

Witness Name: Eleri Adams

Statement No.: 1

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Dated: 7th March 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR ELERI ADAMS

I, Dr Eleri Adams, will say as follows: -

Background

Local / Regional Roles

1. I am a Consultant Neonatologist, FRCPCH, GMC No **I&S** CCT Paediatrics (Neonatal Critical Care). I have worked at Oxford University Hospitals as a Consultant Neonatologist since 2002 and I am an Honorary Senior Clinical Lecturer at the University of Oxford. I also lead the regional neonatal transport service for Thames Valley and Wessex (named SOnET). These three roles together take up approximately two thirds of a full-time role.
2. I was previously Clinical Lead for Neonatology (2008-2019) and Clinical Lead for Paediatric Critical Care (2015-2019) at Oxford University Hospitals and was Clinical Lead for the Thames Valley Neonatal Network (2005-2019). I left these clinical leadership roles to take up a national leadership role in 2019.

National Roles

3. My main national role is as National Clinical Lead for Neonatology, Getting it Right First Time ("GIRFT") NHS England, since March 2019. This role had been advertised nationally and I was appointed by a competitive process, having been interviewed by a panel of experts from relevant national bodies. I report to Professor Tim Briggs CBE, who is the Chair of GIRFT and NHS England National Director for Clinical

Improvement and Elective Recovery. I am employed in this role by NHS England and this work takes up approximately a third of a full-time role.

4. I am a member of the Neonatal Clinical Reference Group which is an advisory group to NHS England regarding policy matters, and I am on the Neonatal Implementation Board which supports implementation of the National Neonatal Critical Care Review ("NCCR"). These are NHS England roles, which I undertake in my role as GIRFT lead.
5. I am the outgoing chair of the Neonatal Critical Care Expert Working Group for the National Casemix Office (2017-2024) which also leads the national pricing work for Neonatology. This is an NHS England role.
6. Since September 2022, I have been President of the British Association of Perinatal Medicine (BAPM). I was voted into this role, which is a voluntary position and no specific working time is set aside for this role.
7. The detail of this statement is limited to my role as National Specialty Lead, Neonatology GIRFT, NHS England.

Key Terms / Definitions

8. The following key terms, covering general NHS matters are not intended to be a comprehensive explanation, but merely to assist the reader in their understanding of some of the terms used in this witness statement. I understand that further detail in relation to most these areas will be provided by other colleagues at NHS England:
 - a) **NHS England:** leads the National Health Service (NHS) in England. It is an Executive Non-Departmental Public Body sponsored by the Department of Health and Social Care. It is called an Arm's Length Body as it is a public body established with autonomy from the Secretary of State. It was established on 1 October 2012 and is operationally distinct from the Department of Health and Social Care. It is responsible for determining how to operationalise the Department of Health and Social Care's policies to ensure effective delivery and also for evaluation of their impact.
 - b) **NHS Improvement:** was created in 2016 and included the National Patient Safety Team, and was one of the organisations responsible for regulation of Foundation Trusts and performance management of NHS Trusts. It was abolished in 2022 and its functions were transferred to NHS England.
 - c) **NHS Long Term Plan:** The NHS Long Term Plan was published in January 2019 and was aimed at ensuring that the NHS can move forwards as medicine

advances, health needs change, and society develops, to that the service remains fit for the future in 10 years' time.

- d) **Trust:** patients in England receive their services from “providers” who have an arrangement to deliver these services. Providers employ their own staff, procure their own supplies and oversee the day to day running of the services at the point of patient care and are responsible for the day-to-day care and management of patients. NHS Trusts and NHS Foundation Trusts are the two types of providers of NHS secondary care, i.e., in a hospital setting in England.

9. The following key terms are used frequently throughout this statement. Although each are discussed in more detail elsewhere, by way of background to assist the reader:

- a) **British Association of Perinatal Medicine (BAPM):** is a charitable organisation that works to improve standards by supporting all those involved in perinatal care to optimise their skills and knowledge, deliver and share high quality safe and innovative practice, undertake research, and promote the needs of babies and their families.
- b) **Getting it Right First Time (GIRFT):** is an NHS England improvement programme delivered in partnership with the Royal National Orthopaedic Hospital NHS Trust. GIRFT is designed to improve the quality of care within the NHS by reducing unwarranted variations.
- c) **Neonatal Critical Care Review (“NCCR”):** was a national report commissioned by NHS England as a dedicated review of neonatal services and led to the publication of a report: “Implementing the Recommendations of the Neonatal Critical Care Transformation Review” in 2019.
- d) **Operational Delivery Networks (ODNs):** are a managed network of neonatal providers focused on coordinating patient pathways between neonatal units over a wide area to ensure access to specialist resources and expertise.
- e) Types of Neonatal Units:
 - i. **Neonatal Intensive Care Units (NICUs):** provide intensive care (highest level of care) for the smallest and sickest babies from across the whole region, in addition to high dependency (medium level of care), special care (lowest level of care) and transitional care (lowest level of care provided alongside the mother) for their local population.
 - ii. **Local Neonatal Units (LNUs),** which provide short-term intensive care (1-2 days); and high dependency, special care and transitional care for

their local populations. LNUs would not be expected to provide ongoing intensive care beyond initial stabilisation to babies less than 27+0 weeks gestation or birth weight <800g or any baby requiring more complex intensive care.

- iii. **Special Care Units (SCUs)**, which provide special care and transitional care for babies in the local area who do not need intensive care. SCUs would not be expected to provide ongoing care beyond stabilisation to babies less than 32 weeks gestation or birth weight <1000g, or any baby requiring intensive care beyond initial stabilisation.

Getting it Right First Time (“GIRFT”) - Overview

- 10. GIRFT is a national programme designed to improve the treatment and care of patients in England through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change. The programme was first conceived and developed by Professor Tim Briggs to review elective orthopaedic surgery to address a range of observed and undesirable variations in orthopaedics.
- 11. NHS Improvement then facilitated the expansion and development of this concept into a national programme, GIRFT. GIRFT has been applied across over 40 surgical and medical specialties and other themes, known as “workstreams”. It seeks to tackle variations in the way services are delivered across the NHS. By sharing best practice between Trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies, such as the reduction of unnecessary procedures, and cost savings. Each workstream is led by a nationally recognised clinician.
- 12. GIRFT works in partnership with Trusts, specialist clinical professional bodies (Royal Colleges and societies), and its partner NHS organisations in collating, scrutinising and sharing data, highlighting both underperformance and excellence. This evidence has had a major impact in identifying variation in clinical outcomes and has provided the focus for hospital teams, departments and clinical networks to tackle unwarranted variation, where it exists, through benchmarking and adopting best practice.
- 13. The following terminology is used in relation to GIRFT processes:
 - a) **Specialty Review**: a Specialty Review involves a local data pack being produced detailing the Trust’s performance data across that specialty, followed by “deep-dive” meetings with Trusts.

