Witness Name: Helen Vernon

Statement No: 01

Exhibits: 74

Dated: 29 February 2024

**THIRLWALL INQUIRY**

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**WRITTEN STATEMENT OF HELEN VERNON**

**ON BEHALF OF NHS RESOLUTION**

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I, Helen Vernon, Chief Executive of the National Health Service Litigation Authority (**"NHSLA"**), which is now operating under the name of NHS Resolution, will say as follows:

1. I provide this statement on behalf of NHS Resolution in response to a request under Rule 9 of the Inquiry Rules 2006 dated 7 November 2023. The statement is based on information available to NHS Resolution from its records and the knowledge of members of staff. I have made clear where the information is from my own personal knowledge.

2. I would like to begin by saying that my thoughts are with all those who have been affected by the crimes of Lucy Letby.

## INTRODUCTION

3. My full name is Helen Elizabeth Vernon (known as Helen Vernon) and I am the Chief Executive and accountable officer at NHS Resolution, based at our London office, 8th Floor, 10 South Colonnade, Canary Wharf, London E14 4PU.

4. In April 2017 the NHSLA changed its operating name to NHS Resolution. For ease of reference, I will refer to the organisation as NHS Resolution throughout this statement.

## BACKGROUND TO NHS RESOLUTION

### Establishment

5. NHS Resolution, formally known as the NHSLA, was established in 1995, as a Special Health Authority by the National Health Service Litigation Authority (Establishment and Constitution) Order 1995, S.I. 1995/2800 ("**the Establishment Order**"). It carries out the roles given to it by the Establishment Order and those formally delegated to it by the Secretary of State for Health and Social Care ("**the Secretary of State**") through directions. This is in accordance with Regulation 3 of the Establishment Order.

6. The National Health Service Litigation Authority Regulations 1995, S.I. 1995/2801 ("**the Regulations**") make detailed provision about the operation of NHS Resolution. NHS Resolution operates within this statutory framework. Both statutory instruments have been amended and various directions have been issued by the Secretary of State, expanding NHS Resolution's role.

7. In April 2017, under Directions from the Secretary of State, the NHSLA changed its operating name to NHS Resolution.

### Governance

8. As a Special Health Authority, NHS Resolution is an arm's length body of the Department of Health and Social Care, previously known as the Department of Health (**"the Department"**). There is a Framework Document in place between the Department and NHS Resolution that sets out in more detail the shared understanding of how the two organisations work together. This document does not convey any legal powers or responsibilities. The latest version was signed in December 2020 and remains in place.

9. In broad terms, NHS Resolution is a delivery organisation, providing the services described below. It is the role of the sponsoring Department to determine what those services should be (issuing Directions where needed) and to make any policy decisions. NHS Resolution provides subject matter expertise input to the development of policy options when requested to do so by the Department, but it is the Department that is the decision-maker.

10. NHS Resolution is currently led by a board (**"the Board"**) made up of:

    - The Chair
    - The Chief Executive

- Four Non-Executive Directors
- Two Associate Non-Executive Directors (non-voting)
- Three Executive Board Directors (the Director of Safety and Learning; the Director of Finance and Corporate Planning; and the Director of Advice and Appeals)
- One Associate Executive Director (the Technical Claims Director) (non-voting)

The Establishment Order sets out rules about the composition of the Board. The Regulations set out further rules regarding the Board including about appointment of the Chair and members of the Board; tenure of office; use of committees and sub-committees; and the conduct of meetings. Further detail on the role of the Board is set out in the Framework Document.

11. NHS Resolution's detailed governance framework is set out in its Standing Orders and Standing Financial Instructions.

**Funding**

12. NHS Resolution receives funding in two ways:

- Funding (known as contributions) from members of the Clinical Negligence Scheme for Trusts ("**CNST**"), Liabilities to Third Parties Scheme ("**LTPS**") and Property Expenses Scheme ("**PES**"), and income from customers of training and other services offered by our Practitioner Performance Advice service.

- Grant-in-aid funding (cash financing) for services determined by the Department, e.g. Practitioner Performance Advice, Primary Care Appeals, indemnity schemes for legacy health bodies and for general practice and coronavirus indemnity scheme arrangements.

## THE ROLE OF NHS RESOLUTION

13. NHS Resolution provides expertise to the NHS on resolving concerns and disputes fairly, sharing learning for improvement and preserving resources for patient care. We have four key service areas:

- **Claims Management**: handling both clinical and non-clinical claims for compensation on behalf of members of our indemnity schemes.

- **Practitioner Performance Advice** ("**Advice**"): providing advice, support and interventions in relation to concerns about the individual performance of doctors, dentists and pharmacists.

- **Safety and Learning**: supporting the NHS to better understand and learn from the data we hold on claims, concerns and disputes; to target safety activity while sharing learning across the NHS.

- **Primary Care Appeals** ("**Appeals**"): an impartial resolution service for the fair handling of Primary Care contracting disputes.

14. NHS Resolution agrees a multi-year strategy and annual business plan which is approved by its Board and sponsoring Department. The latest strategy, which runs from 2022-2025, includes a strategic priority to '*Collaborate to improve maternity outcomes*' in line with NHS Resolution's role in the healthcare system as a body that does not either provide or regulate healthcare but which works with those who do. Areas of work which fall under this strategic priority include:

- Early investigation of entitlement to compensation for certain cases involving brain injury at birth via the Early Notification (**"EN"**) Scheme.

- Incentivising actions which are designed by system partners to improve the safety of maternity care via the Maternity Incentive Scheme (**"MIS"**).

- Publishing insights from maternity claims via thematic reviews, case stories and resources, such as our *Did you know?* products.

**Claims management**

Clinical claims and our schemes

15. One of NHS Resolution's main functions is handling negligence claims on behalf of the members of our indemnity schemes, namely NHS organisations and independent sector providers of NHS care in England and since April 2019 beneficiaries of the state-backed indemnity for general practice.

16. NHS Resolution manages seven clinical negligence schemes, the largest being the CNST which covers clinical negligence claims for incidents occurring on or after 1 April

1995. Although membership of the scheme is voluntary for NHS Foundation Trusts, all NHS Trusts in England ("**Trusts**") currently belong to the scheme, including the Countess of Chester NHS Foundation Trust ("**CoCH**"). When a claim is made against a member of CNST, the NHS body remains the legal defendant and its permission is required for certain steps such as formal admissions of legal liability. NHS Resolution takes over responsibility for handling the claim, working with the Trust, and meeting the associated costs (damages and legal costs), which are funded via annual contributions. The scheme operates as a risk pool to smooth out the volatility in claims costs for individual members. It is funded on a 'pay-as-you-go' basis which means that NHS Resolution collects in from its membership what it expects to pay out for the relevant financial year. In general terms NHS Resolution's indemnity schemes do not cover criminal matters. However, where the law of vicarious liability applies, NHS Resolution's schemes will apply to compensation for the civil consequences of criminal actions.

17. Under certain sections of the non-clinical scheme, LTPS, there is discretionary cover for the costs of defending criminal prosecutions. For example, under the employers' liability schedule there is such cover for defending health and safety prosecutions. NHS Resolution exercises its discretion only if it concludes that defending the criminal charges would assist in defending actual or potential civil claims. There is no such cover under the CNST.

18. The legal process for determining claims for compensation can be complex, and claims can sometimes take a long time to resolve. There is often a significant time-lag between an incident occurring and a claim being made – on average across all clinical claims, three years, and longer for incidents involving minors. During the period from incident to claim notification, Trust interaction with patients/ patients' families is likely to focus largely on understanding why the harm was caused and dealing with the immediate concerns of patients, including ongoing care. It can take some time for individuals to decide whether they wish to pursue a claim and seek advice, often from solicitors specialising in clinical negligence law. Once a patient or family member decides to make a claim there are several procedural and investigative stages to be undertaken before a decision can be made on liability (whether a claim has merit and damages should be paid).

The Maternity Incentive Scheme

19. In November 2017, in *Safer Maternity Care: The National Maternity Safety Strategy – Progress and Next Steps* [Exhibit HV/01] ("**Safer Maternity Care – Next Steps**") the Secretary of State for Health committed NHS Resolution to launch *"a new scheme to* **INQ0008995**

*incentivise local services for taking steps to improve delivery of best practices in maternity and neonatal services"* to help bring forward the maternity safety ambition (see in particular pages 9, 31 and 32).

20. The MIS supports the delivery of safer maternity care through an incentive element to Trust contributions to the CNST. Developed in partnership with the national maternity safety champions at the time and continuing to be delivered in partnership with a broad range of stakeholders, it rewards Trusts that meet ten safety actions designed to improve the delivery of best practice in maternity and neonatal services. These actions are owned and developed by members of NHS Resolution's Collaborative Advisory Group ("**CAG**"), composed of the Department, other arm's length bodies, the relevant Royal Colleges and Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries ("**MBRRACE-UK**"), with the financial incentive delivered via the CNST.

21. Further detail about the MIS is provided in a separate section below.

Early Notification Scheme

22. NHS Resolution's EN Scheme, established in April 2017, proactively investigates specific brain injuries at birth for the purposes of determining if negligence has caused the harm and therefore whether compensation is payable. We do this by requiring CNST members to notify us of maternity incidents which meet a clinical definition, set out below. In proactively investigating potential eligibility for compensation, it aims to help improve the process for obtaining compensation for families, increase the scope for learning from those claims and reduce legal costs.

23. The introduction of the EN Scheme was referred to in the Department's strategy document *Safer Maternity Care – Next Steps* (see page 25):

*"A new Early Notification scheme launched by NHS Resolution in April 2017 provides a new route for families to access compensation which is based on the current principles of liability, but outside the usual litigation process. This new route includes support for immediate needs such as counselling or respite care in eligible cases. It is now a requirement for trusts to report all maternity incidents occurring on or after 1 April 2017 which have the potential to result in severe long-term brain injury."*

24. From 1 April 2017 to 31 March 2020, in line with the criteria used by the Each Baby Counts programme of the Royal College of Obstetricians and Gynaecologists, the EN criteria included all babies born at term (≥37 completed weeks of gestation), following

labour, that had a potentially severe brain injury diagnosed in the first seven days of life and:

- was diagnosed with grade III hypoxic ischaemic encephalopathy ("**HIE**"); or
- was therapeutically cooled (active cooling only); or
- had decreased central tone and was comatose and had seizures of any kind.

