HEALTHWATCH HERTFORDSHIRE – HOLDING TO ACCOUNT
ACTION RE: LETBY VERDICT
RESPONSES FROM LOCAL TRUSTS AND THE ICB

Introduction

Following the tragic events at the Countess of Chester hospital, Healthwatch Hertfordshire's Board discussed the issues and implications and wanted assurance for people using health services in Hertfordshire that similar incidents would be prevented, identified and dealt with by all providers. Not all Trusts provide Neonatal services but actions following the Letby Verdict and resulting concerns seemed appropriate to all providers.

In September we wrote to all local Trusts where Hertfordshire residents access health and care services and the Herts and West Essex Integrated Care Board.

This included:

A. Central London Community Healthcare NHS Trust
B. East and North Hertfordshire NHS Trust
C. Herts Community NHS Trust
D. Hertfordshire Partnership University Foundation Trust
E. The Princess Alexandra Hospital NHS Trust
F. West Herts Teaching Hospitals NHS Trust and
G. The Herts and West Essex Integrated Care Board

A range of questions were set out in our letter, including reference to the requirements set out by NHS England in a letter they sent to all Trusts and ICBs in August 2023, asking how Trusts and the ICB intended to respond and act in relation to all the issues covered.

Below you will find a table setting out the responses from the organisations to each question that was asked.

Also, links to individual verbatim responses from each organisation are included at the end of this report. For the purpose of identification we have labelled the organisations listed above from A – G.

Next Steps

Through our regular meetings with Leaders of Local Trusts and the ICB we will continue to Hold to Account and monitor progress against new and proposed measures to secure public reassurance to both protect the public in Hertfordshire who use health and care services and to ensure staff have the right tools and process, protection and confidence in speaking up.

Note: Herts County Council's Health Scrutiny Committee concurrently approached neo natal providers in Hertfordshire with a range of questions focused on reporting and protection for whistleblowers. Those results can be found on their website **here.**

Question 1. **Freedom to Speak Up Policy.** All organisations providing NHS services are expected to adopt the updated national policy by January 2024. Has your organisation adopted the updated policy?
Responses
Central London Community Healthcare (CLCH)
The Trust is currently updating our Freedom to Speak Up Policy to ensure it aligns with the NHSE Policy. (6 November 2023)
East and North Hertfordshire NHS Trust (ENHHT)
We have already adopted the National Speak Up policy published by NHS England. This policy was also endorsed by Trust Board in Sept 23.

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Herts Community NHS Trust (HCT)
HCT has a dedicated Freedom to Speak Up Guardian (FTSUG), a diverse team of FTSU champions and a dedicated policy.
Hertfordshire Partnership University Foundation Trust (HPFT)
The Trust is compliant with all the requirements set out in the letter from NHS England dated 18 August 2023, and our Freedom to Speak up policy reflects the national policy.
West Herts Teaching Hospitals NHS Trust (WHHT)
Although not directly responded to by the Trust their policies around Freedom to Speak up are outlined in separate documents.
The Princess Alexandra Hospital NHS Trust (PAH)
Not specified in response.
Herts and West Essex Integrated Care Board (HWEICB)
It is important to note that the process of identifying and implementing learning for the NHS arising from the Countess of Chester case began once the details of what had occurred began to emerge, rather than at the time of the recent trial. Including the introduction of the "Freedom to Speak up Guardian role and service since the Countess of Chester. Our response also sets out the current Freedom to Speak Up (FTSU) processes that exist within the Integrated Care Board, and provider colleagues have set out their own arrangements in their own responses. In addition to the work happening in our individual organisations we are also working collaboratively with partners to ensure we have a joined-up system-based approach and processes which support staff to speak up when they have a concern.

Question 2. Freedom to Speak Up Policy. Do all staff have access to information on how to speak up?
Responses
Central London Community Healthcare (CLCH)
All staff have easy access to information on how to speak up. Information is available through the Trust Intranet outlining all of the avenues to support staff which includes – Patient Safety, Human Resources, Staff Side, Line Managers, Senior Leadership team and a Trust Freedom to Speak Up Guardian supported by a number of Freedom to Speak Up Champions. Following the verdict, we placed an article in our monthly Spotlight on Quality bulletin to remind staff of the support available with contact details and sign posting. As part of Speaking up month in October 2023, we also held webinars for staff on Listening Up (aimed at managers), raising concerns about safeguarding and raising concerns in relation to health and well-being.
East and North Hertfordshire NHS Trust (ENHHT)
A culture of openness In the last year, East and North Hertfordshire NHS Trust have appointed a full time, Freedom to Speak Up Guardian, who was previously a Neonatal Matron. Her work has led to a doubling of concerns being expressed. Additionally, there is a confidential email for staff, 'Ask Adam' email that empowers any member of staff to raise any matter of concern, whether clinical or non-clinical, directly with myself as the chief executive. **A senior leadership team that listens to clinicians** On a daily basis, members of the executive team spend time in clinical areas talking with staff. This enables them to be aware, in real time, of what is happening clinically, of pressures experienced by staff and of incidents as they occur. The

Director of Nursing and Medical Director also take part in chairing the Serious Incident Review Panel and therefore have oversight of potential serious incidents within the organisation.
Herts Community NHS Trust (HCT)
All staff have access to the intranet which includes details of how to raise concerns and contact details for FTSU ambassadors and Guardian plus Executive Lead and Non-Executive Lead.
Hertfordshire Partnership University Foundation Trust (HPFT)
We have a full time Freedom to Speak Up Guardian, supported by an active group of Freedom to Speak Up Champions all based in services, where staff can readily access support and the ability to raise concerns.
West Herts Teaching Hospitals NHS Trust (WHHT)
To ensure that the Trust is promoting an open and transparent culture, it has put on several promotions over the last 18 months to advertise the FTSU service, including a presentation to introduce the Trust's FTSU Guardian, information leaflets, manager guides, an introduction video and training module, and the introduction of a QR code that allows staff easy access to guides, contact details and processes in the easiest and fastest way possible. The senior leadership team operates an open-door policy and the Chief Nurse, Chief Medical Officer and Chief People Officer take part in regular walkabouts to provide visibility to staff and allow for open and transparent conversations to happen. Non-Executive Directors do monthly walkabouts prior to Board meetings, as well as unplanned visits and discussions with staff and patients. In addition, there are planned nighttime walks with senior staff and Non-Executive Directors. The Chief Executive regularly offers the opportunity for staff to meet with him and talk about the issues that are affecting them. The Trust has a Senior Independent Director in place. This Non-Executive Director has a key role in supporting the Chair and is

