Board of Directors (held in Public)
26 October 2023
Response to verdict in the Lucy Letby trial
Report of the Chief Executive

Item 3.2

Presented for:	Discussion and Approval
Accountable Director:	Peter Reading, Interim Chief Executive Clare Ashby, Executive Director of Quality, Governance and Performance Assurance
Presented by:	Clare Ashby, Executive Director of Quality, Governance and Performance Assurance
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Previous Committees:	Trust Executive Group – 12 July 2023 Board of Directors (in Private) – 28 September 2023
Legal / Regulatory:	Regulatory

Key Priorities/Goals	Create a safe and high performing organisation based on openess, ownership and accountability Embed an ethos of continuous improvement and innovation, that has the voice of patients, communities and our people at its heart

Strategic Ambition	(✓)	**BAF Strategic Risk**
1. Patients and communities experience fully joined-up care responsive to their needs		
2. Our people feel empowered, valued and engaged to perform at their best	✓	2c Ability to promote and embed positive workplace culture
3. We achieve excellence in everything we do		
4. We use resources wisely to invest in and sustain services		

Key points	
1. To receiving an update on the response to the issues raised by the trial and verdict in the Lucy Letby case and discuss the response, framework and processes in place.	For decision and approval

1. SUMMARY

1.1 It is proposed that the Trust considers its response, framework and processes in place to respond to the issues raised by the verdict in the trial of Lucy Letby and in response to the NHS England letter about Board oversight.

1.2 Freedom to speak up, listen up and follow up should be strengthened. The Trust has recruited an additional FTSU Guardian in response to the National Guardian Offices recommendations, taking the total to 2.0 WTE. Further review is underway to ensure structure is effective and meets the NGO requirements for 3.0 WTE.

1.3 Fit and Proper Person Framework strengthened with additional background checks. See Appendix B. TEG paper 20 Sept 2023.

1.4 The Trust Board will agree processes to ensure they are assured that staff can speak up with confidence and whistleblowers are treated well giving Board oversight on themes, trends and actions taken.

2. BACKGROUND

2.1 Following the verdict of the trial of Lucy Letby, NHS England set out their expectations on freedom to speak up and the expected prompt follow up and response to any issues. All organisations providing NHS services are expected to adopt the updated national policy on Freedom to Speak Up by January 2024 at the latest.

2.2 NHS England have written to all Trusts advising NHS leaders and Boards that they must ensure proper implementation and oversight and 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 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 whistleblowers are treated well.
5) Boards are regularly reporting, reviewing and acting upon available data.

2.3 NHS England have also reminded boards 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 and the Fit and Proper Person Framework has recently been strengthened with additional background checks.

2.4 On 20 September 2023 the Trust Executive Group have received a paper on proposals to strengthen the Fit and Proper Person and was recommended to the Board (Appendix B)

2.5 The appraisals for each Director will be undertaken by 31 March 2024, which will include an assessment against the new NHS Leadership Competency Framework (LCF). A new board appraisal framework will also be published, incorporating the LCF, by March 2024. By the end of Q1 2024, NHS England will require this to be used for all annual appraisals of all Board directors for 2023/24.

2.6 To ensure local implementation, the Trust's Fit and Proper Person Policy will be updated with the requisite consultation with those affected. The owner of this Policy will be the Trust Secretary, supported by the Director of People & OD.

3. PROPOSAL

3.1 In response to the assurance sought by NHS England, the Trust has in place several processes and frameworks.

Freedom to Speak Up

3.2 The Trust undertook a full review of its policies relating to Freedom to Speak Up, accommodating the relevant NGO guidance earlier this year and a second Freedom to Speak Up Guardian was appointed in June 2023, strengthening our arrangements.

3.3 The Guardians are supported by a team of ambassadors across the Trust and the Trust is regularly communicating and promoting the Guardians and FTSU across a range of staff communication channels. Supporting material has also been produced to explain how to raise a concern and who to contact.

3.4 In addition, the Speak Up, Listen Up training modules have now been made available to all staff, via ESR which focuses on the importance creating an environment in which people are supported to deliver their best. The additional module of 'Follow Up' is also available and aimed at all senior leaders including executive board members (and equivalents), non-executive directors, and governors to help them understand their role in setting the tone for a good speaking up culture and how speaking up can promote organisational learning and improvement.

