Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
Minutes of the meeting held at County Hall
on 14 September 2023

Members Present

Cllr Jeanette McMullen	Great Yarmouth Borough Council
Cllr Stuart Dark	Norfolk County Council
Cllr Lesley Bambridge	Norfolk County Council
Cllr Pallavi Devulapalli	Borough Council of King's Lynn and West Norfolk
Cllr Julian Kirk	Norfolk County Council
Cllr Robert Kybird	Breckland District Council
Cllr Peter Prinsley	Norwich City Council
Cllr Adrian Tipple	Broadland District Council
Cllr Jill Boyle	North Norfolk District Council
Cllr Fran Whymark	Norfolk County Council

*

Co-opted Member (non voting):

Cllr Edward Back	Suffolk Health Scrutiny Committee
Cllr Edward Thompson	Suffolk Health Scrutiny Committee

Substitute Members Present

Cllr Emma Corlett substituting for Cllr Brenda Jones
Cllr Steffan Aquarone substituting for Cllr Lucy Shires

Also Present:

Karen Watts	Director of Nursing and Quality – Norfolk and Waveney Integrated Care Board (N&WICB)
Tricia D'Orsi	Director of Nursing – N&WICB *
Mark Burgis	Executive Director of Patients and Communities – N&WICB
Stuart Richardson	Chief Executive Officer – Norfolk and Suffolk Foundation Trust (NSFT)
Cath Byford	Deputy Chief Executive Officer and Chief People Officer - NSFT
Tumi Banda	Interim Chief Nurse - NSFT
Thandie Matambanadzo	Chief Operating Officer - NSFT
Caroline Aldridge	Author of Forever Gone: Losing Count of Patient Deaths report
Anne Humphrys	Author of Forever Gone: Losing Count of Patient Deaths report
Alex Stewart	Chief Executive, Healthwatch Norfolk
Peter Randall	Democratic Support and Scrutiny Manager
Dr Liz Chandler	Scrutiny and Research Officer
Maisie Coldman	Committee Officer

1 Apologies for Absence

1.1 Apologies for absence were received from Cllr Jones (substituted by Cllr Corlett), Cllr Shires (substituted by Cllr Aquarone), Cllr Price and Cllr Cork.

2. Minutes

2.1 The minutes of the previous meeting held on 6 July 2023 were agreed as an accurate record of the meeting.

3. Declarations of Interest

3.1 Cllr Corlett declared an 'other interest' in relation to item 7, she was a co-author of the Forever Gone: Losing Count of Patient Deaths report. She had sought advice from the Monitoring Officer and confirmed that they were no longer employed at the Norfolk and Norwich University Hospital.

3.2 Cllr Kirk declared an 'other interest', his wife works for the ambulance service.

3.3 Cllr Prinsley declared an 'other interest', he was a surgeon at the Norfolk and Norwich University Hospital.

4. Urgent Business

4.1 There were no items of urgent business.

5. Chairman's Announcements

5.1 There were no Chair's announcements.

6. Accident and Emergency (A&E) services in Norfolk and Waveney

6.1 Mark Burgis, Executive Director of Patients and Communities, N&WICB, provided the committee with a brief introduction to the report, highlighting that the A&E department is one element of emergency care.

6.2 The committee receive the annexed report (6) from Dr Liz Chandler, Scrutiny and Research Officer, that noted information to aid the examination of Accident and Emergency (A&E) services at Norfolk's three acute NHS hospitals, namely: Norfolk and Norwich University Hospital (NNUH), James Paget University Hospital (JPUH) and Queen Elizabeth Hospital, King's Lynn (QEH).

6.3 The following discussion points and clarifications were offered:

- It was acknowledged that some of the challenges seen in A&E services across Norfolk are part of wider issues including recruitment, retention, and patient discharge. Norfolk and Waveney Integrated Care Board (N&WICB) was working to resolve these system challenges. With respect to recruitment, this was being done through engagement with staff, promotion of Norfolk and Waveney as a desirable workplace, encouragement of health-related careers and there was work going through the People Board surrounding this. Relating to patient discharge, a Discharge Programme Board has been developed to offer an overview of areas of improvement and there was an emphasis on early focus on discharge and system collaboration that included local authorities and the voluntary sector.

