Witness Name: [XXXX]
Statement No.: [XXXX]
Exhibits: [XXXX]
Dated: [XXXX]

**THIRLWALL INQUIRY**

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**WITNESS STATEMENT OF Louise Ansari, Chief Executive Officer, Healthwatch England**

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I, Louise Ansari, will say as follows:

**About Healthwatch England**

1. Healthwatch was established under the Health and Social Care Act 2012 to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf.

2. Healthwatch England is a statutory committee of the independent regulator the Care Quality Commission (CQC).

3. Our main statutory functions are to:

    - provide leadership, guidance, support and advice to local Healthwatch organisations;
    - escalate concerns about health and social care services which have been raised by local Healthwatch to CQC. CQC are required to respond to advice from the Healthwatch England Committee;
    - provide advice to the Secretary of State for Health and Social Care, NHS England and English local authorities, especially where we are of the view that the quality of services provided are not adequate. Bodies to whom advice is given are required to respond in writing. The Secretary of State for Health and Social Care is also required to consult Healthwatch England on the annual NHS Mandate, which sets the objectives for the NHS.

4. As the health and social care champion for people in England we use people's feedback to better understand the NHS and other care providers nationally. We also help people to get the advice and information they need to make the right decisions for them to help them get the care and support they need.

5. Healthwatch England has the ability to make sure NHS leaders and other decision makers listen to public feedback and improve standards of care. We also help people to find reliable and trustworthy advice and information.

**Governance of Healthwatch England**

6. Healthwatch England is governed by a Committee that sets our strategy, provides scrutiny and oversight, and approves policies and procedures that are needed for us to work effectively. The Committee is headed by our Chair, Professor David Croisdale-Appleby OBE, who is supported by six other Committee members.

7. As Chief Executive of Healthwatch England, I lead our management structure and a leadership team of five people comprising the Director of Communications, Insight and Campaigns, a Head of Communications, a Head of Network Development, a Head of Policy, Public Affairs and Research and a Head of Operations, Finance and Development. Healthwatch England has 37 staff in total.

**Healthwatch England's working relationship with the Care Quality Commission**

8. The Chair of Healthwatch England is an ex-officio member of the CQC Board. While Healthwatch England maintains strategic and operational independence, back-office functions such as HR support, finance, facilities and IT support are provided by CQC under a set of service level agreements. The funding for Healthwatch England is in the form of grant-in-aid from the Department of Health and Social Care.

9. The Healthwatch England staff team has regular engagement with CQC colleagues. There are regular meetings between Healthwatch England leadership team members and their CQC counterparts, including meetings between myself and the CEO of the CQC.

10. There are also monthly meetings between the Healthwatch England policy team and the CQC policy team to raise concerns. These relate to thematic areas where Healthwatch research and feedback has identified concerns, rather than individual cases.

11. Healthwatch England hasn't specifically advised CQC to carry out special reviews or investigations, but our insight helps inform CQC priorities.

12. Healthwatch England is currently reviewing mechanisms that ensure that concerns identified by local Healthwatch can be rapidly escalated to CQC at national level if required.

**Healthwatch England's role on NHS complaints**

13. Healthwatch England provides general information to the public on our website about making a complaint about NHS or social care services.

14. Through a webform on our website, we provide a means for the public to share experiences about any NHS service or adult social care service. This could include parents of babies who wish to raise a concern, or make a complaint, in relation to a neonatal unit. We state in the webform that the information people share with us is used to help us spot trends to identify areas for improvements. We also state that if the individual requires help in an emergency, they should contact emergency services, and if they are seeking advice or information about local services, they should contact their local Healthwatch.

15. Due to the volume of responses we receive via this webform, we are unable to analyse all the feedback we receive. However, where we analyse data, we follow the safeguarding policy of our legal entity, the Care Quality Commission, who have a specialist team who can advise on such matters. Where appropriate we will also notify the relevant local Healthwatch who will follow local safeguarding procedures.

