Board of Directors - Cover Sheet

Subject:	Assurances following the verdict in the trial of Lucy Letby	**Date: 5th October 2023**	
Prepared By:	Paul Robinson, CEO & Kerry Bosworth, Freedom to Speak Up Guardian		
Approved By:	Paul Robinson, CEO & Kerry Bosworth, Freedom to Speak Up Guardian		
Presented By:	Paul Robinson, CEO & Kerry Bosworth, Freedom to Speak Up Guardian		

Purpose		
To provide assurances to the Board requested by NHS England following the verdict in the trial of Lucy Letby	**Approval**	
	Assurance	**X**
	Update	
	Consider	

Strategic Objectives					
Provide outstanding care in the best place at the right time	Improve health and well-being within our communities	Empower and support our people to be the best they can be	To continuously learn and improve	Sustainable use of resources and estate	Work collaboratively with partners in the community
X		**X**	**X**		

Principal Risk		
PR1	Significant deterioration in standards of safety and care	**X**
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	
PR4	Failure to achieve the Trust's financial strategy	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	**X**
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

N/A

Acronyms

FTSU Freedom to Speak Up
PSIRF Patient Safety Incident Reporting Framework
HSMR Hospital Standardised Mortality Ratio
SHMI Summary Hospital level Mortality Level Indicator
NHS National Health Service
HR Human Resources

Executive Summary

Following the verdict of the trial of Lucy Letby, NHS England wrote to all NHS Trusts and Integrated Care Boards setting out requirements for Board governance and oversight. Specific assurances are required in respect of:

1. All staff have easy access to information on how to speak up
2. Relevant departments such as HR and FTSU are aware of the National Speaking Up Support Scheme and actively refer individuals to the scheme
3. Approaches or mechanisms put in place to support staff who may have cultural barriers to speaking up or in lower paid roles and may be less confident to do so, those working unsociable hours who may not always have access or aware of policies. Methods for communicating with

staff to build healthy and supporting cultures where everyone feels safe to speak up put in place

4. Boards seek reassurance that staff can speak up with confidence and whistleblowers are treated well
5. Boards are regularly reporting, reviewing and acting upon available data

The Trust's Freedom to Speak Up Guardian has reviewed the areas required for assurance and has provided the attached report and provided recommendations to strengthen further.

The Board can also take assurance in a number of additional areas:

1. The Patient safety culture of the Trust, the role of Trust's Clinical Director for Patient Safety and implementation of Patient Safety Incident Reporting Framework (PSIRF) and continued, relentless focus on governance and safety via the governance safety unit
2. Monthly Maternity services reporting to Board in respect of Maternity and Neonatal Safety Champion and Maternity Voice Champion updates, Maternity and Neonatal Incidents and Investigations and Perinatal Quality Surveillance and Mortality Reviews
3. Local, System and Regional mortality and morbidity meetings are established and mature with respect to Neonatal mortality
4. Speciality and Divisional governance process, morbidity & mortality reviews and learning. Patient Safety and sub-committees including Deteriorating Patient and Learning from Deaths
5. Robust oversight and management of Board Assurance Framework Principal Risk 1 - *Significant deterioration in standards of safety and culture* by Quality Committee
6. Quality Committee routine scrutiny of local quality metrics and nationally reportable mortality ratios (HSMR & SHMI)
7. Board Maternity and Neonatal safety Champion fully embedded and undertaking regular walk-rounds of the service
8. Monthly Maternity and Neonatal Forum in place and attended by Chief Executive Office and Chief Nurse
9. The role of the Trust's Medical Examiners to provide independent scrutiny of the causes of deaths. SFH Examiner is the chair of the regional Learning from Deaths Committee
10. Robust application of the current Fit and Proper Persons requirements and commitment to full implementation of the revised requirements
11. Regular promotion of FTSU importance and mechanisms by Chief Executive Officer in staff briefings and weekly blogs
12. Relentless drive to embedding an organisational culture to be curious. To appropriately challenge, escalate, to call out when things don't feel right, along with developing a truly listening organisation

The Board is requested to:

13. **Receive the assurance of the FTSU Guardian and consider and agree the recommendations**
14. **Receive the further assurances provided by the Chief Executive Officer**