IN THE MATTER OF THE INQUIRIES ACT 2005

AND IN THE MATTER OF THE INQUIRY RULES 2006

THE THIRLWALL INQUIRY

NHS ENGLAND'S CLOSING SUBMISSIONS

INTRODUCTION

1. NHS England has listened to and engaged closely with the evidence that the Inquiry has heard about the events that took place at the Countess of Chester Hospital NHS Foundation Trust ("the Countess of Chester"). It has also listened carefully to the questions and concerns raised by the Families during the hearings and to the recommendations they have suggested for improvements.

2. NHS England recognises in particular that it is important for the Families to understand what changes have occurred in the NHS since the events at the Countess of Chester in 2015-2017 and what further work is planned. The evidence heard by this Inquiry will be brought into account by NHS England in its work to develop and enhance the NHS, particularly in relation to the systems, policies and procedures described below. NHS England has also recognised in these submissions where the Inquiry may consider it beneficial to issue specific recommendations to bring about further change, and we welcome the opportunity to work with the Inquiry to consider how recommendations could be best directed to ensure maximum efficiency and effectiveness of delivery.

3. The Chair has also asked Core Participants in these closing submissions to respond to a request from the legal team for the Former Executives to suspend the Inquiry's proceedings under section 17 of the Inquiries Act 2005 ("the 2005 Act") pending the outcome of Lucy Letby's application in respect of her criminal convictions to the Criminal Cases Review Commission. A similar request has been made under section 13 of the 2005 Act to the Minister responsible for this Inquiry, the Secretary of State for Health and Social Care.

4. NHS England's position is that (i) the power to suspend the Inquiry rests with the Secretary of State under s.13 of the 2005 Act[1], not with the Chair under s17 of the 2005 Act; (ii) that if he

[1] cf *In the matter of an application by JR222 for Judicial Review* [2024] UKSC 35

was considering exercising the power under s.13 of the 2005 Act, the Secretary of State would be required to consult with the Chair; (iii) the Chair may use the occasion of these submissions to obtain the positions of the Core Participants in the Inquiry to inform any representations she made to the Secretary of State in the event of such a consultation; and (iv) NHS England adopts a neutral position in relation to whether the Inquiry should be suspended. Whatever decision is ultimately taken, the work NHS England has described in these Closing Submissions as underway will continue.

5. These Closing Submissions hereafter adopt the following structure:

Safeguards and Care of Neonates

Prioritisation of Neonatal Services

6. Professor Mary Dixon Woods properly informed the Inquiry that "substantial reform" has taken place in neonatal care over the last two decades.[2] NHS England's Chief Nursing Officer[3] described in his first witness statement the significant steps taken at a national level in this regard, particularly since the introduction of the Three-Year Delivery Plan in March 2023, and the ongoing work that is being done to improve on the quality and safety of neonatal services.

7. This includes the creation of two new national posts to increase the visibility and scrutiny given to neonatal services: (a) the appointment of a Neonatal Lead Nurse in 2023 to improve the quality of neonatal health provision at both a local and national level; and (b) the appointment of a National Clinical Director for Neonatology in 2024 to provide national clinical leadership in support of NHS England's programmes and priorities.[4] Evidence has been given to the Inquiry by the current post-holders for both these roles, describing their work-to-date; the aims and objectives of the roles; how they work with local, regional and national parts of the neonatal system; and areas where they believe their roles could be strengthened.[5]

8. The work of the Neonatal Implementation Board, whose role (and name) has recently been changed to reflect the progress made and the next stage in its work as the Neonatal Delivery Board, has also been important in driving national work to improve neonatal services.[6]

9. In addition, local provider-level arrangements for neonatal services have changed and strengthened since 2015-2017. This is as a direct result of the Neonatal Critical Care Review, which was commissioned by NHS England following the "National Maternity Review: Better Births Improving outcomes of maternity services in England. A Five Year Forward View for maternity care" (published 2016, "Better Births").[7] Better Births highlighted several challenges facing neonatal medical and nurse staffing, nurse training, the provision of support staff and cot capacity. It also recommended that a neonatal-specific review be carried out, with this

[2] INQ0102624 - Expert Report of Mary Dixon-Woods.pdf, page 41, paragraph 4.3.2
[3] INQ0018080.pdf, pages 7-52, paragraphs 22-185
[4] INQ0017495.pdf, page 178, paragraph 699(b,ii)
[5] INQ0018081.pdf, pages 5-8, paragraphs 15-25 and INQ0108888, pages 4-9, paragraphs 8-23
[6] INQ0108888, pages 13-14, paragraphs 41-43
[7] INQ0014626

recommendation being addressed through the Neonatal Critical Care Review. The final report of the Neonatal Critical Care Review was published in 2019[8] and has been followed by sustained financial investment via the NHS Long Term Plan between 2020/21 and 2023/24. The Operational Planning Guidance,[9] including this year's version,[10] has further emphasised the prioritisation of neonatal care.

10. The Long Term Plan funding has been focussed on enabling delivery of the following objectives:
    a. Developing improved neonatal capacity;
    b. Developing the expert neonatal workforce;
    c. Enhancing the experience for families, through care coordination and investment in improved parental accommodation; and
    d. Implementation Infrastructure.

11. The actions set out in the Neonatal Critical Care Review report are now incorporated within the "Three-year delivery plan for maternity and neonatal services" (March 2023).[11] The Three-Year Delivery Plan forms the critical framework through which NHS England and others working within maternity and neonatal services, including NHS Trusts and NHS Foundation Trusts, will action the objectives set out in the Plan and measure the effectiveness of implementation (the Plan describes how objectives will be actioned, with specific responsibilities assigned to particular parts of the maternity and neonatal system, and how success will be determined).

12. In agreeing the Three-Year Delivery Plan, careful consideration was given to the implementation burden already on providers, particularly in the context of maternity and neonatal services. A wide range of stakeholders contributed to the development of the plan, including women and families who have used or are using maternity and neonatal services. Details of the engagement that supported development of the Plan is contained in the "What you told us" section of the Plan[12] but a clear and consistent shared priority was for safe neonatal care.

[8] INQ0012352
[9] INQ0017944; INQ0014751
[10] https://www.england.nhs.uk/long-read/2025-26-priorities-and-operational-planning-guidance/
[11] INQ0012643
[12] INQ0012643, pages 5-8, paragraphs 8-17

13. Reflecting this engagement, the actions contained in the Three-Year Delivery Plan are, therefore, relatively few in number but are those that are considered most likely to improve the safety and effectiveness of maternity and neonatal services. Actions are concentrated on four themes:

    a. Listening to and working with women and families, with compassion;
    b. Growing, retaining, and supporting our workforce;
    c. Developing and sustaining a culture of safety, learning, and support and
    d. Standards and structures that underpin safer, more personalised, and more equitable care.

14. Implementation objectives for each action are staggered, with immediate, medium and longer-term completion dates. Responsibilities are also clearly defined but a shared responsibility to "provide or support high quality care", which includes "a responsibility at each level of the NHS to understand the quality of care and identify, address and escalate concerns" is recognised.

15. Considerable progress has been made towards halving the 2010 rates of stillbirths, neonatal and maternal deaths and brain injuries occurring during or soon after birth by 2025.[13] NHS England acknowledges that more needs to be done, particularly to reduce maternal deaths and addressing inequalities. As explained below, the introduction of new tools such as Maternity Outcomes Signal System aim to do this, with a targeted focus on maternity critical safety signals.[14]

16. It is, however, important to also recognise that implementation of the Plan remains ongoing and time is needed to embed these actions. NHS England is monitoring implementation to assess progress and effectiveness.[15]

17. The Perinatal Quality Oversight Model ("PQOM") (formerly known as the Perinatal Quality Surveillance Model) is a quality surveillance model that seeks to provide a consistent and methodical oversight of all services, specifically including maternity services. It has also recently been updated[16] to strengthen the integration of neonatal services into perinatal services and ensure alignment with the new operating model and other mechanisms of oversight and support (including to reflect the new delegated commissioning responsibilities discussed below at paragraphs 19-20). The updated model is based on four levels, Trust,

[13] INQ0018080.pdf, page 50, paragraph 181
[14] INQ0106962.pdf, pages 14-19, paragraphs 43-61
[15] INQ0018080.pdf, pages 27-37, paragraphs 104-135
[16] The update is due to be implemented in March 2025. See INQ0018080.pdf, pages 44-45, paragraph 162 and INQ0108888, page 17, paragraph 60

System, Regional and National, and will have more clearly assign responsibility of actions to the relevant body, meaning there are clearer lines of accountability. At each level varied information and data should be considered, including quantitative and qualitative data, and intelligence from maternity and neonatal services. The Government's upcoming 10-year plan for the NHS will also necessarily prompt review and update to existing plans.

18. These neonatal specific improvements and objectives need to be seen in the context of other developments that have taken place since 2015-2017. NHS England has addressed some of these in further detail elsewhere in these Closing Submissions but, in brief, it is important to highlight:
    a. Some simplification and consolidation of the national regulatory landscape, including through the merger of NHS Improvement and NHS England. Work is underway to update and strengthen the NHS Oversight Framework further to reflect the evolving operating model[17] agreed between NHS England and the Department of Health and Social Care.[18]
    b. Evolution to systems-based reporting and response to incidents, through the adoption of the Patient Safety Incident Response Framework ("PSIRF");[19]
    c. Developments in data[20] and standardised reporting/escalation;[21]
    d. Stronger, more developed processes for Freedom to Speak Up;[22]
    e. Learning from other inquiries, investigations and reviews – for example, the changes introduced following Morecombe Bay, East Kent and Ockenden.[23] [24]

Delegation to ICBs

19. NHS England is currently in the process of delegating commissioning responsibility for neonatal services to ICBs. This has happened in three regions to date – the Midlands, North West, and East of England. The delegated arrangements will further advance work to support fully integrated maternity and neonatal care, recognising the interdependencies between these

[17] INQ0108908, and INQ0108907
[18] INQ0017495.pdf, pages 63-67, paragraphs 245-262
[19] INQ0017495.pdf, pages 215-218, paragraphs 815-835
[20] INQ0018080.pdf, pages 28-32, paragraphs 106-115, pages 41-42, paragraph 152, INQ0106962.pdf, pages 16-19, paragraphs 50-61
[21] INQ0017495.pdf, pages 220-232, paragraphs 841-868
[22] INQ0017495.pdf, pages 200-206, paragraphs 761-787, and pages 248-251, paragraphs 931-944
[23] INQ0017495.pdf, pages 150-186
[24] INQ0108012, INQ0108016, INQ0108017, INQ0108022, INQ0108018, INQ0108023, INQ0108013, INQ0108014, INQ0108358, INQ0108359, INQ0108360, INQ0108361, INQ0108362, INQ0108363, INQ0108364, INQ0108365, INQ0108369, INQ0108370, INQ0108371

two services, and have been designed to improve to quality of patient care, quality of access and value.[25]

20. NHS England will continue to monitor the coherence and stability of an England wide delegated commissioning system. ICBs will be monitored, via routine assurance and oversight, on improvements to patient pathways, and the triple aim[26]. In terms of quality, the PQOM (once in operation) will provide the framework of how this will be overseen.

The role of Operational Delivery Networks

21. Operational Delivery Networks ("ODN") were established by NHS England in 2014. During the period of 2015-2017, ODNs were still in their infancy and going through the process of developing systems and processes to use data to support patient flows and improve pathways and workforce standards. The NWNODN was one of the more advanced networks during this period[27].