16. Healthwatch England has never had any remit to provide any statutory independent complaints advocacy, including NHS Complaints Advocacy.

17. There is no national body to oversee the range of statutory advocacy services across NHS or adult social care, which include NHS Complaints Advocacy, Care Act Advocacy, Independent Mental Health Advocacy and Independent Mental Capacity Advocacy.

**Local Healthwatch role on NHS Complaints**

18. Top tier local authorities are required to commission statutory advocacy services with funding coming from the Local Reform and Community Voices Grant. Some local authorities commission NHS Complaints Advocacy and local Healthwatch provision from the same provider, as is the case with Healthwatch Cheshire West. Although we do not keep records, we understand at least 19 local Healthwatch organisations in England currently deliver both the local Healthwatch and NHS Complaints Advocacy contracts in their local authority area. Where the NHS Complaints Advocacy is not awarded to the local Healthwatch provider, the advocacy provider must not subcontract any of the advocacy activities to the local Healthwatch.

19. While the advocacy provider can promote the service under the Healthwatch brand, it is a requirement to clearly state that the provision of the advocacy is by the legal entity. This distinction is necessary to differentiate the advocacy service from that of Healthwatch.

Healthwatch England checked the website of Healthwatch Cheshire West and note that it states that the NHS Complaints Advocacy service is delivered by their legal entity, called 'Healthwatch Cheshire CIC'.

**Healthwatch England relationships with complaints stakeholders**

20. Healthwatch England liaises with a range of other organisations that have a role in patient safety such as the Health Service Safety Investigations Body (HSSIB), the Patient Safety Commissioner (PSC), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), NHS Providers, NHS Confederation, the Patients Association, and National Voices.

21. Liaison with the PHSO, GMC and NMC, includes meeting to share our priorities and strategic objectives, attending their roundtables or speaking at their events. In January 2024, for example, we spoke at a seminar hosted by the PHSO and Professional Standards Authority on tackling barriers to complaints.

22. Healthwatch England liaises with the PSC regularly and in my role as chief executive, I sit on the Advisory Group of the PSC. The PSC's work includes a focus on improving the safety of medicines and medical devices (specifically the use of Sodium Valproate and vaginal mesh). Healthwatch England has a more general remit in listening to all aspects of people's experience of the health and Care system, including positive experiences.

**The role of local Healthwatch and how they are funded**

23. Statutory provision for a public voice organisation has been in place since 1976 with previous structures including community health councils, patient and public involvement forums, and local involvement networks (LINks). Healthwatch was established under the Health and Social Care Act 2012.

24. Our purpose is to make sure NHS and social-care decision-makers hear about and act upon the experiences of people using health and care services. The remit of Healthwatch covers experience of all publicly funded health and adult social care services.

25. The Department for Health and Social Care (DHSC) has overall policy responsibility for the Healthwatch network. The Healthwatch network consists of the national body Healthwatch England, and 153 local Healthwatch organisations.

26. DHSC does not currently set a specific level of funding that each local Healthwatch should receive. Funding of Healthwatch England is through grant in aid to the Care Quality Commission. The total Healthwatch England budget is £3.2m for 2023/24.

27. Funding of core local Healthwatch services is through two sources:

    - the Local Reform and Community Voices Grant, a section 31 grant from the Department of Health and Social Care. Allocations to each local authority are set out each year
    - the local government finance settlement, overseen by the Department for Levelling Up, Housing and Communities (DLUHC).

28. The total amount of funding received by local Healthwatch is £25.4m for 2023/24, as reported by local Healthwatch providers. The amount given to each local Healthwatch is determined by each of the 153 upper tier local authorities in England. Neither source of local Healthwatch funding is ringfenced and local authorities can spend this funding as they see fit to meet local priorities.

29. Local authorities commission a social enterprise or charity to deliver Healthwatch statutory activities. These activities include

    - gathering the views and experiences of people using health and care services
    - making sure health and care decision makers listen and act on people's feedback.
    - providing signposting and information to the public about local services.