25. The EN Scheme was not operational at the time of the deaths that were the subject of the criminal trial. Furthermore, our understanding is that the babies harmed by Lucy Letby would not have met these criteria.

26. From 1 April 2020, the criteria of the EN Scheme were narrowed to babies who have an abnormal MRI scan where there is evidence of changes in relation to intrapartum HIE. This ensured that the scheme remained focused on those cases where there is potential for a high value compensation payment. (Non-EN cases are still able to pursue a claim through the existing compensation route.)

27. Trust legal teams are required to notify NHS Resolution of qualifying EN cases once they have been confirmed by the Maternity and Newborn Safety Investigations programme ("**MNSI**") as under investigation. The MNSI is now part of the Care Quality Commission ("**CQC**"). MNSI was formerly part of the former Healthcare Safety Investigation Branch, ("**HSIB**").

28. Once NHS Resolution receives the MNSI investigation report, NHS Resolution undertakes a clinical triage to confirm whether the clinical criteria for an investigation under the EN Scheme are met. If they are met, NHS Resolution commences investigations into liability and the potential for a compensation payment on behalf of the Trust.

29. NHS Resolution recognises the importance of co-ordinating its EN work with other organisations, particularly the MNSI which also works directly with Trusts where there are immediate concerns. NHS Resolution has an EN Concerns Group which holds a regular joint meeting with the MNSI to share and discuss information. The EN Concerns Group share information regarding concerns about care provided by Trusts arising from EN findings, EN thematic reviews or issues related to MIS declarations about compliance with the ten safety actions.

30. The EN Concerns Group escalate concerns directly with the Trusts concerned, the CQC and NHS England ("**NHSE**") regional leads as well as providing updates to the regional

perinatal surveillance meetings and the National Perinatal Safety Surveillance and Concerns Group.

31. As part of the EN Scheme, NHS Resolution seeks to learn lessons from the cases that are reported to it to improve clinical practice. More about the work of the EN Scheme can be found in NHS Resolution's recent publication – *The second report: The evolution of the Early Notification Scheme* (2022) [Exhibit HV/02]. **INQ0008996**

**Practitioner Performance Advice**

32. The Practitioner Performance Advice (**"Advice"**) service, established in 2001 (formerly the National Clinical Assessment Service), provides impartial advice to healthcare organisations to effectively manage and resolve concerns raised about the practice of individual doctors, dentists and pharmacists at all grades. The Advice service does not provide advice in respect of nurses or midwives.

33. Advice provides a range of core services to NHS organisations and other bodies in England, Wales and Northern Ireland such as clinical performance and behavioural assessments of individual practitioners, and assisted mediations to help resolve workplace difficulties between colleagues. Remediation and return to work action plans for individual practitioners can also be developed to support their return to safe and effective clinical practice. The service also delivers education programmes designed to help healthcare managers deal more effectively with concerns about individual practitioners. Where concerns relate to the functioning of a clinical team, Advice can undertake a team review to identify any barriers to resolving the issues which have been highlighted and to suggest a plan for improving professional relationships within the team.

34. Each year, Advice receives around 900 requests for advice from healthcare organisations with concerns about the practice of individual doctors, dentists and pharmacists.

35. Most enquiries we receive come from the employer or contracting organisation which the practitioner (doctor, dentist or pharmacist) about whom there are concerns is working for. Contact is usually made by a senior member of staff, such as a medical director, a director of HR or a head of primary care. However, we can receive initial contact from

any representative of the employer or contracting organisation, providing they have the delegated authority to act on behalf of that organisation.

36. Some requests for help come directly from practitioners. This may be because they want help clarifying procedural aspects of the management of their case, are concerned about some aspect of their own practice, or perhaps because they wish to access advice about rebuilding their skills after a career break.

37. Occasionally, requests come from whistle-blowers and although we are not set up primarily as a referral point for whistle-blowers (and are not a prescribed body for those purposes), we have procedures in place to respond to concerns raised by them. Although we are not able to take referrals directly from members of the public, if they contact us, we will advise them how to direct their concerns to the bodies best placed to help them.

38. Advice is also responsible for the management of the Healthcare Professional Alert Notices ("**HPANs**") system. This is a system where Advice issues notices to inform NHS bodies and others about any registered healthcare professional (including midwives and nurses) who may pose a significant risk of harm to patients, staff or the public. HPANs are usually used whilst the regulator is considering the concerns and provide an additional safeguard during the pre-employment checking process.

39. NHS bodies can request an HPAN by completing the request form and sending to the HPAN inbox. These are reviewed weekly or earlier, if necessary, by the HPAN Panel, which is made up of NHS Resolution's HPAN Lead and three advisers from the Practitioner Performance Advice service. A minimum of two individuals are required to make a decision. If a decision is taken to issue an HPAN, the alert notice is sent by email to Chief Medical Officers in Northern Ireland, Wales, and Scotland, and Higher Level Responsible Officers in England for them to cascade through their Responsible Officer networks. The relevant professional regulatory body, such as the General Medical Council or Nursing and Midwifery Council, will also be informed. The central HPAN register is updated and employers who are registered for the web check service can use the portal to check for the existence of an HPAN as part of the employment checks for health professionals.

40. In the NHS year 2022/23, 31 requests for an HPAN review were received. 20 of these requests resulted in an HPAN being issued. The historic numbers from 2013 to 2021, as well as other information such as how these are split across healthcare professionals, are

set out in the *Practitioner Performance Advice Insights, Healthcare Professional Alert Notices (HPANs): insights from nine years of managing the scheme* [Exhibit HV/03]. **INQ0014050**

41. The National Health Service Litigation Authority (Amendment) Directions 2019 allow for any "NHS body" (as defined in the NHSLA Direction 2013) and any organisation which provides services to or on behalf of an NHS body to request an HPAN. Given that the purpose of the HPAN is to mitigate the risk of an individual who poses a significant risk of harm to patients, staff or public, if a request was made by an organisation that fell outside this scope, then we would review it to consider whether and how the request could be brought into the scope of the legislation. UK regulators that are not NHS bodies, such as the General Medical Council, do not request HPANs, but we do seek input where necessary from relevant regulators to inform our decision, such as by considering any publicly available documentation published by them.

42. Advice does not cover midwives or nurses in respect of the core services provided where there is a concern about an individual's performance. However, some other Advice workstreams such as HPANs, services to address concerns about the function of multi-disciplinary clinical teams (for example, team reviews) or services to address interpersonal difficulties between healthcare professions (for example, mediation) may cover midwives and nurses.

**Safety and Learning**

43. NHS Resolution is directed by the Secretary of State under The NHSLA (Safety and Learning) Directions 2019 to carry out safety and learning functions as part of administering the indemnity schemes. The Safety and Learning service supports our indemnity scheme members to better understand their claims risk profiles to target their safety activity while sharing learning across the system. We employ clinical fellows to support this work and undertake thematic reviews, publish case stories, provide members of our indemnity schemes with claims scorecards and we have recently launched an eLearning maternity module. A number of these activities are aimed at supporting clinicians working within maternity services.

44. Although the Safety and Learning service uses claims data to inform its analysis, these publications are not focused on any individual Trust. NHS Resolution holds claims scorecards specific to CoCH. The claims scorecard is an interactive spreadsheet that contains confidential data about live and closed claims at an individual claimant level. This includes data about open claims which have not been settled, and such data is

therefore legally privileged and confidential. We have provided by way of [Exhibit HV/04] INQ0014051 a PDF screenshot of the Overview Score Card tab for context. We do not waive privilege in respect of the interactive spreadsheet version of the scorecard. NHS Resolution's claims scorecards are provided to members annually via our Extranet. Claims scorecards are a quality improvement tool designed to help members better understand their claims profile down to a specialty level, which allows them to target interventions aimed at improving patient safety. For example, clinicians can interrogate their scorecard data to assess the clinical effectiveness of the care they provide and identify areas where new guidance and standards may be required to help prevent errors. Members are encouraged to triangulate their claims with other information that they hold locally but which is not held centrally by NHS Resolution, such as incidents and complaints information, to provide further insights and context.

45. We provide two types of scorecards to Trusts: the first includes claims dealt with under the CNST, which covers clinical negligence claims for incidents occurring on or after 1 April 1995. The other includes data from the LTPS which covers non-clinical claims such as public and employers' liability. Only claims that have been notified to NHS Resolution will feature on the claims scorecards. Early Notification Scheme incidents are excluded unless they become a claim.

46. Each CNST scorecard covers CNST claims over a 10-year period.

47. The CNST scorecard provides a snapshot of the totality of claims against a Trust as well as more specific detail on grouped or individual claims. There is also an "all data" sheet which details every claim included in that scorecard. Claims can be grouped by specialty, outcome, location and other parameters to provide tailored information.

48. It includes, for example, a specialty summary. A specialty, such as obstetrics, can be selected from a drop-down list. Once a speciality has been selected, the scorecard provides detail on various metrics over the relevant 10 year period. It also breaks down the claims in the selected specialty into the top five injuries by volume and value (e.g. brain damage or fatality) and the top five causes by volume and value (e.g. failure or delay to treatment or failure to monitor second stage of labour).

49. The CNST scorecard is split up into four further sections illustrating the clinical specialties with the highest value and volume of claims (red zone) to the lowest specialties in terms of value and volume of claims (green zone) and where other specialties sit inbetween (blue and yellow zones). There is an in-depth breakdown of each zone which includes

detail on the causes of those volume and value claims (e.g. failure or delay to treatment) and the injury coded for those claims (e.g. brain damage).