- Members heard that the Electronic Recording system was still in the procurement process, but that a date for its implementation was imminent. The committee would be updated about this in due course. It was hoped that improved information sharing would positively influence the flow across systems and that patients would only need to tell their stories once. This piece of work was alongside work being done by Healthwatch Norfolk who were having conversations with patients as part of their report to the Emergency Care Board.

- The A&E experience for people with mental health illnesses was not at a standard where the ICB wanted it to be and there was a Mental Health Collaborative and Mental Health Transformation Plan for the system. It was noted that the mental health provisions and support were not just the responsibility of NSFT and that there was a collaboration between different organisations (NSFT, local authorities, voluntary sector) to explore solutions to the wider problems. It was confirmed that the need for data to benchmark mental health-related A&E admissions against other areas of the county was being raised nationally.

- Following a member's question about the Unscheduled Care Hub and how it operated, it was clarified that a multidisciplinary team would establish the best course of treatment for a patient to ensure that they have the right care, at the right time, at the right place. Referrals to this service could come from paramedics, community teams and primary care providers.

- The JPUH has the lowest rates of staff turnover and sickness out of the three acute hospitals. This was attributed to the success of recruiting internationally through the recruitment hub. Colleagues in leadership roles were encouraged to share lessons learned. It was acknowledged that the rate of staff sickness and turnover at the QEH needed to be improved and whilst there had been recent improvements to the maternity workforce, the QEH faced challenges with recruitment more generally. There was an eagerness to learn from exit interviews and following a member's response about what lessons have been learned so far, the committee heard that this would be explored.

- It was shared that the virtual wards work by allowing patients to get hospital-level care at home in an environment that was familiar to them. It was noted that some patients do not want to be in the hospital and the virtual wards allowed them to get support from home. This model was being used as a step down from hospitals and was increasing capacity within hospitals; there was scope to explore how virtual wards could be used at the point of admission too. There were currently 131 virtual ward beds online with around 77% occupancy. A member of the committee shared anecdotal evidence of the positive experience they had receiving treatment from a virtual ward.

- Concerning the ambition for 92% occupancy at all three hospitals, it was clarified that this was the level of occupancy that allowed patients to flow through the hospital and afforded a level of protection in case of a surge in demand. This was a figure that was used nationally.

- Data that showed levels of occupancy and waiting times was available by the hour, this data had afforded the ability to predict peaks of demand and was used for future planning and staffing. The ICB had recently established a System Coordination Centre that was in operation 7 days a week to provide support to providers of the system and to help coordinate flow, identify risks, and take steps to avoid further escalation.

- The ICB reassured members that for hospital discharges that happened across the Norfolk and Suffolk border, data was shared, and communication happened between the ICBs. Access to data, strong pathways and processes, and positive working relationships were noted as important factors in ensuring effective patient discharge.

- The ICB said it believed that included within the A&E figures were patients who were seen in the Same Day Emergency Care unit (SDEC) if they have presented through A&E. The ICB would double check if this was correct and report back to the committee.

6.4 The Chair concluded the discussions and noted the progress that was occurring at the three acute hospitals and the learning from good practice. He echoed members feelings of support for A&E staff and the service that they provide. The Chair, and other members, thanked the ICB for the consistency in reporting which made it easier to compare trends across the acute hospitals from the data.

Summary of Actions:

- The ICB to check whether figures for patients attending the SDEC are included in figures for A&E.

