical Director reported that risk management across the ICB and ICS was currently under review, and it was felt that the Committee risk register might not reflect the risks being discussed. A paper was being prepared for the ICB with the main quality risks highlighted as being access, workforce, staff burn-out and the social determinants of health. A workshop was being convened in June 2023 to review the ICB risk register, the outcome of which would be reported back to the Committee.

With regard to eating disorders work was underway to pull together risks from all providers into an over-arching System risk. It was felt that demand and capacity was a key issue. EPUT had established a sub-group to carry out a review of the pathway in Essex, the outcome of which should be available in August 2023. **It was agreed** that it be entered onto the Committee's forward plan for presentation at a future date.

Digital was also a large risk to quality in respect of the impact of providers being at different points with regard to access to information and would be considered in line with the risk workshop.

The Neuro-developmental pathway was a current and future risk.

The Committee;

1) **Approved** the ICB High Risks Quality Risk Register that were not on the BAF.

2) **Noted** the Board Assurance Framework (BAF) for Quality Risks and those Quality Risks rated as medium or below.

23/044 ALLIANCE UPDATES

The Committee received the following Alliance updates.

- Ipswich and East Suffolk Alliance – there was increased risk associated to access to dentistry, and in particular, access for care home residents which had been escalated to the dental team.
- North-East Essex Alliance – there had been improvement to the provision of SMI health checks and the team were congratulated on their performance.
- West Suffolk Alliance

The Committee noted the updates.

23/045 PARTNERSHIP UPDATES

The Committee received updates from the following partners:

a) Suffolk County Council (SCC)
b) West Suffolk NHS Foundation Trust (WSFT)
c) East Suffolk and North Essex NHS Foundation Trust (ESNEFT)
d) Norfolk and Suffolk NHS Foundation Trust (NSFT)
e) Essex Partnership University NHS Foundation Trust (EPUT)
f) East of England Ambulance Services NHS Trust (EEAST)

The Committee noted the partnership updates received.

How we work together.

(The Chair revised the order of agenda items going forward as per below to allow presenters of reports to be in attendance)

23/046 MORTALITY AND LEARNING FROM DEATHS

The report summarised the SHMI data for both Acute Hospitals within SNEE and key issues identified at recent Mortality Review meetings, those being;

- No PSIIs had been raised by the mental health providers in 2022-23.
- Investigating mortality, and reporting data, enabled identification of further ways to improve patient outcomes and safety.
- Preventable deaths were no longer reported on under the new Framework, however there were no deaths occurring during the reported period that were deemed to be ‘avoidable’.
- The SHMI data for the period July 2021 to June 2022 was 0.95. That was banded ‘as expected’ based on NHS Digital’s 95% control limits.
- Deaths registered by local authorities remained constant and included, Cancer, Alzheimer’s / Dementia and Cardio-vascular as the primary cause of death.

- The level of assurance for Learning from Deaths across the ICS was Partial.

The Medical Examiner System was ensuring that providers took a consistent and evidence-based approach to reviewing case records of adults who had died in acute hospitals. National guidance required that all inpatient, outpatient and community patient deaths of people with severe mental illness (SMI) should be subject to case record review.

The report ensured oversight of mortality and reporting on data to identify improvement. It was aimed to launch a formal medical examiners system by April 2024 as it would be a statutory requirement from 24 April 2024. Both acutes had made good progress with setting up teams and the ICB was working with them to support. Mental health Trusts were also building teams but were not quite as advanced. There was a need to better understand primary care and where learning was being shared. At a recent regional meeting there had been discussion with regard to the establishment of learning form death meetings with other Systems being keen to learn from Norfolk and Waveney who were further down the line.

It was queried how learning and data from child deaths might be included as at present it sat with safeguarding information which was not always relevant. It was felt beneficial to link it in and it was highlighted that the regional meeting had received a good report from the national child mortality database.

It was noted that the Committee's forward plan already included a six monthly review of learning from deaths.

The Committee noted the content of the report.

(Paul Molyneux and Simon Froud left the meeting)

23/047 SUFFOLK AND NORTH-EAST ESSEX INTEGRATED MEDICINES OPTIMISATION COMMITTEE (SNEE IMOC)

In accordance with its Terms of Reference, the SNEE IMOC would provide assurance to the SNEE ICB Quality Committee on medicines optimisation related to patient safety. The report was submitted for information to provide assurance of the medicines safety activities undertaken by the Committee.

The Suffolk and North-East Essex Integrated Care Board (SNEE ICB) Quality Committee was asked to note the medicines safety discussions undertaken by the Suffolk and North-East Essex Integrated Medicines Optimisation sub-committee (SNEE IMOC) for the period of October 2022 to March 2023 as detailed in the report. All items were consulted upon by the Suffolk and North Essex (SNEE) Prescribing Clinical Reference Group (CRG) or equivalent prior to SNEE IMOC approval.

Key issues had been antibiotic shortages and a lot of work had been carried out to mitigate the risk and ensure patient safety. When antibiotics had come back into supply the cost had increased which had affected the prescribing budget.

SNEE IMOC continued to work collaboratively as a system to identify medicines safety related issues and support the local health economy in mitigating against it. Occasionally, the issues and solution needed to be raised at an Alliance level to support the work undertaken.

The affect of shortages of HRT on womens health was highlighted, together with the importance of addressing the consequences of shortages on equality and diversity.

The Committee noted the content of the report.

23/048 QUALITY MODEL FRAMEWORK

The quality assurance framework had been developed over the last few months in conjunction with partners across the system and aligned to the current approach of partnership working and system assurance.

Following a number of discussions and workshops with clinical quality colleagues the framework responded and addressed areas of concern by system partners. The framework particularly clarified quality assurance methods, accountability arrangements, internal governance and escalation systems.

Of note, the framework described the ambition and behaviours expected by the system which had been fully endorsed by system partners.

The framework would allow a reset of arrangements with refresh of committee terms of reference as well as commitment for openness and honesty across the system when support was required.

The importance of looking at data, listening to soft intelligence, having strong governance in place and opportunity to appraise were emphasized. Should the model be approved it was important it had whole System sign up.

Quality principles were set out in the model which included the need to be transparent and have honest conversations.

Comments included:

There was excitement with regard to taking the work forward and, if approved, it was recognised that a workplan would need to be developed in order to progress.

The Committee approved the Quality Model Framework as presented and thanked Vanessa Lodge for her work and support.

How are we progressing on priorities?

23/049 ESNEFT QUALITY STRATEGY 2022-27

The ESNEFT quality strategy set out the Trust's commitment to improving the quality of care for its patients over the next five years and how it would make it a reality.

The quality strategy provided the overarching framework for the delivery of quality care at ESNEFT. The way in which staff were empowered and enabled to design and deliver the quality objectives was key to ongoing success, through the QI methodology and approach. The strategy was structured to deliver each set of objectives over a 24-month period which would allow Divisions and staff to be fully engaged in how the Trust planned to deliver its aims over the next five years and enabled the Divisions to focus on quality objectives during business planning cycles. Each Division also provided a quarterly update to the Trust's Patient Safety Group, Clinical Effectiveness Group and Patient Experience Group which included progress against the Quality Objectives as detailed in the report.

Within each of the quality objectives were a number of key priorities and outcomes and their corresponding measures of success and those are detailed within the strategy.
The Quality Strategy had been shared with stakeholders and their feedback had been incorporated into the strategy.

Comments included:

It was pleasing to see that the principles of quality care incorporated EDI and safety culture. In response to questioning the Committee was informed there was intention for the patient

safety academy to be available for System partners going forward.

Having queried how development of the Strategy impacted on other strategies and progression of the quality model framework, it was explained that it fed into the overarching ambition of quality improvement although all organisations would continue to have individual strategies which would feed into the overarching system framework.

There was a recognised need to have variation across the system and organisations were encouraged to have a strategy that worked for them.

The Committee noted the Strategy.

23/050 CARE QUALITY COMMISSION – ACTION PLAN UPDATES

a) Norfolk and Suffolk NHS Foundation Trust (NSFT)

- The CQC's latest report had recognised NSFT's improvements to date.
- Inspectors had lifted the trust's rating to 'requires improvement' overall.
- Across the CQC domains for the whole Trust it was now rated 'requires improvement', with the exception of the Caring domain where the rating remained 'good'.
- 60% of individual services that had been inspected were now rated 'good'
- The legal warning notice relating to quality and safety of care had been lifted.