available for Board members to raise any concerns which have failed to be resolved through the normal channels or for which such contact is inappropriate.
The Princess Alexandra Hospital NHS Trust (PAH)
Introduction of the Freedom to Speak up Guardian role and service. Different approaches adopted by different Trusts; at PAHT we now have a lead guardian, 3 other guardians who are clinical and 11 Freedom to Speak up Ambassadors to support the raising of concerns across the organisation by all colleagues.
Herts and West Essex Integrated Care Board (HWEICB)
Since March 2023, the ICB has employed a highly qualified and experienced Freedom to Speak Up (FTSU) Guardian for workers within the ICB. Our FTSUG has significant experience of delivering and enhancing FTSU provision in other Trusts. Their core focus since commencement has been on enhancing the FTSU provision and understanding of the same for all ICB workers. Information of how to speak up is widely available and publicised throughout the ICB, this includes: 1. Dedicated contact information available through the staff intranet. 2. Regular publicity around Freedom to Speak Up with reminders of the variety of ways that ICB workers can speak up within and outside the ICB. 3. A dedicated policy, accessible to all, which includes information on how to speak up both internally and externally. 4. A diverse network of FTSU Champions by geographic location, professional group and protected characteristics who increase visibility and promotion of the FTSU agenda throughout the ICB. 5. Significant promotion and embedding of freedom to speak up training, including target audiences and capacity to monitor uptake and take such further action as required in response to the same. 6. A core slot for the FTSUG within Corporate Induction sessions. The Integrated Care Board is currently working with system partners to develop our approach to FTSU as a system. In particular we are focusing on ensuring we take a collaborative, cross system approach to ensuring there are robust routes for staff to speak up across our providers and within primary

care. This will be in addition to a significant amount of work already taking place which the provider organisations will have detailed in their response. FTSU is just one element of ensuring there are sufficient routes for concerns to be raised.

A further key area where the ICB will have oversight and assurance regarding patient safety concerns is the PSIRF, the new approach to patient safety incident investigation and learning responses requires curiosity and challenge in a supportive manner to empower open and transparent conversations about learning from incidents. From Autumn 2023 all main NHS Trusts are implementing the PSIRF which replaces the Serious Incident Framework (2015).

The ICB is working across our local system to ensure robust processes are in place for provider Boards to have oversight and ICB to be sighted on key information, trends and learning from the new approach to learning from patient safety incidents. You can find out more on the Patient Safety Incident Response Framework **here**

Question 3. Freedom to Speak Up Policy. Are all relevant departments, such as Human Resources, and Freedom to Speak Up Guardians aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme?
Central London Community Healthcare (CLCH)
Relevant staff are aware of the National Speaking Up Support Scheme and actively refer individuals to the scheme as appropriate. The Trust Freedom to Speak Up Lead also works with the London Network of Freedom to Speak Up Guardians, sharing good practice, and enabling staff to feel valued for having raised their concerns in CLCH as required.

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East and North Hertfordshire NHS Trust (ENHHT)
We are aware of the national speaking up support scheme. Since April 2022, no staff member who has spoken up has reported detriment. This scheme is primarily for staff who have lost jobs as a result of speaking up or staff who felt compelled to leave the organisation due to consequences of speaking up and have not been able to move on or secure another job. No staff member since April 2022 has reported to a speak up champion that they are resigning due to detriment in response to speaking up.
Herts Community NHS Trust (HCT)
Yes – aware – but to date not aware they have referred any individuals.
Hertfordshire Partnership University Foundation Trust (HPFT)
We have an active campaign for 'speaking up' including a reminder to all new starters that the ask of them is not to walk by poor practice or poor behaviour, but to call it out. Although already in place, since Letby we have again increased our communication to staff, service users and families on how to raise concerns.
West Herts Teaching Hospitals NHS Trust (WHHT)
The Trust has a part time Freedom to Speak Up Guardian alongside a Non-Executive Director FTSU lead, who is a senior, independent lead and predominantly a support for the FTSU Guardian. This role offers a fresh pair of eyes to ensure that investigations are conducted with rigor and to help escalate issues, where needed. Both roles are vitally important allowing impartial, confidential and a safe space to escalate any concerns staff may have. The Trust has 36 FTSU champions that provide support to staff and work with the FTSU Guardian. To ensure that the Trust is promoting an open and transparent culture, it has put on several promotions over the last 18 months to advertise the FTSU service, including a presentation to introduce the Trust's FTSU Guardian, information leaflets,

manager guides, an introduction video and training module, and the introduction of a QR code that allows staff easy access to guides, contact details and processes in the easiest and fastest way possible.
The Princess Alexandra Hospital NHS Trust (PAH)
Introduction of the Freedom to Speak up Guardian role and service. Different approaches adopted by different Trusts; at PAHT we now have a lead guardian, 3 other guardians who are clinical and 11 Freedom to Speak up Ambassadors to support the raising of concerns across the organisation by all colleagues.
Herts and West Essex Integrated Care Board (HWEICB)
The FTSUG, Human Resources are aware of the national Speaking Up Support Scheme and the requirements and rules associated with it in terms of referring individuals and would make use of this as appropriate.

Question 4. Freedom to Speak Up Policy. Are approaches or mechanisms put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.
Responses

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Central London Community Healthcare (CLCH)
The Freedom to Speak Up Guardian has embarked on an engagement programme with all staff groups as part of a "Know your FTSU" campaign with a view to supporting staff voice and promoting the Speaking Up agenda. Mechanisms are in place to support staff who may have cultural barriers to speaking up include a 'whats app' group for our internationally recruited staff, a regular meeting with the International Recruitment team, and a pastoral support role for international recruits who is available for any support. We have implemented pastoral/induction facilitators in each division to support staff and to provide a buddy scheme for all new starters. We have a new staff side led bullying and harassment hotline for staff to contact anonymously and an active tackling unacceptable behaviour campaign In place. For staff working unsociable hours, we have dedicated email addresses for staff to use to raise a concern and out of hours, an on call system if needed.
East and North Hertfordshire NHS Trust (ENHHT)
A culture of openness In the last year, East and North Hertfordshire NHS Trust have appointed a full time, Freedom to Speak Up Guardian, who was previously a Neonatal Matron. Her work has led to a doubling of concerns being expressed. Additionally, there is a confidential email for staff, 'Ask Adam' email that empowers any member of staff to raise any matter of concern, whether clinical or non-clinical, directly with myself as the chief executive. The professional nurse advocate role is being introduced into neonatal services to increase support, hear the voices of staff and to offer restorative supervision sessions.
Herts Community NHS Trust (HCT)
All staff can access the intranet 24 hours per day for information – training has been rolled out as mandatory for all staff to ensure aware of processes and available support. FTSU Ambassadors recruited through HCT's staff network groups as well