22. This has been improved by formalising the role and operation of ODNs. Since 11 March 2024, the new Neonatal Critical Care Clinical Network Specification[28] has required all ODNs to, amongst other things, monitor key indicators of quality across the network and regularly review clinical outcomes across the network, use clinical outcome measures to compare and benchmark providers, undertake audits, identify service issues and regularly review mortality and outcomes across the network. This has brought greater clarity and focus on neonatal critical care provider governance, underpinned by a contractual duty to have evidence of written clinical procedures and operational policies, which must include joint maternity and neonatal safety and governance processes.[29]

23. As detailed further below at paragraphs 26-34, NHS England recognises that the timely availability of data, and the implementation of mechanisms and processes to allow this data to be shared within the system, is fundamental to improving the quality of care and patient safety. ODNs have a key role to play in identifying issues and patterns in mortality for the area for which they are responsible. In order to carry out the functions specified above, the North

[25] INQ0017495.pdf, page 269, paragraphs 1004-1007, and INQ0009259
[26] Pursuant to s.26A of the National Health Service Act 2006, NHS trusts have a statutory duty to have regard to the wider effect of decisions on health and wellbeing, the quality of services, and efficiency and sustainability
[27] INQ0107030.pdf, page 18, paragraph 65
[28] Neonatal-critical-care-service-specification-March-2024.pdf
[29] INQ0018081.pdf, pages 15-16, paragraph 49 and INQ0018029

West ODN now has a specific Mortality Reporting Process, which includes a mortality tracker, that was implemented in 2020 and updated in 2023 to evaluate the data provided by Trusts and evaluate data, monitor and tracking responsibilities and ensure any themes and learning is identified, disseminated, and escalated[30].

24. Other networks have their own processes and procedures for monitoring mortality and improving quality of care and patient safety. The purpose of the national network is to bring together ODN leads together and to share/collate good practice and common issues as well as escalate internally. The national neonatal nursing lead post was created to help drive this learning process and ensure good practices are embedded nationally.

25. NHS England acknowledges that had these systems been in place in early 2016 the increased mortality rate at the Countess of Chester may have come to its attention sooner. Whilst the NWNODN Steering Group did receive data about the number of deaths within the neonatal unit, along with all the other neonatal units within the region, no specific concerns were raised with the Steering Group about the cause of these deaths or an increase in the rate of mortality generally. In addition, whilst there were discussions between the NWODN clinical lead and the Countess of Chester in February 2016 about reporting the increased mortality rate to NHS England, this was unfortunately not shared with NHS England either directly or via the North West ODN Steering Group (of which NHS England was a member). NHS England has acknowledged previously that this was a missed opportunity by the NWODN.

The importance of data

26. The events at the Countess of Chester have reinforced the importance of accurate, timely data and a clear process to be followed in terms of analysing and escalating the information.

27. Three baby deaths occurred on the NNU in June 2015; on 8 June [Child A], 14 June [Child C], and 22 June [Child D] respectively.[31] The Countess of Chester Hospital knew that this represented an unusual spike in deaths.[32] What was not known was what was causing the increase. The data also only related to deaths; it did not monitor increased morbidity.

[30] INQ0018081.pdf, pages 17-19, paragraphs 53-58
[31] INQ0108782.pdf, page 2
[32] Eirian Powell, Week 6, Day 4, page 96, lines 10-12

28. In the period since 2015-2017, there has been increased refinement and development in the way that data is collated and interpreted and systematic governance around how it is used in neonatal settings. Important developments in this regard include:
    a. PSIRF[33] (discussed below at paragraphs 122-133).
    b. PQSM (discussed above at paragraph 17).[34]
    c. The MBRRACE Perinatal Mortality Review Tool ("PMRT") - a tool that has been available since 2019 for standardised perinatal mortality review of individual cases for services and families,[35] which reviews baby deaths from 22 weeks' gestation onwards, including late miscarriages, stillbirths and the deaths of babies who die in the post-neonatal period.
    d. Getting it Right First Time (GIRFT) Neonatology - a national programme designed to improve the treatment and care through in-depth review of services, benchmarking, and presenting a data-driven evidence base to bring about effective change[36]. Dr Eleri Adams explains in her statement the work she has done as clinical lead in terms of promoting best practice and making recommendations for proposed changes and improvements to be delivered at both national and local levels.[37]
    e. Real time monitoring tools (discussed below at paragraphs 31-32).
    f. Safeguarding data collation (discussed below at paragraph 35(d)).

29. The NHS Standard Contract also provides that Trusts must participate in:
    a. any national programme within the National Clinical Audit and Patient Outcomes Programme;[38]
    b. any other national clinical audit or clinical outcome review programme managed or commissioned by the Healthcare Quality Improvement Partnership (HQIP receives funding from NHS England to commission, manage, and promote quality improvement programs);[39] and
    c. any national programme included within the NHS England Quality Accounts List for the relevant Contract Year.[40]

[33] INQ0009265
[34] INQ0018080.pdf, pages 43-44, paragraph 160
[35] INQ0018080.pdf, pages 41 and 47, paragraphs 150 and 177
[36] Professor Mary Dixon-Woods, Week 3, Day 4, pages 58 (line 16 onwards) – 61 (until line 15)
[37] INQ0014572.pdf, pages 8-11, paragraphs 22-27
[38] 03-NHS-Standard-Contract-2024-to-2025-Service-Conditions-full-length--version-2-March-2024.pdf, pages 37-38
[39] Ibid
[40] Ibid

30. There are two programmes commissioned by HQIP of particular significance[41]:
    a. The **National Clinical Audit and Patient Outcomes Programme**, which includes the National Neonatal Audit Programme. This relies on upon data extracted from the BadgerNet system to assess whether babies admitted to neonatal units receive consistent high-quality care in relation to the specified audit measures that are aligned to a set of professionally agreed guidelines and standards.
    b. The **National Child Mortality Database** – a national data collection and analysis system created in April 2019 to capture, analyse and disseminate appropriate data and learning from child death reviews and drive the quality of child death reviews.[42]

31. The Inquiry has also heard evidence about the development of signalling tools for maternity and neonatal care; the way in which signalling tools can assist with the detection and investigation of critical safety issues; and the design principles that apply when signalling tools are developed. The following two signalling tools, currently either in-use or at pilot stage, did not exist in 2015/2016:
    a. **MBRRACE-UK Real Time Data Monitoring**: a tool that became operational in 2019 to support improvements in perinatal mortality (including preterm death) through monitoring trends and analysing the epidemiology of perinatal death.[43]
    b. **MOSS**: a signalling tool designed to improve critical mother and baby outcomes at term through monitoring safety signals about the service and care and delivery of women in labour. It has been developed by NHS England in response to Recommendation 1 of Reading the signals Maternity and neonatal services in East Kent – the Report of the Independent Investigation.[44] MOSS provides data visualisations of signals which could indicate potential safety issues. This is a new way of employing safety data in maternity services, with a focus on routine monitoring of signals and rapid investigation in response to determine underlying safety issues. A test version of MOSS is now being piloted until Summer 2025. The tool will be refined on an iterative basis and operating procedures will be tested during piloting.[45]

[41] INQ0017495.pdf, pages 226-231, paragraphs 860-862
[42] INQ0017495.pdf, page 229, paragraph 862
[43] INQ0106962.pdf
[44] Reading the signals: maternity and neonatal services in East Kent, the report of the independent investigation (print ready), page 159
[45] INQ0106962.pdf, INQ0108744.pdf, page 3, paragraph 16

32. There are several differences between these tools, which Dr Murdoch explains in her two witness statements.[46] This evidence on the role, development and operation of signalling tools was explored by the Inquiry with Professor David Spiegelhalter in his oral evidence.[47] He agreed that reducing perinatal mortality and critical outcomes at term are both important and require different tools with different purposes and sensitivities to enable optimal improvement. Complex services can require a number of real time monitoring tools. It is NHS England's position that combining these tools risks reducing their effectiveness and impact.[48] However, further work is being currently undertaken to embed the shared governance around their use and for a single dashboard to be accessible to clinicians that will show the MOSS signal and include a link to access to MBRRACE-UK Real Time Data Monitoring. NHS England will consider whether further development and integration of the two systems would be beneficial when reviewing the operation of MOSS (once it has been operational for at least 12 months).

33. The Inquiry has heard evidence from a range of witnesses about the limitations with data; what was available, how it was used, who had access to it and how it was shared. The Inquiry has also heard about some of the challenges around data and, particularly, the burden of reporting on staff (addressed below at paragraph 37) and issues around interoperability.

34. NHS England has recognised in its evidence[49] that these are valid concerns that require careful consideration whenever new data systems or processes are being developed and implemented. Difficulties with the interoperability of systems involving patient data is not confined to maternity and neonatal services; the complexity of NHS records and difficulty in getting electronic patient records to be accessible by various systems means there is no easy solution. However, this is something that the NHS is working hard to remedy in conjunction with the Department for Health and Social Care, with the NHS Federated Data Platform being a key illustration of this work[50]. The work of the Maternity Outcomes Group highlights how an expert-led approach to the development, testing and implementation of a new data tool (in this case MOSS) can overcome some of these challenges.[51]

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[46] INQ0106962.pdf, INQ0108744.pdf
[47] Professor Sir David Spiegelhalter OBE, Week 15, Day 3, Page 26, lines 4 – 20; page 28, line 18, page 29, line 5; page 30, lines 5-16
[48] INQ0108744.pdf, page 2, paragraph 13
[49] INQ0017495.pdf, pages 220-232, paragraphs 841-868, and INQ0108888, pages 18-20, paragraphs 65-74
[50] INQ0017495.pdf, page 263, paragraph 986
[51] INQ0106962.pdf

Staffing

35. The Inquiry has heard evidence regarding staff capacity in maternity and neonatal services.[52] NHS England has recognised that safer, more personalised, and more equitable care can only be delivered by skilled teams with sufficient capacity, which is why growing, retaining and supporting the workforce is the second theme of the Three-Year Delivery Plan. This is being achieved through:

    a. **The Neonatal Critical Care Service Specification**. This requires each neonatal unit to have sufficient capacity to deliver the appropriate service for their booked maternity population and local network. Capacity must be planned in co-ordination with network maternity and fetal medicine services and the neonatal ODN. This should take into account the level of care provided at the unit and the anticipated neonatal network transfers.[53]

    b. **Additional investment**. Since the £95m additional investment in 2021, this has now grown to £186m a year – allowing for significant investments in workforce related programmes and the creation of new posts.[54]

    c. **Retention of staff**. As set out in the Three-Year Delivery Plan, workforce is not just about growing numbers of staff, it is also about valuing and retaining our clinical provision and investing in skills. It is also about having the right quality of nursing provision, the composition of the team in terms of roles, skill, experience, and support staff, plus leadership, supervision, management and training. NHS England's wider Workforce, Education and Training directorate is working to improve staff experience and the retention across the NHS and we continue to invest in the skills needed to provide high quality care.[55]

    d. **Data collection**. NHS England is currently developing more regular collection and interpretation of neonatal staffing data by utilising provider workforce returns in the same way we do for maternity, where we currently have more granular workforce data. This data is collected quarterly via regional ODNs, which work directly with NHS provider neonatal teams to provide additional data quality assurance.[56]

    e. **Improving Leadership and culture**. NHS England recognises that these are important factors within workforce and, as outlined above, we have strengthened the national clinical leadership of neonatology with a National Clinical Director for Neonatology and a Neonatal

[52] INQ0018076_.pdf, pages 9, 51-55, 58
[53] INQ0018029
[54] INQ0018080.pdf, page 12, paragraph 45 and see also NHS England » Update from the Maternity and Neonatal Programme
[55] INQ0017495.pdf, page 182, paragraph 708(b)
[56] INQ0018080.pdf, pages 41-42, paragraph 152

Nursing Lead. NHS England also launched the Safe Learning Environment Charter in February 2024 to support the development of positive safety cultures and continuous learning across all learning environments in the NHS,[57] and the Perinatal Culture and Leadership Programme focused on improving the culture and leadership of perinatal services.[58] Perinatal teams from every Trust with a maternity or neonatal service in England enrolled in the leadership programme[59] and the next phase of the programme is currently in development.

36. Overall, NHS England is making progress on growing and retaining the maternity and neonatal workforce, which demonstrates that earlier investments, national and local targeted support programmes and policy interventions are starting to deliver improvements, although this remains a work in progress.

37. NHS England acknowledges the views expressed by Dr Stephen Brearey about the administrative time of clinicians to complete the notification requirements for neonatal deaths[60]. However, the process of notifying neonatal deaths to MBRRACE-UK and CDOPs plays an important role in improving patient safety and safeguarding and ensuring lessons are learnt to prevent future deaths from occurring. This necessarily involves the provision of detailed information. However, in most cases, a clinician will only need to personally complete this process a handful of times a year. The Neonatal Critical Care Specification makes it clear[61] that NHS England expects each neonatal unit to ensure there is adequate time in consultant job plans for a relevant professional (such as the named clinical lead) to complete reviews for the Perinatal Mortality Review Tool and Child Death Overview Panel.