7. Norfolk and Suffolk NHS Foundation Trust (NSFT) Mortality Recording and Reporting review

7.1 The committee received a statement from Stuart Richardson, Chief Executive Officer at NSFT. He offered the trust's deep sympathies and thoughts to everybody affected by the publication of the Grant Thornton report, particularly the people to whom it brought back memories and issues that they thought hadn't been resolved. He also personally apologised for this and for any issues related to how the trust had recorded mortality data in the past. He explained that the report that was the focus of Newsnight and BBC East investigations was requested by NSFT as the trust accepted that it needed help on the way it gathered its data, particularly on people in the community. All recommendations have been accepted and many actions to address issues were being put in place. Mr Richardson explained that as is common practice, the Trust was asked to comment on the report when the auditors delivered their first draft and additional evidence was provided by the Trust in response to questions the auditors put to them. He confirmed that this is a standard process for all internal audits that the Trust undertakes. NSFT felt that they were open and honest throughout the whole process and the improvement plan would allow for improvements to the quality of the service to continue. They shared that it was important that staff shared any concerns, and that staff could speak up and raise concerns through the independent guardian organisation and Freedom to Speak Up service. NSFT wanted to hear those concerns in order to act upon them. The Trust was working with partners across the system to improve wider transformation of mental health services but acknowledged more work needed to be done to ensure consistent quality of mental health services.

7.2 Cath Byford, Deputy Chief Executive Officer and Chief People Officer at NSFT, acknowledged that what they had shared at a previous committee was incorrect but that at the time, she believed that the independent report that was being commissioned would be able to provide a single version of truth in terms of the data and she also believed that there was confidence in the mortality data. Ms Byford committed to continuing an open, transparent, and trusting relationship with the committee and hoped there would be continued confidence going forward between herself, the Trust, and the committee.

7.3 Caroline Aldridge and Anne Humphrys introduced their report entitled Forever Gone: Losing Count of Patient Deaths. They highlighted that NSFT had been unable to establish a single version of the truth and shared their feelings about this and the fact that there was no streamlined system for data collection. Additionally, they noted their concerns that sections of the draft Grant Thornton report had been removed from the final version. Concerns were raised about NSFT's ability to address the root causes of the issue effectively and sustainably; these concerns were amplified by the fact that this was not the first report on deaths and mortality reporting at NSFT. Previous recommendations had not been implemented or sustained and there was a general lack of confidence in the follow-through of actions that were being promised. The limited involvement that bereaved families have had in the co-production of an action plan has reduced confidence further. Concerns were raised regarding data collection and the appearance that corporate reputation was being prioritised over patient safety and improving poor practices.

7.4 Stuart Richardson confirmed that the action plan presented in the report to NHOSC was the action plan that came from the Grant Thornton report. The Trust did not feel it was appropriate to start adding to that action plan at this point until a co-production discussion had taken place with both ICBs and the report authors. This discussion was due to happen next week. Mr Richardson also clarified that while conversations had been had with Healthwatch Norfolk and Healthwatch Suffolk about their involvement with this co-production, no decisions had been made.

7.5 Tricia D'Orsi, Director of Nursing at the ICB, shared that the ICB was committed to working with the NSFT and others to ensure that the co-produced action plan properly addresses the concerns in a systematic way.

7.6 The committee receive the annexed report (7) from Dr Liz Chandler, Scrutiny and Research Officer, which noted information to aid the examination of the report from Norfolk and Suffolk NHS Foundation Trust (NSFT) regarding the findings and recommendations of the Grant Thornton Mortality Recording and Reporting review, as well as NSFT's actions in response to those recommendations.

7.7 The following discussion points and clarifications were offered:

- NSFT was working with the ICB to ensure that there was a consistent offer and delivery of mental health provision, which took into consideration place-based needs, throughout the whole of Norfolk and Waveney.

- It was clarified that reference to 'other mental health deaths' referred to those that had not been ruled a suicide by a coroner. For example, it could refer to death by psychosis, an overdose, an eating disorder, or a physical illness that was caused/amplified by a mental illness. There was a desire to explore, through working with co-production partners, how data could be reported to ensure that all mental health-related deaths were being captured and not just those that meet the criteria of the factual definition used by corners. This work would feed into the wider national picture of mental illnesses.