- b) **Deep-Dive visits:** Deep-Dive visits are meetings with a Trust's medical staff and senior Trust managers. At each Deep-Dive meeting, the GIRFT clinical leads review the findings from the data analysis and discuss with the Trust's representatives at the meeting, which provides more context to unwarranted variations and opens up a discussion around individual practice and any challenges the Trust faces. It is also an opportunity to share best practice and any solutions that have already helped to reduce variations.
 - c) **National Report:** Once a number of Trust reviews have been completed, the clinical lead oversees the creation of a GIRFT national report for their specialty. The National Report presents the original data, GIRFT's findings, examples of best practice and recommendations for proposed changes and improvements to be delivered at both a national and local level.
14. I explain the GIRFT methodology in more detail below, but I will provide an overview here. One of the first steps is the collation of relevant clinical data, which is then scrutinised by the clinical lead in the development of data packs. These are then shared with the relevant Trust and network in advance of a meeting, in which the GIRFT lead and the local Trust or network representatives collaborate in the Deep-Dive visit. In my experience, by using the data as a starting point, and having a proper and open discussion about what can be seen from the data and why it looks like that, as well as talking about the service more generally, we are able to get to the bottom of some issues and to unearth things that are not evident in the data alone. I find that this is the value of the Deep-Dive visits, as they pick up both known and unknown issues. Trust response to these issues, as well as areas of good practice are discussed and then set out in an action plan with specific actions suggested.

Neonatal Critical Care Review (NCCR) – Purpose of GIRFT Neonatology

15. The NCCR is important background and context to the purpose of GIRFT Neonatology. The NCCR was commissioned by NHS England in response to the Better Births report of 2016, which focussed on improving the outcomes of maternity services in England.
16. The NCCR was carried out by the Neonatal Clinical Reference Group of which I was member. To put the Neonatal Clinical Reference Group into context, specialised services commissioned by NHS England are grouped into six national programmes of care. Clinical Reference Groups are groups of clinicians, commissioners, public health experts, patients and carers who advise the national programmes of care on how specialised services should be provided. The Neonatal Clinical Reference Group

is one of the 15 CRGs which sit within the Women and Children national programme of care.

17. "Implementing the Recommendations of the Neonatal Critical Care Transformation Review" was published by NHS England and NHS Improvement in December 2019 **[Exhibit EA/0001 [INQ0012352]]**.
18. The NCCR was based on national data stream sources and recommendations, plus high-level meetings with clinicians about what actions were needed, based on the findings. The NCCR was therefore not specifically focused on provider level issues, but some findings were relevant at a provider level. For example:
 - a) It provided some information on cot capacity which showed that there was not enough capacity, but it did not highlight where capacity was needed.
 - b) It recognised that units should be doing a certain amount of activity, but it did not provide insight about whether each unit was delivering that activity.
 - c) It highlighted capacity and patient flow issues at a general level.
 - d) It highlighted issues with facilities for families and how well supported they were.
 - e) It highlighted workforce gaps at a national level.
19. As a result of these findings, funding was granted under the NHS long term plan for improvements to cot capacity, staffing (nursing, medical and Allied Healthcare Professionals) and the development of parent involvement in care. The intention was for a Specialty Review under GIRFT to give more granular detail on where the issues were in each of those areas. "Implementing the Recommendations of the Neonatal Critical Care Transformation Review" set out the role of GIRFT Neonatology in supporting the implementation of NCCR as follows:
 - a) "Questionnaires: The GIRFT team have sent out questionnaires for neonatal networks, transport services and neonatal units which were completed and returned by the end September 2019. These questionnaires will support key areas of work required by networks for the national review. Questionnaires were sent out via the ODNs. A key priority for Neonatal ODNs will be to ensure 100% returns and to validate the data. Providers have ownership of their own GIRFT action plans keeping ODNs informed of progress".
 - b) "Visits: GIRFT is developing data packs for use at both network and individual Trust level. The network data packs will have detailed information on workflow and capacity, in addition to information on workforce and parental support. It

will also contain key clinical benchmarking data. GIRFT network Deep-Dive visits will take place between January and March 2020. ODNs will have an important role in determining the structure and attendance for the visits (e.g., whole ODN or individual clinical networks done separately in 2 or more visits or sessions). Attendance will include the full ODN management team, key neonatal and maternity clinical and managerial staff from each Trust, network transport service representatives, senior specialist commissioning team and LMS representatives, regional directors and medical directors. Actions arising out of the GIRFT network Deep-Dive visits will inform further iterations of the ODN Implementation Plans. GIRFT findings following the neonatal network Deep-Dive visits will be shared with the Neonatal Implementation Board and included in the GIRFT national report which will be published following completion of the individual Trust GIRFT visits”.

20. The GIRFT neonatology Specialty Review was therefore commissioned by NHS England in 2019 as one of the specialty GIRFT workstreams and was designed to use GIRFT methodology to add to what was known from NCCR, look at some of the areas in more depth and look at new areas for development in order to assist the implementation of the NCCR action plan and to provide further understanding and support to the key challenges facing neonatology. The scope of the neonatology Specialty Review was wide-ranging to include data required to support networks and Trusts with the action plans needed for the NCCR, as well as exploring possible new areas for action. For example, the NCCR recommended that neonatal networks and services should produce a gap analysis of medical and nurse staffing, and that workforce transformation was needed, with greater recognition of allied health professional roles. GIRFT therefore provided detailed benchmarking data against national standards for medical, nursing and AHP workforce as well as a snapshot survey of neonatal services and workforce done in conjunction with Royal College of Paediatrics and Child Health.
21. The Neonatology Implementation Board (NIB) is a workstream of the Maternity Transformation Programme (now called the Maternity and Neonatal Programme). The NIB is responsible for overseeing the actions from NCCR and has responsibility for allocating the funding to improve targets. As GIRFT lead, I sit on the Neonatology Implementation Board and report my findings, including advising when new problems arise and any potential funding issues. The Maternity and Neonatal Programme has overarching responsibility for all workstreams within the programme. I sit on the Maternity and Neonatal Programme Board as part of my BAPM role.

GIRFT Neonatology

My Role and Team

22. I was appointed as Neonatology Clinical Lead in March 2019. I was the first person appointed to this role, as neonatology was a new workstream for the programme.
23. I see GIRFT Neonatology as a vehicle for supporting quality improvement in local hospitals, as well as making improvements at a national level. As I have described above, it does that through in-depth visits with benchmarking data, not all of which is available elsewhere. The GIRFT data pack pools this information into a resource that tells a story which supports a structured approach to the deep-dive visit. The actions GIRFT suggests during the deep-dive visit are designed to support change and improvement.
24. In order to support me in my role, the GIRFT programme has a variety of support functions and resources. There is a central team of data analysts and PAs who support the development of data packs. There is a project manager who works with me to support and facilitate my work, plus project officers who support me on Deep-Dive visits and the follow-up tasks. The project manager and project officer are not specific to Neonatology GIRFT alone, as they also have responsibilities in other GIRFT work streams. However, I nearly always work with the same project manager and project officer and although they are not clinical, they have built up a lot of knowledge and understanding in neonatology and are an invaluable resource for me.
25. There are also policy leads who help to write reports or guidelines, and I have discussions with clinicians across the country, including members of the Neonatology Clinical Reference Group (see paragraph 16 above) and neonatal operational delivery network managers and clinical leads. I also appointed a nursing advisor (Ms Kelly Harvey) and an allied health professional advisor (Ms Michelle Sweeting) for a 12-month period in 2020/21 to provide a full multidisciplinary view, including development of the national reports and recommendations.