as usual trust communication channels to improve diversity across the geography, professional roles and protected characteristics across the trust. FTSU Guardian also attends staff networks and corporate induction.
Hertfordshire Partnership University Foundation Trust (HPFT)
We have put systems in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so. Also, for those who work unsociable hours and may not always be aware of, or have access to the policy or processes supporting speaking up.
West Herts Teaching Hospitals NHS Trust (WHHT)
Any concerns that are raised are reported to the Chief Nurse and Chief People Officer to provide assurances that, as a Trust, we are listening to staff who have concerns and that matters are being addressed in a fair, open and transparent way without risk of reprisal. The FTSU Guardian can access support from the NED FTSU Guardian if there are any concerns. Executive Directors do monthly walkabouts prior to Board meetings, as well as unplanned visits and discussions with staff and patients. In addition, there are planned nighttime walks with senior staff and Non-Executive Directors. The Chief Executive regularly offers the opportunity for staff to meet with him and talk about the issues that are affecting them. The Trust has a Senior Independent Director in place. This Non-Executive Director has a key role in supporting the Chair and is available for Board members to raise any concerns which have failed to be resolved through the normal channels or for which such contact is inappropriate. As above, the executive team regularly spends time in clinical areas talking to staff. This ensures that in real time, they are aware of what is happening clinically and what pressures the staff are facing. The executive team also do nighttime walks to ensure they are visible to all staff, including those that work night shifts and can see the pressures which may not be apparent when working in the daytime. om the NED FTSU Guardian if there are any concerns.

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The Princess Alexandra Hospital NHS Trust (PAH)
Introduction of the Guardian of Safer Working role to support doctors in training in raising concerns about anything and supporting them with their working hours, shift patterns and access to relevant learning In terms of immediate actions, locally, we have discussed the Letby verdict in one of our weekly all staff briefings including highlighting to colleagues how they can raise concerns, encouraging them to do so and asking colleagues to speak to the Patient Safety and Quality teams if they feel any patient safety concerns or incidents raised have not been fully addressed. This message has also been communicated via email to all colleagues. Our next Senior Management Team meeting is tomorrow and there is an item on this agenda to discuss our collective actions post the Letby enquiry. This will focus particularly on: • how all our senior managers support colleagues in their divisions to have easy access to information on how to speak up and • how we will all support ensure the right culture is in place so that line managers can ensure approaches are in place to support all colleagues to speak up, regardless of their band, role, cultural background or shift pattern. • Introduction of the Guardian of Safer Working role in every Trust to support doctors in training in raising concerns about anything and supporting them with their working hours, shift patterns and access to relevant learning.
Herts and West Essex Integrated Care Board (HWEICB)
Since commencement in post in March 2023, the dedicated FTSUG has prioritised enhancing the FTSU provision and understanding of the same for all ICB workers, including those who may have cultural barriers to speaking up etc. This work has included:

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1. setting up dedicated and confidential systems for workers to raise speaking up matters directly with the FTSUG. 2. wide and frequent publicity around the new FTSUG and dedicated contact details.
3. an extensive round of presentations with a wide variety of teams within the ICB helping to increase understanding and expectation of good/best practice speaking up culture, including reaching out to those who can face additional barriers to speaking up through, for example the staff partnership forum, staff networks and targeted work with specific professional groups.
4. creating new confidential systems for recording and reporting on speaking up matters raised directly with the FTSUG (for both internal and external purposes).
5. seeking to work closely and collaboratively throughout the ICB and particularly with those involved in Equality, Diversity and Inclusion, Partnership forum and Race Equality Improvement Network to ensure that workers are aware of the wide variety of parties within the ICB they can speak up to (including the FTSUG) and to address specifically any particular barriers identified by them or members of such forums.
6. Ensuring that the ICB continues to strengthen a business as usual/multi-track approach to speaking up noting in all publicity/presentation work, the wide variety of people with which ICB workers can raise speaking up issues.
7. Setting up systems for anonymous gathering of demographic data across the range of protected characteristics from those raising speaking up matters directly to the FTSUG. Such information to be included within internal FTSU Board level reporting.
8. Preparation and promotion of Speak Up month around the national theme of Breaking Barriers, including designing events that specifically seek to stimulate discussion, identify and consider what actions may be needed to address any barriers to speaking up that might exist for particular groups within the ICB.
9. Refresher training, support and promotion of the diverse network of FTSU Champions to ensure that they increase visibility and promotion of the agenda and provide a number of initial points of contact.

Question 5. Freedom to Speak Up Policy. Are Boards seeking assurance that staff can speak up with confidence and whistleblowers are treated well?
Responses
Central London Community Healthcare (CLCH)
There are a number of avenues for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up. This includes staff networks and professional conferences, a monthly bulletin – Spotlight on Quality and Spotlight on People (alternate each month), a bullying and harassment hotline, CEO connect events held by the Chief Executive and Executives held in local boroughs, Clinical visits to teams from the Senior Leadership teams, divisional and local team meetings and, health and wellbeing seminars. We have also developed a new wellbeing conversations digital handbook and template to support staff in their wellbeing conversations and to make note of the wellbeing support they require and develop a personalised wellbeing action plan. Active Bystander training continues to be implemented to help promote a psychologically safe culture in which staff feel safe to speak up and tackle inappropriate behaviour. The aim is to deliver 2 sessions/month. Each session is 75 minutes in total and delivered via MS Teams. Staff attend 1 session only.
East and North Hertfordshire NHS Trust (ENHHT)
Yes. ENHT's Board supported the creation of a full-time Freedom to Speak Guardian role who has been in post for over a year. Approval of the Freedom to Speak Up and Whistleblowing policies have been intentionally reserved to Board under the Trust's Scheme of Reservation and Delegation given the importance of functions in the context that only five other Trust

policies are viewed as sufficiently sensitive to warrant being reserved to Board. This ensures that the Board is fully sighted on how the FTSU and whistleblowing processes work. In addition, the Board receives regular reports. The Trust also created a People Committee in May 2022 to further drive HR standards. The FTSU Strategy was considered by the Trust Board Seminar in the last year. The FTSU policy was reviewed and approved by the Board in the last year. FTSU is on the annual Board cycle and a report was received on good progress in the last year.

Herts Community NHS Trust (HCT)

The FTSUG prepares and delivers reports to the Quality Committee and then Full Board. These reports provide opportunities for the sub-committee and Board to hear about internal work and developments, as well as receiving anonymous quantitative and qualitative data about casework contacts (including for example, speaking up themes/categorisation, staff groups, demographics, actions taken, learning and feedback) and consider recommendations from the FTSUG. These reports also include coverage of key national developments in FTSU provision. The reports, alongside other reporting, (in particular in relation to Patient Safety, Human Resources, Equality, Diversity and Inclusion and worker wellbeing) and the NHS Staff Survey, provide a strengthened framework for the Board to reflect and consider what further actions they feel are necessary to strengthen confidence and assure themselves that whistle-blowers are treated well throughout the Trust.

