Questions posed	Response
Action 1: All staff have easy access to information on how to speak up.	Response: 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.

Action 2: Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.	Response: 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.
Action 3: Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.	Response: 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: 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.
Action 4: Boards seek assurance that staff can speak up with confidence and whistle-blowers are treated well.	Response: 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. 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.
Action 5: Boards are regularly reporting, reviewing and acting upon available data.	Response: 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.
Medical Examiners	Response: The Medical Examiner scrutiny of all hospital deaths has been in place since 2021 and the implementation of Medical Examiner scrutiny of all non-coronial community deaths is currently taking place with full implementation by April 2024 when it will also be a statutory requirement. Medical examiners are senior medical doctors who are contracted for a number of sessions a week to provide independent scrutiny of the causes of death, outside their usual clinical duties. They are trained in the legal and clinical elements of death certification processes. The purpose of the medical examiner system is to: • provide greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths. • identify cases for further review under local mortality arrangements and contribute to other clinical governance processes. • ensure the appropriate direction of deaths to the coroner. • provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased. • improve the quality of death certification. • improve the quality of mortality data. The implementation of the Medical Examiner scrutiny of all non-coronial community deaths has been included in the National Patient Safety Strategy as a key priority with the overarching aim being to improve learning from deaths and the quality and safety of care. Within Hertfordshire and West Essex ICB, the implementation is progressing well with good engagement from our community providers including primary care. We have a monthly system meeting to support progress, encourage consistency in approach across our local system and work collaboratively with wider system partners. Updates on progress are reported through to our Quality Committee and Board.
PSIRF and shift in the way we respond to incidents.	Response: A key element of the National Patient Safety Strategy is the new Patient Safety Incident Response Framework (PSIRF) which replaces the Serious Incident Framework (2015). The framework applies to all providers with an NHS standard contract, with the requirement to implement by Autumn 2023. The framework is not currently applicable for primary care however the national publication outlining how the framework will be implemented for primary care is due to be published later this year.

	PSIRF has four main principles: • Compassionate engagement and involvement of those affected by patient safety incidents. • Application of a range of system-based approaches to learn from patient safety incidents. • Considered and proportionate responses to patient safety incidents • Supportive oversight focused on strengthening response systems and improvement. The new framework requires a culture shift and change in mindset in order to maximise the benefit of the new approach. The focus is on developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. By not requiring a threshold for 'Serious Incidents' it supports organisations and systems to review incidents where there hasn't been harm but there is significant potential for learning or where there has been positive care. It embeds patient safety incident response within a wider system of improvement. It also means that incident response resources can be used more effectively to maximise improvement rather than repeatedly responding to patient safety incidents based on a threshold of 'seriousness' where learning may be limited. It requires all staff involved to be trained in relevant areas through approved training providers (systems approach to learning from patient safety incidents, involving those affected, oversight of learning from patient safety incidents). This will help ensure that we are really engaging and listening to our patients, families and staff involved in incidents, and support them when they raise concerns. It will also support staff to tailor their approach to meet individuals' needs. Alongside other review processes it also helps to identify themes and investigate trends. Within Hertfordshire and West Essex ICS, we are working with our main trusts and independent sector providers (approx. 50 providers in total) to implement PSIRF throughout October 2023. In some cases, providers are working with lead commissioners outside of our local system and timeframes may vary. As a system we are committed to implementing the new framework well, focusing on an approach where there is psychological safety, and everyone feels empowered to ask curious questions to help drive improvement as well as identify care concerns that warrant more significant investigation. To support this further, HWE ICB has worked with our local authority colleagues to build in PSIRF principles and the new approach with their providers as well.
Whistleblowing procedures, F2SU and requirement to adopt the updated national policy by January 2024.	Response: This work is included within the FTSUG initial workplan presented to the Audit and Risk committee in May 23 and is due to be completed by the FTSUG prior to January 2024.

ICBs to consider how all NHS organisations have accessible and effective speaking up arrangements.	Response: 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.
Strengthening of the Fit and Proper Person Test.	Response: 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. The ICB will implement and adhere to the recommendations within the timescales prescribed.
Please include a wider summary outlining further action the ICB plans to take or to consider in relation to the wider issues arising from the Letby case.	Response: As indicated throughout the response to your enquiries from both the ICB and our individual provider partners, there have been a number 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 • 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 • Introduction of the Freedom to Speak up Guardian role and service. • 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 (see appendix 1). 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. • Implementation of a new national Patient Safety Incident Response Framework (PSIRF) across all Trusts in the autumn this year, replacing the current Serious Incident Framework • Use of SPC charts for performance oversight enabling a better and easier to see indication of variation over time, supporting enhanced identification of potential areas of concern. 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 Trust.
Please outline how you are planning to make the public aware of your approach and to keep people updated, including in the longer-term in the light of the pending inquiry.	Response: 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.