GIRFT Neonatology work with other organisations

26. A large part of my role is working with other organisations in the field of neonatology. GIRFT neonatology has worked with a large number of professional organisations to improve neonatal care. These include:
 - a) The Royal College of Paediatrics and Child Health to produce a neonatal services and workforce report: "A snapshot of neonatal services and workforce in the UK" [Exhibit EA/0002 [INQ0012416]] in September 2020. As GIRFT

lead, I led the work with the Royal College of Paediatrics and Child Health to produce this report. It was published as a Royal College of Paediatrics and Child Health report, but written by me as GIRFT lead, and supported by GIRFT's work.

- b) British Association of Perinatal Medicine (BAPM) to produce a Framework for Practise for babies presenting with Bilious Vomiting. This was a recommended action from the GIRFT National Report and I requested that BAPM work on this as a result. I provided BAPM with all the background data to support the need for a pathway review to assist them in writing the BAPM document. A draft was published in August 2023 **[Exhibit EA/0003 [INQ0012370]]**, which was finalised in February 2024¹.
- c) British Association of Perinatal Medicine (BAPM) to produce a Framework on Pulse Oximetry. Universal access to pulse oximetry screening was also a recommended action from the GIRFT national report to reduce regional and racial inequity in detection of critical congenital heart disease. I have worked with other colleagues within NHS England to get agreement for NHS England to commission BAPM to develop a Framework of Practise on this topic. A working group has been set up in January 2024, of which I am a member as GIRFT neonatology lead, and the terms of reference have been outlined for this work to take place in 2024 **[Exhibit EA/0004 [INQ0012387]]**.
- d) Royal College of Nursing and Neonatal Nursing Association to support Health Education England to develop new career pathway frameworks for neonatology. The GIRFT nursing advisor drew up some suggested career pathway flows, using GIRFT's findings and worked with Royal College of Nursing, Neonatal Nursing Association and Health Education England in order for Health Education England to develop the career pathway framework. This work is currently paused due to merger of Health Education England into NHS England to form NHS England Workforce, Training and Education.
- e) Specialist Allied Health Professional organisations including Association of Chartered Physiotherapists, (APCP), Royal College of Occupational therapists (RCOT), Royal College of Speech and Language Therapists (RCSLT), and British Dietetic Association (BTA) to support Health Education England work to develop training resources to support new career pathway frameworks for

¹ Final version, February 2024: https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/2422/Bilious_Vomiting_Framework_Feb_2024.pdf

Allied Health Professionals working in neonatal care. Good Practice and Case Study guides [Exhibit EA/0005 [INQ0012356], Exhibit EA/0006 [INQ0012357] and training modules for neonatal Allied Health Professionals which were added to the e-Learning for Healthcare platform were led and produced by Health Education England, but were initiated and supported by GIRFT.

- f) British Psychological Society to develop standards for neonatal psychological support and to improve mental health support to families of babies receiving neonatal care. I asked key individuals within British Psychological Society to write standards for psychological support, and also co-ordinated meetings between network psychologists and community maternity mental health teams to look at how to provide links and pathways between the teams. Once I had made these links and progress started, the network psychology leads and maternity mental health teams continued this work.
- g) National Paediatric Pharmacy Group on several drug safety issues, including developing national standardised infusions for babies under 2kg. I initiated a BAPM drug safety group (under my BAPM role, but also to support GIRFT) which meets jointly with National Paediatric Pharmacy Group to take forward several drug safety issues, which are then implemented through either BAPM, National Paediatric Pharmacy Group, NHS England via Chief Paediatric Pharmacist, Medicines and Healthcare products Regulatory Agency (MHRA) and /or the Joint Medicines Committee, Royal College of Paediatrics and Child Health, depending on which organisation needs to input on approvals.
- h) Bliss (a charity for babies born premature or sick) to improve family integrated care, and parental facilities and support for families. Through both my GIRFT and BAPM roles, I work with Bliss to advocate for family involvement in care and facilities for families.

27. I also work with leads from Royal College of Paediatrics and Child Health, Royal College of Obstetricians and Gynaecologists and Royal College of Midwives to advise and advocate for neonatal/perinatal care to NHS England and Department of Health and Social Care through several routes. I sit on the Neonatal Implementation Board, which is my primary reporting route for GIRFT, as the Neonatal Implementation Board is specifically tasked with implementing NCCR, which GIRFT is also supporting. I sit on the NHS England Maternity and Neonatal Outcomes Group (which was set up by NHS England in response to the October 2022 report by Dr Kirkup which was

commissioned by NHS England as an independent review: “Maternity and neonatal services in East Kent: Reading the signals” [Exhibit EA/0007 [INQ0012366]², Exhibit EA/0008 [INQ0012388]³]) which is looking at developing a tool for the rapid identification of outliers. I am also on the Maternity and Neonatal Programme Board (formerly Maternity transformation programme) as BAPM president, and also attend the Strategy and Policy Committee under Maternity and Neonatal Programme Board Governance. I also sit on the Independent Maternity and Neonatal Advisory Board as BAPM and Royal College of Paediatrics and Child Health representative, which reports separately to NHS England and Department of Health and Social Care and the Government’s Maternity & Neonatal New Action Forum as BAPM representative.

Scope and purpose of the GIRFT Deep-Dive Visits – General Overview

28. Across all of GIRFT’s workstreams, there are broad principles on how to undertake the Deep-Dive visits. They aim to invite people from many different roles whose work impacts the specialty being reviewed. This will include managers, clinicians and Allied Health Professionals, but will vary across each specialty depending on its approach and sub-culture.
29. GIRFT has developed its overall methodology since the programme first began in 2012. It is not specific to the neonatology specialty and is not specifically governed by an NHS England standard or guideline. The work is however aligned in terms of rigour by the work that the Royal Colleges are sometimes called upon to undertake in terms of peer review.
30. The work of the Deep-Dive visits starts long before the visit with data gathering, and involves combining publicly available information (including Hospital Episode Statistics), and other relevant registry or professional body data, varying by specialty), and the results of a questionnaire issued to the Trusts where services or pathways are being reviewed. The review of a specialty and its services examines a wide range of factors, from patient pathways and flows, clinical factors, workforce and costs. This leads to a data pack being produced by GIRFT, detailing performance data across that specialty. Separate data packs are produced at the regional level and at an individual Trust level. It takes about a year to develop the packs. The data packs

² Kirkup - Reading the signals Maternity and neonatal services in East Kent – the Report of the Independent Investigation October 2022

³ DHSC Policy Paper - Government response to ‘Reading the signals: maternity and neonatal services in East Kent - the report of the independent investigation, August 2023

enable the region and Trusts to understand where they are performing well and where they could do better, drawing on the input of senior clinicians.

