

Witness Name: Graham Peter Urwin
Statement No: 1
Exhibits: 75
Dated: 14 February 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF GRAHAM PETER URWIN

I, Graham Peter Urwin, will say as follows: -

1. My Name is Graham Peter Urwin, and I am employed by NHS Cheshire and Merseyside Integrated Care Board, 1 Lakeside, 920 Centre Park Square, Warrington, WA1 1QY ("the ICB") as Chief Executive. I have been employed by NHS Cheshire and Merseyside ICB since its legal establishment on 1 July 2022.
2. Prior to this role, I held several senior NHS management posts in NHS England and NHS Improvement, including:
 - a. Director of Commissioning Operations for Greater Manchester and Lancashire (January 2015 – February 2017)
 - b. Director of Commissioning Operations for Cheshire and Merseyside (February 2017 – June 2019)
 - c. North West Regional Director of Performance and Improvement (July 2019 – November 2021)
 - d. A secondment to Cheshire and Merseyside Integrated Care System to support the transition from Clinical Commissioning Groups to Integrated Care Boards (November 2021 – June 2022).
3. Before working in the North West, I was the Shropshire and Staffordshire Area Team Director at NHS Commissioning Board Authority (April 2013 – January 2015) and prior to April 2013, I was the Chief Executive of NHS Stoke-on-Trent Primary Care Trust.
4. This statement is provided in response to the Thirlwall Inquiry's Request for Evidence under Rule 9 of the Inquiry Rules 2006 dated 9 November 2023 and updated on 30 November 2023, reference NHS Cheshire and Merseyside/1.
5. NHS Cheshire and Merseyside ICB was established as a statutory NHS body on 1 July 2022.

6. This statement covers both NHS Cheshire and Merseyside ICB and its legal predecessors, specifically:
- a. NHS Cheshire Clinical Commissioning Group (in existence from 1 April 2020 – 30 June 2022); and
 - b. NHS West Cheshire Clinical Commissioning Group (in existence from 1 April 2013 – 31 March 2020),
- (“the former CCGs”) due to their commissioning responsibilities and liaison with the Countess of Chester Hospital, part of the Countess of Chester Hospital NHS Foundation Trust (“CoCH”).
7. I did not work for the ICB, or the predecessor commissioning bodies at the time of the events at the CoCH between June 2015 and June 2016, but I make this statement to provide an overview of:
- a. The ICB’s current preparedness and response arrangements; and
 - b. Our predecessor commissioning bodies’ principles, policies, and practices at the time of the events at the CoCH.
8. As the legal successor body to the former CCGs, I have consulted with several of our current employees who held positions of responsibility within those former CCGs. In particular:

Name	Previous role at NHS West Cheshire CCG	Current role at NHS Cheshire and Merseyside ICB
Alison Lee	Accountable Officer	Place Director, Knowsley
Dr Andy McAlavey	Medical Director	Cheshire West Place Clinical Director
Laura Marsh	Director of Commissioning and Transformation	Acting Place Director, Cheshire West
Paula Wedd	Director of Quality and Safeguarding	Associate Director of Quality and Safety Improvement, Cheshire West
Fay Quinlan	Starting Well Commissioning Lead	Head of Transformation and Partnerships, Cheshire West

9. I have taken assurance from these staff, placing reliance on both their recollection and the review of historic documentation. A list of CCG/ICB key individuals is attached to my statement at **Appendix A**.
10. On behalf of the ICB, may I take the opportunity to express my sincere condolences. The thoughts of everyone at NHS Cheshire and Merseyside ICB are with the children at the heart of this case, their families and loved ones.

Background

11. I am conscious that this statement includes references to NHS terms and acronyms, so I have attached:
 - a. A glossary of terms at **Appendix B**
 - b. A chronology of the notification of concerns with references to exhibits at **Appendix C**
 - c. NHS Cheshire and Merseyside ICB organogram showing how the various committees, networks and groups interrelate at **Appendix D**
 - d. NHS West Cheshire CCG organogram showing how the various committees, networks and groups interrelate at **Appendix E**

NHS Cheshire and Merseyside ICB

12. When the Health and Care Act 2022 became law, Integrated Care Boards (“ICBs”) were formalised as legal entities with statutory powers and responsibilities, replacing Clinical Commissioning Groups (“CCGs”).
13. Integrated Care Systems (“ICS”) are partnerships that bring together NHS organisations, local authorities, and others to take collective responsibility for planning services, improving health, and reducing inequalities across geographical areas. There are 42 ICSs in England, and they are made up of two components:
 - a. ICBs are statutory bodies that are responsible for planning and funding most NHS services in the relevant area.
 - b. Integrated Care Partnerships are statutory committees that bring together system partners such as local government, voluntary sector, NHS organisations and others, to develop health and care strategies for the relevant area.

14. On 1 July 2022, ICBs were established as a statutory body. This occurred nationally. Here in Cheshire and Merseyside, as an ICB, we work within and across, 9 local authority areas referred to within the ICB structure and governance as 9 “Places”.
15. On establishment of the ICB, the statutory functions and duties, together with staff, assets, and liabilities of the 9 legacy CCGs for Cheshire, Halton, Knowsley, Liverpool, South Sefton, Southport and Formby, St Helens, Warrington, and Wirral were transferred to NHS Cheshire and Merseyside ICB.

The ICB's Role and Responsibilities

16. Our core purpose is to lead integration within the NHS, bringing together all those involved in planning and providing NHS services, taking a collaborative approach to agreeing and delivering ambitions to improve the health of our population.
17. NHS Cheshire and Merseyside ICB is responsible for:
 - a. Commissioning certain health services (which are the responsibility of an ICB, or which have been delegated to it by NHS England) that meet the reasonable needs of all people registered with our General Practices within the Cheshire and Merseyside ICS footprint, and people who are usually resident within the area and are not registered with any of the member practices.
 - b. Commissioning emergency care for anyone present in the geographical area.
 - c. Developing a plan to meet the health needs of the population of Cheshire and Merseyside, having regard to the Health and Care Partnership's strategy. The Cheshire and Merseyside Health and Care Partnership is a broad alliance of organisations and representatives concerned with improving the care, health, and wellbeing of the population, jointly convened by local authorities and the NHS as equal partners to facilitate joint action to improve health and care outcomes and experiences, influence the wider determinants of health, and plan and deliver improved integrated health and care. Its primary purpose is to act in the best interests of people, patients, and the system, rather than representing individual interests of any one constituent partner.
 - d. Allocating resources to deliver the plan across the system, including determining what resources should be available to meet the needs of the population in each place and setting principles for how they should be allocated across services and providers (both revenue and capital).

- e. Establishing joint working arrangements with partners that embed collaboration as the basis for delivery of joint priorities within the plan.
 - f. Establishing governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations, to ensure the plan is implemented effectively within a system financial envelope set by NHS England and NHS Improvement (now dissolved).
 - g. Arranging for the provision of health services in line with the allocated resources across the ICS.
18. Whilst most services have been delegated to the ICB, NHS England is responsible for directly commissioning some specialist services, including neonatal services. The ICB (and its predecessor CCGs) is responsible for commissioning obstetrics, gynaecology, and midwifery services.
19. The ICB commissions Perinatal Mental Health which is a NHS support service working with women and families to offer psychological and emotional support as set out at **Exhibit GU/01** INQ0012655. The service has therapists, psychologists, assistant psychologists, specialist midwives and peer support workers. The Perinatal Mental Health service role is to identify distress that has come from the patient's maternity, neonatal or reproductive journey. They work to support trauma, loss and fear around pregnancy and the maternity setting.

The ICB's Management and Governance Structure

20. When ICBs were established in July 2022, meetings which were held in CCGs continued, such as Contract Quality and Performance Meetings and Serious Incident meetings which reported, by exception, to the Quality and Performance Committee, and then ultimately to the ICB's Board. However, quality surveillance mechanisms changed in line with National Quality Board requirements and a ICB System Quality Group for Cheshire and Merseyside was established. Please see **Exhibit GU/02** INQ0012656 for the ICB's management and governance structure.
21. The ICB's System Quality Group is chaired by the ICB's Executive Director of Nursing and Care with membership of NHS providers and regulators. Details are included within the Terms of Reference at **Exhibit GU/03** INQ0012657 As a result of the NHS England publishing guidance, on 30 March 2023, entitled a Three-year delivery

plan for maternity and neonatal services, the ICB has further strengthened its oversight of maternity services.

22. The ICB's System Quality Group provides joined up quality intelligence and engagement, enables improvement and supports resources to be deployed in response to system risks. The Group reports to NHS England's Regional Quality Group. The NHS England Regional Quality Group seeks assurance and support of management of risks from the ICB, if they involve persistent or serious risks, conflicts of interest and issues affecting the wider geographical area. The NHS England Regional Quality Group would escalate to the NHS England National Executive Quality Group if a national response was required, including a recovery support programme. Not restricted to but may include inclusion within the Maternity System Support Programme established by NHS England in September 2017.
23. The ICB's Quality and Performance Committee has been established to seek assurance as to the quality and safety of services commissioned by the ICB, as detailed in the Terms of Reference at **Exhibit GU/04** **INQ0012658** . The ICB's Quality and Performance Committee meets monthly and has an agreed work plan that allows for thematic and dynamic focus of any emergent risks as set out at **Exhibit GU/05** **INQ0012659** . Maternity services reporting is a standard item on the agenda and reports monthly to the ICB's Quality and Performance Committee.
24. The ICB's governance arrangements include Contract Quality and Performance meetings who meet regularly to internally scrutinise quality and performance of contracted providers with clear line of sight to the ICB's executive committees. Intelligence gathered from Contract Quality and Performance meetings supports the submission of the Place Specific Key Issues Report that is submitted and presented to the ICB's Quality and Performance Committee
25. The ICB attends the North West Specialised Services Committee, which was established in April 2023, in accordance with section 65Z6 of the NHS Act 2006. This North West Specialised Services Committee was established by NHS England and is attended by the following members from the ICB:
- a. Assistant Chief Executive
 - b. Director of Finance
 - c. Associate Medical Director for Transformation / Deputy Medical Director

d. A Non-Executive Member.

26. Please refer to paragraph 67 for more information on the NHS England North West Specialised Services Committee.

Learning from Deaths

27. A Care Quality Commission (“CQC”) review of national arrangements took place in December 2016 titled ‘Learning, candour and accountability: a review of the way Trusts review and investigate the deaths of patients in England’. This found that some providers were not giving learning from deaths sufficient priority and as a result were missing valuable opportunities to identify and make improvements in quality of care. In March 2017, the National Quality Board introduced new guidance for NHS providers on how they should learn from the deaths of people in their care.

28. Previously CCGs sought, and subsequently the ICB seeks assurance from providers on their policies, processes, and outcomes in relation to learning from deaths. This assurance can take the form of inclusion within the NHS Standard Contract, within schedule 4 or a presentation of findings and subsequent learning at the ICB's Contract Meetings which are held with providers. The NHS Standard Contract is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care. Schedule 4 includes specific quality requirements which the provider is required to achieve and report to the commissioner.

Cheshire and Merseyside Local Maternity and Neonatal System

29. Local Maternity Systems were established following recommendations made in the National Maternity Review's report from 2016, Better Births: Improving outcomes of maternity services in England, A Five Year Forward View for maternity care. As a result, 42 Partnership Local Maternity Systems were established, one of which covered the geographical area of Cheshire and Merseyside. The Cheshire and Merseyside Local Maternity System was hosted by Halton CCG (2016 – 2018), Liverpool CCG (2018 – 2021) and then Liverpool Women's Hospital (2021 - 2023).

30. All 42 Local Maternity Systems were given annual targets and funding by NHS England, to deliver Better Births. The role of the Local Maternity System was primarily focussed on maternity transformation, working in partnership with the North West Neonatal

Operational Delivery Network. The Local Maternity System would provide assurance to the NHS England Regional and National Teams on progress against the Better Births annual targets.

31. 10 Neonatal Operational Delivery Networks were established in April 2013 nationally, commissioned by NHS England's Specialised Commissioning Team. One of these was the North West Neonatal Operational Delivery Network. There are now 22 neonatal units within the North West Neonatal Operational Delivery Network, covering Cheshire and Merseyside, Greater Manchester and Lancashire and South Cumbria.
32. The Neonatal Operational Delivery Networks have a mandate to develop and implement programmes of work to improve access to specialist resources, and to improve neonatal outcomes and patient experience, working closely with both providers and commissioners. Maternity and neonatal care are inextricably linked and work together to produce the best outcomes for women and their babies who need specialised care.
33. The Specialised Commissioning team within NHS England were, and currently remain solely responsible for commissioning neonatal services. The ICB (and its predecessor CCGs) were and currently remain responsible for commissioning obstetrics, gynaecology, and midwifery services for people registered with a General Practice within its geographical boundaries.
34. On 18 March 2022, NHS England Maternity Transformation Programme shared a letter with the Local Maternity System Senior Responsible Officer and CCGs which included 22/23 deliverables and transformation funding. This resulted in the role and function of Local Maternity Systems evolving to include neonatal, expanding from a focus on transformation to include quality oversight. The Cheshire and Merseyside Local Maternity System and Neonatal System was hosted by Liverpool Women's Hospital. The change resulted in a formalised reporting structure with the North West Neonatal Operational Delivery Network. The Local Maternity and Neonatal System's Programme Director is a core member of the North West Neonatal Operational Delivery Network Board.
35. Nationally, greater clarity of the role of the Local Maternity Neonatal System model has evolved in response to other national reviews, as detailed within the learning section of this witness statement.

36. The Local Maternity and Neonatal System was transferred into the direct control of the ICB in July 2023. We have established governance for the Local Maternity and Neonatal System within the ICB. There are three meetings which report into the Local Maternity and Neonatal System Quality Safety and Surveillance Group, all of which are attended by representatives of the North West Neonatal Operational Delivery Network:
- a. ICB Maternity Serious Incident Panel, which considers incidents involving neonatal services. This panel facilitates improvement following the triangulation of risks to patient safety and the commonality of action/learning.
 - b. ICB Maternity Gold Command, who meet weekly to look at dynamic risks across the system.
 - c. Provider Intelligence meetings, which are currently being developed to support triangulation of data from multiple sources, with terms of reference currently in draft form, awaiting publication.
37. An example of current practice is the Cheshire and Merseyside Local Maternity and Neonatal System Review of the Outlier Status of Neonatal Mortality from 20 November 2023 at **Exhibit GU/06** INQ0012660. This shows how the Local Maternity and Neonatal System have actioned gaps within previous external reviews, including key areas for enquiry, next steps of deep dives and outputs through reports.
38. The Local Maternity and Neonatal System Assurance Board, chaired by one of the ICB Non-Executive Directors with experience in nursing and quality assurance, receives escalation and assurance reports from the Local Maternity and Neonatal System's Quality Safety and Surveillance Group. This meeting is attended by the North West Neonatal Operational Delivery Network.
39. The ICB's Quality and Performance Committee, chaired by an ICB Non-Executive Director, receives items of escalation and assurance on a monthly basis from the Local Maternity and Neonatal System Assurance Board.
40. In addition to the governance arrangements within the ICB, the leaders of the ICB are connected to NHS England's governance arrangements and attend:
- a. NHS England's North West Regional Quality Group, which supports triangulation of quality concerns across systems and pathways; and
 - b. NHS England's North West Peri-Natal Safety, Surveillance and Concerns Group.

Clinical Commissioning Groups (CCGs)

41. CCGs were established nationally on 1 April 2013, replacing Primary Care Trusts ("PCTs") following the Health and Social Care Act 2012.

