Written evidence submitted by NHS North East London ICB (PSN0022)

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?

In April 2017, the Health Service Investigation Branch (HSIB), now known as Maternity and Newborn Safety Investigation (MNSI, October 2023), was formed to investigate maternity cases that meet the following criteria:

- Any term baby from 37+0 born following labour that results in an:
  - Intrapartum stillbirth,
  - Early neonatal death within the first 6 days of life
  - Potential severe brain injury diagnosed with grade 3 HIE, was therapeutically cooled or had decreased central tone, comatose and had seizures of any kind.
- Maternal deaths within 42 days of birth

MNSI are invited to share finding and themes at the North East London Local Maternity and Neonatal System (NEL LMNS) board twice a year.

The Perinatal Mortality Review Tool (PMRT) was released in January 2018 and wholly integrate within the MBRRACE UK programme of work. The tool is used to investigate perinatal deaths meeting the following criteria:

- All late fetal losses from 22+0 up to and including 23+6
- All antepartum and intrapartum stillbirths
- All neonatal deaths from birth at 22+0 days gestation until 28 days of birth (excluding termination of pregnancy and those with a birth weight <500g if the gestation is not known)
- All post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 days following care in a neonatal unit, the baby may be receiving palliative care elsewhere, including home when they die.

In 2024, we are planning for the North East London Trust's to share their PMRT reports and themes with the LMNS.

In London, there is local guidance supporting the investigation of maternal deaths, which require all investigations to have an external panel member(s) to provide independent scrutiny.

Since the publication of the interim findings from the Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust (2020), any local maternity serious incidents reported in North East London are shared with the LMNS and maternity providers across North East London to enable shared learning of any immediate learning and essential actions from additional scrutiny. The trends and themes from these cases are monitored and shared across the system. Where appropriate, a quality improvement project may be undertaken. Furthermore, a midwife within the ICB patient safety team reviews all completed serious incidents before final sign off and is supporting the transition to Patient Safety Incident Response Framework (PSIRF).

1. **Are there any mitigating factors or conflicting policy decisions that may have led to the recommendation <u>not being implemented</u> or not being on track to be implemented? How significant are these? Was appropriate action taken to account for any mitigating factors?**

All providers in North East London have engaged with the work outlined above to implement these recommendations. However, there are challenges with clinicians providing independent scrutiny when the investigation is being undertaken by the maternity providers, due to competing clinical commitments. The LMNS supports maintaining a database of clinicians and their specialities who maybe be contacted to support this process. If there is no external clinician available, final reports are scrutinised by the ICB patient safety team.

2. **To what extent has the NHS's Covid-19 response affected progress on implementing the recommendation**

With the HSIB/MNSI cases there was initially a delay in reviewing newly reported cases. There was a slight amendment to the criteria. Under the amended criteria, trusts would continue to refer all cases in line with the existing criteria, and HSIB would temporarily cease investigations of cases relating to babies who had received cooling therapy where there was no apparent neurological injury (brain damage). In these cases, if a family or trust reported concerns about care, the case would be individually reviewed, and an investigation progressed where appropriate. Adjusting the criteria in this way reduced the overall investigation caseload by 15% during 2020/21. This also enabled HSIB to release some clinical staff to frontline duties in support of the response to the pandemic.

In addition, the Covid-19 pandemic had an impact on the workforce availability to review PMRT cases, due to competing staffing and capacity issues. However, the reporting and investigations of serious incidents by the maternity providers continued throughout the pandemic.

3. **How has this recommendation been interpreted in practice at trust/patient level?**

All Trust's in North East London have implemented the requirements outlined above. Duty of Candour is provided to all patients affected. Parents' perspectives of care are sought and they are given the opportunity to raise questions. Final reports are shared with them following the investigation.

Within the NEL LMNS Safety Workstream all serious incidents feed in to the workstream and learning and immediate actions are shared across the system. In 2023, quarterly shared learning events were commenced to further support this process.

4. **Does data show achievement against implementing the recommendation (if applicable)?**
   There is a monthly North East London LMNS dashboard & exception reporting process. If themes are identified, further analysis or audits are requested from the Trust. Following this, feedback into the LMNS system to providers and other stakeholders is provided to improve maternity care. The dashboard and monthly exception reports are shared at the Maternity and Newborn Acute Provider Collaborative Oversight Group (APC).
   HSIB/MNSI are also invited to present a summary of cases, themes and recommendations to the LMNS board.

