Witness Name: Jane Tomkinson
Statement No: 3
Exhibits: JT/273
Dated: 27 March 2024

THIRLWALL INQUIRY

WITNESS STATEMENT 3 OF JANE TOMKINSON

I, Jane Tomkinson, of the Countess of Chester Hospital NHS Foundation Trust, Countess of Chester Health Park, Liverpool Road, Chester CH2 1UL, will say as follows: -

1. I am the Chief Executive of the Countess of Chester Hospital NHS Foundation Trust ("the Trust"). I provide this statement on behalf of the Trust in response to a request dated 27 October 2023 under Rule 9 of the Inquiry Rules 2006 ("the Rule 9 Request"). However, this statement provides my personal views and response to the questions asked by the Inquiry based on what I have heard about the events concerning Lucy Letby and the Trust's response to those events, and based on actions we have taken as a Trust since I took on the role of acting Chief Executive at the Trust on 19th December 2022 and was appointed as substantive Chief Executive Officer from 1st February 2024.

2. I have included the questions asked of the Trust in the Rule 9 Request in bold below for ease of reference and context.

Do CoCH have current concerns about the effectiveness of governance and management structures in keeping children in hospital safe and ensuring the quality of care?

3. I do not have concerns about the current governance and management structures in place at the Trust, but I cannot comment on structures in place in other Trusts. A number of improvements have been made to such structures at the Trust over the last few years.

4. Between June 2015 and June 2016 ('the relevant period'), the Trust had three Divisions: Urgent Care, Planned Care and Diagnostics, Pharmacy, Estates and Facilities. The Paediatrics and Neonatal Care Services were part of the Urgent Care Division and Maternity Services sat within the Planned Care Division. The Women and Children's Governance Board monitored all quality and risk related issues across the Women and Children's Services. The Women and Children's Governance Board fed into the Quality, Safety and Patient Experience Committee (QSPEC). It was through QSPEC that indirect reporting to the Trust Board occurred.

5. From 15 February 2022 to 17 March 2022, the Care Quality Commission ('CQC') undertook a risk-based inspection. As part of the inspection, CQC visited Urgent and Emergency Care Services, Surgical Services, Maternity and Medicine Core Services. CQC rated the Trust as 'requires improvement' overall. It also rated the domains of safe, effective and responsive as 'requires improvement'. The Well Led provider rating for the Trust was 'inadequate'. However, the care within the Trust was rated as 'good'. CQC did not inspect Children and Young People Services and as such, the rating from the previous CQC inspection remained which was 'good' overall. Leadership in Maternity Services was deemed to be 'inadequate'. The CQC was informed that Maternity Services, at the time of inspection, were part of the Planned Care Division but that there were plans to change the divisional structure to create a separate Women and Children's division to include Neonatal Services at the Trust. Concerns were also raised in relation to Maternity and Trust wide governance processes. This led to the CQC serving the Trust with two warning notices under Section 29A of the Health and Social Care Act 2008. The warning notices instructed the Trust that it needed to make significant improvements in governance systems relating to referral for treatment processes, implementation of the electronic patient record system and around the management of incidents, learning from deaths and complaints.

6. In September 2022, the Trust Board approved a new divisional structure which brought the Women and Children's services into one division. From January 2023, a distinct 'Women and Children's Division' was established. The Division brought the Paediatric and Neonatal Services and Maternity Services into one Division with a single leadership team. The services provided are referred to as 'perinatal services'. The perinatal services cover pregnancy and the year following birth. The Division reports directly to the Trust Board on perinatal quality, performance and safety metrics. One purpose of this change was to

ensure the Executives and Trust Board have better oversight of the Trust's Women and Children's Services.

7. The divisional leadership for both the NNU and Midwifery Services includes the Director of Midwifery, the Divisional Director, and the Associate Medical Director all of whom are line managed by members of the Executive Directors. These individuals are also members of the Operational Management Board (OMB). The OMB was established in January 2023 by the Trust Board of Directors. It has responsibility for oversight of the implementation of the Trust's operational strategies and objectives. It provides assurance to the Board of Directors that effective management is being discharged through the OMB which in turn ensures delivery of the Trust's operational targets and plans.

8. There is also a Clinical Lead for Neonatal Risk within the new structure. Dedicated time is provided within their role to oversee risk management.

9. Since these structural changes have been implemented, the changes have put in place a clear and robust divisional reporting process for reporting to the Board. There is now clear Board oversight of perinatal services and all neonatal deaths are formally reported to the Board.