NHS West Cheshire CCG (1 April 2013 – 31 March 2020): Roles and Responsibilities

42. NHS West Cheshire CCG was established on 1 April 2013, replacing NHS Western Cheshire PCT.
43. NHS West Cheshire CCG was responsible for commissioning an agreed list of healthcare for the people of West Cheshire. CCGs' duties were set out in section 13 of the Health and Social Care Act 2012 and the associated regulations. They included:
- a. Commissioning certain health services (where NHS England was not under a duty to do so) that meet the reasonable needs of all people registered with General Practices within the West Cheshire footprint, and people who were usually resident within the area and were not registered with any of the member practices.
 - b. Commissioning emergency care for anyone present in the geographical area.
44. NHS West Cheshire CCG was not a provider body and was therefore not regulated by the CQC, but it was overseen by NHS England. Each CCG had a constitution and was run by its governing body.
45. NHS West Cheshire CCG was responsible for planning, buying, and monitoring the following healthcare services for people registered with a General Practice in West Cheshire, circa 266,000 people:
- a. General Practice services (primary care)
 - b. Planned (or elective) hospital care (including obstetrics and gynaecology)
 - c. Urgent and emergency care
 - d. Community health services
 - e. Maternity services
 - f. Older people's healthcare services
 - g. Healthcare services for children including those with Complex healthcare needs
 - h. Rehabilitation services
 - i. Healthcare services for people with mental health conditions

- j. Healthcare services for people with learning disabilities and autism
- k. Continuing healthcare and funded nursing care support for people with complex needs who require specialist nursing support

46. As mentioned in paragraph 18, NHS West Cheshire CCG were not the commissioners for neonatal services. The Specialised Commissioning Team within NHS England were, and currently remain solely responsible for commissioning neonatal services.

47. In addition, people registered with a Welsh General Practice in receipt of any non-urgent and emergency care pathways from the CoCH would have been commissioned by Betsi Cadwaladr University Health Board.

48. NHS England and Betsi Cadwaladr University Health Board were not associate commissioners to the CCG contract. Each had their own contract with the CoCH for the services they commissioned, with their own oversight and governance processes. However, they were offered the opportunity to attend the CCG Contract Quality and Performance meetings for purposes of collaboration.

NHS West Cheshire CCG (1 April 2013 – 31 March 2020): Quality and Performance Oversight and Governance

49. As detailed within the NHS West Cheshire CCG Governance Structure attached at **Exhibit GU/07** INQ0012661, the CCG held monthly Contract Quality and Performance Meetings with CoCH to monitor the NHS Standard Contract¹ and review any matters considered necessary, which did not include neonatal services. The Contract Quality and Performance meetings reported to both the CCG's Quality Improvement Committee and the Finance, Performance and Commissioning Committee. Reports from the Committees were presented at the CCG's Governing Body formal meetings.

50. The Terms of Reference for the Contract Quality and Performance meetings between NHS West Cheshire CCG and CoCH dated November 2016 state that the underlying approach was that the Contract Quality and Performance meetings would support the commissioner and provider in working closely together to continuously improve and

¹ The contract was mandated by NHS England for use by commissioners for all contracts for healthcare services that they were responsible for commissioning. The contract in place was between the CCG as the commissioner and CoCH as the provider.

maintain clinical quality. It was recognised that the aim of all parties was to ensure that patients receive the highest standards of care available (**Exhibit GU/08**) **INQ0012662**

The Terms of Reference were updated in October 2017, which included changes to the core membership for CoCH and chair arrangements (**Exhibit GU/09**) **INQ0012663**

51. Although the CCG did not commission neonatal services, they would have been party to discussions on these topics due to the link to maternity and wider governance arrangements.
52. It was expected that CoCH would report serious incidents on Strategic Executive Information System ("StEIS") aligned with NHS England's Serious Incident Framework: Supporting learning to prevent recurrence published on 27 March 2015 and the NHS Standard Contract. The CCG were not responsible for the lead oversight of serious incidents reported on StEIS relating to CoCH's neonatal service. However, the CCG would have been aware of any serious incident that was reported by CoCH as part of wider governance arrangements. NHS West Cheshire CCG Quality Team had access to StEIS.
53. The NHS England Quality Surveillance Group was established in April 2013 to bring together different parts of the health and care system, to share intelligence about risks to quality. This provided commissioners and partners the opportunity to escalate specific service concerns. NHS West Cheshire CCG's Director of Quality and Safeguarding attended on behalf of the CCG's Accountable Officer. The group met monthly initially to collectively consider and triangulate information and intelligence to safeguard the quality of care. The NHS England Quality Surveillance Group was primarily concerned with NHS commissioned services and was attended by multi-agency partners, including the CQC, Local Healthwatch, Local Authority, Monitor, NHS Trust Development Authority, Public Health England Centre Director, and Health Education England Local Education and Training Board Director of Education Quality.

NHS Cheshire CCG (1 April 2020 – 30 June 2022): Roles and Responsibilities

54. In September 2019, the Governing Bodies of NHS Eastern Cheshire CCG, NHS South Cheshire CCG, NHS Vale Royal CCG and NHS West Cheshire CCG agreed to the dissolution of the four organisations and the formation of a single, strategic

commissioning organisation called NHS Cheshire CCG with effect from 1 April 2020. NHS Cheshire CCG was the legal successor body of NHS West Cheshire CCG.

55. NHS Cheshire CCG was responsible for planning, buying, and monitoring the following healthcare services for a population circa 770,000 people:

- a. General Practice services (primary care)
- b. Planned (or elective) hospital care (including obstetrics and gynaecology)
- c. Urgent and emergency care
- d. Community health services
- e. Maternity services
- f. Older people's healthcare services
- g. Healthcare services for children including those with Complex healthcare needs
- h. Rehabilitation services
- i. Healthcare services for people with mental health conditions
- j. Healthcare services for people with learning disabilities and autism
- k. Continuing healthcare and funded nursing care support for people with complex needs who require specialist nursing support

56. As mentioned in paragraph 18, NHS Cheshire CCG were not the commissioner for neonatal services. The Specialised Commissioning Team within NHS England were, and currently remain solely responsible for commissioning neonatal services.

57. In addition, people registered with a Welsh General Practice in receipt of any non-urgent and emergency care pathways from the CoCH would be commissioned by the Betsi Cadwaladr University Health Board.

58. NHS Cheshire CCG was not a provider body and was therefore not regulated by the CQC, but was overseen by NHS England, including its Regional Offices and Area Teams. Each CCG had a constitution and was run by its governing body.

59. Betsi Cadwaladr University Health Board and NHS England were not associate commissioners to the CCG contract. Each had their own contract with the CoCH for the services they commissioned, with their own oversight and governance processes.

NHS Cheshire CCG (1 April 2020 – 30 June 2022): Quality and Performance Oversight and Governance

60. NHS Cheshire CCG held monthly Quality and Performance Meetings with CoCH to monitor the NHS Standard Contract² and review any matters considered necessary, which did not include neonatal services.
61. The quality and performance oversight at NHS Cheshire CCG mirrored the arrangements in place at NHS West Cheshire CCG, as described in paragraphs 49 – 53.

Commissioning of Neonatal Services

NHS England commissioning (from 1 April 2013 – date)

62. The Specialised Commissioning Team within NHS England were and currently remain solely responsible for commissioning neonatal services.
63. 10 Neonatal Operational Delivery Networks were established in April 2013 and commissioned by NHS England's Specialised Commissioning Team, one being the North West Neonatal Operational Delivery Network. There are 22 neonatal units within the North West Neonatal Operational Delivery Network, covering Cheshire and Merseyside, Greater Manchester and Lancashire and South Cumbria.
64. The Operational Delivery Networks have a mandate to develop and implement programmes of work to improve access to specialist resources, and to improve neonatal outcomes and patient experience, working closely with both providers and commissioners. Maternity and neonatal care are inextricably linked and work together to produce the best outcomes for women and their babies who need specialised care. Neonatal Operational Delivery Networks work closely with the Local Maternity and Neonatal System.

² The contract was mandated by NHS England for use by commissioners for all contracts for healthcare services that they were responsible for commissioning. The contract in place was between the CCG as the commissioner and CoCH as the provider.

CCG commissioning (from 1 April 2013 - 30 June 2022)

65. NHS West Cheshire CCG and NHS Cheshire CCG were not the commissioners for neonatal services. The CCGs were responsible for commissioning obstetrics, gynaecology, and midwifery services.

ICB commissioning (1 July 2022 – date)

66. The ICB does not currently commission neonatal services. However, as a key stakeholder, the ICB is routinely represented, alongside NHS England's Specialised Commissioning Team at the North West Neonatal Operational Delivery Network, as set out in paragraphs 12 - 26. This is to support the triangulation of risk and escalation of concerns, both regionally and at a local ICB level in Cheshire and Merseyside. These meetings include NHS England's Regional Quality Group, the NHS England North West Peri-Natal Board and NHS England's North West Peri-Natal Safety, Surveillance and Concerns Group, as detailed in paragraph 40.
67. From April 2023, a national joint working model was established between NHS England and ICBs. As detailed in the NHS England North West Specialised Services Committee Terms of Reference, this arrangement introduced joint decision-making between NHS England and ICBs for specialised services that are suitable and ready for greater ICB involvement, as approved by NHS England's Board on 2 February 2023 (**Exhibit GU/10**) INQ0012664.
68. The delegation of specialised services budgets to ICBs is scheduled to take place on 1 April 2024. The split of services is nationally prescribed and includes neonatal commissioning. Neonatal services are 1 of 59 services moving to the ICB from NHS England on 1 April 2024. The ICB has been working with NHS England North West on the delegation of services and have transition, delegation, and assurance processes in place to ensure a safe transfer. We have received national approval to take on the delegated neonatal service.
69. The ICB will therefore have responsibility for overseeing the implementation of any recommendations made by the Inquiry.

Notification of concerns relating to CoCH Neonatal Unit

70. NHS West Cheshire CCG was the CCG operating in the key period to which the concerns related i.e., 2015 – 2016.
71. Please see paragraph 52 above which provides detail in respect of StEIS incident reporting.
72. Section SC 33 of the NHS Standard Contract 2015/2016 confirms that providers must comply with the revised NHS Serious Incident Framework (March 2015). NHS England Specialised Services held an NHS Standard Contract for neonatal services at CoCH.
73. NHS England North Region Team had access to all serious incidents reported on StEIS, including neonatal and maternity incidents.
74. The NHS England Serious Incident Framework published on 27 March 2015 states at paragraph 3.2 on pages 34 - 35:

“Where a serious incident indicates an issue/problem that has (or may have) significant implications for the wider healthcare system, or where an incident may cause widespread public concern, the relevant commissioner (i.e., lead commissioner receiving the initial notification) must consider the need to share information throughout the system i.e., with NHS England Sub-regions and Regions and other partner agencies as required. This is a judgement call depending on the nature of the incident, although the scale of the incident and likelihood of national media attention will be a significant factor in deciding to share information.

Where the commissioner receiving the initial notification recognises the need to share information, they must liaise with and alert NHS England (where they are not the commissioner receiving the initial notification). Commissioners should share information with members of their local Quality Surveillance Group (QSG), which bring together different parts of the system to proactively share intelligence on real or actual quality failures. A Risk Summit may be required to share information if very serious concerns about the quality of care being provided to patients remain.”

75. NHS England Specialised Services provided reports on neonatal services to the Cheshire and Merseyside Quality Surveillance Group as the commissioner of neonatal services.

76. NHS West Cheshire CCG held a Standard NHS Contract with CoCH for the services it commissioned. Section SC 33 of the NHS Standard Contract 2015/2016 confirms that providers must comply with the revised NHS Serious Incident Framework (March 2015) which describes the role of the commissioners and providers in this process.
77. Commissioners are required to evaluate root cause analysis investigations produced by providers and seek assurance that the processes and outcomes of these investigations, including identification and implementation of improvements to prevent recurrence of serious incidents. These reports should be submitted within 60 working days of the incident being reported onto StEIS, though providers may extend this timeframe when matters are more complex and need other partner agency involvement.
78. Providers are required to notify other relevant partners and agencies, such as the police, local authority, and regulators. The NHS Serious Incident Framework (March 2015) has a detailed appendix describing this.
79. The NHS West Cheshire CCG Serious Incident Policy (**Exhibit GU/11**) INQ0012665 was included in the CCG's contract with CoCH. The scope of that policy states that Section SC 33 of the NHS Standard Contract 2015/2016 requires providers to comply with the revised NHS Serious Incident Framework (March 2015) and that the NHS West Cheshire CCG's Serious Incident Policy is intended to compliment (rather than replace) the incident reporting systems already operating within organisations that provide NHS funded care.
80. The NHS West Cheshire CCG's Serious Incident Policy reiterated much of the national NHS Serious Incident Framework (March 2015) but in addition, described in more detail, the CCG's internal processes for the commissioner oversight role of any serious incidents reported to the CCG. The CCG's policy, in line with the national NHS Serious Incident Framework (March 2015), also included reference to NHS West Cheshire CCG not performance managing organisations based on the number of serious incidents they report as this could discourage reporting and inhibit learning.

Notification of concerns

81. The ICB has conducted a review of NHS West Cheshire CCGs records to identify when and how it first became aware of concerns about the neonatal unit at CoCH and the steps taken in response. Relevant correspondence and documents including minutes of

meetings have been exhibited to my statement and are referred to within the detailed chronology at **Appendix C**.

Notification of concerns relating to CoCH neonatal unit in 2016

82. On 30 June 2016, CoCH reported two separate maternity obstetric serious incidents on the StEIS system, which referenced deaths of neonates. As an immediate response, due to the reference to maternity services, the CCG's Director of Quality and Safeguarding reviewed the number of maternity related serious incidents reported on StEIS reported by CoCH since April 2015. Excluding the two incidents reported in June 2016, there were three incidents identified that were linked to maternity and deaths of neonates from April 2015 to June 2016. The ICB is unable to confirm whether these deaths reported in 2015/2016 were babies murdered by Lucy Letby.
83. In line with the national NHS Serious Incident Framework (March 2015), the CCG would expect CoCH to undertake an initial review within 72 hours of an incident being reported onto StEIS. The aim of the initial review is for the provider to identify and provide assurance that appropriate immediate action has been taken, assess the incident in more detail and propose the appropriate level of investigation.
84. On 1 July 2016, the day after the two StEIS notifications, the CCG's Director of Quality and Safeguarding was forwarded an email by CoCH's Director of Nursing and Quality that had been sent to the CQC regarding CoCH identifying an increase in the number of deaths of newborn babies on CoCH's neonatal unit along with the actions that had been put in place in response to investigate this (**Exhibit GU/12**) INQ0012666. The ICB has not identified any written evidence of previous reviews prior to June 2016 being shared by CoCH.
85. As detailed in paragraph 18, NHS West Cheshire CCG were not the commissioner of neonatal services at CoCH but, as a local stakeholder, it was usual and expected for the CCG to be informed and notified of increased numbers of deaths and serious incidents and formal dialogue with regulators.
86. On 5 July 2016, the CCG's Director of Quality and Safeguarding was notified by the commissioner of the neonatal service via email from NHS England's Director of Nursing for Specialised Commissioning (North) (**Exhibit GU/13**) INQ0012667. The email contained notification of serious issues in the neonatal service at CoCH following the

unexpected deaths reported on 30 June 2016. It also set out the immediate actions CoCH were implementing for neonatal services at CoCH, including that CoCH were commissioning an external review of all aspects of the unit including staff, equipment, pathways, competency, and incidents reported.

87. In response, on the same date, the CCG's Director of Quality and Safeguarding confirmed that the two unexpected deaths of neonates had been reported on StEIS on 30 June 2016 and so the NHS England Regional Team should have had sight of the incidents. This response refers to including a copy of the detail taken from the system. It was also confirmed that the CCG had not been sighted on the wider context of earlier concerns at CoCH in relation to the neonatal service as this had not been shared with the CCG's Director of Quality and Safeguarding (Exhibit GU/13) **INQ0012667** . Had those concerns been raised by CoCH with the CCG, they would have raised these with the NHS England Regional Team through the Quality Surveillance Group report, which is how concerns were routinely escalated.

88. In line with NHS England's Serious Incident Framework (March 2015), CoCH were required to notify the relevant commissioner of serious incidents:

- a. NHS England as commissioner of neonatal services; and
- b. The CCG as commissioner of maternity services.

89. The CCG's Director of Quality and Safeguarding confirmed to NHS England that the CCG would focus efforts on the work that CoCH needed to undertake for the system to be assured in respect of their internal governance of serious incidents reporting, to avoid any duplication of actions between the CCG and NHS England.