Methodology and data sources for the Neonatology Specialty Review

31. To support and prepare for starting the programme of neonatology network and Trust visits, I analysed a range of data collected directly from Trusts as well as collating data from existing sources.
32. When scoping the work, I compiled a pro-forma to collate ideas for benchmarking metrics, which was sent out to all neonatologists via the neonatal ODNs in March 2019. The form gave a drop-down list of suggested areas for possible data collection alongside a request for more specific information about the data to include and suggestions for where the data should come from. Neonatal ODN managers were asked to collate responses from their local hospital clinicians and these were sent back for GIRFT to consider when pulling information together for the data packs.
33. As an early piece of work, a snapshot survey of neonatal services' workforce across the whole UK (191 services) was done in conjunction with the Royal College of Paediatrics and Child Health on a weekday and weekend day in September 2019. The goal was to provide an 'on the ground' picture of shortages and day-to-day realities for people working in neonatology. The aim was for each Trust to see how it compared in terms of workforce as against similar units. Results from this snapshot were reported back to neonatal services in January 2020 through individual benchmarking reports to each Trust, produced by the GIRFT team. I exhibit to this statement the two returns provided by the Countess of Chester Hospital NHS Foundation Trust (CoCH) containing their individual returns (one for weekdays and one for weekends) **[Exhibit EA/0009 [INQ0012408]; Exhibit EA0010 [INQ0012409]]**, two summaries of each of those returns⁴, and the unit level report produced to show the results of the snapshot for COCH **[Exhibit EA/0015 [INQ0012383]]**. The findings nationally were also later reported in a joint publication with the Royal College of Paediatrics and Child Health in September 2020 **[Exhibit EA/0002 [INQ0012416]]**.
34. Data pack sources include:
 - a) The workforce snapshots (set out above), which were then matched with activity data for each Trust before being included in the Trust data packs

⁴ PDF versions: **Exhibit EA/0011 [INQ0012404]; Exhibit EA/0012 [INQ0012405]**. Excel versions: **Exhibit EA/0013 [INQ0012406]; Exhibit EA/0014 [INQ0012407]**

- b) GIRFT questionnaires to neonatal ODNs and neonatal transport services (100% returns by October 2019).
 - c) Four GIRFT questionnaires for each hospital (100% returns by December 2019) covering the following areas:
 - i. medical staffing, clinical services, governance and research;
 - ii. nurse staffing;
 - iii. allied health professionals, pharmacy and psychology; and
 - iv. parents and families.
 - d) In addition to the surveys described above, my review used data from a range of other sources. These included:
 - i. BadgerNet, a key data source used by all units to collect data for multiple purposes;
 - ii. Hospital Episode Statistics and Diagnostic Imaging Dataset data;
 - iii. National Neonatal Audit Programme data; a longstanding national clinical audit run by the Royal College of Paediatrics and Child Health on behalf of Healthcare Quality Improvement Partnership;
 - iv. MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK), National Perinatal Epidemiology Unit, University of Oxford, which provides risk-adjusted stillbirth and neonatal and perinatal mortality data;
 - v. NHS England Quality Surveillance Team compliance scores;
 - vi. NHS England Blueteq High Cost Drugs Management System; and
 - vii. National Cost Collection Data, NHS Digital.
35. Using the information gathered and data packs prepared, I planned to conduct “Deep-Dive” visits to all neonatal operational delivery networks and most neonatal units in England.

ODN visits

36. In Neonatology, the regional packs to the ODNs were completed first, to support the development of regional NCCR implementation plans. The ODN data packs (completed in March 2020), included information on network organisation and relationships (commissioning, maternity services, providers, and parents), activity and capacity, network pathways and flows, regional neonatal transport services,

clinical processes and outcomes, research and governance, parent facilities and involvement in care, and workforce information. In addition, the ODNs received appendices with key data at an individual hospital site level, for parent facilities and family support, and workforces as these were key areas for action in the NCCR.

37. The ODN data packs were followed by visits to the neonatal ODN teams, regional transport services and providers of neonatal services within a region. On the visits, these teams and services came together with regional maternity and commissioning groups to review organisation and network-level data in depth and share good practice.
38. Network visits to the ODNs started in March 2020.
39. NHS England regional commissioners were present at the GIRFT network visits and so were aware of the network action plans which followed the meetings. I raised issues with NHS England regional and national teams if there were exceptional issues which I felt required their attention. I also fed back to the Neonatal Implementation Board on specific issues of concern that needed to be raised nationally or to raise general concerns common to many (see below for more detail on the Neonatal Implementation Board).
40. ODN visits were originally held in-person. However, after March 2020, I had to pause the ODN visits due to the Covid-19 pandemic. When the visits re-started, they moved to online meetings. They were all completed by October 2020, ahead of ODN submission of NCCR implementation plans to the Neonatal Implementation Board in November 2020. Every Neonatology ODN in England has had a Deep-Dive visit from me. Therefore, every Trust and unit has been covered, at least via the ODN visits.
41. GIRFT follow-up visits with all neonatal ODNs are currently taking place (December 2023 onwards) – see paragraph 83 for more information.

Trust Visits

42. After the ODN visits, data packs for Trusts were first produced in March 2021 (including data up to the end of June 2019) and then updated in September 2022 (including data to the end of December 2021). They covered neonatal activity and capacity, network pathways and patient flow, clinical performance, governance and research, parents and family experience and workforce. They showed a Trust how it compares against other units of a similar designation, i.e. NICU, LNU, SCU
43. Separate Trust level data packs were prepared for surgical NICUs, medical NICUs, LNUs and SCUs, covering similar domains to the network packs, but with more

granular detail, including benchmarking against similar unit types, and additional information on reference costs.

44. The data packs were followed by Deep-Dive meetings with the Trusts.
45. My visits to Trusts commenced in September 2020 and were completed in August 2023, having experienced some disruption due to the ongoing pandemic. They were all conducted online. I attended and led each meeting.
46. At the beginning of the programme, neonatal units were selected randomly but NICUs were prioritised. Over time, we realised that it would not be possible to visit every Trust. Therefore, we conducted visits based on delivery population, with a threshold of more than 3,000 deliveries. A Trust with less activity than 3,000 deliveries was less likely to be visited. Some smaller neonatal units that were based in the same Trust as larger neonatal services would have their visit at the same time as the larger service and I would present both sets of data, but not all the standalone smaller units were visited.
47. Overall, 116 out of 156 units were visited (74%). This comprised 100% of NICUs, 79% of LNUUs, and 37% of SCUs.
48. The core GIRFT way of doing visits is to ensure that there is a broad variety of attendees, but these must be tailored by clinical leads such as myself, to ensure that we have who is needed. My approach is to ask to meet with teams from neonatal care, as well as obstetrics and maternity. Therefore, in advance of a meeting, I send a list of clinical roles that I would like to attend. The tone of the meeting is set by me as the clinical lead. I do not like it to feel like an inspection, and I make that clear to the Trust and all attendees. I found that when the work of the Deep-Dive visits to Trusts started, people perceived these as an extra inspection, but word spread that people found them to be discursive and helpful, and I received feedback that people found them to be very supportive. My general philosophy in the meetings is to look at both what a Trust is doing well, understand why they are doing well, and to celebrate that, as well as trying to understand what is not going well and to explore what the Trust is trying to do about it. I will also pick up national themes, or be able to tell the Trust whether the issue is specific to them, or where another Trust has had the same issue but been able to improve it, and I put them in touch with those locations. The data pack is a guide and starting point for discussion so I go through the data pack as a way to structure the meeting but I also ask a lot of questions around areas which are not included in the data pack, including for example, information on support

services (e.g. radiology, radiography), equipment issues, managerial support, facilities, and workforce.

