Hertfordshire Community NHS Trust

Quality Committee

Title: **Board Assurance Report relating to the Countess of Chester Hospital Deaths**

Meeting Date: **21st November 2023**

Executive Lead: **Sarah Browne, Director of Nursing and Quality**
Elizabeth Kendrick, Medical Director

Author(s): **Claire Peck Patient Safety Specialist,**
Shaun Butler Freedom to Speak Up Guardian,
Sue Thompson Named Nurse for Safeguarding Children,
Mark Hayden Head of Risk and Assurance

For: **Information/Assurance**

Risk Rating: **Amber/Green**

1.0 Purpose and Recommendations

1.1 To provide assurance to the Quality Committee and Board that the Trust has systems and process in place to identify, review, triangulate and learn from deaths, incidents and other intelligence/data relating to safety, and improvement plans in place to address any gaps.

2.0 Executive Summary

2.1 The Trust has well-established and robust systems and processes in place relating to freedom to speak up, learning from the deaths of adults and children in our care, safeguarding children and reporting and monitoring incidents, and a well-established assurance framework.

2.2 There are some areas where we need to make improvements to ensure that we meet the initial recommendations made by NHS England in their open letter of 18 August 2023:

- Further work is required by the Risk team and Radar to ensure that there is a robust process to collate information relating to those reporting and involved in incidents in order to identify any trends.

- Work must continue to ensure that the Trust has incident and risk dashboards that support the analysis of data at a Trust and local level.
- The roll out of the PSIRF must be supported Trust wide to support the identification of areas of concern and appropriate learning responses.
- In house training and an awareness programme needs to be developed in line with the new ways of working outlined in the PSIRF.
- The Trust needs to develop a dashboard related specifically to deaths occurring in our care so that themes and trends can be identified for those deaths that do not meet the Learning from deaths policy criteria.
- The Trust needs to develop its processes in relation to seeking feedback from bereaved relatives and carers following the death of a patient.

3.0 Relevant Strategic Objective(s) / Strategies

The report impacts on all strategic objectives and links to all Trust strategies.

4.0 Appendices and Attachments

(1) *None*

Author(s) of paper:

Name Claire Peck, Patient Safety Specialist
Date: November 2023

Hertfordshire Community NHS Trust

To be completed as part of paper

Committee Consideration

This Report has previously been considered by the following committees:	
Committee:	Date (Month / Year):
Issues arising from committee consideration	

Data Quality Statement

By way of assurance to the Board, and in order to inform discussion / decision, the accountable executive director confirms that to the best of their knowledge, and subject to any exceptions identified, data contained in this report is:

Data Quality Domain	Description	Comments / Exceptions	√ / x
Complete	Information is as comprehensive as possible to inform the board / committee and no significant known facts or statistics which may influence a decision are omitted.		√
Accurate	As far as can be reasonable ascertained or validated, information in the report is accurate.		√
Relevant	Information contained in the report is relevant to the matters considered in the report.		√
Up To Date	Information in the report is as up to date as reasonably possible in the context of the time at which the paper is written		√
Valid	Information is presented in a format which complies with internal or national models or standards		√
Clearly Defined	The meaning of any data in the report is clearly explained		√

Executive Director Sign-Off

This paper has been approved by the accountable executive director who is satisfied that (i) the implications for risks, (ii) quality/service/regulatory impacts and (iii) resource implications, have been considered.	Sarah Browne Director of Nursing and Quality	√

Board Secretary Sign-Off *(Board papers only)*

This paper has been quality control checked and approved by the Assistant Trust Secretary	N/A

Board Assurance Report Relating to the Countess of Chester Hospital Deaths

Introduction
The purpose of this paper is to provide assurance to the Executive team and Board that the Trust has systems and process in place to identify, review, triangulate and learn from deaths, incidents and other intelligence/data relating to safety, and improvement plans in place to address any gaps.

Background
The recent trial and conviction of the registered nurse Lucy Letby and the subsequent inquiry launched into the events at the Countess of Chester Hospital has resulted in concern about whether The Trust would be able to detect such activity and the Trust Board requiring reassurance around systems and processes in place within the Trust.

While it is recognised that the individual sought to cause harm, there is much learning about the systems and process in place to ensure that deaths are monitored, reviewed, themes and trends identified and that staff are able to share concerns about safe practice without fear of reprisal.

NHS England has published an open letter relating to the case which included assurances around how things have changed in England since these incidents occurred:

- Roll out of the Medical Examiner programme to include all community deaths from 2024/25

- Patient Safety Incident Response Framework (PSIRF) rolling out across the NHS from autumn 2023

- Strengthened the Freedom to Speak Up policy in 2022

NHS England also stated the following:

“That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.

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.

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.

