Written evidence submitted by North Central London ICB (PSN0014)

SUBMISSION – North Central London Integrated Care System response. Information from ICB leads and a number of providers.

We are very willing to add additional details as required contact: jamesavery@nhs.net Clinical Director NCLICB

Policy area	Recommendation	NCLICB comments
Maternity care and leadership	1. "There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is in our view no less applicable to maternal and perinatal deaths, and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay." (From the inquiry into Morecambe Bay Investigation, 2015)	ICB position Each of the providers within NCL currently report perinatal deaths as Serious incidents (Sis), these are captured on their Perinatal Surveillance Quality tool, reported internally to a quality committee and Board and reported to the ICB through the monthly Perinatal Quality Surveillance group. There is no additional funding specifically for this, however there is funding through Ockenden actions for a number of related workstreams such as, Equality and Equity. An ICB wide incident reporting systems is under procurement and currently makes use of the national reporting and learning system . Each provider has an effective incident reporting system Provider comment - Maternity: All learning from SIs is shared with teams and at monthly departmental briefings and maternity learning bulletin. Attendance for monthly briefings is mandated for all clinical and governance maternity staff. RFL perinatal review process is well developed with monthly Perinatal dashboard reported to Quality Committee and active mechanism of escalation to Board in place. All significant serious incidents, HSIB investigations, deaths and never events have oversight by Quality Committee. Action plans are closely monitored and feed into the processes for dissemination of learning. For general population, active Mortality and Morbidity groups in place for London, each specialty, division and at Trust level . Bi-monthly Mortality Surveillance and End of Life Care Group provides oversight on Mortality and Morbidity reviews, outputs from medical examiners and learning from deaths. Any of these cases (M&M, LfDs, ME reviews) with care service delivery issues are reviewed for investigation as a serious incident. 100% of all deaths are scrutinized by the medical examiner. Escalation of any concerns

	2. "A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it." (From the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013.)	are taken to the Quality Committee and escalated to Trust Board as necessary. 2. Nolan principles are in place with also fit and proper person test plus a number of programmes including ' civility saves lives ' . Each provider has a clear set of values include areas of safety, transparency, commitment to improvement and learning plus inclusion. Performance in relation to coworkers and patients against which are assessed as part of appraisal processes , see example booklet 'Living our values booklet-2'. Delivery against this areas is measured across a number of routes including national staff survey and training survey
Health and social care training	3. "Targeted interventions on collaborative leadership and organisational values, including a new, national entry-level induction for all who join health and social care." (From the Health and social care review: leadership for a collaborative and inclusive future report, 2022)	No national training however Care Certificate as an entry level set of standards is in place. The national electronic learning for health system does have modules on this area and each providers provides a mandatory induction to all new staff covering trust values, incident reporting and core safety knowledge . Additionally organisations do have safety, culture and reporting often within induction and annual updates. National and local leadership programmes are in place and cover this area. Provider comments NCL – Provider delivering the 'What matters to you (staff)' program across the trust. This is a staff engagement and civility program. Initial feedback from the teams highlighted areas where staff would like to see changes, to make them more included, safe and supported, this includes psychological safety and civility. A QI methodology is used and targeted improvement actions are being delivered. Specific to maternity leadership a bespoke organisational development program has been deliver . Since 2021, an intense and continuous targeted intervention with the Women's & Children's Divisional Leadership team on collaborative leadership, leadership team purpose, strategy and staff engagement programme work has been undertaken. There is strong evidence that the Maternity Culture has shifted substantially. At Royal Free London this has been recognised by staff, external partners (NEDs, Maternity Voice Partners) and oversight bodies e.g. reference by Kate

		Brintworth Chief Midwifery Officer, England during Ockenden review visit. Verbal feedback from CQC well-led inspection of our maternity unit in Edgware hospital included noting the good culture in the maternity unit.
Culture of safety, and whistleblowing	4. “Culture of safety: Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns. Action 1.1: Boards should ensure that progress in creating and maintaining a safe learning culture is measured, monitored and published on a regular basis. Action 1.2: System regulators should regard departure from good practice, as identified in this report, as relevant to whether an organisation is safe and well-led.” (From the Freedom to Speak Up Review, 2015) 5. “Primary Care: All principles in this report should apply with necessary adaptations in primary care. Action 19.1: NHS England should include in its contractual terms for general/primary medical services standards for empowering and protecting staff to enable them to raise concerns freely, consistent with these Principles. Action 19.2: NHS England and all commissioned primary care services should ensure that each has a policy and procedures consistent with these Principles which identify appropriate external points of referral which are easily accessible for all primary care staff for support and to register a concern, in accordance with	ICB comment The ICB has a policy for freedom to speak up in place that sets out the organisational approach to supporting staff regarding whistleblowing / speaking-up The policy and supporting information is easily accessible for staff via a dedicated section on the Intranet Speaking up (Whistleblowing) | (icb.nhs.uk) The ICB’s Freedom to Speak-Up Guardian has completed all of the mandatory training requirements as set out by the National Guardian’s Office and is registered on the NGO website The ICB Guardian is supported by the Freedom to Speak-up Ambassadors and, for clinical matters, by the ICB’s Chief Nursing Officer Through national ‘speaking-up month’, the ICB runs a series of reminders to staff on the importance of speaking-up and the support that is available should the need arise A high-level summary of the speaking-up activity is provided annually to the Board The ICB has provision in place to support staff members in General Practice – should they wish to have a confidential ‘speak-up’ conversation Following the issue of new speaking-up guidance from NHSE earlier this year – the ICB is seeking assurances from Trusts in NCL that suitable speaking-up arrangements are in place in each organisation The ICB awaits further guidance from NHSE (likely to be by March 2024) on further arrangements, in the context of speaking-up, to support Primary Care, DOPs and Trusts. Provider comment - Nolan principles are in place with also fit and proper person test. RFL place a very strong emphasis on our Trust values to foster civility, respect and a good safety culture. Trust values include ‘positively welcoming, actively respectful, clearly communicating and visibly reassuring’, performance in relation to coworkers and patients against which are assessed and embedded as part of our appraisal, see ‘Living our values booklet-2’.

	this report. Action 19.3: In regulating registered primary care services CQC should have regard to these Principles and the extent to which services comply with them." (From the Freedom to Speak Up Review, 2015)	RFL strongly promotes an open and transparent reporting culture. Principles of Culture of Safety are covered in RFL induction process, at the induction day and in more detail at the local induction of staff. Currently all medium harm and above harm incidents are taken to our Safety Incident Review Panel for scrutiny and investigated as an SI as appropriate. We have a just culture policy in place and 'Just culture' principles are enacted as part of incident policy. RFL Board via the Quality sub-committee has oversight of all significant Serious Incidents, HSIB, death or never event or those that are particularly noteworthy. Currently all medium harm and above harm incidents are taken to our Safety Incident Review Panel for scrutiny and investigated as an SI as appropriate. A 'Just culture' approach is in place as part of our incident policy, see incident policy. Learning is shared as per our Sharing the Learning SOP (attached) and learning shared in a variety of forms with services and at governance meetings. Completion of action plans and changes of incident reporting patterns, as measures of reporting culture, are monitored and reported through to the Quality Committee. With the implementation of PSIRF the safety culture will be further strengthened. RFL have a very active Freedom to speak up (FTSU) programme in place with over 100 FTSU champions, and safety concerns are immediately escalated to relevant clinical leaders. Our Audit Committee closely monitored the outputs from our FTSU programme, Whistle blowing and measures on safety culture.