5. **Have there been any important developments since the recommendation was made or accepted that affect its implementation? For example, has the implementation of the recommendation been superseded, and if so, has the superseding recommendation been implemented?**

N/A

Has there been specific and adequate funding to enable the recommendation to be implemented?

1. **Were specific funding arrangements made to support the implementation of the recommendation? If not, why? If so, what were these, when and where were they made?**

   No specific funding was given to the LMNS, however the LMNS has historically funded via SDF monies the support to fund the backfill of staff with external reviewers for the PMRT panel.
   The NEL ICB is piloting the Independent Senior Advocate (ISA) role. NHS England has provided funding for this pilot. This role will support families to navigate the investigation process to ensure they receive the answers they require.

2. **What factors were considered when funding arrangements were being determined?**

In NEL LMNS the following factors were considered:

- The LMNS has previously undertaken a review and identified availability of SDF monies to support the PMRT process.
- Ockenden recommendation to support ISA role. NHSE have continued commitment to support funding for this role for the duration of the pilot.

3. **Do healthcare stakeholders view the funding as sufficient?**

The monies to support the PMRT process was only available for the financial year 2022/23 and no further monies were available for 2023/24. Therefore, this has since been insufficient to stakeholders.

4. **Was any financial commitment a 'new' resource stream? If not, did reallocation of funds result in any unforeseen consequences/ undesirable 'work arounds' at local level?**

- Funding taken from SDF monies to support limited PMRT resources which is not recurrent.
- All LMNS funding is non-recurrent and crucial roles to enable the Perinatal Quality Surveillance Model (PQSM) to be delivered may not be able to be continued if there is a reduction in SDF monies which is determined on an annual basis.

5. **What factors were considered when funding arrangements were being determined?**

The population of North East London and any transformation work being undertaken were considered.

Has there been a positive impact on patients and people in receipt of social care as a result of the recommendation being implemented?

1. **Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the implementation of the recommendation?**

   The LMNS supports implementation of all the recommendations from the investigations undertaken by HSIB/MNSI, PMRT and maternity providers to avoid similar incidents occurring in the future. With the introduction of the ISA role this will further support minority groups to ensure their voices are heard.

2. **Will (or have) service users benefit(ted) directly, indirectly or both?**

Services users will benefit both directly and indirectly.

3. **What category of service users have benefitted? And why?**

All service users have benefited from the implementation of this recommendation. The introduction of the ISA role will be of particular benefit to families who may previously have experienced difficulty in accessing maternity services to seek answers where there have been adverse outcomes.

4. **Have (some) service users been hindered by the recommendation being implemented?**

Multiple reporting requirements, sometimes for the same incident. Additional workload to support external agencies completing this work. In addition, service users being interviewed more than once and potentially can be traumatising. The role of the ISA will be of additional valuable support for service users that have experienced an adverse outcome.

5. **Was (or is) the recommendation likely to achieve meaningful improvement for service users, healthcare staff and/or the healthcare system as a whole?**

The recommendation set out to ensure robust investigations that would produce meaningful recommendations to change practice, improve maternity care and reduce adverse outcomes which would be of benefit for service users, healthcare staff and the system.

Was the Government's interpretation and implementation of the recommendation appropriate?

1. **Has the implementation of the recommendation had any unintended consequences?**
   Multiple reporting requirements, sometimes for the same incident. Additional workload to support external agencies completing this work.

2. **Was the level of ambition as expressed by the implementation of the recommendation reasonable, or has it been surpassed by developments since?**
   Yes, this was reasonable. However, challenges persist with meeting the PMRT requires for external reviews due to ongoing workforce challenges.

3. **How has working to implement the recommendation affected other aspects of care?**
   By providing external scrutiny there is a risk that workforce is taken away from clinical care, particularly when there are factors that impact on workforce numbers such as industrial action. Workforce vacancies have been impacted by Covid-19 and Brexit (International recruitment)
   However, the benefits of this implementation have the potential to improve maternity services.