10. The effect of these changes is reflected in the CQC's latest report. The CQC inspected the Trust on a number of days between 17 October 2023 and 16 November 2023. This was an unannounced inspection of Maternity Services and Children's and Young People Services. The CQC ratings for the Trust's maternity services and in the well led domain moved up from "inadequate" to "requires improvement" as a result of this inspection.

What further changes, if any should be made to the current structure or professional regulation to improve the quality of care and patient safety?

Would such changes address any concerns with the conduct of the board, managers, doctors, nurses and midwives at the hospital?

11. It is believed that the changes the Trust has made provide these groups with a clear and effective route to raise issues and concerns. A more open culture supported by a Freedom to Speak Up framework would offer many channels to address concerns about conduct.

Do you consider that there were structures in the management and governance of CoCH that inhibited members of staff and/or patients from reporting suspected criminal

activity by Letby? To what extent do you consider the cultures of CoCH contributed to any lack of reporting of criminal activity by Letby?

12. During the relevant period, there was no formal reporting process in place to report concerns, such as the concerns about Lucy Letby, to the police. Whilst there were no active inhibitors to reporting concerns about criminal activity to the police, it is most probably the case that the old divisional structure, outlined above, in place during the relevant period did not provide a clear mechanism for such concerns to be escalated and individuals within the Trust may have felt that there were barriers to them reporting activity directly to the police. Culture within the Trust at that time would also likely have inhibited staff from reporting suspected criminal activity. However, it should also be borne in mind that some staff may have felt that, due to a lack of clear evidence of criminal activity on the part of a named member of staff, a report to the police was simply either not appropriate or not warranted.

What changes do you think could be made to CoCH's governance and management to improve the quality of care and safety of neonatal babies? What changes in culture, if any, do you think would be appropriate?

13. As referred to above and below, a number of significant changes have already been made by the Trust to its governance, management and culture as a result of learning from the events during the relevant period.

14. During the relevant period, staff were able to approach their manager, shift leader or Matron as applicable if they had concerns regarding a patient's care or a staff member. A staff member could also raise concerns in their appraisals and one to one meetings with their manager. There was no allocated "Speak Out Safely" Champion within the Trust at the time, although the Trust had Speak Out Safely initiatives and whistleblowing polices in place during the relevant period.

15. The Trust now actively promotes an 'open door' policy. There is a new Perinatal Nurse Advocate who can signpost where to direct a concern or complaint and provide confidential support. There are also Speak Up Champions on each unit as part of the Trust wide Freedom To Speak Up (FTSU) initiative. There is an improved exit interview process which provides a further opportunity for staff to raise concerns.

16. There are no restrictions on how concerns are raised. Concerns may be raised by staff, volunteers, patients, the police, NMC, GMC, members of the public or others. Datix, the Trust's incident reporting system, can also be used as a way to flag concerns.

Investigations into concerns raised are carried out including actively speaking to those involved with assistance from Human Resources, as appropriate. Discussions between staff and managers are recorded as required on personnel records and actions/help is provided as needed.

17. The Patient Advice and Liaison Service (PALS) together with the Maternity Neonatal Voices Partnership (MNVP) provide a forum for parents and patients to raise their concerns and make reports.

18. It remains open to all staff to raise concerns with the GMC, NMC, CQC or Northwest Operational Delivery Network (NW ODN).

19. The Trust's Medical Director and the GMC's Liaison Officer meet regularly to discuss what is happening in relation to ongoing conduct or capability cases. The GMC's Liaison Officer offers advice about formal referrals that should be made by the Trust. The Trust also considers if a referral is appropriate or necessary at the conclusion of any internal disciplinary. The possibility of a referral to a professional regulator is often outlined in any outcome letter issued to a member of staff following a disciplinary.

20. The Trust's perinatal services have recently undergone the National SCORE Survey. The survey measures various dimensions of culture within the service. The survey was open to all perinatal staff from 31 March 2023 to 14 May 2023. The questions focussed on teamwork, safety, local leadership and learning systems. In August 2023, the results were made available. The results highlighted an improvement within the perinatal service and the current leadership team was commended for their commitment and dedication to continuously aiming to improve the perinatal service. Feedback demonstrated that staff recognised the sense of support, collaboration and teamwork within the service with specific reference to improvements in the leadership and culture of the Trust over the last 5 years which included improved communication and listening.