The report went onto provide more detailed information.

It was noted that NSFT was currently having lots of meetings and it was understandable that representatives were absent today. There was recognition of the work carried out to date and the challenge being faced to sustain the improved performance levels. As the Trust moved out of national oversight it would need support from the System to continue improvement.

b) ESNEFT CQC Action Plan update report – Medicine/Older People's Services – Colchester Hospital

The report provided an update on the action plan development and activities as shared with the Trust's Quality Committee. There was evidence of appropriate management, executive oversight and actions being taken with expected completion dates by the end of April 2023.

The Committee was informed that although the recommendations had been made in relation to Colchester they had also been transferred to actions for Ipswich as well. An action plan was in place, and it was anticipated that all actions would be completed by the end of July 2023.

The Committee noted the updates.

23/051 MENTAL HEALTH AND LDA QUALITY UPDATE (MH AND LDA SPECIALIST SERVICES)

The report provided information on the highlights and oversight of ICB mental health quality over the previous two months.

NSFT was congratulated on its recent CQC inspection report, and rating improvement from 'Inadequate'' to 'Requires improvement'. Jointly through a quality safety re-review on the community forensic team, significant patient and staff satisfaction improvements had been seen with regard to how the service was operated and delivered.

Host commissioner oversight of Elysium Chimney's had reduced from enhanced to routine.

Both transforming care partnerships (Suffolk and Essex) remained within agreed inpatient trajectories for LDA.

The report went on to provide more detailed information on key issues within Section 2.

The Committee noted the report.

23/052 QUARTERLY SEND UPDATE – DEFERRED TO JULY 2023 MEETING

a) Programme Report

b) Accelerated Progress Plan

The Committee agreed that the reports be deferred until the July 2023 meeting.

23/053 a) SNEE SAFEGUARDING REPORT – QUARTERLY OVERVIEW (Q4)

b) LIBERTY PROTECTION PROGRAMME AND RISK UPDATE REPORT.

a) SNEE Safeguarding Report – Quarterly Overview (Q4)

The report provided a Safeguarding quarterly overview across SNEE on:

- Key issues (National and Local)
- Actions/mitigations
- Escalations/Risks – RAG rated
- Child Death Review Quarter 4

The Committee was informed that within the MASH team there was heavy reliance on bank staff which was affecting the team's ability to function effectively and feedback to organisations was delayed. To mitigate that situation the manager was currently working as part of the team.

IES safeguarding incident – the pathway was due to be reviewed and information was currently being gathered.

The review of GP identification of safeguarding concerns within Colchester was complete and the outcome awaited.

Child death review data had been included. Two key issues were the difficulty in making diagnoses for children in a timely manner due to a lack of IT system compatibility across organisations and a rise in Serious Incidents reviewed by organisations following the death of a child.

Comments included:

The report was welcomed, and it was felt some of the information would be worth discussing at the Health Executive Forum. Having queried whether other ICBs were producing similar information, it was explained that Norfolk and Waveney produced similar information although others did not due to a lack of resource. There was a statutory duty to supply safeguarding information on a regular basis to the Committee.

Having queried what the Committee could offer, it was advised that the most important thing would be for the Committee to listen and provide support.

Having recognised that people with dementia were entering acute Trusts and getting stuck, work had begun to explore review of the pathway.

b) Liberty Protection Programme (LPS) and Risk Update Report.

Following implementation of The Mental Capacity (Amendment) Act 2019 the new Liberty Protection Safeguards (LPS) were planned with publication of a Code of Practise and Regulations. The LPS Programme was established and a LPS Programme Lead was recruited into post December 2022 to work across SNEE, Mid and South Essex and West Essex systems.

On the 5 April 2023 the Department of Health and Social Care announced its decision to delay the implementation of the Liberty Protection Safeguards beyond the life of Parliament as part of work being planned and undertaken to improve adult social care, as a result, many of the national and regional leads would move to other departments and areas as the LPS Programme was stepped down.

Following that announcement, the LPS Programme would be stepped down across Suffolk and Essex at the end of May 2023 and, as such, it was suggested that the risk regarding LPS implementation now be removed from the corporate risk register.

NHSE Regional communications had advised that, as systems had spent more than two years planning and preparing for implementation of LPS which had included work around Deprivation of Liberty and Mental Capacity Act 2005 assurance it was vital that health and social care providers continued to make applications in line with current legislation to ensure the rights of those who might lack the relevant capacity were protected.

It would be up to each area to decide how to continue work around MCA assurance and what ongoing improvements were required. NHSE had suggested individual systems take stock and continue system collaboration on MCA improvement. ICB's would retain responsibility for seeking assurance directly from NHS providers on their MCA practise.

Over the next six weeks LPS Programme evaluation would be undertaken with recommendations for next steps and future MCA practise and assurance.

The Committee noted the updates.

23/054 MATTERS ARISING AND REVIEW OF ACTION LOG

There were no matters arising and the action log was reviewed and updated.

23/055 ANY OTHER BUSINESS

Norfolk and Suffolk NHS Continuing Healthcare Joint Working Policy

The ICB had had a co-produced joint working policy for NHS Continuing Healthcare covering Suffolk, since 2017. That policy had been subject to routine review and, as a result, had had a minor update as detailed in Section 2 of the report. Material changes related to changes in the National Framework for NHS Continuing Healthcare.

The policy covered Ipswich and East Suffolk Alliance and West Suffolk Alliance. There was an existing Pan-Essex policy that would be updated in due course, in collaboration with the Essex ICBs and Local Authority partners.

The policy update was subject to approval via the governance processes of all the organisations involved and, to date, had been through the appropriate governance processes within Suffolk County Council and had been approved.

The Committee recommended the policy to the SNEE ICB Board for approval.

System risk around Colchester's Paediatric Waiting List re Autism, ADHD and Neuro development delay

The Committee was informed that the waiting list had grown dramatically with there now being over 5000 referrals which resulted in initial assessments being out of date by the time individuals were invited to attend. There were on average 265 referrals a month with 185 new medical slots per month being available. There was a 52-53 week wait for a first appointment. Although some capacity had been utilised in mid-Essex it was not consistently available. It could take over two years to diagnose a child which was a huge clinical risk. The Trust was looking at additional roles and taking all appropriate actions with regard to the provision of additional slots and sessions which included nurse led clinics. The Trust was advertising for a full-time psychologist and developing demand and capacity models, together with looking at IT solutions.

The current issue was the responsibility of the whole System to resolve.

There was a need to pursue the provision of training and development of the workforce via the People Committee, together with considering the future workforce need.

The issue was being discussed at the Alliance Committee and there was a need to assess the wider system risk. It was importance to ascertain what mitigations were available and how voluntary services and local authorities could be supported in order to support children.

It was suggested that the best support might be support from families that had been through it and perhaps there was potential to explore facilitation of such support.

It was recognised that neuro diversity was separate from learning disability and Learning Disability Nurses did not always have the necessary skills. It was suggested that Lianne Joyce and Katherine Searle be invited to a future meeting to provide more awareness.

The Committee noted the concern and **the ICB's Medical Director agreed** to make contact with Lianne Joyce and Katherine Searle with regard to the issues raised, prior to reporting back.

23/056 ITEMS FOR ESCALATION

The ICB's Medical Director reported that it had been agreed that, going forward, there would be an agreed formal section on the SNEE ICB Board agenda for a quality report. The report for the May 2023 SNEE ICB Board would include report on the dashboard, regulatory assessment, learning from deaths, safety culture, risk, access to treatment, collective assurance framework and, following today's discussion would include a verbal update on the neuro-development risk.