90. On 6 July 2016, the CCG's Director of Quality and Safeguarding received an email from NHS England's Director for Nursing Specialised Commissioning (North) (Exhibit GU/14) **INQ0012668** with a copy of a document which summarises the action being taken by CoCH. In this, it was reported that as a result of identifying an adverse variation in CoCH's mortality rates for newborn babies on the neonatal unit in 2015 and 2016 compared to previous years, CoCH had asked for an external review of its neonatal provision in partnership with the Royal College of Paediatrics and Child Health and the Royal College of Nursing ("the External Review"), and were temporarily changing the admission criteria for its neonatal unit to focus predominantly on lower risk and more mature babies. This decision was

reported to have been taken with the support of the Cheshire and Merseyside Neonatal Care Network³ (**Exhibit GU/15**) **INQ0012669** .

91. NHS West Cheshire CCG's Accountable Officer informed the CCG's Finance, Performance and Commissioning Committee on 7 July 2016 of the actions being taken by CoCH in relation to neonatal services, the External Review and temporarily changing the admission arrangements for the neonatal unit to focus predominantly on lower risk babies, who are born after 32 weeks. It was noted that a number of patients would potentially need to transfer to other neighbouring NHS Trusts and local hospitals for their maternity care and that CoCH would be managing this process. It was also confirmed that the External Review was expected to be completed by the end of September 2016 and that CoCH had taken the decision not to share details of the increased numbers of deaths until the External Review had been completed (**Exhibit GU/16**) **INQ0012670** .

Neonatal admission arrangements at CoCH and the External Review commissioned by CoCH – 2016 developments

92. NHS West Cheshire CCG's Governing Body was further updated as part of the Quality Improvement Committee Report presented on 21 July 2016 at the Formal Governing Body Meeting held in public (**Exhibit GU/17**) **INQ0012671** . This report confirmed the temporary changes to admission arrangements being taken by CoCH in relation to neonatal services and the External Review was expected to be completed by the end of August⁴. It was reported that the findings of the External Review would be shared with the Quality Improvement Committee and the Governing Body would be briefed on the outcome of the External Review report. This was recorded as an action on the Formal Governing Body Meeting action log, assigned to the CCG's Director of Quality and Safeguarding as: *(16/07/67 - Quality Improvement Committee Report a. Governing body to be briefed on outcome of External Review of CoCH neonatal unit).*

93. NHS West Cheshire CCG were updated on the action being taken at CoCH regarding neonatal services at the Contract Quality and Performance Meeting on 28 July 2016 by CoCH's Director of Nursing. The Contract Quality and Performance Meeting minutes

³ Cheshire and Merseyside Neonatal Care Network forms part of the North West Neonatal Operational Delivery Network.

⁴ Suspected error in the minutes, given that subsequent minutes confirm the visit is arranged in September.

show at **Exhibit GU/18** **INQ0012672** that the CoCH Director of Nursing briefed on the following:

- a. That a Trust mini-incident room was set up to try and understand the data.
- b. CoCH's actions from this were to help support teams, manage communication and sensitivities with parents.
- c. Data had been looked at from over a number of years and no themes or significant data was found.
- d. Patient information had been looked at to see how many deaths involved twins or triplets and the number of babies that had come from Wales as antenatal issues in Wales were considered, although this was not the case.
- e. It was reported that there has been a reduction in capacity from a staffing element and sickness rates of staff had gone up.
- f. It was recorded that a copy of the report⁵ had gone out to everyone. This also looked at babies who had been transferred out and died in other units.
- g. CoCH clinicians had gone through every case clinically and a detailed update on the report⁶ was provided at the last Neonatal Board⁷.
- h. The External Review of the service would be taking place on 2 September 2016.
- i. CoCH confirmed that a complete review of staff competency was to be completed to look at how the team is being supported.

The minutes of the meeting confirm no actions were assigned to NHS West Cheshire CCG, and there is no evidence in previous Contract Quality and Performance meetings of receiving reports in respect of the internal reviews referred to.

94. On 15 September 2016, it was confirmed at the CCG's formal Governing Body meeting held in public that the External Review was expected to be completed by the end of September 2016 (**Exhibit GU/19**) **INQ0012673** .

95. The CCG's Governing Body was updated on 17 November 2016 at the CCG's formal Governing Body meeting held in public as part of the Quality Improvement Committee Report (**Exhibit GU/20**) **INQ0012674** . The minutes confirm that the External Review was completed in September 2016. CoCH had received the initial report from the

⁵ It is suspected that this is regarding internal reviews undertaken by the CoCH.

⁶ Ibid.

⁷ We are unaware if this is a CoCH internal Board meeting or an NHS England commissioner led meeting.

External Review and was reviewing it for accuracy. It was reported that several recommendations were made which had also contributed to the delay in the publication of the External Review report. The verbal feedback that had been received at that time was that no immediate safety concerns had been identified. CoCH had advised that the External Review report was due in October 2016 and would be shared rapidly upon receipt by CoCH Directors with the CCG and NHS England who commission the neonatal service. It was expected that the report would be shared in November 2016, following which the findings would be shared with the committee and the governing body would be briefed on the outcome of the report . The Governing Body action log within the minutes was updated accordingly for action 16/07/67 (**Exhibit GU/21**) **INQ0012675** .

Neonatal admission arrangements at CoCH and the External Review commissioned by CoCH – 2017 developments

96. On 19 January 2017, the CCG's formal Governing Body meeting was held in public. The Quality Improvement Report was presented which reported that CoCH were waiting for the final version of the External Review report and were developing a communication plan to share this with stakeholders, including commissioners and families (**Exhibit GU/22**) **INQ0012676** . There is no reference to action 16/07/67 within the formal Governing Body meeting minutes dated 19 January 2017 under the agenda item: "*matters arising from the minutes of 17th*" November 2016" (**Exhibit GU/23**) **INQ0012677** . There is no action log for January 2017 available and nothing is logged on the March 2017 action log regarding this action. However, updates were provided at future CCG Formal Governing Body meetings as part of the Quality Improvement Reports.
97. The minutes from the CCG's Quality Improvement Committee on 9 February 2017 confirm that the committee were advised that the External Review was leaked to the press ahead of its official publication and that the CCG's Director of Quality and Safeguarding informed CCG Quality Improvement Committee members of this via email. The minutes also confirm that CoCH had contacted all families concerned. A small article had been published in the Times and CoCH published the External Review report on 8 February 2017 on its website⁸. The minutes also confirm that relevant issues had been referenced in the report about how deaths are reported and the information link between neonatal unit and the rest of the hospital, that the neonatal unit may not have the staffing

⁸ This link is no longer live.

consistency at mid-grade level for Level 2⁹, and that personnel issues had been noted. Whilst the CCG did not commission the service, it was recorded that the CCG needed assurance that staff were confident to escalate concerns. The CCG's Director of Quality and Safeguarding planned to meet with the Designated Doctor for Safeguarding to discuss the report findings to ensure that proper reflection and investigation took place. It was reported that one action plan would be developed from the recommendations and the CCG's Director of Quality and Safeguarding was going to suggest that one person lead on this. Any broader issues were to be discussed with CoCH and reported back through the CCG's Quality Improvement Committee (**Exhibit GU/24**) INQ0012678 .

98. On 16 March 2017, the Quality Improvement Report was presented at the formal Governing Body meeting held in public. The Quality Improvement Report confirmed CoCH's action plan in response to the recommendations following the External Review, and the implementation of actions would be overseen by NHS England's North West Specialised Commissioning Hub, who were responsible for commissioning neonatal services (**Exhibit GU/25**) INQ0012679 . The CCG's formal Governing Body meeting minutes confirm that the Quality Improvement Report includes a link to the External Report that was published on CoCH website¹⁰. The CCG were not the lead commissioner for neonatal services but had a role in monitoring the action plan to support CoCH and NHS England's Specialised Commissioning. The CCG's Director of Quality and Safeguarding confirmed that she had been working with the Designated Doctor for Safeguarding Children to identify any actions required in respect of references within the External Review report to the Cheshire Child Death Overview Panel (**Exhibit GU/26**) INQ0012680 .

99. On 23 March 2017, at the CCG's Contract Quality and Performance Meeting with CoCH, CoCH's Medical Director provided an update following the External Review. This included that the External Review had recommended a number of individual clinical reviews which had now been completed and were being reviewed by CoCH's Medical Director and paediatricians to identify learning. It was reported that parents/families had been contacted with a view to meeting within 6 weeks to receive individual care review findings. 8 families had accepted the offer and others had reportedly declined or had not been traceable. A draft action plan had been shared with the CQC on 22 March 2017 by

⁹ Level 2 – Local Neonatal Units care for babies greater than 27 weeks gestation if a singleton pregnancy and greater than 28 weeks if a multiple pregnancy. Babies cared for in a Local Neonatal Unit can receive short term intensive care treatment requiring respiratory support on a ventilator.

¹⁰ This link is no longer live.

CoCH. The Director of Nursing at CoCH confirmed that a version of the draft action plan would be available on 24 March 2017. CoCH was waiting on responses from the North West Neonatal Operational Delivery Network in relation to recommendations that the Network would be leading on. Once completed, the action plan would be revised and redistributed. The CCG's Director of Quality and Safeguarding requested that this item remain on the agenda (**Exhibit GU/27**) INQ0012681 .

100. At the next CCG Contract Quality and Performance Meeting with CoCH on 27 April 2017, CoCH's Medical Director confirmed that the work in relation to the action plan following the outcome of the External Review was ongoing and was at that time incomplete as CoCH were waiting on information from the North West Neonatal Operational Delivery Network. It was agreed that one single action plan was needed that included the recommendations following the External Review. CoCH's Medical Director reported that he had met with the Cheshire Child Death Overview Panel to provide an update on the investigation and discuss next steps in relation to a small number of unexplained deaths. He also confirmed that inquests were pending, individual reviews had been completed and an update was to be provided to the CCG (**Exhibit GU/28**) INQ0012682 .

101. NHS West Cheshire CCG became aware of police involvement by email from NHS England's Chief Nurse North on 9 May 2017. The email was sent to NHS West Cheshire CCG's Director of Quality and Safeguarding and states that CoCH had met with Cheshire Police, and it had been agreed that there would be an investigation, but it would be described as an invited police investigation to investigate unexplained deaths, not a criminal process (**Exhibit GU/29**) INQ0012683 .

102. On receipt of the email, NHS West Cheshire CCG Director of Quality and Safeguarding escalated this to the NHS West Cheshire's Accountable Officer at the time. There are no emails or documentation to support this although the Director of Quality and Safeguarding has reported that they and the Accountable Officer shared an office and so would have discussed this in person. There was no action for NHS West Cheshire CCG as the response was being led by NHS England as the commissioner.

103. On 16 May 2017, CoCH's Head of Communications and Insight shared details of the point of contact at Cheshire Police with key stakeholders, including NHS England, the CQC and the CCG. The CCG's Director of Quality and Safeguarding shared this with the CCG's Accountable Officer and Head of Communications and Engagement so that if the

CCG received any enquiries, it was known where to re-direct them (**Exhibit GU/30**)

INQ0012684 .

104. On 16 and 17 May 2017, the CCG's Head of Communications and Engagement attended communications calls as a key stakeholder, alongside NHS England, NHS Improvement and CoCH, which involved discussions around drafting staff briefing lines, patient briefing lines, FAQs, media statements and media protocols. The outcomes following the calls were shared with the CCG's Accountable Officer, Director of Quality and Safeguarding and Director of Commissioning via email (**Exhibit GU/31**)

INQ0012685 .

105. On 25 May 2017, a neonatal update was provided by CoCH at the CCG's Contract Quality and Performance Meeting with CoCH. The minutes show that the Director of Nursing at CoCH confirmed that a police investigation had been launched and information was being gathered and that their Silver Commander was the CoCH Director of Corporate Affairs. They also confirm that the Executive Team were offering direct support to staff on the neonatal unit. It was noted that the unit was at capacity and had been for the last two weeks with some patients being transferred out and that this was being monitored daily. They confirmed that enquiries had been received from families and that Blacon Police Station continued to be the central point for staff to be interviewed. It was agreed at this meeting that support mechanisms needed to be put in place for staff at CoCH. There were no actions for NHS West Cheshire CCG from this meeting in relation to this recorded in the minutes (**Exhibit GU/32**) INQ0012686 .

106. On 25 May 2017, the CCG's Head of Communications and Engagement confirmed to the CCG's Accountable Officer that he had been in contact with the Head of Communications at CoCH (**Exhibit GU/33**) INQ0012687 and had received copies of the Regulators and Stakeholder brief (**Exhibit GU/34**) INQ0012688 and External Stakeholder FAQs Neonates (**Exhibit GU/35**). INQ0012689 There were no further updates and no plans to issue any further statements or briefs. The police had confirmed at that time that their investigation was in its very early stages and that they were unable to provide any further details at the time. It was suspected that the police investigation could take up to 18 months. It was confirmed that CoCH's Director of Corporate and Legal Affairs was the operational lead at CoCH, and the CCG had been assured that it would be sighted on any further updates and communications.

107. On 8 June 2017, the CCG's Quality Improvement Committee was held, and the Quality Improvement Report was presented (**Exhibit GU/36**) INQ0012690. This confirmed that:

- a. The External Review provided 24 recommendations for improvement which were underway.
- b. One of the recommendations required a further detailed case note review by an independent neonatologist, who was unable to answer all questions regarding the cause of death for a number of babies.
- c. CoCH had asked for the input of Cheshire Police in May 2017 to seek assurances to rule out any unnatural causes of death, as the CoCH and its doctors had continuing concerns.
- d. Specially trained officers from Cheshire Police had been in contact with the families directly affected.
- e. Cheshire Police had launched an investigation that focused on the deaths of 8 babies that occurred between June 2015 and June 2016 where practitioners had expressed concern, and a review of a further 7 baby deaths and 6 non-fatal collapses during the same period.
- f. CoCH Directors were reported to be supporting staff and patients currently receiving care at the hospital. The neonatal unit at CoCH remained open to women over 32 weeks in their pregnancy.

108. The CCG Quality Improvement Committee on 8 June 2017 minutes (**Exhibit GU/37**) INQ0012691 confirm that plans were in place for CoCH to update the CCG on the action plan that had been drawn up following the External Review of neonatal services at a future Contract Quality and Performance meeting as a key stakeholder linked to the CCG's commissioning of maternity services.

109. On 20 July 2017, the CCG's Governing Body received the Quality Improvement Report (**Exhibit GU/38**) INQ0012692 at the Formal Governing Body meeting held in public, where they were first informed of the involvement of Cheshire Police and their investigation. This was the first formal Governing Body meeting following notification in May 2017. An update on the timeline and progress on recommendations for improvements to the neonatal service was requested. It was confirmed that CoCH had been asked to provide an update at the next Contract Quality and Performance meeting in September 2017 and NHS England Specialised Commissioning, as commissioners of the neonatal service, would be invited to attend.

110. Also on 27 July 2017, a Contract Quality and Performance Meeting was held between CoCH and NHS West Cheshire CCG to look at quality and performance across all areas. It was agreed that NHS England Specialised Commissioners would be invited to attend the September 2017 Contract Quality and Performance meeting to discuss the External Review action plan (**Exhibit GU/39**) **INQ0012693** CoCH's Head of Contracts agreed to progress the invite with NHS England. CoCH's Medical Director informed the group that the neonatal police investigation was continuing and advised that there were no further updates. The actions recorded at the meeting were for CoCH to:

- a. Provide a copy of the updated External Review action plan.
- b. Invite NHS England Specialised Commissioners to the next meeting (September 2017).
- c. Provide an update to the Contract Quality and Performance Group.

111. On 28 September 2017, at the CCG's Contract Quality and Performance Meeting with CoCH (**Exhibit GU/40**) **INQ0012694**, a representative from NHS England's Specialised Commissioning team was invited but apologies were received from the Deputy Director of Nursing from NHS England Specialised Commissioning. CoCH's Medical Director also sent apologies; however, an update was provided by CoCH's Divisional Medical Director. The minutes confirm that:

- a. The External Review action plan had been updated and that the majority of actions had been completed although due to the ongoing police investigation, some actions were unable to be completed.
- b. Cross border issues between England and Wales, communication between teams, nurse staffing and progress on the actions were discussed.
- c. The CCG's Director of Quality and Safeguarding fed back that CoCH needed to be aware of every unexpected death in neonates, including babies that had been transferred out to another neonatal unit, and that all would need to be reported through Datix (NHS incident management system) to ensure that they all sat in one place until all investigations were completed. This was to be reflected in the External Review action plan updates.
- d. CoCH confirmed that the death of any neonate that happened following a transfer out would be reported through the North West Neonatal Operational Delivery Network and a comprehensive review process would take place which would then be reported to Trust corporate level.