30. Local Healthwatch are accountable through their contract with the local authority for delivery of their core services. They are required to make provision for decision-making, including involvement of local people, who for instance, may serve as board members of the local Healthwatch organisation or as members of an advisory Board if the local Healthwatch is delivered by a host organisation, such as a Council for Voluntary Service.

31. Healthwatch England provides leadership, advice and support to local Healthwatch providers. This includes the provision of training, guidance and facilitating sharing of issues and practice. We collect reports and data from local Healthwatch, which we analyse to inform our national work, for example our recent report in November 2023 'The public's perspective: The state of health and social care' (published at https://www.healthwatch.co.uk/public-perspective-report). Our powers also include the ability to escalate concerns about health and social care services which have been raised by local Healthwatch to CQC.

**The effectiveness of the central and local Healthwatch model**

32. There is a mixed picture of the effectiveness of the existing Healthwatch model. On the positive side, local Healthwatch are rooted in their communities, speak directly to local people, particularly those facing inequalities and are connected to community groups and

the voluntary sector. They can respond to local priorities, establish relationships with decision-makers, and ensure accountability through the local authority. Furthermore, a Healthwatch presence in each local authority area uniquely provides nationwide coverage. Unlike previous models, such as LINks, the inclusion of a national body adds leadership, coordination, and the capacity to leverage insights from local Healthwatch to shape national policy, assess implementation nationwide and share practice examples.

33. While not expressly required by law, there has been a discernible change over time in the engagement approach of local Healthwatch. This transformation places a strong emphasis on reaching individuals whose voices are often not heard within the health and care sector, a direction actively promoted and endorsed by Healthwatch England.

34. However, the Healthwatch model faces significant challenges. Since 2014/15, funding has decreased by 26% in absolute terms. Typically, a local Healthwatch operates with around four full-time equivalent staff, 20 volunteers, and a budget ranging from £60,000 to £500,000. Despite the aim of local commissioning of Healthwatch to address local needs, the absence of a comprehensive commissioning framework results in variations in Healthwatch delivery. The broad Healthwatch remit, coupled with limited resources, affects the ability to engage with a large portion of the public. Prioritisation becomes crucial, often guided by contractual obligations.

35. The introduction of 42 integrated care systems (ICSs) in July 2022, with statutory responsibility for commissioning NHS services, has added responsibilities to, and impacted on local Healthwatch capacity, especially in areas where the geography of the ICS includes multiple local Healthwatch. This requires collaboration and coordination between local Healthwatch. As well as variable Healthwatch contract amounts from councils, some local Healthwatch also receive ad-hoc and variable funding from ICSs to support their work. In 2022/23, 17 Healthwatch reported that 19 ICSs had provided over £20,000 in funding, to support activities like Healthwatch coordination and community engagement.

36. These challenges were recognised by a report from the House of Commons Health and Social Care Committee, on its 2023 inquiry into ICSs, which included a recommendation for a review of Healthwatch funding and commissioning.

**Healthwatch England interaction with Healthwatch Cheshire West**

37. Healthwatch England's remit with local Healthwatch includes providing general advice to local authorities to support them in their role of commissioning an effective local Healthwatch. From our records, the incumbent provider has been recommissioned at least

twice since Healthwatch were set up in 2013 - in 2017 and again in April 2022. Healthwatch England met with the local authority in October 2021 and provided comments on the tender specification. No concerns were shared about Healthwatch provision. This provides us with a level of assurance from the local authority perspective, which has responsibility for monitoring effectiveness.

38. Healthwatch England also provides a trademark licence under which the local Healthwatch operates the Healthwatch brand. In additional we provide advice, support, training guidance and an optional self-assessment quality framework, to local Healthwatch. As independent organisations, local Healthwatch can choose whether to take up any support offer.

