

**From the Permanent Secretary  
and HSC Chief Executive**



All Chairs and Chief Executives  
of HSC Trusts

Castle Buildings  
Stormont Estate  
Upper Newtownards Road  
BELFAST  
BT4 3SQ

Tel: 028 90 520559

Email: [peter.may@health-ni.gov.uk](mailto:peter.may@health-ni.gov.uk)

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Dear Colleagues

**QUALITY AND SAFETY SYSTEMS**

I am writing to you following the outcome of the trial of Lucy Letby. The crimes committed in this case have shocked us all. Our thoughts must be with the parents and families of her victims. Lucy Letby's crimes are an abuse of the trust that was placed in her. Healthcare professionals are often cited as some of the most trusted professions and, in the vast majority of cases, that trust is well placed and well deserved. It is therefore particularly devastating and bewildering when a member of a caring professions acts in such a way as reported in this case.

We are all acutely aware of the small number of instances where local HSC safety and governance systems have failed to detect and to intervene quickly enough to prevent harm to patients. The Department and the HSC has shown a strong commitment to learning and to continuous improvement in patient safety and clinical governance in response to such events, for example through significant and ongoing action across the HSC to implement public inquiry recommendations. However, we must never be complacent. It is important – indeed it is our obligation - that we must always continue to look for opportunities to strengthen and further enhance these systems and arrangements.

**Board-level Oversight and Assurance**

Good clinical governance, oversight and assurance are essential across health and social care services, particularly in our HSC Trusts. As set out in the [HSC Board Member Handbook - A resource to support the delivery of safe and effective care \(May 2021\)](#), Boards must always be a

key driving force for continuous quality improvement and have a critical role in ensuring that there is effective and robust accountability for the three key areas of governance: clinical and social care governance, staff governance and corporate governance.

There should be proactive systems in place to identify and report poor performance, near misses, complaints, adverse incidents, serious adverse incidents so that these can be dealt with appropriately and in a timely manner, and lessons can be learnt, implemented and shared. This should be supported by data and information systems which provide sufficient, clear and accurate information regarding the organisation's safety and quality risk profile to assist the Board in making informed decisions and timely interventions where these are required.

Actively supporting and promoting a healthy organisational culture and demonstrating a commitment to openness, transparency and candour must also be a core focus. Board members have a responsibility to ensure that staff have confidence in the fairness and impartiality of procedures for registering and dealing with concerns they have raised; supported by clear organisational whistleblowing or freedom to speak up policy and procedures and, importantly, that these are operating effectively.

There must also be strong arrangements in place to provide sufficient assurance to the Board that all clinical and social care governance systems within their organisation are robust and are operating effectively in practice. Such assurance arrangements should be routinely scrutinized – including externally where required - and enhanced as necessary.

### **Leadership at all levels**

The [HSC Collective Leadership Strategy \(2017\)](#) sets out a vision of compassionate leadership with a strong focus on quality improvement, learning from error, and ensuring that service users and staff have a voice is key to building this leadership culture. It remains of critical importance that HSC and Trust leaders utilise existing procedures and mechanism to listen to the concerns of patients, families and of staff and where needed act upon these in a robust and timely manner. This is vital at all levels of leadership.

There is a clear onus and responsibility on individuals and managers - both clinical and non-clinical - and on teams to speak up when they have concerns, and to take appropriate action when others raise concerns with them. For our clinical staff and registered professionals, these responsibilities are often clear and reinforced in respective codes of professional conduct.

### **Being Open and Speaking Up**

It is vital that health and social care staff have the confidence to speak up and to voice any concerns that they may have, and that those concerns are listened to and are appropriately acted

upon. This is particularly the case when things go wrong to help support learning and improvement of services and where appropriate to help prevent harm.

All HSC organisations will have existing policies and procedures in place which enable and support staff to raise concerns and issues, including those related to questionable practice. It is important that these are robust and are operating effectively and that all steps are taken to create a psychologically safe environments for staff to work in - where they feel able and are encouraged to come forward and to raise issues and concerns in their workplace and be assured that they will not suffer any detriment as a result.

However, we must continue to work together to build on and to enhance existing policy and processes. The RQIA issued guidance for whistleblowers and published its [Review of the Operation of Health and Social Care Whistleblowing Arrangements in September 2016](#). The Department is currently working with HSC Trusts and Trade Unions to develop a refreshed regional framework policy which sets out the accountability and governance within HSC organisations to encourage people to engage with the process for raising a concern and ensure they feel safe while doing so.

The Department is also continuing with work to develop proposals for a *Being Open* framework. This work is in relatively early stages but key aims are to ensure that individuals are fully empowered to exercise candour and openness, and that HSC organisations have in place the necessary support and systems required to enable and to nurture a truly open culture. Further engagement and discussion with HSC Boards and leaders is planned – this engagement, buy-in and ownership at senior level is critical to the success of this work and to further enhancing and realising an open culture in our HSC.

## **Reporting and Learning from Serious Adverse Incidents**

The current *Procedure for the Reporting and Follow-up of Serious Adverse Incidents* provides guidance to the Health & Social Care in Northern Ireland on the reporting, management, follow-up and learning following a serious adverse incident (SAI). While the Department has recognised the need to redesign the current process, and indeed this programme of work is underway, in the interim and until further notification, the current guidance must continue to be followed. It is important that all SAIs continue to be identified, reported and followed-up to ensure that learning is identified and embedded in a timely manner. Early identification of learning and continuous improvement opportunities from SAIs and other safety events is a critical component of a mature quality management system – helping to identify and to address emerging issues at an early opportunity to prevent escalation.

I have written previously to advise that the Department is taking forward a programme of work to refresh and redesign the current approach. The principles of co-design and co-production are embedded across relevant aspects of this work, and a programme of involvement and engagement activity is under way. It is essential that Executive teams and Board members are fully engaged with this important work as it develops, and I know that the Department's policy team is scheduled to meet with HSC Boards in the period ahead. This programme of work will result in the introduction of a new and enhanced framework to deliver learning and improvement from health and social care incidents/events across the HSC; including better support for staff, service users and families and carers involved in reviews, and with enhanced oversight and assurance mechanisms at organisational and regional level.

## **Conclusion**

The Department of Health and Social Care, England, has announced an independent inquiry into the crimes that have been committed and the circumstances surrounding the deaths and incidents. The inquiry will be key to ensure that vital lessons are learned and to provide transparency and answers to the parents and families impacted by the events at the Countess of Chester Hospital. The Department of Health, Northern Ireland, will follow the inquiry closely and is committed to working collectively with HSC colleagues to ensure that all relevant lessons and learnings are identified and fully considered here.

We all share a collective determination and commitment to do everything within our power to ensure our HSC services are as safe as possible for all those that use them, and to deliver the best possible care to patients and their families. This continuing commitment, along with robust application of existing policies and a collective commitment to optimise those that are in development, is key to realising continuous improvements in safe, high-quality care across in our HSC. This in turn will help provide patients with robust safeguards against poor standards of care, while ensuring that health and social care professionals are still supported and respected as they seek to deliver care to the highest standard.

This letter is supported by all Departmental Chief Professional colleagues. I am copying this to medical and nursing directors.

Yours sincerely



**PETER MAY**