Written evidence submitted by NHS Cornwall and Isles of Scilly ICB (PSN0017)

Introduction

This submission is made on behalf of Cornwall and Isles of Scilly ICB and integrated care system at the request of the parliamentary health and social care select committee. We have been asked to submit our views on the extent to which these recommendations have been implemented and funded by the Government, the impact this has had on patients and people in receipt of social care and whether the Government's interpretation of the recommendations was appropriate. We have answered to the best of our ability the request drawing on the relevant subject matter experts in our organisation. It is also noted the recognition that not all stakeholders will be able to answer all questions. It must be noted that these questions have been asked in conjunction with a document entitled final patient safety evaluation grid which asks some questions that are not possible to answer at this time due to guidance being awaited and funding not allocated. We have therefore answered as best we can.

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)* 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.)*

Response to Maternity care and Leadership point 1

Medical examiner implementation – the Cornwall Medical Examiner Office is made up of a team of 13 consultants and GPs providing a medical examiner service 5 days each week. They are supported by 7 medical examiner officers. The 3 main functions of the medical examiner are to ensure that there is accurate medical certification of the cause of death, to identify significant problems in treatment and to ensure these are reported to the coroner/ hospital/ community governance system and finally to increase transparency for the bereaved, listen to their concerns and to explain the cause of death to them. The medical examiner provides advice and support to clinicians including which deaths need to be reported to the coroner and how to complete the medical certificate of cause of death. The medical examiner service is due to be extended to primary care in April 2024.

One of patient safety specialists (PSS) priorities is to support implementation of medical examiners. CIOSICB PSS also provides a link between the medical examiner and the system mortality and morbidity group, Local maternity and neonatal system (LMNS) and system patient safety group. This

facilitates greater sharing and triangulation of information to identify adverse trends, learning and inform improvement actions.

Maternal and neonatal deaths identified as patient safety incidents are reported to The Maternity and Newborn Safety Investigations programme (MNSI), this is part of a national strategy to improve maternity safety across the NHS in England. The MNSI carry out an independent investigation and, where relevant, make safety recommendations to improve services at local level and across the whole maternity healthcare system in England. Our maternity services have welcomed the MNSI investigations and collaborated openly. considerable improvements have been made because of this.

In addition, perinatal and maternal deaths are discussed at the Royal Cornwall Hospitals NHS Trust (RCHT) maternity and neonatal safety champions group and the incident review and learning group both have representation form CIOS ICB quality team. The learning is shared with the Local Maternity and Neonatal System (LMNS) on a monthly basis.

Ockenden funding has been received to the value of £804,000.00 which has been invested into Cornwall and Isles of Scilly maternity services and this is reflected in the positive reputation of our maternity services.

The Integrated Care System mortality and morbidity group also reviews maternal and neonatal maternity data, triangulated with child death data, looking for trends, learning and opportunities for quality improvement.

Cornwall and the Isles of Scilly LMNS are recognised by NHSE as having good quality arrangements for listening to women and families. Our Maternity and Neonatal Voices Partnership (KMNVP) is an early implementer of many important improvements and has supported NHSE in its development of core guidance for commissioning MNVPs.

As a system the strength of our co-production has resulted in better outcomes for women and babies locally, as fully recognised within the RCHT CQC inspection, and the Insight report. This includes new service innovations such as perinatal pelvic health services, maternal mental health services and the WREN team who provide enhanced continuity of care for vulnerable women.

Advanced clinical practice (ACP) in midwifery and professional midwifery advocates (PMA) are a strength in RCHT supporting staff disclosure and whistleblowing. This is due to the quality and standard of training they have received through a robust training programmes. Other staff have commented on the fabulous support that the ACP's and PMA's have been able to give them through difficult circumstances and just being there to give support and advice.

Please also see the section with regard to culture of safety and whistleblowing for further information.

