Meeting title:	Public Trust Board	**Public Trust Board paper J**
Date of the meeting:	14 September 2023	
Title:	UHL Response to the Lucy Letby Trial	
Report presented by:	Andrew Furlong, Medical Director & DCE, Robin Binks, Deputy Chief Nurse	
Report written by:	Eleanor Meldrum, Deputy Chief Nurse	

Action – this paper is for:	Approval		Assurance	x	Update	
Where this report has been discussed previously	N/A					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
To provide assurance that UHL has reviewed the recent NHSE guidance from NHSE following the verdict of the Lucy Letby Trial. This includes current arrangements for freedom to speak up and listening to the concerns of patients, families and staff.

Acronyms used:

TLT- Trust Leadership Team
NHSE - National Health Services England
ICB - Integrated Care Boards
CQC - Care Quality Commission
FPP - Fit and Proper Person
FTSU - Freedom to Speak Up
LL – Lucy Letby

Purpose of the Report

On 21st August 2023 Lucy Letby was served a 'whole life order' for committing appalling crimes that were a terrible betrayal of the trust placed in her. Our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

The report provides a summary of the trial and how we plan to address some of the wider issues that have emerged to ensure we truly learn from these devasting events.

Summary

A registered nurse (LL) working on the neonatal unit of the Countess of Chester hospital has been convicted of murdering new-born babies on the unit. The nurse used a variety of methods to secretly attack a total of 13 babies between 2015 and 2016. Seven babies died as a result and a jury found the nurse guilty of their murder. She was also found guilty of seven counts of attempted murder relating to six other babies.

During the trial, which began in October last year, Manchester Crown Court heard that doctors at the hospital noticed a significant rise in the number of babies who were dying or were unexpectedly collapsing. When they were unable to find a medical explanation, police were alerted, and an investigation followed. LL was first arrested in July 2018 and subsequently charged in November 2020. The prosecution was able to

present evidence of LL of using various methods to attack babies, including: the injection of air and insulin into their bloodstream; the infusion of air into their gastrointestinal tract; force feeding an overdose of milk or fluids; impact-type trauma. Her intention was to kill the babies while deceiving her colleagues into believing there was a natural cause.

The nurse was sentenced on Monday 21st August 2023, and received a whole life order. An independent inquiry was announced by the Department of Health and Social Care into the events at the Countess of Chester.

Recommendation

It is recommended that the Trust Board:

- Receive assurance that we are compliant with the 3 programmes identified by NHS England to support a safe culture
- Note the steps being taken to support a culture of psychological safety where colleagues feel safe to speak up and have confidence that they will be heard

Main report detail

NHS England Response to the Trial Outcome
On the 18 August 2023, following the outcome of the LL trial, NHS England confirmed that they were committed to doing everything possible to prevent anything similar ever happening again. The decisive steps being taken towards strengthening patient safety were described and included the following initiatives:

- ***The national roll-out of Medical Examiners (ME) since 2021 creating additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality. Therefore, making it easier to identify potential concerns including the use of the Structured Judgement Review process.*** UHL has fully implemented the ME process. Carers and families are routinely contacted by our Medical Examiners and Bereavement Nurses and any concerns relating to care are welcomed and acted on. This is underpinned by robust monitoring of nationally reported mortality rates with further in depth review, supported by external agencies, via the mortality review committee and maternity assurance committee and then reported on to the Quality Committee and public Trust Board.
- ***The new Patient Safety Incident Response Framework will be implemented across the NHS from this autumn representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incident happen, engaging with families, and taking effective steps to improve and deliver safer care for patients***. This will be adopted at UHL in October 2023. Themes from our Learning from Deaths have been used to help identify the proposed PSIRF themes.
- ***In 2022, a strengthened Freedom to Speak Up (FTSU) policy was implemented. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.*** The FTSU service was transitioned to an external independent provider in September 2023 to provide 24/7 support to clinical areas. UHL are fully compliant with this guidance.

NHSE also stated the need for 'good governance' and requested that NHS leaders and Boards must urgently ensure the following:

- All staff have easy access to information on how to speak up.
- Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
- Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up.
- Methods for Boards seek assurance that staff can speak up with confidence and whistle-blowers are treated well.
- Boards are regularly reporting, reviewing, and acting upon available data.

UHL Current Position on Raising Concerns
a) Freedom to Speak Up
During the most recent UHL Friday Focus (update number 99), our Chief Executive Richard Mitchell emphasised the significance of establishing a culture where individuals feel secure sharing their concerns, knowing that they will be heard and responded to professionally. Plans previously approved by the Trust Board were shared around extending our existing Freedom to Speak Up (FTSU) Guardian service in

collaboration with The Guardian Service, an independent FTSU provider, starting 1 September 2023. This service will meet the most recent NHSE guidance namely offering increased accessibility, operating around the clock.

UHL will have two dedicated Speaking Up Guardians available for virtual or face-to-face meetings as needed. More information about the Guardians and their contact details will be provided shortly across the organisation but until then colleagues will continue to reach out with concerns to freedom2speakup@uhl-tr.nhs.uk.

All colleagues are also able to escalate concerns through existing Datix reports and a dedicated staff concerns reporting line '3636'. In addition, there is a junior doctor 'gripe reporting tool' and 2 Guardians of Safe Working (national compliance requirements with safe working for doctors).

The Senior Leadership Team in each CMG have been asked to reflect on the way they communicate out to all staff groups how concerns are raised and, where appropriate, strengthening these.

b) Professional Bodies
The Royal College of Nursing has released new guidance for nurses, nursing associates and healthcare support workers on raising and escalating concerns for colleagues and managers. Whilst this is aimed at the nursing profession, much of it is applicable to all colleagues at UHL and it has been disseminated widely across the organisation by the Chief Nurse who has encouraged colleagues to take the time to read and share within teams. The GMC has clear guidance regarding 'Speaking Up' which is available to all doctors.

c) Learners in Clinical Practice
If healthcare students, learners and apprentices witness or suspect there is a risk to the safety of people in your care there are dedicated routes of escalation for them to report their concerns immediately to the appropriate person or authority within a Higher Education Institution or clinical placement provider.

Next Steps
UHL have made significant changes over the last 18-month to the reporting culture and listening and acting upon concerns, but it is recognised that there is more progress to be made. Achieving a genuinely open culture hinges on our collaborative efforts and the Executive Team and Board are fully committed to fostering a culture of openness and accountability.