39. Healthwatch Cheshire West have regularly shared reports with Healthwatch England on their work. They have contributed to a national project on developing an Integration Index, made a presentation on their work on the NHS Long-Term Plan to our national committee and updated us on how they work positively with their integrated care board at their local ICS and health and care bodies. They have an above average numbers of volunteers and reported effective relationships with other local Healthwatch in their area who, in turn, reciprocated this view. Again, all of this gives us assurance that Healthwatch Cheshire West are working effectively.

**Healthwatch England review of communications or evidence held about Countess of Chester Hospital or communication with Healthwatch Cheshire West**

40. Healthwatch England carried out a search on our digital systems. This included:

- All staff carrying out a search on their email system, Microsoft Outlook and capturing results in a spreadsheet. This search found an email exchange between the Chief Executive Officer of Healthwatch Wirral on 4 November, 2022, to Healthwatch England on a separate issue, which included a reference to the criminal trial and potential implications for proposed work by Healthwatch England on maternal mental health. There was an exchange of emails on 19 August 2023, between myself and the Healthwatch Cheshire Chief Executive about the involvement of Healthwatch Cheshire West with regards to the case including affected parents and/or the staff/management of the Countess of Chester, or any of their ongoing engagement on the issue. There were also email exchanges relating to a meeting of local Healthwatch convened by Healthwatch England on 31 October 2023, on the matter of patient safety, where the Lucy Letby case was one of the examples discussed.

- A search of our National Data Store (a system introduced in 2022 which stores data collected and shared by local Healthwatch including those who fall within the catchment area of the Countess of Chester Hospital). The search found 23 instances of data on anonymous public experience of Countess of Chester of potential relevance. These are set out and summarised in Exhibit LA/1 INQ0011964
- A search of Microsoft SharePoint. The search found data on anonymous public feedback on the Countess of Chester maternity services relating to 2017, which is duplicate data held on the National Data Store. Reference to Countess of Chester maternity services was also found in various spreadsheets held in a secure folder relating to people's experiences of maternity services. This data was collected by the local Healthwatch. This data is duplicates of the date included in Exhibit LA1 INQ0011964
- A search of our National Reports Library, which stores all reports shared by local Healthwatch. There are two reports which mention maternity services at the Countess of Chester 2015-2022 which are summarised below.

  **Title**: Enter and view: Ward 32, Countess of Chester Hospital
  **Author**: Healthwatch Cheshire West and Chester
  **Date of Publication**: 8 September 2015
  **Number of people sharing their views: 3**
  **Summary** Healthwatch Cheshire West conducted an unannounced Enter and View visit to Ward 32 at Countess of Chester Hospital on the 8th of September 2015. Ward 32 offers antenatal and postnatal care. The team spoke to patients and staff using survey methods, and made general observations during their visit.

  **Title**: Accessibility of Health and Social Care services in Neston
  **Author**: Healthwatch Cheshire West and Chester
  **Date of Publication**: 11 November 2019
  **Number of people sharing their views:** 120
  **Summary** The report shares findings on accessibility of some health and social care services for people living within the CH64 postcode. In relation to maternity services, there was a mixed response to awareness of choice of service location, although the majority of respondents used their GP Practice for antenatal care and Arrowe Park for the birth of their babies. No reference to neonatal care.

- A search of Facebook Workplace – an online forum which local Healthwatch and Healthwatch England use to share information. The only reference is to the Letby Public Inquiry itself.

41. Healthwatch England also annually collects some activity data from local Healthwatch, such as the number of people assisted by provision of information and signposting and number of people with whom the Healthwatch has engaged. Data from Healthwatch Cheshire West places them well above the median of all Healthwatch for the various indicators.

42. As far as we can see from our records search, Healthwatch England has no record of any complaints or concerns received directly from parents of babies treated in the neonatal unit at the Countess of Chester Hospital.

43. Healthwatch England also has no record of being requested to escalate, or escalating issues, related to the neonatal services at the Countess of Chester Hospital.