23/057 DATE OF NEXT MEETING

13 July 2023 – 1400-1700

NHS
Suffolk and
North East Essex
Integrated Care Board

Meeting of the Integrated Care Board People Committee
held on 21 June 2023
(via MS Teams)

PRESENT:

Paul Driscoll-Evans	PDE	HEI Representative (Chair)
Ganesh Baliah	GB	ICS Strategic AHP Workforce Lead, Suffolk and North-East Essex ICS
Peter Bumphrey	PB	EEAST Representative
Kate Coplestone	KC	Suffolk County Council
Catherine Castleton	CC	NSFT Representative
Rachel Jennings	RJ	ICP Representative
Victoria Joffe	VJ	University of Essex
Dr Andrew Kelso	AK	ICB Medical Director (Part)
Rachel Laverty	RL	EPUT Representative
Amanda Lyes	AL	Director of People and Workforce
Lisa Nobes	LN	ICB Director of Nursing
Jeremy Over	JO	West Suffolk NHS Foundation Trust
Deborah O'Hara	DO	ESNEFT
Kate Read	KR	ESNEFT
Graham Seward	GS	ICB Head of Workforce Transformation
Mark Smith	MS	Allied Health Professionals
Giles Thorpe	GT	ESNEFT
Fiona Wilson	FW	Essex County Council

IN ATTENDANCE:

Amina Chitembo	AC	System Culture Transformation Lead
Therese Elliott	TE	ICB Education Transformation Lead
Simon Morgan	SM	ICB Head of Communications
Alice Robinson	AR	WSFT
Giles Turner	GT	ICB Head of Workforce
Renee Ward	RW	ESNEFT
Jo Mael	JM	ICB Corporate Governance Manager (Minutes)

ACTION

23/029 WELCOME, INTRODUCTION AND APOLOGIES

Amanda Lyes, the ICB's Director of People and Workforce welcomed everyone to the meeting and in the absence of Tanya Curry, Chair of the People Committee it was agreed that Paul Driscoll-Evans would take the Chair for today's meeting.

Apologies for absence were noted from:

Kirsten Alderson, Chair, Voluntary Sector Assembly
Alison Andreas, Principal and Chief Executive, Colchester Institute
Penny Ashbee, Primary Care Representative
Tanya Curry, Non-Executive Member, People, Remuneration and Diversity, Chair
Susannah Howard, ICP Director
Jo Lennox, Digital & Workforce – ICS Programme Lead
Saffron Rolph-Wills, HEE Representative
Dr Mark Shenton, ICS Clinical Lead & ICS Integrated Care Academy Representative

23/030 MINUTES OF PREVIOUS MEETING, MATTERS ARISING AND REVIEW OF ACTION LOG

The minutes of the previous ICB People Committee meeting held on 19 April 2023 **were approved** as a correct record.

The action log was reviewed and updated.

23/031 DECLARATIONS OF INTEREST AND HOSPITALITY AND GIFTS

No declarations of interest were received.

STRATEGY

23/032 WORKFORCE, TRAINING AND EDUCATION

Purpose, Objectives and Key Deliverables 2023/24

The People Plan set out actions to support transformation across the whole NHS. It focussed on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as action to grow our workforce, train our people, and work together differently to deliver patient care.

The health and care sector was made up of people in many different roles, in different settings, employed in different ways, by a wide range of organisations. Working closely with partners in social care and local government, as well as with the voluntary and independent sectors. we also benefit from the contribution of those in unpaid roles too – particularly carers and volunteers. How different elements of the plan were implemented would vary across those different settings, but the principles it set out applied across all organisations, and to all our people involved in providing or commissioning health and care.

Key elements were:

- Growing the workforce
- Working differently and productively
- In compassionate and inclusive culture

There were a number of programmes and activities taking place across the three elements. It was intended that today's meeting would focus on work taking place across the 'growing the workforce' and 'compassionate and inclusive culture' elements, together with considering the system workforce risk register.

The reported provided an introduction to the objectives and key deliverables set by NHSE and examples of the programmes established across those areas.

Managing the Workforce Risk:

The Committee was in receipt of the revised workforce risk within the Board Assurance Framework for debate and discussion.

It was important to ensure that all risks were related to the objectives and that there was identification of high-level risks in order to seek mitigation and assurance. The Committee was asked to review and comment on the risks highlighted within the report as high-level system risks.

Comments included:

Having queried where risks would be raised within the system, it was felt essential that risks were raised through the People Committee in the first instance.

There was concern as to how risks that were within the control of partner organisations would be managed. It was felt that whilst it was recognised that providers would hold their specific risks, they also had responsibility to provide assurance and support across the system.

Having noted that the risks reported were high level and generic, it was highlighted that providers might have other risks that were hybrid situations such as the future system programme at West Suffolk NHS Foundation Trust which held workforce challenges associated with inhabiting a new building, which the Trust would not be able to address on its own.

How much was within the control of the ICB was questioned, together with whether the system wide view would draw out anything specific about challenges associated with the voluntary sector workforce which was low paid and had more reliance on short term funding. In response it was felt that those challenges should be identified and monitored within individual workstreams and may not be appropriate for the high-level risk register.

The emerging workforce risk report was welcomed and the need to seek to connect the system workforce risk with the quality risk going forward was emphasized.

Having noted that the language was very health orientated, the need for it to be more system focused was highlighted.

The Committee approved the direction of travel with regard to risk **whilst recognising** that further work was required.

23/033 GROWING THE WORKFORCE

Establishing a Network of Excellence in Health Apprenticeships

The University of Suffolk, in partnership with further education providers from across East Anglia, was proposing the creation of the East of England 'Centre of Excellence for Health Apprenticeships' (CEHA), to support the region's integrated care system's strategic intention to grow their future supply pipeline via apprenticeship pathways. The report provided an updated overview of the CEHA proposal.

The report provided detail on background information, objectives, phase 1 activity and investment.

Funding was available to enable the initiative to launch in 2023, with income received from the apprenticeship levy ensuring its future sustainability. It was hoped that further funding would be available to support a phase 2 roll out. It was explained that as phase 1 had been nurse focussed the language within the report had focussed on health to obtain funding, it was anticipated that the language would be more social care focussed for phase 2.

Having queried the need to consider integrated apprenticeships, it was highlighted that

Children and Young People was an area of work that might be suitable to begin that work. It was good to get front line staff identifying potential opportunities and also to take the work across mental and physical health and adult services and in those areas where there were quality issues.

The Committee noted the update.

SNEE ICS Strategic Clinical Education Governance Group – proposal

With the changing nature of ICBs, the proposed delegation of responsibilities from NHSE, alongside the requirement to deliver the 10 outcome-based people functions, there was a greater need for system working, collaboration and oversight. There was currently a lack of awareness and co-ordination of education related activity to support the delivery of system workforce plans. The report recommended the implementation of a senior level system clinical education governance group essential to promote a strategic vision and support the governance and assurance for workforce training and education and associated funding for health and social care partners.

The report sought support to identify a SRO for Education Identified and for establishment of the SNEE ICS Strategic Clinical Education Governance Group which would feed into the People and Quality Committees as indicated by the governance structure set out within the report.

It was noted that the presentation had been to various forums before coming to People Committee and if approved the next steps would be to develop terms of reference and the focus on development of an Education Strategy.

Comments included:

There was recognition of the work that had taken place. It was reported that although there was currently some scepticism across the system as there was a lack of understanding of need, the report set out why a system approach was required. The voluntary sector was an important partner and a high user of clinical staff and it was suggested that it might be worth seeking out information as to what had already been done in that area.

The Chair advised the Committee that by agreeing to take the decision to move forward there was responsibility for partners to participate and support its success. It was felt that the objectives were interesting and at the right level.

The Committee approved the recommendations as set out within the report.

23/034 IN A COMPASSIONATE AND INCLUSIVE CULTURE

System Culture Support from NHSE to SNEE

Amina Chitembo was welcomed to the meeting and proceeded to give a presentation which introduced herself as System Culture Transformation Lead and set out the vision for system culture work going forward.

The presentation provided information on the role of the System Culture Transformation Lead and its focus on EDI local priorities whilst recognising that different systems were at different levels. There was a need to consider the needs of the local population and provider organisations. The presentation detailed work to accelerate the aims of the Anti-racism Strategy; looked at baseline questions with regard to where we are as a system; how EDI was being embedded in all processes; expectations; assessment findings; the delivery of actions and development of a first three month plan; and challenges and opportunities.

Comments included:

Amina was thanked for her powerful presentation and work to take issues to the next level and look at opportunities within the system to develop the EDI agenda. It was suggested that Amina might like to contact Susannah Howard ICP Director as it was felt that some of Susannah's work might compliment Amina's going forward.

Support to gain feedback from the voluntary sector was offered.