Hertfordshire Partnership University Foundation Trust (HPFT)

From the outset we have supported staff affected by the Letby case, emphasising the wellbeing support available, the different routes to raise concerns and need to always be curious and challenge practice.

Our Integrated Governance Committee and Trust Board receive regular reports on the Freedom to Speak Up concerns that have been received. The reports provide an analysis of trends, the services involved and timescales to resolve. It is worth noting that the number of anonymous concerns raised is very small and has decreased over recent years, evidence that those raising concerns are happy to do this freely and be involved in the resolution. It is also worth noting that despite the

national coverage, and indeed our own campaign, we have not seen a rise in the number of Freedom to Speak Up cases since the outcome of the court case, but we continue to monitor the situation closely
West Herts Teaching Hospitals NHS Trust (WHHT)
Non-Executive Directors do monthly walkabouts prior to Board meetings, as well as unplanned visits and discussions with staff and patients. In addition, there are planned nighttime walks with senior staff and Non-Executive Directors. The Trust has a Non-Executive Director who is the Board lead for maternity. He acts as a Maternity Champion and has strong links with the maternity unit, engages regularly with maternity staff at all levels and attends maternity meetings. The Trust is in a transitional stage of introducing a different approach to managing and learning from both patient safety incidents and those related to employee relations. This will be in line with the new Patient Safety Incident Response Framework (PSIRF). Our ambition is to establish a restorative, just and learning culture within the organisation, one that promotes no blame, psychological safety and quality improvement without jeopardising accountability. On a Board level, the People, Education and Research Committee provides assurance to the Board on the FTSU policy and the number of cases. The Board receives a regular report on FTSU and the Guardian comes to Board meeting to provide assurance on this. The Audit Committee through the annual work programme provides oversight and scrutiny on the policy, implementation and support to the FTSUG. A Board Development Session was held in July 2023 which was supported by the National FTSU Guardian. The Board also supports the annual National Freedom to Speak up Month.

The private section of the Trust Board regularly receives a report on employment tribunals and maintaining high professional standards. This provides an overview of current employment tribunal activity and a summary of all cases within the remit of maintaining high professional standards framework for doctors and dentists, as well as updates on restrictions and exclusions.
The Board receives a quarterly paper in the private section of the meeting on the National Perinatal Mortality Review Tool (PMRT). This provides evidence of assurance that the Trust is meeting its requirements and is in line with Safety Action 1 in the Maternity Incentive Scheme (MIS) Year 4. The latest report is part of this Board meeting pack (07 September 2023).

As part of September 2023's Board meeting, the Board received an annual report on the work of the Trust's safeguarding team. In 2022/23, the Integrated Care Board undertook a joint section 11 assurance audit of the Trust's safeguarding service. This concluded that the Trust had immense commitment to ensuring safeguarding is embedded in all areas of the organisation promoting the health, safety and welfare of children, young people and adults that access its services. The safeguarding service was graded good to outstanding.

In July 2023, the Public Trust Board meeting approved an action plan which addressed recommendations from an independent well-led review of the Trust's leadership and governance arrangements. The review was undertaken by Deloitte in 2022/23. Feedback from the review was positive and it was noted that the Trust had enjoyed high levels of stability in Board leadership over recent years and the Board was functioning at a mature level. In particular, it highlighted the excellent work the Trust had done to embed its clinically led triumvirate model, as well as a range of initiatives that has positively influenced the Trust's culture. The review acknowledged that the Trust had strong foundations in place to continue its journey toward becoming a CQC 'outstanding' trust in the well-led domain and noted it was on a positive trajectory.

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The Princess Alexandra Hospital NHS Trust (PAH)
In terms of immediate actions, locally, we have discussed the Letby verdict in one of our weekly all staff briefings including highlighting to colleagues how they can raise concerns, encouraging them to do so and asking colleagues to speak to the Patient Safety and Quality teams if they feel any patient safety concerns or incidents raised have not been fully addressed. This message has also been communicated via email to all colleagues. Our next Senior Management Team meeting is tomorrow and there is an item on this agenda to discuss our collective actions post the Letby enquiry. This will focus particularly on: • how all our senior managers support colleagues in their divisions to have easy access to information on how to speak up and • how we will all support ensure the right culture is in place so that line managers can ensure approaches are in place to support all colleagues to speak up, regardless of their band, role, cultural background or shift pattern. This will require ongoing dialogue and review rather than just a one-off discussion. At PAHT we will be reviewing all our current process for raising concerns and reporting incidents to ensure that they are all as tight as they can be and that all relevant learning is taken from these. We will make any changes to the processes as relevant to strengthen them in line with the new national Patient Safety Incident Response Framework (PSIRF.) There will also be a range of Trust specific developments and enhancements to local processes related to the management and understanding of risk and governance and openness in reporting and escalation.
Herts and West Essex Integrated Care Board (HWEICB)
1. The FTSUG produced and agreed a workplan through our Audit and Risk committee in May 2023 to cover the initial 6 months setting out initial priorities as well as FTSU Board reporting arrangements for the future.

2. The FTSUG reports will be delivered to both the Audit and Risk Committee and then to the full ICB Board. This will provide opportunities for the sub-committee and Board to hear about internal work and developments, as well as receiving anonymous quantitative and qualitative data about casework contacts (including for example, speaking up themes/categorisation, staff groups, demographics, actions taken, learning and feedback) and consider recommendations from the FTSUG. These reports will also include coverage of key national developments in FTSU provision. The reports, alongside other reporting, (in particular in relation to Human Resources, Equality, Diversity and Inclusion and worker wellbeing) will provide a strengthened framework for the Board to reflect and consider what further actions they feel are necessary to strengthen confidence and assure themselves that whistle-blowers are treated well throughout the ICB.
3. 3. The FTSUG reports directly to the Director of Performance and also has a close working relationship with the Non-Executive Director for FTSU and meets with both parties on a regular basis to keep them informed about work undertaken both within and outside of the agreed workplan. Within the bounds of confidentiality arrangements, the FTSUG also utilises these meetings to discuss any existing casework matters.
4. The FTSUG has discussed and agreed structures for the escalation of casework matters raised to ensure that there are clear lines of accountability for addressing the same.

