Our trust:
Hertford County Hospital, The Lister Hospital,
Mount Vernon Cancer Centre, New QEII Hospital

East and North
Hertfordshire
NHS Trust

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Lister Hospital
Coreys Mill Lane
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SG1 4AB

19 September 2023

Dear Neil and Geoff,

Re: ENHT action following the Lucy Letby verdict

We were shocked to hear the details following the conviction of the neonatal nurse Lucy Letby which has led us to reconsider the processes we have in place at East and North Hertfordshire NHS Trust. There are several important safety actions in place but nevertheless we are not complacent.

1. 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.

2. 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.

3. 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

and share learning, check for any themes or trends of concern and escalate any patient safety issues identified.

4. 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.

5. 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.

6. Patient Safety Incident Response Framework (PSIRF)
Our Trust is in the initial stages of introducing a different approach to managing and learning from both patient safety incidents (PSIRF) and those related to employee relations. Our ambition is to establish a restorative, just, and learning culture (RJLC) within the organisation, one that promotes no blame, psychological safety, and quality improvement without jeopardising accountability.

7. 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 multi-disciplinary 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.

- 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.

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.

Yours sincerely,

Ellen Schroder
Chair

Adam Sewell-Jones
Chief Executive