West Hertfordshire Teaching Hospitals NHS Trust

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Neil Tester, Co-Chair
Geoff Brown, Chief Executive
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Via email:
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Dear Neil and Geoff

Firstly, our apologies for the delay in responding to your email.

Following the five NHS England recommendations relating to the Lucy Letby case, the Trust placed six important protective factors in place. These are:

1. A culture of openness
2. A senior leadership team that listens to clinicians
3. Board level scrutiny of mortality data and deaths
4. Child's Death Overview Panel
5. Medical Examiners
6. Patient Safety Incident Response Framework

Protective factor 1. A culture of openness
Following The Francis Report into Mid Staffordshire hospitals in 2013, the Trust was an early adopter to implement recommendations for a Freedom to Speak Up (FTSU) Guardian and Non-Executive Director (NED) lead. This has been supported by the Board. The Trust has completed a lot of additional work over the last seven to eight years with a specific focus over the last 12 - 18 months on providing a culture of openness.

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.

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.

Following the Lucy Letby case, the Trust reviewed outstanding grievances and mediations and was assured that none were taking place as a result of speaking up about patient safety issues.

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.

Senior leaders and the Trust Board are required to complete Level 3 FTSU training.

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.

Protective factor 2. A senior leadership team that listens to clinicians
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.

The Chief Nurse and Chief Medical Officer take part in chairing the Serious Incident Panel and therefore have oversight of potential serious incidents within the organisation.

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.

Protective factor 3. Board level scrutiny of mortality data and deaths
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.

Protective factor 4. Childs Death Overview Panel
The Trust has a Child's Death Overview Panel which has been in place since 2008 and monitors all child deaths. The Panel has a statutory role in looking at the deaths of all children from the age of viability to 18. It works closely with all the other agencies and across the county to facilitate the monitoring of and learning from child deaths.

Protective factor 5. Medical Examiners
The Trust has a team of Medical Examiners which scrutinises all in-hospital deaths. 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 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.

Protective factor 6. Patient Safety Incident Response Framework
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.

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 Non-Executive 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.

In conclusion, the details above outline the processes and system in place to provide assurance that 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).

We hope this letter provides you with the reassurance you require. Please do not hesitate to contact us again, should you need further information on any of the above.

Yours sincerely

Phil Townsend
Chair

Matthew Coats CB
Chief Executive