49. NHS England regional commissioners were not present at trust level visits, but network leads would generally attend and any specific issues could be raised with NHS England if needed. I raised issues with NHS England regional and national teams if there were exceptional issues which I felt required their attention. I also fed back to the Neonatal Implementation Board on specific issues of concern that needed to be raised nationally or to raise general concerns common to many (see below for more detail on the Neonatal Implementation Board).
50. Often, if the Trust has read the pack in detail and is able to explain why a certain issue arises in the data or what they are already doing about it, I will not need to explore that further if I am satisfied that they understand the issues and are already actioning them.

North West ODN Visit

51. A North West ODN report was completed by March 2020 [**Exhibit EA/0016 [INQ0012389]**] and contained information on activity, capacity, network pathways and patient flow, transport services, clinical processes, parents and families and workforce. The appendix [**Exhibit EA/0017 [INQ0012375]**] collated key unit level data, required to support the NCCR, important areas for review around family care and nursing, medical and allied health professional staffing gaps. Unit staff filled in information from the family questionnaire on: sufficiency and quality of family rooms, transitional care, bereavement facilities and various facilities for families; compliance with BLISS baby charter audit (a structured audit supporting improving family involvement in care); UNICEF Neonatal Baby Friendly Initiative progress (an international structured QI project for improving access to breastmilk in neonatal units); and parent feedback. Staffing was calculated against activity using standards set by professional bodies (BAPM for nursing and medical staff, Association of Paediatric Chartered Physiotherapists, British Dietetic Association, Royal College of Speech and Language Therapists, Royal College of Occupational Therapists, Neonatal and Paediatric Pharmacy Group, and British Psychological Society). Data on staffing was taken from questionnaires filled out by trusts and activity data was taken from BadgerNet. Other information from the questionnaires on sufficiency of service and level of training was included.

52. There were minor updates and corrections to the network reports over a number of months and the final reports for all networks were finalised in August 2020 **[Exhibit EA/0018 [INQ0012419]]**.
53. Both March and August 2020 reports showed that:
- a) The North West ODN were within the middle two quartiles for proportion of babies 24-31 weeks who die before discharge or 44 weeks (whichever occurs sooner) (data source: National Neonatal Audit Programme 2015/18). The North West figure was 7.5% and 4th out of 12 neonatal ODNs (with 1st being the worst, 12th being the best) (figure 7.13a)
 - b) The North West ODN were within the middle two quartiles for adjusted neonatal mortality rate, at 1.7% and 5th out of 12 neonatal ODNs (with 1st being the worst, 12th being the best) (figure 7.13a)
 - c) The North West ODN were in the highest (worst) quartile for adjusted extended perinatal mortality rate and 3rd out of 12 neonatal ODNs (with 1st being the worst, 12th being the best) (figure 7.13a)
 - d) The North West ODN had the lowest proportion of neonatal deaths occurring outside of the tertiary NICUs compared with other networks (figure 7.13a) and this was noted as a point of good practise in the action plan.
 - e) Adherence to patient pathways across all units in the North West ODN was considered excellent or good (Fig 3.5b) based on the 2019 questionnaire and this was noted in the network action plan "Network pathway monitoring is very robust including exception reporting through transport service. Adherence to pathways across all hospital sites is excellent."
 - f) The North West ODN had a network death reporting tool, network management team review of neonatal deaths, and network mortality and morbidity review group meetings.
 - g) The North West ODN was involved in the Child Death Overview Panel Process, (Fig 3.6) based on the 2019 questionnaire. Whilst the Child Death Overview Panel is a compulsory process, involvement of the neonatal ODN was not required and was very rare at the time of this visit, therefore I felt that it was a piece of notable good practice.
54. On 4 March 2020, I visited the Northwest ODN in-person. This was my second visit in the GIRFT programme, with the first being Yorkshire & Humber ODN. Gail Roadknight, Neonatology GIRFT Project Manager and Donna Dodd, GIRFT Implementation

Manager, attended with me. There were around a dozen core network staff who accepted the invitation, the morning Network Management Meeting. Around 50 further people, who were mainly drawn from the various Trusts across the region, plus regional specialised commissioners, obstetric and maternity regional leads/ Local Maternity Systems representatives, and Public Health England accepted invitation to the afternoon GIRFT Neonatology Network Meeting, including representatives from CoCH. The regional GIRFT ambassador and the GIRFT National Delivery Director were also in attendance at the afternoon meeting.

55. My overall impression was that it was a very organised ODN with a good central management team that were well engaged with regional specialised commissioners, and very coordinated in how they managed the service. They seemed to have a “can-do” attitude, were interested to make changes and were overall very positive.
56. I wrote into the action plan issues that I thought required action, as well as areas of good practice **[Exhibit EA/0019 [INQ0012415]]**:
- a) There were no issues flagged with the mortality rate, as it was within the expected range. There were low numbers of deaths occurring outside of the NICUs and there was a high degree of centralisation of the smallest and sickest infants, which is very positive. Other key morbidity outcomes were Necrotising enterocolitis (within expected range) and chronic lung disease (upper (worst) quartile). In terms of optimal start measures, which have an impact on mortality and morbidity - there was some work to be done (in common with many other networks at that time).
 - b) Performance was in the lowest quartile or 10th percentile for provision of antenatal steroids, magnesium sulphate, thermal care and mothers' milk within 24 hours.
 - c) Delayed cord clamping was not consistently being done.
 - d) Some investigation was required to understand why the network was performing less well in respect of the requirement for cardiac compressions and adrenaline in babies <27 weeks.
 - e) I also noted significant deficits in medical, nursing and allied health professional staffing, but there appeared to be good workforce strategies across nursing and medical staff in place to try to address this.
57. The action plan recorded notable good practice including that “there are very robust governance reporting structures and processes for neonatal deaths. Trust

confirmation of PMRT completion and M&M review are now happening and there is network involvement in CDOP processes which is a positive outlier nationally". By way of explanation of the terminology used:

- a) Perinatal mortality review tool (PMRT) is a standardised tool for investigating and reporting stillbirths and neonatal deaths, with data collated centrally as well as producing reports at a local level.
 - b) M&M is the morbidity and mortality review meeting, which can include the use of the perinatal mortality review tool or one may feed into the other. These are always done at local level, but network governance arrangements varying from network to network.
 - c) CDOP is the Child Death Overview Panel, which is a multi-agency review of all child deaths, and includes representatives from the wider community including police and social services.
58. I do not recall CoCH being specifically flagged to me as having particular issues in the ODN visit. They stood out on the basis of the data because their levels of activity were lower than were expected of a LNU. I do not recall the Trust being talked about in any more detail than that.

