Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **9 May 2024**

Time: **10:00 am**

Venue: **Council Chamber, County Hall, Martineau Lane, Norwich**

Persons attending the meeting are requested to turn off mobile phones.

Members of the public or interested parties may, at the discretion of the Chair, speak for up to five minutes on a matter relating to the following agenda. A speaker will need to give written notice of their wish to speak to Committee Officer, Maisie Coldman (contact details below) by **no later than 5.00pm on 2 May 2024**. Speaking will be for the purpose of providing the committee with additional information or a different perspective on an item on the agenda, not for the purposes of seeking information from NHS or other organisations that should more properly be pursued through other channels. Relevant NHS or other organisations represented at the meeting will be given an opportunity to respond but will be under no obligation to do so.

Membership

MAIN MEMBER	**REPRESENTING**
Cllr Jeanette McMullen	Great Yarmouth Borough Council
Cllr Stuart Dark	Norfolk County Council
Cllr Lesley Bambridge	Norfolk County Council
Cllr Brenda Jones	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 Justin Cork	South Norfolk District Council
Cllr Peter Prinsley	Norwich City Council
Cllr Richard Price	Norfolk County Council
Cllr Adrian Tipple	Broadland District Council
Cllr Robert Savage	Norfolk County Council
Cllr Lucy Shires	Norfolk County Council
Cllr Jill Boyle	North Norfolk District Council
Cllr Fran Whymark	Norfolk County Council

CO-OPTED MEMBER (non voting)	**REPRESENTING**
Cllr Edward Back	Suffolk Health Scrutiny Committee
Cllr Edward Thompson	Suffolk Health Scrutiny Committee

For further details and general enquiries about this Agenda please contact the Committee Officer:

Maisie Coldman 01603 638001
or email committees@norfolk.gov.uk

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However, if you wish to attend in person it would be helpful if you could indicate in advance that it is your intention to do so as public seating will be limited. This can be done by emailing committees@norfolk.gov.uk

Current practice for respiratory infections requests that we still ask everyone attending to maintain good hand and respiratory hygiene and, at times of high prevalence and in busy areas, please consider wearing a face covering.

Please stay at home if you are unwell, have tested positive for COVID 19, have symptoms of a respiratory infection or if you are a close contact of a positive COVID 19 case. This will help make the event safe for attendees and limit the transmission of respiratory infections including COVID-19

A g e n d a

1. **Election of Chair**
   The Chairman to be elected from the Norfolk County Councillors on the Committee.

2. **Election of Vice-Chair**
   The Vice-Chairman to be elected from the Norfolk District councillors on the Committee.

3. **To receive apologies and details of any substitute members attending**

4. **Minutes**
   To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on 21 March 2024.
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5. **Members to declare any Interests**
   If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is on your Register of Interests you must not speak or vote on the matter.
   If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is not on your Register

of Interests you must declare that interest at the meeting and not speak or vote on the matter

In either case you may remain in the room where the meeting is taking place. If you consider that it would be inappropriate in the circumstances to remain in the room, you may leave the room while the matter is dealt with.

If you do not have a Disclosable Pecuniary Interest you may nevertheless have an **Other Interest** in a matter to be discussed if it affects, to a greater extent than others in your division

- Your wellbeing or financial position, or
- that of your family or close friends
- Any body -
    - Exercising functions of a public nature.
    - Directed to charitable purposes; or
    - One of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union);
      Of which you are in a position of general control or management.

If that is the case then you must declare such an interest but can speak and vote on the matter.

6. To receive any items of business which the Chair decides should be considered as a matter of urgency

7. Chair's announcements

8.	**10:10 – 11:00**	**Update on the NSFT mortality data action plan**	Page 13
9.	**11:10 – 12:00**	**Local Maternity Neonatal System (LMNS)**	Page 56
10.	**12:00 – 12:10**	**Forward Work Programme**	Page 70

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Date Agenda Published: 30 April 2024

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
Minutes of the meeting held at County Hall
on 21 March 2024

Members Present:

Cllr Jeanette McMullen	Great Yarmouth Borough Council
Cllr Lesley Bambridge	Norfolk County Council
Cllr Brenda Jones	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 Justin Cork	South Norfolk District Council
Cllr Peter Prinsley	Norwich City Council
Cllr Richard Price	Norfolk County Council
Cllr Robert Savage	Norfolk County Council
Cllr Lucy Shires	Norfolk County Council
Cllr Jill Boyle	North Norfolk District Council
Cllr Fran Whymark	Norfolk County Council

Co-opted Member (non voting):

Cllr Edward Thompson	Suffolk Health Scrutiny Committee

Substitute Members Present

Cllr Tom FitzPatrick	Norfolk County Council

Also Present:

David White	Interim Chair, OneNorwich Practices
Emma Bugg	Associate Director Primary Care Network Development Norwich, Norfolk & Waveney Integrated Care Board
Sadie Parker	Director of Primary Care, Norfolk & Waveney Integrated Care Board
Karen Watts	Director of Nursing and Quality, Norfolk & Waveney Integrated Care Board
Emily Arbon	Head of Communications and Engagement, Norfolk & Waveney Integrated Care Board
Kristen Hall	Communication and Engagement Manager – Primary Care, Norfolk & Waveney Integrated Care Board
Tracey Bleakley	Chief Executive, Norfolk & Waveney Integrated Care Board
Alex Stewart	Chief Executive Officer, Healthwatch Norfolk
Peter Randall	Democratic Support and Scrutiny Manager
Dr Liz Chandler	Scrutiny and Research Officer
Maisie Coldman	Trainee Committee Officer

1 Apologies for Absence

1.1 Apologies for absence were received from Cllr Back and Cllr Dark (substituted by Cllr FitzPatrick).

2. Minutes

2.1 The minutes of the previous meeting held on 18 January 2024 were **agreed** as an accurate record of the meeting.

3. Declarations of Interest

3.1 There were no declarations of interest.

4. Urgent Business

4.1 There were no items of urgent business.

5. Chair's Announcements

5.1 There were no Chair's announcements.

6. Holt Medical Practice's Application to close Blakeney Branch Surgery

6.1 The Chair welcomed the six public speakers that had registered to speak on item 6.

6.1.1 Duncan Baker MP spoke to the committee, highlighting that the closure of Blakeney Branch Surgery, and the subsequent requirement to travel, would impact the elderly and vulnerable communities, which was the majority of the local population. Mr Baker shared that he had received large amounts of engagement from the community noting the impact that a decision to close the surgery would have and that they did not feel that sufficient mitigation had been put in place.

6.1.2 Michael Archer made comments regarding the financial and operational measures which included financial and governance concerns, GP reimbursement and the difference between direct and indirect reimbursement. He also highlighted that NHS payments to Holt Medical Practice (HMP) had increased, and thus argued that HMP had the resources to keep open its three sites. He provided a different view on the issue of attracting new partners, suggesting that the HMP was relatively over-doctored compared to the national average.

6.1.3 Andrew Chapman shared anecdotal and historical evidence from his time as a senior partner of HMP with the committee. He highlighted that the CQC inspection in 2018 found no operational or infection issues and that this remained the case when it was reviewed in 2023. HMP temporarily stopped face-to-face consultations at Blakeney Branch Surgery based on non-compliant infection control and inadequate disabled access. It was suggested that a 2021 review of the premises noted that the surgery could be brought up to standards at a moderate cost. He felt that HMP not making changes to the premises went against the infection control and standards they were responsible for meeting.

6.1.4 Alexandra Hooper was a patient of HMP. She shared that she wanted patients to be assured that their interests were being considered and that the correct governance and procedures had been followed. She noted the historic service withdrawal in 2017 and 2019 and suggested that because the withdrawal of clinical services that took place during the Covid 19 pandemic remained, there had been a substantial variation of services that ought to have been handled accordingly. It was suggested that the withdrawal of clinical services should have prompted a consultation on this matter The Integrated Care Board's duties and the NHS Act were referenced, as was the ICB's Joint Forward Plan.

6.1.5 Cllr Victoria Holliday referred to the patient demographic, accessibility of the main building and the impact on health and health inequalities as considerations that were noted in the NHS England Policy Manual. The committee heard an overview of the community, including age, disability rates and access to transport, based on the 2021 census data. Cllr Holliday also highlighted the issue with transport and illustrated this by giving examples of potential public transport routes, the time they would take and how much they would cost. The importance of patients, especially those that are elderly or disabled, having access to healthcare was emphasised to the committee. The committee heard a quote from England's Chief Medical Officer who suggested that resources should be directed towards areas of greatest need including rural and coastal areas.

6.1.6 Sheelin Cuthbert shared with the committee anecdotal evidence, highlighting the importance of the surgery and the centring of the patient. She also reemphasised the issue with transport in the local area.

6.1.7 Many of the speakers requested that the Norfolk Health Overview and Scrutiny Committee (NHOSC) refer the closure of Blakeney Branch Surgery to the Secretary of State. The Chair informed the speakers that any one of them could write to Secretary of State and request that they exercise their power to call in this decision.

6.2 Sadie Parker, Director of Primary Care, Norfolk & Waveney Integrated Care Board (N&WICB), introduced the Holt Medical Practice Application to close Blakeney Branch Surgery report.

6.2.1 A decision had not been made by the N&WICB on HMP's application that was received in January 2024. Public engagement work was being undertaken, some of which was with the involvement of Healthwatch Norfolk, to ensure engagement was fair and thorough. Included within this work was the N&WICB's Equality Impact Assessment (EIA) which highlighted that further work may be beneficial to the practice's proposed medication collection service. Members of the committee heard that this was why there had been an emphasis on this particular issue and engagement specific to this. N&WICB had attended a public meeting organised by Blakeney Parish Council; the issue raised by the local community was being recorded. The committee heard that the N&WICB would be unable to attend meetings during the pre-election period ahead of the Police Crime Commissioner elections in May 2024.

6.2.2 In response to some of the comments made by the public speakers, the committee heard that the report referred to the NHS England Policy Guidance Manual and ICB statutory duties. The committee deciding on the application would be required to bear the content of these in mind and to also consider the wider impacts of any decision. A decision on the application was anticipated to be taken in February 2024, this had been deferred and was rescheduled to be taken on 7 May 2024. The decision would be required to cover the areas set out in the NHS England Policy Guidance Manual.

6.2.3 Sadie Parker took the opportunity to respond to comments regarding the governance of the reduction of services at Blakeney Branch Surgery. The service provision at Blakeney Branch Surgery was reduced in 2017 and 2019, and information on the governance arrangements of this has been provided. NHS England was asked and provided support for, those changes and, in addition, the patient participation group was involved. Face-to-face services ceased temporarily during the Covid-19 pandemic, with the support of the commissioner, and was still the current position. This would be concluded alongside the application decision.

6.3 Alex Stewart, Chief Executive Officer, of Healthwatch Norfolk (HWN), noted that HWN felt that Holt Medical Practice had undertaken all reasonable consultation that it could. He reiterated the N&WICB's earlier point that the delivery and collection of prescription medication was a concern for the local community. He shared concerns that some of the villages that would be impacted by the closure had no access to public transport. It was highlighted to members that the census information that was referred to by the public speakers had now changed and that the data collected from surveys and petitions had some duplication within it.

6.4 The committee received the annexed report (6) from Dr Liz Chandler, Scrutiny and Research Officer, that noted information to aid the examination of the of Holt Medical Practice's application to close its branch surgery at Blakeney.

6.5 The following discussion points and clarifications were offered:

- Following a member's comment about the importance of ensuring that the needs of everyone are met and not just the needs of the majority, members were assured that the N&WICB was considering how HMP could meet the needs of the whole population and if this could be achieved through the proposed application. Sadie Parker apologised for the wording in the report that could have suggested that that the needs of the whole population were not being considered.

- Members generally felt that the access and availability of public transport would be a potential barrier in accessing health care provisions if Blakeney Branch Surgery closed. This was a particular concern for those within the population who had financial constraints, lack of personal transportation, those with mental health issues or those who were in education. The N&WICB was not able to comment on the public transport provision given that this was not within its remit.

- In response to a question about whether the accessibility of Blakeney Branch Surgery included being able to access transport to attend the surgery and was not limited to the physical building. It was confirmed that the accessibility considerations included transport implications. The N&WICB would be required to consider the impacts of any implications and plan to reduce inequalities. The EIA would also consider this alongside other issues.

- It was confirmed that the current services offered at Blakeney Surgery were a receptionist, who was on-site daily and patients could collect their prescriptions in the morning. There were no face-to-face appointments: where patients needed to see a GP, and were unable to travel, measures had been put in place. The committee heard that there was a dedicated early visits GP who provided face-to-face appointments for patients who were housebound.

- The N&WICB was unable to comment on whether closing the Blakeney Branch Surgery would have any adverse effects for patients until a final decision had been made. It was acknowledged that this would be a difficult decision. The decision on the application will be final, but there were ways of challenging this decision including a referral to the Secretary of State and a legal challenge.

- It was highlighted to members that it was a challenge to offer services in rural areas, especially at a time when general practice more broadly was experiencing issues, including the limited uplift of general practice funding. The

committee heard anecdotal evidence of other practices that were experiencing financial difficulties.

- Tracey Bleakley, Chief Executive of N&WICB, emphasised the importance of the system working together, including with NHOSC, to think about the wider determinants of health, including transport.

- HMP could submit an application and business case to N&WICB to request support to help make improvements. It was noted, however, that N&WICB had limited capital and had to prioritise accordingly.

- It was confirmed that N&WICB could not take away parts of the contract and that it could only discuss practice boundaries.

- A member shared their frustration regarding the limited amount of national NHS funding.

- A member questioned why there were no representatives from Holt Medical Practice present at the meeting.

- Following a member's question, it was clarified that the Blakeney Branch Surgery site was owned by the partnership, and they would decide how it would be used if the surgery were closed.

6.6 The Chair concluded the discussion, highlighting that this was an ongoing piece of work that had high public interest and engagement. Public transport in rural areas was an issue raised by many committee members and was an area that possibly needed more exploration concerning health implications. It was, however, acknowledged that it was reassuring to hear that there was a provision for GP home visits. It was confirmed that HMP was not invited to the meeting and that there could be an opportunity to write to the practice.

7. OneNorwich Practices

7.1 Emma Bugg, Associate Director of Primary Care Network Development Norwich, Norfolk & Waveney Integrated Care Board, introduced the OneNorwich Practices (ONP) report to the committee. The report highlighted the timeline of actions taken and the factors that lead to issues within ONP. The committee also heard the services that the N&WICB commissioned ONP to provide, had been transferred to alternative organisations and thus, these services remained in place.

7.2 David White, Interim Chair, OneNorwich Practices, noted that ONP had worked closely with the N&WICB to manage the transfer of services and ensuring service continuity.

7.3 The committee receive the annexed report (7) from Dr Liz Chandler, Scrutiny and Research Officer, that noted information to aid the examination of what led to the collapse of OneNorwich Practices (ONP) and the recommissioning of services previously provided by ONP.

7.4 The following discussion points and clarifications were offered:

- Following a member's question, it was clarified that there was no formal requirement for annual audits to be conducted as the turnover of ONP was below the threshold. A member felt that the requirement for an audit should be written into contacts that involved public money. David White assured the

committee that the liquidator, who had been complimentary of the joint working between ONP and N&WICB, would look into the finances and escalate any concerns identified.

- Some members felt that those individuals and organisations charged with spending public money on health services should have a a higher level of understanding of scrutiny with regard to this funding .