It was highlighted that thought was required as to how the national improvement programme might change locally driven priorities. The facilitation of active staff networks would be important in joining work up.

The Committee noted the update.

System EDI Programme Update

SNEE ICS, in line with current legislation and NHSE policy, had responded by collaborating with system partners to formulate an EDI Programme and oversight function, which recognised the central importance of developing an inclusive workplace culture to support current and future staff and measure the impact on that regarding the recruitment and retention of staff and additionally patient care and outcomes.

The report synchronised with the recent launch of NHS England's EDI improvement plan and was set in the context of the NHS People Plan and People Promise, as well as the 'Leadership for a collaborative and inclusive future' report. It would also compliment the imminent Long-term Workforce Plan.

The NHSE EDI plan included six key actions, those being:

1) Implement measurable objectives
2) Recruitment and talent management
3) Eliminating pay gaps
4) Addressing health inequalities
5) Induction and onboarding internationally recruited staff
6) Bullying and harassment

The ICS EDI Programme would use those to influence on-going work.

The Committee was informed that the EDI Working Group continued, and it was planned that a Workforce and People EDI summit would be held later in the year. Work would be taken forward in line with the Joint Forward Plan and there would be development of undergraduate healthcare student placements and staff networks. There was a System inclusive recruitment project and staff networks had been established within the ICB which tied in with the NHSE EDI improvement plan.

The University of Essex representative welcomed further exploration of the work and expressed concern at potential unfairness and discrimination experienced by international students.
The ESNEFT representative questioned how long the work had been going on for and where it was connected in with the Trusts. It was explained that initial work had taken place across the System with partners asked to share their priorities and work to date. **GB agreed** to pick up the issue with KR outside of the meeting.

The importance of using the term 'global majority' rather than others such as 'ethnic minorities was highlighted. The work was welcomed, and it was important to challenge ourselves to see people holistically and not by one characteristic. Whilst there was a need to address the racism agenda the System should seek to be more ambitious and go further.

The Committee noted the report.

Integrated Leadership Proposal

SNEE ICS had identified a requirement to design and implement an Integrated Leadership Development Model. Scoping to date had established that the model would:

- Span all public sectors – NHS, Social Care, Primary Care, VCSE, and potentially wider public sector caring communities such as education, police, fire etc.
- Include all levels of managers and leaders – it would embrace a distributed leadership model.

It was recognised that the proposal required further work and NHSE had sponsored that piece of work as developing people to lead was high on its list of priorities. Comments were welcomed on the brief.

Having queried what would attract people to the model, it was felt that it was about collating a range of opportunities for individuals to pursue.

There was concern from partner organisations such as Suffolk County Council and the University of Essex that they already had similar programmes/models they were pursuing, and it was important not to duplicate and reinvent but to work together and ensure there was common ground in respect of leadership.

The Leading Greater Essex programme had already been established which annually sought focus on key issue for Essex at the time.

It was reported that the voluntary sector was exploring how to build resilience and a lot of the approach aligned to what its task and finish groups were requesting. One example of good work was that post graduate tutors had requested placements within the voluntary sector for foundation course doctors.

The Committee approved the proposal of an Integrated Leadership Programme as set out within the report.

23/035 SNEE ICS WORKFORCE PROGRAMME: OUR PRIORITY AREAS, WHERE NEXT?

Due to time constraints the item was deferred.

23/036 RETAINING THE WORKFORCE

SNEE Advanced Practice Faculty

Advanced practice was a level of practice in which a practitioner had demonstrated their ability to work autonomously at a high level (level 7/ Masters level) across all four pillars of advanced practice. The four pillars of advanced practice were clinical practice, leadership and management, education, and research.

Until recently there had been no regulation of the job title “Advanced practitioner” thus creating great variation and disparity of skill set and no clear minimum skill set. That in turn led to concerns over competence amongst that workforce. Therefore since 2017 NHSE (and formally HEE) had been working to create an agreed standardisation and expectation of the Advanced practitioner role – ensuring that there was a clearly defined framework practitioners must adhere to and be able to demonstrate evidence against to hold and maintain the job title.

Next steps included:

- Review of SNEEs population health aims and the impact that advanced practice roles could have on the success of those.
- A first F2F conference for SNEE APs on 30th June 2023.
- Commissions for new trainee APs had now been approved by NHSE.
- There was a critical shortage of appropriately trained personnel to act as educational
  supervisors for trainee ACPs across the ICS which was delaying the development of new trainee AP roles. We welcomed our new supervision ambassador for the training hub early in the year and were working collaboratively as an ICS on a supervision framework in order to address the shortfall of supervisors across the region. The first stage of that had been a large-scale supervision questionnaire posed to both supervisors and those receiving supervision to ascertain the status quo across SNEE. That would be fed back and formally workshopped with the advanced practice workforce across the ICS on 30th June at the AP conference.

In response to questioning it was explained that the purpose of the presentation was to highlight advanced practice and question where it was on the Committee's agenda and how those involved with it might help its progress.

It was noted from a previous presentation that there was intention for the Advanced Practice Group to feed into the SNEE ICS Strategic Clinical Education Governance Group which would be focusing on development of an Education Strategy, and input from the Advanced Practice Group would be beneficial.

The work was interesting, and the roles complemented other independent roles. It was hoped they could be included within the Workforce Strategy.

The Committee noted the update.

Flexi-Working in HCSWs (action from SOAC) and proposed Retention Hub/Programme

Chronic vacancies and a lack of HCSW staff across health and social care was putting patient safety and care at risk. There was a need to address the underlying causes of staff high turnover rate, stress levels and burnout rather than just provide support by offering better flexible working opportunities at the point of recruitment. A proposal for the establishment of a Retention Hub was set out within the report for consideration.

Key issues were:

- A high vacancy rate and pressure on services during winter surge.
- The supply of staff had not kept pace with the increase demand for health and social care services.
- Significant recruitment and retention challenges continued to be faced due to flex working and work-life-balance.
- A lack of flexibility in shift patterns had been highlighted as an issue for the retention of HCSWs, contributing to the loss of 21 WTE in the ten months to December 2022.
- Several offers of employment being rejected by applicants due to flexibility.

There was recognition that HCSWs were a key retention group and there was a need to align actions with the emerging retention hub work across the system. There was an aim to seek NHSE funding for a retention lead post for 12 months with that individual developing the work to establish a retention hub.

There was challenge from SOAC to do something different with regard to flexible working opportunities for HCSW and that work would be brought back once identified.

The Committee approved the proposed Retention Hub approach as outlined within the report.

UPDATES AND ITEMS FOR INFORMATION

23/037 WORKFORCE TRANSFORMATION PROGRAMMES

The Chair advised that the following reports would be taken as read.

Integrated Care Academy

Primary Care Training Hub

The Committee noted the updates.

23/038 ANY OTHER BUSINESS

The ICB's Director of People and Workforce gave an update on the requirement for all ICBs to reduce running costs. SNEE ICB was required to reduce running costs by 30% by 2025/26 which equated to a £7m challenge. A lot of work had been carried out to date in respect of pay and non-pay and to date £5m of the £7m had been identified leaving at gap of £2m. In the last couple of weeks NHSE had granted ICBs permission to apply to run a voluntary redundancy scheme and SNEE had endorsed submission of a business case at its meeting held on 20 June 2023.

The business case to run a voluntary redundancy scheme would be considered by the national NHSE team on 25 July 2023 after which, if approved, it was intended that the voluntary redundancy scheme would be launched.