The Countess of Chester Hospital ("CoCH") visit 13 January 2022

Background to the CoCH Deep-Dive visit

59. As part of the programme of Deep-Dive visits to Trusts, I met with CoCH on 13 January 2022. This was part of the normal schedule of visits. I was not asked specifically to prioritise CoCH, and nothing in my work at ODN level indicated that CoCH should be a priority.
60. CoCH was classed as an LNU, caring for babies born at less than 27 weeks gestation. At that time, I was focusing my visits on LNUs and NICUs, hence the CoCH visit being arranged.
61. On 6 January 2022, my team emailed CoCH with our usual list of roles that, as far as practicable, we would wish to invite to a Deep-Dive meeting **[Exhibit EA/0020 [INQ0012358]]**:
- a) Board level executives/ Trust GIRFT lead
 - b) Divisional/Directorate management & finance
 - c) Neonatal Clinical Lead & all consultants working in neonatology

- d) Obstetric Lead
- e) Head of Midwifery/Head of Neonatology
- f) Matron
- g) Ward Manager
- h) Allied Health Professionals working within your neonatal team
- i) Other interested nursing and medical staff keen to support quality improvement projects
- j) Network representative
- k) Education Lead
- l) Governance Lead

62. CoCH replied later on 6 January 2022 with a list of people they wished to be invited to the meeting. They also noted that: "Mr McGuigan [Consultant Paediatrician, Clinical Lead] has asked me to raise a point prior to the review next week: ***The Trust's neonatal unit operated as an LNU until July 2016 – since then it has operated as a SCU. However the Deep-Dive report provides benchmarking data that compares the Trust's SCU to other LNUs. i.e. we are being benchmarked against units who have completely different admission criteria to our unit.*** Please can this be reflected during the discussions." (emphasis as per the email) [Exhibit EA/0020 [INQ0012358].
63. I recall querying the change in thresholds at CoCH in advance of my visit in response to this email. On 10 January 2022 I therefore forwarded the email to Louise Weaver-Lowe, the Neonatal Network Director for the North West ODN, to ask for further clarification and understanding about this change [Exhibit EA/0020 [INQ0012358]. Had I known that CoCH was operating as a SCU at this time, I would not have arranged my visit for this stage of the programme (NICUs and LNUs were being prioritised). CoCH would not have made the threshold for a visit after the decision to limit the visits to units with more than 3,000 deliveries, unless the network or commissioners had specifically asked me to visit.
64. Louise replied that day and suggested a call [Exhibit EA/0020 [INQ0012358]. I cannot recollect the exact details of the conversation, but I believe she told me that there had been concerns about high mortality rates in 2015/16 and that a nurse had been arrested in connection with deaths at the neonatal unit at CoCH. Specialised Commissioning had subsequently changed the referral threshold for babies to be

born in or remain at CoCH from 27 to 32 weeks gestation and North West ODN and specialised commissioning teams were keeping a close eye on the unit but they were not worried about how the unit was operating at the present time. I also recall coming away from the conversation with the impression that the clinical team at CoCH had found the experience very traumatic.

CoCH data pack

65. As with other Trusts, questionnaire data were completed in September and December 2019. I exhibit the four questionnaires returned by CoCH, one for each of: Nursing **[Exhibit EA/0024 [INQ0012413]]**, Family Care **Exhibit EA/0023 [INQ0012412]**, Clinical Service **Exhibit EA/0022 [INQ0012411]**, and Allied Health Professionals **Exhibit EA/0021 [INQ0012410]**. These were included in the data packs used for the visit. Most of the data available was from 2018-19, with some activity data going back to 16-19.
66. The data pack for CoCH is contained within the CoCH Unit Level report, dated March 2021, which was used for the visit **[Exhibit EA/0025 [INQ0012359]]**. It showed:
- a) Mortality data was from the MBRRACE-UK year 2017. There were no indications of concern and the mortality rate was well within the expected range (this observation is true when compared with LNUs or SCUs as a benchmark).
 - b) The Trust was below average and in the middle two quartiles for adjusted neonatal mortality rate and adjusted perinatal mortality (excluding congenital abnormalities) per 1000 live births (Figure 5.15a). This observation is true when compared with LNUs or SCUs as a benchmark).
 - c) Preterm infant deaths (<37 weeks) and term infant deaths admitted to the neonatal unit were 0 between July 2016-June 2019 from BadgerNet data. No earlier data were available in this report.
 - d) Data on incident reporting per admission was also in the normal range
 - e) The Trust answered 'yes' to reviewing and reporting all neonatal deaths at the M&M meeting within 28 days (Fig 6.1).
 - f) There were low numbers of high-risk admissions <27 weeks, and compliance with prompt movement of higher risk babies from Chester to a NICU according to network pathways was consistently in the upper (best) quartile (fig 4.2) compared with LNUs (or middle quartiles for SCUs). Network pathway adherence and close working with North West ODN were noted as good practise within the action plan.

- g) There were higher numbers of preterm babies requiring cardiac compression/drugs at resuscitation (July 2016-June 2019) from BadgerNet data (fig 5.4a) compared with both LNUs and SCUs. Joint neonatal, antenatal/perinatal review of cases in conjunction with the network was recommended in the action plan.
 - h) The unit met BAPM standards for nurse staffing. It met the BAPM standards for medical staffing for a special care unit, but not a local neonatal unit (when it was currently functioning as a special care unit).
67. CoCH did not provide any further data over and above the initial questionnaire, and what is included in the data pack. However, I would also have looked up any more recent data online if it was available prior to the visit - most notably MBRRACE and National Neonatal Audit Programme data and will have asked them to tell me what their most recent results were for optimal preterm start metrics, including in respect of antenatal steroids, magnesium sulphate, thermoregulation, delayed cord clamping, and early mothers' milk.

CoCH Deep-Dive meeting

68. The Deep-Dive meeting with CoCH was on 13 January 2022. Assisting me with the visit was Suzannah Davies, GIRFT Project Manager and Donna Dodd, GIRFT Implementation Manager. Suzannah took informal notes of the meeting [**Exhibit EA/0026 [INQ0012420]**], and throughout the meeting I indicated important points for her to record for the action plan.
69. The visit was conducted online, in an approximately 2-hour intensive discussion⁵ with members of the clinical team, the directorate management team and senior managers and executives in the Trust. It included discussion of the findings in the data pack, as well as information on support services (e.g. radiology, radiography), equipment issues, managerial support, facilities, and workforce. We also discussed more recent performance, and any changes in performance, QI initiatives, challenges and good practice.
70. The following CoCH personnel accepted the invitation to the online discussion, although I cannot be certain as to whether they in fact attended:
- a) Susan Gilby, Chief Executive
 - b) Darren Kilroy, Medical Director

⁵ See video recording of the meeting [**Exhibit EA/0027 [INQ0012414]**].

- c) Hilda Gwilliams, Director of Nursing and Quality
- d) Jo Dangerfield, Consultant Paediatrician
- e) Michael McGuigan, Consultant Paediatrician, Clinical Lead
- f) Anne McGlade, Matron for Children's Services
- g) Pippa Scott-Heale, Women & Children's Directorate Manager
- h) Yvonne Griffiths, Clinical Manager
- i) Daniel Bass, Clinical Coding
- j) Veda Carter, Project Manager
- k) David Coyle
- l) Kimberley Jones

71. I do not know whether the staff in this meeting worked on the neonatal unit at CoCH between June 2015 and June 2016. I expect some of them might have done, but that would have to be confirmed with CoCH.
72. Kelly Harvey (Lead nurse for North West Neonatal ODN) and Louise Weaver-Lowe (North West Neonatal ODN Manager) also attended the meeting.
73. Parents are not part of the GIRFT visit process and were not included in any of the GIRFT visits. The meetings are set up to look at data and benchmarking with senior Trust teams and professionals. Parental presence has never been a part of the GIRFT process. I therefore did not speak with any parents as part of the visit, but as I have set out above, the review does gather information from the family questionnaire and information regarding compliance with the BLISS Baby Charter and UNICEF Neonatal Baby Friendly Initiative.
74. As with all Deep-Dive meetings⁶, I led the discussion, asking questions of the various attendees, to guide discussion across the breadth of people attending. I did not see any warning signs to suggest that CoCH was not functioning as expected in the current designation of a special care unit. The culture came across as very open and transparent. Attendees were very engaged in the visit. They were interested in data and keen to improve. I would note that the visit was substantially after the incidents that are the subject of this Inquiry. It was also after the changes to pathway had occurred (as above), so the unit was functioning as a SCU rather than a LNU. This

⁶ These paragraphs summarising the meeting are based on my personal recollections of the meeting, in addition to a review of the meeting recording.

was the main change since the original data pack had been put together. They seemed to be focussing on the things they should have been focussing on, based on their data. They seemed to be actively trying to make improvements. Some Trusts can be defensive of the issues flagged in their data, and I tend to be more concerned about those than the ones that are inquisitive about why there are issues, or are actively telling me what specific actions they are taking.