- e. The actions recorded at the 27 July 2017 Contract Quality and Performance meeting as set out in paragraph 111 were marked as closed, stating that CoCH's Divisional Medical Director had provided an update to the group.

The CCG's role in seeking an update on the External Review action plan was as a key stakeholder in maternity commissioning and in seeking assurance on Trust governance in the delivery of an action plan.

112. On 26 October 2017, at the CCG's Contract Quality and Performance Meeting with CoCH, there was no one in attendance from NHS England Specialised Commissioning and no apologies had been received (**Exhibit GU/41**) INQ0012695. CoCH's Medical Director reported that there was no further update in respect of the action plan that was brought to the meeting in September where CoCH's Divisional Medical Director had provided the last update. Plans were in place with all parties' agreement to progress the neonatal unit back to Level 2¹¹. The police investigation was continuing, and it was noted that there would be no further updates on this for the foreseeable future. The CCG would continue to be involved outside of the Contract Quality and Performance Meeting if any further updates were reported.

113. No updates were provided at the CCG Contract Quality and Performance Meetings with CoCH between November 2017 and June 2018.

Neonatal admission arrangements at CoCH and the External Review commissioned by CoCH – 2018 developments

114. On 4 July 2018, NHS West Cheshire CCG's Director of Quality and Safeguarding attended a call, chaired by NHS England's Chief Nurse (North), regarding the ongoing police investigation and incident management approach which was being led by NHS England. An email summarising the call is at **Exhibit GU/42**) INQ0012696.

115. NHS West Cheshire CCG's Director of Quality and Safeguarding recalls:

- a. The CCG were informed by NHS England of an arrest made by the police.

¹¹ Level 2 – Local Neonatal Units care for babies greater than 27 weeks gestation if a singleton pregnancy and greater than 28 weeks if a multiple pregnancy. Babies cared for in a Local Neonatal Unit can receive short term intensive care treatment requiring respiratory support on a ventilator.

- b. NHS England had established an Incident Coordination Panel meeting following notification of the arrest. The ICB does not have a transcript or notes from the 4 July 2018 meeting but has minutes of an Incident Coordination Panel meeting held on 10 July 2018, chaired by the NHS England's North Chief Nurse, which the CCG's Director of Quality and Safeguarding attended (**Exhibit GU/43**). **INQ0012697**. Subsequent Incident Coordination Panel meetings were held by NHS England after 10 July 2018.
- c. Information being escalated to the CCG's Accountable Officer.

Re-designation of CoCH Neonatal Unit

Re-designation of CoCH's Neonatal Unit 2016

116. NHS West Cheshire CCG's Director of Quality and Safeguarding received communications by email on 6 July 2016 from NHS England's Director of Nursing Specialised Commissioning (North) including two attachments (Exhibit GU/14 **INQ0012668** and Exhibit GU/15 **INQ0012669**). This communication was regarding CoCH identifying an increase in the number of deaths of new born babies on CoCH's neonatal unit along with the actions that had been put in place to investigate, which included a proposal to downgrade the neonatal unit at CoCH to Level 1 and confirming that an action plan was being developed by CoCH's clinicians.
117. From 7 July 2016, the CoCH's Local Neonatal Unit had temporarily reduced its admittance criteria from a Level 2 Local Neonatal Unit to a Level 1 Special Care Baby Unit. The redesignation meant that the Special Care Baby Unit only provided care for babies who were born at 32 weeks and over who;
- a. Were on short term ventilation;
 - b. Required Continuous Positive Airway Pressure;
 - c. Needed Total Parental Nutrition; or
 - d. Required High Flow therapy.

The number of cot spaces was reduced from a total of 16 (Intensive Care cots 3; High Dependency cots 3; Special Care cots 10) to 13 as the gestational age limit was raised from 27 weeks to 32 weeks.

118. The re-designation of the Neonatal Unit at CoCH from a Level 2 Local Neonatal Unit to a Level 1 Special Care Baby Unit was a decision made by the CoCH through dialogue with the North West Neonatal Operational Delivery Network.
119. NHS West Cheshire CCG was not involved in the decision-making process to re-designate the Neonatal Unit at CoCH as the CCG did not commission the service. However, the CCG was identified as a key stakeholder in CoCH communications plan due to the potential impact on maternity services, which was commissioned by the CCG (and is now commissioned by the ICB). NHS West Cheshire CCG's Director of Quality and Safeguarding has confirmed that the impact was discussed internally with the CCG's Accountable Officer.
120. NHS England, as the lead commissioner for neonatal services across Cheshire and Merseyside, initiated and implemented the change of designation from a Level 2 to a Level 1.
121. NHS West Cheshire CCG's Governing Body was updated at the Formal Governing Body Meeting held in public on 21 July 2016, as part of the Quality Improvement Report (Exhibit GU/17) **INQ0012671**. This confirmed the temporary changes to admission arrangements being taken by CoCH in relation to neonatal services and the temporary change in admission arrangements for the neonatal unit to focus predominantly on lower risk babies, who were born after 32 weeks. While the External Review was taking place, three intensive care cots were closed on the neonatal unit. A total of 13 cots were reported to continue to provide specialist and high dependency care for newly born and premature babies born at 32 weeks and above. Intensive care unit cots require 1:1 staffing so in CoCH, temporarily removing these cots freed up staffing for the wider unit, where the staffing ratios were 1:2 for high dependency care cots, and 1:4 for all other cots.
122. NHS West Cheshire CCG were updated on the neonatal arrangements at the Contract Quality and Performance Meeting on 28 July 2016 by CoCH Director of Nursing, which included notification of the decision made with the North West Neonatal Operational Delivery Network to reduce capacity (Exhibit GU/18) **INQ0012672**. This was to be managed by CoCH daily in conjunction with the maternity unit.

Re-designation of CoCH Neonatal Unit 2017

123. On 12 January 2017 at the CCG's Contract Quality and Performance Meeting with CoCH (Exhibit GU/44) INQ0012698, it was confirmed that NHS England, as specialised commissioners, had taken the decision to place the neonatal unit on Enhanced Quality Surveillance until they received the required assurances that the unit could safely re-open to accept admissions at Level 2. When asked about the impact on the units of reduced cots by the CCG's Director for Quality and Safeguarding, CoCH reported that the North West Neonatal Operational Delivery Network had been very supportive of how they had managed the temporary closure of the Level 2 unit to only accept Level 1 babies. The CCG noted that the surveillance level had been escalated by NHS England due to delays in sharing the External Review report, but it was acknowledged that this had to be done in a managed way. CoCH reported that they had developed a communication plan for all stakeholders which would commence on 26 January 2017.

Re-designation of CoCH Neonatal Unit as at today's date

124. CoCH are currently operating between Levels 1 and 2, with 32-week gestation used as the limiting criteria.

North West Neonatal Operational Delivery Network Stakeholder Reference Group

125. The North West Neonatal Operational Delivery Network held two Stakeholder Reference Group Meetings on 25 November 2016 and 24 January 2017, led by the North West Neonatal Operational Delivery Network Director and Clinical Lead, to discuss neonatal intensive care services within the Cheshire and Merseyside Neonatal Network area, to make recommendations on the optimal configuration of neonatal intensive care services within Cheshire and Merseyside, which fully aligned with the Neonatal Toolkit, the Neonatal Critical Care Service Specification and that could meet the predicted levels of future demand in a sustainable way. The case for change that was presented at the 25 November 2016 meeting included:

- a. Non-compliance with the National Neonatal Critical Care Service Specification
- b. Non-compliance with the National Service Standards
- c. Workforce challenges (nursing and medical)
- d. Variation in access to neonatal intensive care and specialist paediatric services

- e. Clinical outcomes
- f. Inefficient utilisation of existing cot capacity

126. NHS West Cheshire CCG was represented at both North West Neonatal Operational Delivery Network Stakeholder Reference Group Meetings on 25 November 2016 and 24 January 2017 by the CCG's Starting Well Commissioning Lead, as a key stakeholder for maternity services.

127. The CCG's Starting Well Commissioning Lead provided an update via email to colleagues in NHS West Cheshire CCG after the 25 November 2016 Stakeholder Reference Group (**Exhibit GU/45**) INQ0012699, as well as to CoCH colleagues (**Exhibit GU/46**) INQ0012700.

128. Following the 24 January 2017 Stakeholder Reference Group, the CCG's Starting Well Commissioning Lead provided an update via email to colleagues in NHS West Cheshire CCG (**Exhibit GU/47**) INQ0012701 as well as to Cheshire and Merseyside CCG colleagues (**Exhibit GU/48**)¹² INQ0012702. The November 2016 email updates included reference to the North West Neonatal Intensive Care Project Initiation Document (**Exhibit GU/49**)¹³ INQ0012703 being in place, the key objective of which was to make recommendations on the optimal configuration of neonatal intensive care services within Cheshire and Merseyside, which was to fully align with the Neonatal Toolkit, Neonatal service specifications and that it could meet the predicted levels of future demand in a sustainable way. The project's approach was:

- a. A benchmark review of current neonatal intensive care services against current quality standards framework.
- b. A review of activity capacity and demand data activity.
- c. Engagement events and surveys to gather the views of various stakeholders.
- d. An option appraisal approach.
- e. A final report to the North West Neonatal Operational Delivery Network Board, followed by recommending the preferred service delivery model to NHS England, as lead commissioner of neonatal services, for consideration and decision.

¹² Suspected error in GU52

email subject line; should state 24 January 2017

¹³ Suspected error in the date of the meeting recorded on page 1 of GU/49
believe it should state 9 March 2017

; we

129. The draft North West Neonatal Intensive Care Project Report was reported to the North West Neonatal Operational Delivery Network Board Meeting on 9 March 2017.
130. The Starting Well Programme Update Report was presented to the CCG's Finance, Performance and Commissioning Committee on 4 May 2017 (**Exhibit GU/50**) **INQ0012704**. The report confirmed that the:
- a. North West Neonatal Operational Delivery Network Board endorsed the preferred options for the Cheshire and Merseyside Neonatal Surgery Service Delivery Model and Neonatal Intensive Care Services for Cheshire and Merseyside Neonatal Network on 9 March 2017
 - b. Recommendations were progressing through the NHS England assurance processes and would have implications for organisations providing maternity and neonatal services within Cheshire and Merseyside.
131. The minutes of the CCG's Finance, Performance and Commissioning Committee on 4 May 2017 highlight that NHS England had advised that the preferred option for neonatal surgery had been endorsed, however further assurance was required by NHS England, and that it was their understanding that it would impact on the provision at that time at Arrowse Park Hospital (which is part of Wirral University Teaching Hospital NHS Foundation Trust) (**Exhibit GU/51**) **INQ0012705**.

Concerns

Complaints

132. Neonatal services across Cheshire and Merseyside are currently directly commissioned by NHS England. Therefore, the ICB does not maintain records or hold information regarding how many times neonatal units in Cheshire and Merseyside have conducted investigations into complaints or the details of any such investigations.
133. The ICB's Patient Advice and Complaints Team has carried out an extensive search of our complaint record systems for both the ICB and predecessor CCGs (including Datix, Ulysses and individual excel spreadsheets) to identify any formal complaints and/or concerns raised directly by clinicians and/or patients or parents of babies.

134. Each record of concern and/or complaint held by the predecessor CCGs and subsequently by the ICB regarding CoCH (from January 2015 to the end of October 2023) has been scrutinised for topics related to maternity and neonatal services by the ICB's Patient Advice Liaison Services. Our records have shown that two complaints were received:

- a. One case reported to the ICB regarding reported poor general nursing care on Ward 32 at CoCH following an emergency C section in May 2023. The case was passed to CoCH, with the complainant's consent that CoCH would investigate the concerns raised. The ICB closed the case on 15 May 2023.
- b. One case reported to NHS West Cheshire CCG regarding the reported attitude of midwives during a patient's labour in January 2016 at CoCH and Arrowe Park Hospital¹⁴. It is recorded that the complaint was upheld. An apology was provided, and the patient attended a meeting with CoCH.

135. The ICB is not aware of whether the case at paragraph 134b referred to above is linked to the criminal activity. Aside from the two cases detailed above, the ICB has not identified any records that demonstrate that the ICB or its predecessor CCGs received any complaints or concerns directly from clinicians or from parents of babies between January 2015 and October 2023.

136. No interactions between the ICB or its predecessor CCG (NHS West Cheshire CCG in 2016) took place with other organisations, aside from the CoCH in respect of the above identified records of complaint. This would not be expected.

Whistleblowing

137. The ICB has not identified any records that show that the ICB or its predecessor CCGs received any whistleblowing reports from clinicians between January 2015 and October 2023.

Freedom to Speak Up

138. The role of Freedom to Speak Up Guardians and the National Guardian were established in 2016 following the Public Inquiry into the Mid Staffordshire NHS

¹⁴ Part of Wirral University Teaching Hospital NHS Foundation Trust

Foundation Trust (national report dated February 2013). The recommendations following the Mid Staffs Inquiry were designed to make the culture of the NHS patient focused, open and transparent, where patients are always put first, and their safety and the quality of their treatment are the priority. The contribution staff can make to patient care through speaking up was recognised. However, a continuing problem with regard to the treatment of staff who raise genuine concerns about safety and other matters of public interest, and the handling of those concerns was identified leading to the subsequent independent Freedom to Speak Up review conducted by Sir Robert Francis and the recommendations for improvement in this area (national report dated February 2015).

139. Freedom to Speak Up has become a key part of governance within all NHS organisations, including ICBs and its predecessor CCGs. The responsibility for its implementation and effect sits with an organisation's Board.
140. The ICB has not identified any records that the ICB or its predecessor CCGs received any concerns via our Freedom to Speak Up Guardian from clinicians at CoCH between January 2015 and October 2023.
141. The ICB does not have copies of the Freedom to Speak Up policies that were in place at CoCH at the time. The ICB is not in a position to comment on whether the processes and procedures at the time were used or whether they were adequate.
142. NHS West Cheshire CCG first became aware of clinicians raising concerns at the Contract Quality Performance meetings as a result of CoCH's decision to commission the External Review in July 2016, as detailed in paragraphs 92 – 93. This is not documented within the documentation that the ICB has identified.

The CCGs' policies and procedures in place for staff to raise concerns

143. NHS West Cheshire CCG and NHS Cheshire CCG had policies and procedures in place for CCG staff to raise concerns:
 - a. NHS West Cheshire CCG (1 April 2013 – 31 March 2020)
 - i. NHS West Cheshire CCG Whistleblowing Policy and Procedure (Raising Concerns at Work), July 2016
(Exhibit GU/52) INQ0012706

- ii. NHS West Cheshire CCG Whistleblowing Policy – Freedom to Speak Up, November 2018 (**Exhibit GU/53**) **INQ0012707**
- iii. NHS West Cheshire CCG Management of Public Interest (Whistleblowing) Policy, September 2014 (**Exhibit GU/54**) **INQ0012708**
- iv. NHS West Cheshire CCG Complaints Policy, March 2016 (**Exhibit GU/55**) **INQ0012709**
- v. NHS West Cheshire CCG Complaints Policy, December 2018 (**Exhibit GU/56**) **INQ0012710**

b. NHS Cheshire CCG (1 April 2020 – 30 June 2022)

- i. NHS Cheshire CCG Whistleblowing Policy – Freedom to Speak Up, April 2020 (**Exhibit GU/57**) **INQ0012711**
- ii. NHS Cheshire CCG Complaints, Compliments, Patient Advice and Liaison Service Policy 2020/21 (**Exhibit GU/58**) **INQ0012712**

144. Following the inception of the ICB, revised policies and procedures relating to complaints, whistleblowing, and freedom to speak up were developed and published.

