Norfolk Health Overview and Scrutiny Committee

Date:	**18 January 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 12 January 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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Agenda

1. To receive apologies and details of any substitute members attending

2. Minutes

To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on 9 November 2023. (Page 5)

3. 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.

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

5. Chair's announcements

6.	**10:10 – 11:00**	Norfolk and Waveney Integrated Care Board's (N&WICB) Digital Transformation Strategy	(Page 14)
7.	**11:10 – 12:00**	Norfolk and Suffolk NHS Foundation Trust (NSFT) Mortality Recording and Reporting Review	(Page 35)
8.	**12:00 – 12:10**	Forward Work Programme	(Page 68)

Tom McCabe
Head of Paid Service
County Hall
Martineau Lane
Norwich
NR1 2DH

Date Agenda Published: 10 January 2024

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NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
Minutes of the meeting held at County Hall
on 9 November 2023

Members Present

Cllr Jeanette McMullen	Great Yarmouth Borough Council
Cllr Stuart Dark	Norfolk County Council
Cllr Lesley Bambridge	Norfolk County Council
Cllr Pallavi Devulapalli	Borough Council of King's Lynn and West Norfolk
Cllr Robert Savage	Norfolk County Council
Cllr Justin Cork	South Norfolk District Council
Cllr Lucy Shires	Norfolk County Council
Cllr Richard Price	Norfolk County Council
Cllr Jill Boyle	North Norfolk District Council
Cllr Fran Whymark	Norfolk County Council

Co-opted Member (non voting):

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

Substitute Members Present
Cllr Maxine Webb

Also Present:

Tricia D'Orsi	Executive Director of Nursing – Integrated Care Board (ICB)
Sadie Parker	Director of Primary Care
Fiona Theadom	Head of Primary Care Commissioning
Chris Bean	Head of Acute Transformation and Clinical Programmes
Dr Caroline Barry	Palliative Care Consult and Clinical Adviser to the ICB on Palliative and End of Life Care
Marlini Finney	Director of Strategic Finance, St Elizabeth Hospice
Jason Stokes	Norfolk Local Dental Committee Secretary
Peter Randall	Democratic Support and Scrutiny Manager
Maisie Coldman	Committee Officer

1 Apologies for Absence

1.1 Apologies for absence were received from Cllr Tipple, Cllr Kybird, Cllr Jones (substituted by Cllr Webb), Cllr Kirk and Cllr Prinsley.

2. Minutes

2.1 The minutes of the previous meeting held on 14 September 2023 were agreed as an accurate record of the meeting subject to the following corrections:

- Cllr Richard Price was present at the meeting,
- Tricia D'Orsi's job title was corrected to Executive Director of Nursing,
- With regard to item 8.1 paragraph 3, Cllr Webb raised that the ICB noted that an item on Speech and language therapy was appropriate and due, but it had been added onto the forward plan as a briefing note and not a substantive item.

3. Declarations of Interest

3.1 Cllr Webb declared an 'other interest' in relation to the dentistry item as she had used the disabilities specialist service.

4. Urgent Business

4.1 There were no items of urgent business.

5. Chairman's Announcements

5.1 The chair shared with the committee that Cath Byford, Deputy Chief Executive, and Chief People Officer, requested that an update be shared with NHOSC to clarify a comment made at the last meeting on 14 September 2023. Due to an administrative error, the letter written to the Parliamentary and Health Service Ombudsman, in which there was an offer to meet him to discuss the concerns that he had raised, was not sent. Cath Byford wanted the committee to know that the explanation to NHOSC was made in good faith and she apologised for the error. The BBC, who reported on the September meeting, has been contacted, and so has the Parliamentary and Health Service Ombudsman, Mr. Rob Behren CBE.

5.2 The Chair updated the committee on the progress of some of the work that had been undertaken by the Norfolk & Suffolk Foundation Trust since the meeting on 14 September 2023. There had been weekly meetings to develop the action plan, and the following work had been completed and or discussed:

- Agreement on principles, benefits, and risks,
- Co-production principles which included working with bereaved relatives,
- Outline the improvement plan that will supplement the recommendation noted within the Grant Thornton report,
- Plan a schedule for improvements and activities.

The committee would receive an email noting the letter received from Caroline Donovan, Interim CEO of Norfolk and Suffolk Foundation NHS Trust, Tracey Bleakley CEO of Norfolk and Waveney ICS, and Ed Garratt OBE, CEO of Suffolk and North East Essex ICS. An email received from Rt Hon Patricia Hewitt would also be shared with the committee.

The authors of the Forever Gone report asked to attend today's meeting. The Chair advised that this was not appropriate but that he would meet with them, alongside officers, to discuss any difficulties they may be experiencing as part of the co-produced action plan process..

6. Access to NHS Dentistry in Norfolk and Waveney

6.1 Sadie Parker, Director of Primary Care - Norfolk and Waveney ICB, introduced to the committee the report on NHS Dental Services in Norfolk and Waveney. Following

engagement with the Local Dental Committee and Local Dental Professional Network, the ICB committed to three priorities. These included listening to the views of local dental professionals, considering how the local dental workforce can be strengthened, and listening to feedback from patients to improve treatment and access.

The long-term plan was still being developed and there was an ambition to have it published by March 2024. A short-term dental plan was produced in September 2023 that included actions to be implemented immediately. The committee heard that these actions had included the commissioning of an urgent service pilot, agreeing to investment for oral health intervention and prevention for children, and a short-term workforce plan that included incentives.

The ICB was pleased with the progress that had been made as part of the short-term dental plan but acknowledged that the challenges within dentistry in Norfolk and Waveney, including the NHS dental contract, were difficult and it would take time for residents to see changes.

6.2 Jason Stokes, Norfolk Local Dental Committee Secretary, noted that the working relationship and interactions with the ICB had improved. They highlighted to members the difficulties that the NHS dental contract posed for dental practices and that private work was being sought to fill the gap that NHS work had created. Any improvements to dentistry would need to include changes to the NHS contract. This was coupled with local pressures on workforce and the changes to the processes that enable people to move to the UK from abroad to work in dentistry.

6.3 The committee receive the annexed report (6) on progress regarding integration of NHS dentistry services into Norfolk and Waveney ICB since 1 April 2023.

6.4 The following discussion points and questions were asked to Jason Stokes:

- A member asked if it would be possible to offer incentives for practices to take on additional NHS contacts. In response, Jason Stokes shared with the committee that most practices were working flat out and there was not a pool of dentists to recruit from to help ease the pressure. Taking on NHS business was not profitable for practices and the pay was not sufficient to deliver quality staff and training.

- The improvement in the relationship with the ICB was attributed to the move to a place-based approach. This allowed for the ICB to have honest conversations with dental providers, practice owners, and managers to understand the challenges. Whilst there had been improvements, it was appreciated that there was still a long way to go.

- Tricia D'Orsi, Executive Director of Nursing, ICB, acknowledged the contributions that the team had made and their openness to listen. This was not just the contribution of the ICB but also the Integrated Care System (ICS).

- Concerning training dental staff and dentists, the committee heard that the key to this issue was understanding why staff do not want to work for NHS practices. Whilst training additional dental staff and dentists was important, ensuring adequate working conditions and pay would also play an important role in retaining staff.

- Previously, dentists had come to the UK from abroad, additional barriers to this process emerged as a consequence of the UK leaving the European Union. Additionally, for dentists from abroad to practice in the UK, there was a

requirement to pass a test. Discussions were being had to streamline and speed up this process. Recruiting dentists from abroad, however, did not solve the challenges of retaining staff.

6.5 Fiona Theadom, Head of Primary Care Commissioning, noted that improving patient access was closely linked to recruitment and retention. There was a need to create an environment that attracts dentists and dental staff, to find different ways of working, and to upskill staff. The changes would require working closely with system partners, the NHS, and the Primary Care Team.

6.6 The following discussion points and clarifications were offered:

- Following a member's question, it was noted that the ICB was looking into the possibility of overseas recruitment, this would need to be explored further to understand the processes and any restrictions. In response to this, a member questioned if overseas recruitment was appropriate given that they would be recruited into an environment that UK dentists would not work in.

- The ICB does not have the jurisdiction to establish a Dentist School in Norfolk, there are also no Dentistry University places.

- Suffolk has opened a Dental Training School that intends to train and educate both qualified and trainee dental professionals. The University of East Anglia was looking to implement something similar in Norfolk and Waveney, although, a member questioned if this would result in dental professionals staying in Norfolk and Waveney long-term.

- Once dentists have completed their schooling, they are required to do foundation years of training. There were limited opportunities for foundation training in Norfolk and Waveney, encouraging practices to become a training school, and dentists to come to Norfolk and Waveney, was an area that needed focus. The committee heard that the assignment of placements was managed nationally and that places locally had struggled to be filled.

- It was appreciated by members that not all the barriers to an effective dentistry service were the responsibility of the ICB to resolve and that the solutions to some issues would require lobbying the government.

- A member shared anecdotal evidence of a resident who struggled to access local dentistry treatment and ended up visiting A&E which resulted in oral surgery and time off work. In response, the committee heard that this was not an isolated event and that the ICB had heard similar stories. The Urgent Treatment Service has now gone live with the ambition that if you call 111 with a dentistry problem, you will be triaged to a local appointment. It was felt that making members aware of the Urgent Treatment Service would be beneficial and also that bringing the progress of this service back to HOSC would be worthwhile. A member shared that they had used these new services and it had been a positive experience.

- It was shared that it would be a long time until general access to dentistry was improved and the ICB could not put a timeframe on when this would happen.

- There was currently no resource capacity to assess the oral hygiene and dental decay of every five-year-old in Norfolk, figures were based on the proportion of children surveyed. Children and Young people's oral health had been identified

as a priority for the long-term dental plan. The ICB shared that there were around 7 practices that were working with the ICB on oral health prevention in schools.

- In response to a member's question on whether the Community Dental Service in Norwich had changed, it was confirmed that it had not changed but that a general dental service that operates 8 till 8 was also now occupied in the Siskin Centre. The committee heard that community dental services were facing the same challenges concerning the workforce and that a good working relationship was being built with the ICB to improve services. Ensuring that community dental services can provide sufficient care and support to patients would be incorporated into the long-term dental plan. NHOSC members would receive a briefing note that outlined the services that are provided through the community dental service.

- Within the ICB was a Learning Disability and Autism Programme Board that would closely look at health checks and how there can be better integration across the ICS. It was confirmed that there was currently no dental clinical check or screening.

- The importance of ensuring that people were aware of the work being done and what was available for people to access now was highlighted. The ICB acknowledged that there were always improvements that could be done around communication and that they were considering setting up a specific meeting with Councillors to inform them of changes and progress. However, it was noted that the size of the team was limited, and thus, hosting meetings and focus groups meant less time working on other priorities.

- Conversations were being had with the Nursing School at the College of West Anglia in West Norfolk to discuss the possibility of training dental nurses.

- Public health was responsible for school dental nurses' initiatives within schools. The committee had previously received a briefing note on this topic and there was an offer from Public Health to attend a meeting and present the work on dentistry that falls in their remit.

- A member shared that they had heard that there were vacant dental chairs and questioned the reason for this. In response, the committee heard that vacant dental chairs are often the result of not having the workforce to resource them. The detail of the specific examples the member provided was not known and there would be further exploration of this.

- The difficulties that the NHS contact poses were known and the ICB was exploring solutions such as flexible commissioning. The ICB was also reviewing the rates of units of dental activity (UDA), this was being completed with the support of other localities who were doing similar reviews.

- It was noted that the ICB does not work with dental practices in the same way as GP practices and the dental practices can fund premises out of UDA funding.

- With respect to the UDA funding and rates, a member asked how these were set and by whom. In response, it was shared with members that the rates were established when the NHS contract was set up in 2006 and was based on a year of treatment. They were calculated by units of dental activity and contract activity; they have been uplifted since 2006. Commissioners can change the rate, and this was being looked at.

- There was no information on dentistry waiting lists or how many people have access to a dentist. Members heard that in NHS dentistry, you are only a practice patient whilst you are receiving treatment.

6.7 The chair concluded the discussions and noted the progress that has been made to dental services in Norfolk and Waveney since the ICB gained responsibility. It was appreciated that the process to improve access to density would take time but that positive steps were being taken, including reviewing the NHS contract. Communication of changes made, and those that still need to be made, needed to be shared across the system so that responses could be streamlined, and resources used effectively. The Norfolk Health Overview and Scrutiny Committee has previously written to the Sectary of State and local MPs to note concerns with no substantial changes occurring. It was recommended that there be further communication with the Sectary of State to reiterate concerns, particularly noting the barriers that the NHS contract presents.

6.8 Summary of actions:

- The Committee would receive a briefing note that provided a six-month update on the progress of the Urgent Treatment Service and an overview of the provisions provided by the Community Dental Service.

- Public Health would attend an NHOSC meeting to share the work being done on prevention,

- A letter would be written to the Sectary of State that outlines the concerns of the current NHS dental contract and encourage that this be amended.