44. Healthwatch England has no record of any action being taken by Healthwatch England or Healthwatch Cheshire West once either became aware of concerns regarding the neonatal unit at Countess of Chester Hospital. Our assumption is that, as the criminal investigation was underway when Healthwatch England first became aware of these concerns, the only action we could have taken would have been cooperating with that investigation. Healthwatch England was not contacted by the investigating authorities.

**Healthwatch England evidence on any neonatal or maternity services**

45. Healthwatch England does not maintain a central record of the number of times a local Healthwatch has been approached in relation to concerns or complaints about neonatal units. However, Healthwatch England will store records of local Healthwatch who have undertaken activities to understand people's experiences of maternity services, including neonatal units, which have been shared with us.

46. Healthwatch England has searched the following central records which contain local Healthwatch reports, data and contacts with Healthwatch England:

    - National Reports Library. This contains a repository of reports prepared by local Healthwatch and shared with Healthwatch England. Between 2013 and present, 41 Healthwatch have shared a report on maternity services with Healthwatch England, of which eight applied neonatal as a keyword in the descriptor. This includes reports where local Healthwatch have used their 'Enter and View' powers to understand the experiences of service users within a particular facility. These reports can be found in Exhibit LA/2 INQ0011967
    - National Data Store. This contains general feedback data collected by local Healthwatch in the course of carrying out their statutory activities to engage local people and provide information and signposting information. This data will include mixed sentiment feedback about the full range of health and care services, some of which may relate to complaints. Of this general feedback data, we found that local Healthwatch shared 76 pieces of mixed sentiment feedback, when we searched using the keyword 'neonatal' between October 2016 and the present. This includes

duplicates, all 23 pieces of general feedback we found are set out and summarised as Exhibit LA/1 INQ0011964 We do not hold data prior to 2016. We do not separately record complaints that form part of general feedback.

**47.** Healthwatch England has not advised the CQC to carry out a special review or investigation of neonatal services at Countess of Chester Hospital. This is due to the lack of concerns raised with us or present in any feedback we held on these services.

**How Healthwatch England has revised its approach following Letby and other cases**

48. Healthwatch England convened a meeting of local Healthwatch from areas affected by patient safety investigations, including Healthwatch Shrewsbury and Telford and Nottingham and Nottinghamshire, in August 2023. The outcome from this meeting, plus the tragic cases of Martha Mills and, and the victims of Lucy Letby, led to us re-examining the role of Healthwatch in patient safety, as reported by our National Committee in September 2023 and discussed at our National Conference for local Healthwatch leaders.

49. I wrote, as Healthwatch England chief executive, about patient safety in the Health Service Journal in September 2023, citing the case of Lucy Letby (Exhibit LA/3 **INQ0011968**

50. In September 2023, I also wrote to the CEO of NHS England, Amanda Pritchard, on the importance of building a culture where the concerns of patients and staff are heard by the system. (Exhibit LA/4 **INQ0011969**

51. Healthwatch England convened a meeting in October 2023 of Healthwatch from areas affected by significant patient safety investigations, such as Morecambe Bay and Staffordshire. Actions arising from this meeting include:

- I communicated via a member of my leadership team, to all local Healthwatch about what more we could do on patient safety and issued an invitation to attend a quarterly meeting for local Healthwatch to share patient safety matters, supported by Healthwatch England. (Exhibit LA/5 **INQ0011970**
- Healthwatch England reviewing the process for local Healthwatch to raise concerns with the Care Quality Commission and other patient safety bodies. We have drafted a new process which we will be sharing with local Healthwatch and the Care Quality Commission for implementation from March 2024.
- Sharing of how local Healthwatch held health and care organisations to account and how they communicated and engaged local people, particularly those using services directly affected by safety concerns, during and after investigations were taking place.
- Strengthening how local Healthwatch explain to the public their role, remit and expectations, given their resources.