38. Further, and in response to requests from Trusts to reduce the amount of duplicate reporting of perinatal deaths, a new process for notifying neonatal deaths to Child Death Overview Panels (CDOPs) has been developed by NCMD and MBRRACE-UK (as part of the work they are commissioned by NHS England to carry out) called Cascade. Cascade combines the notification of neonatal deaths to MBRRACE-UK and CDOPs into a single step. Cascade was launched on 8 January 2025 and the new process has applied in England from this date.[62]

[57] INQ0017966 and INQ0018080.pdf, page 42, paragraph 156
[58] INQ0018080, page 152
[59] Ibid
[60] Dr Stephen Brearey, Week 10, Day 2, page 8, lines 15-25, page 9, page 10, line 11
[61] INQ0018029, page 12
[62] INQ0108909

Insulin

39. NHS England has recognised in its evidence[63] the existence of some variation nationally in relation to: (1) the presence of a pharmacist on the units to check and to aid in those processes around insulin; and (2) training regarding the safe handling of insulin.

40. NHS England's view is that neonatal units should continue to follow national and local policies and guidelines on the safe and secure handling of medicines (including insulin) and to audit local practice regularly.[64] Relevantly, the General Pharmaceutical Council published on 20 January 2025 new regulatory standards for the conduct of Chief Pharmacists.[65] The combined effect of these new standards, the obligations set out in the NHS Standard Contract and the updated job specification of the Medication Safety Officer published in 2022, will ensure that: (1) each hospital has a Chief Pharmacist who has oversight of the safe and secure handling of medicines; and, (2) a Medication Safety Officer with the knowledge, skills and experience to be delegated the responsibility to anticipate, identify and manage risks using innovation and improvement science, and respond compassionately and proportionately to safety incidents within strengthened governance arrangements.

41. In relation to the additional training that NHS England has identified may be necessary, NHS England provides support for medicines safety through a contract with the NHS Specialist Pharmacy Services. NHS England has commissioned the publication of on-line resources and educational materials that support the safe use of medications relevant to neonatal units. The first of these was in June 2024 on Managing complexities of medication use across care boundaries which provided education and training in the complexities of dosing of paediatric medication. The second, in March 2025, is on the safer use of insulin. By the end of 2025 further guidance will be published that supports medication safety officers to deliver improvements in safety through the Patient Safety Incident Response Framework and its relevance to neonatal care.[66]

[63] INQ0014552.pdf, pages 6-7, paragraph 23(b)(i), and Professor Sir Stephen Powis, Week 15, Day 4, pages 47-52
[64] INQ0017495.pdf, page 233, paragraph 873
[65] Standards for Chief Pharmacists
[66] As will be explained in NHS England's supplemental statement due to be provided to the Inquiry on 7 March 2025

CCTV

42. The term CCTV has been used to mean a range of monitoring tools, including conventional CCTV used to monitor entry and access; monitoring tools on clinical settings (such as live streaming from devices); and surveillance tools deployed when suspected deliberate harm is raised.

43. In terms of conventional CCTV, many Trusts use CCTV in hospitals to control access to buildings and particular units[67]. Health Building Notes and Health Technical Memoranda provide some guidance on this,[68] as does the CQC's guidance. [69]

44. As far as NHS England is aware, CCTV is not used on units as a safety measure, except for the purpose of monitoring access to the unit (so as to mitigate the risk of child abduction, for example). Any broader use on units would require careful, context-specific analysis of a range of factors, including around privacy and safeguarding, as well as all applicable legal considerations.

45. Finally, in terms of real-time live access monitoring for parents and other family members of neonatal babies in hospital to improve patient experience, NHS England understands that this type of technology has been trialled in the United Kingdom and elsewhere worldwide, and that it continues to be used in some units.[70] There is no national policy or framework in place governing the use of such technology and deployment would, therefore, be a decision for individual providers, taking into account the needs of their population and following appropriate consideration of applicable legal and regulatory duties.

46. When NHS England's National Medical Director gave oral evidence to the Inquiry, he indicated NHS England's intention to explore this issue further through the commissioning of pilots.[71] Since then, NHS England's Chief Nursing Officer has undertaken further work in this area and coordinated a review of the relevant literature relating to pilot studies of the use of live stream technology and sought views from the National Clinical Director for Neonatology and University College London (which has particular academic expertise in this area). While the

[67] INQ0018076 .pdf, pages 12 and 181
[68] INQ0017495.pdf, pages 232-236, paragraphs 870 – 878
[69] Using surveillance in your care service - Care Quality Commission
[70] INQ0018076 .pdf, Page 181-183, 189
[71] Professor Sir Stephen Powis, Week 15, Day 4, page 52 (line 23-25), pages 53-55

literature review recognises the benefits to families, it also demonstrates that the use of such technology requires adequate staff training and support, education for families, and ongoing maintenance.[72]

47. As a result of this further work, and after careful consideration taking into account the other priorities for the improvement of neonatal services described above, NHS England has concluded that a formal pilot scheme would not currently be efficient or effective in terms of progressing the use of live-stream technology in neonatal units as a means of improving patient experience.[73]

48. As technology improves, there will be more options for allowing parents to monitor a neonate remotely and Trusts will be able to tailor the use of this technology (alongside adequate staff training and supporting policies) to enhance the services they provide to parents. Currently, this will remain a matter for each Trust to decide.

Policies and Processes

Safeguarding

49. The Inquiry has asked NHS England, along with other Core Participants, to address a number of specific questions relating to the overall topic of safeguarding. NHS England has addressed below the questions that relate to it or on which it considers it can draw on its own practices and procedures in order to assist the Inquiry (where the Inquiry's questions are directly addressed to the DHSC or others, NHS England has not responded to these).

50. Areas for improvement and potential recommendations relating to safeguarding are set out from paragraph 188 of these Closing Submissions.

51. Before turning to address the Inquiry's specific questions, NHS England would like to emphasise that, as each publication of Working Together[74] has made clear, successful outcomes for children depend on strong partnership working. The key principles are listed in Working Together, the first of which is that children's welfare is paramount. **Anyone** working

[72] As will be explained in NHS England's supplemental statement due to be provided to the Inquiry on 7 March 2025
[73] As will be explained in NHS England's supplemental statement due to be provided to the Inquiry on 7 March 2025
[74] Working together to safeguard children 2023: statutory guidance

within the NHS is expected to understand key duties and to know who to approach if they have concerns. A range of tools are made available to those working within the NHS, both nationally and at a local level.[75]

52. Working Together is statutory guidance, published under section 11 of the Children Act 2004, which means that all those who have statutory safeguarding duties **must** have regard to the guidance when performing their duties and good reasons would be needed to lawfully depart from it.

53. However, the precise scope and nature of safeguarding duties varies depending on the specific context that a body or individual operates within. At a very simplistic level, a provider of healthcare services will need to have a range of measures that an Arm's Length Body will not need because day-to-day its staff do not come into contact with children or vulnerable adults in the context of providing healthcare to them. This is reflected in the gradated training available to those working within the NHS, as per the Intercollegiate Document.[76] However, NHS England employees may hold dual roles, with an aspect of their total role including a clinical component, or they may have access to potentially vulnerable individuals through an education or other public-facing role.

54. Section 11 of the Children Act 2004 is a key statutory duty and it applies to the following bodies:
    a. NHS England
    b. NHS Foundation Trusts and NHS Trusts (therefore including the Countess of Chester Hospital)
    c. Integrated Care Boards
    d. Local Authorities.

55. The duty, which is a mandatory one, requires that each person and body subject to section 11 must make arrangements for ensuring that:
    a. "their functions are discharged having regard to the need to safeguard and promote the welfare of children; and

[75] INQ0017495.pdf, page 191-193, paragraphs 734-743
[76] INQ0017495.pdf, page 193-194, paragraph 745

b. any services provided by another person pursuant to arrangements made by the person or body in the discharge of their functions are provided having regard to that need".

56. What this duty means for NHS England is set out below.

57. Additional duties apply to other specified bodies, primarily (in the case of each local authority area in England) the local authority; the applicable integrated care board and the chief office of the applicable police force. This includes statutory duties around child death review.

How safeguarding duties and/or procedures in respect of babies apply to NHS England

58. Working Together describes NHS England's role as follows[77]:

NHS England is responsible for ensuring that the health commissioning system as a whole is working effectively to safeguard and promote the welfare of children. It is accountable for the services it directly commissions or delegates...

NHS England also leads and defines improvement in safeguarding practice and outcomes and should also ensure that there are effective mechanisms for safeguarding partners to raise concerns about the engagement and leadership of the local NHS. Each NHSE region should have a safeguarding lead to ensure regional collaboration and assurance through convening safeguarding forums.

59. NHS England's website[78] explains what safeguarding is and why it is important. Safeguarding, to NHS England, is broader that the specific statutory duties it and others are subject to. For NHS England, safeguarding means "protecting a citizen's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care."

60. However, as the statutory framework recognises, certain citizens are in need of greater protection, and this includes children. There are no separate safeguarding obligations for

[77] INQ0012897, page 111, paragraph 237
[78] NHS England » About NHS England Safeguarding

babies but, in contrast to the general position that unborn children do not have legal status, safeguarding does extend legal protection to unborn children.

61. NHS England sees this difference as being between a responsibility (as per the definition above at paragraph 59) and a duty, with the latter being the specific statutory obligations that certain bodies have.

62. NHS England's expectations for the NHS as a whole are clear:

All staff, whether they work in a hospital, a care home, in general practice, or in providing community care, and whether they are employed by a public sector, private, or not-for-profit organisation, have a responsibility to safeguard children and adults at risk of abuse or neglect in the NHS.

63. This includes those volunteering or 'working' in an unpaid capacity.

64. The NHS England governance structures through which it discharges its statutory safeguarding responsibilities were summarised in the First Witness Statement of Professor Sir Stephen Powis.[79] Executive lead responsibility for NHS England's statutory safeguarding responsibilities rests with the Chief Nursing Officer for England.

65. The Chief Nursing Officer is responsible for providing overall assurance to the NHS England Board, with annual assurance sought from NHS England's Regional teams. Each NHS England Regional team has a safeguarding lead, who will oversee other professionals working within the Regional team on safeguarding matters.

66. The National Safeguarding Steering Group ("NSSG") plays a key role in bringing together regional safeguarding reports; assuring the system overall; and identifying and disseminating common issues, emerging trends and learning.[80] The NSSG is a permanent structure, chaired by the Deputy Chief Nursing Officer for England – Professional and System Leadership. Its work is supported by a number of working groups, national networks and implementation groups. These vary, reflecting safeguarding priorities; new legislation and specific projects.

[79] INQ0017495.pdf, pages 195-199, paragraphs 747-760
[80] INQ0108890, page 2, paragraph 8, INQ0017495.pdf, page 195, paragraphs 747-748

67. Currently, these additional structures include:
    a. The National Network of Designated Healthcare Professionals for Children, which brings together NHS Designated Professionals (doctors and nurses) who work in the areas of children's safeguarding, looked after children and child death overview panels;
    b. A working group on contextual safeguarding and digital data, which is a multi -agency workstream working to co-create a contextual safeguarding informatics strategy;
    c. An implementation group overseeing the Child Protection Information Sharing ("CP-IS") System. The CP-IS identifies and safeguards unborn babies and children who are subject to a local authority Child Protection Plan when attending unscheduled healthcare settings across England. Building on the success of the initial CP-IS programme, this programme is now being extended in a second phase to include scheduled healthcare settings.

68. In addition, NHS England discharges its system statutory safeguarding responsibilities in the following ways:
    a. Publication of guidance, including the Safeguarding Accountability and Assurance Framework[81], and associated protocols;
    b. The NHS Safeguarding App and online Guide;[82]
    c. Supporting and coordinating the statutory and mandatory training programme and setting the national mandatory training framework (this is currently under review and a redesigned framework is due to be launched this year);[83]
    d. NHS Standard Contract framework, which incorporates clear provisions setting out expectations for those who are contracted to provide NHS services, including defined safeguarding guidance, requirements around policies and roles.