Cllr Webb left the meeting at 11:40.

7. Patient Pathway: Palliative and End of Life Care (PEOLC)

7.1 Chris Bean, Head of Acute Transformation and Clinical Programmes – Norfolk and Waveney ICB, and Dr Caroline Barry, Palliative Care Consult and Clinical Adviser to the ICB on Palliative and end-of-life care, introduced the report on PEOLC. A review has been taking place since May 2023 to look at the PEOLC services that the ICB commissions across Norfolk and Waveney and to ensure that statutory duties are being met. From the review, nine urgent actions and six long-term objectives were identified. The ICB has recently refreshed its PEOLC programme board with representation from across the system, this included representation from a range of partner organisations. The committee heard that there was significant policy in this area and that actions needed to be thought through and in line with policy.

7.2 The committee receive the annexed report (7) on Palliative and End of Life Care (PEOLC) provided by Norfolk and Waveney ICB.

7.3 The following discussion points and clarifications were offered:

- It was clarified that whilst the Queen Elizabeth Hospital (QEH) in Kings Lynn operated on 5-day weekday services, patients still receive end-of-life care. QEH staff receive training to ensure that they can offer PEOLC support when specialist services are not available. For specific care, help can be accessed through a helpline. There was an aspiration to move towards a service that operated 7 days a week. The ICB worked closely with the teams in QEH.

- Specialist beds required specialist consultant-level in-patient support; this was different from the support offered by hospices, such as Tapping House, which were considered to be an enhanced service as they do not have a named consultant.

- A member asked if the Louise Hamilton Centre at James Paget Hospital (JPH), which provided palliative care support, and complementary and relaxation therapies was operating and providing the same services it was before the Covid-19 pandemic. In response, Marlini Finney, Director of Strategic Finance, at St Elizabeth Hospice shared that St Elizabeth Hospice was moving into the center and the current focus was on providing community provisions.

- A member requested that data on deaths be represented in percentages and not bar charts as they felt that it could allow for misinterpretation of the amount of deaths in hospitals.

- The shortage of community matrons was raised by a member, they asked if work could be done to fill the gaps and ensure that people were dying with dignity at home. Work around this was being driven, and guided by, the National Delivery Plan and the three pillars of quality, access, and sustainability. Palliative specialist care teams were often small and the need to invest in the workforce on the ground was acknowledged. The member of the Borough Council of King's Lynn and West Norfolk asked if the ICB could produce protected learning time on Palliative Care.

- Members felt that palliative care needed to be included in the implementation of the Shared Care Records (SCR). In response to this, members were informed that barriers needed to be overcome before implementation and that electronic patient records across acute hospitals were unlikely to be the reality for a few years yet.

- The Chair shared his experience from his recent outing with the Ambulance service and read to the committee an email from a patient's wife. He highlighted the importance of palliative and hospice support in the home and that in the case he witnessed, an end-of-life package was not in place. The Chair asked what information was available for carers to ensure a death with dignity. In response, the committee heard that a key part of access was future planning and being able to recognise when someone was approaching their last year of life. The programme board was going to look at what would ensure that advance care planning can take place, additionally, raising awareness of death, death literacy, and wider community involvement was all felt to be important.

- The lack of knowledge within Mental Health services working with older people about end-of-life care was raised and the Vice-Chair wondered if there was an opportunity for joint working and education to address this gap. In response, Dr Caroline Barry felt that Palliative Care needed to work alongside professionals and see where they can add value. Within the ICB there was a specialty advisor for Mental Health, Dementia, and Frailty, who was working closely to help support the development of programmes of work. Additionally, collaborative work between NSFT and the ICB on the Parity of Esteem agenda would touch on this.

- Members shared their thanks to the Palliative and End of Life Care for all the work that they do.

7.4 The Chair thanked the speakers for attending and for presenting the report to the committee. He recognised how difficult it could be working in PEOLC, and conversations around death.

7.5 Summary of actions:

- Members would receive a briefing note on the Transformation Plan.

8. Forward Work Programme

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

8.2 The next meeting was scheduled for 18 January 2024, the digital transformation strategy and an update from NSFT were expected as items. There would be an opportunity for members to input into the forward work programme at the workshop due to be held in January 2024. Speech and Language Therapy and Maternity services would be brought as substantive items to NHSOC.

8.3 Members identified the following topics as potential items to be considered:

- An overview of Public Health services and initiatives with a particular focus on dentistry,

- The logistics of NHS 111, including an overview of the mental health response cars; Trica D'Orsi noted that this could be a collaborative item with Integrated Care 24, EAST, and the ICB as commissioners,

- An analysis of the collapse of One Norwich practice to understand what happened and what can be learned,

- An update on the over 40's health checkups to understand what value they have offered; this service was commissioned with Public Health and the ICB would be happy to collaborate,

- An update on menopause services and women's help hubs,

- Overview of the changes to policing and their response to mental health from a health angle.

8.4 A member suggested that Blue Badges, and the difficulties obtaining them, be explored. This was not in the remit of the ICB or HOSC to explore. The People and Communities committee at Norfolk County Council may be best placed to explore this.

Fran Whymark Chair
Health and Overview Scrutiny Committee

The meeting ended at 12:23

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Norfolk and Waveney Integrated Care Board Digital Transformation Strategy

Suggested approach from Liz Chandler, Scrutiny and Research Officer

Examination of Norfolk and Waveney Integrated Care Board's (N&WICB) Digital Transformation Strategy.

1.0 Purpose of today's meeting

1.1 To examine the report from N&WICB regarding its Digital Transformation Strategic Plan and Roadmap as part of its vision to develop a fully integrated digital service across Norfolk and Waveney. The report is attached at **Appendix A.**

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

2.0 Previous reports to NHOSC

2.1 This is the first time that N&WICB's Digital Transformation Strategy has been reviewed by NHOSC.

3.0 Background

3.1 In June 2022, the Government published '[A plan for digital health and social care]'. The plan includes a raft of initiatives to improve and increase digital services in the health and social care sector in a bid to improve patient care. The aim is that the majority of health and social care services will have digital foundations in place, including electronic records, by March 2025. The NHS App is at the heart of these plans. See also: [Our strategy to digitise, connect and transform – NHS England].

3.2 National

3.2.1 In 2016, NHS England (NHSE) closed down the Care.data programme three years after its launch in 2013. The project attempted to join up patients' data across different parts of the health and social care system. It was axed following an outcry about the lack of consultation with patients about their data was being shared. However, in May 2021, a similar scheme – the General Practice Data for Planning and Research (GPDPR) – was launched. However, this scheme was also indefinitely halted in July 2021 after concerns were raised about privacy and a lack of communication with patients which led to more than one million people opting out of sharing their data. According to the latest figures (July 2023), more than 3.3 million people have opted out

of sharing their data.[1] See: Care.data: How did it go so wrong? - BBC News; Why the closure of care.data is bad news for the NHS and society - The Guardian

3.2.2 There was controversy in November 2023 after NHS England awarded the contract for the setting up and operation of its Federated Data Platform (FDP) to US-based firm Palantir and four partners. The FDP will enable individual health service trusts and integrated care systems to connect to each other digitally and share data. Palantir's links to international intelligence agencies and military organisations, as well as its founders' support of Donald Trump, led to concerns about the security and privacy of patient medical records.[2] See: US tech group Palantir wins lucrative NHS data contract – Financial Times; Patient privacy fears as US spy tech firm Palantir wins £330m NHS contract - The Guardian.

3.2.3 In January 2024 NHSE launched an investigation into whether Palantir had breached the terms of its contract to run the FDP by launching an influencer marketing campaign. See: NHSE to investigate Palantir for possible breach of FDP contract – Digital Health; Good Law Project.

3.2.4 The introduction of a new EPR at two hospital trusts in Surrey led to a number of safety reports being filed, including one in which a patient died and 30 suffered harm. A lack of training for staff in using the system was blamed for the situation. See: Surrey Safe Care EPR leads to catastrophic harm incident – Digital Health.

3.3 Local

3.3.1 In December 2023 the NHS issued a National Patient Safety Alert following identified risks with the Euroking EPR which meant that there could be inaccuracies in patient records. The system is used in the maternity departments of some NHS Trusts including Norfolk and Norwich Hospitals NHS Foundation Trust (NNUHFT). Although there was no evidence of actual harm being reported, Trusts using Euroking have been given until 7 June 2024 to ensure that Euroking meets their maternity service's needs and that their local configuration is safe.[3]

4.0 Suggested approach

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

- Request further information on how the EPR in Norfolk and Waveney will be delivered particularly in terms of software providers.

[1] NHS England closing Care.data, James Illman, HSJ, 6 July 2016; The Download: The rebirth of care.data (sort of), Nick Carding, HSJ, 18 May 2021; Government halts controversial GP data sharing scheme, Nick Carding, HSJ, 20 July 2021; NHSE project will stop patients sharing data, government advisers fear, Nick Carding, HSJ, 19 September 2023.

[2] US firm awarded £330m national data contract, Joe Talora, HSJ, 21 November 2023.

[3] NHSE warns widely used EPR could pose 'serious risks to patient safety', Joe Talora, HSJ, 8 December 2023.

- How will N&WICB ensure the safety and security of patient data across all its digital systems?
- Is N&WICB on tract to meet the March 2025 deadline to have electronic records in place?
- Request further information on NNUHFT's use of Euroking EPR.
- Request further information on how patients will be informed of how their data is used and the extent to which they will be able to opt-out of data sharing.
- Request further information on how virtual services for patients will operate and how this will benefit both patients and hospitals.
- Request further information on how N&WICB will ensure both patients and staff will have the appropriate skills and access to N&WICB's digital systems.

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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Agenda item: 6

Subject:	**Digital Transformation Strategy** – an examination of N&W ICB's digital transformation strategy as part of its vision to develop a fully integrated digital service across Norfolk and Waveney
Presented by:	Ian Riley, Executive Director for Digital and Data, Norfolk and Waveney Integrated Care Board
Prepared by:	Collated by Norfolk and Waveney Integrated Care Board: - Ian Riley – Director of Digital & Data (N&W ICB). With contributions from system partners.
Briefing:	Norfolk Health Overview and Scrutiny Committee
Date:	

Purpose of paper:

To provide Norfolk Health Overview and Scrutiny Committee (HOSC) with an examination of N&W ICB's digital transformation strategy as part of its vision to develop a fully integrated digital service across Norfolk and Waveney.

Executive Summary:

The national digital strategy is to **digitise services**, **connect** them to support integration and, through these foundations, **enable service transformation**.

Our Digital Transformation Strategic Plan and Roadmap has been developed collaboratively and reflects the perspectives of our citizens, patients, front-line clinicians and staff across Norfolk and Waveney. They have helped shape our vision of a digitally enabled Norfolk and Waveney where access to information, services and support make it easy to deliver high quality health and care for and with our citizens.

Our strategic plan and roadmap sets out the steps we want to take on this journey, including:

- Improving our communication between different parts of our system so that people only have to tell their story once;
- Delivering a single Electronic Patient Record (EPR) across all three of our acute Trusts so staff can access the same information about patients whenever they attend one of our hospitals cutting out so much wasted time;
- Expanding our virtual services, so that people can be cared for in their own home, using the latest technology to monitor their progress remotely, and even prevent or shorten hospital admissions; and
- Expanding how we store, interpret and use data to help us plan services much more wisely, focusing on the people who need the most help.

Through our commitments around key digital enablers. We will:

- Engage **system leaders** to champion the digital transformation strategy objectives at all levels, supporting their teams to work differently, and collaboratively agreeing system priorities. Embed **a transparent governance structure** around digital, including ensuring streamlined processes, information governance, cyber security and clinical safety.
- Develop a culture that embraces digital and data and **embed a 'digital first' approach** as part of wider transformation efforts.
- **Upskill all our staff, patients and citizens** to use digital and data confidently and to encourage inclusion and digital adoption.
- **Leverage partnerships and opportunities to innovate** our services and embrace the potential of digitisation.
- **Bring together key digital transformation skills** to enhance collaboration across the system.

To make these digital promises a reality, we will need to make wide-ranging and long-term changes across our health and care organisations. Probably the most important and hardest change will be to change our attitudes and culture to embrace digital opportunities. That is why we will also work together to adapt how we are organised (governance), our leadership, the training we provide to staff in digital skills, and crucially work to help our citizens who haven't previously used much digital technology to **make sure that nobody is left behind**.

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1.1 Background and Context

The national strategy is to digitise services, connect them to support integration and, through these foundations, enable service transformation. The ambition for the majority of health and social care services is to have digital foundations in place, including electronic records, by March 2025. At present only 20% of NHS organisations are digitally mature, although 86% have a form of electronic patient record in place. Only 45% of social care providers have any form of digital care records. When paper processes and outdated systems are replaced by modern electronic health or social care records, staff and people will be able to safely access information when they need it and at a time and place that is convenient to them.