3.5 The Trust Executive Group will be considering whether and how to introduce an Ask the Chief Executive facility on the Trust intranet whereby any member of staff (with the option to do so either anonymously or with their name) can ask any question (on any matter relating to business and functioning of the Trust, including matters of patient safety and management and staff behaviour) of the Chief Executive. They will be guaranteed a full and open answer personally signed off by the Chief Executive. This is a facility commonly used in other trusts, and one which both gives another practical route for staff to raise concerns and sets the cultural tone in the organisation as one of encouragement of speaking out, openness of management at all levels, and approachability and openness of the most senior management, including the Chief Executive.

3.6 Line management and support of the FSTU team will come under the Director of Corporate Services in the new structure.

Learning from Deaths, Medical Examiners and Coroners

3.7 The Trust is compliant with the national standards for Learning from Deaths framework, led by the Executive Medical Director and coordinated by the Clinical Audit and Informatics team. All deaths are screened, and any meeting agreed criteria are escalated for clinical review by the Area Clinical Governance Lead. Any deaths in which there is a potential for learning are reported to the Trust Incident Review Group for consideration under the Serious Incident framework.

3.8 In addition, from April 2024 there will be a statutory requirement for all deaths in the community to undergo independent scrutiny by a Medical Examiner. This is facilitated in YAS under the Management of Deceased policy in which all deaths are reported automatically through the electronic Patient Record to the patient's own Primary Care team through the Post Event Messaging system. This generates a medical examiner referral. All community deaths meeting the existing referral criteria for Coronial oversight are reported to the Police by the attending YAS clinician. There are open communications channels between the Executive Medical Director and the regional medical examiner, with place based medical examiners having open communication with the Area Clinical Governance Leads. Any concerns raised from the ME are managed through the Learning from Deaths policy.

3.9 The Trust Executive Group will conduct an urgent review guided by the returning Executive Medical Director, Dr Julian Mark and the Deputy Medical Director, to advise on any additional capacity or strengthening of arrangements to ensure effective input advice from the Executive Medical Director and their team into the oversight and delivery of quality governance and patient safety, following the introduction of the new executive leadership arrangement under the Operating Model changes.

Patient Safety Incident Response Framework

3.10 As updated at Board in July 2023, the new Patient Safety Incident Response Framework will be implemented across the NHS and in the Trust by the end of September. This represents 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.

Triangulation of data collection

3.11 The Trust Incident Review Group reviews the following.

- All moderate and above incidents reported using the DATIX system,
- Complaints of moderate or above severity
- Service to service in bound cases
- HMC cases and any relevant significant claims such as clinical negligence
- FSTU cases where there is a patient safety theme/impact.

3.12 Decision making about case management is supported by call audits, clinical based discussions, staff statements and other data such as ePR review. Currently staff names 'of concern' would be noted by those working with them and undertaking CBDs or may be noted via the number of complaints or incidents reported, however specific read across on names, especially in terms of incidents, is currently limited and potentially not being fully realised.

3.13 At the Quality Committee following the Lucy Letby hearing and subsequent NHS E letter release, committee members asked the question 'could case like Lucy Letby happen here?' Presently Quality Committee members believe it could and we must improve our processes for recognising where we have concerns about a particular member of staff, using the data sets we have. Further work is underway to determine how this process would work using the systems that we have in place, in particular the DATIX iCloud data base. There may be some areas of reporting that need to be explored and strengthened to achieve this level of insight.

4. FINANCIAL IMPLICATIONS

4.1 The current arrangements and their development are funded from within agreed budgets. A review of the current FTSU arrangements may result in a business case requiring additional funding, which will be considered as part of the Trust's business planning process.

4.2 Proposed alterations to the DATIX reporting system may involve further investment or procurement of another supplier, if DATIX is not able to support insight required. Further options to be explored.

4.2 The new Fit and Proper Person framework will be supported by the incoming Director of Corporate Services, who may require additional funding in terms of supporting administration once the process is fully implemented.

5. RISK

5.1 If staff are not aware or confident in the systems and processes for speaking up and raising issues and prompting responding, the Trust will not be able to confidently say that they are able to keep staff and patients safe, which will in turn lead to challenge from our regulatory bodies.