- David White explained to the committee that the role descriptions for a director-level role were not adequate. The Finance Director, for example, has no executive day-to-day management or oversight of ONP's finances. The Non-Executive for Finance of ONP had ambitions to improve the financial reporting and management, establishing a finance and audit sub-committee. In response to a member's question about the financial management of ONP, Mr White explained that there had been discrepancies in financial reporting to the ONP board and subsequently a retrospective review of accounts for the previous three years was undertaken and presented to ONP shareholders.

- It was confirmed that all the services that were the responsibility of the N&WICB had successfully been transferred to other organisations. A caretaker contact arrangement was entered into which meant that there would be no disruption to services and that the estate and staff would remain the same. The committee was assured that N&WICB had regular contact with the new service providers. Members welcomed the successful transfer of services.

- The N&WICB would be arranging an independent review to be undertaken to understand what could be learned. A member questioned why this had not been commissioned yet and in response, the committee heard that the priority was the safe and suitable transition of services. The N&WICB was engaged with NHS England regarding the learning that needed to be undertaken to ensure suitable commissioning. The independent review would still be taking place.

- Following a member's question, it was clarified that the Care Home at Scale service was a requirement of the Norwich Primary Care Network (PCN) and that there was a responsibility to cover this requirement.

- In response to a member's question about the relationship between the PCN and ONP, it was shared that ONP supported the management functions. The staff that supported this had been transferred to the alternative providers and the management functions had been retained by clinical directors that are responsible for the contact. The lead clinical director of PCN was seeking advice on the impact of their financial resilience.

- The committee heard in response to a member's question that there was no separation between the N&WICB and PCN funding streams until 2023. There was a small surplus present in 2021, but this was based on a misunderstanding as a result of the funding streams not being separate.

- A member questioned the recruitment process of directors and non-directors. It was shared that company directors of ONP were recruited through a public appointment process and the remuneration that they received was in line with NHS non-executive directors. The board appointed non-executive directors. The weakness of the general governance of the board was highlighted about

this, and members heard that new governance arrangements were being established before ONP was no longer able to trade.

Cllr Jones left at 11:52

7.5 Chair concluded the discussion, noting that the transfer of services to new providers had been good and that it was reassuring to hear that the N&WICB were regularly in contact with them. The discussion around the financial and governance arrangements of ONP had been interesting and it was positive that learnings would be taken away from this experience.

8. Proposed Forward Work Programme 2024/25

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.

8.2 The following comments and suggestions for the forward work programme and briefing note were provided by members of the committee:

- Malnutrition was on the forward work programme for July 2024. Members requested that the report include information on both under and over-nutrition and have details on how other factors, such as disabilities, social isolation and drug and alcohol misuse, play into, and/or are affected by, malnutrition.

- Weight management services, specifically looking at tier 3 and 4 weight management provision.

- The community Doppler and leg ulcer service..

- Health implications of transportation access and what services are available. The committee heard that this issue fell into several authority areas and that a briefing note could look into this.

- Exploration into the current infection and death rates due to Covid-19, as well as service provision for people with long Covid.. A member also requested data on ME and CFS given that the symptoms and treatment are similar to long Covid.

- An overview of school dental services. It was shared with the committee that the Norfolk County Council (NCC) People and Communities Select Committee had a substantive item on oral health scheduled for a future meeting presented by NCC Public Health.

- A briefing note to update the committee on ONP's financial deficit and how this will be managed.

- Explore the data on falls. The Chair noted that work was being done by the Health and Wellbeing Partnership in Broadland and South Norfolk and had been briefly discussed by the Norfolk Health and Wellbeing Board.

Fran Whymark Chair
Health and Overview Scrutiny Committee

The meeting ended at 12:34

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Norfolk and Suffolk NHS Foundation Trust (NSFT) Mortality Recording and Reporting Review

Suggested approach from Liz Chandler, Scrutiny and Research Officer

Update on activity undertaken following the Grant Thornton review of mortality recording and reporting in mental health services across Norfolk and Suffolk.

1.0 Purpose of today's meeting

1.1 To examine the report from Norfolk and Suffolk NHS Foundation Trust (NSFT) entitled Leaning from Deaths Quarterly Report: 1 November 2023 to 31 January 2024. The report is attached at **Appendix 1.**

1.2 This is the second time NSFT has presented an update to an NHOSC meeting following the committee's examination of the trust's response to the findings and recommendations of the Grant Thornton Mortality Recording and Reporting review on 14 September 2023. Published in June 2023, independent company Grant Thornton was 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 NSFT.

1.3 Representatives of NSFT and Norfolk and Waveney Integrated Care Board (N&WICB) will be in attendance to answer members' questions.

2.0 Previous reports to NHOSC

2.1 Following the NHOSC meeting in September 2023, NSFT provided the committee with an update on actions being taken following the Grant Thornton report at the NHOSC meeting on 18 January 2024.

2.2 On recommendation of the committee, the Chair of NHOSC wrote to the Secretary of State for Health and Social Care calling for a statutory public inquiry into mortality recording and reporting at NSFT on 30 January 2024. A response from Parliamentary Under-Secretary for State for Mental Health and Women's Health Strategy Maria Caulfield MP was received on 16 April 2024. Ms Caulfield responded that the department was taking the concerns raised by NHOSC seriously and continuing to work with NSFT, N&WICB and other organisation to ensure that vital improvements continue to be made.

2.3 Prior to the meeting held in September 2023, NSFT has attended the following NHOSC meetings over the past 5 years:

- In December 2017, NSFT attended NHOSC with a report regarding the impact of the Care Quality Commission (CQC) inspection which took place in July 2017 (published October 2017).
- NSFT returned to NHOSC in April 2018 with an update on its improvement plan following the meeting in December 2017 and responses to recommendations made by the committee at that meeting.
- In January 2019, NSFT presented a report to NHOSC following the CQC inspection in September 2018 (published November 2018).
- A progress report on the 2018 CQC inspection was provided by NSFT at the NHOSC meeting in July 2019.
- In September 2020, NSFT returned to NHOSC following another CQC inspection in October – November 2019 (report published January 2020). At this meeting, Members also examined the CQC's focussed inspection of specialist community mental health services for children and young people which took place in February 2020 (report published May 2020).
- The use of out of area placements was the subject of a report by NSFT at the NHOSC meeting November 2021.
- In September 2022, NHOSC examined NSFT's improvement plan following the CQC inspection in November-December 2021 (published February 2021). This was re-examined by NHOSC in November 2022.
- Also in September 2022, NSFT attended a Joint HOSC (JHOSC) with Suffolk HOSC regarding the redesignation of Psychiatric Intensive Care Units (PICU) in Norfolk and Suffolk.

2.4 The most recent editions of the NHOSC Briefings to contain reports from NSFT are as follows:

- In October 2020, NSFT provided information regarding staff training to avoid physical restraint or seclusion of patients, support for schools, accessibility of mental health services, waiting lists and the next CQC inspection.
- A report on the CQC inspection in November-December 2021 (published February 2021) was included in the March 2021 Briefing.
- For the August 2021 Briefing, NSFT provided an update on progress with CQC requirements, information on discharge from acute mental health beds to hotel/B&B accommodation and information on conveyance of patients to out of area placements.
- Intensive care beds were the subject of a report in the October 2021 Briefing.
- In the December 2021 edition, NSFT provided information on waiting times for mental health services, commissioned capacity of services compared with demand and pauses to admissions.
- A situation briefing on mental health services was included in the February 2022 edition.
- An overview from NSFT of the range of community health services it provides was provided in the April 2023 Briefing.
- An update on PICU provision in the April 2024 Briefing.

3.0 Background information

3.1 The Grant Thornton report was specifically designed to review the collection, processing and reporting of data related to patient deaths at NSFT. It was not intended to ascertain levels of mortality within NSFT or investigate the circumstances of individual deaths, but to review the processes used by NSFT to collect and report mortality data.

3.2 Grant Thornton found a number of shortfalls in NSFT's recording and reporting of mortality data. It consequently includes a number of recommendations for improvements, together with an action plan by NSFT outlining how it will address those recommendations. The Grant Thornton Report provided a clear action plan, with 16 recommendations across 5 key themes. A copy of the report can be read here.

3.3 In response to the Grant Thornton review, the independent Forever Gone: Losing Count of Patient Deaths report by Caroline Aldridge, Anne Humphrys and Emma Corlett was published in July 2023. The authors were also present at NHOSC's meeting in September.

4.0 Suggested approach

4.1 The committee may wish to discuss the following areas with representatives from the three acute trusts:

- Request further explanation of the Medical Examiner process.
- Provide feedback to NSFT on the structure and presentation of its report.
- Review and discuss the Learning from Deaths action plan provided at appendix B of NSFT's report.
- Request an update on coproduction activity, and work to include a broader range of partners in delivery of the Grant Thornton action plan. This should include details of learning from people with lived experience.
- Request a broader overview of key sector challenges to the healthcare system, and the systemic barriers to reducing the number of deaths of people experiencing poor mental health.
- Discuss how local authority and broader system partners can undertake to support necessary improvements.

5.0 Action

5.1 The committee may wish to consider whether to make comments or recommendations as a result of today's discussion.

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Norfolk and Suffolk NHS Foundation Trust Learning from Deaths Quarterly Report: 1 November 2023 to 31 January 2024

Report to Norfolk and Suffolk Health Overview and Scrutiny Committee (HOSC) members

In January 2024, both the Norfolk and Suffolk Health Overview and Scrutiny Committee's discussed an update in relation to actions being taken following publication of the review of mortality recording and reporting in mental health services in Norfolk and Suffolk (June 2023.

An update was developed collaboratively by, Norfolk and Suffolk NHS Foundation Trust (NSFT), NHS Norfolk and Waveney Integrated Care Board (N&W ICB) and, NHS Suffolk and North East Essex Integrated Care Board (SNEE ICB) and shared with both Committee's.

On 28 March 2024, at its Board of Director's meeting in public, NSFT shared the first Learning from Deaths Quarterly Report using the new data platform which went live on 1 November 2023. Content from the report is included below, as well as appendices attached which includes an integrated learning from deaths plan which includes the actions from The Grant Thornton Review and the Collaborative Working Group. (Appendix B).

Recommendations

- HOSC members are asked to consider the information and updates provided in this report.
- HOSC members are asked to consider and share their views on the structure and presentation of the revised report.
- HOSC members are asked to review the composite Learning from Deaths action plan at appendix B of this report.

Report shared and discussed at NSFT Board of Directors meeting: 28 March 2024

One of our core transformation and improvement programmes is focussed on learning from deaths, which is split into three clear areas of focus:

- **Collecting, analysing and reporting on deaths**; involving the creation of a new electronic system for mortality information collection, analysis and reporting.
- **Ensure learning through improvements to clinical practice**; reviewing all Prevention of Future Deaths reports from 2013 to identify themes and ensure learning and improvement, including themes from the Forever Gone Report, Domestic Homicide Reviews and Serious Case Reviews.
- **Work with service users, carers and bereaved families**; detailed work with service users, families, carers and bereaved relatives who sit on our Learning from Deaths Action Plan Management Group

This was the first Board of Directors report using the revised Learning from Deaths quarterly report template. Attached as an appendix to this report is a co-designed summary document which has been produced with the support of bereaved families and carers. This includes definitions and a summary of key data included in this report.

The Report begins to highlight how our Trust will:

- Use our data
- Identify, share, and spread our learning
- Measure the impact and change in our practice

It is also the first board report which utilises the data from the new mostly automated mortality recording and management system.

The report covers the period 1 November 2023 to 31 January 2024. Future reports will be aligned to normal reporting cycles.

During the reporting period there were a total of 437 deaths notified to NSFT that met our criteria for reporting. The breakdown of these death is:

- Unexpected Natural 209 = 48% of all deaths
- Expected Natural 147 = 34% of all deaths
- Awaiting cause of death/unable to obtain cause of death 66 = 15% of all deaths
- Unexpected Unnatural 15 = 3% of all deaths

Whilst most of the report focuses on the new mortality data it also provides updates on:

- The work with service Users, carers, and bereaved families.
- The Medical Examiner process
- External support, scrutiny and assurance on our mortality data systems
- Highlights Learning from incidents and reviews
- Coroners Hearings

Recommendations for Board of Directors

- The Board of Directors are asked to consider the information and updates provided in this report.
- The Board of Directors are asked to consider and comment on the structure and presentation of the revised report.
- The Board of Directors are asked to consider the future publication of our mortality data on our Trust's website.
- The Board of Directors are asked to confirm that the board approve the composite Learning from Deaths action plan at appendix C of this report to be shared with both Norfolk and Suffolk Health Overview and Scrutiny Committees.

1. Background and Introduction

In 2022, Norfolk and Suffolk NHS Foundation Trust (NSFT) asked NHS Norfolk and Waveney and NHS Suffolk and North East Essex Integrated Care Boards (ICB's) to commission an independent review to assess mortality reporting at our Trust between April 2019 and October 2022.

In September 2022, Grant Thornton UK LLP were commissioned to undertake the review, following a procurement process. The review was commissioned for a specific purpose – to provide an independent audit of the processes used by our Trust to collect and report data relating to mortality.
It was not designed to investigate the circumstances of individual deaths or to compare the levels of mortality reported by or related to NSFT with other NHS trusts in the UK.

The Grant Thornton report was published on 28 June 2023. A copy of the report can be read here.

The expectations in relation to reporting, monitoring and Board oversight of mortality incidents are set out in NHS England's National Quality Board's 'Learning from Deaths' guidance (March 2017), and builds on the recommendations made by the Mazars investigation into Southern Health (Dec 2015), the CQC report 'Learning, Candour and Accountability publication' (Dec 2016) and the Learning Disabilities Mortality Review (LeDeR) which is managed by NHS England.

The Learning from Deaths framework (LfD) places particular responsibility on Trust Boards to ensure their Trust has robust systems for recognising, reporting and reviewing or investigating deaths where appropriate. The LfD states 'the aim of this process is to ensure that all deaths of people under the Trusts' care are reviewed at the appropriate level and organisational learning occurs'.

This is in addition to the detailed reporting and investigation of deaths meeting the national criteria and local priorities under the Patient Safety Incident Response Framework (PSIRF). To note, PSIRF has replaced the Serious Incident Framework (2015) as of 2023.
Since 2023, our Trust, as with most other NHS mental health trusts follow the Mazars Framework which was written to assist trusts in developing a case selection process for Structured Judgement Reviews.

The three main categories are:

- Expected Natural – e.g., person on end-of-life care
- Unexpected Natural – e.g., cardiac arrest, stroke, diabetes
- Unexpected Unnatural – deaths that potentially meet the Patient Safety Incident Response Framework Priorities e.g., all unexpected inpatient deaths, which is nationally mandated.

Our Trust would like to thank the bereaved families and carers who have supported us to inform how the data is represented in this report, as well as their continued and invaluable support to help us as a Trust, learn from the deaths of their loved ones. We recognise that this report is data focused, however this has been a crucial step in our learning, as this intelligence will allow us to make more informed and focused decisions moving forward.

2. Mortality Incident Recording and Reporting

In response to recommendations from the Grant Thornton review and to improve our Trust's management and reporting of mortality data, we have developed a new largely automated system. This comprises two key components:

- A Microsoft SharePoint list, which holds data on all patient deaths that have occurred during care at NSFT or within 6 months of discharge from NSFT services,
- A Microsoft PowerBI dashboard which displays the patient data and allows users to view the information according to a range of different perspectives, such as age, gender and ethnicity.

Work started on this new process in April 2023, the system was put live on the 6 November 2023 (covering deaths notified after the 1 November), addressing many of the recommendations found in the Grant Thornton report.

Following go-live, the system has been working effectively and further developments and enhancements have been added, through appropriate change control and based on the requirements of the patient safety and mortality teams.