23/039 DATE AND TIME OF NEXT MEETING

16 August 2023 – 1500-1700 hrs

MINUTES
People & Communities Integrated Care Board (ICB) Involvement Subcommittee

Wednesday 3rd May 2023
10.00am to 11.30am
Held virtually via Microsoft Teams

Present:

Claire Martin (Co-Chair)	**CM**	**Patient Representative, Ipswich & east Suffolk**
Sophie Martin (Co-Chair)	**SM**	**Head of Patient Experience & Public Involvement, Suffolk & North East Essex Integrated Care Board (SNEEICB)**
Lisa Coham	LC	Engagement Lead, Suffolk & North East Essex Integrated Care Board (SNEEICB)
Richard Cracknell	RC	Assistant Director Public Health & Communities, Suffolk County Council (SCC) (in part)
Tracy Fortescue	TF	Head of Corporate Services, Community 360 (C360)
Stuart Halsey	SH	Integration & Partnership Programme Manager, Ipswich Borough Council (IBC)
Ray Hardisty	RH	Patient Representative, north east Essex
Rachel Jennings	RJ	Integrated Care Partnership Communities Lead, East Suffolk and North Essex Foundation Trust (ESNEFT)
Chris Lawson	CL	Integration & Partnership Service Manager, Suffolk & North East Essex Integrated Care Board (SNEEICB)
Sas Lynch	SL	Patient Experience Engagement Officer, East Suffolk and North Essex Foundation Trust (ESNEFT)
Paula Martin	PJM	Strategic Projects Support Officer, Suffolk & North East Essex Integrated Care Board (SNEEICB) (Minutes)
Ann Nunn	AN	Patient Representative, Ipswich & east Suffolk
Amy Poole	AP	Head of Patient Experience & Volunteers, Essex Partnership University Foundation Trust (EPUT)
Leni Sepp	LS	Physical Activity & Partnership Manager, Colchester Borough Council (CBC)

Item		Action
109	**Welcome & Introductions:** As CM had yet to arrive, SM agreed to stand in as Chair until CM joined the meeting. She began by welcoming everyone to the meeting and those present introduced themselves. Apologies were received from Steve Bruce (ESNEFT, Ella Humphries (CBC), Vicki Marsh (SNEE ICB), Lucy Pettitt (WSC), Tammy Shepherd (ESNEFT), Matthew Sisto (EPUT), Tom Tayler (CBC), Dave Taylor (WS Pat Rep), Anna Turner (ESNEFT), Will Wright (WSC), Andy Yacoub (Healthwatch Suffolk).	
110	**Declarations of Interest (DoI's):** None declared.	
111	**Minutes of Meeting held on 5th April 2023:** Approved.	
112	**Actions from Previous Meetings:** There was discussion around the previous actions on migrants and asylum seekers. TF explained that she had been with working with Refugee Action, Essex Integration and Colchester City Council. Links were also in place with One Colchester. SM felt that issues surrounding migrants and asylum seekers were increasing and felt that this was something that the group needed to look at in more detail. She stated that she would liaise with KS and others about moving the various actions forward. She commented that there were lots of challenges, not least that, in terms of healthcare provision, many	**SM**

	migrants and asylum seekers were not eligible to receive healthcare as they did not have the correct status, thus their care was being left to the voluntary services who were not able to provide the appropriate care in terms of health. AP suggested that she look at what was being done in mid and south Essex to see if anything could be replicated for Suffolk and north east Essex.	**AP**
113	**Matters Arising from Last Meeting:** None.	
114	**Chair for Next Meeting:** Although no one volunteered at this stage of the meeting, CM, who arrived later, subsequently agreed to stand as Chair for the June meeting.	
115	**Integrated Care Board Budget:** SM reported that at the end of March 2023, the ICB received a letter from Government instructing it to make a 20% cut on base budget (salaries and operating costs) over the next year, and a further 10% in 2024/25. All ICBs have been so instructed and it is non-negotiable. The cut does not apply to programme or commissioning costs but will have a significant impact on what the ICB can support and how it operates. She explained that the structure of the organisation was currently being examined and a restructuring would be happening as a result. SM stated she felt it was important to make the group aware of the situation although she did not have any further details at present. SM went on to say that a letter had been sent out to all partners regarding this and asking for ideas on how savings may be made, along with any suggestions for shared posts and/or opportunities.	
116.1 **116.2**	**Annual Report 2022/23:** SM drew attention to the draft annual report that had been circulated previously, explaining that the public involvement team were committed to producing an annual report of activity for the previous 12 months. She explained that the document detailed the activities of the engagement team within the ICB only and aimed to give an overview and record of the team's work. **Priorities for 2023/24:** SM stated that it was very important, as part of the annual report, for priorities to be set for the next year; to this end she was keen for the group to be involved and asked if there was anything that they felt should be included. SH felt that it was important to ensure that there was minimal impact, due to all the potential changes of the ICB restructure, on the populations of Suffolk and north east Essex. SM agreed and asked whether he meant in terms of supporting people and communities, thus meaning the priority was to ensure that good communication and enduring relationships were maintained. SH answered yes, commenting maintaining relationships was essential in order to get a real picture of what is happening for both residents and voluntary organisations. RJ commented that various ICP task and finish groups were working on things such as co-production and suggested that the findings and recommendations of these groups could be included. SM agreed, saying that there was a commitment to supporting the recommendations of the Resilience Charter. RH stated that people and communities within north east Essex was at a different stage to that in Suffolk and he felt it was necessary that this be recognised. SM agreed and suggested she include something around consistency and equity across the various Alliance areas. She then asked if there was anything of particular relevance to the NHS Trusts in Suffolk and north east Essex. AP stated there was a need to address inequalities and improve access and information. She felt it was important to work with those people experiencing such issues to better	

	understand and thus make improvements. SL agreed, saying there was a need to reach out to people and communities. SM then reported that she had recently come across a piece of work but NHSE around continuous improvement, of which one of the 3 principles highlighted had been about co-production being essential to enable continuous improvement to quality to take place. She stated that it was an idea the ICS had signed up to but wondered whether there was a need for a particular focus on this. CL felt it would be good to document what was being done but stated that conversations with community groups were already happening around this. He also felt it was important for work to be done around prevention rather than reaction. SM replied that this was already done, in terms of individuals and health, but agreed that there was a need for this from an organisational point of view. She felt it was important for organisations and communities to build resilience. TF agreed with previous comments about collaboration with the voluntary sector and stated, in terms of prevention, a lot had been incorporated into the work done around the Be Well domains. Referring to the savings needing to be made by the ICB in terms of running costs, she explained that the possibility of joint posts was being investigated and support of both clinical and non-clinical services was also being considered. Finally, TF felt there was a need to look at those harder to reach communities and individuals and commented that this was also something being looked at by the voluntary sector. SM thanked everyone for their input, saying that she would work this up into something that could be incorporated into the draft annual report which had already been submitted to NHSE. The involvement team would also be gathering input from the public regarding priorities for the next 12 months. RJ suggested that perhaps the findings from the various task and finish groups, could also be incorporated. SM agreed, saying it was important to ensure a tie in with the Resilience Charter. SM then went on to speak about changes within the public involvement team of NHSE, saying that 6 members had recently been made redundant. She explained that she did not have details about how engagement was likely to be handled going forwards, but would know more in due course as she was involved in an ICN Engagement Network which was due to meet very soon.	
117	**Measuring the Impact of Engagement:** As CN had been unable to attend the meeting due to an urgent commitment, it was agreed that this item be deferred to the June meeting.	
118	**Upcoming Projects/Programmes:** RJ stated that she would be happy to present on the Resilience Charter at the June meeting. SL will also speak about ESNEFT's Patient Experience and Carers Co-production Strategy at the June meeting. *CM joined the meeting at this point.* CL and SH will present on community wellbeing hubs at the June meeting. SM mentioned on-going work on a mental health collaborative and a focus group which fed into this. She felt that this would be of interest to the group and would note it for addition to a future agenda, after the June meeting. *SH, CL and AP left the meeting at this point.*	
120	**Issues to be escalated to Board:** Although there were no issues to be escalated to the Board, CM asked for advice about how to escalate some concerns relating to a GP surgery. SM explained that from 1st April 2023, the ICB had overall responsibility for primary care, ophthalmology, pharmacy, and dentistry, therefore advising CM to send the concerns into the SNEE ICB PALS and Complaints Team.	

	CM asked SM if there was more cohesion due to this commissioning change. SM replied that it depended on what was being talked about; in terms of the Alliances there was, but perhaps across the whole ICB area it could be better. CM commented that it was difficult to maintain momentum and keep achieving good outcomes when there continued to be so much change and restructuring.	
121	**Any Other Business:** None.	
122	**Next Meeting:** Via Microsoft Teams Wednesday 7th June 2023 10.00 am to 11.30 am The Chair thanked everyone for attending and closed the meeting at 11:17 am.	