- The committee heard that people with significant mental health illnesses were more likely to die from a physical illness and were five times more likely to die 15 – 20 years younger than those without a significant mental health illness. The relationship between poor mental health and inequalities was discussed and work was being done on a strategic level by the Integrated Care Service (ICS) and ICB to encourage collaborative working between the Trust, ICB and Public Health

about population health management. Members of the committee were prompted to promote the uptake of the over-40s health checks that afford early intervention of physical illnesses.

- In response to members questions about the disparity between the final published report in June and the draft version that was shown on BBC Newsnight, the committee heard that the change was a result of Grant Thornton receiving additional information. Grant Thornton requested additional information, and this was gathered in the form of interviews and written questions and responses. All information was collected over a number of weeks. The owner of the report was the ICB, who commissioned the report and had been involved in conversations that aided that auditing process.

- As part of Grant Thornton's regulatory responsibility, it would be regulated by its internal control processes. These require any changes to be evidence-based and for there to be a record of the justification for any changes made. NSFT was not aware of any person at the Trust requesting that the report be rewritten, nor were they aware of any person at the Trust who had rewritten the report. It was also shared that the Trust had reached out to the Parliamentary and Health Services Ombudsman, who commented on the report as part of the BBC Newsnight investigation, to discuss their comments on the difference between the versions, but they had not had a response.

- Some members questioned the justification that supported the deletion of statements from the draft report. It was felt that the evidence presented in the final report supported the statements that were removed, this was particularly in relation to working culture. This was not something that could be commented on as no one from Grant Thornton was in attendance. It was suggested that NHOSC write to Grant Thornton to both express its concerns and seek information about the different versions of their report.

- Following a comment from NSFT that there were no changes to the recommendations between the draft report and the published final report, the committee heard that this was not the case and there was variation in the number of recommendations proposed. NSFT noted that this was a result of combining multiple recommendations into one and that the final report remained inclusive of all the recommendations noted in the draft.

- It was acknowledged that morale was low amongst staff and that there was hesitation to speak up and raise concerns. There were efforts to improve the working atmosphere and culture, and conversations with staff had shown that bullying, harassment, unfairness, inequality, and nepotism were identified as themes to be addressed. NSFT was honing in on these themes and practically tackling them although it admitted it would take time to do this. There has been the implementation of an independent freedom to speak up guardian service, contact with this guardian service has remained consistent and NSFT has recommissioned it with additional capacity. Whilst the rate of contact remained consistent, NSFT was reassured that it was being used and that confidence to report concerns was improving.

- The committee heard that overall retention figures were improving but that the rate of staff leaving after two years of employment had not improved. There was an over-recruitment to compensate for the loss of staff after two years. Clinical support workers and admin staff were noted as hard roles to retain.

- The committee requested information on the number of consultant vacancies and the number of consultant locums there are working for NSFT in proportion to locum to the anticipated full consultant complement. These figures were not available to hand but would be followed up on.

- Following a question from a member on whether the data as recorded can identify any adverse correlation with any treatment or medication pathway, it was noted that a written response from the Chief Medical Officer would be given.

- Members of the committee asked for reassurance that the recommendations from the report would be implemented and that it would not follow the same trajectory as recommendations made in 2016. In response, the committee heard that NSFT acknowledged that previous recommendations had either not been addressed or were not sustained and that concerns should have been listened to sooner. There was a commitment to addressing historic and current issues and for there to be an open and regular conversation.

- An action plan was being developed through co-production. The development of the plan would need to be a collaboration of partners and people who have lived experience. It was clarified that HOSC would not be involved in the production of the action plan but would continue to have oversight.

- It was generally felt that more work was needed to be done across the system to improve the treatment and discharge of patients with mental health illnesses, this would also include the offer that the voluntary sector could provide.