5.2 If the process for Fit and Proper Person is not updated will be no longer be in line with NHS E requirements.

6. COMMUNICATION AND INVOLVEMENT

6.1 Following the outcome of the trial, all Trust staff were sent an email from the Chief Executive on 29 August, responding to the verdict, reminding staff of the routes to speak up and their role as well as reiterating the commitment of the Board and senior leaders to ensuring that their concerns would be heard and acted upon. A copy of the message is in Appendix A.

6.2 As part of the regular communication and engagement with staff, October is Freedom to Speak Up month and will be another opportunity to focus on how staff can speak up, the routes available, as well as encouraging take up of the training opportunities.

7. EQUALITY ANALYSIS

7.1 Access to speaking up routes is made available to all staff and specific work is undertaken where barriers are identified to accessing information or feeling confident to speak up.

8. PUBLICATION UNDER FREEDOM OF INFORMATION ACT

8.1 This paper is exempt from publication under Section 22 of the Freedom of Information Act 2000, as it contains information which is in draft format and may not reflect the organisation's final decision.

9. NEXT STEPS

9.1 Implement the Fit and Proper Person Framework as per NHS E guidance

9.2 Continue to provide regular FTSU communications, review of FTSU team structure and work to ensure staff are trained in all relevant FTSU eLearning, including senior managers undertaking the listen up and follow up modules.

9.3 Review all data sources and ensure adequate triangulation and read across to ensure we can highlight individual staff that there are concerns about.

9.4 Discuss and agree processes to ensure they are assured that that staff can speak up with confidence and whistleblowers are treated well giving Board oversight on themes, trends and actions taken.

10. RECOMMENDATION

10.1 Review the contents of this paper and take assurance from the existing processes and agree to the strengthening of processes going forward to ensure adequate oversight for Trust Board.

11. SUPPORTING INFORMATION

11.1 APPENDIX A - Message sent to all staff from the Chief Executive following the Lucy Letby trial and verdict.

11.2 APPENDIX B – Fit and Proper Person Framework proposal agreed at TEG 20 September 2023.

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Appendix A
Message to staff following Lucy Letby case.

Dear colleagues,

The recent case of neonatal nurse Lucy Letby who was found guilty of seven counts of murder and six counts of attempted murder for her actions at the Countess of Chester Hospital, has been shocking for all, but particularly those of us working in the NHS.

There has been blanket media coverage of these appalling crimes and the terrible betrayal of the trust placed on her. Much of the debate around the case has focused on reports that suspicions of the crimes were not treated seriously, staff were not supported to speak up and concerns were not followed through because senior leaders were concerned about the reputation of the hospital or its maternity and neonatal service. These issues will be covered in the independent inquiry which will, I hope, lead to clear learning for the NHS and a set of actions.

Here at Yorkshire Ambulance Service, please remember we have a range of processes to support staff who wish to raise work-related concerns, including the person's immediate supervisor or more senior manager in the department, Datix and HR processes including those relating to dignity and respect and issue resolution. Trade union representatives are also available to support staff in raising issues or concerns.

The Freedom to Speak Up process acts as a safety net, complementing these other routes for raising issues or concerns, for example in situations where staff do not feel confident to speak up via other routes or an issue that they have raised remains unresolved. It is available for all staff to use, no matter what your role. Please refer to Pulse for more information.

While speaking up is fundamentally important, we are absolutely committed to the 'Listen Up' and 'Follow Up' ethos behind Freedom to Speak Up. This year we have strengthened our Freedom to Speak Up arrangements and now have two Guardians, supported by a team of Ambassadors, to help ensure we keep patients and colleagues safe.

Our Guardians act as 'critical friends' to our senior leadership teams as they seek to identify barriers, commit to the learning outcomes that emerge, and foster an open and safe culture. It is everyone's role to ensure that patients are always safe in our care.

All concerns raised under Freedom to Speak Up are logged by the Guardians and reviewed confidentially (and anonymously if necessary). The Guardians can escalate matters directly to myself, Jeremy Pease, the Non-Executive Director lead for Freedom to Speak Up, and other Executive Directors to ensure an appropriate and effective senior level review of concerns raised, so matters can be addressed and resolved.

On behalf of the Trust Board, I would like to reassure staff that we are totally committed to patient safety and staff wellbeing above everything else.

Please continue to let us know your concerns and if you are aware of issues that need investigating. It is crucial that you raise them through one or more of the routes described above. We promise we will investigate all concerns that are raised, support and thank you for raising them, and ensure that we take all appropriate action to ensure that your concerns are fully addressed.

Thank you for your continued hard work.