Written evidence submitted by NHS Norfolk and Waveney ICB (PSN0009)

Maternity care and leadership: Recommendation one

Has the recommendation been implemented? Or is the recommendation on track to be implemented?

All maternity-related deaths are reviewed by the Local Maternity and Neonatal System (LMNS) panel made up of the LMNS Team and our three local acute trusts. All deaths are also reported to the LMNS Board. This is in addition to ICB and trust board oversight.

All deaths are referred to PMRT panels as required and reported to the Clinical Negligence Scheme for Trusts (CNST) and the Healthcare Safety Investigation Branch (HSIB).

Part of the recommendation is for the local Maternity and Neonatal Voices Partnership to be sighted on cases, which is now in place and themes are shared. Annual thematic analysis of all cases is undertaken and shared across the system.

Has there been specific and adequate funding to enable the recommendation to be implemented?

The LMNS Programme Team are now funded substantively in the ICB, to ensure oversight and governance across the system.

Has there been a positive impact on patients and people in receipt of social care as a result of the recommendation being implemented?

All service users can expect a response and families are included in PMRT cases and HSIB cases as standard. Reasonable adjustments are made for the families who may struggle with engagement.

Was the Government's interpretation and implementation of the recommendation appropriate?

The recommendation has ensured that all deaths have system scrutiny and oversight as intended.

Maternity care and leadership: Recommendation two

Has the recommendation been implemented? Or is the recommendation on track to be implemented?

There are tests that are applied to the appointments to NHS boards that are intended to ensure that only 'fit and proper persons' can take up places on NHS boards. Like others, the ICB is going through the process of implementing the recent changes to the Fit and Proper Persons Test. It is also the case that a number of executives are subject to regulation by virtue of their professional body, as by law, boards must have a medical, nursing and finance member.

In addition, there are standards of behaviour and values that all ICB and NHS provider board members are expected to abide by (including the Nolan Principles) and all of our ICP members have agreed a set of values.

NHS England issued a letter following the conviction of LL, asking leaders and boards to ensure all staff have easy access to information on how to speak up. Relevant departments, such as Human

Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.

Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well. Boards are regularly reporting, reviewing and acting upon available data. The letter also reminds organisations of their obligations under the Fit and Proper Person requirements and makes reference to Medical Examiners and the Patient Safety Incident Response Framework, as well as listening to the concerns of patients, families and staff.

The ICB's Chief Executive is to communicate to provider organisations regarding the ICB's line of sight, governance and auditing processes and agreement that SQG and QSC will have oversight of policies and guidance arising from the conviction.

Has there been specific and adequate funding to enable the recommendation to be implemented?

The three-year Maternity and Neonatal Plan required FTSP Champions to be present within maternity services.

Has there been a positive impact on patients and people in receipt of social care as a result of the recommendation being implemented?

FTSP are visible and active with maternity services across Norfolk and Waveney.

Training of health and social care staff: Recommendation one

Has the recommendation been implemented? Or is the recommendation on track to be implemented?

The national entry-level induction and national mid-career programmes are still in development, due to launch over the next few months. Our local Workforce Strategy has the overarching approach of 'one workforce', looking at health and social care collectively. Existing workforce development and educational networks are looking to reduce variation and the ICS Workforce Team commissions training programmes and delivers education to support skills development across sectors, exploring digital opportunities to increase uptake across the geography as this is a local challenge. Care Certificate is used widely to support entry-level care skills and covers core content such as safeguarding, IP&C, nutritition etc.

There is a joint local health and social care plan to streamline and coordinate leadership development across the system. The NHS 'Scope for Growth' career conversation tool is being piloted across health and social care across Norfolk and Waveney, supporting career development, retention and talent management. The regional System Leaderhip e-module has been rolled out locally. Individual organisations from across the system also have their own approaches to leadership development that reinforce what is done as a system.

Has there been specific and adequate funding to enable the recommendation to be implemented?

There has been no additional funding to the system. This work has relied on innovative, collaborative working within existing resources to maximise training, education and leadership development opportunities.

Has there been a positive impact on patients and people in receipt of social care as a result of the recommendation being implemented?

Yes; increased access to skills development and retention of staff has a positive impact on care delivery and patient experience. We know that there is a strong correlation between good people management skills and patient safety.

Schwartz Rounds are also in place to support staff to unpack the emotional impact of delivering care.

Was the Government's interpretation and implementation of the recommendation appropriate?

We strongly support the introduction of a common entry-level induction and mid-career development programme for health and care staff. As a Sustainability and Transformation Partnership, we were one of the pioneers of the Trainee Nurse Associate programme, recruiting and placing people in both NHS and social care roles. However, the differences in pay between the NHS and social care, even for people with similar or identical qualifications and roles, create real challenges in recruitment and retention within social care. We hope that the welcome NHS Workforce Plan will soon be followed by a Social Care Workforce Plan.

Safety and whistleblowing: Recommendations one and two

Has the recommendation been implemented? Or is the recommendation on track to be implemented?

The NHS England Patient Safety Strategy has provided guidance and structure regarding the implementation of new safety systems that centre on four core aims:

1) Compassionate engagement and involvement of those affected by patient safety incidents
2) Application of a range of system-based approached to learning from patient safety incidents
3) Considered and proportionate responses to patient safety incidents, and
4) Supportive oversight focused on strengthening response system functioning and improvement.

This is driven operationally by the new Patient Safety Incident Review Framework (PSIRF). This is not mandated to primary care currently, but as a local system we have begun to test concepts and processes with a number of pilot sites, pending release of a national framework due imminently.

The ICB continues to support FTSU, including through a designated FTSU Champion for Primary Care. We also provide guidance and support to practices, in response to patient safety and quality intelligence received; adverse incident reports, complaints, CQC feedback and requests for resilience input.

Whilst primary care staff can raise concerns with the ICB FTSU Champions / Guardian, the ICB can only support and advise, but ultimately it has no authority to act in respect of their employer. Primary care staff are aware of this and we have seen cases where FTSU concerns have been raised directly with the NHS national team and / or CQC.

Oversight of the ICB's FTSU Policy is provided through the People, Culture and Remuneration Committee, which reports to the ICB Board

Has there been specific and adequate funding to enable the recommendation to be implemented?

There has been no additional funding to providers to implement PSIRF. This has relied on innovative, collaborative working within existing resources to deliver within the set timescales.

Whilst FTSU within the ICB is adequately resourced, it is nevertheless being supported by staff who are themselves sometimes working over and above their contractual hours and duties – and its effectiveness relies on their continued engagement, motivation and good will.

Whilst feedback is regularly provided through established governance channels, the service remains largely reactive and could be improved with the collection, reporting and analysis of data to give more insights into themes and patterns of concerns. This will be addressed as part of ongoing work to develop the culture and leadership of the ICB.

Has there been a positive impact on patients and people in receipt of social care as a result of the recommendation being implemented?

Provider feedback indicates that PSIRF has already begun to support patient safety and quality governance and increase the oversight and opportunities for learning from adverse incidents.

Provider plans include nationally set priorities as well as local themes. The new approach has a clearer focus on supporting those involved with patient safety incidents, i.e. staff, patients and families, in an open, supportive and inclusive way.

Was the Government's interpretation and implementation of the recommendation appropriate?

Interoperability issues between existing patient safety incident management systems and the new national Learning from Patient Safety Events system has caused a delay, however NHS England is providing advice on work-arounds and supporting digital discussions.

Jan 2024