The SharePoint list is updated daily with notifications of deaths from our Electronic Patient Record (EPR) systems and from the Service User Death Report (SUDR), which is a daily Spine notification of any deaths associated with NSFT patients.

In order to provide a secondary check that there are no deaths which the SUDR has failed to notify us of, we also run a monthly Demographic Batch Service trace, which takes our entire patient database and completes a check on what their current death status is on the Spine.

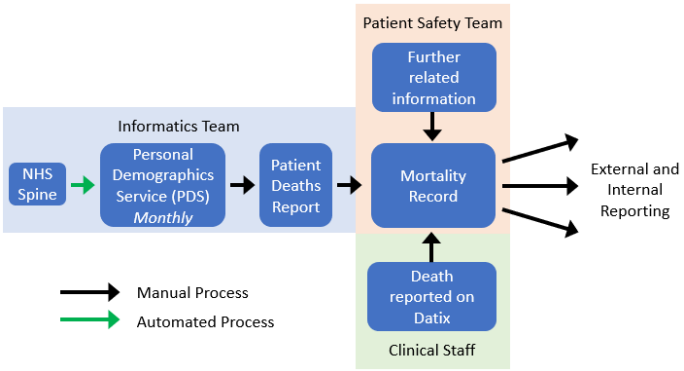
We have now run this monthly process 4 times and (on the third occasion) identified 2 deaths that were not notified to us by the daily SUDR. The 2 cases were subsequently updated in our EPR, which ensures that they are pulled through onto the SharePoint list.

This provides a good degree of assurance that we are being notified of all relevant deaths daily, as well as a means of identifying and including any additional patient deaths that we do find, through a monthly validation process.

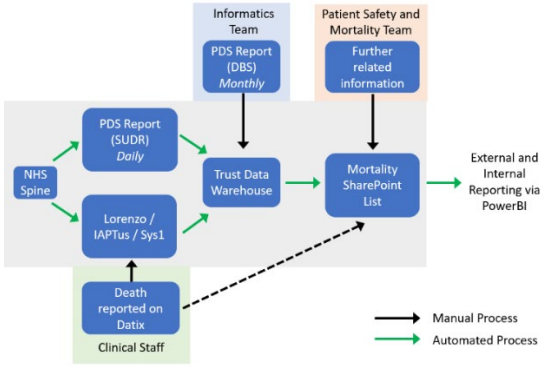
A before and after comparison is shown below, highlighting the benefits of the new approach.

Image 1 – 'Old' vs 'New' mortality recording and reporting processes and associated benefits

Old mortality recording and reporting process



New mortality recording and reporting process



Old	New	Benefit of process change
Mainly manual process	Largely automated process	• Reduced risk of transcription error • Time saving for staff in collating information • Deaths entered manually will be visible in our PowerBI dashboard the next day
Two sources of data	Multiple sources of data	• A more complete and accurate set of mortality data
Run monthly	Run daily	• More regular and up-to-date reporting • Missing information can be quickly identified, and clinical systems updated overnight
Data in different places	Data within a single place	• Easier to manage • Mortality data can be combined with other sources for greater insight
Manual reporting	Automated reporting	• A single consistent reporting source (Power BI) • Time saving for staff to create reports • Greater accuracy of reporting • Potential for more interactive and insightful reports
Limited process documentation	Standard Operating Procedures	• Agreed approach and accountability • Enables complete overview of Trust's end to end Mortality process
Limited audit control	Audit control	• Good governance and visibility of all changes that are made

Key to the clarity of reporting are the specific definitions we use:

- **Deceased whilst patient** – The patient has an open referral or hospital stay (a referral without a discharge/end date) within one of our Electronic Patient Record systems.

- **Within 6 months of discharge** –
  - The patient had a recorded contact (regardless of attendance or cancellation) where the date of the contact took place within the 6 months prior to their death.
    OR
  - The patient had a referral or hospital stay where the referral was ended/discharged within the 6 months prior to their death
    OR
  - The patient had a continuation note added to their record within the 6 months prior to their death.

Each case is then screened by a clinician in the Mortality team to check the individual was under the care of NSFT, either receiving treatment or awaiting treatment within a 6-month timeframe. Once the Mortality team confirm the case needs further investigation, they seek to clarify the cause of death. To do this they make contact with the individual's GP and / or the Medical Examiner service to get cause of death.

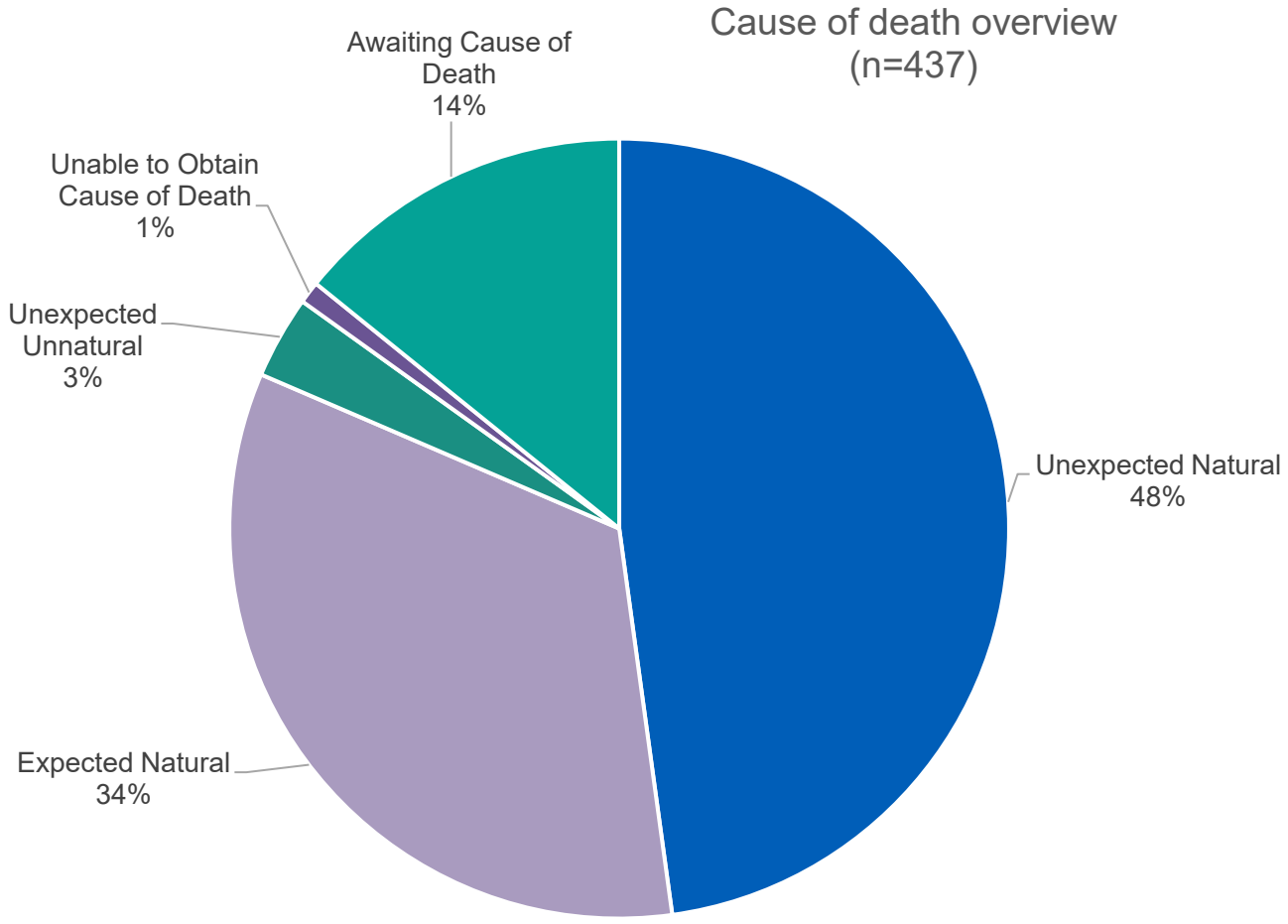
The total number of deaths reported for the period from 1 November 2023 (the launch of our new reporting system) until 31 January 2024 is reflected in the tables below.

This data is correct as of 15 March 2024 when the reports were collated. The information reported may change in future reports, based on when additional information comes to light. For example, as cause of death information becomes available those cases which are 'Awaiting cause of death' will be re-categorised accordingly.

Table 1 – Cause of death overview

Cause of Death	Unexpected Natural	Expected Natural	Unexpected Unnatural	Unable to Obtain	Awaiting cause	Total of deaths
Number of deaths	209	147	15	4	62	437
Report definitions: The source of the data is deaths identified via the national Spine, Trust EPRs and clinician reported Datix incidents. The period relates to deaths notified to NSFT between 1/11/23 and 31/01/24 inclusive. The data is reflective of the position as at 15/03/24. The data includes patients who died with an open referral to NSFT services; or who died within 6 months of discharge from NSFT services; or had a contact or continuation note added to their record within the 6 months prior to their death; and were considered to be under NSFT care following a manual screening process by NSFT's Mortality team						

Chart 1 – Cause of death overview



Report definitions: The source of the data is deaths identified via the national Spine, Trust EPRs and clinician reported Datix incidents. The period relates to deaths notified to NSFT between 1/11/23 and 31/01/24 inclusive. The data is reflective of the position as at 15/03/24. The data includes patients who died with an open referral to NSFT services; or who died within 6 months of discharge from NSFT services; or had a contact or continuation note added to their record within the 6 months prior to their death; and were considered to be under NSFT care following a manual screening process by NSFT's Mortality team

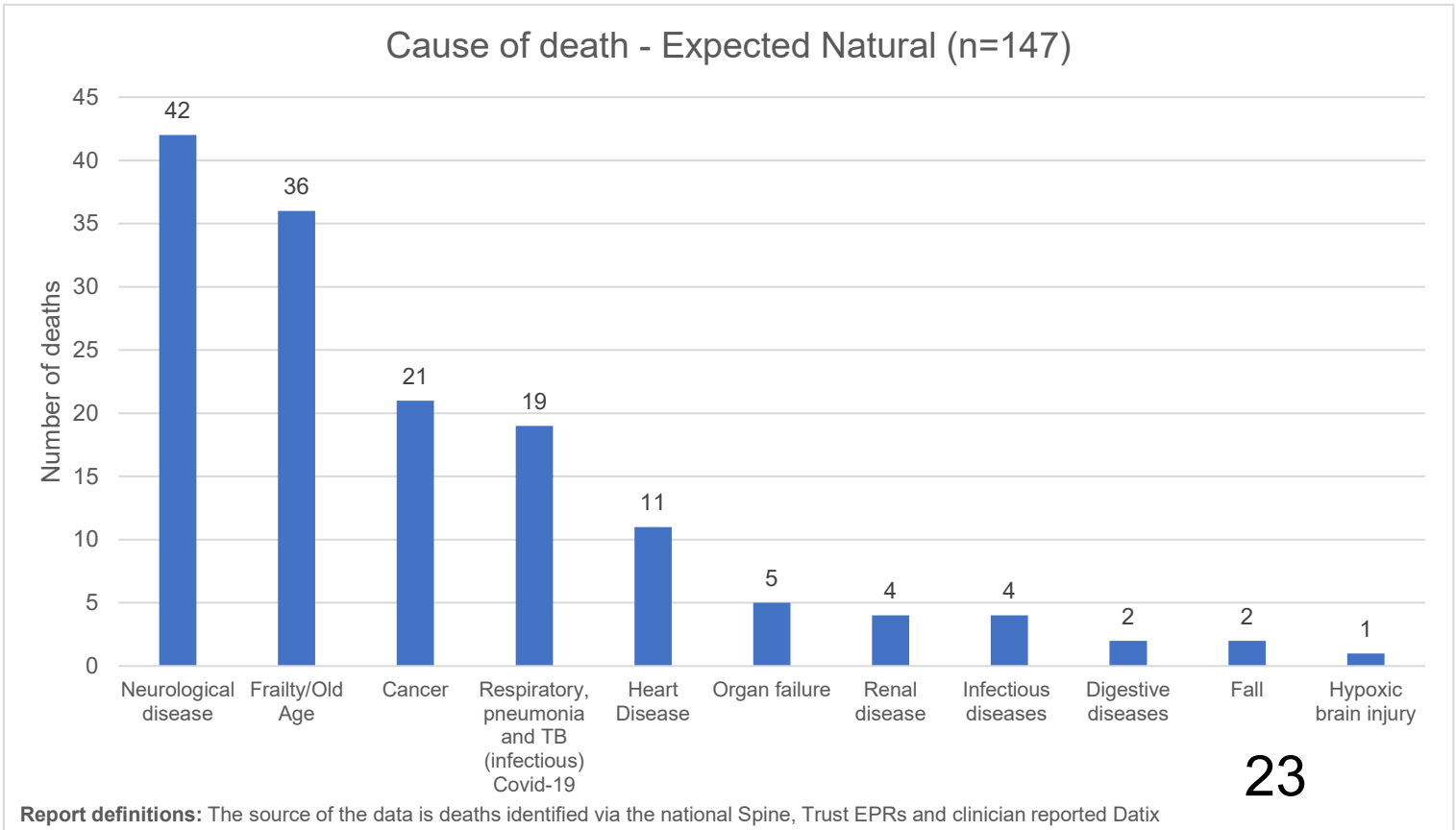
Table 2 – Cause of death by category

Cause of Death	Unexpected Natural	Expected Natural	Unexpected Unnatural	Unable to Obtain	Awaiting Cause	Total
Respiratory, pneumonia and TB (infectious) Covid-19	64	19			1	84
Neurological disease includes dementia, Parkinson's and epilepsy	20	42				62
Frailty/Old Age	21	36				57
Heart Disease inc. heart attack, CVA and cardio-vascular diseases	40	11	1			52
Cancer	13	21				34
Infectious diseases including Sepsis	19	4				23
Digestive diseases include Gastric, Bowel	14	2	1			17

Organ failure	6	5	1			12
Renal disease including cirrhosis	4	4				8
Hanging			5			5
Respiratory diseases - Chronic includes COPD and asthma	4					4
Unable to obtain cause of death				4		4
Fall		2	1			3
Drug toxicity			2			2
Unspecified effects of external causes	1		1			2
Auto-immune including MS, Chron's Disease, HIV	1					1
Choking	1					1
Drowning			1			1
Herniation of brain	1					1
Hypoxic brain injury		1				1
Injuries from external cause			1			1
Awaiting Cause of Death			1		61	62
Total	**209**	**147**	**15**	**4**	**62**	**437**

