PAHT RESPONSE TO SCRUTINY QUESTIONS re Letby Verdict (sent as an email 13/9/2023)

I will respond to the specific questions separately.

I think the responses from the 3 Trusts would also be enhanced and strengthened in terms of assurance to committee members, by a description of how the ICB oversees performance, concerns etc across the providers.

To provide some initial assurance to the Chair and members of the Scrutiny Committee, whilst there are always governance and risk management processes that can be tightened, it's worth noting that 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
- 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. (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).
- 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 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 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.

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.