4. **Did the system have the relevant tools to support the change?**

When the recommendations were implemented, little consideration was given to the additional impact on the workforce to complete actions and organise workplans to free up time to complete activities as part of the recommendations such as completing PMRT reviews, to participate as an external reviewer and support HSIB/MSNI through coordination of investigations at provider level. Within the LMNS, not having substantive roles to support the Perinatal Quality Surveillance Model is an issue.

Expert Panel Evaluation: Progress made on patient safety recommendations made to, and accepted by, the Government.

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*

Has the recommendation been implemented?

Yes, the NHS NEL Freedom to Speak Up (FTSU) Guardian Service was launched on the 23 January 2023. It is an independent and confidential service delivered by an external company and is available to any member of staff within NHS NEL to discuss any matter relating to patient care, patient safety and work-related concerns.

Progress updates regarding the implementation and delivery of the Freedom to Speak Up service were published on the NHS North East London website within:

- the July 2022 Board meeting papers (via the Chair's report)
- the January 2023 Board meeting papers (via the Workforce and Remuneration Committee Exception Report)
- the March 2023 Board meeting papers (via the Audit & Risk Committee minutes)
- the May 2023 Board meeting papers (via the Audit & Risk Committee minutes)

A comprehensive overview of progress regarding the implementation of the service both in NEL ICB and North East London Trusts was presented at the September 2023 Board meeting. This paper provided annual comparison metrics regarding:

- the number of contacts with a freedom to speak up service in NHS NEL and the five trusts working in North East London,
- the category contacts would fall into.

NHS North East London also commission the delivery of the NHS Staff Survey. Trends, themes and updates on progress are reported to the Board via the Workforce and Remuneration Committee.

Are there any mitigating factors or conflicting policy decisions that may have led to the recommendation not being implemented or not being on track to be implemented? How significant are these? Was appropriate action taken to account for any mitigating factors?

N/A

To what extent has the NHS's Covid-19 response affected progress on implementing the recommendation?

N/A

How has this recommendation been interpreted in practice at trust/patient level?

All Trusts within North East London have a Freedom to Speak Up Service:

Trust	Who undertakes the service / function	How is the service / function delivered?	What does the service / function cover?
Barts Health NHS Trust	External provider	Telephone, email, face to face and virtual meetings	Staff can raise any type of concern
Barking, Havering and Redbridge University Trust	External provider	Telephone, email, face to face and virtual meetings	Staff concerns and quality/patient safety concerns
East London NHS Foundation Trust	In-house delivery	Telephone, email, face to face and virtual meetings	All work and patient related concerns
North East London NHS Foundation Trust	In-house delivery	Telephone, email, face to face and virtual meetings	Issues that may impact the delivery of care
Homerton Healthcare NHS Foundation Trust	In-house delivery	Telephone, email, face to face and virtual meetings	All work and patient related concerns

CQC inspection reports for North East London Foundation Trust, East London Foundation Trust, Homerton Healthcare NHS Foundation Trust and Barking, Havering and Redbridge University Trust have been largely positive regarding the implementation of FTSU. There is no mention of FTSU in the most recent Barts Health CQC inspection report.

The number of reports to Freedom to Speak Up services across NHS Trusts has increased across North East London services, with 522 reports in 2021/22 and 715 reports in 2022/23.

Examples of updates regarding measurement, monitoring and publication of information re FTSU in Trusts:

- Barts Health NHS Trust provide updates on progress against the implementation of their Freedom To Speak Up service, themes/trends arising from it and impact of it to the Board via their Audit & Risk Committee (September 2023). An annual Freedom to Speak Up report was presented at their July 2023 Board Meeting. Barts Health NHS Trust published their annual NHS Staff Survey and analysis within their May 2023 Board papers.
- Barking, Havering and Redbridge NHS Trust provide updates on both progress against the implementation of their Freedom To Speak Up service, themes/trends arising from it and

impact of it to the Board via their People & Culture Committee. An annual Freedom to Speak Up report was presented at their July 2023 Board Meeting. Barking, Havering and Redbridge NHS Trust published their annual NHS Staff Survey and analysis within their May 2023 Board papers.

