Written evidence submitted by
Frimley ICB (PSN0015)

	Independent inquiry or review recommendation under evaluation	Has the recommendation been implemented? Or (in the case of a recommendation whose deadline has not yet been reached) Is the recommendation on track to be implemented?	Has there been specific and adequate funding to enable the recommendation to be implemented?	Has there been a positive impact on patients and people in receipt of social care as a result of the recommendation being implemented?

1	**Maternity care and leadership** **Recommendation 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	Partially- Maternity and newborn safety investigations programme (MNSI) hosted by CQC (and formally HSIB) review stillbirths, early neonatal deaths and maternal deaths and provide independent reviews and recommendations. Alongside this MBRRACE (mothers and babies reducing risk and confidential enquires) provide trends and analysis of cases at trust, regional and national levels. MBRRACE reports are published two years retrospectively which is the key barrier to independently scrutinising trends in real time.	Partially Additional funding to provide MBRRACE data in real time or with a lag that is shorter than the current two years would dramatically improve the ability to independently analyse and scrutinise deaths and trends and pick up on early warnings	n/a

	Investigation, 2015) Specific evidence needed: - Data from national scrutiny of perinatal and maternity deaths. - Examples of independent scrutiny of perinatal deaths and maternal deaths and its application at local, regional and national levels. - Evidence of adoption and quality of review. - Progress following the consultation on coronial investigations of stillbirths in 2019. - Progress of the statutory medical examiner scheme and its application to perinatal and maternal deaths. - Perinatal and maternal mortality surveillance data post 2021.			

	Recommendation 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.) Specific evidence needed: - Example of code of ethics for senior leaders and managers. - Examples of measures to train, educate, accredit and continuously develop leaders and managers to comply with the code of ethics. - Examples of an obligation on leaders and managers to comply with the code of ethics, sanctions for non-compliance and disqualification from other senior roles in cases of serious breach of the code. - Any available analysis of a code of ethics effectiveness and impact. - Evidence of a central database of directors and the type of information.	Nolan Principles are implemented and more recently the Fit and Proper Person Test which addresses sanctions for non-compliance and disqualification. Organisations report to NHSE on their compliance with FPPT. Within the ICB the Chief Medical Officer, Chief Nursing Officer and two Primary Care Partner Members (both GPs) need their annual professional revalidation / accreditation. The Chief People Officer also needs to have a professional HR registration, similarly the Chief Finance Officer.	n/a	n/a

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2	**Training of staff in health and social care Recommendation 1:** "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) Specific evidence needed: - Examples of local initiatives of induction training for entry-staff joining health, and social care organisations. - Analysis or evaluations of impact of induction training for entry-level	Frimley has run its own system collaborative leadership initiatives since 2017. Most notable our flagship 20/20 system leadership programme and Wavelength digital leadership programmes, pre-date the 2022 (Messenger/Pollard) review but are very much aligned in terms of leading-edge content, and impactful outcomes, with the common findings and the 'triple lens' recommendations within the 2022 review and others (including Hewitt 2023). The programmes provide unique opportunities for large cohorts of predominately mid to senior level professionals from a broad range of professional sectors across all parts of	ICB funded - following a stringent investment review process. Funding is adequate for the Frimley System Academy to maintain current 20/20 and Wavelength programme schedule and momentum. Additional funding and staff resource would be required to deliver larger scale universal implementation envisioned in the review, and to enable greater leverage of the significant distributed network potential. No specific funding has been identified nationally to support recommendation and all programmes locally funded from ICB budget.	To date 20/20 and Wavelength programmes have been a catalyst for c.200 change challenges a broad ranging powerful method for unlocking cross system collaboration and personal agency, alongside numerous transformation ideas. Current examples include: • System wide home first programme which has significantly reduced hospital discharge times. • Improving health inequalities and access to underrepresented families in Slough with complex diabetes conditions • Successful financial investment for other sector partners to facilitate stronger leadership and culture programme with potential to work cross system with our Frimley Academy. Personal and Professional Impact - successive programme evaluations report increases typically c. 40%, in levels of system collaboration, increased knowledge, skills, awareness, and the proliferation of networks which are breaking down barriers, building trust and strengthening relationships across our system.

	staff. - Examples of targeted interventions on collaborative leadership and any evaluations of such initiatives. - Examples of national level issued guidance for running collaborative leadership, or entry-level induction, training.	health and social care, local government, Ministry, of Defence, Fire, Police, Education, emergency services and the voluntary, community and social enterprise sector, to come together develop their leaderships skills to create networks of leaders committed to advancing community driven partnership working to tackle the complex change challenges we commonly face. Work being undertaken across the system on local induction staff for entry level health and social care staff.		

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	Culture of safety/whistleblowing Recommendation 1: "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)	Frimley ICB actively fosters a culture of safety. The ICB has a patient safety network which is designed to openly share learning across the system. The ICB and System Partners participate in the staff surveys which is a great barometer to monitor if staff feel comfortable to raise concerns; any actions that arise are responded to. The ICB' S F2SU Guardian has created a 'community of practice' with the other Guardians in the system and the Executive and Non Executive Leads. This group will meet quarterly to highlight issues/share learning and best practice . The ICB F2SU and Trust Guardians also meet separately to highlight any concerns/barriers and share best practice. The guardians have delivered a seminar to the Board on speaking up and creating positive cultures of psychological safety and as part of Speak Up Month delivered a seminar on creating psychological safety in organisations for people to speak up safely.	All System Partners work collaboratively to ensure safety is a priority in everything we do. Patient safety wouldn't be compromised due to funding. Frimley ICB has a robust risk and QIA process in place, especially when decision need to be made. No specific funding was made available for this recommendation.

	A f2SU system report has also been delivered to the Board , detailing number of speak up cases and themes. The ICB F2SU guardian has built positive relationships and works closely with other guardians in the system and any cases needing escalation are highlighted. Action 1.1 - Within Frimley ICB, there are clear governance arrangements in place to escalate safety and learning and regular reports are shared at Place, System and Board levels. Action 1.2 System Regulators are part of our System Meeting and actively engage in discussions and they have opportunities to raise concerns or highlight good practice.	

3	**Recommendation 2:** "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 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) Specific evidence needed: - Metrics for measuring and maintaining a safe learning culture. - Evidence of system regulator action on areas of concern. - Evidence of roll out to primary care. - Evidence of review of NHS complaints system. - Examples or extracts from NHS	Frimley ICB have supported Primary Care to have robust FTSU policies and currently the CQC have not identified any areas for improvement on this metric. There are currently no Primary Care organisations within the ICS that have been recorded as inadequate Frimley ICB has a nominated Board Member as the FTSU Guardian, and they are currently working with the Primary Care Team to identify an ongoing solution which is challenging given the lack of resource. Frimley ICB CNO reviews all Primary Care Complaints.	As no additional funding has been received Frimley ICB are currently working toi identify a solution using current resources

	Board papers and contracts for services. - Supporting data from the CQC.		