50. It is important to note that the scorecard is not tailored to a type of Trust (e.g. a Mental Health Trust). It is an annual snapshot of data and is not updated monthly, or more frequently. As with all claims analysis, there are limitations given that the data does not include all clinical incidents (because not all incidents become claims) and is historical rather than real-time information. The extent to which organisations disseminate their scorecard information is a matter for them to determine locally, as NHSR would be unaware of who is best placed to ensure effective use of the information.

**Significant Concerns**

51. Although NHS Resolution is neither a regulator nor a commissioner, on rare occasions, one of our individual functions may identify a significant concern where we consider we have a duty to share information externally, for example, with other NHS bodies or those with responsibility for regulation within the healthcare system. The process we have in place to help identify and manage such significant concerns is known as the Significant Concerns Framework and is run by our Significant Concerns Group. The first meeting of the Significant Concerns Group was in April 2019. The first meeting of the Significant Concerns Group was in April 2019 supported by Significant Concerns Framework **INQ0014052** [Exhibit HV/05]. There have been minor process/guidance changes and changes to Group membership since its inception in 2019.

52. To make the process of sharing and identifying concerns as robust as possible, since the Group's formation we have:

- Set up a formal system for exchanging information between functions about potential significant concerns. This was initially set up between Advice and Claims **INQ0014053** Management (June 2020) [Exhibit HV/06] but was later expanded to include EN **INQ0014054** Exhibit [HV/07] and Appeals during 2021 [Exhibit HV/08]. **INQ0014055**

- Agreed a position statement on information sharing between NHS Resolution functions (August 2022) [Exhibit HV/09]. **INQ0014056**

- Updated documentation to reflect the introduction of the Significant Concerns key performance indicators (September 2022), as demonstrated in version 11 of the Significant Concerns Framework [Exhibit HV/10] – see box 5 of Annex D. **INQ0014057**

- Included a new process to deal with immediate (i.e. same day) concerns. This was added to the Significant Concerns Framework in November 2023 [Exhibit HV/11]. INQ0014058 This remains the current version of the Framework that is in force.

**Primary Care Appeals**

53. NHS Resolution's Appeals service is responsible for ensuring a prompt and fair resolution of appeals and disputes between primary care providers and those wishing to provide primary care services (including GPs, dentists, opticians and pharmacists) on the one hand, and NHS commissioners of those services on the other. The work of Appeals is not connected to the issues which are the subject of this statement.

## WORKING WITH OTHER ORGANISATIONS

54. NHS Resolution collaborates with the Department, relevant Royal Colleges, the CQC, the MNSI, the Health Services Safety Investigations Body, NHSE, frontline staff and patients, and other key stakeholders in the maternity arena with the aim of helping the system deliver effective and sustainable action to improve care, improve its response to concerns from patients and their families and to share learning.

55. Examples of collaboration include but are not limited to:

- Establishing the EN Maternity Voices Advisory Group, to provide external stakeholders, in particular families and their representatives, with a forum through which they can advise and support future service developments within the EN Scheme. The group currently includes representatives from: Action against Medical Accidents, Baby Lifeline, Peeps HIE Charity, Campaign for Safer Births, the MNSI and members of our panel of solicitor firms.

- Working with NHSE's Getting It Right First Time (GIRFT) maternity and gynaecology teams.

- Being a past member of the Royal College of Obstetricians and Gynaecologists' Each Baby Counts Advisory Board (the board is no longer in place) and the Royal College of Obstetricians and Gynaecologists / Royal College of Midwives Learn and Support programme.

- Contributing to Baby Lifeline Training events.

- Working with other key stakeholders such as the MNSI and the CQC and to share insights and intelligence at regional perinatal surveillance groups and the National Perinatal Safety Surveillance and Concerns Group.

- Working with key stakeholders such as NHSE to contribute to insights and intelligence regarding maternity safety.

## DEVELOPMENT OF THE MIS AND THE TEN SAFETY ACTIONS

56. I can briefly summarise the policy development of the MIS as follows. On 17 October 2016 the Secretary of State announced a high-level policy intention to make CNST maternity contributions more responsive to the relative safety of different maternity units. Over the course of 2015, 2016 and 2017 work was done by NHS Resolution, the Department and others to try and identify "indicators" – data points that could be built in to the CNST pricing model, to make CNST maternity contributions more responsive to the relative safety of different maternity units. Possible indicators that were explored included data on unexpected admission of term babies to neonatal units; perinatal mortality rates (perinatal deaths include both still births and deaths within seven days of birth); and CQC ratings.

57. Ultimately, none of the indicators explored in this work had a sufficiently strong correlation with claims to be used as the basis for adjusting CNST contributions. In October 2017 the Secretary of State invited the national maternity champions at that time – Professor Jacqueline Dunkley-Bent and Dr Matthew Jolly – myself and a colleague from NHS Resolution to discuss the issue. One of the outputs from that meeting was a decision by the Secretary of State that CNST contributions for 2018/19 should be linked to approximately ten "safety actions". The adoption of a safety actions approach meant that the focus turned to measures that would encourage behaviour that would in turn help to reduce future claims, rather than looking for data points that could be used to predict future claims. Further work was undertaken, and this proposal became the MIS. The MIS and the ten safety actions were announced on 28 November 2017. Work continued on the finer detail of MIS. Trusts were able to submit their first completed MIS board reports to NHS Resolution from Friday 1 June 2018. The deadline for submissions was 23:59pm Friday 29 June 2018.

58. As set out above, NHS Resolution is an operational arm's length body of the Department. This means that NHS Resolution does not itself set Government policy but the

Department will often seek our input as subject matter experts in the areas that NHS Resolution covers. This was the case with the development of the MIS.

59. I have set out below a chronology that highlights the key dates and documents. In addition to the documents referred to below, we have a large number of other documents including internal emails, external emails (for example with stakeholders such as the Department and the then NHS Improvement now NHSE) and drafts of documents. The chronology focusses on interactions with the Secretary of State. This is for three reasons. Firstly, it is ultimately the Secretary of State who sets policy, including in relation to the MIS. Secondly, the submissions made to the Secretary of State helpfully summarise the work done by NHS Resolution and others to inform policy development. Finally, I am mindful of the Inquiry's request for a proportionate and focussed approach when responding to its request for documents, accepting that MIS was not in existence when the harm was caused, which is the principal subject matter of this inquiry.

60. The Department has overall responsibility for the content of submissions that go to the Secretary of State. The recommendations in any submission are therefore technically those of the Department. However, NHS Resolution provided detailed input into the submissions listed below, and supported the recommendations made.

61. It is the responsibility of the Department to put the submission before the Secretary of State. The documents held by NHS Resolution are only those shared by the Department and whilst they appear to be the final versions, this would need to be confirmed by the Department. We would expect any disclosure of such submissions to be managed by the Department.

**Key dates and documents**

| **Date** | **Event/ document** |
|---|---|
| 8 March 2016 - 17 May 2016 | CNST 2016 consultation (not exhibited) |
| 17 October 2016 | Secretary of State announces a high-level policy intention to make CNST maternity contributions more responsive to the relative safety of different maternity units. |
| 17 October 2016 | CNST 2016 consultation report published by NHS Resolution [Exhibit HV/12]. **INQ0008997**<br>The consultation report: |

| Date | Event/ document |
|---|---|
| | - sets out an explanation of how CNST pricing operated at the time (see page 11)<br>- looked at building in a "forward view" to pricing to incentivise improvements (section 5.5, page 25)<br>- referred to work on developing indicators in relating to maternity claims in particular (page 30) |
| 26 October 2016 | Submission to the Secretary of State |
| By 2 November 2016 (exact date unknown to NHS Resolution) | Following receipt of the submission, the Secretary of State agrees to the use of (1) unexpected admissions of term babies to neonatal units and/or (2) stillbirth data, as indicators for calculating next year's risk-based CNST maternity contributions . |
| November 2016 | NHS Resolution instructs the Government Actuary's Department ("**GAD**") to carry out data analysis. |
| 14 December 2016 | Submission to the Secretary of State |
| 15 December 2016 | The Department confirms to NHS Resolution by email that the Secretary of State has agreed to publishing the contributions in shadow form for 2017/18, and that he would like this to be based on a combination of unexpected admissions and CQC rating. |
| 21 August 2017 | The Secretary of State's "Care meeting" was scheduled to cover various issues relating to maternity data. NHS Resolution did not attend this meeting.<br>NHS Resolution has a copy of the slides created for the meeting, which include an update on CNST indicators and pricing in relation to maternity-related services. |
| 18 September 2017<br>(We understand from subsequent emails with the Department that although dated 18 September 2017 this submission was sent to | Submission to the Secretary of State |

| Date | Event/ document |
|---|---|
| the Secretary of State on 25 September 2017.) | |
| 25 September 2017 | The Secretary of State's "Care meeting" was scheduled to cover maternity safety.<br>We have a copy of the slides created for that meeting, which refer to the CNST pricing approach for 2018/19. |
| 18 October 2017 | Meeting between the Secretary of State; the then national champions for maternity safety Professor Jacqueline Dunkley-Bent and Dr Matthew Jolly; myself and an NHS Resolution colleague to discuss CNST pricing for maternity premia.<br>We have a copy of the email sent by the Department summarising the actions coming out of the meeting.<br>[Exhibit HV/13] **INQ0008998**<br>Beneath the heading *1. CNST maternity pricing* it recorded that the Secretary of State:<br>*"asked us to set maternity prices for 18-19 in a way that rewarded Trusts that could successfully demonstrate that they were complying with ?10 key maternity safety actions, and supported the whole maternity safety agenda"* |
| 5 November 2017 | Date of NHS Improvement document regarding the key maternity safety actions<br>[Exhibit HV/14] **INQ0008999** |
| 6 November 2017 | The 16 November 2017 submission to the Secretary of State refers to a Care meeting on 6 November. |
| 8 November 2017 | Meeting of stakeholders convened by NHS Resolution to develop the maternity safety actions. I have exhibited an email chain that sets out the purpose of the meeting and attaches a spreadsheet with details of the potential safety actions and who proposed them [Exhibit HV/15]. **INQ0009002** **INQ0009000** **INQ0009003** |
| 16 November 2017 | Submission to the Secretary of State<br>We received feedback from the Department that the Secretary of State decided to proceed with the setting of CNST |

| Date | Event/ document |
|---|---|
| | contributions in line with the draft safety actions, a 10% uplift to CNST contributions and a smaller amount of funding being made available to non-compliant Trusts to help them progress towards full compliance. |
| 28 November 2017 | Secretary of State announces *Safer Maternity Care – The National Maternity Safety Strategy – Progress and next steps* in a speech to the House of Commons<br>The Department publishes *Safer Maternity Care – The National Maternity Safety Strategy – Progress and next steps*<br>[Exhibit HV/01] **INQ0008995**<br><br>The strategy document gives an overview of the new incentive scheme, including the ten safety actions, at pages 31-32 beneath the heading *Rewarding the delivery of best practice to improve safety*. |
| November 2017 onwards | NHS Resolution continued to work with stakeholders to develop the detail of the MIS, for example the verification process. |
| 19 December 2017 | Email chain concluding with an email from the Department stating that, following input from NHSE, CCGs would not assure Trust submissions and that *"we will now proceed on the basis of trusts self-reporting"* [Exhibit HV/16] **INQ0009004** |