MINUTES
People & Communities Integrated Care Board (ICB) Involvement Subcommittee

Wednesday 7th June 2023
10.00am to 11.30am
Held virtually via Microsoft Teams

Suffolk and North East Essex Integrated Care Board

Present:

Claire Martin (Co-Chair)	**CM**	**Patient Representative, Ipswich & east Suffolk**
Charlotte Britton	CB	Head of Strengthening Communities, Essex County Council (ECC)
Lisa Coham	LC	Engagement Lead, Suffolk & North East Essex Integrated Care Board (SNEEICB)
Rachel Durmishi	RD	Executive Lead for Thriving Communities, Community 360 (C360)
Luke French	LF	Lead for Strengthening Communities, Essex County Council (ECC)
Stuart Halsey	SH	Integration & Partnership Programme Manager, Ipswich Borough Council (IBC)
Rachel Jennings	RJ	Integrated Care Partnership Communities Lead, East Suffolk and North Essex Foundation Trust (ESNEFT)
Chris Lawson	CL	Integration & Partnership Service Manager, Suffolk & North East Essex Integrated Care Board (SNEEICB)
Sas Lynch	SL	Patient Experience Engagement Officer, East Suffolk and North Essex Foundation Trust (ESNEFT)
Paula Martin	PJM	Strategic Projects Support Officer, Suffolk & North East Essex Integrated Care Board (SNEEICB) (Minutes)
Sophie Martin	SM	Head of Patient Experience & Public Involvement, Suffolk & North East Essex Integrated Care Board (SNEEICB)
Cassia Nice	CN	Head of Patient Experience & Engagement, West Suffolk Foundation Trust (WSFT)
Ann Nunn	AN	Patient Representative, Ipswich & east Suffolk
Lucy Pettitt	LP	Families & Communities Manager, West Suffolk Council (WSC)
Amy Poole	AP	Head of Patient Experience and Volunteers, Essex Partnership University Foundation Trust (ESNEFT)
Elissa Rospigliosi	ER	Assistant Director Strategy and Change - Adult and Community Services, Suffolk County Council (SCC)
Leni Sepp	LS	Physical Activity & Partnership Manager, Colchester Borough Council (CBC)
Anna Turner	AT	Essex Partnership University Foundation Trust (ESNEFT)
Andy Yacoub	AY	Chief Executive Officer, Healthwatch Suffolk

Item		Action
123	**Welcome & Introductions:** The Chair began by welcoming everyone to the meeting and those present introduced themselves. Apologies were received from Sam Glover (HWE), Tammy Shepherd (ESNEFT), Tom Tayler (CBC).	
124	**Declarations of Interest (DoI's):** None declared.	
125	**Minutes of Meeting held on 3rd May 2023:** Approved.	
126	**Actions from Previous Meetings:** Updates were given on the previous actions as follows: **Action 22: KS to liaise with CN, SN & TS regarding a project to find ways to effectively capture the voice of refugees and asylum seekers**. KS reported that a meeting had been scheduled and there would be further updates at the July meeting. It was also agreed to merge action number 25 into this action.	

	Action 27: KS reported that a meeting had been scheduled and there would be further updates at the July meeting. It was also agreed to merge action number 25 into this action. AP reported that she would be attending networking meetings across SE Essex and would report further at the July meeting.	
127	**Matters Arising from Last Meeting:** None.	
128	**Chair for Next Meeting:** Anna Turner agreed to chair the July meeting.	
129	**Resilience Charter:** Referring to the May meeting, RJ reminded those present that she had spoken about the Resilience Charter and had agreed to come along today to provide more information and an update. RJ explained that the Resilience Charter would be led by the voluntary sector; 2 years previously ways of working with that sector had been set out and signed off by the Integrated Care Partnership. However, challenges had impacted the Charter, so it had been revisited as a more co-designed approach had been deemed preferable. RJ then went through her slide presentation which is attached to the back of these minutes as appendix 1. LP commented that the presentation had been very good but wondered if it could be improved further by some wording changes. RJ agreed to contact LP outside of the meeting to discuss. SM asked how, as a group, the People & Communities sub-committee could help embed the Charter in working practices and what the next steps were to ensure this happened. RJ agreed there was work to be done ensuring that the Charter was embedded as a way of working within the system and that co-design became the standard way of working. However, getting the Charter agreed would be a foundation to be built on and progress would continue to be reported. CB thanked RJ for her presentation, saying that it had been helpful to have been involved. SM then asked if there were further ways, in terms of implementation, that the Peoples & Communities sub-committee could get involved. RJ replied that there were parts of the Charter that were particularly relevant to People & Communities, and she would continue to bring these to the sub-committee.	**RJ**
130	**Community Wellbeing Hubs:** CL and SH's slide presentation can be found at the back of these minutes as appendix 2. CL began by sharing his slide presentation on the Michael Burke Wellbeing Centre in Eye. This was followed by SH speaking about the Waterloo Centre in Leiston. SH explained that this was opening very soon, after a year in development, and would be called "Wellbeing Hub, Leiston". It would be open 3 days a week. The final part of the presentation covered The Unity Centre, based at the Whitton Clinic. Following their presentation, the Chair thanked CL and SH, saying it was refreshing to see community support being offered that had been tailored for the individual community it served and it would be good if, in the future, there could be similar centres for every neighbourhood. SM was keen to explore how ideas and learning could be rolled out into the other parts of Suffolk and north east Essex. She felt that none of the buildings spoken about today were particularly large or specialised, so was interested to see how existing estates could be used in similar ways. SH felt that showing the success of current hubs was key to this and this was one reason why on-going monitoring of how the hubs were being accessed and used was so essential. *(AP & CN left the meeting at this point.) (ER joined the meeting at this point.)*	

	CL agreed that it did not have to be a dedicated building and added that there had been some opposition to using a clinical building for the Unity Centre, but there were some definite advantages and he also felt that it helped to affect a culture change. He commented that starting with smaller spaces meant a lower cost. *(AT left the meeting at this point.)* Referring to SM's comments about utilising existing estates, RJ stated that she also attending the Integrated Care Partnership's estates committee and has been asked to pull together a report capturing learning from community spaces. She felt CL and SH's presentation had been very helpful in this regard. KS commented that there was also a community hub in west Suffolk as well as the one in Colchester run by Community 360. She wondered if it would be beneficial for there to be a hub networking group so that good practice and learning could be shared and for this to feed into Alliance committees. She then went on to mention that, in terms of gathering soft intelligence, the engagement leads for each Alliance area had set up a survey for each neighbourhood, asking people what it was like to live in their locality. She wondered whether the same sort of thing could be used to gather information about usage of the hubs. SH felt this would be useful and agreed to link up with the Alliance Engagement Leads.	
131	**New Adult Social Care Strategy for Suffolk:** The Chair welcomed ER to the meeting. ER's slide presentation is attached to the back of these minutes as appendix 3. Following ER's presentation, SM commented she hoped that links could be built with north east Essex and felt that there was a lot of work to be done in terms of coming together across Suffolk and north east Essex. She asked ER if there was a more detailed strategy that could be shared with the sub-committee. ER replied that there was more that she could share that could further the conversation. RJ asked ER to link up with her about ways in which she could help share the strategy more widely, if she felt this was appropriate.	
132 132.1	**Upcoming Projects/Programmes:** **Mental Health Collaborative & Focus Group:** Due to time constraints, it was agreed that this item be deferred to the July meeting.	
133	**Issues to be escalated to Board:** There were no items to be escalated.	
134	**Any Other Business:** None.	
135	**Next Meeting:** Via Microsoft Teams Wednesday 5th July 2023 10.00 am to 11.30 am The Chair thanked everyone for attending and closed the meeting at 11:30am.	

NHS
Suffolk and North East Essex
Integrated Care Board

Title	**Estates Committee Highlight Report**
Lead Director	Paul Fenton, ICB Strategic Estates Advisor and Chair of the SNEE ICB Estates Committee
Author(s)	Corporate Governance Manager

1. Summary

1.1 The ICB Board is asked to note the highlight report from ICB Estates Committee meetings held in May 2023.

2. Key points to note

2.1 At its meeting held on 30 May 2023 the Estates Committee received the following reports/updates:

1) **Estates implications and opportunities from the health pathway work West Suffolk Council has developed with Abbeycroft,** key points:

The Committee received a presentation from representatives of West Suffolk Council that had previously been seen by the ICB Board and had been felt important to share with the Estates Committee.