Whether it is accepted that child safeguarding duties and/or procedures in respect of babies apply to the Countess of Chester; the CQC; the RCPCH; the DHSC; NHS England and the NMC?

69. All those operating as part of the health and care system owe a broader responsibility, in accordance with the NHS England definition set out above at paragraph 59. However, only some also have specific statutory duties. NHS England has not commented in detail on the

[81] NHS England » Safeguarding children, young people and adults at risk in the NHS
[82] INQ0108890, pages 2-5, paragraphs 8-18
[83] NHS England » Statutory and mandatory training (StatMand) programme

duties that other Core Participants owe, save from the brief overview of the applicable statutory framework included at the start of this section.

70. It is also worth noting that many individuals working for the organisations that the Inquiry has named will, in their individual capacity, be regulated healthcare professionals and, in that capacity, they will be subject to applicable professional duties (such as those contained within the Nursing and Midwifery Council's Code[84]).

What safeguarding duties and procedures apply where a member of staff has a suspicion or concern that another member of staff may be harming a baby who is in the hospital?

71. The same fundamental duties and procedures apply, regardless of who is suspected of harming a baby or the location for where such harm has taken place.

72. Harm, or the risk of harm, to a child outside the home is described in Working Together as "extra-familial harm". Healthcare settings are just one setting where there is a risk of this type of harm and harm to a baby in hospital by a member of staff would fall into this category of safeguarding.

73. Where such harm is suspected, there are three key actions that anyone who has safeguarding concerns about a member of staff must consider (each part must be considered):
    a. Internal escalation and guidance from a line manager; designated safeguarding professional, or other appropriate individual (such as the Freedom to Speak Up Guardian or a member of the Human Resources team). If the individual is a professionally regulated member of staff, then the appropriate clinical responsible lead should be involved as early as possible, where concerns of this nature are raised.
    b. External notification to the Local Authority Designated Officer ("LADO") and direct to police, in a sufficiently urgent situation. (Either by someone who the individual has escalated their concerns to, such as a member of the Human Resources ("HR") team or a line manager or direct to the LADO).
    c. HR involvement – to restrict duties, suspend or take other action, ensuring that the advice of the LADO informs such decisions and acting in accordance with the organisation's Disciplinary Policy or other employment policies.

[84] The Code

74. The precise nature of these steps will depend on who has the concerns (in terms of who their first point of contact might be to raise such concerns); what the concerns relate to; and about whom the concerns relate. NHS England's policy Managing Safeguarding Allegations Against Staff: Policy and Procedure (updated 2019)[85] provides that notification to the LADO and, where necessary, the police must be made in writing within 24 hours of the allegations being received (paragraph 5.4).

75. The guiding principle should be a low threshold for seeking the advice and guidance of safeguarding specialists and, once a referral has been made, ensuring that all action is directly informed by their advice

What safeguarding duties and procedures should HR professionals apply when they learn that a member of staff at the hospital is suspected of harming babies in the hospital? Why and to what effect?

76. The same steps should be followed by HR professionals if they become aware that a member of staff at the hospital is suspected of harming babies in the hospital.

77. HR are an important part of the initial decision-making group when safeguarding concerns about a member of staff are raised because an employment decision (for example to suspend, redeploy and/or restrict duties) may be needed.

78. Once such a concern has been raised and a safeguarding referral sought, any further HR actions taken in relation to a member of staff must be directly informed by safeguarding advice. This includes where a grievance or similar process has been invoked by the member of staff against whom the concerns have been raised. In such a case, redeployment or suspension should be taken following an appropriate risk assessment and in light of any advice given by the LADO (although in some circumstances a suspension or alternative decision may need to be taken urgently before discussions with the LADO take place). This ensures that any such decision is properly risk assessed and informed by the safeguarding team's judgment as to severity of the situation. NHS England's HR teams use a suspension checklist[86] to help inform

[85] INQ0107001, page 6, paragraph 4.6 and pages 6-7, paragraph 5.4
[86] Awaiting INQ

decision making and risk assessment when a suspension or alternative is being considered. The checklist and NHS England's processes are described below.

79. As Professor Bowers KC made clear[87], the primary duty throughout must remain patient safety and, in the specific case of a baby, the welfare of that and any other babies at risk.

80. Each case needs to be considered on its own circumstances but, to illustrate the above principles, it may assist the Inquiry to understand in high level how NHS England balances safeguarding and HR considerations.

81. Safeguarding concerns can be raised to one of NHS England's Regional teams or via a National team/individual. All those operating as part of NHS England are expected to comply with the process set out in the Managing Safeguarding Allegations Against Staff: Policy and Procedure (updated 2019).[88]

82. Part 3 of the policy sets out the scope, making it clear that it applies to all employees and contractors, including clinical staff; secondees; volunteers; students; trainees; temporary workers. It also provides that the policy applies to allegations made against staff "both within and outside their" NHS England duties. Examples are provided to illustrate this point. Part 4 of the policy sets out the immediate actions that must be taken when allegations are raised, with part 5 describing these steps in more detail and assigning roles and responsibilities in relation to handling concerns.

83. Specific provision is made in part 6 of the policy for the process that applies in relation to non-directly employed staff, reflecting the 2015 Savile inquiry findings and recommendations.

84. The importance of record-keeping to document the nature of the allegation and the decision-making process is emphasised at part 8 of the policy, alongside appropriate information security arrangements (with restricted access to appropriate personnel).

85. Also important is the routine process of reviewing safeguarding cases to identify, share and action learning (part 9 of the policy).

[87] Professor John Bowers KC, Week 12, Day 4, pages 63 and 73
[88] INQ0107001

86. To give a sense of the spectrum of safeguarding concerns NHS England deals with, these have recently included allegations of:
    a. Grooming of vulnerable children;
    b. Behaviour falling in-scope of Prevent;
    c. Historic child and other sexual offences;
    d. Domestic abuse;
    e. Criminal conduct in a non-work capacity.

87. If concerns were raised at a Regional level, the Nominated Safeguarding Senior Officer would coordinate obtaining National safeguarding and HR advice. Any associated HR decision would be taken in accordance with the checklist[89] developed to guide HR-decision making, with ultimate approval for any suspension resting with NHS England's National Director of Human Resources. As part of considering suspension, other alternatives must also have been considered (e.g. restriction of duties, redeployment, enhanced supervision).

88. Where there are safeguarding concerns, a decision to suspend may be taken at an earlier stage, where the evidential basis to substantiate or not the concerns may remain uncertain, recognising the importance of minimising the risk of potential harm. Any such decision is informed by risk assessment both to the organisation, third parties (such as children) and to the individual. The same approach would apply to any redeployment or restriction of duties, with risk-based assessment of what was appropriate in the circumstances and what mitigation measures (e.g. restricted access to systems) would need to be put in place. Occupational Health would routinely be involved as part of this assessment.

89. All suspensions are reviewed on a 2-weekly basis to consider whether they remain appropriate. The individual and their representative are informed of this decision in writing by the line manager.

90. In each case, there would be close liaison with the relevant LADO and police (such as, in the case of Prevent, the Metropolitan Police). If an individual was a member of a professionally regulated profession, then a regulatory referral may also be needed. In the case of a doctor,

[89] Awaiting INQ

for example, this would include liaising with the Responsible Officer and the equivalent would apply for other roles. It may also be relevant to make a Disclosure and Barring Service ("DBS") referral as well and, where this is the case, this can be made by either HR, safeguarding or the professionally regulated lead.

How should an HR professional reconcile any employment process with child protection procedures. If they cannot be reconciled, which takes precedence? Why and to what effect?

91. The statutory framework and NHS England's own policies and procedures make it absolutely clear that protection of the baby, child, young person, or adult at risk takes precedence.

92. NHS England's policy provides that "The safety of the child, young person or adult at risk is of paramount importance, and immediate action may be crucial in safeguarding an investigation. Where there is concern that other individuals may be at risk of harm or abuse, this must be reported immediately" (paragraph 4.3).

93. HR and safeguarding should not need reconciling if a safeguarding-led process is followed, ensuring that any steps are appropriately informed by safeguarding advice, the organisation's policies and procedures, and a robust risk assessment.

How does NHS England discharge safeguarding obligations via its individual employees?

94. The NHS England policy referred to above applies to all staff.

95. Regular training is provided to staff and forms part of the mandatory organisational training all staff must complete every three years. This is in addition to the statutory and mandatory training that applies across the NHS.

96. Pre employment screening will also apply and, depending on an individual's role, this will include a DBS check if the individual is undertaking a regulated activity[90].

97. In addition, and as set out in the policy, safeguarding case reviews and learning are shared as appropriate within the organisation.

[90] INQ0017495.pdf, page 211, paragraph 803(b)

Where a union representative is providing support and/or representation to a person about whom the representative knows there are suspicions of causing harm to a baby or babies what, in law, is the union representative's duty to take steps to safeguard the baby or other babies?

98. NHS England is unable to comment on the organisational arrangements that specific unions may have in place. However, individuals working for a union will often be professionally regulated in their own capacity and accordingly subject to the requirements of applicable professional codes of conduct. In the specific circumstances involving Letby, the union representative who provided her with support and representation confirmed that they were a registered nurse at the relevant time.[91]

What duty, if any, is owed by a lawyer advising a hospital, or other institution, on the safeguarding steps it should take where suspicions have been raised that a member of staff may be harming a baby or babies? Is there a duty on the lawyer to take any steps in the absence of action from the hospital or other institution? If so, what?

99. The term lawyer encompasses the following roles:
    a. Solicitors;
    b. In-house solicitors;
    c. Barristers (including some who are in-house barristers).

100. NHS England is not the regulatory body for any of the above; the relevant bodies are the Solicitors Regulation Authority and the Bar Standards Board. The Inquiry's question is complex and involves a close examination of the various codes and standards that are set by the relevant regulatory bodies. Expert evidence, including the views of these regulatory bodies, would assist the Inquiry in this respect.

101. However, to assist the Inquiry, NHS England has sought to identify below some of the applicable rules and factors that would need to be considered, to form a view on this question.

102. **For solicitors**, obligations are codified in a number of documents issued by the Solicitors Regulation Authority (referred to collectively as Standards and Regulations). The most

[91] Hayley Griffiths, Week 8, Day 3, page 1, lines 16-24

relevant documents in this context are likely to be the Principles[92] and the Code of Conduct[93]. In considering the Inquiry's question, the relevant parts of these documents include:

a. Obligations on solicitors not acting so as to restrain a third party from making a report that they would be entitled to make to the proper authorities[94].
b. Safeguarding responsibilities in relation to a solicitor's own client and the requirement to act in the client's best interests, depending on the scope of the retainer[95].
c. Where the appropriate balance lies between confidentiality and public interest disclosure, noting the Solicitors' Regulation Authority has sought to address the relationship between this and their rules on client confidentiality[96] in its Guidance on *Confidentiality of client information*[97].

103. On public interest disclosures, i.e. where there is no obligation or permission to make a disclosure, the Solicitors' Regulation Authority states that it will take public interest justification factors into account when deciding whether to pursue a breach of client confidentiality, with the following examples provided where such a justification *may* apply, noting that this only applies where the risk is yet to materialise (i.e. there seems to be no justification where a report would apply to disclosure after the event):
    a. Client intention to commit suicide or self-harm;
    b. Prevention of abuse to children or vulnerable adults[98];
    c. Preventing the commission of a criminal offence.

104. The Solicitors Regulation Authority also recognises that a solicitor will not have a duty of confidence if they are being used by a client to perpetrate a fraud, and, by analogy, any other crime (the 'iniquity' exemption)[99].