Question 6. Freedom to Speak Up Policy. Are Boards regularly reporting, reviewing and acting upon available data?
Responses

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Central London Community Healthcare (CLCH)
Meetings are taking place monthly with the Freedom to Speak Up Guardian, Deputy Chief Nurse and Director of Patient Safety and Quality and Associate Director of Safeguarding to triangulate concerns being raised by staff and take action where any themes are emerging. The Trust Board also receive regular reports on speaking up through specific Quality, Safeguarding and HR reports in addition to a specific FTSU report presented to the Trust People Committee and Trust Board.
East and North Hertfordshire NHS Trust (ENHHT)
Mortality Surveillance and Learning from Deaths The Trust works with CHKS (a leading provider of healthcare intelligence) who provide and benchmark our mortality data. This is reviewed by our mortality team and discussed at our Mortality Surveillance Committee. Key data and analysis are then presented to both the Quality and Safety Committee (QSC) and the Board. Every month CHKS provides refreshed data, including crude mortality, SHMI and HSMR, together with detail of any alerts relating to specific diagnosis groups. A significant number of cases are also independently reviewed by a clinician who was not involved in the care of the deceased patient, using the standardised structured judgement review methodology first introduced by the Royal College of Physicians in 2016. Cases for review are selected in a number of ways including, if there is any suspicion of increased mortality in any patient group or diagnosis group; referral by the Medical Examiner; and also if any member of staff or relative feels that there was anything lacking in the care received by the patient. This assessment of care is used to identify Lister Hospital Coreys Mill Lane Stevenage SG1 4AB 19 September 2023 and share learning, check for any themes or trends of concern and escalate any patient safety issues identified

Child Death Overview Panel (CDOP)

CDOP monitors all child deaths and have been in existence since 2008. They have a statutory role in looking at the deaths of all children from the age of viability to 18. They work closely with all of the other agencies and across the county to facilitate the monitoring of and learning from child deaths.

The establishment of the Medical Examiner Office

The Trust has a team of medical examiners who scrutinise all in-hospital deaths. From April 2024 they will also be responsible for the scrutiny of deaths in the community. Their primary function is to provide independent scrutiny of all deaths and they are directly responsible to the National Medical Examiner. In their work, in addition to agreeing the cause of death, they also speak with relatives to check if they have any concerns and importantly, monitor deaths to identify any themes or trends. They are in a unique position to challenge the Trust and escalate cases that they consider need further review or investigation.

Maternity Incentive Scheme (MIS)

As part of the maternity incentive scheme, we undertake the following in relation to safety actions and to provide assurance:

- At the Quality and Safety Committee, we report neonatal nursing / neonatal medical staffing position (SA4) and training compliance (SA8). We review and present the learning from avoidable term admissions into the neonatal unit (ATAIN) (SA3). A quarterly bereavement report is submitted to the committee (SA1) alongside quarterly reporting through the "learning from deaths report".
- The neonatal governance structure includes: a monthly perinatal mortality and morbidity meeting, a monthly neonatal risk management meeting, monthly neonatal risk management meeting and a neonatal specialty meeting with representation from the parents advisory group.
- We utilise the perinatal mortality review tool (PMRT) to review all perinatal deaths to the required standard (SA1). This includes utilisation of the PMRT to undertake multidisciplinary review for all baby deaths. We also invite parents' perspectives and questions as part of the review.

• Monthly walkarounds are undertaken across maternity and neonatal services by the board level maternity and neonatal safety champions to hear any concerns from staff and this enables ward to board reporting (SA9). • 100% of qualifying maternity and neonatal cases must be reported to the Healthcare Safety Investigation Branch (HSIB) and to NHS resolutions early notification scheme to achieve compliance with SA10. • All neonatal outcomes are reported through the divisional, Trust and local maternity and neonatal system (LMNS) governance structure via the monthly maternity dashboard with thematic reviews and outcome data presented at the women's and neonatal quality and safety committee and the local maternity and neonatal system (LMNS) serious Incident oversight and scrutiny group.
Herts Community NHS Trust (HCT)
The FTSUG prepares and delivers reports to the Quality Committee and then Full Board. These reports provide opportunities for the sub-committee and Board to hear about internal work and developments, as well as receiving anonymous quantitative and qualitative data about casework contacts (including for example, speaking up themes/categorisation, staff groups, demographics, actions taken, learning and feedback) and consider recommendations from the FTSUG. **Incident management:** Incident reporting is underpinned by the Trust's Incident Policy and Patient Safety Incident Response Policy and Plan as well as the Being Open and Duty of Candour Policy. Incident data is gathered by the Trust's Risk Management team and a bimonthly data report is shared at the Trust's Clinical Governance Subcommittee, to provide an overview and identify areas that require deeper scrutiny or that can support improvement projects. Reports are drafted for the Quality committee to provide assurance relating to the systems and processes and outcomes from Serious Incidents and Duty of Candour. The Clinical Governance Subcommittee also receive regular reports providing a deep dive into medication incidents, falls incidents and pressure ulcers which support improvement work in these areas. The Trust began its transition to the Patient Safety Incident Response Framework in October 2023 which represents a significant shift in the way we respond to patient

safety incidents. As part of the new framework the Trust has developed a Patient Safety Incident Response Plan that outlines how we will respond to incidents based on the safety data available to us.

Learning from Deaths:
The Trust has a well-established Learning from Deaths process underpinned by the Learning from Deaths Policy and in line with the National Quality Board guidance. A bi-monthly report is prepared for the Quality Committee to provide assurance relating to the work being carried out in this area, themes and trends of learning, good practice and improvement work being undertaken. There is a well-established process for reviewing and monitoring unexpected child deaths by the CYP Safeguarding Team. Patterns and trends of children's Unexpected Child Deaths are presented by the Safeguarding Children Team to the Learning from Deaths Group. This will be soon expanded to expected deaths. From September 2023, the new Child Death Review process for all Child deaths (expected and Unexpected) commenced, and the new Child Death Review team will scrutinise all children deaths in Hertfordshire, and this will include children living outside the County.

Safeguarding Children:
The Safeguarding Children team and the Child Death Review team scrutinise all neonatal and children's deaths. For neonates there is partnership working with the Acute Trusts, who undertake various meetings to examine practices and involvement, and for infant and children in Hospital, Hospice and in Community, the Joint Agency Response (multi-agency Meeting) information sharing meeting and Child Death Review Meeting are well established and give the opportunity to identify trends, patterns and concerns.

