Written evidence submitted by the NHS Gloucestershire ICB (PSN0020)

1. **Executive Summary**

1.1. We have commented where we have evidence or opinion. However, some areas of the recommendations are beyond our scope or knowledge. In summary, we believe that:

1.1.1. External oversight and scrutiny of perinatal and maternal deaths is in place,

1.1.2. It is too early to assess the impact of the new Fit and Proper Persons Test,

1.1.3. The recommendation relating to entry level induction training for staff joining health and care organisations has not yet been implemented,

1.1.4. A culture of safety and learning is growing and is supported by new frameworks, and

1.1.5. The proposed Primary Care Safety Strategy is ambitious but appears to not be linked to contractual mechanisms.

2. **About Us**

2.1. NHS Gloucestershire Integrated Care Board (NHS Gloucestershire) is responsible for planning and buying services to meet the health needs of local people.

2.2. It also brings partners together to ensure the county's NHS provides the best possible care. Alongside our communities, we want to improve health, improve access to high quality care and support when needed and make Gloucestershire a better place for the future.

3. **Maternity care and leadership**

3.1. **Recommendation 1:**

3.2. "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)

3.3. External oversight and scrutiny of perinatal and maternal deaths in Gloucestershire is provided in several ways. In line with the Ockenden recommendations and the implementation of the revised Perinatal Quality Surveillance Model in 2020, Gloucestershire Local Maternity and Neonatal System (LMNS) has developed and embedded a Framework for Perinatal Quality & Safety Surveillance and Oversight. The framework outlines the role and responsibilities of the Gloucestershire LMNS as a structure within the ICS in relation to the oversight of quality and safety in maternity and neonatal services.

3.3.1. The LMNS Perinatal Quality & Safety Workstream (a sub-group of the LMNS Board) ensures continuous LMNS/ICB oversight of perinatal clinical quality surveillance, planning and improvements to ensure a positive experience for women/birthing people and families in Gloucestershire. Key stakeholders including Maternity & Neonatal Voices Partnership/Users provide ongoing review a range of sources of intelligence relevant to maternity and neonatal services. The LMNS produces a monthly dashboard to ensure oversight of a number of key outcomes including stillbirths, neonatal deaths, brain injury and maternal death data identifying trends and benchmarking against other LMNS's, regional and national maternity dashboards. All cases that meet the criteria for the Maternity and Newborn Safety Investigation Programme (previously HSIB) are referred for external investigation. Safety actions identified are monitored through the Trust Safety Experience Review Group of which the LMNS are a member

3.4. The governance structure in place ensures representation of perinatal quality and safety issues at the ICB System Quality Group and areas of concern are reported to the regional Perinatal Quality & Safety Surveillance Group and, where necessary, support requested.

3.5. As Gloucestershire LMNS has a single provider of maternity & neonatal services a buddying arrangement is in place with Bath, Swindon & Wiltshire (BSW) LMNS with a formally agreed memorandum of understanding**.** As part of this buddying arrangement Gloucestershire and

BSW LMNS supports a process for requesting external expert opinion safety incident reviews and attendance at Perinatal Mortality Review meetings. This arrangement has been established since 2021 and provides objective clinical review, check and challenge as part of the investigation/patient safety review process. Lessons learnt from incidents are shared at a joint Gloucestershire and BSW Safety Forum and across the region at the South West Perinatal Quality Safety Surveillance Group (PQSSG).

3.6. Another critical development was the introduction of the Medical Examiner (ME). Gloucestershire was a trial site for the roll out of the ME programme and we support their independent work which acts as an important safeguard, Due to being a trial site, our ME programme is well established as is now gathering pace to roll out into primary care as part of the death certification reforms.

4. **Recommendation 2:**

4.1. "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.)

4.2. The NHS Constitution (containing key principles) and the NHS Code of Conduct remain in place and inform local policies.

4.3. All NHS Managers are also expected to adhere to the Nolan Principles of Public Life.

4.4. From 30 September 2023 the new Fit and Proper Persons Test (FPPT) came into place setting out new & more comprehensive requirements including:

4.5.

4.5.1. An Annual individual Board member declaration process (self-attestation) reviewed by the Chair & CEO (aligned to the annual appraisal process)

4.5.2. Annual Board declaration process relating to all Board members signed off by Chair and submitted to the Regional Director

4.5.3. A prescribed format and reference template for all Board member references for new appointments after a conditional offer has been made.