- East London NHS Foundation Trust provide regular updates on both progress against the implementation of their Freedom To Speak Up service, themes/trends arising from it and impact of it through a number of Board reports including the CEO Report, ELFT People Plan Progress Report (November 2023), Quality Report (September 2023) and Quality Assurance Committee Report (July 2023). An annual Freedom to Speak Up report was presented at the July 2023 meeting. East London NHS Foundation Trust published their annual NHS Staff Survey and analysis within their May 2023 Board papers. East London NHS Foundation Trust presented the results of the NHS Staff Survey at the March 2023 Board meeting.
- North East London Foundation Trust provide regular updates on the implementation of their Freedom To Speak Up service, themes/trends arising from it and impact of it via their People & Culture Board Sub-committee (July 2023, September 2023), including an Annual Freedom to Speak Up report. North East London NHS Foundation Trust presented the results of the NHS Staff Survey at the March 2023 Board meeting.
- Homerton Healthcare NHS Foundation Trust provide biannual Freedom To Speak Up updates to their Board (September 2023). Homerton Healthcare NHS Foundation Trust at the May 2023 Board Report.

Does data show achievement against implementing the recommendation (if applicable)?

Evidence provided in above responses.

Have there been any important developments since the recommendation was made or accepted that affect its implementation? For example, has the implementation of the recommendation been superseded, and if so, has the superseding recommendation been implemented?

In April 2019, the Patient Safety Strategy was published, which centres the need for safety cultures to be developed. As part of the Patient Safety Strategy, NHS organisations are expected to promote safety cultures which encompass:

- Continuous learning and improvement of safety risks
- Supportive, psychologically safe teamwork
- Enabling and empowering speaking up by all

The ICB Patient Safety Team have been working closely with providers to embed the work of the Patient Safety Strategy, particularly in relation to moving into the Patient Safety Incident Response Framework. Progress updates on the implementation of the Patient Safety Strategy have been reported at:

- the July 2023 Board Meeting (via the Quality Safety and Improvement Committee Exception Report)
- the September 2023 Board Meeting (via the Quality Safety and Improvement Exception Report)

Frequent reporting on patient safety data, supported by the introduction of the Learning from Patient Safety Events service, will be reported to the Quality, Safety & Improvement Committee and then further onto the Board from February 2024 onwards.

Has there been specific and adequate funding to enable the recommendation to be implemented?

Were specific funding arrangements made to support the implementation of the recommendation? If not, why? If so, what were these, when and where were they made?

The NHS North East London Freedom to Speak Up service is managed by an external company, and is commissioned for £142,000 per annum. The NHS Staff Survey is managed by Quality Health and was commissioned for delivery in 2023 for £3048. There is no funding allocated to reporting to the Board on these matters, this work is undertaken as part of business as usual.

What factors were considered when funding arrangements were being determined?

N/A

Do healthcare stakeholders view the funding as sufficient?

N/A

Was any financial commitment a 'new' resource stream? If not, did reallocation of funds result in any unforeseen consequences/ undesirable 'work arounds' at local level?

No. Funding for the Freedom to Speak Up service and the NHS Staff Survey are both allocated from a central corporate budget. There is no funding allocated to reporting to the Board on these matters, this work is undertaken as part of business as usual.

Has there been a positive impact on patients and people in receipt of social care as a result of the recommendation being implemented?

Freedom to Speak Up is an NHS initiative; local authorities have well established whistle blowing policies, which apply to organisations commissioned by and contracted with the local authority. These vary in detail across different agencies but all offer a route for staff at any level in an organisation, whether the Council or commissioned providers such as independent sector social care providers, to raise concerns. They report through local council governance independently. Future discussions regarding how NHS organisations and Local Authorities in North East London can develop a collaborative approach to ensuring oversight of issues raised within FTSU services and whistleblowing processes across the ICS were encouraged at the September 2023 Board meeting.

Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the implementation of the recommendation?

This recommendation is not applicable to social care organisations, as detailed in the above response. Issues reported via the FTSU service within the ICB have not been related to patients/residents. Impact of FTSU on patients/residents in Trusts can be found in the evidence provided in section one of this response.

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Was the Government's interpretation and implementation of the recommendation appropriate?

[cannot answer]

Has the implementation of the recommendation had any unintended consequences?

[cannot answer]

Was the level of ambition as expressed by the implementation of the recommendation reasonable, or has it been surpassed by developments since?

[cannot answer]

How has working to implement the recommendation affected other aspects of care?

[cannot answer]

Did the system have the relevant tools to support the change?

[cannot answer]