Review and Assurance of Neonatal Services

145. During the period in question and currently, formal commissioning responsibility of neonatal units within Cheshire and Merseyside lay with / now lies with the NHS England Specialised Commissioning Team, who were and are responsible for investigating any concerns, inspecting, and monitoring the quality of care and the safety of babies being treated on the neonatal units. Additionally, North West Neonatal Operational Delivery Network were, and remain responsible for supporting the delivery of high-quality care and may undertake external reviews. The CQC are the regulator for inspection of services.

146. The former CCGs had, and the ICB currently has no formal role in inspection and monitoring of neonatal units as it is not the commissioner and does not hold direct contracts with providers of neonatal units. As a result, there are no internal ICB processes for investigating concerns and/or complaints regarding neonatal care specifically. However, the ICB does have a Complaints, Compliments, Patient Advice and Liaison Service Policy at **Exhibit GU/59** **INQ0012713** Freedom to Speak Up

(Whistleblowing) Policy at Exhibit **GU/60** **INQ0012714** and Complaints Standard Operating Procedure ("SOP") at **Exhibit GU/61** **INQ0012715** .

147. Since July 2023, the Local Maternity and Neonatal System, which is part of the ICB, has had a role alongside the North West Neonatal Operational Delivery Network in the oversight of neonatal services. Please see paragraphs 29 – 40 for more information.

148. CoCH commissioned the External Review directly with the Royal College of Paediatrics and Child Health and the Royal College of Nursing. Updates on the External Review were provided to NHS West Cheshire CCG's formal Governing Body meetings held in public as part of the Quality Committee Reports in November 2016 (Exhibit GU/20) **INQ0012674** , January 2017 (Exhibit GU/23) **INQ0012677** and March 2017 (Exhibit GU/26) **INQ0012680** . The Quality Committee report to NHS West Cheshire CCG Board in March 2017 states that the External Review report had been published and the outcome would be overseen by NHS England, as commissioner of neonatal services. Please see paragraphs 98 – 101 for detail.

149. Neither the former CCGs, nor the ICB commissioned any review of the neonatal unit at CoCH between 2016 to the present date. As a result, the ICB (and its predecessor CCGs) did not make any recommendations or changes in policy as a result of reviews undertaken at CoCH neonatal unit.

Assurance of ICB Commissioned Services

150. General information on day-to-day assurance of ICB commissioned services is provided at paragraphs 20 – 26. Please see the glossary at **Appendix B** for details of the networks, groups and committees referred to. I set out a couple of specific examples below:

Management Structure and Governance Review of CoCH

151. The CQC undertook an unannounced reinspection at CoCH between 26 – 27 July 2022 which focused on services provided by CoCH, as part of their continual checks on the safety and quality of healthcare services. They inspected maternity services and the well-led key questions for CoCH overall. The report was published on 30 September 2022 and the previous rating of inadequate remained. The report confirmed that CoCH must take the following actions to comply with its legal obligations:

- a. CoCH must ensure recruitment to governance posts is completed to ensure oversight and monitoring of the service. (Regulation 12 (1)(2)).
- b. CoCH must implement quality improvement systems and processes such as regular audits of the services provided and must assess, monitor, and improve the quality and safety of services. (Regulation 17 (1)(2)(a)).
- c. CoCH must ensure that significant improvement is made in relation to effective governance systems and processes relating to the timely identification, investigation and learning from incidents, complaints, and patient death reviews. (Regulation 17 (1)(2)(a)(b)(e)).
- d. CoCH must ensure that staff are suitably trained on the electronic patient record system so that completed risk assessments can be accessed and patient safety is not put at risk. (Regulation 18 (2)(a)).
- e. Relating specifically to CoCH's maternity service - CoCH must ensure that a rotational thermoelectrometry machine for analysing blood samples to determine blood loss during a post-partum haemorrhage is available for point of care testing on the central delivery suite. (Regulation 12(1)(2)).

152. The report highlighted that, since the last inspection, a System Improvement Board had been put in place, now led by NHS England. This Board brought together senior leaders from CoCH and key stakeholders to support and ensure delivery of the required improvements. The principal purpose of the NHS England System Improvement Board is to:

- a. Oversee the delivery of all outstanding actions arising from CQC inspections.
- b. Ensure the health and social care system works collectively to address the findings of the CQC, with partnership working being core to the delivery of improvements.
- c. Support the system with the development of a short, medium to long term costed improvement plan which could be delivered at pace and focused on outcomes.
- d. Ensure there was appropriate governance and assurance for the delivery of the system improvement plan.
- e. Support the improvement of culture in the organisation, ensuring the improvement plan detailed approaches for cultural change and inclusivity of all staff.
- f. Ensure that quality improvements were aligned with financial recovery plans of NHS England.

- g. Facilitate CoCH and system assurance linked to the delivery of the single improvement plan priorities and assess the sustainability of improvement once resources/support is removed.

The ICB are a core member of the NHS England System Improvement Board.

153. NHS Cheshire CCG commissioned Deloitte LLP to undertake an independent review of Board capability and processes at CoCH which took place between July – September 2022. The review was not undertaken in respect of the neonatal unit at CoCH but was commissioned to review the management structure and governance at CoCH. The aim of this independent review of Board capability and processes at CoCH was to support CoCH in its response to the CQC inspection and to enable the organisation to develop a clear plan that would see it achieve an NHS England System Oversight Framework 2021/2022 (published June 2021) segment 2 rating within 18 months. NHS England System Oversight Framework described a segment 2 rating as Trusts having plans that have the support of system partners in place to address areas of challenge, and that targeted support may be required to address specific identified issues. The ICB (and its predecessor CCGs) were a key stakeholder but not involved in decision making relating to the System Oversight Framework segmentation or undertakings made by CoCH.

154. The national NHS Oversight Framework (published 27 June 2022) replaced the NHS System Oversight Framework for 2021/22 and sets out NHS England and NHS Improvement's approach to oversight of ICBs and Trusts, aligned to the NHS Long Term Plan and the NHS operational planning and contracting guidance. The NHS Oversight Framework (published 27 June 2022) was issued to align with the formal establishment of ICBs in July 2022, and it remains the extant national NHS Oversight Framework. The national NHS Oversight Framework is built around five national themes that reflect the ambitions of the NHS Long Term Plan and apply across both Trusts and ICBs:

- a. Quality of care, access and outcomes;
- b. Preventing ill-health and reducing inequalities;
- c. People;
- d. Finances and use of resources; and
- e. Leadership and capability.

155. There is a sixth theme which applies only to ICBs; local strategic priorities. There are high level oversight metrics aligned to the themes which are used to indicate potential

issues and prompt further investigations. The oversight process follows an ongoing cycle of monitoring ICB and Trusts' performance and capability, identifying the scale and nature of support needs and coordinating support activity so that it is targeted where it is most needed. The segments within the NHS Oversight Framework are:

- a. Segment 1 - Performance against the oversight themes typically in the top quartile nationally, balanced financial plan, actual/forecast breakeven or better and CQC 'Good' or 'Outstanding' overall and for well-led (Trusts), strong and active leadership in supporting and driving wider priorities.
- b. Segment 2 - This is the default segment that all ICBs and Trusts are allocated to unless the criteria for moving into another segment are met.
- c. Segment 3 - Performance against multiple oversight themes in the bottom quartile nationally, or a dramatic drop in performance, or sustained very poor (bottom decile) performance against one or more areas or financial plan not balanced and/or a material actual/forecast deficit, or a CQC rating of 'Requires Improvement' overall and for well-led, material concerns around governance, leadership, or quality.
- d. Segment 4 - In addition to Segment 3 criteria, longstanding and/or complex issues that are preventing improvement, or a catastrophic safety failure or a catastrophic failure in leadership or governance that risks damaging the reputation of the NHS or a significant underlying deficit and/or significant actual or forecast gap to the financial plan or CQC recommendation.

156. The Deloitte LLP independent review of Board capability and processes at CoCH objectives were:

- a. Overall diagnostics of CoCH current Board level governance arrangements, including analysis of relevant supporting documentation, using the Well-Led Key Lines of Enquiry as a framework.
- b. Interviews with each member of the Board and selected other leadership colleagues as determined by identified issues, risks, and diagnostic assessments.
- c. Observations of the key governance and assurance forums and a look forward by observing Board meetings and sub committees. An assessment of the culture and dynamics of current governance practices within CoCH.
- d. The quality and appropriateness of risk, quality and performance reporting received by the Board.

- e. A review of the skills, knowledge, and expertise of the current Board, identifying any gaps or development needs for current members.

157. The final report from Deloitte LLP's independent review of CoCH Board capability and processes was agreed and shared on 25 October 2022 (**Exhibit GU/62** **INQ0012716**). The report findings were that CoCH's Board at that time consisted of several experienced and capable individuals, and new members of the executive team were described by Board members as having made a positive contribution to the functioning of the Board after a relatively short period. Furthermore, they observed examples of collaborative and engaged discussion within Board and Committee meetings, often conducted in an open and friendly atmosphere. However, their observations, interviews and Board survey indicated that Board effectiveness was relatively low due to a lack of cohesion amongst Executive Directors, Non-Executive Directors, and the Board. Of specific note was an ineffective working relationship between the Chair and Chief Executive Officer, which needed to be resolved as a priority. Board impact was further compounded by a lack of connectivity between the Board and decisional leaders, and external stakeholders had indicated the potential for more collaborative engagement from CoCH. The report made 10 recommendations, aimed at building Board capacity, capability, and cohesion, as well as enhancing Board impact both inside and outside the organisation. The recommendations are currently monitored by the System Improvement Board, chaired by NHS England. The System Improvement Board has oversight of leadership improvement and the ICB is represented by senior leaders. The ten recommendations are:

Executive Directors

- a. The Chief Executive Officer, in collaboration with other system leaders, should consider the appointment of a Trust or place-based Director of Strategy and Partnerships to support the development of a sustainable strategy and to further enhance system wide working.
- b. They commend the Chief Executive Officer's plans to commence an executive team development programme imminently. They advise structuring the programme to focus heavily on good practice in relation to promoting multi-disciplinary Executive Director working and joint accountabilities across all Board and committee activities.
- c. The Chief Executive Officer should consider additional activities to promote executive team connection with the divisional leaders and wider organisation. This should include increased physical presence, more regular Chief Executive

Officer one-to-ones with divisional leaders and increasing that status and executive presence in Executive Performance Review Meetings and Senior Leaders Group. The Chief Executive Officer should also consider engagement opportunities with other experienced Chief Executive Officers to gain insight to best practice in effective stakeholder engagement.

- d. The Chief Executive Officer should request a facilitated workshop with system leaders to discuss areas for further collaboration between the Trust and the system. This should include agreeing material responsibilities for the Chief Executive Officer and other Executive Directors, but particularly the Trust's clinical leaders. This should also consider the appointment of a joint system approach to leading on Strategy and Partnerships.

Non-Executive Directors

- e. The Chair, in consultation with the Council of Governors, should review succession planning for Non-Executive Directors with a view to enhancing the skill set of Non-Executive Directors with greater exposure to areas such as quality, people and culture.
- f. The Chair should ensure that any future Board development activities are designed to also promote team building, inclusion, and cohesion amongst the Non-Executive Director group.
- g. The Board should consider opportunities to build greater Non-Executive Director awareness of divisional operations and leadership. This could be achieved through a rolling programme of divisional engagement for the Board committees and through introducing a rotational programme of 'buddying' arrangements between divisions and Non-Executive Directors.
- h. The Chair should review opportunities for increasing the profile and impact of the Non-Executive Directors external to the organisation. This may, for example, include additional engagement activities for the Chair or wider Board engagement in Board-to-Board forums at the provider, place of system levels.

Board Functioning

- i. The Trust should commission a series of Board development activities covering topics such as operating as a unitary and strategic Board, timely engagement of Non-Executive Directors and sharing of information, effective scrutiny, and challenge, and generally act as a forum to build team cohesion and relations. They recommended a Board 360 survey, individual feedback, and coaching.

- j. The Chief Executive Officer and Chair should consider the merits of undertaking a programme of coaching to address any tensions and improve working relations. Consideration should be given by the Board and Council of Governors to succession planning should this approach not prove successful. The Senior Independent Director should also liaise with the Lead Governor in this regard.

NHS England and NHS Improvement System Improvement Board are responsible for overseeing and seeking assurance from the CoCH for the implementation of the recommendations and the subsequent action plan.

158. In addition, Appendix 4 of Deloitte LLP's report (**Exhibit GU/63** **INQ0012717**) following the independent review of Board capability and processes at CoCH contains CoCH's Board Member Survey results. This survey sought views on the effectiveness of the leadership and governance arrangements and was completed by 15 CoCH Board members. Deloitte LLP also provided a copy of their Change Log (**Exhibit GU/64** **INQ0012718**) which documents factual inaccuracy comments which were received by CoCH's Chair and CoCH's Chief Executive Officer in October 2022, based on the draft report that was shared.

Cheshire and Merseyside Maternity Serious Incident Panel

159. A Cheshire and Merseyside Maternity Serious Incident Panel was established on 18 May 2022 to provide a review of maternity and neonatal serious incidents reported on StEIS across the ICB and aims to triangulate systemic intelligence and actions with agreement as to how escalation and / or learning best takes place. The North West Neonatal Operational Delivery Network attend the Cheshire and Merseyside Maternity Serious Incident Panel. The Cheshire and Merseyside Maternity Serious Incident Panel reports to the Local Maternity and Neonatal System Quality and Safety Surveillance Group, onto the Local Maternity and Neonatal System Assurance Board, and then ICB Quality and Performance Committee, in addition to the relevant Place governance structures.

NHS England's System Improvement Board

160. On 19 August 2022, I¹⁵ chaired the CoCH System Improvement Board via Microsoft Teams in my capacity as the System Improvement Board Deputy Chair to NHS England

¹⁵ I was exceptionally chairing the NHS England System Improvement Board in the absence of the NHS England Regional Medical Director

Regional Medical Director (**Exhibit GU/65**) **INQ0012719** . As mentioned in paragraph 152, this is an NHS England System Improvement Board which is attended by CoCH, Betsi Cadwaladr, the CQC and colleagues from the ICB. As part of the agenda, the Acting Director of Nursing at CoCH stated that following the recent re-inspection by the CQC, positive feedback had been received verbally in respect of maternity services and that CoCH was awaiting formal feedback and the CQC's draft report. CoCH were able to demonstrate progress against restoration and recovery targets. NHS England's Senior Clinical Quality Lead for Maternity advised, as part of the National Maternity Safety Support Programme, that they had recently visited CoCH along with colleagues from the national team. The CQC were pleased with the progress that CoCH had made in strengthening leadership within maternity services and were also making good traction on several of the improvements required. The CQC's Director of Operations (North) confirmed that they were more assured about the progress in maternity than they were in terms of the well-led warning notice, particularly around Regulation 17¹⁶ (see paragraph 151). They were assured that there had been some improvement, and the team at the CQC were going through the evidence forensically to establish next steps. In terms of the well-led warning notice, the CQC were due to meet in the week commencing 22 August 2022 to consider the evidence and correspondence from CoCH and would respond accordingly. I requested that an action be taken forward at this meeting for a clear map to be produced by NHS England Director of Intensive Support / Acting Director of System Improvement, of the different support offers made available to CoCH, to allow CoCH capacity to own and embed delivery. The action was covered on the System Improvement Board's agenda on 21 October 2022 (agenda item 9: exit criteria and support offer) (**Exhibit GU/66**) **INQ0012720** and subsequently, the action was closed as the final paper was presented and the System Improvement Board approved the final criteria (**Exhibit GU/67**) **INQ0012721** . The minutes of the System Improvement Board dated August 2022 were presented at the ICB's Private Board on 27 October 2022.

Medication

161. The ICB does not provide guidance on security arrangements and policies for the storage and administration of medication to neonatal or maternity units within Cheshire and Merseyside. The management of medicines and insulin is the responsibility of each individual NHS Trust.