75. I did not discuss LL or the events leading up to the decision to change the thresholds to that of a Special Care Unit. I was focussed on data in more recent years. I did point out that it was unlikely that CoCH would be likely to meet the intensive care/high dependency activity threshold required to be a Local Neonatal Unit (given the size of the maternity population) but understood that specialised commissioning were looking at neonatal unit designation across the whole of the North West and that CoCH would be included in that review.
76. I did not have any concerns about how CoCH was operating currently.

CoCH Action Plan

77. On 14 January 2022 I emailed Joanne Dangerfield, Consultant Paediatrician at CoCH and Anne McGlade, Matron for Children's Services of CoCH, providing a copy of the action plan arising from the Deep-Dive visit **[Exhibit EA/0028 [INQ0012360]]**. I always send my action plans directly to the clinicians to ensure they have a direct copy of the plan as soon as possible.
78. My email was copied to Louise Weaver-Lowe, Manager of the North West Neonatal Operational Delivery Network, and Kelly Harvey, Lead Nurse for the North West Neonatal Operational Delivery Network and GIRFT Nursing Advisor for Neonatology.
79. A copy of the Action Plan is exhibited to this statement **[Exhibit EA/0029 [INQ0012361]]**. No issues were raised with regards to mortality or morbidity and the number of recommendations is similar to other local neonatal units/ special care units. However, the activity was very low and was unlikely to ever meet LNU activity requirements, given the size of the birthing population. This would be decided at a regional level, following due process. The action plan included the following recommendations:
- a) To improve the implementation of delayed cord clamping. This affects mortality in the preterm population and so this was a significant area. (It should be noted that delayed cord clamping in preterm infants was not routine practice across many neonatal units in England at this time).

- b) To conduct an investigation of higher cardiac compressions and adrenaline in order to look for modifiable factors. This was because there was a recognition that the small data set might not be signifying an important issue.
- c) To improve early respiratory management. This is important to reduce the risk of chronic lung disease.
- d) To implement volume-targeted ventilation (a specific form of ventilation available on some neonatal ventilators which has been shown to reduce the risk of chronic lung disease). I was aware that the Trust were in the process of getting a suitable ventilator at the point of my visit.
- e) To improve breastfeeding rates at discharge, which is desirable for lots of reasons.

80. I also attached to the same email an annotated version of the March 2021 data pack **[Exhibit EA/0025 [INQ0012359]]**⁷, which was also to be put on the NHS Future Collaborations platform. The annotations show the benchmarking for SCUs, so that CoCH could see that information which was potentially more relevant to how it was operating at that time, as well as the original LNU benchmarking that we had used before we were aware of the change in thresholds. I set out those annotations in an appendix to this statement, to be read alongside the data pack itself. I noted to CoCH Trust. "This is for your own internal use and I hope it proves useful. Please let me know whether you wish [sic] to have your updated data pack compared against SCUs– if I don't hear from you I will leave against LNUs" **[Exhibit EA/0028 [INQ0012360]]**.

CoCH refreshed data pack

- 81. Refreshed data packs were created for all Trusts. The new packs were used at Deep-Dive visits occurring after September 2022 and all Trusts were notified that they now had a new data pack for their own use. The refreshed data packs were created in the same way as the previous packs with data updated from BadgerNet and some national data sources such as National Neonatal Audit Programme and MBRRACE. However, questionnaire data was not requested again.
- 82. A refreshed data pack for CoCH was published in September 2022 **[Exhibit EA/0030 [INQ0012374]]**. The following may be noted:

⁷ Please note that the yellow comment boxes indicate where there is an annotation. The contents of those annotations are also set out in an appendix to this statement.

- a) It did not show any negative outliers regarding mortality and morbidity based on the more recent data period. Mortality continued to be in the middle two quartiles on MBRRACE (2019 data).
- b) There were ongoing higher numbers of preterm babies requiring cardiac compression/drugs at resuscitation (Jan 2019- Dec 2021) from BadgerNet data (fig 5.4a). These remained in the highest (worst) decile (mid-year 2016-19 compared with calendar year 2019-21) compared with both LNUs and SCUs.
- c) There was a reduction in preterm babies needing intubation and ventilation in delivery suite (fig 5.4a) and in the first week of life (Fig 5.5a). Managing preterm babies without intubating them in the first week of life reduces the risk of developing chronic lung disease.
- d) There was a reduction in the proportion of babies with chronic lung disease (Fig 5.7).
- e) The data was available for delayed cord clamping for the first time. This showed that they performed in the lower quartile for this in 2021 (Fig 5.1), but that rate of compliance increased very significantly in 2022 (NNAP online data).
- f) There was also an increase in the rate of hypoxic ischaemic encephalopathy receiving cooling in financial year 2020-2021 (from middle two quartiles to upper (worst) decile). Significant hypoxic ischaemic encephalopathy cases are all subject to detailed investigation by Maternity and Newborn Safety Investigations programme (formerly HSIB). The team mentioned during the Deep-Dive meeting that the incidence was higher in 2021 and following a cluster of cases there was extensive review with a learning actions plan shared with Clinical Commissioning.

Next round of visits

- 83. In December 2023, I started the process of re-visiting networks to see what they have implemented from the ODN action plans and national recommendations. I am looking at how they have managed, what are they getting stuck on, and how to resolve any outstanding issues. I hope to have completed all the re-visits by end of April 2024. I hope that this will give me an idea of how the whole country is progressing in implementing both my regional recommendations, and the recommendations from the GIRFT national specialty reports.
- 84. The visit to the North West took place on 18 January 2024. I am also hoping to provide updated data packs for networks in 2024 (timeframe to be confirmed). We do not

propose to provide Trust-specific data packs, but the Trusts within the networks will receive the network pack for visibility of wider issues and improvements in their region.

GIRFT's role in implementation of actions arising from Trust visits.