Response to Health and Social Care Training point 3

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)*

We welcome the recommendation to have the new national entry level induction for all new health and care staff but this hasn't been supported through dedicated funding that would overcome the practicalities of organising a common induction process for NHS, primary care and multiple independent care sector organisations. We are awaiting guidance that we understand has been delayed and will now be released in 'spring'2024, and if no additional funding were made available we would need to address how we divert existing leadership development or workforce development funding to meet this recommendation, balanced against other staff development priorities We are working across our system to develop an integrated workforce strategy and plan.

The latest from Skills for Care Induction and leadership support in 2024 (skillsforcare.org.uk) which builds on the 2022 Messenger recommendations. We are expecting the new supporting resources to be made available sometime this spring but don't have a more detailed timeline as yet. This links to the proposed care workforce pathway Care workforce pathway for adult social care: call for evidence - GOV.UK (www.gov.uk) . The intention to develop a universal career pathway reflects the move towards more integrated health and care systems. The pathway aims to ensure parity between equivalent roles in health and adult social care to build a more agile workforce, with the skills and opportunities to work across the wider system. We also understand there are some funding issues to be worked through which are highlighted in the Care England response which covers some of the funding issues (from a Care England perspective): Care Workforce Pathway - Care England.

Response to Culture of safety and whistleblowing Point 4

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 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)*

Cornwall and the Isles of Scilly ICB/ICS are fostering a developing culture of safety and whistleblowing. It is important that all staff at all levels have the confidence to speak up when

things aren't right. They need to be confident to know they can speak up, be listened to, be heard and for action to follow (if appropriate).

We have recently signed off at our December Board the new **sexual safety charter** (please see embedded document for full details of our plans). We are embedding the 10 principles of the charter into all that we do as part of our staff support. This will be managed by our safeguarding and people team. We expect to embed these principles within our ICS and will be adopted by all ICS partners.

We support and have **freedom to speak up** champions in all our organisations, who are trained to support colleagues who feel they need to talk to someone. This is well established within our organisations. We have updated the Cornwall ICB **whistle blowing policy** as per the new national system guidance and our partners have followed suit in updating their policies.

Our Quality and pathways of care committee regularly review any safety concerns as does our morbidity and mortality board.

Cornwall and Isles of Scilly integrated care system (ICS) were an early adopter for the new national Patient Safety Incident Response Framework (PSIRF) 2019 which enabled all NHS Trusts in the system to work collaboratively, testing new approaches to patient safety management, systems, learning and culture. Following the successful pilot and launch of PSIRF guidance by NHSEngland, the ICS now have a monthly system patient safety forum in place between all health and social care providers to enable rapid mitigation of risk, shared learning and improved relationships. All Patient Safety Incident Response Plans (PSIRP) from NHS Trusts have been formally signed off by the ICB with oversight and assurance in place. This has further been extended by the launch of Learning from Patient Safety Events (LfPSE) whereby organisations are now required to enter patient safety incidents, enabling wider triangulation at local, regional and national level. The draft national primary care patient safety strategy is currently in consultation phase, led by patient safety specialists and patient safety partners across the system.

The civility and respect programme led by RCHT has brought a series of speakers to Cornwall on compassionate leadership and created a safe and compassionate leadership programme.

We have our primary medical care services representative on our board and our integrated care managing directors (our place) are part of all the decision making we do to support primary care and we support the premise that all policies should be relevant with adaptations to Primary Care.

From the Lucy Letby report we have also done a stocktake of the areas of concern and produced a gap analysis of work to be done. A paper was taken to our Board in November 2023 which contains all the information around the gap analysis and next steps.

Our Board and board committees are kept fully appraised of all safety and whistleblowing concerns as appropriate and are just about to do their safeguarding training as a Board. This ensures all Board members and executives understand their responsibilities as individuals and as board members.

Please see embedded documents for reference and further details of our plans.

ICB Freedom to speak up policy

Freedom to speak up policy.pdf

Sexual safety charter Pt 1 December 2023 ICB Board

ICB2324164b Sexual safety charter.pdf

Lucy Letby self assessment Pt 1 November 2023 ICB Board

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