Assurance Framework:
The Trust has an internal Quality Assurance Framework for our operational services. This includes monthly record keeping 'dip tests,' quarterly self-assessment using the Quality Wheel, and annual peer reviews. All of these are aligned to the Five Key Priorities in our Clinical & Quality Strategy. Any quality improvement actions identified are added to each service's

individual Continuous Quality Improvement Plan and reviewed by our operational services through regular Operational Performance Review meetings, with assurance of progress monitored through our Good to Outstanding Steering Group. The Trust has begun rolling out an accreditation programme reported on via the Good to Outstanding Steering Group. A framework that outlines the identification of teams who need interventions to support them is being developed to enable a number of risk factors, soft intelligence and reporting data to be triangulated in order to provide intensive support to teams, which could be in the form of additional supervision, training, team building, depending on their needs
Hertfordshire Partnership University Foundation Trust (HPFT)
Our Integrated Governance Committee and Trust Board receive regular reports on the Freedom to Speak Up concerns that have been received. The reports provide an analysis of trends, the services involved and timescales to resolve. It is worth noting that the number of anonymous concerns raised is very small and has decreased over recent years, evidence that those raising concerns are happy to do this freely and be involved in the resolution. It is also worth noting that despite the national coverage, and indeed our own campaign, we have not seen a rise in the number of Freedom to Speak Up cases since the outcome of the court case, but we continue to monitor the situation closely
West Herts Teaching Hospitals NHS Trust (WHHT)
The Board has a Quality and Safety Committee which meets monthly. It has an annual work programme and scrutinises and reviews mortality data before it goes to Board. The Board regularly receives reports and data which is reviewed and acted upon in relation to Medical Examiners, serious incidents, learning from deaths, mortality and Dr Foster. The Board receives a quarterly learning from deaths report, which includes mortality and the Dr Foster intelligence report.

The Trust has a consolidated system for the analysis of mortality. This system includes:
• Examination of monthly mortality reports (produced by Dr Foster)
• Specialty Mortality and Morbidity meetings
• Mortality Review Group meetings
• Structured judgement reviews by trained Consultant reviewers which identifies themes and learning.
• Medical Examiners who scrutinise deaths at the time of Medical Certification of Death

The system allows scrutiny of mortality trends, highlights outlying groups, when they arise and triggers review to determine influencing factors, including poor care. This provides an opportunity to learn from deaths and make changes to reduce future risk.

The mortality metrics include The Hospital Standardised Mortality Ratio, Summary Hospital Level Mortality Indicator and Standardised Mortality Ratio. The Trust has been identified as a regional exemplar for this due to having 100% Medical Examiner who scrutinise deaths at the time of the medical certification of death.

A significant number of cases are also independently reviewed by a clinician who was not involved in the care of the deceased patient, using the standardised structured judgement review methodology first introduced by the Royal College of Physicians in 2016. Cases for review are selected in several ways including, if there is any suspicion of increased mortality in any patient group or diagnosis group, referral by the Medical Examiner, and if any member of staff or relative feels that there was anything lacking in the care received by the patient. This assessment of care is used to identify and share learning, check for any themes or trends of concern and escalate any patient safety issues identified.

Perinatal and neonatal deaths receive significant scrutiny internally, as well as externally by Local Maternity and Neonatal System and Integrated Care Board reviews. Perinatal deaths are discussed at Maternity Safety Champions meetings, where

there is challenge on learning, trends, potential avoidability, adhering to evidence-based practice, gaps in assurance and governance.

The private section of the Trust Board regularly receives a report on employment tribunals and maintaining high professional standards. This provides an overview of current employment tribunal activity and a summary of all cases within the remit of maintaining high professional standards framework for doctors and dentists, as well as updates on restrictions and exclusions.

The Board receives a quarterly paper in the private section of the meeting on the National Perinatal Mortality Review Tool (PMRT). This provides evidence of assurance that the Trust is meeting its requirements and is in line with Safety Action 1 in the Maternity Incentive Scheme (MIS) Year 4. The latest report is part of this Board meeting pack (07 September 2023).

As part of September 2023's Board meeting, the Board received an annual report on the work of the Trust's safeguarding team. In 2022/23, the Integrated Care Board undertook a joint section 11 assurance audit of the Trust's safeguarding service. This concluded that the Trust had immense commitment to ensuring safeguarding is embedded in all areas of the organisation promoting health, safety and welfare of children, young people and adults that access its services. The safeguarding service was graded good to outstanding.

In July 2023, the Public Trust Board meeting approved an action plan which addressed recommendations from an independent well-led review of the Trust's leadership and governance arrangements. The review was undertaken by Deloitte in 2022/23. Feedback from the review was positive and it was noted that the Trust had enjoyed high levels of stability in Board leadership over recent years and the Board was functioning at a mature level. In particular, it highlighted the excellent work the Trust had done to embed its clinically led triumvirate model, as well as a range of initiatives that has positively influenced the Trust's culture. The review acknowledged that the Trust had strong foundations in place to continue its journey toward becoming a CQC 'outstanding' trust in the well-led domain and noted it was on a positive trajectory.

The Princess Alexandra Hospital NHS Trust (PAH)
There have been a lot of developments and improvements to risk management, mortality reporting and reviews, Board reporting and speaking up that have been implemented both nationally and locally in the 7 – 8 years since the babies at the Countess of Chester were sadly killed or harmed by Lucy Letby (between June 2015 and June 2016). These have increased oversight, triangulation of data and early identification of concerns at multiple levels through acute Trusts, including at Trust Boards. These include: • Medical Examiners service, independently reviewing all deaths in hospitals • Monthly mortality oversight group supporting enhanced mortality and morbidity meetings in all specialties • Enhancements in Dr Foster analysis of mortality • Regular Learning from Deaths oversight paper to Quality and Safety Committees and Trust Board meetings • Enhancements in mandatory neonatal mortality data returns, supported by a perinatal mortality review tool • Regional neonatal operational delivery networks with regular meetings overseeing the provision of care across their neonatal and special care units including the oversight of mortality rates in all units • Healthcare Safety Investigation Branch (HSIB) review of all neonatal deaths nationally within 7 days of death • Enhanced oversight of nursing levels on all wards on a daily (or often 3 x daily) basis, aligned with the real time case mix and acuity of the patients on each ward, reported formally every month through a Safer Staffing Report to Trust Boards • Implementation of Maternity Safety Champions, both a NED and an Exec Director in each organisation
Herts and West Essex Integrated Care Board (HWEICB)
For neonatal care across our system each Trust has divisional governance forums that include mortality and outcomes. The PMRT forums feed into these meetings. and the maternity and neonatal safety champions interface to the executive teams.

Changes in trends or cases are also reported upward in each Trust, this includes cases referred to Healthcare Safety Investigation Branch (HSIB) as well as discussions with the LMNS and ICB.

The East of England Operational Delivery Network (ODN) holds quarterly mortality forums for the region to present and share cases, to support learning and improvements.

The ICB's Quality committee acts as a point of escalation for quality and safety issues across the system, and in turn can escalate those concerns to the Integrated Care Board for consideration. The Quality Committee has system representation across the acute, community, mental health and primary care sectors, alongside Healthwatch and Local Authorities sitting within its geographical areas. The Committee and wider ICB also reports through to NHS England.

Any areas showing trends or outliers linked to neonatal mortality would also be shared with the ICB Board, this includes those identified through MBRRACE data.

The ICB Nursing and Quality Team also review information and data relating to mortality including neonatal deaths through review of provider internal reports.