105. Specific rules and guidance apply to in-house solicitors, and this has evolved and developed since the 2015-2017 period. See, for instance, the Solicitor Regulation Authority's guidance for in-house solicitors, published in final version on 18 November 2024.[100]

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[92] SRA | Principles | Solicitors Regulation Authority
[93] SRA | Code of Conduct for Solicitors, RELs and RFLs | Solicitors Regulation Authority
[94] SRA | Code of Conduct for Solicitors, RELs and RFLs | Solicitors Regulation Authority; SRA | Use of non-disclosure agreements (NDAs) | Solicitors Regulation Authority.
[95] SRA | Principles | Solicitors Regulation Authority; https://www.sra.org.uk/solicitors/guidance/accepting-instructions-vulnerable-clients/
[96] SRA | Code of Conduct for Solicitors, RELs and RFLs | Solicitors Regulation Authority
[97] https://www.sra.org.uk/solicitors/guidance/confidentiality-client-information/
[98] SRA | Confidentiality of client information | Solicitors Regulation Authority
[99] SRA | Confidentiality of client information | Solicitors Regulation Authority
[100] SRA | Reporting concerns about wrongdoing when working in-house - Guidance | Solicitors Regulation Authority

106. **For barristers,** subject to the same caveat above that NHS England is not the regulator for barristers and so is not best placed to express a view in relation to the duties that may or may not arise in the circumstances described, the following points may assist the Inquiry:
    a. Barristers are regulated by the Bar Standards Board ("BSB"). The regulatory objectives of the BSB derive from the Legal Services Act 2007. The BSB Handbook[101] sets out the standards that the BSB requires the persons it regulates to comply with. The current version of the BSB Handbook is version 4.8 which came into force on 21 May 2024.
    b. The standards in the BSB Handbook include Core Duties and Conduct Rules. It is apparent that the Core Duties focus on a barrister's duties to their client and to the court. Core Duties CD1-10 are likely to be relevant to the Inquiry's question.
    c. From a regulatory perspective the potential duties on a barrister would be informed by the context and their instructions. Where a barrister's instructions are to advise the hospital on safeguarding issues in their hospital in the context of suspicions being raised that a member of staff may be harming a baby or babies it would appear unarguable that it is in the client's best interests to be advised on the full range of safeguarding steps that are available and could be taken pursuant to Core Duty 2. Such advice is also likely to be required by the duty to provide a competent standard of work and service to each client (Core Duty 7).

107. Whether the regulatory framework gives rise to a duty on the barrister to take any other positive steps absent action from the hospital is less clear. It could be argued that the requirements of Core Duty 3 (honesty & integrity) and Core Duty 5 (public trust & confidence) gives rise to a duty on a barrister to raise concerns of such a serious nature with the relevant safeguarding, criminal justice or other agencies. For example, if a barrister became aware of potential harm to a baby or babies, and that harm was found to have occurred, it would appear arguable that the failure to raise their concerns with the relevant agencies diminishes the trust and confidence with the public places in them or in the profession. Such inaction might also amount to a failure to act with the honesty and integrity required[102].

[101] The BSB Handbook - Version 4.8
[102] Core Duty 3 and section C2 of the Conduct Rules; Rules C8-C9, Core Duties 3 and 4

108. Barristers are required to preserve their client's confidentiality, but this is subject to exceptions.[103] Disclosures by barristers required or permitted by law appear to be relatively limited. One example given in the BSB Handbook is where a barrister may be obliged to disclose certain matters by the Proceeds of Crime Act 2002. As far as NHS England understands, there are currently no statutory duties that would require a barrister to take active steps in the absence of action by the hospital or other institution in the circumstances described. There appears to be no equivalent guidance to barristers as exists for solicitors in relation to reconciling the express duties of client confidentiality with a public interest in making such a report when not legally obliged or permitted. However, as emphasised at the start of this section, this question is complex and would benefit from expert evidence from the relevant regulatory bodies.

What is the process that must be followed and by whom on the occasion of a sudden and unexpected baby death?

109. NHS England has heard the evidence as to the uncertainty that clinicians have about whether the Sudden Unexpected Death in Infancy and Childhood ("SUDIC") guidance applies to sudden and unexpected baby deaths in hospital.

110. The SUDIC guidance provides that it does apply, although it also recognises that it will be relatively rare for this to be the case.[104]

111. As set out in the second witness statement of Duncan Burton,[105] NHS England is committed to working with the DHSC to support a review of the SUDIC guidance.

112. NHS England has set out below the processes that apply today in relation Medical Examiner scrutiny, which provides an important safeguard that did not apply in 2015-2016.

Freedom to Speak Up

113. As the Inquiry has heard, in response to one of the recommendations from the Freedom to Speak Up Review by Sir Robert Francis, NHS Improvement (as it was then) published the first

[103] The BSB Handbook - Version 4.8
[104] Sudden-unexpected-death-in-infancy-and-childhood-2e.pdf, page 14, paragraph 5
[105] INQ0108890, page 5, paragraphs 19-21

'National Policy for Raising Concerns (whistleblowing)' on 1 April 2016[106], which all NHS organisations were expected to adopt as a minimum standard.[107] There was no national policy or equivalent prior to this[108]. Arrangements for speaking out were, therefore, "not very" developed in the period 2015-2016.[109]

114. Since then, considerable progress has been made, including through the establishment of the National Guardian's Office[110] and the work of Freedom to Speak Up Guardians. The Inquiry heard evidence that guardians have managed "more than 100,000 cases" since 2017.[111]

115. Under the NHS Standard Contract[112] NHS England requires all providers of NHS services to appoint a guardian and have in place, promote and operate (and ensure that all sub-contractors have in place, promote and operate) a policy and effective procedures, in accordance with Freedom to Speak Up policy and guidance, to ensure that staff have appropriate means through which they may speak up about any concerns.[113]

116. NHS England also requires NHS organisations and those providing NHS healthcare services in primary and secondary care in England to appoint a senior lead responsible for Freedom to Speak Up. NHS organisations with boards are also required to appoint a non-executive director responsible for Freedom to Speak Up. The non-executive director responsible for Freedom to Speak Up provides more independent support for the Freedom to Speak Up Guardian, providing a fresh pair of eyes to ensure that investigations are conducted with rigour and helping to escalate issues, where needed.

117. The Inquiry has heard evidence about the employment arrangements for guardians, with some witnesses proposing that external employment of all guardians would be beneficial.[114] NHS England does not agree; its clear view is that employment within an organisation best enables a guardian to understand the organisation, provide an approachable and visible resource for staff and to contribute to a culture of openness.

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[106] INQ0014643
[107] INQ0017495.pdf, page 200, paragraphs 762-763
[108] INQ0017495.pdf, page 200, paragraph 763-764
[109] Helene Donnelly, Week 12, Day 3, page 150
[110] Mr Bershadski (reading for Dr Jayne Chidgey-Clark), Week 15, Day 2, page 1, lines 14-17
[111] Mr Bershadski (reading for Dr Jayne Chidgey-Clark), Week 15, Day 2, page 3, lines 6-8
[112] INQ0017495.pdf, pages 210-212, paragraphs 800-804
[113] INQ0017495.pdf, pages 201-202, paragraph 770
[114] Helene Donnelly, Week 12, Day 3, page 161, lines 4-24

118. However, there is more that could be done to strengthen and support guardians. For instance, through each organisation's Chief Executive Officer and Chair (or equivalent senior leaders) ensuring that non-executive director FTSU leads understand their role and the role of FTSU Guardians and ensure Boards are setting the right tone. NHS England has been working with the National Guardian's Office to support this work. In 2018, for instance, NHS England (in partnership with the National Guardian's Office) published a guide for leaders in the NHS and organisations delivering NHS services (the "Freedom to Speak Up Guide").[115] This was most recently updated in June 2022 and is now called the FTSU Guide. It is aimed at leaders so that it is relevant to as many organisations as possible (reflecting that smaller organisations do not have boards). This guidance is supplemented by a 'a self-reflection tool'[116].

119. Learning and evolution of the arrangements for speaking-up continues. In 2022, NHS England published an updated Freedom to Speak Up policy for the NHS (the "Freedom to Speak Up Policy").[117] This policy applies to all NHS organisations and others providing NHS healthcare services in primary and secondary care in England.[118] It explains what the external escalation routes are if an individual does not feel able to raise their concerns within their organisation.[119]

120. NHS England has reflected on the oral evidence given by Helene Donnelly to the Inquiry to the effect that although both the FTSU policy and training documents signpost to external bodies (such as the CQC, the National Guardian's Office, Health Education and the police) where an individual has significant concerns that are not being appropriately addressed within an organisation, this could be done more explicitly.[120] NHS England agrees that clear routes for external escalation are important and it has been working with CQC to progress an updated process for sharing escalated concerns[121].

121. As an alternative to externalising all FTSU Guardians so that they are employed by a national body, a suggestion has been to introduce an independent regulator, akin to the Scottish Independent National Whistleblowers Office[122], which is able to investigate a concern that a

[115] INQ0014733
[116] INQ0014733
[117] INQ0014746
[118] INQ0017495.pdf, page 201, paragraph 769
[119] INQ0014746, page 5
[120] Helene Donnelly, Week 12, Day 3, pages 184 and 185, lines 1-8
[121] INQ0107952 NHS England Written Opening Statement.pdf, page 28, paragraph 146.1.1
[122] INQ0107952 NHS England Written Opening Statement.pdf, page 219, paragraph 90.2

person feels has not been dealt with appropriately (and intervene at an earlier stage, to seek to prevent this from occurring) and then make recommendations. Whilst NHS England is of the view that the introduction of an independent FTSU regulator could be beneficial, it requires further exploration to determine whether it would work in England. In any event, NHS England does not believe that it should be appointed as the FTSU regulator, as this would be in conflict with its oversight role and any FTSU regulator would need to be sufficiently neutral in order to be effective. The more appropriate body could be the Care Quality Commission.

Patient Safety Strategy and the Patient Safety Incident Response Framework

122. The introduction of the Patient Safety Strategy in July 2019[123] and the publication of the PSIRF Framework in August 2022[124] represented a commitment to system-based learning, directly informed by developments in safety science. The PSIRF Framework formally replaced the Serious Incident Framework on 1 April 2024.[125]

123. The PSIRF Framework has, as one of its four aims, "compassionate engagement and involvement of those affected by patient safety incidents." The Inquiry has heard evidence from the Families about how they were not involved in the reviews that were conducted into their babies' deaths or deteriorations and about the missed opportunity this represented to take the views of the Families into account, as a valuable source of information to inform a review. This is related but distinct to the duty of candour and the importance of keeping families informed. The PSIRF Framework includes guidance on engagement[126], which makes NHS England's expectations around the involvement and engagement with families clear.

124. Structures and processes for incident recording, investigation and learning from incidents have evolved significantly (and continue to develop and evolve) in the last twenty years. As acknowledged in the First Witness Statement of Professor Sir Stephen Powis[127], concerns about the effectiveness of the previous Serious Incident frameworks had been raised in almost every previous inquiry, investigation and review into the NHS or a specific NHS organisation, from the Government response to the Freedom to Speak Up Consultation, the Public

[123] INQ0009251
[124] INQ0009265
[125] This was to allow for organisations to fully understand the new requirements and ensure full compliance
[126] https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/engaging-and-involving-patients-Families-and-staff-following-a-patient-safety-incident/
[127] INQ0017495.pdf, page 215, paragraphs 816-817

Administration Select Committee report 'Investigating Clinical Incidents in the NHS', and the Morecambe Bay review. This culminated in the Patient Safety Incident Response Framework.

125. The Inquiry has published tables detailing the evidence of what steps were taken by the Countess of Chester in respect of each death in the neonatal unit during 2015-2017.[128] As set out in the Fourth Witness Statement of Professor Sir Stephen Powis,[129] NHS England conducted a similar exercise in 2023 by reviewing the reports made by the Countess of Chester via the National Reporting and Learning System and the Strategic Executive Information System. NHS England set out its observations about this evidence in its Opening Statement and those observations are not repeated here. However, it is NHS England's position, as explained in oral evidence by Professor Powis[130], that had the PSIRF Framework been in operation in 2015-2016 this may well have supported a more thematic and considered approach at the Countess of Chester. This is because the new Framework would have removed the requirement to categorise events as either 'serious incidents' or not and instead supported a more curious and open exploration of the events. It would also have encouraged, as noted above, a more compassionate approach by the Countess of Hospital to engagement and involvement of the Families.

Adoption of the PSIRF Framework

126. A programme of implementation support and resources was provided by NHS England to support adoption of the PSIRF Framework, with initial adoption by pilot sites ('early adopters') beginning in 2020. All providers of NHS-funded secondary care services are now required to have implemented the PSIRF Framework, with this requirement being underpinned by inclusion in the NHS Standard Contract.[131]

127. The new Patient Safety Strategy and Patient Safety Incident Response Framework adopt a systems-based approach, informed by developments in safety science. The Framework has four key aims:

    a. Compassionate engagement and involvement of those affected by patient safety incidents.