## THE MATERNITY INCENTIVE SCHEME

### Overview of the MIS

Initiation of the MIS

62. The Department's document *Safer Maternity Care – The National Maternity Safety Strategy – Progress and Next Steps* published on 28 November 2017 (**"National Maternity Strategy – Next Steps"**) [Exhibit HV/01] sets out the background to the **INQ0008995**

introduction of MIS – see in particular pages 31-32. The safety actions were listed as follows:

***Box 2: Criteria for the Maternity Safety Strategy CNST discount***

1 *Are you using the National Perinatal Mortality Review Tool to review perinatal deaths? (Y/N)*

2 *Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? (Y/N)*

3 *Can you demonstrate that you have transitional care facilities in place and operational to support the implementation of the ATAIN Programme? (Y/N)*

4 *Can you demonstrate an effective system of medical workforce planning? (Y/N)*

5 *Can you demonstrate an effective system of midwifery workforce planning? (Y/N)*

6 *Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives care bundle? (Y/N)*

7 *Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback? (Y/N)*

8 *Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year? (Y/N)*

9 *Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues? (Y/N)*

10 *Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?*

63. At the time the National Maternity Strategy – Next Steps was published the National Champions for Maternity Safety (**"Maternity Champions"**) were Dr Matthew Jolly and Professor Jacqueline Dunkley-Bent (see page 7). At the time of writing, Dr Jolly and Professor Dunkley-Bent have left their roles. Professor Dunkley-Bent has been

succeeded by Kate Brintworth RM and Dr Jolly has been succeeded by Professor Donald Peebles.

64. The safety actions were agreed by the Maternity Champions, with NHS Resolution administering the scheme via the CNST. The MIS commenced in 2018. We have completed four cycles and are part way through year five:

| | **Start of reporting period** | **End of reporting period** |
|---|---|---|
| MIS year one | January 2018 | 29 June 2018 |
| MIS year two | 12 December 2018 | 15 August 2019 |
| MIS year three | 20 December 2019 | 15 July 2021 |
| MIS year four | 6 May 2022 – relaunch | 2 February 2023 |
| MIS year five | 31 May 2023 | 1 February 2024 |

65. The variation in reporting period represents a considered response to system pressures and the Covid-19 pandemic. Timings have also been adjusted so that the collection of contributions and the making of payments are carried out at more appropriate time of the financial year. This is why the reporting periods vary from year to year.

66. The MIS has evolved over the five years in which it has been in operation, as we have learnt from experience and refined our ways of working. I have begun by setting out the core elements of the scheme. I then go on to detail the changes that have been made each year.

67. Provision for the MIS is built into our CNST maternity pricing. Trusts contribute an additional 10% on top of their CNST maternity contribution ("**MIS contribution**") to finance the MIS. The MIS contributions from the various Trusts are treated as the CNST maternity incentive fund ("**MIS Fund**") from which MIS payments are made.

68. Trusts that do not meet all ten safety actions do not recover their MIS contribution but can be eligible for a smaller discretionary payment from the scheme to help them make progress against any actions they have not achieved. There is a cap on the amount that each Trust can receive from a discretionary payment, set by reference to their MIS

contribution. In year four, this maximum was increased in recognition of the additional challenges that the system faced.

69. Trusts that demonstrate they have achieved all the ten safety actions recover their MIS contribution and will also receive a share of any unallocated funds (MIS funds from those Trusts that have not met the safety actions less any discretionary awards). They receive a share proportionate to their MIS contribution. To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution by the deadline provided and must comply with the conditions of the scheme set out in the published guidance.

70. For years one to three inclusive the MIS was a self-certification scheme with all scheme submissions requiring sign-off by Trust boards. From year four of the MIS, sign-off has also been required by Integrated Care Boards ("**ICBs"**). ICBs were established by the Health and Care Act 2022 in July 2022. Before ICBs were established, their predecessor organisations – Clinical Commissioning Groups ("**CCGs**") – were involved in place of ICBs. In years one to three of the MIS there was a requirement for discussions with CCGs before sign-off.

**External verification**

71. All submissions also undergo an external verification process, where we cross-check what is said in the submission against other sources of evidence.

- Safety action 1 includes a check of all Perinatal Mortality Review Tool referral data, verified with MBRRACE-UK;
- Safety Action 2 includes a check of the submission of data to the MSDS, undertaken by NHS England digital team;
- Safety Action 10 includes a check that all eligible cases have been reported to the EN Scheme, and latterly to the HSIB/ MNSI. This check has not been undertaken fully over that last year due to data access issues and the HSIB to the MNSI transition. The checks resumed from October 2023.

72. Submissions are also sense-checked by the CQC. From year three onwards the HSIB (now the MNSI) have also carried out a sense-check. The CQC and the MNSI consider whether they potentially have any concerns or information that may call into question the MIS submission made by the Trust. For example, the CQC may highlight that they have recently carried out an inspection that has raised concerns. In such a case deciding the MIS compliance status for that Trust may be delayed until the full CQC report is

published so that the CQC information can be compared with the Trust submission. This may result in asking the Trust to reconfirm their submission and provide evidence to NHS Resolution to support their submission, in line with the reverification process.

73. A copy of the verification process for year two was published on 26 February 2020 and is INQ0009005 exhibited here [Exhibit HV/17]. Further details of how verification evolved over time are set out in documents exhibited in the year-by-year section below.

**Non-compliance and action plans**

74. Where a Trust does not meet all the ten safety actions, it can apply for discretionary funding from the MIS Fund to address the consequent safety concerns. In order to receive such funding, the Trust must submit an action plan, setting out the actions it will take to address the safety concerns and an associated cost.

75. The action plan must be agreed by NHS Resolution through our internal Approvals Group (see further below) in order for the Trust to receive a discretionary payment to support implementation of the plan. If a plan is not approved NHS Resolution provides feedback and the Trust is given an opportunity to refine it.

76. The Approvals Group was established to consider recommendations from the CAG and make decisions on awarding funding to Trusts in relation to the MIS. This group takes the final decision on all funding to be awarded to Trusts. Local Maternity and Neonatal Systems have oversight of the delivery of action plans.

77. A copy of the current Terms of Reference of the Approvals Group is exhibited at [Exhibit INQ0009006 HV/18]. There are also earlier versions.

**Appeals process**

78. Trusts can appeal against a decision that they have not complied with one or more of the safety actions. As NHS Resolution's Chief Executive, I am the final decision-maker regarding any appeal. I receive advice on appeals from the Appeal Advisory Committee (the "**AAC**") – further detail on the AAC is provided below.

79. There are two possible grounds for appeal:

- alleged failure by NHS Resolution to comply with the published conditions of scheme and/or guidance documentation; or

- technical errors outside the Trust's control and/or caused by NHS Resolution's systems.

Trusts are not able to appeal against a decision to refuse an application for discretionary funding.

**Reverification process**

80. Reverification of a Trust's submission is initiated if a concern is raised that a Trust board has incorrectly certified compliance with one or more of the ten safety actions or sub-requirements of the safety actions within the MIS. This may be identified through whistleblowing or following a CQC report that calls into question the original declaration. In the first instance, Trusts are asked to complete an internal review of the evidence that was used to support their compliance for the relevant year at the time of submission. This must be the same evidence that was used to inform the Trust board at the point of declaration. Trusts will be given the opportunity to downgrade their position at this point. If the Trust remains confident that their compliance declaration was correct, the Trust will be asked to provide all evidence to NHS Resolution. A full review of the relevant evidence will then be undertaken by two members of the MIS team (reverification).

81. If a Trust originally declared compliance with all ten safety actions and is subsequently found not to have been compliant with all ten actions, the Trust is asked to pay back any MIS payments to it for the year (or years) in question.

82. A small number of Trusts have been required to repay funds for two successive historic MIS years for which the reverification process has demonstrated they were non-compliant with all ten safety actions within the scheme. Our usual practice would be to continue to review the previous years' MIS submission whenever an incorrect declaration has been identified. However, as the MIS matures into year five and beyond, with an increasing number of cycles, we recognise both the increased administrative burden on providers from sourcing and reviewing historic evidence, and the increasing financial consequences. Following discussions with NHSE finance leads, we have reached an agreement that for all Trusts we will limit reverification reviews to the current (ongoing) year, plus two previous years. This will ensure that no Trust is ever required to repay funds for more than two historic years of the MIS.

83. Any repaid MIS payments are utilised to provide discretionary funding to support the Trust's safety improvement action plan (if the action plan is agreed by the Approvals

Group), and the remainder is redistributed to all Trusts declaring compliance within the relevant MIS year(s).