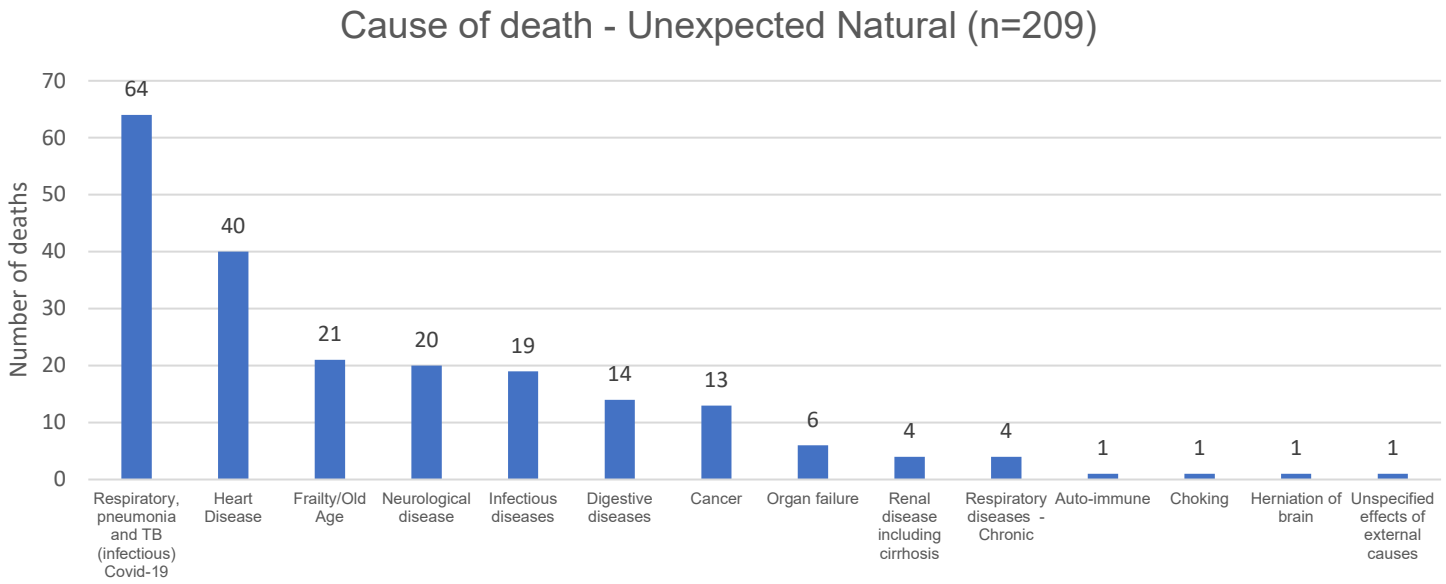
Report definitions: The source of the data is deaths identified via the national Spine, Trust EPRs and clinician reported Datix incidents. The period relates to deaths notified to NSFT between 1/11/23 and 31/01/24 inclusive. The data is reflective of the position as at 15/03/24. The data includes patients who died with an open referral to NSFT services; or who died within 6 months of discharge from NSFT services; or had a contact or continuation note added to their record within the 6 months prior to their death; and were considered to be under NSFT care following a manual screening process by NSFT's Mortality team

Chart 2 - Cause of death – Expected Natural



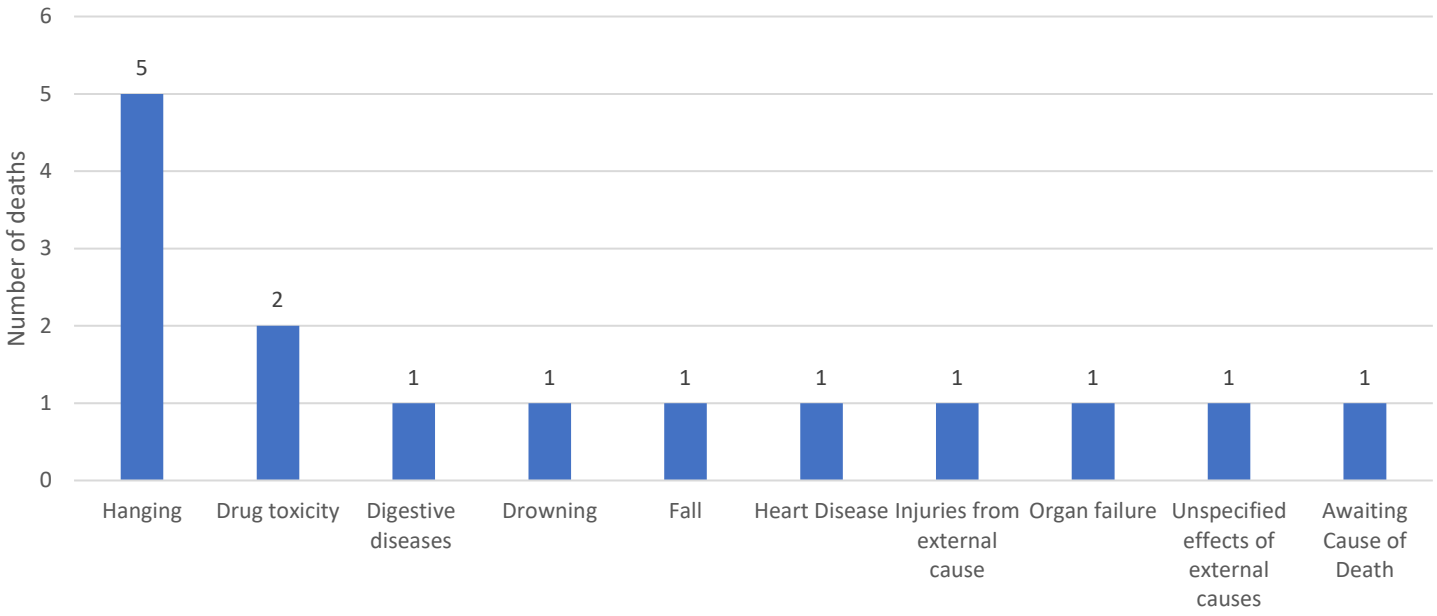
Report definitions: The source of the data is deaths identified via the national Spine, Trust EPRs and clinician reported Datix

Chart 3 - Cause of death – Unexpected Natural



Report definitions: The source of the data is deaths identified via the national Spine, Trust EPRs and clinician reported Datix incidents. The period relates to deaths notified to NSFT between 1/11/23 and 31/01/24 inclusive. The data is reflective of the

Chart 4 - Cause of death – Unexpected Unnatural



Report definitions: The source of the data is deaths identified via the national Spine, Trust EPRs and clinician reported Datix incidents. The period relates to deaths notified to NSFT between 1/11/23 and 31/01/24 inclusive. The data is reflective of the

Table 3 – Age overview

Age Group	Unexpected Natural	Expected Natural	Unexpected Unnatural	Unable to Obtain	Awaiting Cause	Total
0 to 25					3	3
26 to 40			5		5	10
41 to 60	13	6	4		12	35
61 to 75	36	18	3	2	19	78
75+	160	123	3	2	23	311
Total	**209**	**147**	**15**	**4**	**62**	**437**

Report definitions: The source of the data is deaths identified via the national Spine, Trust EPRs and clinician reported Datix incidents. The period relates to deaths notified to NSFT between 1/11/23 and 31/01/24 inclusive. The data is reflective of the position as at 15/03/24. The data includes patients who died with an open referral to NSFT services; or who died within 6 months of discharge from NSFT services; or had a contact or continuation note added to their record within the 6 months prior to their death; and were considered to be under NSFT care following a manual screening process by NSFT's Mortality team

Table 4 - Ethnicity Overview

Ethnicity	Unexpected Natural	Expected Natural	Unexpected Unnatural	Unable to Obtain	Awaiting Cause	Total
Black African					1	1
Black Caribbean		1				1
Indian	1					1
Not stated / Unknown	63	43	4	2	17	129
Other Black					1	1
Other ethnic category	2	5	1		1	9
Other mixed	2	1				3
White - British	134	95	10	2	37	278
White - Irish	2					2
White - other white	1	1			3	5
To be completed	4	1			2	7
Total	**209**	**147**	**15**	**4**	**62**	**437**

Report definitions: The source of the data is deaths identified via the national Spine, Trust EPRs and clinician reported Datix incidents. The period relates to deaths notified to NSFT between 1/11/23 and 31/01/24 inclusive. The data is reflective of the position as at 15/03/24. The data includes patients who died with an open referral to NSFT services; or who died within 6 months of discharge from NSFT services; or had a contact or continuation note added to their record within the 6 months prior to their death; and were considered to be under NSFT care following a manual screening process by NSFT's Mortality team

Table 5 - Gender Overview

Gender*	Unexpected Natural	Expected Natural	Unexpected Unnatural	Unable to Obtain	Awaiting Cause	Total
Female	89	73	2	3	28	195
Male	120	74	13	1	34	242
Total	**209**	**147**	**15**	**4**	**62**	**437**

Report definitions: The source of the data is deaths identified via the national Spine, Trust EPRs and clinician reported Datix incidents. The period relates to deaths notified to NSFT between 1/11/23 and 31/01/24 inclusive. The data is reflective of the position as at 15/03/24. The data includes patients who died with an open referral to NSFT services; or who died within 6 months of discharge from NSFT services; or had a contact or continuation note added to their record within the 6 months prior to their death; and were considered to be under NSFT care following a manual screening process by NSFT's Mortality team

*The Trust recognises that not all people identify as male or female and will look to reflect this in future reports

3. Coroners Updates

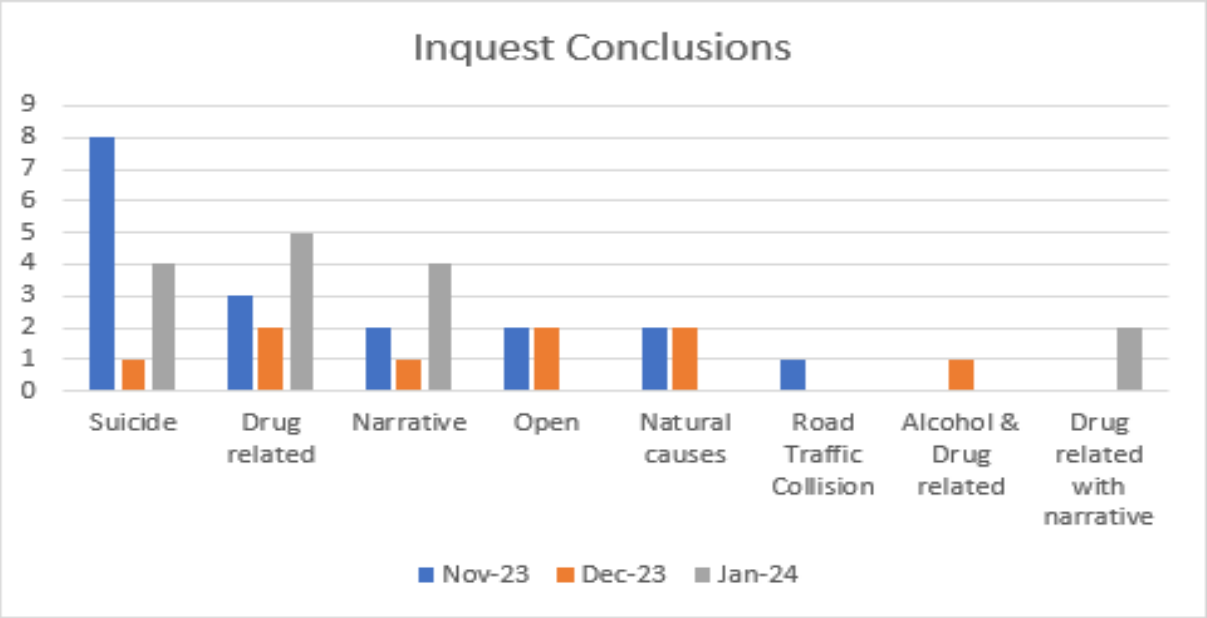
Forty-two inquests were concluded during the reporting period. Of the inquest conclusions reported in the period, none of the deaths occurred within the reporting period (Nov 2023 – Jan 2024).

Inquests are an independent statutory enquiry into who the deceased was, when, where and how they came by their death. This can include the coroner requesting evidence of involvement with the deceased many months prior to their death where no patient safety screening would be triggered.

Coroners are under a duty to complete an inquest within 6 months of opening the inquest, where possible, and must report all inquests over 12 months to the Chief Coroner.

The conclusions for the 42 inquests which reported during this reporting period are described below:

Chart 5 – Inquest conclusions during the reporting period



Open conclusions are returned when there is insufficient evidence to determine how the deceased came by their death.
Narrative conclusions are returned when the Coroner/Jury is not satisfied that a short form conclusion will adequately describe how the deceased came by their death.

During the reporting period, the Trust did not receive any Prevention of Future Death notifications.

4. Working With Service Users, Carers and Bereaved Families

We have met with representatives of bereaved families, and we are also working with local user and carer forums. We have sought their views about the most appropriate way to present data on mortality as we start to publish it. This can be found in appendix A attached to this report.
We will continue to work with families as we develop how best to share and report this data and to be completely transparent with the information we share.

Development of new roles in our Trust

The trust has recently launched new, specialised roles aimed at providing comprehensive support to bereaved families. Our dedicated Family Liaison Officers (FLOs) serve a multifaceted purpose. Not only do they offer impartial support to families throughout the investigative process, but they also play a pivotal role in facilitating avenues for families to openly share their experiences. Furthermore, these officers actively engage families in initiatives geared towards supporting ongoing improvements through a process of collective learning and reflection.

Crucially, the Family Liaison Officers are committed to ensuring that families are informed about the impact of the outcomes of any learning. By fostering transparent communication and providing insight into the tangible outcomes of lessons learned, they aim to empower families and strengthen trust within our organisation. Their efforts ensure our commitment to not only supporting families during times of loss but also to fostering a culture of continuous improvement and meaningful engagement.

The Family Liaison Officers are actively undertaking programmes of work aimed at enhancing the support provided to families affected by mental health-related deaths. These initiatives include:

- Engaging closely with bereaved families to co-produce a comprehensive standard operating procedure. This procedure will establish a framework for safe and meaningful involvement of families with the organisation, acknowledging the distress and trauma they may be experiencing. It emphasises that involvement remains relevant regardless of the time that has passed since the loss, as every experience holds significance and value.
- Networking and establishing connections with Voluntary, Community, Social, Faith, and Enterprise (VCSFE) partners and other system stakeholders. This proactive engagement ensures that we have access to a comprehensive list of support services readily available for staff and easily accessible to bereaved families. By expanding our network of resources, we strive to address the diverse needs of families in a holistic manner.
- Collaborating with bereaved families to develop Trust resources tailored specifically for FLOs. This collaborative effort involves creating informative leaflets, information packs, and other materials designed to provide practical guidance and support to both FLOs and bereaved families. By listening to the insights and experiences of those directly affected, these resources aim to offer meaningful support and facilitate effective communication and engagement.

Through these ongoing initiatives, our FLOs demonstrate our commitment as a Trust to continuously improve our support services for families affected by mental health-related deaths. By actively involving bereaved families in the development and implementation of these programs, we strive to ensure that our efforts are informed, responsive, and ultimately, beneficial to our communities.

Duty of candour Lead

Our Trust appointed a Duty of Candour officer in October 2023. This is an important new role in our Trust. The Duty of Candour Officer works with the People Participation Team and our Family Liaison Officers to support improvements in the way in which our Trust communicates with families, carers and patients following incidents where duty of candour applies. This role supports the development of processes, polices and facilities to support our staff to discharge duty of candour requirements, providing targeted support to specific teams where necessary and promoting best practice.

Patient Safety Partners

A Patient Safety partner is a member of the patient safety team who is actively involved in the design of safer care in our organisation. This includes sitting on relevant committees to support compliance monitoring and how safety issues should be addressed to ensure learning and change in the organisation. Our patient safety partners consider and prioritise the service user, carer and family perspective and champions a diversity of views. We have also developed the Trust website page resources to support bereaved people - Young People Who are Experiencing Grief and Loss | Norfolk and Suffolk NHS (nsft.nhs.uk).

In accordance with findings from Public Health and the LeDeR programme, service users with Serious Mental Health Illness are at greater risk of experiencing health inequalities, poorer physical health, and have a reduced life expectancy when compared to the general population. As an organisation, we are committed to bridging this gap and will use local and national learning to be proactive in ensuring learning into action.