A connected health and care system means that information can flow safely and seamlessly between IT systems, care providers and settings. The insights generated from it can help to tailor services to the needs of populations, enable more targeted care and reduce unnecessary interventions. The real value of digital technology comes not from digitising existing practices, but from using it to reengineer them completely. In banking or retail for example, digital has changed the entire business model. Health and social care, by contrast, have changed how they provide services remarkably little. We must design inclusive services to benefit those whose health outcomes and outlook are poorest.

Supporting this national direction, there is a need to digitise health and care services across Norfolk and Waveney to support joined-up care, reduce inefficiencies, and improve patient outcomes. We are setting out on an ambitious journey of transformation. Our current care models rely on a mixed economy of predominantly legacy disparate systems and paper, which fall short of delivering the best care experience for our patients and staff. The inefficiencies that surround these models of care are costly and unsustainable, posing clinical and quality risks.

Investing in digital is essential to supporting collaborative working, truly joined-up care, improved outcomes, and a reduction in health inequalities across our region. Digital holds the potential to empower our population to take an active role in their own health through personalised care journeys and choice over where and how they receive care. Digital plays a key role in supporting our staff to work efficiently as one workforce across the system, reducing duplication and making the best use of their time. Digital also sets the foundation for operational, finance and estates transformation to ensure we make best use of resources.

Building on our Strategic Transformation Partnership (STP) Digital Strategy developed in 2018, the Norfolk and Waveney ICS Digital Transformation Strategic Plan and Roadmap, takes into account the shifts in digital thinking since the COVID-19 pandemic and establishes updated shared priorities for digital investment. It sets out the direction of travel for delivering digital solutions across the ICS. Our transformation journey is rooted in key national guidance such as the NHS Joint Forward Plan and the NHS ‘What Good Looks Like’ (WGLL) framework, as well as the Digital Health and Social Care Plan.

Our Digital Transformation Strategic Plan and Roadmap has been developed collaboratively with our people and reflects the perspectives of our citizens, patients,

front-line clinicians and staff across Norfolk and
Waveney. They have helped shape our vision of a digitally enabled Norfolk and Waveney where access to information, services and support make it easy to deliver high quality health and care for and with our citizens.

The need now is for the health and care sector to adopt digital tools, urgently and consistently, to address both our long term health improvement goals and the immediate tasks of recovering from the pandemic.

1.2 National Assessment of our Digital Maturity

The system is made up of the County Council, 3 Acute Hospitals, Mental Health Trust, 2 Community Health trusts, the ICB & hundreds of smaller health and care organisations including GPs and private sector care providers. The level of digital maturity in our organisations has significant implications for the health of our population and sustainability of the system. The criticality of embracing digital in the health and care setting is significant. Since the establishment of Norfolk and Waveney ICS, efforts have progressed in digitising the provision of health and care in the system. According to NHS Improvement figures (2018), Norfolk and Waveney STP was significantly less digitally mature than other systems in the country at that time, with examples of innovation existing in many areas such as primary care.

In March 2023 the Digital Maturity Assessment (DMA) was developed by NHS England and the first iteration launched, with its' focus on capturing a baseline of the current digital maturity of care provider organisations across England (Social care & primary care were not included in the first iteration) to highlight areas of achievement and inform local plans re future focus areas. It is intended that the DMA process will be repeated annually to capture each organisation/ICS' progress towards digital maturity ambitions. The DMA comprised a self-assessment questionnaire in 2 parts, with questions grouped in line with the 7 What Good looks Like (WGLL) Pillars:

- **Well Led** - Your ICS has a clear strategy for digital transformation and collaboration. Leaders across the ICS collectively own and drive the digital transformation journey, placing citizens and frontline perspectives at the centre. All leaders promote digitally enabled transformation to efficiently deliver safe, high quality care.
- **Ensure Smart Foundations** Digital, data and infrastructure operating environments are reliable, modern, secure, sustainable and resilient. Across your ICS, all organisations have well-resourced teams who are competent to deliver modern digital and data services
- **Safe Practice** - Organisations across the ICS maintain standards for safe care, as set out by the Digital Technology Assessment Criteria for health and social care (DTAC). They routinely review system-wide security, sustainability and resilience.
- **Support People** - Your workforce is digitally literate and are able to work optimally with data and technology. Digital and data tools and systems are fit for purpose and support staff to do their jobs well.
- **Empower Citizens** - Citizens are at the centre of service design and have access to a standard set of digital services that suit all literacy

and digital inclusion needs. Citizens
can access and contribute to their healthcare information, taking an active role in their health and well-being.

- **Improve Care** - Your ICS embeds digital and data within their improvement capability to transform care pathways, reduce unwarranted variation and improve health and wellbeing. Digital solutions enhance services for patients and ensure that they get the right care when they need it and in the right place across the whole ICS.
- **Healthy Populations** - Your ICS uses data to design and deliver improvements to population health and wellbeing, making best use of collective resources. Insights from data are used to improve outcomes and address health inequalities.

The DMA survey was completed in July 2023 via an online portal by NHS providers in N&W. There was a total of 49 individual questions across the seven WGLL domains mentioned earlier.

Capabilities levels: Least mature 1 – 2 – 3 – 4 – 5 Most mature

Region	Well Led	Ensure Smart Foundations	Safe Practice	Support People	Empower Citizens	Improve Care	Healthy Populations	Overall
Norfolk & Waveney ICS	**3.0**	**2.8**	**3.0**	**2.5**	**2.1**	**2.2**	**1.7**	**2.4**
East of England Region	2.8	2.8	2.7	2.4	1.9	2.3	1.8	2.4
National Average	2.7	2.8	2.6	2.3	2.0	2.4	2.1	2.4
Suffolk and North East Essex ICS	2.5	2.9	3.0	2.9	2.6	3.0	2.5	2.8
Norfolk & Waveney ICS	**3.0**	**2.8**	**3.0**	**2.5**	**2.1**	**2.2**	**1.7**	**2.4**
Bedfordshire, Luton & Milton Keynes	3.0	3.1	4.0	2.0	1.9	2.2	1.3	2.4
Mid & South Essex ICS	3.5	2.6	2.3	2.3	1.9	1.8	2.0	2.3
Cambridge & Peterborough ICS	2.5	2.7	2.3	2.4	1.7	2.2	1.7	2.3
Hertfordshire & West Essex ICS	2.5	2.4	2.0	2.3	1.4	2.2	1.7	2.1

Capabilities levels: Least mature 1 – 2 – 3 – 4 – 5 Most mature

Region	Well Led	Ensure Smart Foundations	Safe Practice	Support People	Empower Citizens	Improve Care	Healthy Populations	Overall
East of England Region	2.8	2.8	2.7	2.4	1.9	2.3	1.8	2.4
National Average	2.7	2.8	2.6	2.3	2.0	2.4	2.1	2.4
ECCH	3.0	3.5	3.3	3.4	2.6	2.8	2.5	3.1
NCH&C	3.5	3.6	2.7	3.4	2.0	3.0	2.3	3.0
NNUHT	2.0	2.4	1.3	1.8	1.6	1.7	1.8	1.9
JPUH	3.0	3.5	3.7	2.4	2.0	2.3	2.0	2.7
QEHKL	2.0	2.6	3.0	2.2	1.7	1.5	1.5	2.1
NSFT	2.5	3.7	4.0	3.3	1.7	2.0	2.3	2.9
EEAST Ambulance	2.5	3.4	3.3	2.7	1.8	2.0	2.5	2.7

The DMA survey is not meant as a comparative tool but we can see that N&W does benchmark fairly well against other East Of England regional ICS's There is significant variation across the different domains but it does give us a strong benchmark and identifies the areas to improve.

1.3 Norfolk and Waveney ICS Digital Strategy

Taking on board the recent assessments of our digital maturity, we recognise that we are at the start of an incredibly exciting, but incredibly challenging, digital transformation journey. In response the Norfolk and Waveney ICS Digital Strategy was agreed in Nov 2022 and was developed through engaging with over 250 staff and patients to develop this strategic roadmap from June to September 2022,

Digital innovation plays a crucial role in enabling progress towards our clinical objectives and the Norfolk and Waveney clinical strategy objectives help anchor our digital ambitions to ensure we are delivering a service that is reliable, resilient, holistic, proactive, and addressing health inequalities.

Together, we are determined to transform the way we use technology to deliver better, more personalised and easier to access care for the people of Norfolk and Waveney. The strategy aims to sharpen our focus on how we use the digital and technology capabilities to achieve the goals of our ICB: to ensure that the people of Norfolk and Waveney only have to tell their story once, to help them to live as healthy a life as possible, and to make our ICS the best place to work in health and care.

Our new strategic plan and roadmap sets out the steps we want to take on this journey, including:

- **Improving our communication** between different parts of our system so that people only have to tell their story once;
- **Delivering a single Electronic Patient Record** (EPR) across all three of our acute Trusts so staff can access the same information about patients whenever they attend one of our hospitals cutting out so much wasted time. Also ensuring we have effective patient record capabilities in other care settings (MH, Comm, GP, social care, VCSE etc…)
- **Expanding our virtual services**, so that people can be cared for in their own home, using the latest technology to monitor their progress remotely, and even prevent or shorten hospital admissions; and
- expanding how we store, interpret and **use data to help us plan services** much more wisely, focusing on the people who need the most help.

Alongside our core digital initiatives, we will implement a set of underpinning system-wide enablers:

- **Engage system leaders** to champion the digital transformation strategy objectives at all levels, supporting their teams to work differently, and collaboratively agreeing system priorities. Embed a transparent governance structure around digital, including ensuring streamlined processes, information governance, cyber security and clinical safety.

- **Develop a culture** that embraces digital and data and embed a 'digital first' approach as part of wider transformation efforts.
- **Upskill all our staff, patients and citizens** to use digital and data confidently and to encourage inclusion and digital adoption.
- **Leverage partnerships** and opportunities to innovate our services and embrace the potential of digitisation.
- **Bring together** key digital transformation skills to enhance collaboration across the system.

This is a massive opportunity and an incredibly challenging prospect. To make these digital promises a reality, we will need to make wide-ranging and long-term changes across our health and care organisations. Probably the most important and hardest change will be to change our attitudes and culture to embrace digital opportunities. That is why we will also work together to adapt how we are organised (governance), our leadership, the training we provide to staff in digital skills, and crucially work to help our citizens who haven't previously used much digital technology to make sure that nobody is left behind.

1.4 Electronic Patient Record (EPR) programme

> *"The EPR will enhance patient care and safety by providing real-time access to patient records, enabling more informed decisions and better outcomes which will help people live happier, healthier lives. The EPR will also improve efficiency streamlining workflows, reducing administrative burdens and will give healthcare professionals more time to focus on the people they care for".*
>
> **Alex Stewart**
> Chief Executive
> Healthwatch Norfolk

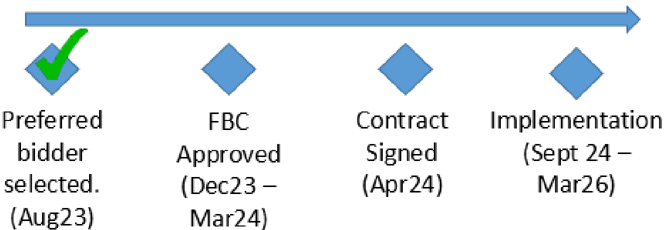
The NHS Long Term Plan and the Plan for Digital Health and Social Care committed all trusts to meeting a core level of digitisation and to implementing an EPR. Investment and support will be targeted to where it is needed most and providers were ranked on a scale of current digital maturity. The Plan for Digital Health and Social Care also committed to 80 percent of social care providers having a Digital Social Care Records (DSCRs). in place by March 2024.

The NHS Frontline Digitisation programme works to level up NHS trusts to a baseline level of digital capability (and will begin to address many of the areas highlighted in the DMA assessments). This investment in digitising the frontline will ensure that health and care staff have access to health-related information when and where it is needed, supporting them to deliver care efficiently, effectively and safely, reducing variation and improving outcomes. The vision is that an EPR will act as an enabler for a greatly improved health care system in which care givers and patients have electronic access to more complete health records and are empowered to make better health decisions with this information. An EPR system contains patient-centric, electronically maintained information about an individual's health status and care and focuses on tasks and events directly related to patient care. The EPR provides support

for all activities and processes involved in the delivery
of clinical care. The EPR is part of an overall strategy, that includes a data hub and Shared Care Record (SCR) across the ICS.

For Norfolk and Waveney's three Acute hospitals this investment represents the minimum required to bring digital maturity to a level similar to that of most other acute Trusts and will:

- Enhance patient care by empowering clinicians, providing them with the right information at the right time;
- Replace Trust-specific and specialty-specific digital silos with integrated data;
- Provide clinicians with a 'single source of truth', making sharing information across pathways much simpler and improving tracking and communication;
- Maximise efficient working and reduce errors when making decisions thus improving patient care with a robust audit trail for continuous quality improvement;
- Provide embedded clinical decision tools to support informed decision-making at the point of care;
- Enable integration and/or reconfiguration of acute services across the three Trusts;
- Allow significantly greater clinical information-sharing with our partners in primary care, community care and mental health;
- Improve the recruitment and retention of skilled healthcare professionals.