¹⁶ Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17

CCTV

162. The ICB is aware of CCTV arrangements and the areas covered by CCTV in NHS Trusts with neonatal units in Cheshire and Merseyside, however this service is commissioned by NHS England. The ICB understands there are currently no plans to install additional CCTV. This information was requested by the North West Neonatal Operational Delivery Network's Senior Lead Nurse from Trust Neonatal Leads on 19 December 2023. Responses were shared by the North West Neonatal Operational Delivery Network Senior Lead Nurse with the ICB's Executive Director of Nursing and Care.
163. The ICB, as commissioner of maternity services, would support any recommendation to extend provision of CCTV throughout clinical maternity areas, should the evidence base suggest this would improve patient safety, whilst balancing the impact of such surveillance upon the privacy and dignity of mothers, babies, and families within the unit.

Data Systems Governance and Assurance

164. NHS Trusts are expected to follow all national standards set out by the Data Alliance Partnership Board, which are monitored through management of NHS Standard Contracts. Relevant standards for neonates include:
- a. DAPB1595: Neonatal Data Set (this captures a significant amount of data relating to: Baby Demographics, Parents, Antenatal, Labour and Delivery, Admission details, Discharge details, Clinical trials, Infection Cultures, Abdominal Xray, Retinopathy of prematurity, Cranial Ultrasound, Biochemical Screening, Hearing Screening, Daily summary, and Two Year Follow Up)
 - b. SCCI0075: Neonatal Critical Care Minimum Data Set (version 2).
165. Compliance with data submissions is monitored by the ICB through contractual processes, with clear lines of escalation where compliance and / or data quality issues can be addressed.
166. The ICB ensures it complies with all nationally required data submissions and returns using NHS Digital's Information Standards Notices process. All requests for returns to NHS England are complied with and are dealt with by various departments across the organisation.

167. There are local data flows which are agreed with health care providers to flow into the organisation and are collated and processed in accordance with national processing rules. Data is used to create reports which support health care commissioning (service redesign, pathway optimisation, health inequalities' monitoring). Reports and data are used in a wide variety of settings and utilised to inform meetings and decision making for the services we commission.
168. The ICB's Business Intelligence function enables the production of routine reports or ad hoc requests for data, analysis, and reports for the services we commission. Data trends usually allow the ability to benchmark performance data to other systems/places in order to identify variation from usual levels. The report requestors may ask for further analysis to understand a potential issue that they have identified. Data trends are usually monitored by those receiving reports and they may do this through a meeting, committee, or Board. Their decision making is informed by the data and intelligence. Additional contextual information about a particular service or provider is also used to formulate questions which may be directed to a provider for further investigation.
169. The quality monitoring of performance indicators happens at place level in the ICB, for the services we commission. We have contract quality and performance monitoring processes with each Trust. As part of these processes, Trusts provide information that includes learning from deaths and performance against several national mortality indicators. Place Quality Key Issues Reports are submitted monthly to the ICB Quality and Performance Committee, highlighting areas of focus arising from the contract quality and performance processes. The ICB's Quality and Performance Committee scrutinise the quality and performance of the services we commission. The committee use national data, and robust statistical methods to understand statistically significant changes in performance through NHS Digital's Summary Hospital-level Mortality Indicator, Confidence Intervals (updated 16 February 2023 as set out on Gov.uk) and NHS England's Statistical Process Control Tool.
170. The ICB's Executive Director of Nursing and Care has established a forum, Emerging Concerns Group, which allows for more detailed discussion on provider quality. This forum sits alongside the ICB's Quality and Performance Committee, to support decisions on establishing a Rapid Quality Review.
171. There is a national process for establishing a Rapid Quality Review should there be significant quality concerns. This is detailed within the National Quality Board National

Guidance on Quality Risk Response and Escalation in ICSs (June 2022) published by NHS England.

172. Once a Rapid Quality Review is stepped down, a Trust would remain in enhanced surveillance. The Summary Hospital-level Mortality Indicator is one of the measures which is ordinarily required to be resolved before a Trust is stepped down from NHS Oversight Framework Level 3 to NHS Oversight Framework Level 2, and until the ICB sees sustained improvement (please refer to paragraph 155 for more information on the NHS Oversight Framework).
173. The ICB utilises expertise from around the health and care system including colleagues from Public Health, and support organisations such as Advancing Quality Alliance North West. These partners support organisations to understand issues in quality, an example being high rates of sepsis; the partners work with organisations to devise and deploy an improvement plan to address the issues. Advancing Quality Alliance North West offer several different quality support programmes for example, mortality surveillance. Since the inception of the ICB, we have engaged with these improvement partners to better understand the landscape of improvement across Cheshire and Merseyside and look to harmonise the offerings that are made. In addition, we are engaged with the new NHS IMPACT programme to move from Quality Improvement as a purely clinical entity, into continuous improvement as a methodology to pervade all aspects of our work.

Data Systems: Primary Care Medical Services

174. When looking at data systems specifically for child death, the ICB's Associate Medical Director for Primary Care (who is a practising General Practitioner), advised that demographic data about a child will be collected if the child was registered at a General Practice Surgery. If a child has died before leaving hospital, then minimal, or no data will be recorded on the General Practice system, as they are unlikely to have been registered with a General Practice Surgery. Where data was sent to the General Practice, this is likely to have been part of the child's mother's record, as part of the mother's maternity discharge. There may be variation between General Practices as to whether the information is moved to the child's record when, and if, they register at the General Practice.
175. The Associate Medical Director for Primary Care at the ICB confirmed that whilst there is no formal guidance for General Practice regarding medical records showing a mother or

parents that have suffered the death of a neonate, it would be common and expected practice for a record to be marked to show that a mother has suffered the death of a neonate, or indeed any other child death. This can be done either by adding a code to the record or by placing an alert on the record which will alert staff at the General Practice. There are several appropriate codes that can be used. The code forms part of the permanent record for the individual. 'Alerts' are not coded, cannot be searched for, and do not form part of the formal medical record, rather they are there to alert the surgery to important details to be aware of. They can signpost to further information or provide specific advice about how the practice should respond to the individual. In practice, it is expected that General Practices code that a neonatal or child death has occurred, and to consider adding an alert with more specific information. If information relating to the death of a neonate is relevant to future maternity care, it is expected that this would be recorded to inform future pregnancies. It would be good practice to record this on both parents' records, although in practice it is harder to do this for parents other than the mother where the General Practice may not know who the other parent is. They may also be registered at a different practice, and it is likely that the General Practice will only receive information from the hospital relating to the mother. The National Child Mortality Database has published "Advice to GPs following the death of a child" dated 11 August 2022, although this does not include guidance on recording of information.

176. All Trusts should have a policy in place that sets out how they respond to deaths of children who die in their care. The National Quality Board National Guidance on Learning from Deaths dated March 2017 sets this out for NHS Trusts and advises that General Practices should be notified. Also, Chapter 2 of the Child Death Review Statutory and Operational Guidance published October 2018 outlines the process of notification and immediate actions to be taken. It also states that General Practitioners should be notified.

Current Policies, Procedures and Processes

Concerns regarding competencies and behaviours of staff

177. If concerns are raised regarding the competence or behaviour of a member of clinical staff or Hospital Manager, this would primarily be dealt with at Trust level in accordance with the Trust's employment policies and procedures, and Employment Law. The Trust's Freedom to Speak Up Policy, which should reflect the National Freedom to Speak Up Policy, will be engaged where concerns are raised as whistleblowing concerns. The

responsibility for performance management sits with the employing organisation, who are obliged to refer to the appropriate regulatory body where there are concerns regarding patient safety and/or it is in the public interest to refer.

178. If staff have raised concerns but do not feel they have been listened to by their Trust, they can escalate to the ICB, National Freedom to Speak Up Guardian, the CQC, NHS England or via their Professional Bodies or Trade Unions. This is not currently documented within our ICB policy but will be factored in on review.

179. If a concern is escalated to the ICB, the ICB would work with the staff member to understand their concerns, the evidence that has been gathered to substantiate those concerns and to understand what the Trust's policies are. In some circumstances, it may be possible for the ICB to facilitate a supported development or coaching opportunity. This is current working practice.

180. The ICB's response would align with the following ICB policies and SOPs:

- a. Complaints, Compliments, Patient Advice and Liaison Service Policy (Exhibit GU/59) INQ0012713
- b. Freedom to Speak Up (Whistleblowing) Policy (Exhibit GU/60) INQ0012714
- c. Complaints SOP (Exhibit GU/61) INQ0012715

Safeguarding: Local Safeguarding Children Partnership

181. The Department of Health issued "Working Together to Safeguard Children" as statutory guidance in 2006. This has subsequently been updated in 2013, 2018 and 2023.

182. Following the updates in July 2018, CCGs, and subsequently ICBs, became statutory partners of Local Safeguarding Children Partnerships alongside the Police and Local Authorities. There is a Safeguarding Children Partnership within each local authority boundary. The Partnership is the key statutory mechanism for agreeing how relevant organisations in each local area will co-operate to safeguard and promote the welfare of children in that locality. Each Local Safeguarding Children Partnership is responsible for Section 11 audits under the Children Act 2004. Section 11 places a statutory duty on key organisations to self-assess the extent to which they meet the safeguarding requirements and standards to safeguard children. The ICB's Place Associate Directors

of Quality provide exception reports and assurance to the ICB's Executive Director of Nursing and Care through an agreed governance structure.

183. Child Safeguarding Practice Reviews are commissioned and led by the Local Safeguarding Children Partnerships. These are statutory multi-agency reviews where abuse of a child is known or suspected, and the child has died or has been seriously harmed. A multi-agency rapid review is undertaken initially to determine whether a Child Safeguarding Practice Review is required. Multi-agency learning is undertaken with action plans developed for the Local Safeguarding Children Partnership and individual agencies. Wider learning is shared across the Local Safeguarding Children Partnership through lunch and learns, seven-minute briefs and updates to training programmes.

Safeguarding: ICB Assurance

184. The ICB's Safeguarding Team request assurance bi-annually from NHS Trusts on how the NHS Trust is performing against the ICB's Safeguarding Commissioning Standards. Any areas of performance against those standards reported as amber or red result in an action plan being developed. This action plan is monitored and overseen by the Designated Nursing Team at the ICB through the Named Safeguarding Leads at each Trust. Any escalation is reported to Trust Safeguarding Groups and, if further escalation is required, this is done through the ICB's Safeguarding Oversight Group.
185. The ICB has relevant policies in place that reflect the current national guidance "Working Together to Safeguard Children" published in July 2018:

- a. Safeguarding Supervision Policy (**Exhibit GU/68**) INQ0012722
- b. Safeguarding Children, Adults at Risk and Children Care Policy (**Exhibit GU/69**) INQ0012723

Safeguarding: Child Deaths

186. Following the Department of Health's statutory guidance "Working Together to Safeguard Children" in 2006¹⁷, the Child Death Review process and the Child Death Overview Panel became a statutory function from 1 April 2008.

¹⁷ This has subsequently been updated in 2013, 2018 and 2023.

187. Before the establishment of Child Death Reviews and Child Death Overview Panels, there was no standardised multi-agency approach to systematically review and investigate child deaths in the UK. Child Death Reviews and Child Death Overview Panels were implemented to provide a more structured and comprehensive system for this purpose, with the aim of better protecting children and improving child welfare.
188. Local Safeguarding Children Partnerships are the key mechanism for agreeing how relevant organisations in each local area cooperate to safeguard and promote the welfare of children, with the purpose of holding each other to account and ensuring that safeguarding children remains high on the agenda.
189. Local Safeguarding Children Boards (which were in place prior to the Local Safeguarding Children Partnerships) were tasked nationally with establishing multi-disciplinary Child Death Overview Panel subgroups to conduct reviews into the deaths of all children 0-17 years of age, normally resident in their geographical area.
190. Locally, NHS Cheshire CCG set up England and Wales Cross Border Child Death meetings with Public Health Wales and Betsi Cadwaladr University Health Board representatives. These meetings were chaired by Cheshire Child Death Overview Panel's independent chair. The independent chair is funded jointly by the ICB (previously by CCGs) and Local Authorities. The meeting focuses on processes and learning between England and Wales for child deaths. The first meeting was held on 22 January 2021 and thereafter 6-monthly. The meetings are also held to discuss child deaths with potential border issues for children who live in Wales but have died at CoCH. The Designated Doctor for Child Death for Cheshire West and their counterparts in Wales have reviewed the Welsh Procedural Response to Unexpected Deaths in Childhood (PRUDiC) 2023 guidance published in February 2023 and have strengthened child death partnership working processes across the local English and Welsh border.
191. The England and Wales Cross Border Child Death meeting has since been expanded to invite wider partners from other areas in England that border Wales (including Shropshire, Hertfordshire, Gloucestershire) and Public Health Wales, Aneurin Bevan University Health Board, Betsi Cadwaladr University Health Board, Cardiff, and Vale University Health Boards in Wales and focuses on how the English and Welsh child death processes work along with sharing any learning that is identified. Cheshire West's

Designated Doctor for Child Death and the Designated Nurse for Safeguarding Children attend the meetings.

192. The England and Wales Child Death Cross-Border Meetings were introduced as a result of the events at CoCH. The meetings have been reported to have enhanced communication and discussions between Welsh and English Partners.

Safeguarding: Child Death Review

193. In October 2018, HM Government published the Child Death Review: Statutory and Operational Guidance (England) for CCGs and Local Authorities, as Child Death Review partners. The guidance sets out the full process that follows the death of a child and builds on the statutory requirements set out in "Working Together to Safeguard Children" (2018). The guidance clarifies how individual professionals and organisations across all sectors involved in the Child Death Review process, contribute to the reviews in order to improve the experience of bereaved families and professionals involved in caring for children. The overarching purpose of Child Death Review is to understand how and why children die, to put interventions in place to protect other children, and to prevent future deaths. They should identify matters relating to deaths that are relevant to the welfare of children in the area, or to public health and safety, and to consider whether action should be taken in relation to matters identified. The processes to be followed when a child dies are described in Chapter 5 of the statutory guidance document; "Working Together to Safeguard Children" (2018).
194. The ICB is one of the statutory Child Death Review partners. In this role, the ICB is a key partner in the Child Death Review process and jointly funds the independent chairs and business managers of the Child Death Overview Panels. The statutory responsibilities for Child Death Review partners are:
- a. Partners must make arrangements to review all deaths of children normally resident in the local area and, if they consider it appropriate, for any non-resident child who has died in their area.
 - b. Partners for two or more local authority areas may combine and agree that their areas be treated as a single area for the purpose of undertaking Child Death Reviews.
 - c. Partners must make arrangements for the analysis of information from all deaths reviewed.

Safeguarding: Child Death Overview Panel

195. Child Death Review meetings take place before an independent multi-agency Child Death Overview Panel is arranged by the Child Death Review partners. The purpose of the Child Death Overview Panel includes undertaking a review of all deaths of children normally resident within the local authority areas where a death certificate has been issued and to consider what, if any, action should be taken in relation to any modifiable factors identified. The Child Death Overview Panel will also make recommendations to Multi-Agency Safeguarding Arrangements, Health and Wellbeing Boards and other relevant Strategic Partnerships.
196. Each Child Death Overview Panel has a Terms of Reference in place which outlines the accountability of the ICB and the local authorities within each Child Death Overview Panel. All child deaths at the Child Death Overview Panel are discussed anonymously, and papers are only shared with panel members. The sign-in sheet for each panel includes a confidentiality statement, and any declarations of professional interest in any of the cases.
197. If Child Death Review partners find action should be taken by a person or organisation, the Child Death Overview Panel can hold strategic partners to account in relation to its recommendations, and any other identified matters relating to the death(s) that are relevant to the welfare, public health and safety of children, as detailed in the Pan-Cheshire Child Death Overview Panel Terms of Reference (2019)
(Exhibit GU/70) INQ0012724 .
198. The Child Death Overview Panel is the final stage of the Child Death Review process. The Child Death Overview Panel report into Health and Wellbeing Boards as well as sharing reports with the Local Safeguarding Children Partnerships and Community Safety Partnerships.
199. The ICB is a member of the Quarterly Business Meetings for each Child Death Overview Panel and is represented by an ICB Associate Director of Quality and Safety. These are partnership meetings to ensure oversight of the Child Death Review process. Any themes, trends, or escalations from the Child Death Overview Panel are included in the ICB Safeguarding Report which goes to the quarterly ICB Safeguarding Oversight Group, with escalation to the ICB System Oversight Board, chaired by the ICB's Executive Director of Nursing and Care.