84. Trust mis-declarations are escalated to the CQC to consider whether any further steps should be taken. NHS Resolution also publishes details on its website and informs:

- the relevant Trust Chief Executive;
- the Director/ the Head of Maternity and Neonatal at the Department;
- the following post-holders at NHSE:
    - Chief Midwifery Officer for England;
    - the Regional Director;
    - the Regional Chief Midwife;
    - the Regional Lead Obstetrician,

  and their deputies.

85. In response to some NHS Trusts mis-declaring compliance with the MIS safety actions over the years that the scheme has been in operation, the process and conditions of the scheme have been and continue to be revised and strengthened to reduce the risk of future mis-declarations. The steps taken in each year of the MIS's operation are set out in the guidance identified in the year-by-year sections below.

86. There is a standard operating process for reverification [Exhibit HV/19]. **INQ0009008**

**Governance**

The Collaborative Advisory Group

87. In terms of the governance of MIS, the CAG was established by NHS Resolution to bring together other arm's length bodies and the relevant Royal Colleges to support the delivery of the MIS. The CAG includes appropriate NHS Resolution staff and external representatives from:

- NHSE (including the two National Maternity champions);
- MBRRACE-UK;
- Royal College of Obstetricians and Gynaecologists;
- Royal College of Midwives;
- CQC including from MNSI (previously an arm of HSIB); and
- the Department

88. This structure, alongside our Significant Concerns process and other escalation processes (Perinatal Surveillance Group meetings), allows NHS Resolution to inform our external partners of any concerns identified through the MIS.

89. The CAG was established to support the delivery of the MIS and advise on the following issues:

- Reviewing Trusts' progress and potential challenges in achieving the safety actions and agreeing on next steps.
- Reviewing any responses for requests for more information or evidence in relation to submissions.
- Reviewing the MIS process and outcomes, including MIS reverification.
- Ongoing evaluation of the maternity scheme.
- Advising on the process of evaluation for the scheme.
- Advising on the setting of criteria on the awarding of funding and the principles for any discretionary decisions.
- Advising on future steps and support for Trusts who have submitted action plans for MIS discretionary funding.
- Advising on the drafting of the MIS guidance and additional reports/communications letters as required, which can be shared in the public domain and with Trusts.
- Advising on the approach regarding external verification for the safety actions.
- Considering next steps in terms of Trusts which failed external verification of compliance with the MIS.

90. A copy of the earliest CAG terms of reference are exhibited as [Exhibit HV20]. (This **INQ0009011** version contains some track changes but we believe it to be the final or close to final version in use from May 2018.) Please note that the external membership has changed slightly over time. The current version is exhibited as [Exhibit HV/21]; there have been further versions in between these two documents. **INQ0009013**

The Approvals Group

91. The Approvals Group was established by NHS Resolution's Senior Management Team to consider recommendations from the CAG and make decisions on awarding funding to Trusts in relation to the MIS. The Approvals Group is made up of:

- Director of Safety and Learning, NHS Resolution (Chair);
- Deputy Director of Safety and Learning, NHS Resolution (Deputy Chair)

- Director of Finance and Corporate Planning, NHS Resolution;
- Non Executive Director of NHS Resolution;
- NHS Resolution senior clinical advisers (2);

Also in attendance are:

- Finance lead, NHS Resolution;
- Deputy Director of Corporate and Information Governance, NHS Resolution.

92. This group takes the final decision on all funding to be awarded to Trusts in line with the criteria agreed by the CAG and the principles for any discretionary decisions. A copy of the original and most recent Approvals Group terms of reference are exhibited as [Exhibit INQ0009015 HV/22] and [Exhibit HV/23]. There have been two other versions in between these. INQ0009016

Appeal Advisory Committee

93. The AAC was established to receive and consider appeals submitted by Trusts within the designated appeals window and make recommendations to NHS Resolution's Chief Executive as to whether those appeals should be allowed or dismissed. The AAC is chaired by the Chief Nursing Officer for England (a position at NHSE) or their designated deputy. A copy of the original and current AAC terms of reference are exhibited as [Exhibit HV/24] INQ0009019 INQ0009018

NHS Resolution oversight

94. It is the responsibility of NHS Resolution's MIS Internal Stakeholder Group to consider risks pertaining to the MIS and its delivery and escalate to NHS Resolution's Senior Management Team.

95. We exhibit the current Terms of Reference for the Internal Stakeholder Group dated 27 INQ0009020 July 2023 [Exhibit HV/25]. The first version of the Terms of Reference was approved on INQ0009023 13 May 2020 [Exhibit HV/26]. There are other versions dated 16 September 2020 and 23 June 2023.

96. NHS Resolution's internal team supports the operational delivery and governance of the MIS. It helps to identify Trusts of concern and interacts with the EN Team as appropriate. Both groups are made up of internal NHS Resolution staff. The terms of reference for NHS Resolution's MIS team meetings, introduced in July 2023 are exhibited here [Exhibit INQ0009026 HV/27]. These were introduced to support and improve the governance of such meetings, and the meetings now feed into the Internal Stakeholder Group.

**MIS guidance and results – year by year**

97. I have set out below the core guidance documents for each of the five years that the MIS has been in operation. These documents show how the scheme has evolved over time. I have also provided the results for each of the first four years – year five results are not yet available as the reporting window is still open at the time of writing. Much of the documentation that I refer to can be found on the NHS Resolution website. We do hold further documentation, such as drafts, communications with Trusts and additional material on our website.

98. In some years, there was more than one version of the guidance (see below). I have exhibited here the final versions for each year, as these set out the rules against which submissions were assessed.

99. Please note that the reverification and appeals processes mean that results can be amended. Documents were correct at the time they were published or circulated but results in later documents may vary because of this.

Year one: reporting period 1 January 2018 – 29 June 2018

100. This briefing paper sets out the safety actions, minimum evidential requirements and verification processes for year one at Appendix 1; and the year one results at Appendix 3: [Exhibit HV/28]. **INQ0009029**

101. The results for year one were published on 27 November 2018. Details of the safety actions that had not been met by each Trust were set out in the results spreadsheet [Exhibit HV/29]. **INQ0009030**

Year two: reporting period 12 December 2018 – 15 August 2019

102. From year two onwards we published a standard MIS guidance document. This document includes:

- The conditions of the scheme;
- the ten maternity safety actions;
- supporting technical guidance; and
- responses to frequently asked questions.

**INQ0009033**

103. The year two standard guidance is exhibited here [Exhibit HV/30]. Details of the verification process for year 2 were published separately [Exhibit HV/17]. **INQ0009005**

104. The results for year two were published on 13 February 2020. Details of the safety actions that had not been met by each Trust were set out in the results spreadsheet [Exhibit HV/31]. **INQ0009034**

Year three: reporting period 20 December 2019 – 15 July 2021

105. Following a pause in the MIS in in response to the Covid-19 pandemic in March 2020, year three of the scheme was re-launched on 1 October 2020. The year three standard guidance is exhibited here: [Exhibit HV/32] **INQ0009037**

106. From year three of the MIS onwards, MNSI (formerly part of HSIB) and NHS Resolution have been jointly responsible for safety action ten.

107. The results for year three were published in February 2022. Further details of the safety actions that had not been met by each Trust are set out in the results spreadsheet [Exhibit HV/33]. **INQ0009038**

Year four: reporting period 6 May 2022 – 2 February 2023

108. The scheme was initially launched on 9 August 2021 for year four. However, Trusts continued to face significant workforce challenges due to high staff absence rates as well as clinically vulnerable staff that were required to isolate due to Covid-19. As a result, the decision was made by the CAG in December 2021 to pause the scheme. The year four standard guidance is exhibited here [Exhibit HV/34]. **INQ0009041**

109. On 1 December 2022 a clarification letter was issued in relation to safety action five **INQ0009043** [Exhibit HV/35]; and a change letter issued in relation to safety action eight due to workforce pressures [Exhibit HV/36]. **INQ0009044**

110. The results for year four were published on 19 May 2023. Details of the safety actions that had not been met by each Trust are set out in the results spreadsheet [Exhibit HV/37] **INQ0009045**

Year five: reporting period 31 May 2023 – 1 February 2024

111. The final version of the standard guidance was published on 19 July 2023 [Exhibit HV/38]. **INQ0009048**

112. Following feedback from Trusts on the impact of industrial action, on 23 October 2023, NHS Resolution sent Trusts a letter revising the guidance on safety action one and safety action eight [Exhibit HV/39]. **INQ0009049**

113. As the reporting period for year five has not yet ended, there are no results for year five.

**CoCH and the MIS – year-by-year**

Year one

114. In year one of the MIS, CoCH submitted a board report that suggested they had complied with all ten of the safety actions. However, an action plan to achieve safety action eight was also included, therefore suggesting compliance with only nine out of ten safety actions [Exhibit HV/40]. Further correspondence on 19 July 2018 confirmed that only nine of the ten safety actions had been complied with [HV/41]. CoCH therefore did not receive their full rebate for year one as they were not fully compliant; they did receive £35,000 in discretionary funding.

INQ0009050 INQ0009051 INQ0009052 INQ0009055

Year two

115. In year two, CoCH initially self-declared as being compliant with all safety actions [Exhibit HV/42] [Exhibit HV/43]. At this point in time, CoCH were found to be compliant and received the full rebate of MIS funds.

INQ0009056 INQ0009058

116. However, CoCH was later found to have made an incorrect declaration for year three (as set out from paragraph 121 onwards). In accordance with the MIS conditions, CoCH were therefore required to undertake a full review of their evidence submitted for year two and to re-confirm whether they had met the safety actions. This was set out in a letter from me to CoCH's Chief Executive dated 22 May 2023 [Exhibit HV/44].

INQ0009059 INQ0009060

117. There then followed correspondence between CoCH and NHS Resolution:

- [Exhibit HV/45] INQ0009087 INQ0009062 INQ0009088
- [Exhibit HV/46] INQ0009111
- [Exhibit HV/47] INQ0009139 INQ0009138
- [Exhibit HV/48] INQ0009141
- [Exhibit HV/49] INQ0009142

NHS Resolution found that for year two safety actions 1, 3, 4, 5, 6, 7, 8 and 9 had not been complied with. Further detail is set out in [Exhibit HV/50]. NHS Resolution asked for repayment of the MIS funds paid out to CoCH in year two and offered CoCH the opportunity to apply for discretionary funding by submitting an action plan.