Current EPR Implementation plan

It is important that we ensure all providers in N&W have adequate systems in place to manage their patient records, share clinical data and reduce the administrative burden. There are ongoing plans to look at a new EPR for NSFT and we should also constantly review the systems used by our community providers, general practice and VCSE providers and balance this against the levels of available capital & revenue funding.

1.5 Shared Care Record (ShCR) programme & DATA HUB

There is a common misconception that health and care workers across Norfolk and Waveney already have access to people's full system wide health and care records. This is not always the case and often means that you are asked to repeat your medical history.

The NHS and social care sector is made up of thousands of individual organisations, many of them using different computer systems to record patient information. These systems often are not connected to each other, so the health and care organisations looking after patients at the point of need may be unable to see the information held by other organisations such as general practice, hospitals, VCSE, ambulance services, etc.

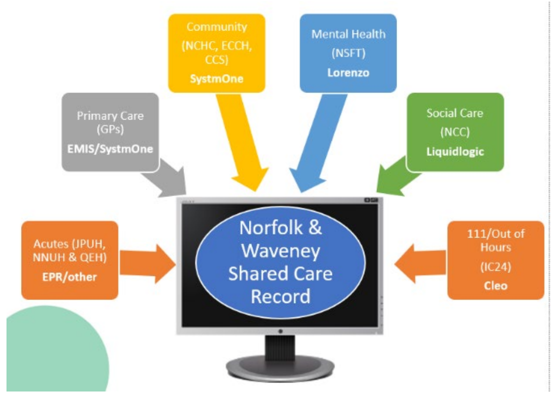
First published in 2021, the Department of Health and Social Care (DHSC) set out a strategy with ambitious plans to harness the potential of data in health and care in England. *Data saves lives: reshaping health and social care* with data sets out how data will be used to improve the health and care of the population in a safe, trusted, and transparent way.

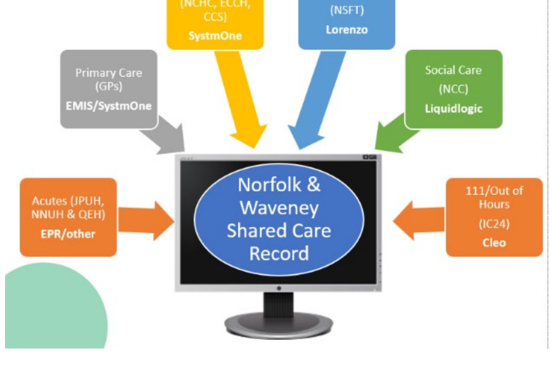
The final version has evolved following full and open engagement, with feedback given during the period informing the current strategy. The strategy recognises that the future of the NHS depends on improving how data is used for four related purposes:

- for the direct care of individuals
- to improve population health through the proactive targeting of services
- for the planning and improvement of services
- for the research and innovation that will power new medical treatments

Norfolk and Waveney Shared Care Record (ShCR)

The NHS has issued a national target for all ICB areas to deliver a patient health and social care shared record that is accessible to staff involved in the direct care of the patient or citizen. This enables the best decisions to be made and leads to better outcomes.





Shared records that are accurate and of a high clinical quality are identified as key to providing patient-centred care at the point of need. Ensuring that staff and providers have access to the right, high quality data and patient information, at the right time, is vital to the NHS providing effective, safe, and good value services.

Norfolk and Waveney have made good progress through the first few phases of implementation and now have most health and care organisations data flowing and clinical usage is increasing. We are building up a good set of use cases

Shared Care Record
New Data Available

Improving lives together
Norfolk and Waveney Integrated Care System

Who Can Access This Data?

- Norfolk and Norwich University Hospitals (NNUH)
- Queen Elizabeth Hospital (QEH)
- James Paget University Hospital (JPUH)
- Norfolk Community Health and Care (NCH&C)
- Community Clinical Services (CCS)
- East Coast Community Healthcare (ECCH)
- Norfolk County Council (NCC) Adults and Children's Services
- Integrated Care 24 (IC24)
- Norfolk and Suffolk NHS Foundation Trust (NSFT)
- Norfolk and Waveney GP Practices (SystmOne)

EMIS Practices will be able to access the ShCR soon!

What Data is Now Available?

The ShCR now encompasses a wealth of data to enhance patient care and streamline processes. The newly available data includes:

- Norfolk County Council (NCC) Adults Social Care information
- Norfolk and Suffolk NHS Foundation Trust (NSFT) data
- GP Connect resources
- GP Connect structured data
- James Paget University Hospital (JPUH) & Queen Elizabeth Hospital (QEH) data

and outcomes as services such as NCC adults and
children and young people services have far easier access to data which they used to have to spend time and effort trying to gather from system partners over phone and email exchanges. This leads to faster decisions and better outcomes for patients and citizens.

We are currently in discussions with the VCSE sector on how we can design future phases to give them access to the system and also allow them to contribute the important data they hold for patients and citizens which helps to complete the overall picture and prevent people repeating their story.

Data Sharing and Population Health analysis

The health and care needs of Norfolk and Waveney residents are changing: our lifestyles are increasing our risk of preventable disease and are affecting our wellbeing, we are living longer with more multiple long-term conditions like asthma, diabetes and heart disease – and the health inequality gap is increasing.

Population health is one of our core strategic aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across the entire population, with a specific focus on the wider determinants of health (things like housing, employment, education). Population Health Management is a way of working to help frontline teams understand current health and care needs and predict what local people will need in the future. This means we can deliver better care and support for individuals, design more joined-up and sustainable health and care services and make better use of public resources.

The PHM programme in N&W is supported by the DATA HUB (formerly HCDA) programme which links historical and current population wide data sets from health and care providers to support the understanding what factors are driving poor outcomes in different population groups. Local health and care services can then design new proactive models of care which will improve health and wellbeing today as well as in future years' time. This supports the planning and improvement of services & the research and innovation that will power new medical treatments.

As we move towards a more 'place based' approach it is vital we give our teams and services the best possible, joined up information about where our patients and citizens are receiving poor outcomes or we have health and care inequalities.

1.6 Information Governance

Information governance (IG) is all about how to manage and share information safely and securely. We want to make sure that IG guidance is clear and consistent for everyone working in health and care organisations as It enables and underpins many of the areas discussed in this paper. The legal framework governing the use of

personal confidential data in health & care is complex. It includes the NHS Act 2006, the Health and Social Care Act 2012, the Data Protection Act, and the Human Rights Act.

The law allows personal data to be shared between those offering care directly to patients but it protects patients' confidentiality when data about them are used for other purposes. These "secondary uses" of data are essential if we are to run a safe, efficient, and equitable health service. They include:

- Reviewing and improving the quality of care provided
- Researching what treatments work best
- Commissioning clinical services
- Planning public health services

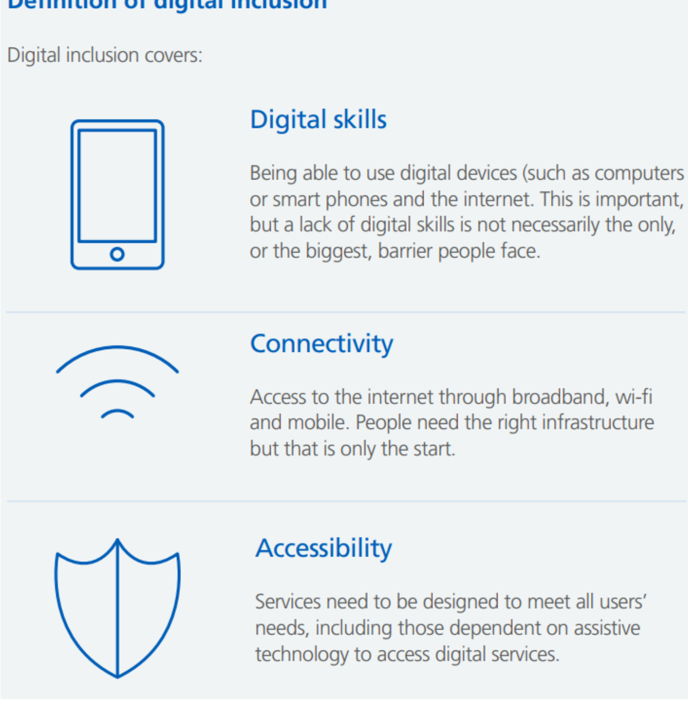
We utilise Regional and ICS wide networks of Information Governance professionals to ensure we have the necessary challenge in order to have the correct documentation and legal basis in place to support the vital data sharing activities. This is constantly reviewed and communicated to the providers of care and citizens and patients.

1.7 Digital literacy and Inclusion of citizens and staff

> "Every Norfolk resident is provided with the appropriate digital access opportunities to meet their needs and enable them to be digitally included in all aspects of their lives"
>
> **Norfolk Digital Inclusion Strategy**

The NHS, and the wider health and care system, is committed to delivering information and services digitally wherever appropriate. For patients, digital health can mean better access to information and care, increased convenience, and more opportunities for greater control of their own health and shared care. For the health and care system digital health can mean more effective delivery of care, better outcomes and reduced costs.

However many of the people who could most benefit from digital services are the least likely to be online. Local health and care services need to take into account the needs of people who may be digitally excluded. Health and care organisations can work with a range of community partners to improve digital inclusion.



We are fortunate in Norfolk and Waveney that we have two county councils who have strong strategies, programmes and success in this area. Current NCC strategy and successes are below:

Working in partnership to target activity and make best use of resources

Enabling universal access to connectivity in the county

Supporting access to devices and equipment

Increasing digital skills and confidence in key cohorts

Developing the skills of our staff to understand how to support residents to access and use technology to improve their lives

- Over 1000 devices refurbished and distributed last financial year – schools, voluntary sector (on top of over 5000 in previous years).
- Expanding successful schools' pilot and starting up afterschool digital clubs for children and parents supported by Digital Services, Adult Learning and Libraries
- Over 500 residents supported with free or subsidised connectivity through NAS or the libraries
- Currently working with Digital Cabinet Office, Aviva, District Councils to increase supply of devices and equipment
- Digifest – 112 events held, 719 attendees in February, double the previous year, in total over 1000 young people have benefitted from attending digital technology events
- Libraries Lending scheme rolled out August 2023 throughout Norfolk loaning laptops and tablets to residents
- Over 1000 learners have been supported with digital skills courses over the last 2 years
- Nearly 800 businesses have been supported through the Go Digital Project plus support through the Business Intellectual Property Centres at Libraries, Adult Learning courses focussing on business skills
- Ambitious staff training and development plan for improving our staff's basic digital skills, induction of new starters successfully started August 2023 and a programme of digital champions to support our staff and encourage use of technologies to drive better more efficient practice utilising the technology and software we already have
- Accessibility built into our digital technologies – hardware and software
- Wraparound support being provided for Care Leavers
- Digital Web content Silktide WCAG 2.1 AA compliance score has increased to 98.5% target was 95%
- Promotion of programme at the House of Lords, Norfolk Show and through the Chamber of Commerce

There are also numerous charities and VCSE providers who have offerings in this space and it is really important we continue join up these services and ensure the communications and engagement reaches people to make them aware of what is available so that we continue to leave no one behind digitally.

1.8 Risks

Delivering digital transformation on this scale entails the effective management of risks including the lack of joined-up leadership, transformation siloes, insufficient funding, significant cultural change required, as well as governance challenges.

Area	Risk	Mitigations
Leadership	Lack of alignment between system and organisational leaders given financial constraints & competing priorities	Galvanize ICS system leadership on the compelling case for change, articulating risks of not digitising and championing this digital roadmap
Funding	Limited funding to fully deliver strategic ambitions	Regularly review & prioritise digital programmes and projects, as required Engage with regional and national leaders on additional potential funding sources and look to minimise additional technical 'asks'. Deliver system improvements to release funds for re-investment (Newton work)
Capacity	Limited operational, technical and Digital resources	
Culture	Lack of workforce readiness for transformation. Significant cultural change required, potential for 'change fatigue'. Siloes when it comes to digital and wider transformation efforts across the system	Join-up efforts around digital and wider transformation including a comprehensive change management programme /workstream that includes digital. Support frontline champions among staff of digital and wider transformation efforts
Governance	Potential for inertia and delayed decision-making while governance structures are formed and matured.	Regularly review the digital governance so that it provides effective and transparent support to the transformation ambitions.

1.9 Conclusion

The recent DMA work has shown that the Norfolk and Waveney system has a considerable amount of work to do to increase its digital maturity across all providers to deliver the best outcomes for its staff, citizens and patients. Unfortunately for us this is also a moving target as technology never stands still. The ICS system remains committed to the ongoing developments and improvements set out in the jointly produced ICS Digital Transformation Strategy & Roadmap. Within this there are several key programmes which will significantly shift our current maturity (EPR, SHCR & Data Availability). There will be risks to mitigate along the way and system dependencies, including one major risk / constraint around sufficient central funding being available to deliver the strategy over multiple financial years. We also need to focus organisations on the continuous development of digital skills within the workforce and the increased awareness and knowledge required across health, social care and our wider communities.