[128] INQ0108782.pdf
[129] INQ0107908.pdf, page 11-14, paragraphs 35-46
[130] Professor Sir Stephen Powis, Week 15, Day 4, page 113 (lines 2-19)
[131] 03-NHS-Standard-Contract-2024-to-2025-Service-Conditions-full-length--version-2-March-2024.pdf, page 53

b. Application of a range of system-based approaches to learning from patient safety incidents.
c. Considered and proportionate responses to patient safety incidents.
d. Supportive oversight focused on strengthening response system functioning and improvement.

128. The new system seeks to support organisations in drawing meaningful conclusions from the themes identified from recorded incidents, including learning that is relevant to and actionable by particular organisations and the specific risks in their area of work.[132]

129. Unlike the predecessor Serious Incident Framework of 2015, the PSIRF Framework makes no distinction between 'patient safety incidents' and 'Serious Incidents'. NHS England recognises the concerns raised by the Families about the removal of the 'serious incident' designation given the events at the Countess of Chester, but can provide assurance that all these events are still subject to incident recording and this change alongside the wider promotion of a 'just' culture has been adopted as a result of learning from other industries and recommendations from previous inquiries, such as Mid Staffordshire and Morecambe Bay.

130. Professor Mary Dixon-Woods also highlighted in her evidence how avoiding unfair blame during incident responses is important to encouraging openness and learning to prevent future error.[133] This does not mean that, where individuals behave recklessly, wilfully neglect or maliciously harm patients, they are not held to account but it recognises that the focus when recording and learning from incidents should be on seeking to generate insight to improve the safety of systems and that separate processes should be used for disciplinary proceedings, for example.

131. Alongside the adoption of the PSIRF Framework, the new Learn from Patient Safety Events ("LFPSE") service was introduced in July 2021 and has now replaced the National Reporting and Learning System which was decommissioned on 30 June 2024. The LFPSE service is intended to provide a better system to facilitate national learning about patient safety events across all settings by:

[132] INQ0102624 - Expert Report of Mary Dixon-Woods.pdf, pages 55-56, paragraph 5.6.1.3 and INQ0012335.pdf, page 47, paragraphs 124-125
[133] INQ0102624 - Expert Report of Mary Dixon-Woods.pdf, pages 7-9, paragraph 2.1

a. making it easier for staff across all healthcare settings to record safety events, with automated uploads from local systems to save time and effort, and introducing new tools for non-hospital care where reporting levels have historically been lower;

b. collecting information that is better suited to learning for improvement than what was previously gathered by legacy systems;
c. making data on safety events easier to access, to support local and specialty-specific improvement work; and,
d. utilising new technology to support higher quality and more timely data, machine learning, and provide better feedback for staff and organisations.

132. The LFPSE service is currently in a public-beta stage and will continue to grow and evolve in response to user feedback. More tools will also be added over time.

133. These new systems are in their infancy and NHS England will continue to evaluate their effectiveness over time as they are embedded at the local Trust level. NHS England is also continuing to explore how to support patients' ability to input their experiences of safety events to support learning[134].

Medical Examiner System

134. The development and purpose of the Medical Examiner System is set out in the first witness statement of Professor Sir Stephen Powis,[135] as well as the witness statements of Dr Alan Fletcher (the content of which will not be repeated here in detail)[136].

135. As the Inquiry is aware, in September 2024, the statutory Medical Examiner System came into effect under the Medical Examiners (England) Regulations 2024, which formed part of the wider death certification reforms. Under the statutory framework, all deaths in any health setting in England and Wales that are not investigated by a coroner will be reviewed by NHS medical examiners.

[134] INQ0017495.pdf, pages 217-218, paragraphs 827-829
[135] INQ0017495.pdf, pages 107-109, paragraphs 424-439
[136] INQ0014570.pdf

136. There are three key points that NHS England would emphasise in relation to the Medical Examiner System, as follows:
    a. Delay in implementation;
    b. Whether earlier implementation would or may have prevented some of the deaths that occurred at the Countess of Chester Hospital; and
    c. How the system operates now, and how it will help to prevent a recurrence of these events.

Delay in implementation

137. It has taken close to twenty years for the Medical Examiner System to be implemented on a national, statutory basis. Dr Alan Fletcher has set out in his evidence the history of the Medical Examiner System[137].

138. The length of time it has taken to implement and the reasons for this were explored by the Inquiry with Mr Jeremy Hunt, the former Secretary of State for Health for the period 2012-2018,[138] and Mr William Vineall, for the DHSC.

139. Mr Hunt suggested that the apparent delay in the development and implementation of a statutory Medical Examiner System could be attributed to an unwillingness or reluctance of the NHS to fund it[139] and that there may have been a concern that money would be diverted from other priority areas.[140]

140. When referred to Mr Hunt's views, that the NHS did not support Medical Examiners for financial reasons, Mr Vineall explained the Health and Social Care Act reforms in 2012 meant that the initial intention was for medical examiners to be funded by local government (as per the arrangements for Coroners) but that this position changed in 2018, as part of the ongoing consultation around implementation of the Medical Examiners System, when it was decided that the service would operate out of the NHS and the non-statutory scheme was introduced.[141]

[137] INQ0014570.pdf, pages 5-11, paragraphs 11-35
[138] INQ0107827.pdf, page 9, paragraph 36
[139] The Rt Hon Jeremy Hunt MP, Week 14, Day 3, page 175, lines 15-25, page 176, lines 1-3
[140] The Rt Hon Jeremy Hunt MP, Week 14, Day 3, page 238, lines 9-17
[141] Mr William Vineall, Week 15, Day 3, page 157, lines 11-25, pages 158-161, page 162, lines 1-4

141. As NHS England has emphasised, it cannot give additional detail about the early stages of the evolution of thinking around the Medical Examiner System because it was not directly involved. However, when NHS England was asked in 2018 to undertake responsibility for implementing the Medical Examiner System as a non-statutory system, this was actively and promptly done, "at pace"[142]. On the suggestion from Mr Hunt that there were not enough doctors or that there was reluctance from the medical profession to support the Medical Examiner system, NHS England can only point to its experience since 2018 when it implemented the non-statutory system and the "very good uptake" that was evidenced at that time and since[143]. As NHS England's National Medical Director explained, "… I think the system has been welcomed. That doesn't mean that, as ever, when you introduce a new system there are bumps to get over and there are glitches along the way, but we were ready for statutory implementation in September [2024]".[144]

Whether earlier implementation would or may have prevented some of the deaths that occurred at the Countess of Chester Hospital

142. Mr Hunt apologised for the fact that the Medical Examiner System was not in place when some of the deaths at the Countess of Chester Hospital occurred and that the external scrutiny provided by a Medical Examiner was not, therefore available.[145]

143. Dr Fletcher's evidence is that a correctly functioning Medical Examiner, involving a proportionate review; interaction between the Medical Examiner and an attending clinician; and conversation(s) with the families, would mean that it would be "extremely difficult" to "fail to detect a problem at an early stage".[146] Dr Fletcher referred to "the Shipman question" because of the evidence Dame Janet Smith heard in the Shipman Inquiry about the valuable evidence family members can contribute, which acts as "an alarm bell for every Medical Examiner".[147]

144. Dr Fletcher's view overall is that if the Medical Examiner System had been in place, and was functioning correctly, then some of the deaths would have been preventable[148].

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[142] Professor Sir Stephen Powis, Week 15, Day 4, page 60, line 11-16
[143] Professor Sir Stephen Powis, Week 15, Day 4, page 61, lines 23-25, page 62, lines 1-2, INQ0014570.pdf, pages 9-10, paragraph 28
[144] Professor Sir Stephen Powis, Week 15, Day 4, page 62, lines 5-10
[145] The Rt Hon Jeremy Hunt MP, Week 14, Day 3, page 174, lines 18-25, page 175, lines 1-5
[146] Dr Alan Fletcher, Week 13, Day 2, page 40, lines 23-25, page 41
[147] Ibid
[148] INQ0014570.pdf, page 32, paragraph 123, and Dr Alan Fletcher, Week 13, Day 2, page 40, lines 13-24, page 41, lines 1-7

How the system operates now, and how it will help to prevent a recurrence of these events

145. Since 2021, the National Medical Examiner introduced the Good Practice Series, which is a topical collection of focused summary documents, designed to be easily read and digested by busy front-line staff, with links to further reading, guidance and support. In March 2022, the National Medical Examiner's *Good Practice Series No. 6 Medical examiners and child deaths* was published, which focuses on how medical examiners interact with the statutory child death review process in England and Wales. In July 2023, the National Medical Examiner's *Good Practice Series No. 12 Escalating thematic issues and maximising the impact of medical examiner scrutiny* was published, which notes that medical examiners are ideally placed to provide early notice of issues that are more systemic and are not confined to an individual death, and explains how trends, themes and systemic issues can be identified and escalated.

146. During Dr Fletcher's oral evidence to the Inquiry on 12 December 2024, he advised that he has commissioned colleagues and neonatal Medical Examiners, in association with subject matter experts, to update the Good Practice guidelines on neonatal and child deaths[149]. Initial revisions were completed during January 2025 and circulated to current and previous contributors to the paper on 10 February 2025. Comments received in response were then considered and a final version of the paper sent to the Royal College of Pathologists on 27 February 2025 for publication in March.[150]

Culture, leadership and professional regulation - attracting and retaining quality leadership in the NHS

147. NHS England recognises that strong leadership is vital for patient safety, productivity and healthy workplace culture. This has been examined in a number of previous inquiries, investigations and reviews[151]. In a healthy culture, leadership and management support speaking out and speaking up, and the specific learnings around freedom to speak up and whistleblowing are dealt with separately.

[149] Dr Alan Fletcher, Week 13, Day 2, page 19, lines 14-19
[150] Awaiting INQ
[151] INQ0102624 - Expert Report of Mary Dixon-Woods.pdf, pages 31-32, paragraph 3.6.8

148. Working with the DHSC and other partners, NHS England has led on a number of initiatives to implement learning from these previous inquiries, investigations and reviews in relation to leadership and culture, with the work to implement the Kark and Messenger reviews being of particular relevance.

149. NHS England welcomes and supports the Government's consultation on the regulation of managers. In the lead-up to the launch of the formal consultation on this, NHS England convened a number of round-table discussions on the question of regulation.[152]

150. NHS England has previously highlighted the factors that will need to be considered in the development of any formal regulatory system:
    a. duplication and differentiation, recognising that many NHS managers are already regulated professionals by virtue of their clinical background[153];
    b. the entry level of regulation; the cohorts of managers in scope of regulation and to what standards needs to be determined;
    c. the identity of the regulator, how it will operate and its interaction with the existing professional regulatory bodies;
    d. the balance between accountability and development and improvement; and,
    e. fairness and proportionality to ensure that any system does not introduce unnecessary barriers for existing NHS staff or those moving into leadership roles from other industries.

151. The Inquiry has heard evidence from Professor Judith Smith and others on the importance of senior leaders being adequately supported and trained to enable them to set the culture of teams and manage aspects of health organisations such as quality, strategy, productivity and finance, even if they come from a clinical background, and conversely individuals with non-clinical backgrounds need assistance and training to be empowered understand mortality and morbidity data and other associated datasets.[154] NHS England recognises the importance of proper training and support for managers and the steps it has taken in this regard are described below.

[152] INQ0017495.pdf, pages 254-255, paragraphs 958-961
[153] Dr Alan Clamp, Week 14, Day 1, page 154, lines 15-25, page 155, lines 1-19
[154] Professor Judith Smith, Week 14, Day 3, page 70, lines 10-25, page 71, page 101, lines 7-25, page 102, lines 1-14

152. NHS England also recognises that a consistent set of values, behaviours and aims are needed to support a compassionate, inclusive and open 'NHS culture'. Such a culture should, through collective leadership, foster effective, patient centred working practices, working environments that support colleagues to deliver high quality care and inclusive NHS organisations that are attractive places to work and develop careers.[155]

153. This is why NHS England expects leaders at all levels and across all organisations operating within the NHS to model these values. NHS England seeks to support and enable this nationally through training and development initiatives, as well as through its regional offices in the form of more localised support for providers. An enhanced offering for learning and development has been an ongoing focus for NHS England and can be seen through the publication of the Directory of Board level learning and development opportunities which sits as part of the NHS England Fit and Proper Person Test Framework for board members[156].