INQ0009143 INQ0009144 INQ0009145

118. There followed further correspondence regarding the action plan [Exhibit HV/51]. No action plan was submitted by the deadline. The Trust asked for an extension to the deadline and NHS Resolution agreed to this and provided dates for a meeting to discuss the issues. INQ0009148

119. We have contacted the Trust twice since then to discuss their action plan. On 5 December 2023, the Trust replied to say that they are taking the matter up with their ICB and are not actioning anything further at this time [Exhibit HV/52]. INQ0009149

120. On 8 December 2023, we sent a final request for return of MIS funds without any discount, given that we had not received an action plan or bid for discretionary funding [Exhibit HV/53]. INQ0009150

121. The Trust have recently contacted us to discuss year two verification and a further meeting was held on 19 February 2024 between senior members of both organisations. Following this meeting the Trust have arranged a further meeting to discuss their evidence in support of year two.

122. At the time of writing, we can confirm that the Trust agree they were non-compliant with their year three declaration and therefore are required to reimburse us for that year, less the agreed sums for their approved action plan. Year two is still being verified as we await the Trust's further evidence.

Year three

123. CoCH self-declared as being compliant with all safety actions on 20 July 2021 [Exhibit HV/54]. Following a negative CQC report, NHS Resolution wrote to CoCH on 4 August 2022 to ask CoCH to undertake a full review of the year three evidence submitted to the CoCH board and reconfirm whether or not CoCH still considered that the ten safety requirements had been complied with [Exhibit HV/55]. CoCH wrote to us to explain that they no longer considered that all ten safety actions had been met for year three [Exhibit HV/56]. NHS Resolution confirmed that the MIS funds paid to CoCH for year three would need to be repaid and offered CoCH the opportunity to apply for discretionary funding by submitting an action plan [Exhibit HV/57]. INQ0009151 INQ0009152 INQ0009153 INQ0009156 INQ0009160 INQ0009157 INQ0009161

124. There followed correspondence regarding the action plan:

- [Exhibit HV/58]. (The first attachment to the email is not exhibited as it is a further copy of the NHS Resolution letter of 28 October 2022. On the second attachment, see the "ActionPlan EntrySheet" tab of the spreadsheet, as well as the entry sheets INQ0009165 INQ0009167

for each safety action which set out CoCH's position following their review. Note that some rows need to be deepened to view all of the text).

- [Exhibit HV/59] INQ0009168
- [Exhibit HV/60] INQ0009171 INQ0009169
- [Exhibit HV/61] INQ0009173

125. NHS Resolution confirmed with CoCH on 22 May 2023 that their request for discretionary funding of £71,413 had been approved and that the year two submission would need to be reviewed [Exhibit HV/44]. The review led to the finding that the Trust had not complied with all ten safety actions in year two, as outlined above. INQ0009059

Year four

126. CoCH self-declared as being compliant with all safety actions except for safety actions one, six, and eight on 1 February 2023. It submitted action plans for these areas [Exhibit HV/62]. There was an exchange of emails between the two organisations in relation to safety action ten [Exhibit HV/63] and the action plan [Exhibit HV/64]. CoCH's discretionary funding was approved on 7 April 2023. INQ0009174 INQ0009175 INQ0009176 INQ0009179 INQ0009180 INQ0009181

Year five

127. At the time of writing, the reporting window for year five has not yet closed.

128. The EN team recently carried out a thematic review into the cases that CoCH had referred to NHS Resolution under the EN Scheme. The thematic review was carried out in response to concerns raised by the CQC, which subsequently resulted in the Trust downgrading its year three MIS submission from compliance with ten safety actions to compliance with three safety actions on the 30 December 2022. The thematic analysis was commenced on 25 February 2023 and ended on 8 March 2023 for cases reported between 1 April 2017 and 3 March 2023. I have exhibited to this statement a copy of the thematic review outcome letter sent to CoCH [Exhibit HV/65]. INQ0009183

**Surveys and evaluations of the MIS**

129. Surveys have been sent to all participating Trusts following each year of the MIS. These have included questions on which safety actions may have had a significant impact on safer maternity care, as well as querying if there have been any unintended consequences (both positive and negative) as a result of the work done to meet the MIS

objectives. The results of these surveys are not published but undertaken to inform the year-on-year incremental development of the MIS.

130. NHS Resolution published an "interim evaluation" in 2020, to provide an overview of the year two survey results and to evaluate the impact of the MIS as at the publication date. INQ0009184 INQ0009194

131. The survey results from years three and four [Exhibit HV/66] and the published interim evaluation based on the year two results [Exhibit HV/67] are exhibited to this statement. INQ0009195 The survey for the current year (year five) will be issued once the year has concluded.

132. The CAG discussed the possible causes of lower compliance rates for year four in their meeting of 15 March 2023 [Exhibit HV/68] – see the text below the heading *MIS Year 4* and *Reverification Process.* The CAG has worked hard to try and keep the balance between keeping the MIS safety actions achievable for Trusts while continuing to incentivise adoption of the safety actions to achieve safer maternity care. For example, pauses in reporting periods during the height of the Covid-19 pandemic were part of NHS Resolution's effort to reduce some of the pressures. INQ0009196

133. We are currently in the process of carrying out a comprehensive evaluation of the MIS. This work is in progress at the time of writing this statement and is expected to conclude in the financial year 2024/25. NHS Resolution has gone out to tender for a maternity academic partner to join the evaluation team. Their work will add crucial external rigour and validity to the evaluation.

134. Prior to completing this current evaluation of the MIS, we have carried out a rapid early stakeholder engagement exercise. This listening exercise was undertaken from August to September 2023 as a pre-cursor to the full comprehensive evaluation. It involved speaking in detail to over 30 stakeholders about the operation of the MIS, to receive qualitative feedback about how the scheme is operating and what it has achieved. NHS Resolution engaged with a broad range of stakeholders including all safety action lead organisations, regional midwife/obstetric leads, NHS Trust staff (non-executive directors, executive directors, managerial and operational staff) and commissioning staff. NHS staff

from Trusts with a range of MIS compliance ranging from three to ten safety actions were interviewed to ensure a comprehensive range of perspectives were captured.

135. This exercise was carried out for two reasons. The first was to inform the design of the evaluation of the scheme. The second was to inform the safety actions for year six, as the broader evaluation will not be completed in time to do this.

136. A paper setting out the findings of the rapid snapshot was recently considered by NHS Resolution's Senior Management Team and was considered by NHS Resolution's board in January 2024.

## CONCERNS ABOUT THE NEONATAL UNIT AT COCH/ LUCY LETBY

137. While the content of our claims files is covered by legal privilege, we are prepared to voluntarily disclose the information set out below in order to explain when we first became aware of concerns regarding the neonatal unit at CoCH, as requested by the Inquiry. We do not waive privilege in respect of any other information.

### NHS Resolution's early awareness of concerns about the unit/ Lucy Letby

138. NHS Resolution has been asked by the Inquiry how it first became aware of concerns regarding the neonatal unit at CoCH, including concerns raised by individuals or organisations about unexpected deaths or incidents in the neonatal unit.

139. There are three routes through which we might hear about concerns raised by individuals or organisations in relation to unexpected deaths or incidents. The first would be through a claim or request for inquest representation funding under the CNST. The second would be through our Advice service. The third is a report to us as part of the MIS (please note that the MIS was not active during the period June 2015-2016).

CNST

140. The first record that NHS Resolution has of becoming aware of any death in the neonatal unit at CoCH following the start of Lucy Letby's employment as a nurse there, was when we received a request for inquest funding from CoCH on 19 January 2016. This was in relation to Child D (using the identifier used in the criminal proceedings). As well as covering clinical negligence claims, Trusts covered by CNST can request a contribution to funding for legal representation at an inquest through our inquest funding protocol, if it

is considered that a claim for compensation is likely to be made in respect of the deceased patient who is the subject of the inquest. NHS Resolution approved the request for a contribution to funding and a solicitor's firm on our legal panel, Hill Dickinson LLP, was instructed by NHS Resolution in relation to the inquest on 20 January 2016. Approving a request for a contribution to inquest funding is not out of the ordinary, and it is not unusual for Trusts to request such funding.

141. The request for inquest funding appended the CoCH's internal 'case review' report dated 28 August 2015 (watermarked "draft"), setting out the conclusions of a clinical review by the Obstetric Secondary Review Team and the Neonatal Review Team. The case review states that the incident was escalated to the Medical Director and Director of Nursing & Quality and was subsequently discussed at an extraordinary Executive Serious Incident Panel on 2 July 2015. It states that there had been three neonatal deaths in a short period of time and the circumstances were discussed to identify if there was any commonality which linked the deaths. The case review goes on to conclude that two of the babies had medical conditions which could be clearly seen to have contributed to their deaths. The third appeared to be an unexplained death and, at that time, this baby's cause of death was unknown. The report concludes that it was agreed that no further investigation was warranted at that stage as there were no concerns highlighted in the obstetric or neonatal reviews.

142. A letter before action in relation to Child D was received by the Trust on 25 May 2016, pursuant to the Ministry of Justice's Pre-action Protocol for the resolution of clinical disputes. This is a formal letter issued before court proceedings are started to attempt to resolve a claim for compensation before it goes to court.

143. The solicitor for the family of Child D contacted our solicitors on 7 February 2017 asking for a discussion about the "maternity review". This is the first record that our solicitors can locate regarding any broader review of the neonatal unit. Later records suggest that this was a request for a report by the Royal College of Paediatrics & Child Health (**"RCPCH"**). Our solicitors received a version of the RCPCH report that excluded Appendix 4 (Appendix 4 included details of the individual cases that were reviewed) on 13 February 2017 ("**RCPCH Report**").

