BNSSG ICB Board Meeting

Date: Thursday 7th September 2023
Time: 12:15pm
Location: Vassall Centre Gill Avenue, Bristol, BS16 2QQ

Agenda Number :	6.4	
Title:	Reflection of the impact of the verdict in the trial of Lucy Letby	
Confidential Papers	**Commercially Sensitive**	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	No
	Time Sensitive – not for public release at this time	No
	Other (Please state)	No
Purpose: Discussion and information		
Key Points for Discussion:		

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and as with colleagues across the NHS our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families. As an ICB and ICS we are committed to doing everything possible to prevent anything like this happening again.

Oversight of maternal and neonatal outcomes is undertaken both at a Trust level and through the Local Maternity and Neonatology System and includes the Child Death Overview Process (CDOP) and MBRRACE reporting system. In addition, the national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems. The new Patient Safety Incident Response Framework is also being implemented across BNSSG ICS, representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

While it is welcomed that the Health and Social Care Secretary Steve Barclay has announced that the inquiry into the circumstances around the crimes at the neonatal unit at the Countess of Chester will become statutory it is clear that this is not an issue that should be viewed as being specific to neonatal services. As with previous significant patient safety issues we need to review this through the wider lens of the culture within our teams, how we are assured that we are listening and responding appropriately to concerns being raised both by the people who use our services as well as our workforce.

We know that this is being discussed by our system partner organisations including at their boards and we will ensure that this is also discussed through the system health and care leadership channels including the BNSSG ICB System Quality Group where we will explore in more detail the impact of this, explore areas of shared learning and identify actions for individual partner organisations or as a system.

Recommendations:	Seminar session for a discussion about the ICB Board role in assuring the quality and safety of services being provided within BNSSG. Discussion of the attached letter at the System Quality Group who will be requested to make recommendations about next steps re system actions re patient safety culture and freedom to speak up.
Previously Considered By and feedback :	NA
Management of Declared Interest:	No conflicts of interest identified
Risk and Assurance:	Risks and assurance relate to effective and responsive patient safety arrangements and psychologically safe working environments
Financial / Resource Implications:	None identified
Legal, Policy and Regulatory Requirements:	The ICB and constituent partners will need to implement any findings from the ensuing public enquiry
How does this reduce Health Inequalities:	NA at this stage though any impact on health inequalities will be considered as part of system actions
How does this impact on Equality & diversity	NA at this stage though any impact on equality and diversity will be considered as part of system actions
Patient and Public Involvement:	NA at this stage but will be considered as part of any system actions. Maternity and Neonatal Voices Partners will be involved in any discussions at the LMNS.
Communications and Engagement:	NA
Author(s):	Rosi Shepherd, Chief Nursing Officer BNSSG ICB
Sponsoring Director / Clinical Lead / Lay Member:	Rosi Shepherd, Chief Nursing Officer BNSSG ICB

NHS England

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

18 August 2023

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

Publication reference: PRN00719

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

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

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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 whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP 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). The CQC can take action against any organisation that fails to meet these obligations.

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.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer, England

Professor Sir Stephen Powis
National Medical Director
NHS England

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