200. The Children Act 2004 and Working Together to Safeguard Children guidance states that Child Death Review partners must, prepare and publish an annual report outlining what they have done as a result of the Child Death Review arrangements in their area, and how effective the arrangements have been in practice. The annual reports are presented to Health and Wellbeing Board who oversee the Child Death Overview Panel. It is also shared with the Local Safeguarding Children Partnerships and Community Safety Partnerships. The report is then made public on the Local Authority website. A copy of the Pan-Cheshire Child Death Overview Panel Annual Report 2015-2016 and Child Death Overview Panel Priority Action Plan 2016-2017 confirms that 64 child deaths were notified in the period 1 April 2015 – 31 March 2016 with 51 reviewed and subsequently closed by the panel for the period 1 April 2015 – 31 March 2016 (**Exhibit GU/71**) INQ0012725 .

201. There are two Child Death Overview Panels within the ICB's footprint:

- a. Cheshire Child Death Overview Panel covers Cheshire West, Cheshire East, Halton, and Warrington
- b. Merseyside Child Death Overview Panel covers Liverpool, Sefton, Knowsley, St Helens and Wirral and the Isle of Man.

The ICB are represented on the Child Death Overview Panel by Designated Doctors for Child Deaths, Designated Safeguarding Childrens Nurses and a Specialist Child Death Review Nurse.

202. The ICB, as a Child Death Review partner, has a role within the Child Death Overview Panel in ensuring that Trusts undertake Child Death Review meetings before the death is reviewed anonymously by the Child Death Overview Panel. This is supported by the employment of Designated Doctors for Child Death.

203. The ICB employs Designated Doctors for Child Death, commissioned via Service Level Agreements with NHS Trusts in Cheshire and Merseyside. There are currently 3 Designated Doctors for child safeguarding, child deaths and looked after children in Cheshire who attend the Cheshire Child Death Overview Panel, as detailed in the Terms of Reference (Exhibit GU/70) INQ0012724 .

204. The Designated Doctors for Child Death are Senior Paediatricians who take a lead role in the Child Death Overview Panel review process. The Child Death Overview Panel's

secretariat would alert the Designated Doctors for Child Death on notification of a child death and send them the relevant information.

Safeguarding: Child Death Reviews and Child Death Overview Panels: How this works in practice

205. For every child death, the following actions are taken:

- a. A “CDOP” Notification Form is completed by the clinical professional who is dealing with the child death and sent to the Child Death Overview Panel Business Manager immediately after it is reported that a child has died.
- b. The details on the notification form are entered onto the National Child Mortality Database within 24 hours of receipt of the form by the Child Death Overview Panel secretariat or equivalent. In Cheshire, an electronic system, eCDOP, is used to support the Child Death Review case management and reporting process. The eCDOP system uses statutory forms and processes used from the Working Together to Safeguard Children 2018 guidance to assist safeguarding teams in ensuring compliance.
- c. The Child Death Overview Panel secretariat would alert Child Death Review Partners of the death and the Child Death Review processes would commence.
- d. Information is gathered from all agencies that were involved with the child during their life or after death through completion of a “CDOP” Reporting Form.
- e. The Child Death Overview Panel Business Manager identifies the most appropriate agency to complete the relevant supplementary “CDOP” reporting forms, depending on the cause of death, and requests for that agency to complete the relevant forms.
- f. When completed, reporting forms are returned to the Child Death Overview Panel Business Manager, and the information is entered onto the National Child Mortality Database. As set out above, in Cheshire the eCDOP is used so the forms are submitted electronically.
- g. A local Child Death Review meeting is convened to include all professionals that were involved with the child during their life or after death, and at this meeting a draft analysis form is completed.
- h. Anonymous versions of the completed forms (notification, reporting, supplementary reporting, and draft analysis forms) are then presented to the Child Death Overview Panel, so an independent review of the case can be conducted. The review by the Child Death Overview Panel may be many months

after the death has occurred as other Child Death Review processes may need to be concluded first. A draft Analysis Form is completed at the meeting.

- i. Following review by the Child Death Overview Panel, the details are entered on the final analysis form and onto the National Child Mortality Database.

National Child Mortality Database

206. The publication of the Child Death Review Statutory Guidance (England) October 2018 prompted significant changes to the way in which child deaths are reviewed. These changes included the expansion of the Department of Health and Social Care Child Death Review dataset, the national templates used to collate information following a child death, the introduction of the Child Death Review Meeting and the implementation of local data management systems to coincide with the National Child Mortality Database.
207. The National Child Mortality Database is a repository of data relating to all child deaths in England. It enables more detailed analysis and interpretation of all data arising from the Child Death Review process, to ensure that lessons are learned following a child's death, that learning is widely shared, and that actions are taken, locally and nationally, to reduce child mortality.
208. Child Death Overview Panels submit copies of all completed forms associated with the Child Death Review process and the analysis of information about the deaths reviewed to the National Child Mortality Database.
209. The Cheshire and Merseyside Child Death Overview Panels now receive quarterly reports from the National Child Mortality Database reflecting the data that has been submitted by Child Death Overview Panels. The reports were introduced in 2019 and contain confidential information which is intended for use by the Child Death Overview Panel for monitoring and data quality purposes. The data is based on the information report at that time and is continuously updated each quarter. The information is used to inform learning events throughout the year based on themes coming out of the reviews.

Death of Neonates - North West Neonatal Operational Delivery Network

210. The deaths of neonates are reviewed by the North West Neonatal Operational Delivery Network. Place Teams and, more recently, the Local Maternity and Neonatal System,

receive details of these deaths. Representatives from the North West Neonatal Operational Delivery Network are also present at the Cheshire and Merseyside Maternity Serious Incident Panel where serious incidents are reviewed with actions and escalation agreed, as detailed in the Terms of Reference (**Exhibit GU/72**) INQ0012726 .

211. The North West Neonatal Operational Delivery Network highlight outliers at the ICB's Quality and Safety Surveillance Group and via regular reports to Local Maternity and Neonatal System Assurance Board.

Deaths of Neonates - Perinatal Mortality Review Tool

212. All deaths of neonates are reviewed using the Perinatal Mortality Review Tool by an external neonatologist from another NHS Trust which is part of the North West Neonatal Operational Delivery Network. The Perinatal Mortality Review Tool is a web-based tool that is designed to support a standardised review of care of perinatal deaths in neonatal units from 22+0 weeks gestation to 28 days after birth. It is also available to support the review of deaths where the baby dies in a neonatal unit after 28 days but has never left hospital following birth. It might also be used at a clinician's discretion for the review of deaths of live-born infants <22+0 weeks gestation. The Perinatal Mortality Review Tool is integrated with the national collection of perinatal mortality surveillance data. The Perinatal Mortality Review Tool broadly presents three types of 'questions':

- a. Notification of death details referred to as 'core demographics': These questions within the Perinatal Mortality Review Tool are designed to log the fact that there has been a death which requires review and enables a review to be started.
- b. Broadly factual questions: These questions largely relate to 'factual information' about the mother and her pregnancy. These include for example, further demographic details such as the mother's ethnic origin, employment, and main support in pregnancy. Other examples include pregnancy and medical history questions which come from the booking and antenatal information.
- c. The third type of questions support the review of the care and involve consideration of the care provided: They broadly ask the review group to consider whether the care provided was appropriate in the circumstances and whether it met existing national or local guidelines and standards, where these exist. These questions require the review group to make 'judgements' about the quality of care provided.

213. At the completion point of each review, the Perinatal Mortality Review Tool invites the review teams to consider the overall care provided and assign a grading care for the different stages of care. Categories used to grade the different aspects of care for each death are as follows:

- a. No issues with care identified.
- b. Care issues that would have made no difference to the outcome.
- c. Care issues which may have made a difference to the outcome.
- d. Care issues which were likely to have made a difference to the outcome.

214. Any cases graded 'd' would be reported as a serious incident, an investigation would be undertaken and a referral to the coroner would take place. Currently, not all reviews come to the Cheshire and Merseyside Maternity Serious Incident Panel at the ICB, as responsibility for oversight rests with the Specialised Commissioning Team within NHS England, which the North West Neonatal Operational Delivery Network reports directly to. NHS England has responsibility to oversee the Trust investigation of an incident and the implementation of associated learning/actions required. Please refer to paragraphs 246 - 248 regarding the Patient Safety Incident Response Framework.

215. The Local Maternity and Neonatal System is informed of all maternity and neonatal serious incidents uploaded onto StEIS, via the ICB's Central Patient Safety Team.

Effectiveness

216. I asked the Associate Directors for Quality and Safety Improvement for Cheshire West, Cheshire East, and Liverpool Place for their views on the effectiveness of the Child Death Overview Panel reflecting on current practice as well as processes in 2015-2016. Notable practice and lessons identified were highlighted and summarised below.

217. Notable practice included:

- a. There have been several initiatives and campaigns because of the findings from Child Death Overview Panels, including safer sleep and the wearing of seatbelts. The modifiable factors identified have fed into the Joint Strategic Needs Analysis. The Joint Strategic Needs Analysis describes the health, care and wellbeing needs of the population, identifying priorities for action to improve health and wellbeing and reduce health inequalities.

- b. Cheshire Child Death Overview Panel has responded to national guidance changes and have now established meetings with Welsh counterparts to discuss any deaths involving Welsh babies, given the bordering of some areas of Cheshire with Wales.
- c. One Cheshire Child Death Overview Panel across Cheshire East, Cheshire West, Halton, and Warrington works well as this facilitates identifying themes; there are small numbers of deaths for each Local Authority area.
- d. The National Child Mortality Database reports are becoming more detailed and enable themes to be reviewed at a national level.

218. Lessons identified and suggested recommendations to improve the Child Death Overview Panel's effectiveness from the Associate Directors for Quality and Safety Improvement for Cheshire West, Cheshire East, and Liverpool Place include:

- a. Changes to national guidance is required to harmonise multiple Child Death Review processes between England and Wales.
- b. Streamlining of the multiple processes for child deaths as some of these processes ordinarily take months, which delays the Child Death Overview Panel reviewing deaths in a timely manner as the Panels need concluded information. The multiple processes are:
 - i. Findings and conclusions from inquests.
 - ii. Findings from Perinatal Mortality Review Tool findings (Please see paragraphs 212 - 215 for more information).
 - iii. Findings from Specialist Neonatal Network Reviews, such as the North West Neonatal Operational Delivery Network before a review is convened at Child Death Overview Panels.
- c. Resilience around business support to Child Death Overview Panels.
- d. Review of the Independent Chair arrangements including considerations of tenure, independence, and consistency.
- e. Information Sharing Agreements for all partners in the Child Death Overview Panel.

National Policy Development

219. National policy developments have taken place since 2015 which have resulted in local policies, procedures and processes being updated in the ICB (and its predecessor CCGs). This includes:

- a. NHS England Freedom to Speak Up (2016)
- b. NHS England National Quality Board Learning from Deaths (2017)
- c. Healthcare Quality Improvement Partnership Perinatal Mortality Review Tool (2018)
- d. NHS England Medical Examiner (2019)
- e. NHS England Fit and Proper Persons Framework (2019)

National Guardian's Office for Freedom to Speak Up

220. The National Guardian's Office provides leadership, support, and guidance on speaking up in the NHS, and was set up in response to recommendations made in Sir Robert Francis' 'Freedom to Speak Up' review, published in February 2015. The office began its work in April 2016. This principally involves support, training, and guidance for a network of Freedom to Speak Up Guardians across the NHS, whose function is to provide independent support for workers to raise issues in the workplace. The office also undertakes reviews of the speaking up arrangements in NHS Trusts, including how individual cases have been handled, where it receives evidence that workers have not been appropriately supported to speak up. The National Guardian's Office is an operationally independent body funded by NHS England and the CQC.

221. Since 2016, NHS Trusts have been required by NHS England to establish a Freedom to Speak up Guardian role appropriate to local conditions. The role is to ensure that colleagues can speak up about anything that might affect the quality of staff experience or patient care. Reference to this was included in the NHS Standard Contract General Conditions from 2017.

222. In July 2020, NHS England published a tool for NHS Trusts to support Trust Boards to analyse their ability to meet the expectations of NHS England and the National Guardian's Office for Freedom to Speak Up. This planning and reflection tool was refreshed in June 2022 when the Freedom to Speak Up guide for NHS organisations was updated. This guide describes what a "Guardian Report to Trust Boards" should

include. Organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

223. Within Contract Quality and Performance Meetings between the ICB and Trusts, there is the opportunity to seek evidence of Freedom to Speak Up policies and practice within organisations, through the sharing of Board level reports.

Learning from Deaths

224. Please see paragraphs 27 - 28 above.

Medical Examiners

225. Medical examiners provide independent scrutiny of the causes of death in cases not investigated by a coroner. The process gives the bereaved a voice by asking them whether they have questions or concerns about the care of a patient before they died.
226. The Medical Examiner system was introduced to Acute Trusts in 2019. The system was extended to include medical examiner scrutiny of non-coronial deaths across all non-acute sectors (e.g., deaths in the community) from 2021/2022, so that all non-coronial deaths are scrutinised by the end of March 2022.
227. The Medical Examiners (England) Regulations 2024 have been drafted setting out how the statutory medical examiner system will operate in the NHS in England from April 2024.
228. Regional medical examiners support Trusts on matters such as geographical boundaries, networks and how best to work incrementally towards a comprehensive medical examiner system.
229. Medical examiner offices work with General Practices and Medical Directors at specialist, mental health, and community Trusts to plan the facilitation of medical examiner scrutiny of deaths of their patients. Each organisation works with one established Medical Examiner Office.
230. ICBs, and previously CCGs, facilitate partnership working across systems and respond positively to requests for support from local and regional medical examiners.

231. The ICB cannot comment on the effectiveness of the Medical Examiner system as this is a Trust-led process.

Fit and Proper Person Test

232. NHS England has a specific role in appointing and supporting chairs and non-executive directors of NHS Trusts and chairs of ICBs. This includes a duty to ensure that the individuals they appoint comply with the Nolan Principles of Public Life and meet the fit and proper persons requirements. The Nolan Principles of Public Life are:

- a. Selflessness - act solely in terms of the public interest.
- b. Integrity - must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work; should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends; must declare and resolve any interests and relationships.
- c. Objectivity - act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
- d. Accountability - accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
- e. Openness - act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
- f. Honesty – should be truthful.
- g. Leadership - should exhibit these principles in their own behaviour and treat others with respect and should actively promote and robustly support the principles and challenge poor behaviour wherever it occurs.

233. NHS England has developed a Fit and Proper Person Test Framework in response to recommendations made by Tom Kark KC in his 2019 review of Fit and Proper Person Test, the Kark Review. This also takes into account the requirements of the CQC in relation to directors being fit and proper for their roles.

234. The aim of the framework is to provide evidence that appropriate systems and processes are in place to ensure that all new and existing chairs and non-executive directors are, and continue to be, fit for purpose and that none of the criteria of 'unfitness' set out in the regulations apply.

235. In line with NHS England Fit and Proper Person Test Framework, the ICB undertakes this for Board and Non-Executive positions, as detailed in the ICB's Fit and Proper Persons Policy (**Exhibit GU/73**) **INQ0012727** .

Learning and Improving – Maternity

236. As commissioner for maternity services, the ICB is committed to continually learning and improving, including the implementation of actions and new initiatives addressed through the national review of maternity services in 2016, Better Births.

Joint Forward Plan

237. As mentioned in Cheshire and Merseyside Joint Forward Plan 2023-2028, (**Exhibit GU/74**) **INQ0012728** the following priorities were identified:

- a. Maternity - Reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury.
- b. Maternity – Increase fill rates against funded establishment for maternity staff.
- c. Maternity and neonatal services.
- d. Maternity – local equity action plan.
- e. Women's Health.
- f. Gynaecology Network.

