Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

By email only

Healthwatch Hertfordshire

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24th October 2023

Subject: Action following the Lucy Letby verdict

Dear Neil and Geoff,

Thank you for your correspondence regarding the tragic events that occurred at the Countess of Chester Hospital between 2015-16.

I entirely agree with you that it is important that residents of Hertfordshire and West Essex are assured that we are doing all we can to prevent similar incidents occurring in our system, and that the right procedures and processes are in place to detect and respond in the event that they were do so. I am, therefore, grateful to Healthwatch for its interest in this matter. Our response should be read alongside that of our provider system partners, with whom we collaborate fully on this issue.

Learning from the events that occurred at the County of Chester Hospital 2015-2016

As we set out in our response 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. These include but are not limited to:

- The creation of a 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.

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- 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, now being implemented by the ICB. The new framework requires there to be an individual assessment, refreshed annually and recorded on employment records, 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.

In addition to the above, there are several processes in place to detect unexplained variation in key indicators that would present a potential patient safety issue in Neonatal care, which we detail in our response.

The role of the ICB

Whilst it is primarily for the individual provider Boards to ensure that sufficient safeguards are in place to prevent deliberate or accidental harm to patients, the Integrated Care Board'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 from 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.

Freedom to Speak Up

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.

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NHS England

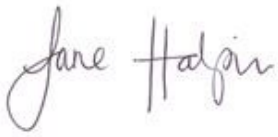
You mention in your letter the recent correspondence from NHS England received by ICBs on this matter. In many of the areas covered within the correspondence we have already implemented or are in the process of implementing the NHS England recommendations, as I hope is clear from the more detailed response attached.

We will continue to review our approach to ensure that it offers the strongest possible protection against a similar incident occurring in Hertfordshire and West Essex, and we are committed to implementing the relevant recommendations from the inquiry into the case in full.

Finally, you mention that you plan to make this an agenda item for your regular meetings. The ICB would be keen to provide any support or assistance required. Please contact our Chief of Staff Michael Watson - Michael.watson9@nhs.net in the first instance.

Thank you again for your interest and support on this important matter.

Yours sincerely



Dr Jane Halpin
Chief Executive