144. Our solicitors' records show:

    a. That on 9 March 2017 they were notified of a review by neonatologist Dr Jane Hawdon commissioned by CoCH ("**Hawdon Report**"). Extracts from the Hawdon

Report (the section relevant to Child D and the overall recommendations) were provided to our solicitors on 10 March 2017. A full copy was provided to our solicitors on 29 August 2017.

b. That on 21 August 2017 they were notified of a thematic review of neonatal deaths at CoCH that was carried out by clinicians at CoCH, which included participation from a clinician from Liverpool Women's Hospital NHS Foundation Trust (**"Thematic Review"**). The review was provided to our solicitors on 4 September 2017.

145. NHS Resolution was notified by its instructed solicitors of "the recent neonatal review" on 7 April 2017. (It is not clear from the notes which review this refers to but from the surrounding documents we consider that it is probably a reference to the RCPCH review.) It is possible that we were aware of the RCPCH review earlier in February 2017, as it appears that there was some publicity about that review around that time. However, we have not been able to locate any contemporaneous records to confirm this.

146. Our solicitors provided NHS Resolution with a copy of the RCPCH Report (excluding Appendix 4) and the Hawdon Report (Child D extracts and recommendations) on 4 September 2017. They provided NHS Resolution with a copy of the Thematic Review on 19 September 2017.

147. While reviews are not uncommon, they are usually an indication that there are concerns about the quality of care being provided. We would therefore date our earliest knowledge of general concerns regarding the neonatal unit at CoCH to our first knowledge of these reviews. It would be more accurate to say that at that time NHS Resolution was aware of concerns held by CoCH about the unit through the existence of these reviews, rather than that NHS Resolution having evidence or a claims history that would indicate that there was cause for concern. At that point in time there was no cause for concern surrounding the individual claim we were managing.

148. For completeness, I should note here that NHS Resolution provided information to the coroner and the solicitors to Child D as part of the usual conduct of an inquest. This sharing took place via our solicitors.

149. CoCH notified NHS Resolution of five further potential clinical negligence claims on 7 August 2017. This notification referenced the earlier confirmation to NHS Resolution of

the police involvement (see paragraph 160 below) and confirmed all families involved had been contacted and subsequently five further potential claims had been received.

150. On 17 August 2017 NHS Resolution instructed its solicitors managing the Child D case to instigate a wider detailed generic investigation into the baby deaths at the neonatal unit to inform the potential for compensation claims. A consultant obstetrician and a consultant neonatal paediatrician were instructed, and their initial reports were received in January and February 2018 respectively.

151. Reports from both experts instructed by NHS Resolution were disclosed to the police. Relevant reports from both experts were disclosed to the coroner. This sharing took place via our solicitors. These reports are legally privileged and contain the personal information of families and are therefore confidential. We do not waive privilege in respect of these reports.

The Advice service

152. Advice is an advisory service. Advice is only aware of performance concerns if these are raised directly with us by either the practitioner (with concerns about their own practice) or the organisation they work for. These may include reference to concerns raised by individuals or organisations in relation to unexpected deaths or incidents but could also include other issues.

153. The Advice service has reviewed its records for any involvement with CoCH from 2012 to August 2023. We have located 14 Advice cases prompted by requests for advice from CoCH in this time period, but these do not raise issues relevant to the Inquiry's terms of reference – in particular, they did not relate to neonatal or paediatric services. We did not receive any request for advice regarding Lucy Letby.

154. Advice deals with concerns raised about an individual doctor, dentist or pharmacist and does not cover concerns regarding nurses. This is because under the NHSLA Directions 2013 we are only directed by the Secretary of State to provide advice, support and interventions about the performance of doctors, dentists and pharmacists. This means that a stand-alone concern about a nurse (such as Lucy Letby) would be unlikely to be referred to the service.

MIS

155. The MIS started in 2018, and therefore does not cover the time of the deaths that were the subject of the criminal trial. We did not receive any notification of concerns about

CoCH's neonatal unit through the MIS, other than the referral from the CQC, discussed above in relation to the reverification of CoCH's year three MIS submission.

156. As explained above, the MIS looks at Trust-level compliance with the ten safety actions. It does not investigate the quality of care or outcomes in particular cases. We therefore would not expect concerns about care of a particular patient, or the behaviour of a particular member of staff, to be raised through the MIS. In addition, only one safety action (safety action three) focuses exclusively on neonatal clinical care. The other nine concern maternity clinical care, staffing, training and governance.

**NHS Resolution's awareness of the criminal investigation**

157. We have been asked how NHS Resolution first became aware of concerns regarding potential criminal behaviour.

158. Our solicitors' records include a note made on 9 March 2017 that the CoCH neonatologists had accused one of the nurses of criminal actions; they had subsequently apologised and there was an on-going HR process. The RCPCH Report (excluding Annex 4), received by our solicitors in February 2017, recorded that "allegations" had been made against "Nurse L" but did not detail the allegations or refer to them as criminal. The extracts from the Hawdon Report, received by our solicitors in March 2017, did not refer to any allegations.

159. NHS Resolution first became aware of concerns regarding criminal behaviour on 16 May 2017 when it received a letter from its solicitors explaining that the police had become involved in the Child D case, so the coroner had agreed to adjourn the inquest. Lucy Letby was not named.

160. NHS Resolution's Technical Claims Director was also contacted by CoCH, about an upcoming press release noting the police were investigating unexplained neonatal deaths at the hospital. This phone call took place on 18 May 2017. Again, Lucy Letby was not named.

161. Our solicitors had a detailed telephone conversation with staff from the legal services department of CoCH on 21 August 2017 which indicated a nurse, unnamed, at the centre

of the issues was being treated as a factual witness and was receiving support from the Trust.

162. NHS Resolution first became aware of an arrest on 3 July 2018, but the name of the individual was unknown to NHS Resolution at that point.

**Complaints from clinicians and the affected families to NHS Resolution**

163. NHS Resolution's role is not to deal with complaints about practitioners from the general public or (except for our Advice service described above) from healthcare organisations. If such concerns are raised directly with us, we direct the individual to the relevant organisation, so that those concerns can be dealt with appropriately. In this case, NHS Resolution has no record of any contact from any whistleblower in relation to the unexplained deaths in the neonatal unit, or in relation to Lucy Letby. (Please note that records of such enquiries are not kept systematically by NHS Resolution, so it is not possible to rule out entirely that such contact was made.)

## NHS RESOLUTION'S SUPPORT FOR THE DUTY OF CANDOUR AND FREEDOM TO SPEAK UP

164. Having an open culture where individuals feel confident to speak up when things go wrong and to raise concerns is one of the key elements of ensuring a safe and effective workforce and the provision of safe patient care. NHS Resolution believes that organisations should foster a just and learning culture which balances fairness, justice and learning when things have not gone as planned.

165. We are committed to working with our system partners to help the NHS to further foster and develop an environment where this culture flourishes. In our day-to-day work NHS Resolution supports this through the advice and support we provide, by developing and sharing related information and tools; and in collaboration with key stakeholders. These activities are outlined in more detail below.

166. At NHS Resolution, we may have or receive concerns about the behaviour of individuals or organisational practices as part of our operational activities that may be detrimental to the safe and effective delivery of care. Our experience shows that, where possible, it is best for issues to be addressed locally where appropriate action can take place quickly and effectively. In situations where we cannot directly support an organisation to effectively address concerns, we will direct individuals to seek appropriate independent

advice and support. These organisations may include The National Guardian's Office, the Patient Safety Commissioner, the British Medical Association, the Royal Colleges or professional regulators such as the General Medical Council, the General Dental Council or the Parliamentary and Healthcare Services Ombudsman. This information can be found on our website [Exhibit HV/69]. INQ0009198

167. In 2018, NHS Resolution released various iterations of a leaflet entitled *Saying Sorry* INQ0009199 [Exhibit HV/70] as part of our work to support the on the duty of candour. This resource aimed at NHS staff highlights that saying sorry meaningfully when things go wrong is vital for everyone involved in an incident, including the patient, their family, carers and the staff that care for them.

168. Our *Being fair* report – [Exhibit HV/71], published in July 2019, sets out the rationale for INQ0009200 organisations adopting a more reflective approach to learning from incidents and supporting staff. This resource includes a practical 'Just and Learning Culture Charter' for organisations to adapt and adopt.

169. Our duty of candour animation (published March 2022) [Exhibit HV/72] offers guidance INQ0009201 on the importance of being open and honest and helps those working in health and social care to better understand the similarities and differences that exist between the professional and statutory duties of candour. The eight-minute animation also offers guidance on how they can be fulfilled effectively.

170. *Being fair 2* [Exhibit HV/73], published in March 2023, builds on the first *Being fair* report, highlighting the importance of: INQ0009202

a. instilling a workplace culture that is psychologically safe, compassionate and meets the basic needs of staff;
b. the need for greater clarity on what constitutes incivility, bullying and harassment; and
c. the need for further guidance for organisations on how to manage concerns fairly, particularly when addressing issues of incivility, bullying and harassment locally, before escalating to professional regulators.

171. I also meet with the National Guardian for the NHS, Dr Jayne Chidgey-Clark, twice a year to discuss how we can collaborate to promote the duty of candour and enable NHS

colleagues to speak up. The National Guardian's Office was included in the development of *Being fair 2*, along with other key stakeholders such as the CQC and NMC.

172. We promote all these documents through our member engagement events and raise awareness of them with our system partners and through our legal panel events.

## NHS RESOLUTION'S RESPONSE TO INQUIRY RECOMMENDATIONS ON CULTURE AND GOVERNANCE RELEVANT TO MATERNITY AND NEONATAL SERVICES

173. NHS Resolution takes any recommendations about safety, culture and governance issues from inquiries very seriously. Such recommendations are routinely considered and the required changes implemented within the organisation. NHS Resolution does not wait for the conclusion of inquiries before implementing changes, and will pro-actively seek to understand any issues, and identify any improvements that can be made at an early stage. A good example of this is that, following work undertaken preparing for the Paterson Inquiry, NHS Resolution developed a comprehensive internal case management policy framework for its case advice function; and also set up its Significant Concerns Group.