238. The Joint Forward Plan highlighted that, as a Local Maternity and Neonatal System, the current metrics show that Cheshire and Merseyside are below (better than) the trajectory for all safety outcomes: stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury. Similarly, the December 2022 preterm birth rate for the largest maternity provider in Cheshire and Merseyside was 4.1% - this is half the 2017 national rate and lower than the 'Maternity Safety Ambition' threshold for 6%. To continue the progress made on the Maternity Safety Ambition, the Local Maternity and Neonatal System will continue to:

- a. Monitor and have oversight of the safety ambition trajectories and outlier status of providers.
- b. Support Trusts in delivery of the Clinical Negligence Scheme for Trusts and Maternity Incentive Scheme actions.

- c. Work with the North West Maternal Medicine Network to develop the Cheshire and Merseyside Maternal Medicine Centre at Liverpool Women's Hospital (part of Liverpool Women's NHS Foundation Trust), improve training around recognition of the seriously ill woman and streamline pathways for access to the appropriate care via Multi-Disciplinary Team working.
- d. Support providers in delivering effective Preterm Birth clinics via the Cheshire and Merseyside Preterm Birth network.
- e. Work closely with the North West Neonatal Operational Delivery Network to progress the safety ambition to reduce serious intrapartum brain injury and deliver on British Association of Perinatal Medicine optimisation.
- f. Work with our business intelligence partners to achieve good data to evidence improved outcomes.
- g. Be responsive to emerging themes from the new Patient Safety Incident Response Framework (see paragraphs 246 - 248), the Cheshire and Merseyside maternity single serious incident Panel, complaints, and feedback. Maternity triage will be a key area of quality improvement focus for the ICB with the aim of reducing the risk of mothers and babies and deliver system level change.
- h. Have real-time oversight of emerging threats through the Birth-rate Plus (BR+) acuity tool and continue mutual aid support via an electronic Situation Report data tool.
- i. The Local Maternity and Neonatal System have oversight and a leadership role in disseminating and auditing the lessons identified from Ockenden, East Kent (Kirkup) and other emergent reports. This includes supporting and oversight of the national Maternity Incentive Scheme linked to the Clinical Negligence Scheme for Trusts, whereby Trusts can recover the element of their contributions for meeting 10 key safety action requirements. The Maternity Incentive Scheme is self-certified, but scheme submissions require sign-off by the Trust Board and the ICB.
- j. Act upon the national single delivery plan combining Ockenden and East Kent reports which the Local Maternity and Neonatal System are leading.
- k. Listening to women and families is a key recommendation from both the Ockenden and East Kent reports. The Local Maternity and Neonatal System will be working with the Maternity Voices Partnership Chairs and Independent Senior Advocate role to ensure the experiences of women and families improve and that this is evidenced by an improvement in the CQC survey.

239. The Joint Forward Plan confirms that the ICB will continue to deliver the actions from the Ockenden report and NHS England's related letter dated 1 April 2022, referencing four key pillars:

- a. Safe staffing levels
- b. A well-trained workforce
- c. Learning from incidents
- d. Listening to families

Personalised Care and Support Plan

240. NHS England and NHS Improvement's Personalised Care and Support Planning guidance for local maternity systems dated March 2021 identifies criteria to define Personalised Care Planning and sets out what the requirement is for Local Maternity and Neonatal System to ensure personalised care planning is embedded into service delivery. The guidance recommends that Local Maternity Systems / Local Maternity and Neonatal Systems undertake an annual assessment of the quality of personalised care planning to determine whether they meet the five technical criteria and identify where personal care and support planning can be improved.

241. The personalised care work that is ongoing within Cheshire and Merseyside includes:

- a. Ensuring maternity providers can collate and share data from the Maternity Service Data Set relating to the number of antenatal Personalised Care and Support Plan fields, which are required by the Maternity Incentive Scheme (year 4 >95% completed for women booked in the month).
- b. The Local Maternity and Neonatal System working with providers and service users to ensure that every woman is offered a Personalised Care and Support Plan in line with NHS England and NHS Improvement's Personalised Care and Support Planning guidance for local maternity systems dated March 2021 and Equity plans.
- c. Ensuring the Personalised Care components of the Core Competency framework are embedded into the Training Needs Assessment in line with Ockenden recommendations.
- d. Developing a Personalised Care and Support Plan strategy for Cheshire and Merseyside which informs best practice across all providers.

- e. Undertaking a survey of women's experiences of the delivery and quality of personalised care using the National Collaborate Tool.

Workforce

242. Wider work which is underway in Cheshire and Merseyside to support the maternity workforce challenges include:

- a. Review staffing establishment workforce tools – to examine validity, reliability, and useability as well as sustainability within Cheshire and Merseyside. This focuses on the Ockenden recommendations and immediate and essential actions to review the feasibility and accuracy of Birth-rate Plus tool and associated methodology, within Cheshire and Merseyside:
 - i. all providers have an up-to-date Birth-rate Plus workforce report.
 - ii. all 7 providers declared compliance against Maternity Incentive Scheme year 4, safety action 5 related to midwifery staffing.

We are working with the national Midwifery Continuity of Care lead to pilot the newly updated NHS England's Workforce planning and resource management workforce tool as a system.

- b. Maximising nursing in Midwifery – to scope what is required to gain full advantage of nursing capacity within maternity services, ensuring their specific roles are fully understood and enabled within the maternity workforce.
- c. Refreshed National Maternity Transformation delivery plan – The current plan seeks to achieve the vision set out in the National Maternity Review's report from 2016, Better Births by bringing together a wide range of organisations to lead on and deliver across several workstreams. This plan is currently being updated in line with Ockenden recommendations. Within Cheshire and Merseyside, we have supported Midwifery Continuity of Care to provide staff alternative working patterns, supporting with advanced roles within maternity services.
- d. NHS England's health and social care workforce plan – NHS England is reviewing the long term needs for the health and social care workforce. Within Cheshire and Merseyside, we have developed innovative non-clinical roles to support the delivery of direct midwifery care, ensuring midwives are freed up to provide care that can only be delivered by a midwife.
- e. Maternity Culture and Leadership - a national 18-month programme has been implemented to support maternity leaders to deliver a high-class maternity service. Within Cheshire and Merseyside, we have developed a bespoke aspiring midwifery talent programme for aspiring Heads/Directors of Midwifery and

midwifery leaders, supporting succession planning and talent management within Cheshire and Merseyside.

- f. Establishing Independent Senior Advocate roles – Cheshire and Merseyside are presently recruiting an Independent Senior Advocate role. This role will support both families and providers to support leadership when maternity care is sub-optimal, highlighting to Executive Boards when issues have occurred, and supporting the Local Maternity and Neonatal System to address this.

243. The Local Maternity and Neonatal System have developed a workforce collaborative to implement the national initiatives as outlined. Our aim is to review how we as a system, recruit, retain, deploy, develop, and continue to support our maternity workforce, ensuring we develop talent and support aspiring leaders within maternity services. We now have access to a bi-monthly workforce report, and this coupled with intelligence from our clinical front-line staff via surveys and via midwifery leaders. This allows us to address the workforce gaps and provide solutions to areas of concern, which include high vacancy rates within some providers, increasing sickness rates sighting mental health concerns as reasons for absence, increased leavers within early career midwives, increased retirement requests post 55 age group, direct concerns from Heads/Directors of Midwifery including a reduction in pre-registration places, lack of development of Maternity Support Worker workforce, inability to recruit experienced midwives, and issues with flexible working. Our collaborative workstreams are:

- a. Pre-registration capacity – including Registered Nurse/Registered Midwife conversion.
- b. International Recruitment including Cheshire and Merseyside standardised recruitment programme.
- c. Return to Practice
- d. Recruitment and retention (Pastoral care)
- e. Cheshire and Merseyside Band 5 standardised preceptorship Programme
- f. Advanced Clinical Practice (Midwifery)
- g. Maternity Support Worker workforce (Implementation of Maternity Support Worker Framework)

244. Additionally, there has been the establishment of Perinatal Safety and Surveillance Framework and the Quality, Safety and Surveillance Safeguarding Group, along with ongoing work to ensure closer working relations through the North West Neonatal Operational Delivery Network with neonatal departments within Trusts and Local

Maternity and Neonatal System provide greater assurance and oversight. Please see paragraphs 29 - 40 for more detail.

245. The ICB acknowledges the need to strengthen governance relating to neonatal services and is working with its local partners to identify gaps in governance and develop local processes to support this. This has been iterative in nature since the creation of the ICB in July 2022.

Patient Safety Incident Response Framework

246. Providers across Cheshire and Merseyside are introducing the Patient Safety Incident Response Framework which will replace the current Serious Incident Framework (2015). It is anticipated that its roll out will be completed by April 2024. NHS England published *Recording responses to patient safety incidents during the transition to Learn from Patient Safety Event and Patient Safety Incident Response Framework* on 15 August 2023.
247. During this transition period, once a provider has moved to working under the Patient Safety Incident Response Framework, they are asked to use StEIS to record incidents that are subject to a Patient Safety Incident Investigation. A new incident type has been added to StEIS that allows organisations to record incidents which are responded to using a Patient Safety Incident Investigation.
248. The Patient Safety Incident Response Framework sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The Patient Safety Incident Response Framework is a contractual requirement under the NHS Standard Contract and, as such, is mandatory for services provided under that contract, including acute, ambulance, mental health, and community healthcare providers. This includes maternity and all specialised services.

Interoperable Maternity Records

249. The National Maternity Review's report from 2016, Better Births recommended that NHS England and the National Information Board support the national roll out of interoperable maternity records for professional use, combined with support for a digital tool (or

personal health record) for women as an urgent priority. The Standard Maternity Record data set now includes the ability to record "Previous Pregnancy Congenital abnormality", "Stillbirth" or "Neonatal death" in the Clinical Risk Factors section, and in the Family History section: "Family History: Sudden Infant Deaths", "Stillbirth" or, "Multiple Miscarriages".

250. The national information standard provides for local implementation of this maternity record within maternity services and supplier systems, to enable the future exchange of information between maternity providers. This will ensure that both health and care professionals and maternity service users have the necessary information in the right place at the right time, to improve the quality and safety of maternity care.
251. The standard will also support maternity service users by enabling more personalised care, as well as helping midwives and clinicians to provide holistic care. The ICB expects providers to comply with all national standards for information, and this is captured within the NHS Standard Contract that all providers sign up to annually. Compliance with the contract is monitored and managed via contract governance (Contract Review Boards and subgroups such as Clinical Quality and Performance, Finance and Activity Groups, and Information Subgroups).
252. The North West Neonatal Operational Delivery Network has produced a briefing note for Trusts along with the offer of psychological therapies and support. The Local Maternity and Neonatal System have tried to use this as an opportunity to strengthen the neonatal element of the Local Maternity and Neonatal System and are working with all Local Maternity and Neonatal Systems in the North West and the North West Neonatal Operational Delivery Network to strengthen governance, oversight, assurance and support for Neonatal services, workforce, and families.
253. The ICB's Private Board on 28 September 2023 focussed on learning lessons. The ICB's Executive Director of Nursing and Care and Deputy Director of Nursing and Care presented to the Private Board on the system wide response to managing quality and safety in Cheshire and Merseyside. (**Exhibit GU/75**) INQ0012730

Reflection

254. We continue to work closely with colleagues at CoCH to support the day-to-day delivery of safe and effective care through peer support and the commissioning of the Deloitte LLP report as mentioned at paragraph 153. CoCH's maternity services is part of the National Maternity Safety Support Programme which aims to help maternity services achieve sustained improvement across the five CQC domains. The CoCH neonatal services remain with the North West Neonatal Operational Delivery Network, but both maternity and neonatal services at CoCH have continued support from the Local Maternity and Neonatal System. However, regularly monthly meetings had to be paused at the request of the NHS England's Chief Midwife, whilst the Maternity Safety Support Programme is underway. The Local Maternity and Neonatal System have supported CoCH with NHS England's "Saving babies' lives: version 3, a care bundle for reducing perinatal mortality" published June 2023 and Maternity Gold Command meetings during this time. CoCH are working towards leaving the Maternity Safety Support Programme in February 2024, when the regular monthly meetings will be reinstated.
255. Whilst the ICB is working with partners to manage risks in relation to current commissioning arrangements of neonatal services, we would suggest that a review is needed in ensuring greater clarity of roles and responsibilities for oversight, alongside streamlining of those roles and responsibilities.
256. Policies, processes, and structures should be designed to support all staff to report any suspected patient harm and criminal activity. All Trusts should have robust whistleblowing, freedom to speak up and serious incident processes aligned with national guidance, which allow staff to raise concerns, have their concerns heard and acted upon. Issues such as reputation, behaviours and rumours may impact on staff confidence, but Trade Unions and Professional Bodies are experienced in representing their members in such matters.
257. There are a variety of factors relating to culture that are measurable; previous recommendations focus on openness, a duty of candour and raising concerns. I believe the Trusts across Cheshire and Merseyside have taken appropriate measures to implement these recommendations, which are tangible and generally supported by appropriate internal Trust policies and governance. The wider issues which impact on culture; behaviours, attitudes, bureaucracy, and trust, are much harder to measure and implement.

258. All managers are bound by the Nolan Principles (Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty, and Leadership) and professional codes of conduct, if appropriate. All managers are subject to annual appraisal and usually wider evaluation through tools such as 360° Review. However, in the absence of a national register and agreed standards, measures of acceptable behaviour and agreed competencies, it is difficult to implement a consistent approach and hold people to account. It is the view of the ICB that it is the responsibility of the employing organisation rather than a professional body to obtain and ensure assurance of compliance with standards and expectations.
259. For clinicians, there are defined processes and procedures for dealing with concerns regarding conduct and competence. However, for managers and members of Boards there is not. There is no clear process for staff to escalate concerns if they do not have confidence in the Executive Team or the HR processes for dealing with internal conduct issues. In NHS Foundation Trusts, this should be via the Governing Body, but it is rare this would happen. Most whistle-blowers or service users would report to the CQC. It is the ICB's view that the NHS Foundation Trust constitution makes it very difficult for ICB's to have any real traction on managing conduct issues within individual organisations.
260. All maternity services in Cheshire and Merseyside are in the NHS England's Culture and Leadership programme and will be undertaking the SCORE (safety culture) survey. This is an NHS England Culture and Leadership programme which focuses on supporting and providing opportunities for organisations to understand their own culture using evidence-based tools, develop tailored leadership strategies for developing compassionate, inclusive, and collective leadership and deliver culture change. It is designed for the Heads of Midwifery / Directors of Midwifery / Clinical Directors / Business Managers / Neonatal Leads.
261. Mapping of compliance with the Ockenden Immediate and essential actions has been undertaken and the Local Maternity and Neonatal System continues to work with the providers to reduce variation in care and embed the safety culture via clinical networks, Heads of Midwifery Group, and an operational group for service clinical leads. Culture and demands on workforce have not helped to address these issues. Reviews and inquiries have placed an additional burden for data, evidence, returns, compliance which can detract from high quality care due to staff burn out and fear of reprisals. Lack of opportunity for transformation, Quality Improvement work and financial constraints all make this a difficult space to implement significant improvements. We need to rebuild

trust and relationships with staff, patients, and families. If clinicians and families would have had an avenue outside of the Trust to raise concerns i.e., via the North West Neonatal Operational Delivery Network, concerns may have been heard sooner and investigated appropriately. As mentioned in paragraph 238, the Local Maternity and Neonatal System have an oversight and leadership role in disseminating and auditing the lessons identified from Ockenden, East Kent and other emergent reports.

262. Staff with a professional body would also be held to account by their respective organisation (Nursing and Midwifery Council / General Medical Council / Accountancy organisation / Chartered Institute of Personnel and Development), albeit that any intervention would usually be triggered by a formal referral. Professional bodies should have a range of processes to address concerns raised about registered professionals i.e., General Medical Council or Nursing and Midwifery Council Fitness to Practise process. The referral to a professional body can be made by an employer, members of the public or following a police / criminal investigation, and the professional body can remove the individual from the register if there is a case found against them or if it is felt that the individual is bringing the profession into dispute, or they can place restrictions or conditions on their practice.

263. The ICB aims to continuously improve, and update plans and procedures based on learning from incidents and, in doing so, recognise that there is always scope for further development. The ICB welcomes the recommendations from the Inquiry in this regard.

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

Graham Urwin
Chief Executive
NHS Cheshire and Merseyside

Dated: 14 February 2024