What we do have in our favour is very strong links and relationships between health and care providers in N&W and in particular the digital leadership to deliver the necessary projects and programmes. One of the issues we will need to keep an eye on as a system will be the uptake, adoption and transformation work as this is probably the most important and hardest change as it requires people to work differently, to change our attitudes and culture to embrace digital opportunities.

Everyone in the system understands the importance of the digital inclusion work which gives our citizens and patients the knowledge, skills and confidence & goes hand in hand with advancements in digital maturity and ensuring that digital is not ‘the only door’ into services but is one channel of access which will increase over time.

These things together give us a great opportunity to deliver our planed outcomes:

- Improving our communication between different parts of our system so that people only have to tell their story once;
- Delivering a single Electronic Patient Record (EPR) across all three of our acute Trusts so staff can access the same information about patients whenever they attend one of our hospitals cutting out so much wasted time;
- Expanding our virtual services, so that people can be cared for in their own home, using the latest technology to monitor their progress remotely, and even prevent or shorten hospital admissions; and
- Expanding how we store, interpret and use data to help us plan services much more wisely, focusing on the people who need the most help.

Appendix 1

Digital Strategy: Vision & Strategic Themes

VISION: our overarching aim	***A digitally-enabled Norfolk and Waveney where access to information, services and support make it easy to deliver high quality health and care for and with our citizens.***

STRATEGIC OBJECTIVES: the results we want to achieve

Together
Use digital technology and skills to work more efficiently and collaboratively across standardised systems.

Connect
Provide effective and joined-up care through systems integration and streamlined information flows.

Activate
Empower citizens with greater visibility and control over treatment and care journeys.

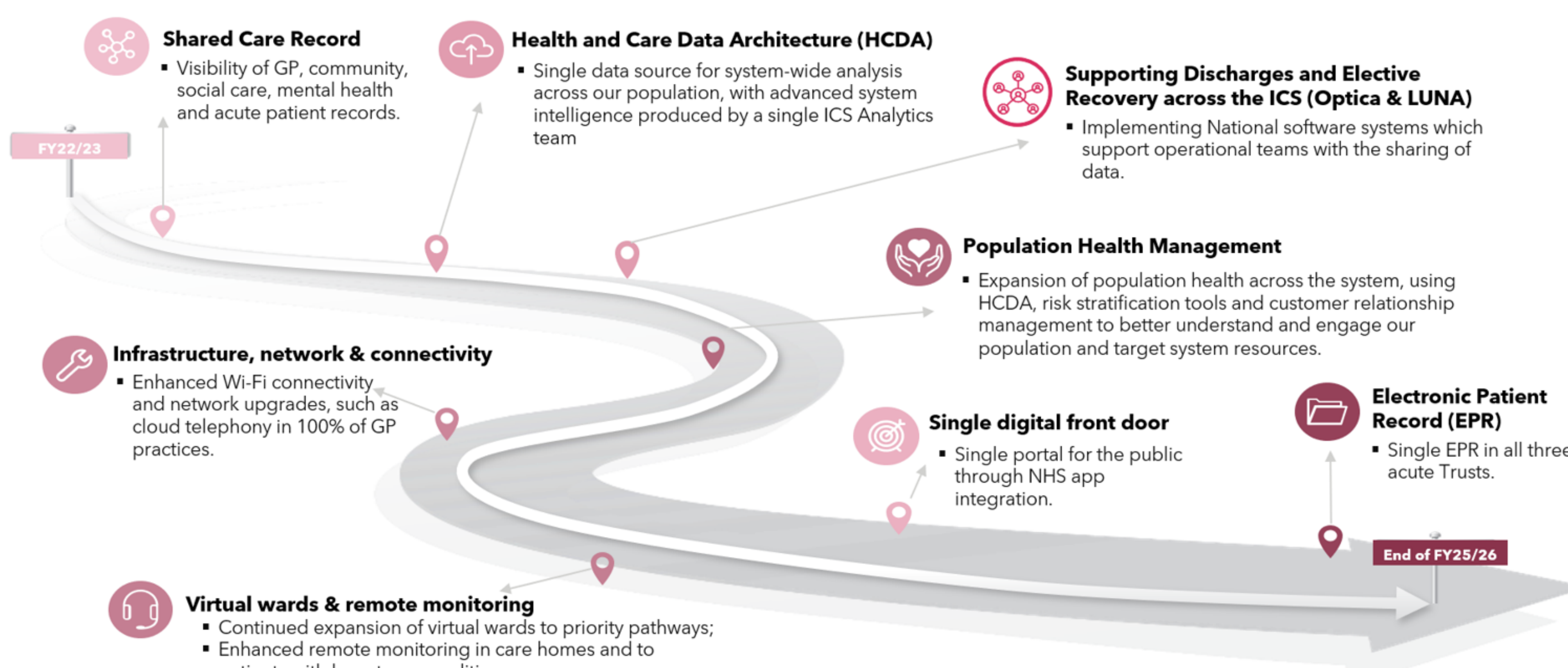
Understand
Use data to drive decisions and harness population health insights.

Innovate
Adopt a clear pathway for digital innovation and research to support the transformation agenda.

Strategic Roadmap of ICS Level Digital Initiatives

Digital Transformation Strategic Roadmap

Digital will enable transformation across all care settings, including outpatients.



Strategic Objective	Description	Delivery Areas
Together	***Use digital technology and skills to work more efficiently and collaboratively across standardised systems.*** Staff working across standardised systems and the same data to enhance care delivery through advanced and joined-up digital solutions.	Acute Electronic Patient Record (EPR); Digitised Mental Health Record (EPR); Digital Social Care Record; Shared Care Record (ShCR); Remote monitoring and virtual wards; Digital Patient Triage; Digital Social Prescribing; Improved E-referrals; Digital pre-operative assessments
Connect	***Provide effective care through systems integration and streamlined information flows.*** Delivering efficient and patient focused health and care regardless of service provider through simplified, consolidated, secure, and reliable infrastructure.	Infrastructure & Connectivity upgrades; Cloud First Infrastructure; Cyber security and Compliant Standards; End User Devices
Activate	***Empower citizens with greater visibility and control over treatment and care journeys.*** Citizens only need to tell their story once and be supported to drive the personalisation of their own care.	Patient Portal and apps; eRedbook; Personalised Care
Understand	***Use data to drive decisions and harness population health insights.*** Access to secure and timely data insights on demand, to support the best outcomes for individuals, our population, and the system.	Health and Care Data Architecture (HCDA); Population Health Management; Advanced Analytics; Business Intelligence (BI); Risk Stratification
Innovate	***Adopt a clear pathway for digital innovation and research to support the transformation agenda.*** Become a centre for excellence, harnessing digital approaches to innovation and research.	Robotic Process Automation (RPA); Virtual Careers Office; Emerging Tools (e.g. Virtual Reality); Streamlined Learning Placements; Integrated Electronic Staff Record & Digital Staffing Bank

Norfolk Health Overview and Scrutiny Committee
18 January 2024
Item no: 7

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

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 This report provides members of the Norfolk Health Overview and Scrutiny Committee with an update on actions being taken by the Norfolk and Waveney ICB, the Suffolk and North East Essex ICB, and Norfolk and Suffolk NHS Foundation Trust (NSFT) in response to the Grant Thornton review of mortality recording and reporting in Mental health services across Norfolk and Suffolk.

1.2 A paper has been prepared jointly by NSFT, Norfolk and Waveney Integrated Care Board (N&WICB) and Suffolk and North East Essex ICB. This is attached at **appendix A**. It will be presented to both Suffolk and Norfolk health scrutiny committees. Suffolk Health Scrutiny Committee will receive this update on the 24 January 2024.

1.3 Representatives from both NSFT and N&WICB will be in attendance at the meeting to present to NHOSC members and answer questions.

1.4 Members are invited to provide challenge to NHS partners, exploring progress with regards to mortality recording and the work of the Trust Learning from Deaths Action plan Management Group as set out in the appended papers. Members are also invited to explore progress against recommendations agreed by the NHOSC at the meeting held on the 14 September 2023, as set out below.

2.0 Previous reports to NHOSC

2.1 Members last received an update on this topic at the meeting held on the 14 September 2023. The papers and associated minutes for this meeting can be found here. Members discussed progress and findings with officers and provided challenge and scrutiny.

2.2 At this meeting, members also received a presentation from Caroline Aldridge and Anne Humphreys, authors of the Forever Gone: Losing Count of Patient Deaths independent report.

2.3 Following discussion, Members agreed the following recommendations:

1. NHOSC supports calls for a statutory public inquiry into in-patient and community mortality at NSFT.
2. Request that ICBs urgently (within one month) review the Mortality Review Action Plan with bereaved families and NSFT and co-produce revised actions.
3. NHOSC shares the concerns set out by the Parliamentary Health Service Ombudsman and rejects the assertion that changes to the Mortality Review were limited to 'factual accuracy'.
4. All co-production with bereaved families should be commissioned by and directly overseen by ICB due to the lack of HOSC, public and bereaved family confidence in NSFT's suitability or competence to undertake this work safely.
5. Write to the Secretary of State for Health to outline these actions and NHOSC's dissatisfaction and ongoing safety concern.
6. The recommendations agreed should not delay the work of the co-produced action plan.
7. NSFT will return to NHOSC with an update in early 2024.

2.4 Following the meeting, NHOSC members received a briefing note on the 24 October 2023 from N&WICB. This provided an update on progress towards implementing the mortality recording and reporting action, and the development of an action plan development group to oversee delivery. This is attached at **appendix B**.

2.5 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 in Norfolk and Suffolk.

2.6 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.

3.0 Background information

3.1 Norfolk and Suffolk Foundation Trust's Mortality Recording and Reporting report was 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.

3.2 The report 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.

3.3 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.

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

3.5 The Grant Thornton Report provided a clear action plan, with 16 recommendations across 5 key themes. Detail on these can be found on pages 10-16 of the linked report, but they are excerpted as a summary below:

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

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

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

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

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

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

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

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

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

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

3.6 In late August 2023, NSFT were the subject of a BBC Newsnight investigation, challenging the manner in which the drafting process for the mortality review was conducted, alongside a number of other articles and reports. NSFT officers responded to media reporting at the meeting held on the 14 September 2023.

4.0 Suggested approach

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

- Request an update on recommendations and timescales set out in the Grant Thorton review action plan, and the reasons behind any outstanding actions.
- Request an update on recommendations agreed by NHOSC at the 14 September 2023 meeting, as outlined in para. 2.3.
- 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.
- Request an update on the work of the Trust Learning from Deaths Action plan Management Group, and how membership and activity has developed since the group began its work in October 2023.
- Request information on the actions that 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.

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

Update on actions being taken following the Grant Thornton review of mortality recording and reporting in mental health services in Norfolk and Suffolk

Purpose

This paper provides a joint update to both Norfolk and Suffolk, Health Overview and Scrutiny Committees (HOSC's) on actions being taken following the Grant Thornton review of mortality recording and reporting in mental health services in Norfolk and Suffolk (June 2023). The paper has been developed collaboratively by, Norfolk and Suffolk NHS Foundation Trust (NSFT), NHS Norfolk & Waveney Integrated Care Board (N&W ICB) and, NHS Suffolk and North East Essex Integrated Care Board (SNEE ICB).

The paper provides a general update on progress to date and next steps as well as addressing specific questions raised by the Suffolk HOSC.

Introduction

In 2022 NSFT asked NHS Norfolk and Waveney and NHS Suffolk and North East Essex ICBs to commission an independent review to assess mortality reporting at NSFT 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 NSFT 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:

https://improvinglivesnw.org.uk/independent-review-published-on-mortality-reporting-and-recording-at-the-norfolk-and-suffolk-nhs-foundation-trust/.

Caroline Aldridge, Anne Humphrys, and Emma Corlett published a comprehensive response to the Grant Thornton report 'Forever Gone: Losing Count of Patient Deaths' (7th July 2023) www.learningsocialworker.com..

The response was subsequently presented to both ICB Boards and the NSFT Board and a Collaborative Working Group was established based on the key 'principles of co-production. With membership from the two ICBs, NSFT, Norfolk and Suffolk Healthwatch, and the authors of 'Forever Gone: Losing Count of Patient Deaths' (7th July 2023).

The work of this Group is to be commended for its commitment and focus on service improvement. The discussions of the Collaborative Working Group, including a draft action plan, will feed into the work of the new Trust Learning from Deaths Action Plan Management Group, which is described in more detail later in this paper.

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'*.

As trusts follow differing approaches to who is included, mortality data is not comparable between Trusts. As such the NSFT will continue to evolve processes and refine reporting over time in accordance with local and national learning. 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 NSFT 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:

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

Further clarification is set out below in relation to the NSFT working definitions for managing and reporting mortality data.