85. Action plans are for each Trust to take forwards. I will link them up with other Trusts who have solved the issues they are facing, in order to see whether they can give further ideas. In my experience, Trusts find that empowering at a local level. The action plans are a tool for Trust-level improvements.
86. I copy the relevant ODN into each Trust action plan so that the ODN know about the detail and can follow up as they see fit. Sometimes there are network actions within the Trust action plan, and I make sure that the ODN is aware of all actions, so that they can see themes across Trusts.
87. My role as GIRFT lead is not to provide assurance on progress at a Trust level. However, throughout the process, I will provide as much assistance as I can for them to take the actions forward. If I identify an issue that is serious and I believe is beyond the Trust's capability to resolve, or if it is a wider issue affecting many Trusts that needs action at a regional or national level to assist them to improve, I would raise it with ODNs or with Specialised Commissioning teams.
88. If there are significant safety issues raised at a Deep-Dive visit, these concerns would be very clearly articulated in the action plan and any serious concerns would be escalated to an appropriate place to ensure actions were being taken seriously and monitored. I would also be specific in instructions to the ODN, or regional and national commissioning, depending on how significant my concern was. As a result of my other national roles, I would usually know who to speak to, to progress any wider concern.
89. In the early stages of my work with GIRFT, there were approximately seven people per region working on implementation (clinical ambassadors, PAs, Project Managers). They would attend the visit with me, as Donna Dodd did at CoCH, and they would then go into Trusts monthly to look at all workstreams that GIRFT had reviewed, to check progress as against action plans. That was an important tool to ensure local oversight and exert gentle pressure to make actions happen. Those teams were TUPE transferred from GIRFT to the individual regions in September 2020. Some regions moved these staff into general improvement teams. If they are undertaking the same GIRFT implementation work as before, we do not have direct

sight of it. I therefore do not have sight of implementation at a Trust level and it was notable how much less often anyone from the regional implementation team attended GIRFT visits after September 2020.

90. I do however have visibility of progress at ODN level as a result of the revisits currently underway (see information above).

The GIRFT Neonatology Review 2022 and Recommendations for Improvement in the Future

91. As part of the overall GIRFT methodology, once a substantial number of the Trust reviews have been completed, the GIRFT clinical lead oversees the creation of a GIRFT National Report for their specialty. The National Report presents the original data, GIRFT's findings, examples of best practice and recommendations for proposed changes and improvements to be delivered at both a national and local level.
92. In April 2022, GIRFT published the first National Report for Neonatology GIRFT "Neonatology: GIRFT Programme National Specialty Report April 2022" **[Exhibit EA/0031 [INQ0012417]]**, authored by me, Kelly Harvey (GIRFT Nursing Advisor for Neonatology) and Michelle Sweeting (GIRFT Allied Health Professional Advisor for Neonatology). A copy of the report is exhibited to this statement. This was the first national review published by Neonatology GIRFT.
93. The report contains 21 recommendations to help improve services for patients, their families and staff, including the following:
- a) Organising services to ensure the right care is given, in the right place. This involves making the best use of networked perinatal pathways; improvements in specialist neonatal transport; and providing more intensive care cots in neonatal intensive care units (NICUs).
 - b) Improving clinical care, helping to reduce and prevent neonatal deaths and major neonatal morbidity. This included: optimising care in the perinatal period for preterm birth; maintain emergency clinical skills of all neonatal clinical staff; particularly those working in LNUs and SCUs; improving respiratory care to reduce the risk of developing chronic lung disease; improving access to breast milk; increasing blood transfusion safety; and developing a better pathway for management of babies presenting with bile-stained vomiting.
 - c) Ensuring a better family experience. Enabling parents to be with their babies at all times leads to better neurodevelopmental outcomes, increasing weight gain

and a shorter hospital stay for newborns. GIRFT suggests measures to improve access to parent accommodation, food and drink facilities, bereavement services, financial support and especially psychological support for families.

94. In the section on recommendations to strengthen clinical governance and safety, and reduce litigation there are 15 specific actions under the following recommendations:
- a) Governance and mortality review processes at local and network level must conform to national recommendations and include clear structures for escalation of risk;
 - b) Improve safety and reduce patient harm due to medication errors; and
 - c) Improving prompt recognition, diagnosis and treatment of conditions commonly screened for or assessed in the neonatal period, which can result in significant clinical harm.
95. In April 2022, GIRFT also published “Neonatology – Workforce: GIRFT Programme National Specialty Report” **[Exhibit EA/0032 [INQ0012418]]**, by the same authors as the main report. We provided five recommendations for building and supporting the neonatology workforce nationally. We identified that there are significant pressures on the neonatal workforce with shortages across medical and nurse staffing as well as allied health professionals, pharmacy and psychology. Recommendations to improve staffing and transforming the workforce include improving staffing to nationally recommended standards across all staff groups, embedding allied health professionals, pharmacy and psychology services into neonatal units and networks, developing transformational workplans, as well as focusing on better education, training, and career structures for nurses and allied health professionals working in neonatology.
96. The two reports are not yet fully publicly available, but they have been published on FutureNHS which is a collaboration platform across the NHS. I have carried out webinars to publicise the reports, and they were publicised via email to ODNs, which in turn cascaded to clinical leads at Trust level. They were also advertised through BAPM. In my view, they should be fully publicly available and accessible, for example available to anyone who visits the GIRFT website, rather than solely through FutureNHS as the current arrangements are a significant barrier to receiving the report, even for those who work within the NHS, and is inaccessible to those outside the NHS. A four-page summary of the National Report’s findings is publicly available on the GIRFT Neonatology web page **[Exhibit EA/0033 [INQ0012365]]**.

Model Health System

97. GIRFT as a whole has a significant and growing presence on the Model Health System (Model Hospital) portal, which is a data-driven improvement tool enabling NHS health systems and Trusts to benchmark quality and productivity. However, GIRFT Neonatology is not yet developing data for input into Model Hospital. I have delayed doing this as there are already multiple national data sets and reporting requirements, with new ones being developed as part of the response to Dr Kirkup's "Reading the Signals" report. For example, clinicians already have neonatal data fed back through NNAP (national neonatal audit project) with improvements to reporting now giving quarterly rolling updates, Neonatal ODN network dashboards (monthly), Neonatal Implementation Assurance Processes (quarterly), MBRRACE (yearly) and through reporting requirements for Saving Babies Lives Care Bundle v3 and Maternity Incentive Scheme, with further development of datasets currently by NHS England Maternity and Neonatal Outcomes Group. I plan to keep this under review in 2024.

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:

Personal Data

Dated: 7th March 2024

Appendix

Annotations to CoCH Unit Level Report March 2021 with SCU averages⁸

The following annotations correspond with yellow "comment" boxes in the margin of CoCH Unit Level Report March 2021 with SCU averages

Page	Paragraph	Annotation
16	3.9	Average for SCUs - 17 total, 10 SC and 6 TC
23	4.6	ATAIN average 4.2 SCUs
25	4.8	SCU medians - 36+1 (27-32) and 35+5 for 30-33
32	5.4a	SCU averages are lower again <27 86%, 27-30 - 38%, 31-32 - 5.8%, <33 weeks 22.6%, Compressions <27 weeks 12%, 27-30 6.9%, 31-32 2.2%, <33 weeks 4.5%
37	5.7	Also BPD 26% for SCUs
40	5.10a	NEC 2% in SCUs, 3 day milk 72% for SCUs, 14day milk 79%, Milk at discharge 60% for SCUs
45	5.14	HIE rate 0.9 in SCUs
46	5.15a	SCU MBRRACE 1.0 and extended mortality 4.1)
62	8.6	Dinning to establishment 3% for SCUs, Dinning to staff in post -4% in SCUs

⁸ PLR NIC LNU NW COCH RJR COC RJR05 20200301 with SCU averages [Exhibit EA/0025 [INQ0012359]]