5. Update on Medical Examiner Process

The Medical Examiner (ME) process is due to become statutory for mental health trusts in April 2024. In readiness for this the Trust implemented the Medical Examiner process for reporting of non-coronial inpatient deaths on 4 March to provide the Mortality team time to embed the new process and address any issues that arise.

The Information Sharing Agreement has been amended and agreed. We have met with acute hospital MEs to agree the process for sharing documents and we have set up a system so we can securely share patient records with the ME offices. The Mortality team can track the progress of the certification process of each death using another SharePoint platform.

ME colleagues at Norfolk and Norwich University Hospitals NHS Foundation Trust have provided training to medical colleagues which has been recorded so this can be shared with all inpatient teams alongside the process flow and referral documentation. Our Mortality team have a secure email address so they can share sensitive documents with the wards. There is a new mortality tab on Lorenzo where the team can upload medical certificates of cause of death (MCCDs) and associated documents once completed by the MEs onto each EPR.

The coroner has requested that Medical Examiners are copied into any inpatient coronial death notifications.

6. External Support, Scrutiny and Assurance

Our Trust has been working with the Royal Collage of Psychiatrists to engage external, independent senior clinicians to undertake:

- Structured Clinical Judgement Reviews
- Some deep dives to add quality assurance to the Learning from Deaths process
- Some checking of the screening that is currently being undertaken
- Some system testing for the Learning from Deaths process
- Help with identifying learning

There has been significant interest from consultant psychiatrists and senior nurses from several organisations to engage in this work which is scheduled to commence in April/May 2024.
In addition, work is scheduled to commence in April to develop the scope for an audit of the new mortality system by Internal Audit.

7. Themes from reviews, investigations and learning identified

For the reporting period, 34 Structured Judgement Review (SJRs) have been identified as requiring completion. 10 SJR’s have been completed, 1 SJR is awaiting sign off from panel and a further 8 SJR’s are underway.

21 reviews were undertaken into deaths during this period using PSIRF methodology.
During April through to July 2024 we will be reviewing and improving the ways we identify, share, and spread learning across the organisation. This work will involve a range of trust staff, as well as

service users, carers, and bereaved families. We will also review national best practice in this area.

Moving forward the Trust holds a firm commitment to fostering a culture of learning and improvement, especially in the aftermath of mental health related deaths. We acknowledge the critical significance of thoroughly analysing each incident, not only to grasp its underlying causes, but also to enact efficient measures to prevent its repetition or minimise related risks.

Central to our commitment is ensuring that families affected by these incidents are kept well-informed about the outcomes of our learning processes. We believe in transparency and accountability, and by openly communicating the insights gained and the actions taken, we aim to empower families with knowledge and understanding. This transparent approach not only builds trust within our organisation but also fosters stronger connections with the communities we serve.

We strive to embed learning outcomes within the organisation, to share learning with our system partners and to provide families with meaningful insights into the impact of our continuous improvement efforts. Additionally, we view this as an opportunity to collaboratively reinforce a culture of continuous improvement, where every stakeholder, including families, plays an integral role in shaping safer and more effective services within our organisation.
A focus on learning into action will be featured within future reporting cycles.

8. Additional activity

Learning from Deaths Action Plan Management Group,
Our Trust has now had two meetings of the Learning from Deaths Action Plan Management Group, with an extended and more inclusive membership to take forward:

- The Grant Thornton report action plan
- Any outstanding actions from the Verita report action plan
- Forever Gone: Losing Count of Patients Deaths and draft action plan from the Mortality Review Collaborative Working Group
- Any outstanding actions from regulation 28 reports to prevent future deaths
- Any outstanding actions from historical thematic reviews
- Domestic Homicide Reviews and Serious Case Reviews.

As part of this work our Trust has developed a composite Learning from Deaths Action Plan which will hold all current and emerging actions in one place in the trust. The composite action plan attached at appendix B reflects the Grant Thornton review and the work undertaken by the Collaborative Working Group, which the trust has agreed to share with both Norfolk and Suffolk Health Overview and Scrutiny Committees (HOSC's)
Work is already underway to develop an electronic version of the Learning from Deaths dynamic action plan.

On the 19 March 2024 the working group, which includes, service users, carers and bereaved relatives received a demonstration of the new mortality dashboard and a presentation of the data reporting period of 1 November 2023 to the 31 January 2024 (as of 12 March 2024). The same data was also presented to the trust Quality Committee.

9. Review of Legacy Cases

Our Trust has commenced a significant piece of work to screen all deaths between April 2019 and October 2023. The time frame is wider than the Grant Thornton review and is using the same definitions – Expected Natural, Expected Unnatural and Unexpected Unnatural - as the new mostly

automated system, which will give our Trust five years of data to inform learning and service improvement.

The Board of Directors will receive a comprehensive report once this work is concluded.

Appendix A – Co-designed summary of mortality data

Example of how we process data

NHS
Norfolk and Suffolk
NHS Foundation Trust

1. **How NSFT is notified of a death -** NSFT has a new, automated database which came into use on 1 November 2023. A list of individuals who have passed away is updated daily with notifications of deaths from our Electronic Patient Record (EPR) systems and from a Service User Death Report (SUDR). The SUDR is a daily notification from a national NHS source of any deaths associated with the NHS patients. A patient's GP is responsible for updating this national source of data. This information is shared safely and securely with us.

2. **Someone passes away -** It is always devastating when a loved one, family or friend passes away. This could be for a number of different reasons. NSFT's new robust screening process receives notifications of every death for patients who died whilst open to NSFT services or within 6 months of their discharge. Every one of these is then manually screened to assess whether they meet the criteria for reporting as 'Under NSFT care'. The system also identifies which care group the individual was receiving care from or which care group they were discharged from.

3. **What we do and who we work with to assign information -** When we receive these daily updates, a dedicated team of NSFT staff analyse the details of those who have sadly passed away. This team includes clinicians and experts who have vast experience of analysing complex information. Using our new system, we identify people that have passed away whilst open to NSFT services, or within six months of discharge from our services. For those records that are confirmed as being under NSFT care we then establish cause of death and categorise these into one of five categories.

4. **How is the information assigned and why -** Our five categories identify the cause of death of loved ones who have passed away. These categories are: expected natural, unexpected natural, unexpected unnatural, awaiting cause of death, unable to obtain cause of death. By using these categories, we are able to analyse the data and in particular, identify loved ones who passed away which could be related to the quality of care they received from our services.

NSFT Mortality data

What the data means

Norfolk and Suffolk NHS Foundation Trust

Expected natural cause of death

This is a death which has a clear natural cause. Examples may include a death linked to a neurological disease, such as Parkinson's or dementia, frailty or old age, cancer and organ failure.

Unexpected natural cause of death

Deaths in this category are when a loved one passes away unexpectedly but from natural causes. This could be as a result of contracting an infection or respiratory illness or infectious diseases. It can also include illness such as cancer.

Unexpected unnatural cause of death

If the death of a loved one is placed into this category, the cause is linked to reasons where the individual may have decided to take their own life and their death was intentional. Examples include hanging, drug toxicity, drowning, a fall and injuries from an external cause.

Unable to obtain cause

In an unfortunate number or small cases, it is very difficult from the information available or shared with us to determine the actual cause of death, even after in depth screening is done. We will always try to identify a cause of death to categorise the deaths so we can learn from any deaths to help improve the outcomes and experiences for our service users, families and carers.

NSFT Mortality data

Information from 1 Nov 2023 to 31 Jan 2024 of people under the care of NSFT

NHS
Norfolk and Suffolk
NHS Foundation Trust

The source of the data is deaths identified via the national Spine, Trust EPRs and clinician reported Datix incidents. The period relates to deaths notified to NSFT between 1/11/23 and 31/01/24 inclusive.

The data is reflective of the position as at 15/03/24.

Total patients who died with an open referral to NSFT services; or who died within 6 months of discharge from NSFT services, or had a contact or continuation note added to their record within the 6 months prior to their death; and were considered to be under NSFT care following a manual screening process by NSFT's Mortality team.

Total - 437

Expected natural cause of death
147
34% of total deaths during this period

Unexpected natural cause of death
209
48% of total deaths during this period

Unexpected unnatural cause of death
15
3% of total deaths during this period

Unable to obtain cause of death
4
1% of total deaths during this period

Awaiting cause
62
14% of total deaths during this period

NHS
Norfolk and Suffolk
NHS Foundation Trust

What is an ‘unnatural death’

Losing a loved one is very difficult and as a Trust, we will always do our best to learn from the causes of an unnatural death.

- If the death of a loved one is identified as being unnatural, the cause is linked to reasons where the individual may have decided to take their own life and their death was unfortunately intentional.
- Examples may include hanging, drug toxicity, drowning, a fall and injuries from an external cause.

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What is a 'natural death?'

- In most cases, the death of a service user, whilst they are receiving care or after they have been discharged from our services in the last six months is usually linked to a natural cause.
- The natural death of a loved one is a death which has a clear natural cause.
- Examples may include a death linked to a neurological disease, such as Parkinson's or dementia, frailty or old age, cancer and organ failure. This is a cause which families, friends and carers will know about an illness or condition which would unfortunately lead to them passing in the future.

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What does 'Awaiting Cause' mean?

- When we routinely review the deaths of our service users as part of our screening process, there are some deaths which we cannot categorise at each given moment in time.
- This could be due to the absence of a coroner's report and the absence of a complete report from a medical examiner.
- Deaths which have been placed in this category will be updated as soon as we have a confirmed cause of death shared with us.


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NSFT
Learning From Deaths
This post includes information about mental health and mortality

Appendix B – Learning from Deaths action plan

Ref	Recommendation	Source		Theme	Responsibility	Expected Timescale	Actions	Updates	Status
		GT	CWG						Green Completed Yellow On Track Amber Timescale slipped but on track for completion Red Outside of timescale
1	Improve the mortality data pathway to automate and digitise the production of mortality reporting, removing manual processes for transferring and	✓		Data	**Executive Lead** Chief Finance Officer **Lead for Delivery** Chief Digital Officer	3 months – August 2023	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.		Completed – signed off at Trust Learning from Deaths Action Plan Management Group 23/01/24

	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. Seagry Consultancy will produce a list of actions with assigned owners to support improvement, processes and tools to assist NSFT in mortality reporting.		Completed – signed off at Trust Learning from Deaths Action Plan Management Group 23/01/24
							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.		Completed – signed off at Trust Learning from Deaths Action Plan Management Group 23/01/24
							4. An audit trail will be incorporated into the process as described in action 1.		Completed – signed off at Trust Learning from Deaths Action Plan Management Group 23/01/24
2	Develop standard operating procedures (SOPs) for each stage of the data recording process, and ensure these are kept up to date	✓		Data	**Executive Lead** Chief Nursing Officer **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding and Medical	6 months-November 2023	1. An overarching SOP will be developed which will detail each stage of the mortality data pathway.		Completed – signed off at Trust Learning from Deaths Action Plan Management Group 23/01/24

					Director for Quality		2. The SOP will include roles and responsibilities within the process.		Completed – signed off at Trust Learning from Deaths Action Plan Management Group 23/01/24
							3. The SOP will describe the formal change management process when mortality reporting requirements change.		Completed – signed off at Trust Learning from Deaths Action Plan Management Group 23/01/24
							4. The Learning from Deaths policy will incorporate the requirements of the SOPs.		Completed – signed off at Trust Learning from Deaths Action Plan Management Group 23/01/24
3	Develop reporting tools or method of measuring incomplete data fields to feed back into the organisation, and support training.	✓		Data	**Executive Lead** Chief Finance Officer	6 months-November 2023	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.		Completed for specific action. New action fed into other business as usual work.
					Lead for Delivery Chief Digital Officer	6 months-November 2023	2. To be reported and included in the Care Group Quality and Performance metrics and scrutinised in the Trust's Quality and Performance Meeting		Completed for specific action. New action fed into other business as usual work.

4	Use the Spine as the definitive reference source of identifying deaths, and update this information on a weekly basis.	✓		Data	**Executive Lead** Chief Nursing Officer **Lead for Delivery** Chief Digital Officer and Director of Nursing, Patient Safety and Safeguarding.	3 months – August 2023	1. Develop a system that utilises NHS Spine's automatic update to Lorenzo to reduce the need for manual downloads.		Completed – signed off at Trust Learning from Deaths Action Plan Management Group 23/01/24
							2. 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.		Completed – signed off at Trust Learning from Deaths Action Plan Management Group 23/01/24
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	✓		Reporting	**Executive Lead** Chief Nursing Officer **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding and Medical Director for Quality	3 months – August 2023	1. The proposed standardised reporting structure for mortality will be presented through the Committee structure and agreed by the Board.		Completed

	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.						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.		Completed
6	Align the internal dashboard with external reporting to ensure that volumes on the internal dashboard clearly reconcile to numbers within Board reports.	✓		Reporting	**Executive Lead** Chief Finance Officer **Leads for Delivery** Chief DigitalOfficer, Director of Nursing, Patient Safety and Safeguarding andMedical Director for Quality	3 months – August 2023	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.		Completed
							2. This will be underpinned by the work completed as part of recommendations 1 and 5.		Completed
							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.	The Mortality team plan to roll out the dashboard to Care Groups through a series of sessions with relevant Care Group leadership. The publication of the internal dashboard will be aligned to the overall programme and therefore after the publication of inital data to the Board and HOSC	
							4. The improved dashboard will be supported by the Patient Safety Team and Mortality Team attending Care Group Governance meetings.	As per update 6.3	
							5. The newly developed dashboard will be available on the Trust's intranet.	As per update 6.3	

7	Work with public health and, when in post, medical examiner to identify key themes in the data and identify and implement timely targeted interventions	✓		Reporting	**Executive Lead** Chief Medical Officer **Lead for Delivery** Director of Operations (Medical Directorate) and Medical Director of Quality	6 months- November 2023	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		Completed
							2. Learning and themes from NSFT Mortality reviews will be shared with the ICB so wider system learning can be considered.		Completed
							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.	The Mortality team plan to roll out the dashboard to Care Groups through a series of sessions with relevant Care Group leadership. The publication of the internal dashboard will be aligned to the overall programme and therefore after the publication of inital data to the Board and HOSC	
							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.		Completed
							5. Ensure that NSFT are part of the membership of the Learning from Deaths forum in Suffolk and North East Essex (SNEE) ICB when commenced.		Completed
							6. NSFT will continue to attend regional and national forums		Completed
							7. NSFT to be members of the Norfolk and Waveney ICB LeDeR forum.		Completed
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	✓		Reporting	**Executive Lead** Chief Finance Officer (SIRO) and Chief Medical Officer **Leads for Delivery** Chief Digital	3 months – August 2023	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		Completed