Question 7. Fit and Proper Person Framework. Are NHS organisations meeting the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement
Responses
Central London Community Healthcare (CLCH)
The recently revised NHS England Fit and Proper Person Framework has been reviewed to ensure that we are compliant with this and co-ordinated by the Trust Secretary.
East and North Hertfordshire NHS Trust (ENHHT)
The Trust is complying with the FPP requirements. All Trusts must submit compliance reports signed by the Trust Board Chair to NHS England before the end of March 2024. As examples of the ENHT's commitment to complying with the FPP requirements, ENHT chose to apply the new FPP test requirements for a new Non-Executive Director who was appointed before September 2023 when the new requirements came into force, despite not being obliged to. A further example is an internal audit of compliance with the FPP requirements has been added to the internal audit plan for 2024/25. The Trust uses an external agency for internal audit which increases the independence and level of assurance that can be drawn from audit findings.
Herts Community NHS Trust (HCT)
HCT meet the Fit and Proper Person Test Framework which has been updated and amended in light of the outcome – the report and policy were approved at Board in December 2023.

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Hertfordshire Partnership University Foundation Trust (HPFT)
Recently NHS England issued new guidance that has strengthened the Fit and Proper Person Framework. The changes have brought in the need for additional background checks, including a Board member reference template. The Trust have implemented the changes ahead of the required timescale and will continue to monitor compliance on an annual basis.
West Herts Teaching Hospitals NHS Trust (WHHT)
The letter with recommendations from NHS England reminded all NHS organisations of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all Fit and Proper Person requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). Following the Francis Inquiry, a registration requirement was introduced that all Executive and NonExecutive Directors of providers registered with the CQC must meet FPPT. This also applies to some Very Senior Manager and Director roles that fall within the remit of the FPPT. NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role. This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes. To be a fit and proper person, the post holder must meet all the following:

• Be of good character – need to take account of whether the person has been convicted of any offence in UK or one which would amount to an offence in the UK if committed elsewhere or whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals. • Have the qualifications, competence, skills and experience necessary for the office or position. • Be capable by reason of their health, after reasonable adjustments are made, of properly performing tasks intrinsic to their office or position for which they are appointed or to the work for which they are employed. • Not have been responsible for, been privy to, contributed to or facilitated any serious misconduct or serious mismanagement (whether unlawful or not) while carrying on a regulated activity of providing a service elsewhere which, if provided in England, would be a regulated activity; and • Not be prohibited from holding the office or position because they are deemed an "unfit person". The Trust currently has 17 Directors and Non-Executive Directors who fall within the remit of the FPPT regulation. As of 26 June 2023, all have signed the annual declaration and remain compliant. At the Public Trust Board in July 2023, a report was presented which provided the outcome of the review and offered assurance of full compliance against the remit of FPPT 2.1
The Princess Alexandra Hospital NHS Trust (PAH)
Enhancement of the Fit and Proper Person Test for all Board members, first introduced in April 2015 and most recently updated with a new framework on 3 August 2023, due for implementation by 30 September 2023. The new framework requires there to an individual assessment, refreshed annually and recorded on ESR, enabling other NHS organisations to have access to the information as part of their recruitment processes.

Herts and West Essex Integrated Care Board (HWEICB)
We have set up a task and finish group to review the requirements of the Fit and Proper Person Framework in response to the recommendations made by Tom Kark KC in his 2019 review (Kark Review) of the FPPT. The Board has received an update of the requirements in the September Board meeting and a development session has been scheduled for November to explore the framework requirements and responsibilities. Enhancement of the Fit and Proper Person Test for all Board members, first introduced in April 2015 and most recently updated with a new framework on 3 August 2023, due for implementation by 30 September 2023 . The new framework requires there to be an individual assessment, refreshed annually and recorded on ESR, enabling other NHS organisations to have access to the information as part of their recruitment processes The ICB will implement and adhere to the recommendations within the timescales prescribed.

Question 8. How are you planning to make the public aware of your approach and keep people updated (including in the longer term) in the light of the pending Inquiry?
Responses
Central London Community Healthcare (CLCH)
Response not required

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East and North Hertfordshire NHS Trust (ENHHT)
We hold public Trust meetings where we provide assurance to the public on such matters and update our website where members of the public can be assured that we continue to operate within a culture of improvement and that the maternity wing at the East and North Hertfordshire NHS Trust is and remains a safe place to give birth. We provide fantastic care for some of our most vulnerable patients, and parents have been grateful for our clinicians' openness as well as their compassionate and expert care.
Herts Community NHS Trust (HCT)
Response not required
Hertfordshire Partnership University Foundation Trust (HPFT)
Response not required
West Herts Teaching Hospitals NHS Trust (WHHT)
Not specified in response.
The Princess Alexandra Hospital NHS Trust (PAH)
Not specified in response.
Herts and West Essex Integrated Care Board (HWEICB)
Our approach is to highlight the ways in which people can raise concerns about the care of their children, either with the hospital (through staff directly involved in their child's care, or through the PALS team), or through an external and independent agency such as the advocacy network PohWER.

We are adding this information to our ICB and ICS websites and will share this information with our local hospitals to put on their websites, so that information about how to highlight an immediate or past concern about a baby's care is shared. The ICB will work with the Local Maternity Neonatal System to share the same information through their professional networks, as well as highlighting 'Freedom to Speak Up' information for staff working in maternity and neonatal care. We will also disseminate the same information through our area's three Maternity Voices Partnerships, organisations run by independent volunteer members who represent service user voices within the community and action improvements to local maternity services. When the statutory inquiry shares its findings, we will act on any additional recommendations for public messaging.

Question 9. What, if any, further action does your Trust plan to take or consider in relation to the wider issues arising from the Letby case? OPPORTUNITY TO PROVIDE FURTHER INFORMATION IF THEY WISHED
Responses
Central London Community Healthcare (CLCH)
Response not required
East and North Hertfordshire NHS Trust (ENHHT)
No specific response received.