- The NSFT Board led the conversation around scrutiny, a member raised a question about whether the board has challenged the data correctly. In response to this, the committee heard that the focus of the board has not been where it needed to be and that training for the Board had been arranged to deepen understanding of mortality data. The independent guardian attends the public board meetings, and it was the ambition to invite other partners along.

- Following conversations about the potentiality of a Joint HOSC with Suffolk, some members shared their concerns that a joint meeting didn't feel relevant, and they questioned the value it would add.

7.8 The chair thanked all attendees for coming to the meeting and for their honesty. They noted that this was an opportunity to make a difference but understood that not all members had been reassured. There needed to be confidence that changes to the ways of working, and to the working culture, would make the difference needed. It was appreciated that this would be a process that would take time and required collaboration.

Summary of Actions:

- NSFT to provide information on the number of consultant vacancies and the number of consultant locums there are working for NSFT in proportion to locum to the anticipated full consultant complement.

- NSFT's Chief Medical Officer to provide a written report on whether the data as recorded can identify any adverse correlation with any treatment or medication pathway.

- NHOSC to consider writing to Grant Thornton to both express its concerns and seek information about the different versions of their report.

Cllr Kybird left the meeting at **12:35**

7.9 The committee took a vote on a joint HOSC meeting between Norfolk and Suffolk HOSCs to discuss the Mortality Recording and Reporting review. Following a show of hands, it was **agreed** that there **would not** be a joint HOSC meeting between Norfolk and Suffolk.

7.10 Cllr Boyle proposed, and was seconded by Cllr Devulapalli, the following recommendations:

1. NHOSC supports calls for a statutory public inquiry into in-patient and community mortality at NSFT.

2. Request that ICBs urgently (within one month) review the Mortality Review Action Plan with bereaved families and NSFT and co-produce revised actions.

3. NHOSC shares the concerns set out by the Parliamentary Health Service Ombudsman and rejects the assertion that changes to the Mortality Review were limited to 'factual accuracy'.

4. All co-production with bereaved families should be commissioned by and directly overseen by ICB due to the lack of HOSC, public and bereaved family confidence in NSFTs suitability or competence to undertake this work safely.

5. Write to the Secretary of State for Health to outline these actions and HOSCs dissatisfaction and ongoing safety concern.

Cllr Dark requested that there be discussion before a vote was taken and the chair agreed to this.

Cllr Aquarone proposed that they move to a vote, this was seconded by Cllr Corlett.

The committee took a vote on each recommendation individually without discussion. All recommendations were **carried**.

Cllr Devulapalli and Cllr Prinsley left the meeting at **12:55**

7.11 Cllr Dark proposed the following additional recommendations:

6. The recommendations agreed should not delay the work of the co-produced action plan.

7. NSFT will return to HOSC with an update in early 2024.

This was seconded by Cllr Corlett on the basis that votes would be taken on each recommendation separately,

Each recommendation was voted on separately. The committee **agreed** the recommendations.

8. Forward Work Programme

8.1 The Committee received a report from Peter Randall, Democratic Support and Scrutiny Manager, which set out the current forward work programme and briefing details. The Committee **agreed** the details for both briefings and future meetings.

Peter Randall shared with the committee that work on the Electronic Paper Recording will be part of the Digital Transformation item that was due to come to the committee in January 2024. They also informed members that in January 2024, there would be a forward work programme planning workshop, and there was also an offer of training.

A member suggested that a substantive item on speech and language therapy be added to the forward work programme. *

Fran Whymark Chair
Health and Overview Scrutiny Committee

The meeting ended at **13:03**

If you need these minutes in large print, audio, Braille, alternative format or in a different language please contact Customer Services on 0344 800 8020 or Text Relay on 18001 0344 800 8020 (textphone) and we will do our best to help.

*It was agreed that this minute be amended and was corrected at the committee meeting on 9 November 2023. Please view the minutes of that meeting in order to note the correction made.