Verdict in the trial of Lucy Letby – Moorfields response

Our Moorfields perspective of horror and sorrow aligns with the views and sentiments expressed in the NHS England letter of 18 August 2023 (attached). Moorfields is committed to ensuring that our primary focus is on patient safety and that staff feel confident to speak up about issues they are concerned about, and that we adhere to the best governance arrangements. We have taken each of the main points referred to in the NHSE (NHS England) letter and have outlined our activity in relation to these issues below.

Strengthening Freedom to Speak Up arrangements at Moorfields

Freedom to speak up (FTSU) is vitally important to the delivery of safe, excellent, equitable and kind care for our patients and our staff. A more open culture encouraging learning and improvement leads to safer care and treatment, improved patient experience and greater staff satisfaction and performance. We must support our staff to feel confidence to speak up, to feel that speaking up will result in change and to feel that speaking up will not result in disadvantage.

People and Culture Committee and Trust Board have been kept up to date on the work, led by Sheila Adam, (Chief Nurse and Director of Allied Health Professionals), to review and strengthen our FTSU arrangements. Over the past year we have:

- Had an external peer review by a Trust known for FTSU excellence.
- Researched best practice.
- Engaged with staff seeking their views about barriers to FTSU, including focus groups.
- Co-created a new FTSU model with staff.
- Developed the beginnings of an approach to comparing and triangulating FTSU and workforce data.
- To enable robust delivery, FTSU has been categorised as a level 1 XDU (Excellence project unit) project at the Working Together Board since April 2023.

The resulting new FTSU model proposal has been confirmed by Management Executive and People and Culture Committee, and FTSU forms an item on September's Trust Board meeting agenda. The next steps are to implement the new FTSU model and ensure that robust measures are in place to track service delivery, to monitor that the new arrangements are meeting the service objectives and staff can access the service and speak up. In particular, we are implementing an anonymous reporting system, externally hosted, which enables staff to report concerns anonymously in an 'asynchronous' two-way conversation between the reporter and a FTSU Guardian to occur while maintaining anonymity.

We are confident that all of the points made in the letter will be incorporated within the new FTSU service arrangements and embedded in the updated FTSU policy. Moorfields updated FTSU policy will change significantly, also it will be aligned with NHS England's national recommendations for FTSU and will be implemented by January 2024.

How is our approach to patient safety strengthening as we introduce the new national framework including progressing the implementation of Patient Safety Incident Response Framework (PSIRF)?

Board members will be aware that they currently receive information about patient safety via Quality and Safety Committee reports and direct notifications about Serious Incidents. This information comes from the current national framework for handling patient safety. The NHS as a whole is part way through introducing a new approach to patient safety incidents (the Board was first updated in July 2022, and has been updated regularly via Quality and Safety Committee reports, with the most recent in July 2023). A detailed update on progress with the Patient Safety Incident Response Framework's (PSIRF) introduction is being brought to September's Quality and Safety Committee, and we therefore cover the main points here.

- PSIRF focuses on:
    - compassion and involving those affected,
    - system-based approaches to learning and improvement,
    - considered and proportionate responses,
    - and supportive oversight.
- PSIRF removes the requirement that all/only incidents meeting the criteria of a 'serious incident' are investigated.
- It also prioritises compassionate engagement and involvement of those affected by patient safety incidents, including staff and families.

The Lucy Letby case, as well as other inquiries into care of patients in the NHS (Mid Staffordshire, Ockenden and Kirkup reviews) have also further highlighted the importance of engaging with patients, families, and staff appropriately after a patient safety incident and involving them in any subsequent investigation. The introduction of PSIRF does not affect statutory and professional duty of candour.

In light of the recent themes of family concern around the Martha Mills case, we already regularly offer second opinions, if requested to do so. We do not currently have a formal policy around this, although this will be reviewed.

PSIRF supports the development of a patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents. Those affected include staff and families in the broadest sense; that is: the person or patient (the individual) to whom the incident occurred, their family and close relations as well as the staff involved. Similarly, PSIRF recognises that staff have important contributions to make about their experience of an incident and the working environment at the time and should be supported and listened to when sharing their accounts.

PSIRF Oversight roles & responsibilities

Previous enquires and the Lucy Letby case have highlighted the requirement for boards to have sight of incidents in an open and transparent manner. Oversight under PSIRF focuses on engagement and empowerment rather than the more traditional command and control. The following mindset principles underpin oversight under PSIRF:

- **The focus is improvement**. PSIRF oversight should focus on enabling and monitoring improvement in the safety of care, not simply monitoring investigation quality.
- **Blame restricts insight.** Oversight should ensure learning focuses on identifying the system factors that contribute to patient safety incidents, not finding individuals to blame.
- **Learning from patient safety incidents is a proactive step towards improvement.** Responding to a patient safety incident for learning is an active strategy towards continuous improvement, not a reflection of an organisation having done something wrong.
- **Collaboration is key**. A meaningful approach to oversight cannot be developed and maintained by individuals or organisations working in isolation, it must be done collaboratively.
- **Psychological safety allows learning to occur**. Oversight requires a climate of openness to encourage consideration of different perspectives, discussion around weaknesses and a willingness to suggest solutions.
- **Curiosity is powerful**. Leaders have a unique opportunity to do more than measure and monitor. They can and should use their position of power to influence improvement through curiosity. A valuable characteristic for oversight is asking questions to understand rather than to judge.