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Herts Community NHS Trust (HCT)
Response not required but this information is relevant. Further work is required by the Risk team and Radar to ensure that there is a robust process to collate information relating to those reporting and involved in incidents in order to identify any trends. • Work must continue to ensure that the Trust has incident and risk dashboards that support the analysis of data at a Trust and local level. • The roll out of the PSIRF must be supported Trust wide to support the identification of areas of concern and appropriate learning responses. • In house training and an awareness programme needs to be developed in line with the new ways of working outlined in the PSIRF. • The Trust needs to develop a dashboard related specifically to deaths occurring in our care so that themes and trends can be identified for those deaths that do not meet the Learning from deaths policy criteria. • The Trust needs to develop its processes in relation to seeking feedback from bereaved relatives and carers following the death of a patient
Hertfordshire Partnership University Foundation Trust (HPFT)
In addition to the immediate response and assurances regarding the requirements set out by NHS England's letter, we have reviewed information on our responsiveness when concerns are raised. This has involved us scrutinising all open Freedom to Speak Up cases, Grievances, Complaints, Serious Incidents and concerns raised by the Care Quality Commission. Our Integrated Governance Committee and Board have received full reports and have been assured that the Trust has applied the appropriate level of scrutiny to this important aspect of quality of care provided to service users. We have also reported to our most recent Board meeting the response to NHS England's letter. We will continue to report on the quality of services to

our Integrated Governance Committee and Trust Board ensuring that we are completely open and transparent with the information and actions being taken.
West Herts Teaching Hospitals NHS Trust (WHHT)
In conclusion, the Trust is proactively ensuring the promotion of an open and transparent culture which encourages staff to speak up especially in the case of patient safety. Furthermore, there are strong systems in place to review any incidents that occur, which will be further strengthened by the introduction of Patient Safety Incident Response Framework (PSIRF).
The Princess Alexandra Hospital NHS Trust (PAH)
There is always more that can be done to ensure that all colleagues, patients and visitors feel confident to and know how to raise concerns. At PAHT we will be reviewing all our current process for raising concerns and reporting incidents to ensure that they are all as tight as they can be and that all relevant learning is taken from these. We will make any changes to the processes as relevant to strengthen them in line with the PSIRF. In terms of immediate actions, locally, we have discussed the Letby verdict in one of our weekly all staff briefings including highlighting to colleagues how they can raise concerns, encouraging them to do so and asking colleagues to speak to the Patient Safety and Quality teams if they feel any patient safety concerns or incidents raised have not been fully addressed. This message has also been communicated via email to all colleagues. Our next Senior Management Team meeting is tomorrow and there is an item on this agenda to discuss our collective actions post the Letby enquiry. This will focus particularly on: • how all our senior managers support colleagues in their divisions to have easy access to information on how to speak up and

- how we will all support ensure the right culture is in place so that line managers can ensure approaches are in place to support all colleagues to speak up, regardless of their band, role, cultural background or shift pattern.

This will require ongoing dialogue and review rather than just a one-off discussion.

We also have an agenda item on the next Part II of the Trust Board on 14 September 2023

Herts and West Essex Integrated Care Board (HWEICB)

There are a number of measures already in place to ensure that unexplained variance in key indicators are picked up.

From the HWE Local Maternity and Neonatal System Neonatal Critical Care Transformation Review (NCCR) position there is access to neonatal data via the Badger system that all units use for neonatal care. All Herts and West Essex Trusts have given access to their data as part of the NCCR project work.

Data for babies transferred out for ITU higher level care can also be seen in the Badger system.

Transfers in and out of the LMNS services are reviewed monthly, with case-by-case oversight. These are discussed with neonatal teams where required.

Data should be entered for all babies who die following support being given by the neonatal teams. This includes babies who die soon after birth in the delivery areas. Babies between 22+0 and 23+6 gestational age are also monitored, as per the British Association of Perinatal Medicine (BAPM) frameworks.
The LMNS monitor this data monthly.

There are mandatory neonatal mortality data returns utilising a Perinatal Mortality Review Tool (PMRT).

The LMNS Midwife for Quality and Safety and the neonatal project lead attend each Trust's Perinatal Mortality Tool reviews, these are held monthly.
Neonatal mortality is an agenda item for the neonatal safety subgroup, each unit's local meeting with the LMNS and the Serious Incident and Oversight forum.

Learning and messages from PMRT reviews are shared across our system in monthly neonatal safety posters.

In line with national requirements, intrapartum and early neonatal deaths are reported to the Healthcare Safety Investigation Branch (HSIB) for external review and scrutiny.

Perinatal mortality is also reported through MBRRACE (Mothers and Babies: reducing risk through audits and confidential enquires across the UK).

The ICB reviews the national MBRRACE reports and discusses any local Trust trends or issues through quality and safety meetings. The Medical Examiners at each acute trust also review all deaths in hospitals.
As well as the processes described above at system level each provider has significant oversight of all neonatal deaths, we are aware that each Trust is responding to you with the details relevant to their own organisation.

As a system we will continue to focus on creating a safe environment for those staff who wish to raise concerns, and to strengthen our risk management and governance processes wherever this is required. We will also fully implement any relevant recommendations arising from the inquiry into the events that occurred at the Countess of Chester NHS Foundation

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Question 10 from NHSE to ICBs While the CQC is primarily responsible for assuring speaking up arrangements we have also asked……ICBs to consider how all NHS organisations have accessible and effective speaking up arrangements
Initial discussions are underway. The ICB will address in detail over the forthcoming year and will actively seek to learn and work with others here including other ICBs, NHSE and the National Guardian's Office. NHS England and the National Guardian's Office have stated that they plan to share further information by 31 March 2024 about the precise expectations of ICBs in regard to Freedom to Speak Up for primary care workers and across their system.

The following is a list of organisations and the evidence they provided to us. Individual documents can be found on our website using the links given below for each organisation.

Organisation A: Central London Community Healthcare NHS Trust

Content provided in response to this request:

- **Letter** dated 6 November 2023 sent from Holly Ashforth Deputy Chief Nurse (Director of Patient Experience and Education)

Organisation B: East and North Hertfordshire NHS Trust

Content provided in response to this request:

- **Letter** dated 19th September sent jointly from Ellen Schroder (Chair) and Adam Sewell-Jones (Chief Executive)
- **Responses** to additional questions asked and received by email on 8th December 2023

Organisation C: Herts Community NHS Trust

Content provided in response to this request:

- **Letter** dated 21st November sharing a report which went to Quality Committee on 21st November and a Board Meeting on 6th December.
- **Copy** of the Board Assurance and Quality Committee Report relating to the Countess of Chester Hospital deaths dated 21 November 2023
- **Responses** to additional questions asked and received by email on 8th December 2023
- **Copy** of the Fit and Proper Persons Test Framework Report to Board dated 5th December 2023

ORGANISATION D: Herts Partnership University Foundation Trust

Content provided in response to this request:

- **Letter** dated 18th October from Karen Taylor Chief Executive Officer at HPFT

ORGANISATION E: The Princess Alexandra Hospital NHS Trust

Content provided in response to this request:

- **Copy** of email content in response to HCC Scrutiny request was shared by Lance McCarthy, Chief Executive at PAH

ORGANISATION F: West Herts Teaching Hospitals NHS Foundation Trust

Content provided in response to this request:

- **Copy** of letter dated 12th January from Phil Townsend, Chair and Matthew Coats CB, Chief Executive

ORGANISATION G: The Herts and West Essex Integrated Care Board

Content provided in response to this request

- **Covering letter** from Dr. Jane Halpin dated 24th October 2023
- **Responses** to each question in a separate document