4.5.4. Completion and retention of a Board member reference for leavers (to be completed even if the individual is not moving to another Board role).

4.6. The purpose of the new Framework is to strengthen individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS. It is too early to assess the impact of the new FPPT.

5. **Training of staff in health and social care**

5.1. **Recommendation 1:**

5.2. *"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)*

5.3. The recommendation relating to entry level induction training for staff joining health and care organisations has not yet been implemented. We understand work is taking place to develop a co-created induction programme between NHSE, DHSC, LGA, Skills for Care and patient representatives and is due for release in 2024.

5.4. NHSE, Skills for Care and NHS Employers provide induction level resources for NHS and social care providers to support best practice.

5.5. In the meantime, local induction programmes remain in place.

5.6. Similarly, we have not seen any national level guidance on collaborative leadership. Locally in Gloucestershire we have provided a range of leadership programmes that feature collaborative and integrated leadership for staff across health, social care and the voluntary and community enterprise sector. These have been locally evaluated and well received by staff as breaking down the barriers between sectors and supporting integrated working. Staff are also able to access programmes provided by NHSE/ the Leadership Academy. However, there is no standard approach across ICSs.

6. **Culture of safety/whistleblowing**

6.1. **Recommendation 1:**

6.2. *"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.*

6.3. Much work has been undertaken at both a national and local level to develop a culture of safety and learning. This has been driven through the introduction of the national Patient Safety Strategy and frameworks such as the Patient Safety Incident Response Framework (PSIRF). When fully implemented, this new way of working will focus on learning and development, rather than root cause analysis and will reduce the potential for blame which can stifle a positive culture.

6.4. At an ICB level, in April 2023, we organised a 'conversation café' supported by the West of England Academic Health Science Network, which was open to all system partners which aimed to drive better understanding of PSIRF and develop a system safety culture. This was attended by over 50 people and resulted in positive system work and involvement. Culture change cannot happen overnight. However, it is events like this that change perceptions and build system relationships.

6.5. Another driver to develop safety culture was the new national patient safety training programme. Unfortunately, the platform that this is delivered through is not used by all organisations and we have needed to wait to integrate this into our own statutory and mandatory training regime. This is now on track, but has caused some delay to roll out within the ICB. While the level 1 and 2 training is basic to many, it sets a baseline which promotes the idea of 'safety' in a similar way to that of safeguarding and can only be seen as good thing.

6.6. One development mandated by NHS England was the implementation of Patient Safety Specialists (PSS). These roles are key to help develop culture, unfortunately no funding was attached to the mandate which has resulted in many organisations, including Gloucestershire ICB, asking each PSS to cover multiple portfolios. Similarly, the mandate to recruit Patient Safety Partners came with no funding and only guidance of rates of remuneration which can be interpreted locally.

6.7. NHS England has now funded training for PSS which is delivered by Loughborough University and is open to all PSS including those from the ICB and is supported by the Board with our PSS currently working through the first module.

6.8. Ultimately, one of the biggest challenges in moving from a framework based on counting incidents to that of learning and development is the challenge of measuring and monitoring. Our Board is committed to this, but new ways of working need time to develop and mature. With each provider organisation now holding sovereign accountability at board level for safety, rather than reporting to the ICB we must continue to develop different relationships and drive a positive culture.

6.9. This new approach to safety and safety training supports other systemic changes designed to improve the culture of speaking up and learning. Freedom to Speak Up Guardians are a critical resource to develop a positive and open culture.

6.10. Gloucestershire was one of the first Clinical Commissioning Groups (prior to the move to ICB) to have a Guardian in place and recent appointments have strengthened our Freedom to Speak Up arrangements.

6.11. While there are local and regional support networks for guardians from which we gain some assurance, we believe a national review would be beneficial to understand the difference they have made.

7. **Recommendation 2:**

7.1. *"Primary Care: All principles in this report should apply with necessary adaptations in primary care.*

7.2. NHS England is developing a new Primary Care Patient Safety Strategy which has great ambition for Primary Care. However, an early draft seen by the ICB suggests that the same contractual mechanisms applied in secondary care will not apply in primary; this is disappointing and is a missed opportunity.

7.3. While many practices are forward looking and foster a positive and supportive culture, 'safety' in primary care often operates at a local practice level. Our opinion is that contractual mechanisms and specific funding could have expanded this to system level resulting in better integration with safety systems in secondary care.