154. There is an established NHS wide Culture and Leadership Programme,[157] in addition to the specific Neonatal Culture and Leadership programme set up under the Three Year Delivery Plan described above. The Culture and Leadership Programme provides a practical, evidence-based approach to help NHS organisations understand how colleagues working within the organisation or system perceive the current culture and guides the creation of a leadership strategy. This programme was initially set up following the Francis Inquiry and has developed over the years to reflect recommendations and learnings from subsequent inquiries, investigations and reviews and is based on the elements and behaviours identified as necessary for high quality, equitable care cultures.[158]

155. In addition, NHS England has also sought to influence and inform workplace culture, through the following national initiatives:
    a. The **NHS People Promise** includes a range of core expectations and actions required by all those working as part of the NHS.[159]
    b. **Our Leadership Way** complements the NHS People Promise.[160] It has been designed as a 'Leadership Compact' that defines the NHS leadership ethos, by which we mean how

[155] INQ0017495.pdf, pages 161-162, paragraph 642
[156] INQ0012645
[157] INQ0017495.pdf, pages 260-261, paragraphs 975-980
[158] INQ0017495.pdf, pages 260-262, paragraphs 975-980
[159] INQ0014794
[160] INQ0014752

leaders are expected to behave towards each other and their teams, delivering on a day-to-day basis the NHS People Promise.

c. The **NHS People Plan**, which was published in July 2020, included an update on NHS England's response to the Kark Review, as well as work by NHS England to develop a set of board competency frameworks for board positions in NHS provider and commissioning organisations, and work to build confidence around building confidence to speak up. It commits the NHS to "welcome all, with a culture of belonging and Trust. We must understand, encourage and celebrate diversity in all its forms."[161]

Implementation of the Kark and Messenger reviews

156. As part of the national Management and Leadership Framework, driven by the recommendations in the Messenger review, NHS England has produced a Management and Leadership programme[162] that includes:
    a. The Fit and Proper Person Test Framework and associated resources (see below at paragraph 172);
    b. Leadership Competency Framework for Board Members, discussed below at paragraph 159;[163]
    c. Chair Appraisal Framework, discussed below at paragraphs 158;[164]
    d. Insightful Board Guidance, discussed below at paragraph d2;
    e. Learning and Development Directory (Board level);
    f. NHS Impact – for continuous improvement and high performance.

157. NHS England recognises that good quality appraisals play an important role in assessing the effectiveness of senior leaders, identifying areas for development and support, and providing a basis to support completion of the Board Member Reference (discussed below). Appraisals of Chief Executives are thorough and a vast amount of evidence is gathered prior to the appraisal, including feedback requested from multiple people, beyond just the Chair.[165] Work is underway to develop a suite of guidance to support this, with the Chair Appraisal Framework having already been published as noted above.[166] This Framework sets out an annual four

[161] INQ0014726, page 24
[162] NHS England » NHS Management and leadership programme
[163] INQ0108668
[164] INQ0108663
[165] Dr Susan Gilby, 24 February 2025, page 22 (lines 8-25), page 23, page 24 (line 1-16)
[166] INQ0108663

stage process consisting of appraisal preparation, a multisource assessment that seeks feedback from various stakeholders, evaluation by the appraisal facilitator, and then finally an appraisal discussion. The Framework contains a template to record key points arising from the appraisal discussion. Additionally, further role-specific guidance is underway.

158. The Chair Appraisal Framework (and future similar publications) provide best practice guidance only – they are not mandatory and it ultimately remains the responsibility of the appointing/employing organisation to determine and implement appropriate arrangements. As a reminder, NHS England is responsible only for appraisal of NHS Trust and ICB Chairs. The appraisal process for Foundation Trust Chairs and Chief Executives is the responsibility of each organisation – the Chief Executive will usually be appraised by the Chair, and the Chair should be appraised by the Senior Independent Director or the Deputy Chair.

159. Linked to appraisals is the importance of a clear set of competencies against which leaders can be measured. This was noted as an area where improvement was needed in the Kark review.[167] The Leadership Competency Framework for Board Members was created as part of NHS England's work to implement the Kark review.[168] It is designed to:
    a. support the appointment of diverse, skilled and proficient leaders;
    b. support the delivery of high-quality, equitable care and the best outcomes for patients, service users, communities and our workforce;
    c. help organisations to develop and appraise all board members; and,
    d. support individual board members to self-assess against the six competency domains and identify development needs.

160. NHS England acknowledges the points made by Tom Kark KC in his oral evidence to the Inquiry about the language used in the Framework, and that the expectations set out in the Framework are high level and should be more robust.[169] However, NHS England's position is that the Framework was carefully designed with the input from NHS Providers, NHS Employers and NHS Confederation and that time is needed to properly assess its effectiveness.

[167] INQ0012637_20,97,133,134.pdf pages 127-128, and Tom Kark KC, Week 15, Day 4, page 16 (lines 6-25), page 17 (lines 1-20)
[168] INQ0108668
[169] Tom Kark KC, Week 15, Day 4, page 31 (lines 10-25), page 32, page 33 (lines 1-23)

161. NHS England will also soon introduce a new Management and Leadership Framework to create greater parity with clinical and other professions and consistency at all levels of management and leadership[170]. This Framework is expected to start in summer 2025 and will comprise:
    a. a code of practice to set out the values and behaviours expected of all leaders and managers in the NHS and social care;
    b. the professional standards that leaders and managers must demonstrate;
    c. the competencies which underpin the standards and outline the specific skills; and,
    d. knowledge and abilities individuals need to perform effectively at each level.

162. NHS England's view is that the Insightful Board guidance will also enable training and developments for Boards to ensure active governance and improve the effectiveness of Boards.[171] The published guidance on the Insightful Provider Board[172] sets out the key aims for Provider Boards, including responsibilities in relation to governance and culture. The guidance makes clear the Boards responsibility to ensure effective governance, understanding the business of the Trust and applying rigorous scrutiny. It also communicates the Board's role and responsibility in shaping organisational culture and the vital need for an open culture where staff can raise concerns and act on feedback to foster a safe reporting culture. The guidance provides six domains[173] for boards to consider, as a suggestion of the types of information and metrics that may be considered by Boards, as well as identifying mandatory reporting responsibilities.

NHS England's role in talent identification, development and in support appointments

163. Sustainable leadership is important to help facilitate efficient, high quality and sustainable operation more generally within the local systems. Consequently, NHS England's regional teams support the local systems which they oversee to ensure they are well-led. This often includes taking an interest in the 'leadership pipeline', talent development and management and in supporting the appointment of senior leaders to NHS Trusts and NHS Foundation Trusts.[174]

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[170] NHS England » NHS Management and leadership programme
[171] INQ0017495.pdf, page 251, paragraph 948(a)
[172] INQ0108906
[173] These are titled 'Strategy', 'Quality', 'People', 'Access and Targets', 'Productivity', and 'Finance'
[174] INQ0100828.pdf, pages 8-10, paragraphs 18-24 and INQ0101420.pdf, pages 5-9, paragraphs 11-25 and INQ0102349.pdf, pages 5-8, paragraphs 15-26

164. This includes the way in which each Regional team does this varies from Region to Region, reflecting the needs of local systems and the dynamics in each Region. However, common ways in which regional teams will support the appointments process include:
    a. Through the identification and development of a pool of potential future senior leaders.
    b. By suggesting potential candidates for consideration at either long or short-listing stage so that there is good competition with diverse candidates. Regional teams may also encourage appointing trusts to look beyond a preferred internal candidate and test the market through expanding the search, to ensure that there is effective competition through the appointments process (with the aim of facilitating a successful and sustainable conclusion to the appointments process).
    c. By providing views on short-listed candidates if they have relevant insight (in the requested format, whether in the form of a reference or informally by conversation).
    d. As a member of interview panels or an observer on the panel. Post-interview feedback will also routinely be shared, including within Regional teams.
    e. As a referee post interview when the candidate had previously worked in the region.
    f. As an interested party by bringing potential candidates to the attention of another NHS England colleague for instance – adding to others' pool of potential.
    g. By providing references to NHS IMAS, to support the interim appointments process.

Training and support

165. NHS England also recognises that training and support is needed to develop senior leaders. The first point is that good organisations will have their own training and support in place for newly appointed leaders and board members, although NHS England also provides some additional national frameworks and guidance to support this process, as detailed below.

166. There are two bodies accountable to NHS England to strengthen the development of senior leaders - the NHS Leadership Academy and NHS Interim Management and Support. The NHS Leadership Academy is now part of the Workforce, Training and Education Directorate of NHS England. The NHS Leadership Academy runs an Executive Director Pathway which aims to support aspiring executive leaders to progress in their careers through a series of targeted

development opportunities.[175] The scheme focuses on preparing participants for any of the following roles, or equivalent in an NHS provider organisation.

167. Further, NHS England has launched non-executive and executive inductions, which have been well attended. The National Induction Scheme was launched in April 2024,[176] which will have the effect of allowing the more reliable assessment of future leadership potential. An induction portal will be going live on 6 March 2025.

168. The Inquiry has asked all Core Participants to address the level of administrative support provided to executives in the NHS. NHS England considers that this is a matter for each organisation and will vary depending on the size and structure of the organisation. It is not something that could or should be mandated nationally.

The role played by Boards

169. The Chief Executive is held to account by the board of its organisation, with the Chair providing a key role in expectation-setting; appraisal and identification of development areas (and corresponding support opportunities).

170. Broadly, for both NHS Trusts and NHS Foundation Trusts, a board's oversight of clinical and corporate governance must be consistent with the NHS England Code of Governance[177] and Well Led guidance[178], while also complying with applicable requirements of the CQC regulatory framework.

171. NHS England has also published a guide ("**The Insightful Provider Board**")[179] to help boards to consider their approach to handling and acting on the information they receive. It considers the leadership behaviours and culture of the board and how these can affect the information it receives and the actions it takes, as well as metrics that can support the board to better understand the organisation's performance.

Fit and Proper Person Test

[175] Aspiring Chair Talent Programme – Leadership Academy and Aspiring Chief Executive programme – Leadership Academy
[176] INQ0017495.pdf, pages 257-258, paragraph 969
[177] INQ0012647
[178] NHS England » Well-led framework
[179] INQ0108906

172. The approach to how leaders are assessed to be fit to hold office within the NHS has evolved and strengthened since 2017. This has been closely informed by the findings of previous inquiries, investigations and reviews but in particular the findings of the Kark Review and the Messenger Review.

173. There are two separate statutory requirements that impose fit and proper persons requirements in relation to director and non-executive director appointments to NHS Foundation Trust boards:
    a. The requirements under Schedule 7 of the 2012 Act, which were incorporated into, and extended by, the Provider Licence Condition G4.
    b. The requirements in regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (known as the Fit and Proper Person Regulation) - overseen by Care Quality Commission (although Trusts had a duty under the conditions of their Provider Licence to establish and effectively implement systems and processes to secure compliance with this requirement).

174. In 2019 the government asked NHS England (then operating as NHS England and NHS Improvement) to engage with as diverse a range of stakeholders as possible to consider each of the seven recommendations in the Kark Review. This led to the development of the Fit and Proper Person Test (FPPT) Framework, including the new Board Member reference template to ensure greater transparency and consistency for the appointment of Board positions within the NHS.[180]

175. NHS England recognises that this is the first iteration of the FPPT Framework and an assessment is needed to determine how effectively it has been embedded and its impact within NHS organisations. The year-one review of how the Framework is being used has already commenced and initial results indicate that all boards are engaging with the new requirements. NHS England has also listened to the evidence given by Sir Robert Francis in this regard.[181]

176. NHS England has taken the non-statutory framework as far as it can at this stage and to the extent that further developments are needed in this area then this will be considered by the

[180] INQ0017471
[181] INQ0101079.pdf, page 86, paragraph 10.6

Government following the conclusion of its ongoing public consultation on options for regulating NHS managers, and on the possibility of introducing a professional duty of candour for NHS managers.