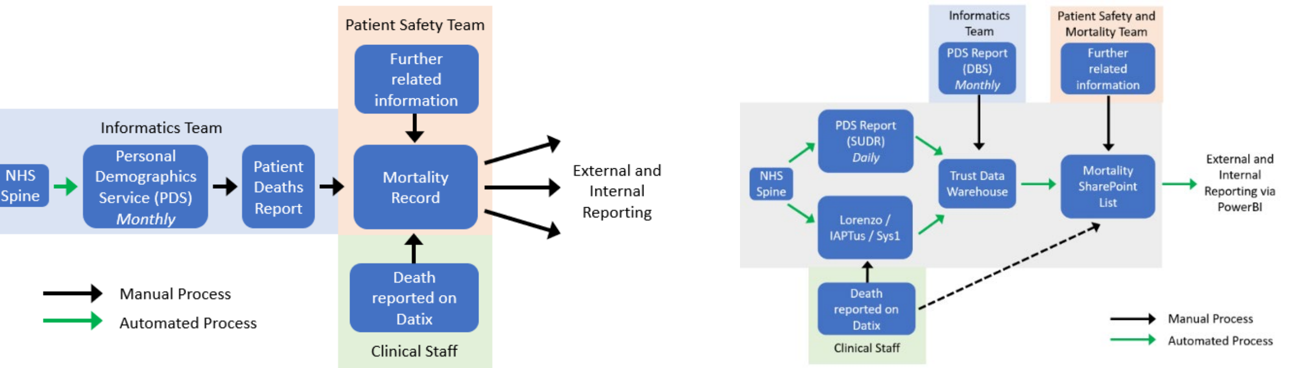
What progress has been made against the actions and timescales set out in the Grant Thornton report action plan?

To improve the NSFT management and reporting of mortality data NSFT have developed a new 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, and it was put live on the 6th November 2023 (covering deaths notified after the 1st November) and addresses many of the Grant Thornton recommendations. A before and after comparison is shown below, highlighting the benefits of the new approach.

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 which are:

- **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.

If actions are outstanding what are the reasons for this?

There are 3 principal areas where actions continue beyond the initial date of delivery within the NSFT Grant Thornton action plan:

1. **Completion of the PowerBI dashboard**. The dashboard is in place and functioning as expected, however we expect that there may be changes to the way the data is presented as part of the final sign-off of the new reporting mechanism.

2. **Standard Operating Procedures (SOP)** have been created for each area of the process, and a draft over-arching SOP that places each within the end-to-end process. Some minor changes are needed as part of the early life support of the new system and then the over-arching SOP can be signed off.

3. **External verification** (action 16) has not yet been sought as the new system is still in early life support. The intention is for the new system to be reviewed as part of the Trust's Internal Audit schedule for 24/25.

The NSFT Grant Thornton action plan was last updated on the 20th December 2023 by the NSFT Grant Thornton Action Plan Programme Management Board and is at appendix 1 of this paper. It shows progress to date, any outstanding actions, rationale for any delays and proposed completion dates.

Next Steps

The Trust has established a new Learning from Deaths Action Plan Management Group (Appendix 2) which will replace the current internal executive led Grant Thornton Action Plan Programme Management Board. The group will have a significantly increased membership which will include NSFT Executives, service users, carers, including bereaved relatives, who will be recruited through the existing NSFT networks. SNEE and N&W ICB Quality/Safety Representatives, both Healthwatch organisations and Public Health leads from the respective Local Authorities. The full membership is set out in the groups terms of reference at appendix 2. The scope of the Group has also been expanded beyond the Grant Thornton action plan.

The Trust Learning from Deaths Action Plan Management Group will be accountable for executive oversight and seeking assurance on the progress of actions resulting from:

- The Grant Thornton report Action Plan
- Any outstanding actions from the Verita report action plan
- 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

The Group will provide the governance framework for the reporting of progress to the NSFT CEO/Management Group, The Trusts Quality Committee, and through it, the Board as well as to the Quality Committees and Boards of the two ICBs.

The groups first meeting will take place on the 23rd January 2024 and monthly thereafter.

The following is a response to specific questions the HOSCs have requested a response to:

What arrangements are in place to ensure partners across the health system in Suffolk and Norfolk are playing their part in supporting delivery against these actions?

ICBs in Norfolk and Suffolk are invited to safety meetings established within the governance of NSFT. To create additional momentum, a collaborative working group was established in September 2023 to respond to the concerns raised by the authors of Forever Gone at the public boards of both ICBs and the trust. The group comprised representatives of both ICBs, the Trust, Healthwatch Suffolk and Norfolk, and bereaved relatives. The discussions of the collaborative working group, including a draft action plan, will feed into the work of the Trust Learning from Deaths Action Plan Management Group.

What work has taken place since Norfolk Health Overview and Scrutiny Committee made its recommendations on 14 September 2023 for a co-produced action plan to be developed?

It is important to note that NSFT, N&W ICB and SNEE ICB are all fully committed to co-production and working in partnership to improve mental health services for our local populations. The collaborative working group met on seven occasions between 29th September and 27th November 2023. Following a contracting process where the principles of co-production and collaboration were explored, a draft action plan was rapidly developed to address some of the concerns highlighted at the three public boards by the authors of Forever Gone. The discussions of the collaborative working group, including a draft action plan, will feed into the work of the Trust Learning from Deaths Action Plan Management Group.

Bereaved relatives worked with Healthwatch Suffolk and Norfolk to explore principles of coproduction in complex grief. The output from these discussions was reflected in the draft action plan.

What evidence exists to demonstrate that a wide range of views from people with lived experience have been taken into account through co-production work?

The collaborative working group was designed as an exercise in coproduction with bereaved relatives occupying active roles in the work, often leading discussion, and challenging statutory partners in their thinking. This is reflected in the output from that group. The Learning from Deaths Action plan Management Group will also include people with lived experience.

What is the learning from the co-production work?

Coproduction with people experiencing complex grief requires special attention, and standard models may not be appropriate. Bereaved relatives have unique perspectives on heath and care services and are advocates for patients who have died. People with lived experience of complex grief may not be able to engage in coproduction work on the same basis as patients or carers, and the process of coproduction in this group can be triggering. Support mechanisms for bereaved relatives need to be provided proactively to facilitate effective coproduction.

What are the key challenges for the wider system in reducing the number of deaths of people experiencing poor mental health?

There is an absence of national benchmarking and guidance. There remains a lack of clarity on the number of preventable deaths in patients with mental health problems (and outside

hospitals in general), and who is accountable for prevention (not all of this will lie with the mental health trusts). Systems for understanding cause of death across different providers in the system are developing, and the implementation of statutory medical examiner system in 2024 will assist with this.

Mortality for mental health trusts became an NHS priority as a response to The Five Year Forward View for Mental Health (NHSE 2016), where it was identified that people with severe and prolonged mental illness are at risk of dying on average 15-20 years earlier than other people. Thus, the health inequalities present for people with severe mental health issues and learning disabilities, should the focus of prevention and early intervention, learning and improving the physical health care provision for this group of people. In 2021, NHS E included in scope people with autism.

What specific actions can system partners (including the local authority) take to achieve the necessary improvements?

NHS Suffolk and North East Essex Integrated Care Board response

Improvement in managing mortality data, learning from deaths and service improvement requires work from all system partners. Greater clarity of information (including cause of death) across health sectors (including community services and primary care) will fundamentally change the way that the trust can monitor the outcomes of its patients and learn from cases where improvements in care may have been possible. The local authority Registrar offices manage rich information on cause of death and stronger links with these offices should be encouraged. Similarly, close links exist already with the Suffolk Coroner, and these should be developed further to facilitate early sharing of information and learning. Finally, the implementation of the statutory medical examiner system across England in April 2024 will require a discussion between the attending doctor and the medical examiner's office for every death, to improve quality of medical certification of death. A greater awareness of the need to understand mortality linked to mental health conditions can be developed through this new statutory system. Medical Examiners and their teams are meeting monthly across Suffolk to track and manage progress against statutory implementation, alongside the recent publication of draft guidelines for the new regulations.

Multidisciplinary system level forums are effective where learning from deaths can be shared, best practice identified, themes and trends explored, and signals of increased mortality identified and understood. These are customary practice in all secondary care providers and are increasingly implemented at ICS level to leverage the power of working across end-to-end patient pathways, rather than within organisations. This forum in Suffolk (Trauma Informed Mortality Meeting) will meet for the first time on 18th March 2024, with invited representatives from primary care, acute and mental health providers, local public health services and bereaved relatives. Engagement from all these constituents is essential to the effectiveness of the group.

NHS Norfolk & Waveney ICB response

Learning Theme 1. Data Management

The ICB participates in the Trust's internal Mortality Meeting, which has driven the implementation of a new data management system set up in early November. The new format meeting is looking at validity of the Trust's new mortality dataset and the ambition will be to draw out themes and trends as the meeting embeds. NHS Spine now automatically downloads each day as definitive source of patient-level data. Reporting tools in place and

reported as part of Data Quality Dashboard. Work to be completed with clinical teams to improve recording consistency.

Learning Theme 2. Reporting

The Trust is part of the ICS Learning from Deaths (LFD) Forum, hosted by the ICB, co-chaired by the ICB Medical Director and NCC Director of Public Health, which brings together partners to review mortality data across multiple sources, identify trends and themes early and share learning to enable improvements across service areas and care pathways. This forum enables partners to flag, escalate and collaborate on risk mitigation and quality/safety improvement. NSFT has a focussed item scheduled for January 2024 LFD Forum. The Trust has already shared learning from an internal Falls Review. Themes from PFD Reports and a separate flagged mortality trend in a specific care group (crisis) which has prompted a thematic review which will be shared with the Forum. Process with Medical Examiners to scrutinise all deaths occurring at NSFT agreed and in place in Norfolk & Waveney locality. Medical Examiner scrutiny of all community deaths also on track to be in place for April 2024.

Learning Theme 3. Clinical Engagement

The clinical leadership for learning from deaths and for mortality reporting has been strengthened at the trust with the new Board level Governance and Safety advisor leading on clinical engagement internally, with all reporting through the NSFT Quality Assurance Committee. The NSFT Medical Director for Quality attends the ICB Learning from Deaths forum for reporting and learning purposes, as well as to engage and strengthen relationships with all other provider clinicians including the Medical Examiner and Public Health teams.

Learning Theme 4. Partnership Working

Dedicated resources are now available to improve current relationships and partnership working with key organisations e.g., Hospital Bereavement Offices, Coroners and GPs, and access IT systems where the cause of death is available. Data and Information Sharing Agreements are already in place. Access to information held by the Norfolk Registration Service has been agreed through the Norfolk Senior Coroner's Office; this has been supported by the ICB Medical Director. The system LFD Forum provides a platform for partners to collaborate and/or share learning and good practice and discuss staff training needs. NSFT has made progress with embedding links to GP Practices to support information flow.

Learning Theme 5. Improvement Plan Governance and Oversight

The ICB attended a weekly Collaborative Working Group between the two ICBs, NSFT, Norfolk and Suffolk Healthwatch. This meeting has now been subsumed into a new Trust Learning from Deaths Action Plan Management Group which reviews evidence against each recommendation and will include Public Health leads from both Local Authorities.

Broader NSFT Improvement Journey

The new Chief Executive, Caroline Donovan joined the NSFT in November 2023 and has already set four strategic priorities:

Improving Health, Improving Care, Improving Culture, and Improving Value.

The four strategic priorities are underpinned by ten Large-scale change programmes. One of which is learning from deaths.

The new Cheif Executive is happy to attend a future HOSC to update on NSFT's improvement journey.

Conclusion

In conclusion the paper provides a general update on progress in relation to the NSFT Grant Thornton Action Plan, highlighting improvements made by NSFT as well as areas where further work is required. Recognises the intensive and comprehensive work of the Collaborative Working Group and the next steps on how system partners intend to take forward the broader work on learning from deaths.

Appendix 1
Grant Thornton Action Plan 31.05.2023 –updated V14 20.12.2023
Grant Thornton - Norfolk and Suffolk Foundation Trust's mortality recording and reporting report (May 2023) – 16 recommendations.