21. As mentioned above, the CQC recently undertook an inspection of Maternity Services and Children's and Young People Services. The CQC acknowledged the work that the Trust has done to relaunch and strengthen the FTSU initiative. The Board lead for FTSU is Cathy Chadwick, Chief Operating Officer and the Non Executive Director lead is Paul Jones. Our FTSU Guardian is Helen Ellis and the Trust has 30 FTSU Champions.

22. Following the outcome of the CQC inspection, I circulated a weekly bulletin on 19 February 2024 which I exhibit as **Exhibit JT/273 [INQ0014065]**. I re-circulated my pledges to the FTSU initiative which are as follows:

- I actively encourage colleagues to speak out if they have concerns about the care or treatment of a patient, colleague or themselves.
- Any concerns raised in good faith will be investigated fully, openly and transparently. This can be done anonymously, or if you do share your name, you will be provided with feedback on the issue you have raised.
- If any colleague raises a concern and feels like they have come to any detriment because of it, to let myself or another member of the Executive Team know, and you will be kept safe and supported.

23. I also reiterated that should a colleague feel that an issue raised is not being dealt with or escalated, to contact myself or another member of the Executive Team and we will help to move this along. I want staff to feel fully supported, heard and safe when coming to work.

24. The following information was also circulated to all staff in a bulletin on 9 February 2024:

The Care Quality Commission has released the National Maternity Survey findings for 2023 today, with 44% of those surveyed about our Trust completing the questionnaire.

This survey captures the perspectives of women who gave birth in February 2023, providing a crucial snapshot into their experiences of the maternity care provided by the Trust. We were really pleased that 20% of respondents were from under-represented groups which reflects a diverse range of backgrounds. We welcome and encourage their input to help us improve our services further.

Families were asked questions about every aspect of their care – starting from their initial encounter with a clinician or midwife, through to the labour and birth process and the care provided at home afterwards.

The results show an improvement in a number of areas compared to the previous year which reflects the dedication the maternity staff show in supporting people through their pregnancy, birth and postnatal journey.

Whilst we are performing about the same as other Trusts, we are doing better than most in four areas. There has also been an improvement in our overall score compared to the previous year and we should be proud of the general satisfaction from our patients.

Feedback shows we are performing strongly across various aspects of maternity care – with positive feedback in areas such as antenatal check-ups, involvement in decisions about care, and the kindness and compassion provided by staff during labour and birth.

The top five areas of care where the Countess of Chester Hospital performed better than the national average were:

1. *Ensuring discharge without delay*
2. *Giving patients who have given birth enough information or explanations while in hospital*
3. *Ensuring support or advice about feeding a baby for patients*
4. *Feeling that midwives and other health professionals gave active support and encouragement about feeding the baby*
5. *Enough information was given about any changes to mental health that might happen after having a baby.*

Work is already underway to transform and improve many aspects of maternity care and the survey indicates that patients are feeling the benefits already.

The findings are also an invaluable tool to help us identify areas for improvement so we can further shape our services to better meet the needs of women and families.

We have identified the following key areas which we now need to focus on:

- *Feeling that a partner can stay with them for as long as they want*
- *Being offered a choice of where to have their baby*
- *Mental health information being provided during the postnatal checkup*
- *Being given enough information about where to have their baby*
- *Help and advice after birth about feeding their baby*
- *Feeling able to ask questions afterwards about the labour and birth*
- *GPs talking enough about physical health during the postnatal checkup.*

A robust action plan is being developed which will be aligned with existing plans and we will be collaborating with relevant stakeholders – especially the Maternity and Neonatal Voices Partnership – to ensure that service improvements are based on feedback from our patients and their families.

Do you have any reflections on the issue of how senior managers should be made more accountable, whether through regulation or otherwise?

25. In relation to professional regulation for senior managers, this is being asked for nationally and has been a consideration for some time. The Executives of a Trust are currently accountable for the actions of the Trust. Therefore, regulation would serve a purpose to ensure that Executives are not only held accountable for their actions but also to provide support and guidance to them. I do not believe that the fit and proper person requirements, as they currently operate, can achieve the same aim as regulation of an NHS senior manager in the same way as health professionals are regulated.

What lessons has CoCH learned and/or what changes has the CoCH put in place, in particular in relation to neonatal and/or maternity services, since the crimes of Letby were known to it?