**Healthwatch England's view on patient safety culture and required improvements**

52. In a blog of 21 September, 2023, published in response to the Letby case, I examined the issue of whether staff and patients know where they can go to raise concerns and what can be done in the future. (Exhibit LA/6 **INQ0011971**

53. Healthwatch England believes the NHS cannot deliver the quality of safe care people need unless listening to patients and carers, and acting on their feedback, lies at the heart of its culture. Listening to patients and their loved ones is key to safety. Although the vast majority of NHS care is safe, embedding an NHS culture of listening is critical.

54. It is important to acknowledge that the NHS is under massive pressure, facing record waiting lists and staff shortages, which will take time to address and could increase the chances of avoidable errors in care. But the introduction of ICSs has offered an opportunity for health and care decision-makers to think differently about how they listen to and act on feedback, moving it from being a 'nice to have' to an essential part of how they work.

55. This requires a culture of openness where from the frontline upwards, staff are open to learning from every conversation with patients. People's concerns and complaints need to be viewed as an early warning system to highlight safety issues, and organisations are open to acknowledging problems and learning from them. Services that provide joined-up care, whether run by the NHS, local government or the third sector, should open to pooling their insight to understand how people feel about their support overall and where barriers exist.

56. This culture does exist in the NHS, but it does so in pockets. This needs to be the norm across the health and care system.

57. There are a variety of factors that inhibit a culture of listening in the NHS. Trusts can be reflexively defensive seeking to protect reputation. Too often there is a 'we know best' attitude by managers or clinicians rather than listening to the concerns of patients. There are also resourcing factors, the actions required to properly understand concerns can be viewed as too time consuming particularly where there are issues of understaffing and a general issue of staff burnout.

58. The demand built up by the Covid-19 pandemic has also prevented providers looking into and responding to patient concerns in a considered manner.

59. More generally, understanding of qualitative experience is superseded by prioritising reporting of performance management data. Embedding a listening culture will require a

leadership style and approach where patient listening is valued and promoted from the top, ensuring patient representatives are treated with respect and seen as part of the solution and not a 'nuisance'. We need to see more examples shared within the system about how listening can achieve positive results and reduce or prevent harms as well as achieving efficiencies.

60. ICBs and healthcare providers should be held to account over their approach to listening and engaging, including in line with the 10 principles set out in the NHSE guidance 'Working with People and Communities'. Political leaders can also play their part in promoting this culture. Trusts should be transparent in showing the kind of concerns raised, how they were investigated and actions they will take or have taken. Regulators also have to show that there is a direct line from concerns raised through to their own work and findings.

**Changes since 2016 impacting on people's ability to speak up about maternity and neonatal care**

61. Since 2016 there have been a number of developments which have potentially increased opportunities for women's or families' voices in maternity and neonatal care to be heard and for safety to be improved. However, there are multiple bodies who can take feedback and concerns, which creates a complex landscape for people. To our knowledge there has been no formal national evaluation of how easy parents of babies find it to speak up.

62. In 2018, the Maternity and Newborn Safety Investigations (MNSI) programme was established as part of the Healthcare Safety Investigation Branch (HSIB). The programme was transferred to a host body, the Care Quality Commission, in October 2023.

63. NHS trusts are required to tell MNSI about certain patient safety incidents that happen in maternity care, so it can carry out investigations that involve talking to families, staff and managers to learn lessons as part of a 'no-blame' approach. MNSI also has an agreement to share information with the CQC which could be used by the regulator to take civil or enforcement action against NHS trusts.

64. The MSNI takes referrals from trusts, rather than directly from patients or relatives. Its latest annual report for 2022-23 says that of families who gave their consent to be contacted by MSNI following a trust's referral, 86% agreed to participate and 14% declined. Reasons for not taking part were:

- wishing to 'move on' or seeing no value in an investigation
- stating they were happy with care received or have a positive prognosis
- stating they prefer a trust/coroner's investigation

- not feeling able to discuss the events as too distressed
- not wishing for an independent organisation to access medical records
- no reason given/known, or requests not responded to.