	Trust is awaiting data (pending), or the Trust feels this data will not be accessible, or will remain unknown				Officer Director of Nursing, Patient Safety and Safeguarding		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).		Completed
9	Establish a process of validation and use of mortality reporting and analysis at service level, aligned to corporate reporting	✓		Clinical Engagement	**Executive Lead** Chief Finance Officer **Leads for Delivery** Chief Digital Officer and Director of Nursing, Patient Safety and Safeguarding and Medical Director of Quality	3 months – August 2023	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		Completed
							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.	The Mortality team plan to roll out the dashboard to Care Groups through a series of sessions with relevant Care Group leadership. The publication of the internal dashboard will be aligned to the overall programme and therefore after the publication of inital data to the Board and HOSC	
							3. The mortality data will be centrally produced, therefore the data will be consistent from 'Ward to Board'.		Completed
							4. The dashboard will be available without patient details on the Trust intranet for all staff to review.	As for update 9.2	
10	Review the process of retaining patients on caseloads, and subsequent discharge from caseloads, to ensure it results in	✓		Clinical Engagement	**Executive Lead** Chief Finance Officer and Chief Operating Officer **Lead for**	9 months-February 2024	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.	There is guidance in place for staff to assist in discharging patients from electronic systems. This guidance is to be reviewed in line with this recommendation through workstreams relating to Standard Operating Procedures for core business	

	consistent data across the services				**Delivery** Chief Digital Officer and Deputy Chief Operating Officer		2. Further guidance will be developed for administration staff as to the process to follow when a person on the team's caseload is found to be deceased.	There is guidance in place for staff to assist in discharging patients from electronic systems. This guidance is to be reviewed in line with this recommendation through workstreams relating to Standard Operating Procedures for core business	
							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.	A discharge policy in place and is clear on expectations, further work to ensure that this is being followed will be audited within 6 months	
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.			Clinical Engagement	**Executive Lead** Chief Finance Officer **Leads for Delivery** Chief Digital Officer, Deputy Chief Operating Officer, Medical Director of Quality	6 months-November 2023	1. Implement training programmes focusing on the importance of mortality reporting dependent on the role the member of staff fulfils.		Completed
							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.	The 'Learning from Deaths Matters' newsletter has been produced in draft and will be made available by 28/03/2024.	
12	Establish links with primary care networks to explore opportunities to improve the completes of the Trust's mortality data (including cause	✓		Partnership Working	**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)	6 months-November 2023	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.		Completed

							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.		Completed
							3. This recommendation will be shared with the ICBs through the dissemination of this report and to be added as an agenda items on ICB Learning from Deaths Forums where/when in place.		Completed
13	Explore opportunities for formal data sharing agreements between the Trust and primary and secondary care in the region	✓		Partnership Working	**Executive Lead** Chief Finance Officer **Lead for Delivery** Chief Digital Officer	6 months- November 2023	1. Establish formal data sharing agreements between the Trust, Primary and Secondary care within the region.		Completed
14	Update the Trust's Learning from Deaths policy to ensure the Trust's governance addresses the issues in this report and explicitly reference community deaths. Ensure the governance in relation to all mortality is clearly understood by clinical and corporate staff involved in the production and reporting of mortality information.	✓		Governance	**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).	3 months – August 2023	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.		Completed
							2. The Learning from Deaths policy will be supported by a 'policy on a page' which will be available to all staff.		Completed
							3. The circulation of information and learning bulletins 'Learning from Deaths Matters' will be published and disseminated throughout the Trust	**19th March 2024 -** The 'Learning from Deaths Matters' newsletter has been produced in draft and will be made available by 28/03/2024.	
							4. This will be supported by learning events.	The Mortality team plan to roll out the dashboard to Care Groups through a series of sessions with relevant Care Group leadership. The publication of the internal dashboard will be aligned to the overall programme and therefore after the publication of inital data to the Board and HOSC	

15	Establish a clear improvement plan to address the issues identified in this report, and report progress to a board committee	✓		Governance	**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	3 months – August 2023	1. The improvement plan will be monitored through the Learning from Deaths and Incidents committee and reported quarterly to the Quality Committee		Completed
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	✓		Governance	**Executive Lead** Chief Finance Officer **Lead for Delivery** Chief Digital Officer	3 months – August 2023	1. An audit process will be developed and implemented every 6 months. The audit will test the comprehensiveness of the mortality data pathway with the findings reported to the Learning from Deaths and Incidents Committee.	SharePoint list has a built-in audit trail of who accessed the record and ability to edit data field and data populated. Now that the pathway is complete, an approach to auditing the SOPs and reporting will be developed. Discussions have been held with N&W ICB's Associate Director of Insight & Analytics and SNEE's Deputy Director for Strategic Analytics.	
							2. External verification will be sought by an external consultancy team who are experienced in data within the NHS	Trust is currently considering whether this should be incorporated within the 24/25 Internal Audit plan or whether an external auditor should be retained for this purpose.	

17	Involvement of bereaved relatives as 'critical friends' in the implementation Grant Thornton NSFT elements of the action plan NSFT's new system will go live on 6.11.23 and they have committed to sharing information about changes with bereaved people once any snagging is completed.	✓	✓	Data	Executive Lead Chief Nursing Officer and Chief Medical Officer Lead for Delivery Chief Digital Officer and Governance and Safety Adviser	Mar-24	1. In January 2024 the new Learning from Deaths Action Plan Management Group was established. This group has service user, carer and bereaved family members on the group.		Completed
18	Establish a project plan to explore and develop co-production with bereaved people on the gathering and reporting of NSFT's mortality data, scrutiny of mortality data quality, using the data for learning within NSFT and externally.	✓	✓	Govern ance	**Executive Lead** Chief Nursing Officer and Chief Medical Officer **Lead for Delivery** Chief Digital Officer and Governance and Safety Adviser	June-24	Mortality data from the new system was presented to the Learning from Deaths Action Plan Management Group on the 19th of March 2024.	Mortality data will be scrutinised by the Learning From Deaths Action Plan Management Group, the Trust Quality Committee, and the Board of Directors. Our Trust has been working with the Royal Collage of Psychiatrists to engage external, independent senior clinicians to undertake: • Structured Clinical Judgement Reviews • Some deep dives to add quality assurance to the Learning from Deaths process • Some checking of the screening that is currently being undertaken • Some system testing for the Learning from Deaths process • Help with identifying learning There has been significant interest from consultant psychiatrists and senior nurses from several organisations to engage in this work which is scheduled to commence in April/May 2024. In addition, work is scheduled to commence in April to	On Track

								develop the scope for an audit of the new mortality system by Internal Audit.	
19	Creation of mortality data that is clear, unambiguous, consistent, reliable and verifiable, which is collected and published in ways that all stakeholders can understand and use.	✓	✓	Data	**Executive Lead** Chief Nursing Officer and Chief Medical Officer **Lead for Delivery** Chief Digital Officer and Governance and Safety Adviser	June-24	Referenced to action 6 above in line with Grant Thornton recommendation new mortality Power BI dashboard in place.	Mortality data will be scrutinised by the Learning From Deaths Action Plan Management Group, the Trrut Quality Committee, and the Board of Directors. Our Trust has been working with the Royal Collage of Psychiatrists to engage external, independent senior clinicians to undertake: • Structured Clinical Judgement Reviews • Some deep dives to add quality assurance to the Learning from Deaths process • Some checking of the screening that is currently being undertaken • Some system testing for the Learning from Deaths process • Help with identifying learning There has been significant interest from consultant psychiatrists and senior nurses from several organisations to engage in this work which is scheduled to commence in April/May 2024. In addition, work is scheduled to commence in April to develop the scope for an audit of the new mortality system by Internal Audit.	On Track

20	Mortality data needs to be fully utilised to increase learning from deaths	✓	✓	Data	**Executive Lead** Chief Nursing Officer and Chief Medical Officer **Lead for Delivery** Chief Digital Officer and Governance and Safety Adviser	June-24	Referenced to action 6 above in line with Grant Thornton recommendation new mortality power BI dashboard in place.	Mortality data will be scrutinised by the Learning From Deaths Action Plan Management Group, the Trrut Quality Committee, and the Board of Directors. Our Trust has been working with the Royal Collage of Psychiatrists to engage external, independent senior clinicians to undertake: • Structured Clinical Judgement Reviews • Some deep dives to add quality assurance to the Learning from Deaths process • Some checking of the screening that is currently being undertaken • Some system testing for the Learning from Deaths process • Help with identifying learning There has been significant interest from consultant psychiatrists and senior nurses from several organisations to engage in this work which is scheduled to commence in April/May 2024. In addition, work is scheduled to commence in April to develop the scope for an audit of the new mortality system by Internal Audit. Learning from Deaths Action Plan Management Group Our Trust has now had two meetings of the Learning from Deaths Action Plan Management Group, with an extended and more inclusive membership to take forward: • The Grant Thornton report action plan• Any outstanding actions from the Verita report action plan• Forever Gone: Losing Count of Patients Deaths and draft action plan from the Mortality Review Collaborative Working Group• Any outstanding actions from regulation 28 reports to prevent future deaths• Any outstanding actions from historical thematic reviews• Domestic Homicide Reviews and Serious Case Reviews	On Track

21	Reparation of relationships with bereaved people and building public trust through restorative approaches. Demonstrate through changed behaviours, in mortality data gathering and reporting, that the concerns of bereaved families have been heard and listened to.	✓	✓	Partnership Working	**Executive Lead** Chief Nursing Officer **Delivery Lead** Patient Participation Lead	June-24	Trust work on service user, carer and bereaved families will be picking up these recommendations as part of the overall co-production workstream	• Duty of candour Lead - Our Trust appointed a Duty of Candour officer in October 2023. This is an important new role in our Trust. The Duty of Candour Officer works with the People Participation Team and our Family Liaison Officers to support improvements in the way in which our Trust communicates with families, carers and patients following incidents where duty of candour is applies. This role supports the development of processes, polices and facilities to support our staff to discharge duty of candour requirements, providing targeted support to specific teams where necessary and promoting best practice. • Patient Safety Partners - A Patient Safety partner is a member of the patient safety team who is actively involved in the design of safer care in our organisation. This includes sitting on relevant committees to support compliance monitoring and how safety issues should be addressed to ensure learning and change in the organisation. Our patient safety partners consider and prioritise the service user, carer and family perspective and champions a diversity of views. • We have also developed the Trust website page resources to support bereaved people - Young People Who are Experiencing Grief and Loss | Norfolk and Suffolk NHS (nsft.nhs.uk) In accordance with findings from Public Health and the LeDeR programme, service users with Serious Mental Health Illness are at greater risk of experiencing health inequalities, poorer physical health, and have a reduced life expectancy when compared to the general population. As an organisation, we are committed to bridging this gap and will use local and national learning to be proactive in ensuring learning into action • Family Liaison officers (FLOs) have been engaging closely with bereaved families to co-produce a comprehensive standard operating procedure. This procedure will establish a framework for safe and meaningful involvement of families with the organisation, acknowledging the distress and trauma they may be experiencing. It emphasises that involvement remains relevant regardless of the time that has passed since the loss, as every experience holds significance and value. There continues to be collaboration with beraved families to develop Trust resources tailored specifically for FLOs. This collaborative effort involves creating informative leaflets, information packs, and other materials designed to provide practical guidance and support to both FLOs and bereaved families. By listening to the insights and experiences of those directly affected, these resources aim to offer meaningful support and facilitate effective	On Track
22	Follow up on the practice issues that Grant Thornton identified in their mortality review and co-produce the plans to address these.	✓	✓	Governance	**Executive Lead** Chief Nursing Officer **Delivery Lead** Patient Participation Lead	June-24	Trust work on service user, carer and bereaved families will be picking up these recommendations as part of the overall co-production workstream		On Track
23	Undertake a co-produced equality and quality impact assessment	✓	✓	Partnership Working	**Executive Lead** Chief Nursing Officer **Delivery Lead** Patient Participation Lead	June-24	Trust work on service user, carer and bereaved families will be picking up these recommendations as part of the overall co-production workstream		On Track

								communication and engagement. • We have met with representatives of bereaved families, and we are also working with local user and carer forums. We have sought their views about the most appropriate way to present data on mortality as we start to publish it. This involvement of all relevant stakeholders will be ongoing as data is published	

Appendix C - Learning from deaths and mortality reporting glossary

This glossary provides information and clarity about some of the terms used in our learning from deaths mortality reporting.

This list is not exhaustive and will be updated as our improvement and transformation work continues.

Term(s)	**What this means**
Co-design	Different groups of people working together to design a document, programme or piece of work – where everyone's views count, are considered, understood and given equal consideration.
Demographic Batch Service trace	This is a national system which allows us to confidentially submit a file of patient information to the national NHS Spine for tracing against the Personal Demographics Service (PDS) for direct care purposes.
Duty of Candour legislation	This national legislation ensure that NHS providers are open and transparent with people who use services. It sets out some specific requirements providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
Electronic Patient Record (EPR)	An EPR system is a digital platform that brings all your patient information, from medical history to results of investigations and medications prescribed, together in one place. Having access to all your information in one place will help improve the quality of care we provide. For example, clinicians will have a full picture of your medical history and treatment in our Trust at their fingertips, which will help inform and speed up decision-making.
Family Liaison Officers (FLOs)	Our Family Liaison Officers (FLOs) offer impartial support to families throughout the investigative process, and play a

Term(s)	What this means
	pivotal role in facilitating avenues for families to openly share their experiences.
Learning from Deaths framework	This national framework places responsibility on Trust Boards to ensure their Trust has robust systems for recognising, reporting and reviewing or investigating deaths where appropriate.
Medical Examiner Process	This process is due to become statutory for mental health trusts in April 2024 and focuses on interaction with the doctor completing the Medical Certificate of Cause of Death, to agree the causes of death. In readiness for this, our Trust has implemented the Medical Examiner process for reporting of non-coronial inpatient deaths to provide the Mortality team time to embed the new process and address any issues that arise.
Microsoft PowerBI	A software tool that allows information to be analysed and visualised. It can create charts, graphs and dashboards and apply a range of filters to a set of data, allowing users to gain better insight from the information they have.
Microsoft SharePoint	A software platform that allows data and documentation to be stored and shared securely. It is like a central hub where you can store, share, and access information from any device and any location, according to permissions assigned.
Mortality	This is another term for a death, a loved one who has passed away.
National Learning from deaths guidance	A framework to help standardise and improve how NHS providers identify, report, investigate and learn from deaths.
Patient Safety Incident Response Framework	This is a national framework that all Trusts must use and sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient

Term(s)	What this means
	safety incidents for the purpose of learning and improving patient safety.
ReSPECT process	The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices. These recommendations are created through conversations between a person, their families, and their health and care professionals to understand what matters to them and what is realistic in terms of their care and treatment.
Service User Death Report (SUDR)	A daily report which provides our Trust with notification of any deaths associated with NSFT patients
Structured Judgement Review (SJR)	Trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.

Maternity and neonatal services

Suggested approach from Liz Chandler, Scrutiny and Research Officer

To review maternity and neonatal services in Norfolk and Waveney through an examination of the Local Maternity and Neonatal System.

1.0 Purpose of today's meeting

1.1 To examine the report from Norfolk and Waveney Integrated Care Board (N&WICB) regarding the Local Maternity Neonatal System (LMNS). The report is attached at **Appendix 1.**

1.2 Representatives of N&WICB will be in attendance to answer members' questions.

2.0 Previous reports to NHOSC

2.1 Maternity services were last reviewed by NHOSC at its meeting on 12 July 2018.

3.0 Background

3.1 The Ockenden review was an independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust. It was commissioned in 2016 following 23 cases of concern involving death and serious health implications that occurred as a result of maternity care at the trust. Covering the period from 2000 to 2019, the review included the examination of maternity care and treatment provided at the trust to 1,486 families. Published in March 2022, the review's final report identified 60 Local Actions for Learning for the trust and 15 key Immediate and Essential Actions to improve maternity services across England.

3.2 In October 2022, the Reading the Signals report was published following a review into maternity and neonatal services at East Kent Hospitals University foundation Trust. Commissioned in February 2020, the review examined the maternity services of two hospitals within the trust between 2009 and 202. Amongst its findings were that 45 of the 65 deaths of babies examined could have been prevented. The report also included recommendations for improvements across the healthcare system in England. See: Maternity and neonatal services in East Kent report: government response.

3.3 A third nationally commissioned independent review of maternity services, this time at Nottingham University Hospitals NHS Trust, began in September

2022. The review relates to concerns about poor levels of car by the trust between 2021 and 202. The final report is expected in September 2025.