Grant Thornton - Norfolk and Suffolk Foundation Trust's mortality recording and reporting (May 2023) Improvement Plan.								
DATA								
Number	**Recommendation**	**Priority**	**Management Responsibility**	**Timescale**	**Actions**	**Updates**	**Status -** **Green Completed /On time** **Amber - Timescale slipped but on track for completion** **Red - Outside of timescale**	**Evidence /Reasons for delay**
1	Improve the mortality data pathway to automate and digitise the production of mortality reporting, removing manual processes for transferring and transforming the data, and introducing an audit trail where user interaction is required. The data pathway covers data entry by clinical and service staff, clinical system configuration for capturing and codifying data, export process from clinical systems, data management within data warehouse (or through manual intervention), rules and categorisations applied to support reporting, the presentation of reporting outputs, and	**High**	**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.	The new solution (developed by Seagry and completed and supported by NSFT ICT) went live on the 6th November. Solution remains in early life support – some changes have been made and others requested, which will be handled through appropriate change control. Power BI dashboard is in place. A schedule of all Mortality / Patient Safety reports has been created to ensure all requirements are covered and that all reporting is issued from this central source. **20th December** – Mortality Data Pathway on Sharepoint in place and operational. Early implementation support has been in place since launch date. Sharepoint being used by Mortality and Patient Safety Teams. The mortality dashboard is scheduled to be taken to the Monthly Operations meeting on the 18th January as a formal 'launch' to Care Groups.	**Completed**	

	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.	Seagry are no longer actively involved (although available should support be required). Actions were created and completed with any outstanding being passed to NSFT ICT.	**Completed**	
					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.	**20th December 2023** SOP in final states with anticipated completion date of the 22nd December 2023. This is due to be on the agenda of the Learning from Deaths Group on 19th January 2024 for approval and the GTPMB on the 5th February 2024.		Reason for delay – December 2023. Draft SOP was completed but required updates from changes requested during early life support of the new system.
					4. An audit trail will be incorporated into the process as described in action 1.	Sharepoint has a built-in audit trail of who has inputted information - Completed.	**Completed**	
2	Develop standard operating procedures (SOPs) for each stage of the data recording process, and ensure these are kept up to date	**Medium**	**Executive Lead** Chief Nursing Officer **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding and Medical Director for Quality	6 months- November 2023	1. An overarching SOP will be developed which will detail each stage of the mortality data pathway.	As for Recommendation 1.3 Overarching Flowcharts for data management and inputting by Patient Safety Team and Mortality Team in place. Mortality and Patient Safety SOPs in place Data SOPs require minor amendment following Early Life Support. **20th December 2023** SOP in final states with anticipated completion date of the 22nd December 2023. This is due to be on the agenda of the Learning from Deaths Group on 19th January 2024 for approval and the GTPMB on the 5th February 2024.		Reason for delay – Draft Overarching SOP. December 2023. was completed but required updates from changes requested during early life support of the new system.
					2. The SOP will include roles and responsibilities within the process.	SOPS contain roles and responsibilities	**Completed -**	

Number	Recommendation	Priority	Management Responsibility	Timescale	Actions	Updates	Status	Evidence / Reasons for delay
					3. The SOP will describe the formal change management process when mortality reporting requirements change.			
					4. The Learning from Deaths policy will incorporate the requirements of the SOPs.	Once finalised, links will be incorporated into the policy to lead the reader the SOPS and overarching flowcharts.		**December 2023** – Once Overarching SOP has been approved, the links will be incorporated into the Learning from Deaths policy.
3	Develop reporting tools or method of measuring incomplete data fields to feed back into the organisation, and support training.	**Medium**	**Executive Lead** Chief Finance Officer	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.	IT fields are already mandatory in Lorenzo (where the system allows this to be enacted). In support of this IT Data Quality Dashboard is in place and shared within the Data Quality Group and is accessible through Power BI. This is available to be used as team level to monitor and manage data quality.	Completed for specific action. New action fed into other workstreams.	
			Lead for Delivery Chief Digital Officer		2. To be reported and included in the Care Group Quality and Performance metrics and scrutinised in the Trust's Quality and Performance Meeting.	As for 3.1	**Completed**	
4.	Use the Spine as the definitive reference source of identifying deaths, and update this information on a weekly basis.	**High**	**Executive Lead** Chief Nursing Officer **Lead for Delivery** Chief Digital Officer and Director of Nursing, Patient Safety and Safeguarding.	3 months –August 2023	1. Develop a system that utilises NHS Spine's automatic update to Lorenzo to reduce the need for manual downloads.	As for recommendation 1 Robotic Process Automation has been implemented.	**Completed**	
					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.	NHS Spine data now automatically downloads each day. This has replaced the requirement for a manual download from NHS Spine.	**Completed**	
REPORTING								
Number	**Recommendation**	**Priority**	**Management Responsibility**	**Timescale**	**Actions**	**Updates**	**Status - Green Completed /On time Amber - Timescale slipped but on track for**	**Evidence / Reasons for delay**

							completion **Red - Outside of timescale**	
5	Agree a standardised reporting structure for board reports, to include thematic analysis and consistent presentations of figures, axis and scales. Clearly define the Trust's methodology for mortality recording and reporting within Board reports . Any changes should be clearly documented and the impact upon historically reported figures should be described to provide continuity.	**High**	**Executive Lead** Chief Nursing Officer **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding and Medical Director for Quality	3 months –August 2023	1. The proposed standardised reporting structure for mortality will be presented through the Committee structure and agreed by the Board.	A review of Mental Health Learning from Deaths Board papers available publicly across providers to benchmark/ establish best practice standard that adheres to the National Quality (NHSE) requirements for mortality reporting has been completed. Review of National Learning from Deaths reporting requirements completed	**Completed**	
					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.	Standardised reporting structure presented to the Learning from Deaths group on the 18th November with minor amendments made following feedback. Standardised reporting structure presented GT PMB agenda for meeting on 04.12.23. Minor amendments recommended. First full Learning from Deaths report agreed to be tabled for March/ April Board 2024.	**Completed**	
6	Align the internal dashboard with external reporting to ensure that volumes on the internal dashboard clearly reconcile to numbers within Board reports.	**High**	**Executive Lead** Chief Finance Officer **Leads for Delivery** Chief Digital Officer, Director of Nursing, Patient Safety and Safeguarding and Medical 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.	A schedule of reports has been created to identify all the reports / data that were previously shared internally and externally relating to Mortality. The new Power BI mortality dashboard is in place. The dashboard is live to a limited number of users. This will be made more widely available and communicated to the Care Groups (currently planned January 18th) and the first Board report will be in March 2024. All reporting will come from this dashboard to ensure that it is consistent and reconcilable from Care Group to Board level		

					2. This will be underpinned by the work completed as part of recommendations 1 and 5.	As per update 1		
					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.	Clinical Teams Roadshows are planned to commence in February 2024. This will include team based training with Clinical Team Leaders and Matrons as well as within the Care Group clinical governance meetings. February start date will enable 2 months of data to be available to share with the teams.		Reason for delay. The data within the Mortality dashboard needs to build so it is of benefit to the teams.
					4. The improved dashboard will be supported by the Patient Safety Team and Mortality Team attending Care Group Governance meetings.	As per update 1 and 3		
					5. The newly developed dashboard will be available on the Trust's intranet.	As per update 1		
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	**Medium**	**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.	Trust is part of the ICB LFD (Norfolk) – Public Health and Medical Examiners attend. The Trust has an established working relationship with Public Health England through various forums and work programmes. An additional improvement for focus is to utilise the expertise of Public Health in assisting the Trust to increase the understanding and analysis of our data.	**Completed**	
					2. Learning and themes from NSFT Mortality reviews will be shared with the ICB so wider system learning can be considered.	Once reporting template is ratified by NSFT governance structures, report will be shared through agreed routes. The ICBs attend the Learning from Deaths group and the Mortality Scrutiny Groups. ICB Norfolk and Waveney Learning from Deaths meeting in place	**Completed**	To note, Learning from Deaths meeting for SNEE discussed and remains with the ICB to take forward.
					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.	As per action 11 roadshows and team attendance. Plan to focus on data quality alongside importance for each Care Group to understand place based learning for our population.		Reason for delay – to ensure adequate data is available within the dashboard to demonstrate to teams.

Number	Recommendation	Priority	Management Responsibility	Timescale	Actions	Updates	Status - Green Completed /On time	Evidence / Reasons for delay
					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.	Established as regular agenda point for discussion.	**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**	October 2023 - Meeting has been held with SNEE ICB to progress a Learning from Deaths Forum
					6. NSFT will continue to attend regional and national forums	Attendance at national Learning from Deaths in place. Early discussions have been held with a number of mental health trusts and the Royal College of Psychiatrists to set up a specific national Learning from Deaths forum.	**In Place**	
					7. NSFT to be members of the Norfolk and Waveney ICB LeDeR forum.		**In Place** with meetings occurring monthly - **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 Trust is awaiting data (pending), or the Trust feels this data will not be accessible, or will remain unknown.	**High**	**Executive Lead** Chief Finance Officer (SIRO) and Chief Medical Officer **Leads for Delivery** Chief Digital Officer Director of Nursing, Patient Safety and Safeguarding	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 cause of death' and cause of death not available'.	Clinical Lead in post who will lead on clinical decision making for case selection criteria (which cases need to be subject to a Structured Judgement Review in line with national guidance) and supervise the clinical classification of the cause of death recorded on Sharepoint	**Completed**	
					2. The Mortality process, criteria and screening will describe this requirement as part of the overarching SOP (Recommendation 2).	Process of case selection criteria in place after appropriate committee agreement and follows national guidance. Available on the NSFT Intranet as part of the Mortality SOP (ratified within the LfG Group in October 2023)	**Completed**	

CLINICAL ENGAGEMENT

Number	Recommendation	Priority	Management Responsibility	Timescale	Actions	Updates	Status - Green Completed /On time	Evidence / Reasons for delay

							Amber - Timescale slipped but on track for completion **Red - Outside of timescale**	
9	Establish a process of validation and use of mortality reporting and analysis at service level, aligned to corporate reporting	**High**	**Executive Lead** Chief Finance Officer **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.	As per update for action 1 and 6	**New SharePoint Mortality Data pathway went live on the 6th November 2023**	
					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 new Power BI mortality dashboard is in place. The dashboard is live to a limited number of users. This will be made more widely available and communicated to the Care Groups (currently planned January 18th) and the first Board report will be in March 2024.		Reason for delay – to ensure adequate data is available within the dashboard to demonstrate to teams.
					3. The mortality data will be centrally produced, therefore the data will be consistent from 'Ward to Board'.	As for update stated above in 9.1.	**Completed**	
					4. The dashboard will be available without patient details on the Trust intranet for all staff to review.	As for update stated above in 9.1.		Reason for delay – to ensure adequate data is available within the dashboard to demonstrate to teams.
10	Review the process of retaining patients on caseloads, and subsequent discharge from caseloads, to ensure it results in consistent data across the services	**Low**	**Executive Lead** Chief Finance Officer and Chief Operating Officer **Lead for Delivery** Chief Digital Officer and Deputy Chief Operating Officer	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		
					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.	This links to action 1 and will be finalised and issues once the Sharepoint process is ratified and live. Therefore completion date TBC but will be well within expected time frame		
					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.	Full schedule for this action is next be addressed and will be staggered post 'go live'.		

Number	Recommendation	Priority	Management Responsibility	Timescale	Actions	Updates	Status - Green Completed /On time Amber - Timescale slipped but on track for completion Red - Outside of timescale	Evidence / Reasons for delay
11.	Create supporting training programme for all staff who input data into systems that have an impact upon mortality data. Ensure that the implications and impacts of incorrect or incomplete data entry are understood by staff.	**Medium**	**Executive Lead** Chief Finance Officer **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.	Training is included in the go-live plan for the new Sharepoint process with 3 dates completed during October 2023. In addition, a daily IT, Mortality and Patient Safety Team huddle occurred following the Go Live launch**.**	**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.	As for 11. 1		Roadshows due to commence in February. This will be supported by a 'Learning from Deaths Matters' newsletter
PARTNERSHIP WORKING								
Number	**Recommendation**	**Priority**	**Management Responsibility**	**Timescale**	**Actions**	**Updates**	**Status - Green Completed /On time Amber - Timescale slipped but on track for completion Red - Outside of timescale**	**Evidence / Reasons for delay**
12	Establish links with primary care networks to explore opportunities to improve the completes of the Trust's mortality data (including cause	**Medium**	**Executive Lead** Director of Strategy and Partnerships **Lead for Delivery** Director of Nursing, Patient Safety and	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.	Mortality Team are currently achieving approx. 80% of Cause of Death from various sources. A small number of GP Practices have been identified where the Cause of Death is difficult to obtain. Further attempts are being made to remedy this. If unsuccessful, to be shared with the ICBs	**Completed**	

	of death), supported and enabled by the ICB		Safeguarding, Medical Director of Quality and Director of Operations- (Medical Directorate)		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.	Scoping work already under way to improve the current established relationships with local Acute hospitals Bereavement Offices, Medical Examiner and GP Practice Managers by direct liaison with the key leads/ supported by ICB. **Additional action being undertaken by the Trust** Exploration are ongoing with Registrars office in Suffolk to apply for direct access to CoD for an individual, which will negate the need to have multiple manual processes for establishing cause of death. Timings of this application process are outside NSFT control/ influence- indicative time frame 4-6 months.		
					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.	Update will be through NW ICB LfD forum once information is available. Will work with Suffolk leads specifically until their forum is established.		
13	Explore opportunities for formal data sharing agreements between the Trust and primary and secondary care in the region	**Medium**	**Executive Lead** Chief Finance Officer **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.	Data sharing agreements already in place with Acute Hospitals prior to GT action plan being implemented- completed April 2023	**Completed**	
GOVERNANCE								
Number	**Recommendation**	**Priority**	**Management Responsibility**	**Timescale**	**Actions**	**Updates**	**Status -** **Green Completed /On time** **Amber - Timescale slipped but on track for completion** **Red - Outside of timescale**	**Evidence / Reasons for delay**

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.	High	**Executive Lead** Chief Nursing Officer and Chief Medical Officer **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding, Medical Director for Quality and Director of Operations – (Medical Directorate).	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.	The Learning from Deaths Policy has been updated to reflect the action. Policy has been presented to the Learning from Deaths Group in October 2023 and will now be presented to the Clinical Governance Group in December.	**Completed**	
					2. The Learning from Deaths policy will be supported by a 'policy on a page' which will be available to all staff.	In progress		Reason for delay – Learning from Deaths policy updated and signed off which enables the development of a Policy on a Page.
					3. The circulation of information and learning bulletins 'Learning from Deaths Matters' will be published and disseminated throughout the Trust.	This will be incorporated in to the Roadshows commencing in February 2024.		
					4. This will be supported by learning events.	As for 14.4		Due to commence in February 2024
15	Establish a clear improvement plan to address the issues identified in this report, and report progress to a board committee	High	**Executive Lead** Chief Nursing Officer and Chief Medical Officer. **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding, Director of Operations- (Medical Directorate) and Medical Director of Quality	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.	Initial oversight of work that was taking place prior to the GT action plan being published was reported through Executive team, supported by CMO and CNO. Separate formal Programme Board has been commenced with CEO as Chair. This will run monthly as a Programme Management Board which includes Executive and Delivery Leads for the duration of the live action plan.	**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	High	**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. Audit timetable will be ratified once Sharepoint process goes live. Therefore date TBC- please cross reference to action 1.		