The presentation set out how the System worked together and the philosophy and model behind West Suffolk Council's partnership with Abbeycroft Leisure to facilitate an active living exercise referral scheme which made difference to individuals lives via the facilitation of sports and leisure activity to improve health.

2) **Infrastructure levy summary,** key points:

The Committee was informed that Government had introduced the Infrastructure Levy concept in the 2020 Planning for the Future white paper before including the Levy in the Levelling Up & Regeneration Bill when laid in Parliament last year. The Bill was progressing through Parliament and was currently in the House of Lords at the committee stage. In advance of the Bill's progress through Parliament, a technical consultation on the Infrastructure Levy was published on 17 March 2023. The document included a high-level summary of changes and sat alongside a technical summary. Government's aim was to deliver at least as much value and affordable housing as the present system, the most recent study was undertaken in 2018/19.

There were 47 questions within the consultation and work was currently being carried out to formulate a response. There was an aim to give local authorities more responsibility with regard to the levy, with the ICB asked to provide its strategies to the local authorities going forward.

3) **Estates Infrastructure Strategy (EIS) Update:**

The Chair reported that the EIS had not been presented to the SNEE ICB Board on 23 May 2023 as previously intended, and had been presented to the ICB Executive meeting instead, ahead of it's submission on the 30th June 2023Further iterations would take place prior to its final submission in December 2023 which is a National requirement for all 42 ICB's

4) Sustainability Update: Key points:

Clean Air Day 15 June 2023.

The theme for 2023 was '*Clean up our air to look after your mind this Clean Air Day'*. Clean Air Day | Action for Clean Air. Within Suffolk (for us NEE too) the ICB approach would be to encourage a one mile walk, ride, wheel and promotion (focus on reconnecting with nature). 'A mile for my mind'. There would be a flashmob walk approach that would be advertised by the council. All the Districts, County and ICB would be encouraging the walk and the council was hoping to get Ipswich Town FC involved. Colleagues are encouraged to work with their communications teams to arrange walks over the lunchtime of 15 June 2023 to promote the theme.

Net Carbon Zero – work continued on delivery of an EV infrastructure by identifying local and regional grid capacity to plan for increased capacity where necessary.

Green NHS – work was being carried out to re-write the annual report for the Green Plan as its one-year anniversary was on the horizon.

5) At each meeting, the Committee also receives One Public Estate updates along with highlight reports from providers and the three Alliances.

3) Recommendation

3.1 The ICB Board is asked to note the report.

Suffolk & North East Essex ICS
Strategic Digital Investment and Assurance Committee

Meeting held on Friday 5th May 2023 from 11.00 – 13.00
Virtual Microsoft Teams Meeting

Notes and Actions

Note for ICB: These are draft minutes and have not yet been approved by SDIAC

Ref:	Item
1	**Welcome & Introductions** Apologies from members were given. There were no declarations of interest. Slides for the meeting were available in FutureNHS. The session took the form of 2 workshops to review the findings from: 'Towards a new Operating Model for DDaT Programme Management for SNEE ICB and Partners. As well as the 'SNEE ICB Digital Landscape. which have been combined under the paper Our ICB Digital Data and Technology perspective - Summary Paper
2	**Review of DDaT Activity** **Workshop 1:** What is the best operating model for the ICB to handle its DDaT programme for work and Strategy? Feedback: There were 5 models presented from the Ideal Health findings but during the discussion a 6th was introduced. Four of the original 5 models were discarded following discussion, and more understanding is needed about how the transformation team and the DDaT team interact (and how they could interact in future). **SDIAC 230505-01 – Transparency and understanding of the Transformation Teamwork**. Discussion to take place on how the work of the transformation team may better align with that of the DDaT Programme Office Team and what might or might not fit in with the current climate. **Workshop 2:** Agree and discuss the DDaT Programme of work Focus areas. Feedback: The work commitments currently carried out by the DDaT Programme Office team and their priority areas, the impact and urgency, need to be better understood. Role of the ICS in the delivery of these projects also needs to be better understood. The view is that the ICB DDaT Programme Office Team adds the most value as a coordinating, collaboration and assurance role between partners rather than a delivery mantle where the resources are already deployed at an organisational level. It was agreed to stick to the principle of subsidiarity, doing things at the lowest point in the System where it is appropriate to do so.
4	**Open Group Discussion** It was felt there was a lot of overlap between the workshop discussions. Some salient points: 1. There is a strong need for system and clinical governance alignment.

	2. There is need for a DDaT gateway system of approval process for new tech ICS wide. 3. The DDaT strategy needs a refresh so everyone can see how they are connected to it, what it means for them, who is doing what and when. 4. The possible option 6 DDaT Programme Team operating model was discounted which left the "Enhanced 'As Is'" model to develop further. Discussed having a systemwide awayday to discuss this further to get agreement and alignment. Agreed this was a good idea and should be scheduled for June. **SDIAC 230505-02 – Systemwide Awayday to discuss the ICB DDaT Strategy.** DDaT Programme Office team to organize a systemwide awayday in June to continue discussions. **SDIAC 230505-03 – Operation models.** Discussions are to take place about the DDaT Programme Office team operating model chosen by the members. The enhanced 'As Is' model is flexible and could cater for a variety of different ways of working; it may also help support the decisions being made in the Transformation Team given resource restrictions. The discussions from workshop 2 will be mapped onto potential 'enhanced model'. These will be taken to the DoFs so they have potential sight of costs for a funding model to be discussed at their meeting. It is the intention that a paper will be taken, summarizing all the recent activity / research as well as the outputs from the SDIAC papers to the Executive Management Team prior to the ICB for approval in July. During June an ICB awayday will be held to get a plan agreed for approval by the all partners to move forward with the programmes of work and DDaT strategy which must be published to our wider public. The SDIAC members **approved** this decision. **SDIAC 230505-04 – Operation Models.** The discussions from workshop 2 will be mapped onto the potential 'enhanced model'. This will be taken to: - the DoFs so they have potential sight of costs and a funding model discussed. - to the Executive Management Team for further discussion and onto the ICB for approval in July.
5	**Investment and Post Project Reviews** <u>22/23 Investment Outcome, End of year</u> Reviewed slide and outlined how the funding had been used. Listed the project and the funding value used for each. It was confirmed that any external investment should be reported to the SDIAC. <u>23/34 Investments Opportunities (Known to date)</u> Reviewed slide and outlined new investment opportunities. Listed the project and the funding value used for each. The adult Social Care Digital Transformation Fund was highlighted in workshop 2 as a requirement to work closely with Social Care colleagues to ensure the programme was handled under a system-wide approach It is important to ensure that there is a joined-up approach to the DDaT activity across the system, but to ensure compatibility with the DDaT strategy and the overall system's aims and objectives. <u>Post Project Reviews and Findings</u>

	Reviewed slide showing the nationally funding projects and programmes that have come to conclusion. Working through the post project evaluations with the focus being on the benefits realisation. Will be in a position to give a more detailed report at the next SDIAC meeting.
6	**Strategic Delivery Programme Update** SDIAC Programme Dashboard Total of 52 digital projects in Smartsheet, 49 at the stage of implementation. All bar three are on track. 11 are in project closure. Supporting Social Care Tech is currently showing a rag status of red. Cassius+ pilot has been successfully implemented and commenced running live in December 22. Next phase was to scale the pilot to 100 patients but we have been unable to secure the funding required to support the operational and development costs for 23/24. Cassius+ Pilot – Cassius is running, Cassius+ work is on hold until sufficient funding is secured so we will not able to restart the pilot activity and at this stage there is no further work that can be done. ROSI – now received approval from the newly formed Project Steering Group and ICS End of Life group to pilot the solution in one PCN in July 23 and the group have agreed that the governance and technical issues raised have been sufficiently mitigated and can be tested during the pilot. It was noted that clinical governance oversight has been given assurance from the lessons learned, but ESNEFT still have questions to be answered in terms of assurance before committing to the pilot. Further discussions also to take place with EEAST. EEAST are very clear that the ROSI product needs to export to the national platform which EEAST will consume from as other ambulance services around the country do for end of life care and mental health plans. **SDIAC 230505-05 – ROSI project.** ROSI project team to receive the feedback from the SDIAC members regarding the further discussions that are required prior to the pilot starting in July 23. Diabetes ROSI – Still on hold awaiting End of Life to complete and review but SDIAC will still need to take a decision on how or if this is a programme the System will work on. ShCR and HIE update ShCR Aim is to improve coordination across the ICS for ShCR. We are needing wider governance considerations at an ICS level. All main providers across the ICS are connected to HIE and connected to Herts and West Essex as an ICS, also to Mid and South Essex. There are both immediate and long-term priorities to be considered. Key highlight is the formation of the ShCR Steering Group as there is a need for this. Request the support for greater involvement and engagement in the process. Enabling Unified Digital Care Committee update