3.4 Findings from both the Ockenden and East Kent reviews were considered in the taken into account for the development of the NHS England's three year delivery plan for maternity and neonatal services. The plan, which was published in March 2023, sets out how the NHS will make maternity and neonatal care safer, more personalised and more equitable for women, babies and families.

4.0 CQC reports

4.1 The attached report from N&WICB provides information about the CQC ratings of maternity services at all three acute trusts in Norfolk.

The full CQC reports can be accessed via the following links:

- Norfolk and Norwich University Hospital
- James Paget Hospital
- The Queen Elizabeth Hospital

5.0 Smoking

5.1 In relation to the information provided in the report from N&WICB regarding smoking, members may find the Norfolk Joint Strategic Needs Assessment (JSNA) Needs Assessment Smoking and Tobacco Control of interest.

6.0 Suggested approach

6.1 The committee may wish to discuss the following areas with N&WICB representatives:

- Explore further with N&WICB how NHOSC can assist with wider system implementation of targeted pre-conception work addressing the social determinants of health in relation to maternity and neonatal services.
- Seek further information and reassurance over the risks identified in the digital information systems at NNUH and JPUH. See also NHOSC meeting 18 January 2024 for the committee's examination of N&WICB's digital transformation strategy.
- Request further information about the rates of intervention (inductions, 'assisted' deliveries [foreps/ventouse], C-sections, etc) to include:
    - Have the rates of interventions increased over the past five/10 years?
    - How do intervention rates correlate to mortality rates in mothers and babies?
- Enquire about the post-natal support services (i.e. Birth Reflections/Afterthoughts Service) and the rate of demand for this service.

- Request further information regarding staffing levels at Norfolk and Waveney's maternity units particularly in relation to national shortage of midwives. See: BBC news.

7.0 Action

7.1 The committee may wish to consider whether to make comments or recommendations as a result of today's discussion.

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Norfolk and Waveney
Integrated Care Board

Agenda item: XX

Subject:	**Local Maternity Neonatal System (LMNS)**
Presented by:	**Tricia D'Orsi ICB Executive Nursing Director -** Senior Responsible Officer (SRO) for LMNS
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Submitted to:	**Norfolk Health Overview & Scrutiny Committee**
Date:	**09 May 2024**

Purpose of paper:

To provide Norfolk Health Overview and Scrutiny Committee (HSOC) with an update on the Local Maternity and Neonatal System's (LMNS) continued commitment to maintaining safe and personalised maternity care, as set out in the Three-Year Delivery Plan for Maternity and Neonatal Services (NHSE, March 2023) and NHS Long Term Plan.

Executive Summary:

The current LMNS approach to maternity and neonatal services can evidence satisfactory progress against the Three-Year Plan and to ensuring safety and quality oversight. This approach identified that most of the contributing factors to poor outcomes for pre-term birth, still births and neonatal deaths were present in women in the pre-conception period and demonstrates a need for further system work into pre-conception care and public health approaches. This aligns with the Women's Health Hub Core Specification.

Further scoping work is underway with Public Health to address issues of obesity.

Significant work is underway within the LMNS to address health inequalities.

HOSC are asked to note the disparities in health outcomes for women and birthing people living within our most deprived areas. The neonatal morbidity and mortality deep dive identified a link between poor neonatal outcomes with poor maternal health, maternal smoking and obesity alongside social deprivation and social concerns.

HOSC are asked to consider how the wider system can implement targeted pre-conception work which addresses the social determinants of health, to support the LMNS to address these areas of concern.

1.1 Background and context

The Norfolk and Waveney (N&W) Local Maternity and Neonatal System (LMNS), brings together commissioners, providers, and service users to develop and implement local maternity and neonatal plans. The systemwide partnership is overseen by the LMNS Board which is chaired by Tricia D'Orsi ICB Executive Nursing Director and Senior Responsible Officer (SRO) for N&W LMNS. The Board includes Directors of Nursing, senior midwives, consultants and colleagues from the ICS, NHS England, and Public Health.

The role of the LMNS is to maintain safety and quality oversight of maternity and neonatal services informed by the Three-year Delivery Plan for Maternity and Neonatal Services (NHSE, 2023) and underpinned by the Better Births vision for maternity services for safer, kinder and more personalised maternity care.

The LMNS work systematically to support service transformation, improvement and quality assurance, underpinned by the priority to reduce health inequalities, in line with the ICS Health Inequalities Framework for Action.

1.2 Health inequalities

Worse health outcomes occur when people experience poorer-quality care and practice more risky health-related behaviours. These factors may be associated with low income, poor housing, education, and unemployment.

In Norfolk and Waveney, our poorest neighbourhoods are clustered in Norwich, Great Yarmouth, Lowestoft and King's Lynn. There are pockets of deprivation in other areas including North Walsham in North Norfolk, Thetford, Watton and Dereham in Breckland and Beccles and Bungay in Waveney. Data identifies these communities as having higher than expected needs.

Demographic data indicates that our region is less ethnically diverse than the national average, with 9% non-British compared to 21% nationally. However, there are communities living in areas of significant deprivation and established white non-British communities living in Norfolk and Waveney, for whom the risk of poorer health outcomes is high.

The latest MBBRACE report on maternal mortality, stillbirth and neonatal death shows significant and widening gaps in health inequalities which strongly correlate to deprivation and ethnicity.

In Norfolk & Waveney:

- 19% of our birthing population live in the most deprived communities in our region.
- In 2020, 20.5% of all babies born in our area were to families living in areas that have been classed amongst the poorest in England.
- Of the total babies born in 2020/21, 14.9% were to Black, Asian, minority ethnic and non-British white women.
- Ethnic minority birth rates are higher within urban areas including Thetford, King's Lynn, Norwich, and Great Yarmouth.

A recent deep dive into pre-term birth, stillbirth and neonatal deaths across Norfolk & Waveney showed a clear trend towards worse health outcomes for mothers and babies living in the areas of highest deprivation.

2022-23 data shows that families from our poorest localities experienced:

- 49% of all pre-term births
- 94% of all stillbirths
- 50% of all neonatal deaths

Common co-factors included smoking, poor mental health, and obesity.
There is strong evidence to suggest that these factors are linked to wider determinants of health – accessibility and quality of health and care services, housing, income, education, and individual behaviours such as poor diet, substance abuse and smoking.

The findings of our mortality and morbidity deep dive correlate with the national MBBRACE report on perinatal deaths, highlighting persistent inequalities and higher rates of stillbirth and neonatal deaths for mothers and babies from ethnic minorities and areas of deprivation.

The data and analysis within the N&W system deep dive demonstrate that five key factors may contribute to an increased likelihood of pre-term birth, stillbirth, and neonatal death: smoking, social and safeguarding concerns, social deprivation, poor mental health, and obesity.

The degree of adverse outcomes is highest among our poorest populations within JPUH and QEH footprints, within the most deprived areas falling into the Indices of Multiple Deprivation (IMD) 1-4.

However, NNUH has a peak of poor outcomes across the more affluent IMD 6; poor mental health and obesity were major factors for this cohort. There needs to be further consideration of causes of this, and targeted support.

Smoking was the largest contributory factor for poor outcomes across all Trusts.

The national MBBRACE report 2024 on maternal deaths identifies a statistically non-significant increase in the overall maternal death rate in the UK between 2019-21 and 2020-22. A statistically non-significant increase also occurred when deaths due to COVID-19 were excluded.

Thrombosis and thromboembolism were the leading cause of death, followed by Covid 19, while the next most common direct cause of death was suicide and pregnancy related infections. After Covid 19, the next indirect cause of death was cardiac disease and neurological conditions.

A Deep Dive into maternal deaths across N&W is now underway, early indications are that system outcomes reflect the national trends. Multi-disciplinary review of maternal deaths and system learning occurs with each adverse event in real time.

2.1 Safety and Quality Oversight

In response to the Ockenden and East Kent Maternity Reports and as a key requirement of the Three-Year Plan, the LMNS has developed robust oversight of Trust safety and quality issues via the Safety Quality Oversight Group (SQOG), formal incident meetings and safety and assurance meetings with the Head/Directors of Midwifery.

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. This has been adopted from maternity within trusts, and the LMNS Programme Teamwork in partnership with trusts to review incidents and provide oversight to external reporting as required.

The Maternity Incentive Scheme (MIS) is a financial incentive program designed to enhance maternity safety within NHS Trusts. It rewards Trusts that can demonstrate they have implemented a set of core safety actions, ultimately aiming to improve the quality of care for women, families, and newborns. These core safety actions, which include the Saving Babies Lives Care Bundle (SBLCB), have been reviewed between Trusts and the LMNS, to achieve compliance. All three Trusts were able to submit their claims within timescale and achieved the expected standards.

The oversight of MIS and SBLCB V3 and trust governance processes enabled the LMNS to support trusts with their CQC inspection and subsequent ratings.

2.2 CQC ratings: maternity services

JPUH - Inadequate

In January 2023, the CQC rated maternity services at the JPUH as inadequate for the “Well-Led” and “Safety” domains following an inspection. The Trust received a Regulation Section 29A warning due to concerns about the service. However, the CQC recognised the Eden Team for its provision of care for women with complex social needs and/ or mental health issues. The Trust subsequently developed a comprehensive Maternity Improvement Plan to address areas identified for improvement and is preparing for a further CQC inspection in early 2024.

NNUH - Good

The NNUH maternity department was inspected in November 2023 and the CQC published its report in February 2024. Maternity services were rated as good for both “Well-Led” and “Safety” domains. During the inspection, many areas of good practice were highlighted, including supportive senior leadership team and the positive culture of teamwork that benefits service users and their families. They also praised the team for their close links with the Maternity and Neonatal Voices Partnership and the local community.

QEH - Good

The CQC rated the QEH’s maternity services overall as good in March 2024. Within the “Well-Led” domain, inspectors particularly noted an improvement in culture and that staff worked well together and felt respected, supported and valued. They also commended the Trust’s understanding of how health inequalities can affect treatment and outcomes for women of different ethnic backgrounds and less privileged

communities. The service retained its rating of “requires improvement” for the “Safety” domain and work continues to improve this area.

3.1 Three-Year Delivery Plan

The LMNS responsibilities are informed by the Three-Year Delivery Plan for Maternity and Neonatal Services (NHSE, March 2023), which incorporates Ockenden and East Kent recommendations. Reporting against the four themes within the Three-year Delivery Plan supersedes Ockenden and East Kent reporting, and Trusts are required to report against the themes at LMNS Safety and Quality Oversight Group (SQOG). In December 2023, a review of progress was undertaken across the system; satisfactory progress is being made against delivery of the Three-Year Plan requirements.

Plan Theme	Key points	RAG
Theme 1 – Listening to and working with women and families with compassion 1. Care that is personalised 2. Improve equity for mothers and babies 3. Work with service users to improve care	A number of Maternity & Neonatal Voice Partnerships (MNVP) requirements are already completed Work is progressing well on: • Achieving UNICEF Baby Friendly Initiative • Commissioning & delivering personalised care and support plans • Commissioning and implementing perinatal pelvic health services by the end of March 2024 • Commissioning and implementing community perinatal mental health services • MNVPs to reflect ethnic diversity of local population and reach out to seldom heard groups	
Theme 2-Growing, retaining and supporting our workforce 4. Grow our workforce 5. Value and retain our workforce 6. Invest in skills	Systemwide work is underway and progressing well to: • Maximise student placements • Monitor and address workforce planning requirements, staff training and compliance with core competency framework • Sharing best practice Areas where work has commenced but require further work include: • ICB to commission and fund safe staffing across the system • ICB to align commissioning of services to meet the ambitions outlined in this delivery plan with the available workforce capacity	
Theme 3: Developing and sustaining a culture of safety, learning and support 7. Develop a positive safety culture 8. Learning and improving 9. Support and oversight	Systemwide work is underway and progressing well to: • Monitor, support and share learning on culture • Respond effectively and openly to patient safety incidents using PSIRF (Patient Safety Incident Reporting Framework), with effective quality oversight and improved data analysis Areas where work has commenced but require further work include: • ICB to Commission services that enable, safe, equitable and personalised maternity care for the local population.	
Theme 4-Standards and structures that underpin safer, more personalised and more equitable care 10. Standards to ensure best practice 11. Data to inform learning 12. Make better use of digital technology in maternity and neonatal services	Systemwide work is underway and progressing well to: • Implement and assure compliance to Saving Babies Lives Bundle 3, Maternity Incentive Schemes and National Standards including CNST (Clinical Negligence Scheme for Trusts) • Using data to compare their outcomes to similar systems and understand any variation and where improvements need to be made • Digital strategies, Procurement of Electronic Patient Record (EPR) that meets Maternity and Neonatal requirements, supporting regional digital maternity leadership networks Areas where work has commenced but require further work include: • Commission care with due regard to NICE guidelines • Support women to set out their personalised care and support plan through digital means	

Key areas of work progressed during the first year of the plan are summarised against the themes.

3.2 Theme One - Listening to and working with women and families with compassion.

Maternity and Neonatal Voices Partnerships (MNVPs) ensure that service user voices are at the heart of decision-making in maternity and neonatal services.
MNVPs listen to the experiences of parents, bring together service users, their families, health professionals, commissioners and support organisations to plan, review and improve local maternity and neonatal care.

Each of the hospital trusts in Norfolk and Waveney have their own group representing service users and their families in their communities.

Examples of projects on which they have worked with LMNS and individually with trusts include:

- Staff training
- Bereavement
- Breast feeding

- Personalised Care & Support Plans
- Health inequalities
- Improving culture
- Perinatal Pelvic Health Service

Breastfeeding promotes health, prevents disease, and benefits babies, families, and the wider community. Breastfeeding is evidenced to generate cost savings for health services. A steep decline in breastfeeding over the latter half of the 20th century has resulted in less than half of babies in England receiving human breast milk by the age of 8 weeks.

Theme 1 of the Maternity and Neonatal 3-Year Delivery Plan is listening to and working with women and families with compassion and providing care that is personalised; To achieve this Trusts are expected to achieve UNICEF Baby Friendly Initiative (BFI) by 2027. The UNICEF UK Baby Friendly Initiative enables public services to better support families with feeding and developing close and loving relationships so that all babies get the best possible start in life. The LMNS, with Norfolk County Council Start for Life funding, has supported and enabled trusts to develop their breast-feeding mentoring services, with trusts appointing staff to lead this service.

Personalised Care and Support Plans (PCSP) Theme 1 of the maternity and neonatal 3-year delivery plan is listening to and working with women and families with compassion and the principle that maternity care should be personalised and safe. A key part of this is to ensure all women and birthing people have access to a tangible, accessible document, or app to complete their personalised plan alongside their midwife or clinician, providing improved personalised care and empowering pregnant people with their choices – a PCSP. This systemwide project involved working with key stakeholders across the system including midwives, obstetricians, MNVP Leads and the LMNS programme team.

A monthly task and finish group was established from December 2022 to progress:

- Understanding the current position
- Working with MNVPs and service users
- Gaining clinical engagement
- Establishing training for clinicians
- Reviewing the process

The new systemwide PCSP launched in March 2024

Following a 2-year pilot the **Perinatal Pelvic Health Service** will be mainstreamed from April 2024.The service is targeted to support women or birthing people with bladder and bowel incontinence, pelvic organ prolapses and vaginal and sexual health concerns such as dyspareunia (painful sex) during pregnancy and up to 12 months following birth.

We know women or birthing people are at increased risk of developing pelvic floor dysfunction (PFD) conditions, with 1 in 3 experiencing urinary incontinence, 1 in 10 experiencing anal incontinence, and 1 in 12 can experience pelvic organ prolapse.