	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				2. External verification will be sought by an external consultancy team who are experienced in data within the NHS.	Consideration currently underway source expert on mortality patient data review to provide assurance over the accuracy of data recording.	This action has been dependent on the implementation of the data pathway	

Appendix 2

Trust Learning from Deaths Action plan Management Group

TERMS OF REFERENCE

1.0 CONSTITUTION

1.1 The Trust Learning from Deaths Action plan Management Group will be accountable for executive oversight and seeking assurance on the progress of actions resulting from:

- The Grant Thornton report Action plan
- Any outstanding actions from the Verita report action plan
- Recommendations 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

1.2 The Group will provide the governance framework for the reporting of progress to the CEO/Trust Management Group, The Trusts Quality Committee and Integrated Care Boards (ICB'S) Quality Committees.

2.0 PURPOSE

2.1 Providing a governance framework for executive oversight on progress of the respective action plans

- To drive improvement (engine room) through receiving updates on the progress of each actions against trajectory from the Executive Lead or deputy each meeting which details progress to date, emerging risks and issues requiring support from the Group to achieve the required actions within the stated timeframe.

3.0 MEMBERSHIP

3.1 Governance and safety Advisor (Chair)
Chief Medical Officer (Deputy Chair)
Chief Nurse
Chief Operating Officer
Norfolk Healthwatch
Suffolk Health Watch
Lived Experience Representatives including bereaved relatives
Head of carers participation and experience

SNEE and N&W ICB Quality/Safety Representatives
Chief Digital Office
Head of Legal Services
Nominated members of the Mortality and Patient Safety Teams.
Communications Lead.
Administration Support.

The above will be the core the membership with the flexibility to co-opt others to attend the meeting where appropriate.

3.2 The Group will be considered quorate when the Chair or nominated deputy, two Executive directors, one lived experience representative and representatives from the Mortality and Safety teams are present.

4.0 ATTENDANCE AT MEETINGS

- All members are expected to attend – absenteeism is an exception.
- Meetings will start and end on time.
- Papers to be presented should be concise, with cover sheet and required outcomes, a long document may be circulated for more detailed information where appropriate.

4.1 Authority to cancel meeting: Chair or Deputy Chair

5.0 FREQUENCY OF MEETINGS

5.1 Meetings will be held monthly and for a duration of two hours.

6.0 AUTHORITY

6.1 To act on behalf of the Trust Management Group making decisions, where appropriate in relation to scrutiny and sign off of action plans within the Groups terms of reference.

7.0 DUTIES AND RESPONSIBILITIES

7.1 Ensuring collective and individual responsibility and accountability for the successful delivery of the agreed actions and any emerging safety risks.

- Clear decisions made and then properly communicated.
- Clear recommendations to the Trust Management Group meeting on key risks, issues and decisions.
- Provide rigorous scrutiny of the evidence underpinning actions being progressed.

- Following the above responsibility, agree actions have been achieved and if sign off can be approved.
- Decisions which are unresolved within the meeting will be escalated to the Trust Management Group for resolution.
- To identify and share with the Trusts Learning from deaths group any learning and ensure sharing of good practice.

8.0 ACCOUNTABILITY AND REPORTING

8.1 The Group is accountable to, and reports to the Trust Management Group. The group also reports into the trust Quality Committee and the two ICB Quality Committees (via the ICB Learning from Deaths forum)

9.0 COMMITTEE SECRETARY

9.1 The Medical Directorate Business manager will support the meeting administration and update of relevant documents.

- Request for updates, risks and completion trajectory will be requested from each of the Executive Leads and Delivery Leads 7 working days prior to the meeting.
- Notes of the meeting will be taken detailing required actions.
- An action log will be completed and presented at each Group meeting.
- An updated action plan and meeting papers will be circulated 5 working days before the Group for consideration.

All papers relating to the meeting and evidence of completion of actions will be held in a central document repository.

10.0. Review

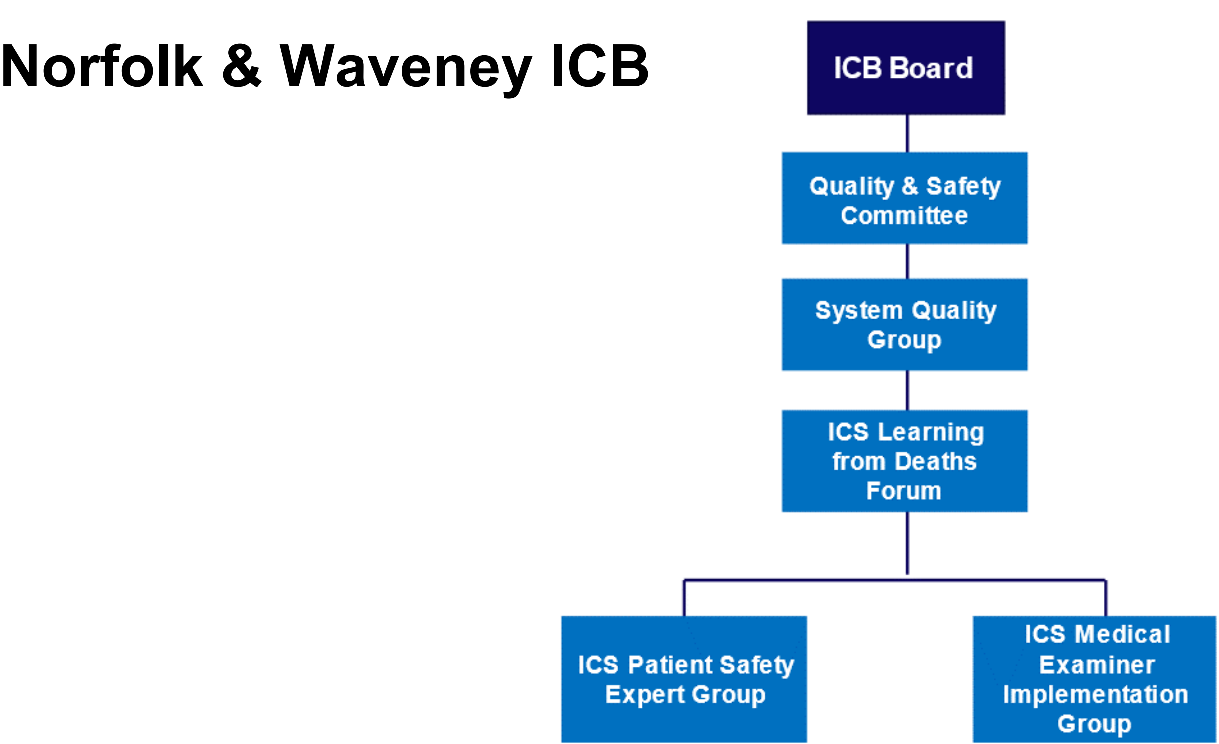
10.1 End of March 2024

Date Approved: 02/01/2024

Review: Initial review end of March 2024

DRAFT SNEE ICB QUALITY STRUCTURE

Learning from Deaths Reporting Structure



NSFT Quality Structure

Appendix B

Briefing note for Norfolk Health Overview and Scrutiny Committee.

Title: Grant Thornton Review Action Plan

Date: 24 October 2023

Author: Tricia D'Orsi, Executive Director of Nursing, NHS Norfolk and Waveney

NHS Norfolk and Waveney and NHS Suffolk and North East Essex Integrated Care Board's, at the request of the Norfolk HOSC, are taking the lead on developing an action plan to ensure the action plan, published by NSFT at the same time as the Independent Audit of Mortality Data, is taken forward and owned by individuals and organisations supporting mental health transformation across Norfolk and Suffolk. This is a vital piece of work, which is intended to help improve both confidence and trust in the gathering, processing and reporting of Mortality Data within Norfolk and Suffolk NHS Foundation Trust. This endeavour will be underpinned by a principle of co-production with bereaved families.

To date, a group has been established and will meet weekly. Membership is as follows:

- Caroline Aldridge, Forever Gone (author)
- Anne Humphry's, Forever Gone (author)
- Andy Yacoub, CEO, Healthwatch Suffolk
- Alex Stewart, CEO, Healthwatch Norfolk
- Tumi Banda, Interim Chief Nurse, Norfolk and Suffolk NHS Foundation Trust
- Alex Lewis, Medical Director, Norfolk and Suffolk NHS Foundation Trust
- Tricia D'Orsi, Executive Director of Nursing, NHS Norfolk and Waveney
- Dr Frankie Swords, Executive Medical Director, NHS Norfolk and Waveney
- Dr Andrew Kelso, Medical Director, NHS Suffolk and North East Essex

The new group established to oversee the development of the action plan has met and will meet on a weekly basis, with regular communication to provide assurance amongst the group.

At the last Norfolk Health Overview and Scrutiny Committee's which took place in September 2023, an action was agreed to produce an action plan to demonstrate how the action plan, published with the Independent Audit of Mortality Data would be overseen and delivered.

This briefing note formally requests an extension to the original deadline of October to ensure that a comprehensive and robust action plan is developed to help oversee, with confidence, that the action plan connected with the Independent Review of Mortality Data can be delivered in a timely and effective way, making sure there is direct input from relevant individuals, organisations, as well as those with lived experience of bereavement that is, families and carers. This will ultimately ensure that partners, stakeholders, patients, families and carers have more confidence in

both Norfolk and Suffolk NHS Foundation Trust and both wider integrated care systems ability to gather, process and report accurate data. The group request that an extension is granted to 9 November 2023.

This is a very serious and important action plan and it is vital we take the time to get this right. If this request is granted, the group will continue to meet between now and 9 November 2023, at which point, a fuller, updated briefing and action plan will be available and shared with the Health Overview and Scrutiny Committee’s of Norfolk.

Norfolk Health Overview and Scrutiny Committee

Proposed Forward Work Programme 2023/24

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. The NHOSC reserves the right to reschedule this draft timetable.

Meeting dates	*Main agenda items*	*Notes*
18 January 2023	**Digital transformation strategy** An examination of N&WICB's digital transformation strategy as part of its vision to develop a fully integrated digital service across Norfolk and Waveney. To include information about the Electronic Paper Record. **Norfolk and Suffolk NHS Foundation Trust (NSFT) Mortality Recording and Reporting Review** An update on actions and activity since the previous discussion at committee in September 2023. **Forward work plan workshop** Planning workshop for agenda and briefing items for 2024.	

Information to be provided in the NHOSC Members' Briefing 2023/24

2023 - **Public Health** – an overview of people's health in Norfolk. TBC.

NHS 111 – an overview of NHS 111 local performance (N&WICB). TBC.

\- **Care Homes At Scale (CHAS**) – an overview of the services/support offered by CHAS. TBC.

Future topics for re-consideration (meeting or briefing) following previous meetings/briefings:

- Major Trauma Unit (MTU) at the Norfolk and Norwich Hospital
- ambulance service
- proposed closure of Holt Medical Practice's branch in Blakeney – update
- proposed closure of Manor Farm Medical Centre in Narborough – update
- widening participation/staff retention workforce strategy

Further topics for future briefings as discussed at January's FWP workshop:

- speech and language therapy
- focus group re. LGBT+ health services
- Change Grow Live (CGL) addiction services
- blood donation
- Carers Identity Passport
- vaping (to be examined at People and Communities Select Committee)
- new hospitals programme
- cancer services for people with disabilities

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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