65. The MSNI's annual report also states that around 30% of investigations identify extra communication or other support that families needed to take part, and that MSNI supported people with interpretation/translation services on 670 occasions, or translated information provided to families into 36 languages.

66. The other development in listening to women and families' voices since 2016 has been the introduction of a network of local Maternity and Neonatal Voice Partnerships (MNVPs). These listen to the experiences of women and families, and bring together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care.

67. The Three-Year Delivery Plan for Maternity and Neonatal Services published by NHS England in March 2023, set an expectation that MNVPs should listen to and reflect the views of local communities and be resourced to have strategic influence over services.

68. This was followed by NHS England guidance to Integrated Care Boards in November 2023 that aimed to address some of the challenges highlighted in a 2022 review of the partnerships, including inconsistent resourcing. The guidance to ICBs does not mandate how much they should fund MVNPs. We do not know if NHSE intends to nationally report on the arrangements each of England's 42 ICBs makes for supporting MVNPs or collate themes or data on the parents that partnerships have engaged with and what difference it has made to services.

69. Complaints or negligence data may be an indicator of the ability of people to speak up. However, we would highlight that there are multiple bodies who collect and/or report data on quality of maternity and neonatal services, yet seemingly no single national body synthesising of all this information. The multiple sources of data include:

    - NHS written complaints data published by NHS Digital (which don't record by maternity and/or neonatal care, but by obstetrics/gynaecology and paediatrics), showing that annual complaints on obstetrics and gynaecology stayed relatively the same between 2016/17 (4,414) and 2022/23 (4,416), while paediatrics complaints rose slightly, from 1,977 to 2,136 during the same time period.
    - PHSO figures showing that they upheld 27 maternity complaints between 2020-2022
    - CQC findings in their 2023 State of Care report that 10% of maternity services are rated as inadequate overall, 39% require improvement and women and babies from ethnic minority groups face greater risks of harm.

- NHS Resolution data on negligence claims, showing obstetric claims (non-cerebral palsy/brain damage) have gone from 884 new claims in 2016/17 to 1154 in 2022/3, while obstetric claims relating to cerebral palsy/brain damage) increased from 232 in 2016/17 to 240 in 2022/3.
- An MBRRACE surveillance report on neonatal deaths in 2021, which shows higher rates by ethnicity and deprivation.

70. Similarly, evidence collected by the CQC as part of its annual Maternity Survey (the survey has been running since 2007) provides information on maternal experiences of care and may indicate challenges that mothers face in being listened to by the system.

71. The CQC's survey asks 26 evaluative questions on experiences of maternity care. Between 2017 and 2022, one question saw a statistically significant upward trend, four showed no change and 21 showed a statistically significant downward trend. Measures of confidence and trust in antenatal, birth and labour, and postnatal care have all dropped since 2017. There has been a downward trend between 2017 (81%) and 2022 (77%) for women and other pregnant people saying that if they raised a concern during labour and birth, they felt it was taken seriously.

72. In May 2022, Healthwatch England published a review of evidence on maternity services we collected from people between April 2021 and March 2022. (Exhibit LA/7 INQ0011972 ). Nearly half of the people we heard from in this period reported broadly negative experiences of maternity services.

73. Healthwatch England also published findings from in-depth interviews with new mothers who spoke about issues with miscommunication with staff, lack of agency over their care and lack of accessible information in formats they could understand. (Exhibit LA/8 INQ0011973 Exhibit LA/9 LA/9 INQ0011974 ,Exhibit LA/10 LA/10 INQ0011965 , Exhibit LA/11 LA/11 INQ0011966 ). However, as stated earlier we have no specific data in that review relating to quality of care at Countess of Chester.

**Statement of Truth**

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

**Signed:** PD

**Dated:** 7/2/24