	Reviewed the slides and noted the key actions since last SDIAC meeting. Outlined the progress and future targets for Virtual Wards. NHSe and the regional teams want to physically visit our virtual ward to see how they are working technically as we sit within the top 13 nationally of the virtual ward technical enablement solutions. Working with the operational teams in ESNEFT and West Suffolk planning to put this in place. Outlined the additional projects taking place, Cassius+ *(now on hold due to funding)*, Virtual Consultations, WHZAN Blue Boxes, Current Health Community Remote Care, Dementia and Frailty iCareHealth App, Patient Portal, Remote Care Monitoring Hub and Virtual Ward Digital Solutions Options Appraisal. Members asked if an options appraisal for the Virtual Ward Solution can be conducted starting in September 2023. This is in response to the need to renew/extend licenses in the future. The options appraisal should look across the wider market at all potential options now available in the marketplace and incorporate EPR Convergence also. SDIAC members **approved** this decision.
7	**SDIAC – Items for ratification / information** SNEE ICS Data Warehouse SDIAC members asked to approve the re-ratification of funding for the SNEE ICS Data Warehouse. SDIAC members **approved** this decision. MBPPP Relaunched. Ask is for ratification of ongoing cost. The system will also receive contributions from suppliers. SDIAC members asked to approve payment of another £25,000 to part fund year two of the Mike Bone People Potential Programme. SDIAC members **approved** this decision.
8	**SDIAC Meeting Governance** Minutes (2302030) – Minutes approved. Actions & Matters Arising – Members asked to review the updates and closed actions. Governance (Appendix A) Delegation of Authority– Attachment for the SDIAC. ToR. This sets out the sub groups that report to the SDIAC, the delegation of authority under which they operate and the governance that applies to each of the groups. Requested approval from members for Appendix A as part of the ToR. SDIAC members **approved** Appendix A. Governance (SDIAC ToR) – Only amendment is the change of name from Strategic Digital Investment and Assurance Board to Strategic Digital Investment and Assurance Committee and the addition of the governance chart. Requested approval from members for the SDIAC ToR which included the change of name and the addition of the governance chart. SDIAC members **approved** the ToR. Proposed changes for DSI Meetings – Wanting to reinstate the DSI meeting with decision making rights. Propose a monthly Strategic DDaT Delivery Committee (SDDC) and a weekly Digital Discussion Forum (DDF). The weekly DDF will be an advisory group which will feed into the SDDC (nee monthly DSI Group) who will have decision making rights, who will ultimately feed into the SDIAC. This will enable a better-informed discussion and provides governance routes to make better, quicker decisions and can

	collaboration more within the forums with their membership. SDIAC members **approved** the proposal for the SDDC and DDF meetings.
	Summary and close Discussions from the workshop groups will be summarized and will make the governance amendments disused.
	Meeting closed at 13.03 **Next meeting 20.7.23.**

Minutes to be approved at SDIAC on 20.7.23

SNEE ICB Board Attendance Log

Role	Name	01-Jul-22	Part 1 and 2 26-Jul-22	Via Email 01-Aug-22	Part 1 and 2 27-Sep-22	Part 1 and 2 22-Nov-22	Part 1 and 2 24-Jan-23	Part 2 21-Feb-23	Part 1 and 2 21-Mar-23	Part 1 and 2 23-May-23	Part 1 and 2 20-Jun-23
Acting Director of Finance	Armitt Chris	Yes	Yes	Yes	Yes						
Member VCSE Sector	Alderson Kirsten					Yes	Yes	Yes	Yes	Yes	Part 2 only
Partner Member Primary Care Essex	Bhatti Freda	Yes	No	Yes	Yes	Yes only part of P1	Yes	Yes	Yes	No	No
Provider Partner Member - Acute	Black Craig	Yes	Yes	Yes	No	No	Yes				
Provider Partner Member - Acute	Cameron Ewen							Yes	Yes	No	Yes
Non Executive, Finance and Audit	Clarke Steve	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	
Partner Member Suffolk County Council	Cook Sue	No	Yes	Yes	No	Yes	Yes only Part of P2	Yes	Yes	No	Yes
Non Executive, People, Remuneration and Diversity	Curry Tanya	Yes	No	Yes	Yes	Yes	Yes only Part of P2	Yes	Yes	Yes	No
Non Executive, Finance and Audit - Interim	Dobson Geoff										Yes
Non Executive, Quality and Safety	Feast Steve	Yes	Yes	Yes	Yes	Yes only part of P1	Yes				
Chief Executive	Garratt Ed	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Partner Member Essex County Council	Higgs Patrick	No	P1 only (part)	Yes	No	Yes	Yes	No	Yes	No	
Provider Partner Member - Community	Hulme Nick	Yes	No	Yes	Yes	Yes P1 only (Part)	Yes	Yes	Yes	Yes (Part P2)	Yes
Medical Director	Kelso Andrew	Yes	No	Yes	Yes	Yes	Yes only Part of P1	Yes	Yes	Yes	Yes
Director of Finance	Martin Howard					Yes	Yes	Yes	Yes	Yes	Yes
Non Executive, Quality and Safety - Interim	Mutumburi Phanuel								Yes	Yes	No
Director of Nursing	Nobes Lisa	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No
Chair	Pope Will	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Partner Member Primary Care Suffolk	Rayner Nick	Yes	Yes	No	Yes	Yes	Yes	Yes (Part)	Yes	Yes (Part P2)	Yes
Provider Partner Member - Mental Health	Richardson Stuart	No	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes
Deputies:											
Provider Partner Member - Acute	Black Craig									Yes (Part P2)	
	Devlin Peter										Yes
Partner Member Suffolk County Council	Keeble Stuart				Yes					Yes	
Provider Partner Member - Community (Deputy)	Moloney Neill		Yes								
Other Regular Attendees											
Director of Ipswich and East Suffolk Alliance	Baker-Woods Maddie	Yes	Yes		No	Yes	Yes only Part of P1	Yes	Yes	Yes	No
Director of Performance and Improvement	Gibara Paul	Yes	No		Yes	Yes	No	Yes	Yes	Yes	Yes
Integrated Care Partnership Director	Howard Susannah	No	Yes		Yes	Yes	Yes	Yes	Yes	Yes	No
Director of People and Workforce	Lyes Amanda	Yes	No		Yes	Yes	Yes	Yes	Yes	Yes	Yes
ICP Chair Suffolk	Reid Andrew Cllr	No	No		No	No	No	No	No	No	Yes
ICP Chair Essex	Spence John Cllr	Yes	No		No	No	No	No	No	No	No
Director of North East Essex Alliance	Taylor-Green Laura	Yes (not in post until 1 Aug 22)	No (not in post until 1 Aug 22)		Yes	Yes	Yes	Yes	No	Yes	Yes
Director of Strategy and Transformation	Watson Richard	Yes	Yes		Yes	Yes	Yes	Yes	Yes	No	Yes
Director of West Suffolk Alliance	Wightman Peter	Yes	Yes		Yes	Yes	Yes	Yes	Yes	No	Yes
Observers (Part 1 Only)			Part 1 Only		Part 1 Only	Part 1 Only	Part 1 Only		Part 1 Only	Part 1 Only	Part 1 Only
NEM Ipswich and East Suffolk Alliance	Creasy Edward	Yes	No		No	Yes	Yes		Yes	No	No
NEM North East Essex Alliance	Cory Mark								No	No	No
NEM West Suffolk Alliance	Gallin Ian								No	No	No
Healthwatch Essex	Glover Samantha	No	Yes		No	No	No		Yes	No	Yes
Healthwatch Suffolk	Yacoub Andy	No	No		No	Yes	No		Yes	Yes	No