4. Boards seek assurance that staff can speak up with confidence and whistle-blowers are treated well.

5. Boards are regularly reporting, reviewing and acting upon available data.”

Situation at HCT

1. **Freedom to Speak Up:**

HCT has a dedicated Freedom to Speak Up Guardian (FTSUG), a diverse team of FTSU champions and a dedicated policy.

The FTSUG prepares and delivers reports to the Quality Committee and then Full Board. These reports 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 also include coverage of key national developments in FTSU provision. The reports, alongside other reporting, (in particular in relation to Patient Safety, Human Resources, Equality, Diversity and Inclusion and worker wellbeing) and the NHS Staff Survey, 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 Trust.

2. **Incident management:**

Incident reporting is underpinned by the Trust's Incident Policy and Patient Safety Incident Response Policy and Plan as well as the Being Open and Duty of Candour Policy.

Incident data is gathered by the Trust's Risk Management team and a bimonthly data report is shared at the Trust's Clinical Governance Subcommittee, to provide an overview and identify areas that require deeper scrutiny or that can support improvement projects.

Reports are drafted for the Quality committee to provide assurance relating to the systems and processes and outcomes from Serious Incidents and Duty of Candour.

The Clinical Governance Subcommittee also receive regular reports providing a deep dive into medication incidents, falls incidents and pressure ulcers which support improvement work in these areas.

The Trust began its transition to the Patient Safety Incident Response Framework in October 2023 which represents a significant shift in the way we respond to patient safety incidents. As part of the new framework the Trust has developed a Patient Safety Incident Response Plan that outlines how we will respond to incidents based on the safety data available to us.

3. **Learning from Deaths:**

The Trust has a well-established Learning from Deaths process underpinned by the Learning from Deaths Policy and in line with the National Quality Board guidance. A bi-monthly report is prepared for the Quality Committee to provide assurance relating to the work being carried out in this area, themes and trends of learning, good practice and improvement work being undertaken.

There is a well-established process for reviewing and monitoring unexpected child deaths by the CYP Safeguarding Team. Patterns and trends of children's Unexpected Child Deaths are presented

by the Safeguarding Children Team to the Learning from Deaths Group. This will be soon expanded to expected deaths.

From September 2023, the new Child Death Review process for all Child deaths (expected and Unexpected) commenced, and the new Child Death Review team will scrutinise all children deaths in Hertfordshire, and this will include children living outside the County.

4. Safeguarding Children:

The Safeguarding Children team and the Child Death Review team scrutinise all neonatal and children's deaths. For neonates there is partnership working with the Acute Trusts, who undertake various meetings to examine practices and involvement, and for infant and children in Hospital, Hospice and in Community, the Joint Agency Response (multi-agency Meeting) information sharing meeting and Child Death Review Meeting are well established and give the opportunity to identify trends, patterns and concerns.

5. Assurance Framework

The Trust has an internal Quality Assurance Framework for our operational services. This includes monthly record keeping 'dip tests,' quarterly self-assessment using the Quality Wheel, and annual peer reviews. All of these are aligned to the Five Key Priorities in our Clinical & Quality Strategy. Any quality improvement actions identified are added to each service's individual Continuous Quality Improvement Plan and reviewed by our operational services through regular Operational Performance Review meetings, with assurance of progress monitored through our Good to Outstanding Steering Group. The Trust has begun rolling out an accreditation programme reported on via the Good to Outstanding Steering Group.

A framework that outlines the identification of teams who need interventions to support them is being developed to enable a number of risk factors, soft intelligence and reporting data to be triangulated in order to provide intensive support to teams, which could be in the form of additional supervision, training, team building, depending on their needs.

Recommendations

- Further work is required by the Risk team and Radar to ensure that there is a robust process to collate information relating to those reporting and involved in incidents in order to identify any trends.
- Work must continue to ensure that the Trust has incident and risk dashboards that support the analysis of data at a Trust and local level.
- The roll out of the PSIRF must be supported Trust wide to support the identification of areas of concern and appropriate learning responses.
- In house training and an awareness programme needs to be developed in line with the new ways of working outlined in the PSIRF.
- The Trust needs to develop a dashboard related specifically to deaths occurring in our care so that themes and trends can be identified for those deaths that do not meet the Learning from deaths policy criteria.

- The Trust needs to develop its processes in relation to seeking feedback from bereaved relatives and carers following the death of a patient.

Claire Peck Patient Safety Specialist
Shaun Butler Freedom to Speak Up Guardian
Sue Thompson Named Nurse for Safeguarding Children
Mark Hayden Head of Risk and Assurance
October 2023

References:

https://www.england.nhs.uk/long-read/verdict-in-the-trial-of-lucy-letby/
https://www.england.nhs.uk/patient-safety/incident-response-framework/
https://www.england.nhs.uk/publication/national-guidance-on-learning-from-deaths/