Introducing PSIRF to the Trust

We are currently launching PSIRF to our staff through a series of themed weeks in September. We are using 'Safety Huddles' in our clinical areas to disseminate themes coupled with a Trust-wide communications campaign.

Week 1 – National Patient Safety Syllabus:

- The Strategy includes a patient safety syllabus and training programme for the whole NHS. This is designed to help everyone who works in the NHS take all the necessary steps to ensure our patients are safe while they are in our care.
- During week 1 staff will be encouraged to complete level 1 of the syllabus via Insight.

Week 2 – Learn from Patient Safety Events (LFPSE):

- The purpose of the LFPSE service is to enable learning from patient safety events – incidents, risks, outcomes of concern and also things that went well.
- Our ability to protect future patients from harm depends on promoting a culture that welcomes and encourages the recording of events. It is essential to abide by these principles to ensure that we continue to successfully learn from patient safety events and reduce harm.
- LFPSE will require mandatory changes to our incident reporting system, so that the national dataset information is captured. We are using this opportunity to respond to feedback from staff regarding the incident reporting form and are undertaking a comprehensive review of the structure and functionality.

Week 3 – Involving patients in patient safety:

- The involvement of patients in their care and in the development of safer services is a priority for the NHS.
- Evidence shows that when patients are treated as partners in their care, significant gains are made in safety, patient satisfaction, and health outcomes. By becoming active members of the

health care team, patients can contribute to the safety of their care and that of the health care system as a whole.

- World Patient Safety Day 2023 was observed on 18th September under the theme "Engaging patients for patient safety", in recognition of the crucial role patients, families and caregivers play in the safety of health care.
- Learn more about our two patient safety partners and what their role within the organisation is.

Week 4 – the Patient Safety Incident Response Framework (PSIRF):

- The framework replaces the current Serious Incident Response Framework and shifts the way in which we respond to patient safety incidents.
- During this week we will be asking the trust board to approve our new patient safety incident response policy and plan.

We will then continue our roll-out of PSIRF across the year, and also continue with our monthly safety briefing themes through the year to share Trust-wide learning from Incidents. This approach to learning has proved successful since we implemented it following last year's 'Safer September' safety month campaign.

Role of the Medical Examiner

The role of the medical examiner (ME) was introduced in 2019 as part of the national patient safety strategy. The need for this independent role was established as a result of several important enquiries, including Mid Staffordshire. The purpose of the medical examiner system is to:

- provide greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths
- ensure the appropriate direction of deaths to the coroner
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- improve the quality of death certification
- improve the quality of mortality data.

Medical examiner offices in England are typically based at acute trusts and they are staffed by a team of medical examiners, supported by medical examiner officers. The role of these offices is to examine deaths to:

- agree the proposed cause of death and the overall accuracy of the medical certificate of cause of death (MCCD) with the doctor completing it
- discuss the cause of death with bereaved people and establish if they have questions or any concerns with care before death.
- act as a medical advice resource for the local coroner
- identify cases for further review under local mortality arrangements and contribute to other clinical governance processes.

Because a patient death in a Moorfields clinical setting is a very rare occurrence, a dedicated ME role for Moorfields is not justified. The expectation of NHS England is that specialist trusts will need to work with one established ME office. It has been agreed from 1

April 2023 that the ME service for Moorfields will be provided by University College London Hospitals NHS Foundation Trust (UCLH). UCLH will be the central point of reporting for deaths occurring at any Moorfields site. UCLH will liaise with the Medical examiner office at a host trust on behalf of the trust and will provide a service whereby the bereaved can ask questions or raise concerns.

New Fit Proper Person's Test (FPPT) Framework

NHS England recently published a Fit and Proper Person's Test (FPPT) Framework in response to the recommendations made by Tom Kark KC (King's Counsel) in his 2019 review of the FPPT. While the related legislation does not change, the new framework aims to support compliance with the regulations and makes some changes to the checks and balances that are intended to ensure directors satisfy the regulatory requirements.

The framework applies to all board members of specified NHS organisations, including interim appointments and non-voting members. ICB (Integrated care board, which commission's trust services), CQC (Care Quality Commission) and NHS England board members are now within its scope, in addition to NHS provider trust and foundation trust (FT) board members. Elements that continue to be assessed are good character; possessing the qualifications, competence, skills and experience required; and financial soundness. These are in addition to standard employment checks such as CV checks, proof of relevant qualifications, proof of identity and right to work, insolvency and disqualified director checks.

The framework introduces a new standardised board member reference to come into effect in October 2023. This will be created whenever a board member leaves an NHS organisation and should be sought by employing NHS organisations when making a job offer. The Electronic Staff Record (ESR) will be used to store information related to FPPT checks and references. This will provide a standard way to record and report compliance internally and will not be applied retrospectively. Annual self-declarations by board members to confirm adherence to the regulations ill continue, as well as checks of registers and online references. An annual submission assuring board members are fit and proper people will now be required to made to the ICB, commencing in 2024.

PEWS (paediatric early warning score)

We already use a paediatric early warning score (PEWS) in the trust, which considers physical parameters such as pulse, blood pressure and also currently includes a way of measuring alertness and distress.

Updated PEWS includes additional weighting on both parental and professional concern. This formalises the voice of the parent and any professionals looking after the child in a situation of an unwell or deteriorating patient and has just been launched by the National CYP (Children and Young People) Transformation Board. Our paediatric team are formulating a plan to embed this in to practice alongside the formal roll-out over this autumn. This work is strongly linked with a review of how patients and families access second opinions if concerned.