26. Patient complaints during the relevant period were managed through the Complaints Office, with responses invited from the department in writing to enable a response to the complaint to be prepared for the Chief Executive to approve. Patient concerns were managed through PALS. Today, all complaints are designated to a nominated Complaints Handler. The Service subject of the complaint identifies a lead Investigating Officer, which is usually a Service Manager or Head of Nursing. The Investigating Officer carries out an investigation which is then provided to the Complaints Handler who then provides a response for Chief Executive Officer review and sign off.

27. Since 2016, a number of measures have been introduced by the Trust with the aim of reducing risk in neonatal services (in addition to the structural changes referred to above). These include:

    a. The introduction of the Freedom to Speak Up Guardian (Trust-wide) and champions and strengthening of the freedom to speak up policy (previously referred to as Speak Up Safely).

    b. Perinatal services are now formally reviewed monthly within the perinatal assurance and improvement board, chaired by the Director of Midwifery (DOM). The perinatal assurance and improvement board provides a dedicated assurance meeting for perinatal services where assurance against the nationally required standards (CNST, Ockenden, Maternity three-year plan) are reviewed. This meeting reports into the Women & Children's Governance Board where risks, incidents, workforce planning, and audit data and performance is reviewed. This means the Trust now has a dedicated perinatal services assurance board providing additional assurance, scrutiny and oversight of the perinatal services.

    c. Introduction of an executive led daily Trust wide review of all moderate and above harm incidents with the senior clinical and nursing leads.

    d. The introduction of daily safety huddles on the neonatal unit and in maternity - neonatal huddles are meetings of nursing and medical staff to discuss issues such as capacity, workload, expected transfers, staffing, any patient safety concerns, risks, escalations and any significant events arising during the previous shift.

    e. Patient Advice and Liaison Service contact details are now clearly displayed on the unit - all staff can signpost parents to this service.

    f. The Maternity Neonatal Voices Partnership (MNVP) is now working with neonatal families to collect independent feedback and arrange formal visits to speak to

parents and encourage parents to complete a feedback survey through their maternity/neonatal journey.

g. The introduction of an allocated executive and non-executive safety champion for the neonatal unit and maternity services – one is the Director of Nursing & Quality (and Deputy Chief Executive) and the other is a Non-Executive Director. This ensures another route for concerns to be escalated if needed.

28. In July 2016, following a request from the Trust, the NNU was downgraded to Level 1 resulting in Transitional Care being closed and the admission criteria temporarily changing to a gestational cut off for planned delivery of 32 weeks or above. Following input from NHS England Specialised Commissioning, the Trust was required to put any further changes to the NNU on hold until the conclusion of the police investigation and subsequent criminal trial of Lucy Letby. In 2021, a new NNU was opened at the Trust which was funded by a publicised charitable campaign. The new NNU is a bigger, modernised space which incorporates family integrated care. This has enhanced the ability of staff and parents to care for babies in an improved environment. Construction to build a further new Women and Children's Unit at the Trust is ongoing. Construction is expected to be completed in 2025.

29. In October 2023, the NW ODN recommended that the Trust return to operating at a Level 2/LNU status, subject to NHS England approval. This process is on-going.

30. In 2017, a Perinatal Mortality Tool was introduced nationally. The tool introduced a template which standardised the review of all babies that die within their first 28 days. This process provides for a meeting to take place to include input from an external Obstetrician, Midwife or Neonatologist depending on the type of death. The outcome of any such meetings is reported to the Women and Children's Governance Board and shared with the NW ODN.

31. In 2018, the Healthcare Safety Investigation Breach (HSIB) programme for investigations into maternity and newborn safety incidents commenced. This was part of a national initiative to improve safety in maternity care. The HSIB programme is now hosted by the CQC and is known as the Maternity and Newborn Safety Investigations Programme. The programme reviews specific cases of babies that have died, for example, term babies that died in the first few days of life and term babies with severe brain damage. The Trust fully engages with this programme (actively referring cases and meeting quarterly with the

programme team local lead) and updates on this are provided in reports to the Trust Board and the Women & Children's Governance Board.