174. Please see below some relevant examples of NHS Resolution's response to previous inquiries, with the most recent first.

The Ockenden Review: Shrewsbury and Telford NHS Foundation Trust

175. The Ockenden Review focussed on the maternity services at the Shrewsbury and Telford NHS Foundation Trust. The report setting out the review's findings was published in March 2022. The Department wrote to NHS Resolution in April 2022, requesting that NHS Resolution review its activity over the period of the report and consider what changes needed to be made in light of the report's conclusions.

176. NHS Resolution responded to the Secretary of State by letter dated 12 May 2022 [Exhibit **INQ0009203** HV/74]. From page 6 onwards, the letter to the Secretary of State sets out the essential standards identified in Chapter 15 of the report (*Immediate and Essential Actions to improve care and safety in maternity services (IEA) across England)* and NHS Resolution's work in those areas. As stated in the response, NHS Resolution remains committed to further work which supports a just and learning culture, including the

development of *Being fair* and the new duty of candour animation (see paragraphs 166-168 above)

The Paterson Inquiry

177. The independent inquiry into the issues raised by Paterson (**"the Paterson Inquiry"**) was prompted by the actions of surgeon Ian Paterson, who performed inappropriate or unnecessary procedures and operations and was convicted of wounding with intent. The report of the Paterson Inquiry was published in February 2020. In 2021/2022 we were involved in task-finish groups led by the Department to consider whether the recommendations were agreed and how they could be implemented.

178. The recommendations of the Paterson Inquiry included:

- Recommendation 12a: "*We recommend that if, when a hospital investigates a healthcare professional's behaviour, including the use of an HR process, any perceived risk to patient safety should result in the suspension of that healthcare professional.*"
- Recommendation 12b: "*If the healthcare professional also works at another provider, any concerns about them should be communicated to that provider.*"
- Recommendation 14: "*We recommend that, when things go wrong, boards should apologise at the earliest stage of investigation and not hold back from doing so for fear of the consequences in relation to their liability.*"

179. The Government's update on implementation of the report's recommendations, published in December 2022, refers to two areas of NHS Resolution's work:

- Launching new guidance on making decisions about excluding staff in relation to whom concerns have been raised. Exclusion is designed as a short-term, temporary measure to remove a practitioner from their usual place of work until the nature and cause of a performance concern are understood and while an investigation is carried out. This work addressed recommendations 12a and 12b; and
- Launching a new animation on the duty of candour, plus NHS Resolution's continued provision of resources and engagement on both the need to apologise where appropriate and how to do so effectively. This work addressed recommendation 14.

The Morecambe Bay Investigation

180. The Morecambe Bay Investigation focussed on the maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust from January 2004 – June 2013. The outcome of the Morecambe Bay Investigation was published in March 2015. Although the MIS was not launched directly in response to a recommendation from the investigation, the policy behind it was developed in line with the Government's heightened focus on maternity following the conclusion of this investigation.

## THE EFFECTIVENESS OF THE CURRENT CULTURE, GOVERNANCE, MANAGEMENT STRUCTURES AND PROCESSES, REGULATION AND OTHER EXTERNAL SCRUTINY IN KEEPING BABIES IN HOSPITAL SAFE AND ENSURING QUALITY OF CARE

181. NHS Resolution works with but does not regulate NHS Trusts. Our interactions with Trusts are mainly through claims under CNST (and other schemes), the administration of the MIS and through our Advice service. We are not a regulator, commissioner or provider of healthcare services. Our perspective is therefore informed by our experience of the services we run, rather than the day-to-day operation of maternity services.

Workforce issues and culture

182. NHS Resolution notes in its recent report *Being fair 2* [Exhibit HV/73] that workforce issues like incivility, bullying and harassment are still prevalent across the NHS system. It also sets out the benefits of adopting a more reflective and fair approach to support staff to learn from incidents of harm. (As the report notes, the vast majority of things that do not go as planned are due to unintentional acts and choices. Only a tiny minority are the result of wilful behaviour and such concerns must be escalated appropriately.) See in particular the sections *The scale of the problem* (page 8), *Improving workplace culture* (page 14) and *Fair resolution of concerns* (page 22); and the *Just and learning culture charter* (page 30). INQ0009202

183. NHS Resolution has been clear in its policy message to the healthcare system that addressing and eliminating incidents of incivility, harassment and bullying, and ensuring fair processes are in place for managing concerns, should be a clear priority.

The role of Trust boards and ICBs

184. NHS Resolution notes that the role of boards in an organisation is key to protecting patient safety and responding to concerns. To help to develop the effectiveness of

boards in this way, NHS Resolution is developing two training sessions, as described below, to support boards so that they can better provide assurance on fair and timely resolution of concerns and understand the services which NHS Resolution offers to support them to respond to harm.

185. NHS Resolution is developing an introductory two-hour session exploring with Trust boards the human, workforce and financial costs of preventable harm and response to harm. This will provide delegates with a framework for providing assurance about the cost of harm, skills to interrogate their organisational claims scorecards and MIS results, and suggestions for how to build a culture that champions safety improvement.

186. NHS Resolution is also developing a masterclass for non-executive directors on resolving performance concerns. This will cover both the board's responsibilities for assurance of performance concerns as well as specifically the role of the designated board member in individual cases. It will focus on equipping board members with the questions to ask to assure themselves that performance concerns are being dealt with in a timely, fair, compassionate and proportionate way. This will be piloted in 2024.

187. NHS Resolution is also undertaking a small number of pilots with ICBs to help understand how we can best support them to manage risk within their systems. Our aim is to help ICBs build their capacity and capability for assurance, and to share our insights. As a first step, we have developed a data pack which is currently being tested and refined.

Working with the CQC

188. NHS Resolution is working closely with CQC in relation to the MIS to improve early information sharing and communication. This includes clarifying the roles of our respective organisations in supporting safety improvements in the service.

## THE ACCOUNTABILITY OF SENIOR MANAGERS

189. As a Special Health Authority, NHS Resolution has the roles given to it by the Secretary of State. Policy direction is set by the Secretary of State, with NHS Resolution taking on an operational and/or implementation role. We may encourage organisations within the healthcare system to take a particular approach where this is connected to one of our

existing roles – as we did with the publication of *Being fair 2* and the *Just and learning culture charter*.

190. The regulation of managers is an issue on which we have been questioned previously, and I have set out below a summary of NHS Resolution's observations on this question to date. I use the term "manager" to refer to an individual at a Trust who spends most of their time on management responsibilities rather than on the delivery of care.

191. While regulation is important, the focus on developing a trusted collective leadership team is vital, as is all members of staff having a shared purpose that puts patients at the centre.

192. Many senior managers within the NHS are already regulated by professional regulators (such as the General Medical Council and Nursing and Midwifery Council) because they are clinically qualified. Such regulation typically covers technical abilities and ethical duties to patients, not the ability to lead a team and an organisation. Adequate support, development and training for people making a transition from a clinical to management role as well as those transferring to a management role from generalist backgrounds, needs to be in place.

193. It is essential that NHS managers and clinical staff (by which I mean staff who spend most of their time delivering care) work collaboratively together with a shared purpose. NHS managers and clinical staff should feel enabled to raise concerns with each other in a safe, supportive environment; discuss risk; share evidence; and agree shared actions. Although regulation is not the only tool needed to achieve this, the CQC has a role in holding organisations and systems to account for the creation of an appropriate working culture, as part of its well-led assessment framework. The key question is how the CQC could obtain assurance that senior managers are adopting appropriate behaviours to achieve this. The CQC also regulates those responsible for care in organisations by ensuring that they are fit and proper to carry out their important role as per the fit and proper person requirement in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

194. The NHSE Fit and Proper Person Test ("**FPPT**") Framework exists with the purpose of strengthening and reinforcing individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS. The Seven Principles of Public Life (also known as the Nolan Principles) could be elaborated on in a way that makes them more relevant to NHS managers. Standards for managers could

also be developed, building on the recommendations of the Messenger Review, published in June 2022. Recommendation 3 was for *"Consistent management standards delivered through accredited training"*. We have learnt from the work of the Advice service and the MIS that it would be beneficial to improve the recording of reasons behind management decisions within Trusts, to aid transparency and assurance. Finally, we suggest that boards' ability to provide assurance about their Trust would be strengthened by developing stronger relationships with those working in roles that sit below board level.

195. Given our role, we have had little direct experience of senior managers at CoCH or the culture in which they operated. We are therefore not in a position to express an informed view of the performance and/or accountability of such managers.

## THE IMPACT OF NHS POLICY ON THE REPORTING OF SUSPECTED CRIMINAL ACTIVITY

196. We have been asked by the Inquiry whether the processes in place at Trusts inhibit clinicians, managers, nurses or midwives from reporting any suspected criminal activity by a member of staff. The *"Maintaining High Professional Standards in the NHS"* guidance issued by the Department ("**MHPS**") provides a framework for the initial handling of concerns about doctors and dentists in the NHS. It states at Part III, paragraph 12:

> ***"Action where investigations identify possible criminal acts***
> *Where an employer's investigation establishes a suspected criminal action in the UK or abroad, this must be reported to the police. The trust investigation should only proceed in respect of those aspects of the case which are not directly related to the police investigation underway. The employer must consult the police to establish whether an investigation into any other matters would impede their investigation. In cases of fraud, the Counter Fraud & Security Management Service must be contacted."*

One challenge is that this guidance can put the employing Trust in a potentially difficult situation if the alleged victim/ complainant does not want the matter reported to the police – because MHPS says this must be done.

197. There is a clear link between the culture within an organisation and a perception by staff that they can "speak up" – whether about suspected criminal activity or other behaviour. This is set out in more detail in the *Being fair 2* report – see page 15 [Exhibit HV/73]. **INQ0009202**

**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**: _____29 February 2024_____