The taboo surrounding pelvic floor disorders is a major barrier to women receiving treatment. It is widely reported that pelvic floor dysfunction is significantly under-reported due to embarrassment, shame, or for women who have had multiple children

to believe that dysfunction is 'normal'. There is poor awareness about PFD, with some patients not realising that treatments may be available.

The PPHS is not a new stand-alone service but is intended to build on and not replace existing pathways and capacity. It is a requirement of Theme 1 of the maternity and neonatal 3-year delivery plan listening to and working with women and families with compassion and delivering care that is personalised.

3.3 Theme Two - Growing, retaining, and supporting our workforce.
There is a significant programme of work across the LMNS to support theme two. Cultural competence has been a key focus for year one. Multidisciplinary scoping and learning have occurred in maternity and neonatal services with two cultural workshops being held, local learning events offered across the system informing a detailed forward plan of work for year two. All trusts are compliant with the implementation of cultural competency education within 3 yearly mandatory training programs**.**

Labour ward coordinator upskilling and enhanced maternal care education projects have been agreed with Trusts, with the LMNS Team supporting development of equitable education programmes for staff across the System.

Education and training and safe staffing for maternity and neonatal is reported quarterly to LMNS Board.

3.4 Theme Three - Developing and sustaining a culture of safety, learning and support.
Taking evidence from the LMNS dashboard and national reports, a deep dive into Neonatal Mortality and Morbidity across Norfolk & Waveney was undertaken, which looked at pre-term birth, still births and neonatal deaths. The deep dive findings show a clear trend towards worse health outcomes for mothers and babies living in the areas of highest deprivation. As part of the analysis, notes and care were reviewed, and there was excellent care given to families with all required guidelines and processes followed.

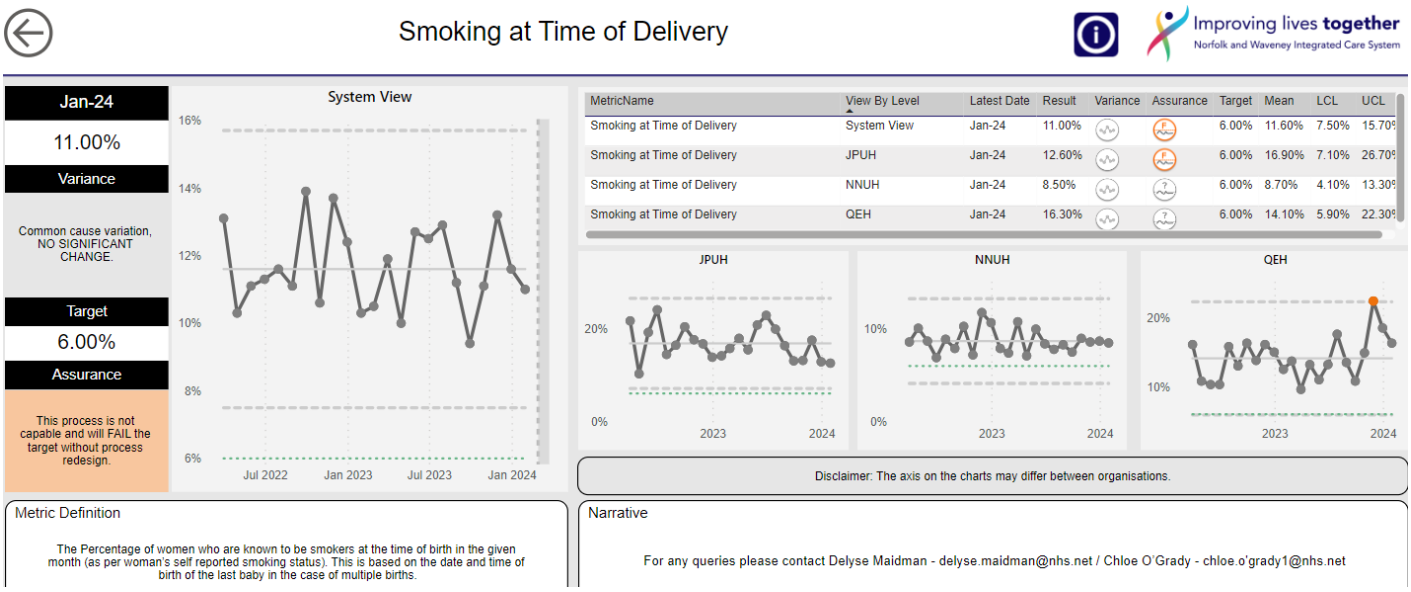
The data and analysis within this deep dive demonstrate that five key factors may contribute to poor neonatal outcomes:

- smoking
- social and safeguarding concerns
- social deprivation
- poor mental health
- obesity

Most of the contributing factors leading to poor outcomes, were present in women in the pre-conception period and demonstrate a need for further system work into pre-conception care and public health. This aligns with the Women's Health Hub Core Specification. Further scoping work is underway with Public Health to address issues of obesity.

Smoking is the largest contributory factor for poor outcomes across all Trusts and a maternity led tobacco dependency service is a key requirement of the NHS Long Term Plan.

Smoking is the most modifiable risk factor in pregnancy and is a priority for our system. It increases the risk of pregnancy complications such as stillbirth, preterm birth, miscarriage, low birth weight and sudden infant death. Last year, 11.6% of the birthing population in Norfolk and Waveney were smokers at the time of delivery. (Against the national ambition of less than 6%).



Smoking in pregnancy is a significant risk and reported to the LMNS and ICS this is rated as **12 Medium Risk**

In response to this, our system has come together to tackle this issue through workshops and planning sessions with key stakeholders from trusts and the LMNS Programme Team to develop a system-wide pathway for a new in-house Maternity Tobacco Dependence Treatment Service with vital contributions from maternity staff and service users as well as external organisations including Public Health. The service launches April 2024. In addition Norfolk County Council commissioned a Smoking Incentive Scheme at JPUH in 2023. Final analysis of the programme is pending, but observation of the data above suggests a decrease in smoking at time of delivery in response to this initiative.

Deep dive findings demonstrate that five key factors may contribute to an increased likelihood of pre-term birth, stillbirth, and neonatal death – smoking, social and safeguarding concerns, social deprivation, poor mental health, and obesity. The LMNS are supporting a significant programme of work with system partners including.

- Maternity led smoking interventions in line with NHS Long Term Plan launched April 2024.
- Maternity social prescribing pilot in areas of high deprivation.
- Targeted outreach events into communities within areas of deprivation.
- The appointment of Pre-term Birth Midwife to support those most at risk.
- Ensuring the Maternity Continuity of Carer (MCoC) model is delivered in targeted areas.
- Improving antenatal education.
- Bereavement care.
- Lotus Team specialist mental health support.

The ICB is currently forming a Women's Health Hub, to bring together healthcare professionals and existing services to provide integrated women's health services in the community, centred on meeting women's needs across the life course. Hub models aim to improve access to and experiences of care, improve health outcomes for women, and reduce health inequalities. The LMNS programme team are using our data on health inequalities to ensure that maternity has influence in developments as outlined in the Women's health hubs: core specification (updated 21 March 2024) which states core services to include preconception care as well as the possibility to include other services for expectant, new or bereaved mothers, for example perinatal mental health services and maternal mental health services, pelvic health clinics and breastfeeding support. This is an exciting opportunity to work for maternity services to work with system partners to address identified health inequalities.

3.5 Theme Four - standards and structures that underpin safer, more personalised and equitable care.

The LMNS has developed robust oversight of trust safety and quality issues via the Safety Quality Oversight Group. (SQOG), formal incident meetings and safety and assurance meetings with the Head/Directors of Midwifery.

The oversight of MIS and SBLCB V3, trust governance and processes enabled the LMNS to support trusts with their CQC inspection and subsequent ratings.

Data to inform learning.

The LMNS & trust digital midwives have worked with the ICB Business Intelligence Team to produce a LMNS data dashboard.
This is updated monthly, formally reviewed and reported to LMNS Board quarterly.

This approach has resulted in:

- Investigation into 3rd & 4th degree tears and further quality improvement work.
- Further investigation into neonatal deaths, still and preterm births with the LMNS team undertaking a neonatal mortality and morbidity deep dive.
- Evidence of trust performance on breast milk given as first feed has helped with the allocation of Start for Life funding to support breastfeeding work**.**

Make better use of digital technology in maternity and neonatal services.

Digital is one of the greatest challenges facing the LMNS currently, and the Norfolk and Waveney digital discovery report (May 2022) highlights:

- A burden of paperwork and duplication of data recording
- No end-to-end digital maternity record
- A lack of connectivity within trusts, across maternity units or into primary care
- Poor community access to digital records

These factors all reduce time to care and raise the risk of error. Two of the highest risks reported to the LMNS & ICS for maternity and neonatal services are digital.

E3 Risk – **16 High Risk**

Maternity information systems across N&W are E3 Euroking (NNUH and JPUH) and Badgernet (QEH). NHS England has issued a National Patient Safety Alert (NPSA) identifying safety risks with the Euroking maternity information system. Resolution is dependent on the supplier (Euroking), a systemwide mitigation approach is in place, this is being monitored by the LMNS and ICS as a significant digital risk.

Electronic Patient Record (EPR) Risk 12 Medium Risk

Maternity and neonatal services are within scope of the Electronic Patient Record (EPR) programme. Phase 1 is expected to go live in April 2026. This is an exciting opportunity for maternity and neonatal services, there are risks in relation to the implementation and planning required in the current digital climate.

The LMNS is supporting systemwide working and has developed strong links both regionally and nationally to ensure that Norfolk & Waveney maternity and neonatal services are well positioned to address the NPSA and prepare for implementation of the EPR.

4.1 Conclusion

The LMNS are really proud of the achievements in maternity and neonatal provision over the past 12 months including but not limited to:

Bereavement care – An improved offer to those experiencing baby loss within our Trusts including employment of specialist leads and the creation of a dedicated bereavement space at the QEH.

CQC Good ratings for two Maternity services in N&W.

The LMNS deep dive approach taken to understand the increase in pre-term birth, stillbirth and neonatal deaths has been commended by the regional team and is now being adopted to be used across the East of England.

By taking advantage of opportunities to be Early Implementer sites N&W are one of only four ICBs to have commissioned and implemented Perinatal Pelvic Health Services and Perinatal Mental Health Services by March 2024, a requirement of the NHSE Long Term Plan and the Three-Year plan.

Working with Norfolk County Council and the Start for Life programme to deliver an an improved offer to support Breast feeding across the system and strengthen connections with Family hubs improving access to services and addressing health inequalities.

The current LMNS approach to maternity and neonatal services can evidence satisfactory progress against the Three-Year Plan and ensuring safety and quality oversight. This approach identifies that most of the contributing factors to poor outcomes for pre-term birth, still births and neonatal deaths were present in women in the pre-conception period and demonstrates a need for further system work into pre-conception care and public health. This aligns with the Women's Health Hub Core Specification. Further scoping work is underway with Public Health to address issues of obesity. Significant work is underway within the LMNS to address health inequalities, with equity being the golden thread that runs throughout all the work and projects undertaken.

HOSC are asked to note the disparities in health outcomes for women and birthing people living within our most deprived areas. The neonatal morbidity and mortality deep dive identify a link between poor neonatal outcomes with poor maternal health, maternal smoking and obesity alongside social deprivation and social concerns.

HOSC are asked to consider how the wider system can implement targeted pre-conception work which addresses the social determinants of health, to support the LMNS to address these areas of concern.

Norfolk Health Overview and Scrutiny Committee

Proposed Forward Work Programme 2024/25

ACTION REQUIRED

Members are asked to consider the current forward work programme:

- whether there are topics to be added or deleted, postponed or brought forward
- to agree the agenda items, briefing items and dates below.

NOTE: These items are provisional only. NHOSC reserves the right to reschedule this draft timetable.

Meeting dates	*Main agenda items*
11 July 2024	**Speech and language therapy** An overview of speech and language therapy services in Norfolk and Waveney. **Malnutrition** A review of malnutrition in Norfolk following Future Health's report Hiding in Plain Sight and the Public Health and N&WICB strategies in place to tackle it.
5 September 2024	**Women's health** To include an overview of the Women's Health Hub, Women's Health Champion and update on menopause services (as part of the the local implementation of the National Women's Health Strategy). (N&WICB and Public Health.) **TBC** **Second item TBC.**
7 November 2024	**Advice and Guidance referral model** A review of the use of A&G in Norfolk and Waveney as part of a wider review of the relationship between primary and secondary care. **TBC.** **NSFT** Update on the mortality data action plan. **TBC**
16 January 2024	**TBC** **FWP workshop**

Information to be provided in the NHOSC Briefing 2023/24
Members may wish to consider updates about agenda items that do not warrant a return to a formal meeting or preliminary information about topics that they may wish to examine at a future meeting for inclusion in the NHOSC Briefing.

June 2024

- **Ambulance service** – annual update from East of England Ambulance Service NHS Trust (EEAST) following its attendance at NHOSC in March 2023.
- **Dentistry** - six-month update on the progress of the Urgent Treatment Service and an overview of the provisions provided by the Community Dental Service (agreed at NHOSC meeting November 2023) (see also below).
- **NSFT community mental health services** – annual update following briefing in April 2023 on community mental health services with particular reference to the REST Hubs.
- **Long Covid update** – update of data and services provided for people with long Covid. **TBC.**
- **ME and CFS** – data and information on services available – link to Long Covid data (?) **TBC.**
- **Public transport** – explanation of public transport provision in relation to health services.

August 2024

- **Cromer Hospital** – overview of services are provided at Cromer Hospital.
- **Weight Management Services** – in conjunction with Public Health.
- **Community Doppler/leg ulcer service**

Future topics for consideration (meeting or briefing):

To discuss with members:

- Healthcare services at HMP Norwich.
- Palliative and End of Life Care – need for a hospice in Gorleston. To include as part of the briefing update on the Transformation plan requested at the November meeting?
- Sexual Assault Referral Services – overview of SARC services in Norfolk.
- Wheelchair services – overview of wheelchair/wheelchair repair services including waiting lists and access.

Ongoing/in process:

- Major Trauma Unit (MTU) at the Norfolk and Norwich Hospital – ICB to provide an update when available.

- Proposed closure of Manor Farm Medical Centre in Narborough - update.
- Same Day Emergency Care Units – an overview of SDEC at the three hospital trusts and how target waiting/treatment times are recorded in relation to A&E data.
- Prescription Ordering Direct Service – update on replacement service in the autumn.
- Wellbeing support for NHS staff – overview of wellbeing support for NHS staff.
- New hospitals programme.
- LGBT+ health services – discuss with Healthwatch Norfolk.
- NHS healthchecks – Liz to provide an overview in first instance.
- Dentistry, pharmacy and ophthalmology – April 2025. Update following two years of transfrer of responsibility fron NHS England to N&WICB. Liz to update on dentistry as updates at N&WICB/Primary Care Commissioning Committee (PCCC) meetings as they occur.

NHOSC Committee Members have a formal link with the following local healthcare commissioners and providers:

Norfolk and Waveney ICB	-	Cllr Fran Whymark
Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	-	Cllr Julian Kirk
Norfolk and Suffolk NHS Foundation Trust (mental health trust)	-	Cllr Brenda Jones
Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Cllr Lucy Shires Substitute: Clllr Jeanette McMullen
James Paget University Hospitals NHS Foundation Trust	-	Cllr Jeanette McMullen
Norfolk Community Health and Care NHS Trust	-	Cllr Lucy Shires

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