The movement of senior leaders

177. The movement of senior leaders around the NHS has significant benefits for the NHS as a whole and the trusts who employ them. It allows individuals to bring their experience to a local setting where improvement may be required or to transform the delivery of services in the area. It also allows the individuals themselves to develop learning and progress on their careers. Overall, NHS England's position is that the movement of senior leaders should be encouraged and supported where the circumstances are right. The DHSC is of the same view[182].

178. It is acknowledged that historically there has been a public perception that "bad apples" are sometimes allowed to move around the NHS in senior leadership positions. The evidence before the Inquiry is that this is not something NHS England would ever knowingly facilitate.[183]

179. In relation to the events that occurred at the Countess of Chester, NHS England and NHS Improvement were aware that:
    a. There was a police investigation ongoing into the reasons behind the increased mortality rate at the Countess of Chester. There was no suggestion at the time, however, that the Countess of Chester as a corporate body or any of the Countess of Chester Executive were being investigated by the police.
    b. There were clearly general concerns held by the North Regional team about the lack of transparency and candour demonstrated by the Countess of Chester's executive team during 2016-2017 period before the police were brought in, but there were no other specific concerns about Tony Chambers' conduct or performance.
    c. On 19 September 2018, clinicians at the Countess of Chester were intending to hold a vote of no confidence in Tony Chambers. The reasons behind this vote of no confidence were not known to NHS England as the Countess of Chester did not provide NHS England or NHS Improvement with copies of the correspondence between it and the clinicians

[182] William Vineall, Week 15, Day 3, page 169, lines 20-21
[183] INQ0100828.pdf, page 13, paragraph 39 and INQ0101414.pdf, pages 12-13, paragraph 47 and INQ0101420.pdf, pages 8-9, paragraphs 22-25 and INQ0102349.pdf, pages 20-21, paragraphs 77-83

during the preceding months.[184] Whilst the evidence of Tony Chambers,[185] Sir Duncan Nichol[186] and Lyn Simpson[187] was that there was no concerted attempt to avoid accountability or transparency by seeking to stop the vote of no confidence, NHS England accepts that had the vote taken place this may ended Mr Chambers career as a senior leader in the NHS.

180. In addition, NHS England accepts that:
    a. NHS Improvement should have been more curious and made additional enquiries with the Countess of Chester to understand the full circumstances that led the Countess of Chester approaching it to assist in facilitating a secondment for Tony Chambers as part of his departure.
    b. This would likely have led NHS Improvement to understand that the vote of no confidence was connected to how Tony Chambers handled the events at the Countess of Chester involving Letby, and that this was connected to his departure from the Trust.

181. In the absence of any formal regulation of NHS managers, there was no process in place or mechanism by which NHS England and/or NHS Improvement assessed whether Tony Chambers remained suitable to continue in a senior leadership role. This was a matter left for the Countess of Chester during his annual appraisal and for other employer trusts when Mr Chambers applied for subsequent posts.

182. It is also apparent from the evidence before this Inquiry that external recruitment agencies play a key role in vetting candidates for senior roles in the NHS, and that these checks may not be robust enough if those agencies have their own interests.[188] This is something that NHS England will reflect on in light of the evidence.

183. Although the position today is more robust due to the Board Member Reference Template discussed above, NHS England recognises that it would require the regulation of managers (with provisions that allow for information sharing between organisations and regions) for such an assessment to be done outside of the job application process. NHS England also

[184] Sir Duncan Nichol, Week 12, Day 1, pages 105, 106 and 107 (lines 1-6)
[185] Mr Tony Chambers, Week 11, Day 3, page 185, lines 21-25, pages 186, lines 1-19
[186] Sir Duncan Nichol, Week 12, Day 1, page 107, lines 7-25, page 108, line 1-8
[187] Lyn Simpson, Week 10, Day 4, page 25, lines 8-25, pages 26-34, page 35, lines 1-6
[188] INQ0101420.pdf, page 13, paragraph 48 and INQ0102349.pdf page 10, paragraph 34 and page 11, paragraph 36

recognises that although the new Board Member Reference Template is a more robust process, this still relies on Trust Chairs providing sufficient information. This arguably did not occur in the case of when Mr Chambers applied for the executive role at Barking & Havering.[189]

Recommendations

184. The Inquiry has heard evidence on what makes a "good" recommendation. In particular, Dr Rosie Benneyworth describes in her statement the report published by the Health Services Safety Investigations Body on 16 September 2024 "*Recommendations but no action: improving the effectiveness of quality and safety recommendations in healthcare"*.[190] This report highlighted:
    a. How the 'noise' created by the significant volume of recommendations being made to the healthcare system means that providers struggle to prioritise and implement recommendations, concentrating on those which are addressed directly to the provider, or where there are immediate patient safety risks.
    b. Some recommendations duplicate or contradict others.
    c. It is unclear how some recommendations are intended to impact the patient, which should be a key consideration in their development where possible.
    d. Most recommendations made to the healthcare system are not costed, either in relation to the cost of implementing the proposed actions or their longer-term cost effectiveness. This may affect providers' ability to implement them and means there is lack of information to support prioritisation decisions.

185. The Inquiry has also seen from Dr Murdoch's evidence how, following the "Reading the Signals" Report of the independent investigation led by Dr Bill Kirkup into maternity and neonatal services in East Kent was published in October 2022, a Task Force was established as recommended by Dr Kirkup to drive the implementation of a system capable of differentiating signals for maternity and neonatal outcomes measures. This task force continues to receive expert advice from Dr Kirkup and David Spiegelhalter in relation to the development of the tool, now known as MOSS.

[189] Sir Duncan Nichol, Week 12, Day 1, page 112, lines 11-25, page 113, page 114, lines 1-8
[190] INQ0012335.pdf, pages 28-30, paragraphs 99-106

186. NHS England encourages the Inquiry to take into account the findings of HSSIB and to also take a collaborative and proportionate approach to the development and implementation of any recommendations made in connection with this inquiry.

187. NHS England welcomes any such recommendations from the Inquiry and will work with the Inquiry to consider how recommendations could be best directed to ensure maximum efficiency of delivery. From the outset of the Inquiry, NHS England has reflected on the effectiveness of neonatal care; what improvements could be made and what recommendations might, therefore, be needed. Suggestions have been provided in NHS England's witness statement evidence[191] and in its Opening Statement.

188. The list below, which is provided as a starting point, focusses on those recommendations that have direct bearing on NHS England and which NHS England respectfully suggests the Inquiry may, therefore, wish to make.

Issue	**Recommendation**	**Responsible body/ies**	**Rationale**
Safeguarding – training	As part of its current review of mandatory and statutory training for NHS[192], NHS England should ensure that (a) it specifically reviews the content to ensure that it adequately trains staff to be aware that unexplained clinical events could have resulted from deliberate harm and what to do if such a scenario arises; and (b) any deficiencies in the review will be addressed.	NHS England (NHS employers to comply with outcomes requirements as per NHS England » Statutory and mandatory training (StatMand) programme)	The Inquiry has heard evidence from a range of staff to the effect that they were not aware of previous inquiries relating to deliberate harm; that they did not feel the training they had received covered this topic and that they were not, as a result, clear that suspected deliberate harm by a member of staff was a safeguarding issue. They were also unsure what steps to take when confronted with such a possibility. The mandatory and statutory training for NHS staff provides a programme of training on core subjects that all staff are required to complete. The content of this programme was already under

[191] INQ0017495.pdf, page 266-270, paragraph 995-1009, pages 272-275, paragraphs 1014-1018 and INQ0107952 NHS England Written Opening Statement.pdf pages 29-30, paragraphs 149-151
[192] NHS England » Statutory and mandatory training (StatMand) programme

			review by NHS England and the review team have been asked to review the content of the safeguarding training to assess the points included in the proposed recommendation.
Safeguarding - Child Death Guidance Review	As the responsible statutory body, the Department of Health and Social Care should undertake a review and update of the Child Death Review Statutory and Operational Guidance, to ensure the Guidance is up-to-date and reflects important changes since 2018, including the statutory Medical Examiner system. Following this review, NHS England should update the Safeguarding Accountability and Assurance Framework to reflect any policy changes.	DHSC NHS England	The CDR Guidance would benefit from an update; the current version was published in 2018. A publishing note has been added to recognise that the Guidance does not reflect the current statutory landscape, post the 2022 Act coming into force and that updates will be made in the "next update". In addition, the evidence that the Inquiry has heard suggests that there remains confusion 'on the ground' as to how the various parts of the guidance framework for child death reviews operate. NHS England's view is that it would be beneficial for any review to consider whether the CDR Guidance and the SUDIC guidelines could be consolidated. NHS England has already committed to supporting the Department of Health and Social Care in relation to any review of the Sudden Unexpected Death in Infancy and Childhood Guidelines.[193] NHS England has also committed to update the Safeguarding Accountability and Assurance Framework to reflect any policy changes.

[193] INQ0108890, page 5, paragraphs 19-21

Sudden Unexpected Death in Infancy and Childhood Guidelines	The Government should provide funding to support the review and update of the Sudden Unexpected Death in Infancy and Childhood Guidelines, involving the RCPCH and other stakeholders. Consideration should be given to consolidating the CDR and SUDIC guidance to ensure the guidance given to staff working in healthcare settings is clear, succinct and easy to follow. It may be that any such review can be done as part of an overall review of the guidance framework for child death reviews.	DHSC Royal College of Child Health and Paediatrics NHS England	At the time that the SUDIC guidelines were developed, the focus was on child deaths in the community.[194] However, the guidelines do provide for their application to in-hospital deaths, albeit recognising the rare circumstances where this would be case. The evidence that the Inquiry has heard evidence about the lack of clarity for staff as to the position on this and NHS England agrees that clearer, updated guidance for staff is needed. As above, NHS England's view is that consideration should be given to consolidating the CDR Guidance and the SUDIC guidelines.
Governance	All NHS Trusts should have at least one non-executive director on the Board who has a clinical background. That person should also chair the Trust's Quality Committee.	NHS England	NHS England recognises the evidence from the Inquiry that clinical expertise in both the executive and non-executive members of a Board is vital for a Board to examine clinical data and provide effective and rigorous curiosity.
Recommendations repository	The Government should establish a central repository for previous statutory and non-statutory inquiry recommendations in the health and social care context.	Government DHSC NHS England	This will enable government and stakeholders to track the progress of the implementation of recommendations and keep track of the work required to ensure delivery of recommendations. This will also mean organisations can be held accountable for their progress and recommendations

[194] INQ0017975.pdf, page 4, paragraph 2.14

	The repository should support monitoring of implementation, through annual statutory reporting processes, by the responsible body/ies and provide a clear process through which recommendations can be closed.		will not go into a state of abeyance.

189. In providing the table, NHS England has reviewed the suggestions it made through the course of the Inquiry and reflected on the evidence heard to refine its proposals. Three potential recommendations were made in NHS England's opening submissions and a fourth considered through the course of the Inquiry but, on further review, NHS England's view now is that these aspects can be addressed without a formal recommendation being needed:
    a. Guidance – unexplained clinical events. NHS England believes this is addressed by the recommendations proposed above in relation to updating relevant national guidance.
    b. Information sharing. A new duty on providers to share invited clinical reviews with, and report suspected criminality or significant unexplained events where patient harm is identified, to other statutory bodies such as NHS England, ICBs and the CQC. The updated Oversight Framework will include expectations around this. When read alongside the Insightful Board, which provides best practice guidance around by exception reporting and triangulation of data from different sources, NHS England's view is that a formal recommendation may therefore no longer be needed.
    c. Social media conduct. This was noted in NHS England's Opening Statement as an area for further work. NHS England's Chief Nursing Officer is already working closely with the Nursing and Midwifery Council to strengthen existing social media and communication policies, as part of the update to the Code.
    d. National best practice all staff safeguarding policy - sharing the approach that NHS England adopts in its own all-staff policy. Again, NHS England believes this is covered by the suggested updates to the Child Death Guidance Review guidance.

NHS England

4 March 2025