32. All acute Trusts in England were initially asked by NHS England in 2019/20 to set up Medical Examiner Offices. The purpose of the Offices is to focus on the certification of all deaths occurring in their own organisation. In June 2021, NHS England sent a system wide letter setting out what local health systems needed to do to extend the role of these Offices to include all non-coronial deaths, wherever they occur. It is understood that in December 2023, the Department of Health and Social Care published draft regulations for the statutory medical examiner system planned for 2024. To the best of my knowledge, the Trust started recruiting a Medical Examiner Officer in January/February 2021. All inpatient deaths were being scrutinised from June 2021. The Office is currently funded for 10 sessions a week. A session is half a day; thus it is funded for 5 days a week. It is understood that from its implementation in December 2023, the Office has scrutinised 4 neonatal deaths. Dr Ian Benton currently leads on all mortality learning and meets bi-monthly with the Medical Examiners within the Trust.

33. Prior to January 2023, the Trust used the NHS England Quality Surveillance Information System ('QSIS') which is a web-based portal that records and reports information to support the Quality Surveillance Programme. Since January 2023, this scheme has been replaced and all provider data is now submitted via the Data Collection Framework.

34. In relation to reporting systems and inspections, the Trust uses the Datix incident reporting system which staff should use to report incidents including a death or patient safety incident. Neonatal incidents are reviewed by the Neonatal Incident Review Group. The learning is shared with those involved in the provision of neonatal care via a newsletter and the incidents are reported to the Women and Children's Governance Board. Incidents are also reviewed at the Executive led daily Trust wide review of all moderate and above harm incidents, which takes place with Senior Clinical staff and Nursing Leads. The Trust also reviews all 'no harm' and 'low harm' incidents to obtain an overview of the Trust's incidents overall which in turn helps to identify any trends.

35. The Trust has summarised its learning and actions since the relevant period in a number of powerpoint slides which I have presented on since taking up the post of acting Chief Executive. That learning can be divided into the following broad categories.

<u>Leadership</u>

- Experience and track record of Executives and Non-Executive Directors
- Corporate style
- Defining 'clinically led'
- Psychology of leaders
- Red flags, escalation and closing down
- Right structure, right leaders and rights skills

System of Assurance and Reporting – no one source of truth

- Patient safety meetings - the Trust now has weekly Patient Safety meetings. During the meeting, each Division is required to present their moderate harm and above incidents and risks from the preceding week. A list of actions is put together during the meeting for the Division to complete. The actions are subsequently followed up in the meeting the week after. Thus, the Divisions within the Trust now hold each other accountable as they are aware of the actions required and the subsequent progress. The Trust also looks at 'no harm' and 'low' incidents to obtain an overview of the incidents being reported overall to identify any trends.
- Clear accountability
- Reporting – the new divisional structure enables direct reporting from women and children's services into the Board, providing the opportunity for any concerns to be escalated and for data such as NNU death rates to be presented to Board
- Robust learning from deaths cascading and embedding
- Relationship with Coroner
- Regular review of Board and Committee effectiveness
- Referrals to SUDIC/LADO/CDOP and circle to Board
- Classifications of deaths
- Triangulating incidents, themes and trends
- Documented reports vs verbal updates
- Reviews presented by reviewers
- Escalation of anomalous test results
- Role and status of safeguarding

Learning organisation

- Collection, access and distribution of learning
- Benchmarking best practice
- Seeking help from other organisations
- Regularly holding the mirror up

- Role and status of research

Requirements from NHSE post verdict

36. The Board received a letter from NHSE on 18 August 2023 requiring confirmation of progress on a number of actions. The actions and outcomes are as follows:

Action	**Completed**
Implementation of National FTSU policy by January 2024	Completed
All staff have access to information on how to speak up	Completed – information available via staff emails, FTSU champions and on the Trust Intranet
Relevant departments e.g. HR and Guardians are aware of the National speaking up support scheme	Completed – information available via staff emails, FTSU champions and on the Trust Intranet
Individuals are actively referred to the scheme	Completed – staff self refer to the scheme
Effective mechanisms to support cultural issues/work patterns etc. with FTSU	Completed
Boards to seek assurance that staff can speak up with confidence and whistleblowers are treated well	Completed – regular reports received at Board of Directors, People & Organisational Development Committee and Audit Committee
Boards regularly review and act upon data	Completed – regular reports received at Board of Directors, People & Organisational Development Committee and Audit Committee
Relevant posts fulfil FPPT	Board level posts are subject to the new Fit and Proper Person Test requirements from NHSE, existing policy is being updated to reflect the full extent of the changes

Statement of Truth

I believe that the facts stated in this witness statement are true to the best of my knowledge and belief. 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

PD

Dated: 27 March 2024