Witness Name: Dame Ruth May
Statement No: 1
Exhibits: See Index to Exhibits
Dated: 1 May 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF DAME RUTH MAY

I, Dame Ruth May, will say as follows:

Introduction

1. I am the Chief Nursing Officer ("**CNO**") for England and I have held this role within NHS England since January 2019. Prior to this, I held various frontline and leadership roles as outlined below:

Date	Role
Since January 2019	Chief Nursing Officer for England, NHS England
April 2016 to January 2019	Executive Director of Nursing, Deputy Chief Nursing Officer for England, and the National Director of Infection Prevention and Control at NHS Improvement.
July 2015 to April 2016	Nurse Director at Monitor.
October 2011 to July 2015	Regional Chief Nurse and Nurse Director of NHS England's Midlands and East Region.
July 2009 to September 2011	Regional Chief Nurse and Nurse Director of the Midlands and East NHS Strategic Health Authority.
September 2007 to June 2009	Chief Executive Officer of Mid Essex Hospitals NHS Trust.
October 2005 to September 2007	Chief Executive Officer of The Queen Elizabeth Hospital King's Lynn NHS Trust.

2. Before this, I held various roles as an adviser or Nursing Director within the NHS, following on from a range of frontline clinical roles from when I first started working within the NHS as a student nurse in 1985.

3. I am a registered nurse on the Nursing and Midwifery Council's register. In terms of relevant memberships, these are as follows:

Date	**Role**
July 1985	Member – Royal College of Nursing
April 2020	Fellow – The Queen's Nursing Institute
September 2023	Member - Florence Nightingale Foundation Global Committee

Role of the Chief Nursing Officer for England

4. The CNO role is a broad role that has existed in some form in England since 1941, pre-dating the creation of the NHS. The CNO post resided in the Department of Health and Social Care ("**DHSC**") until 2012 when, as part of the Health and Social Care Act 2012, it was moved to NHS England. Although I am employed by NHS England and provide expert clinical and workforce advice for nursing to the board of NHS England, I am also an adviser to DHSC, the Government, and the wider NHS on nursing and midwifery related issues.

5. As CNO for England, I am the professional lead for the nursing and midwifery professions in England. There are currently around 383,500 nurses and midwives working for the NHS in England and who make up the largest group of the total NHS workforce. I am accountable for providing clinical and professional leadership for all nurses and midwives in England (the responsibility for public health nurses passed from Public Health England's Chief Nurse to myself on 16 November 2023). As a professional lead, I seek to set an example and to uphold the vital work and values of nurses and midwives.

6. In December 2020, with my support, DHSC established the post of the Chief Nurse for Adult Social Care to provide social care nursing leadership at DHSC. I maintain a

close working relationship with the Chief Nurse for Adult Social Care, to support consistent leadership across all areas of nursing in England. The Chief Nurse for Social Care reports to the Director General of Adult Social Care with a professional line to me as CNO. The Chief Nurse for Adult Social Care is part of the wider CNO team.

7. I would distinguish my work into three categories for the purposes of this statement:

- what I am accountable for as an executive lead;
- where I am a collaborator (where my sign off is required at some point in the approvals process); and,
- where I am a stakeholder or adviser (where my views are sought).

8. Within NHS England I am an executive director and I lead the Nursing Directorate. This means that I am responsible for the delivery of national programmes and policy areas that typically have a strong focus on nursing and midwifery. I also provide the nursing perspective and input into a wide range of clinical and operational issues that are the direct responsibility of other senior colleagues. My core accountabilities and deliverables are set out within the CNO candidate pack **[Exhibit RM/0001 [INQ0018053]]**.

9. In this wide role, I am supported by four Deputy CNOs within NHS England who provide senior leadership and support on specific areas of my responsibilities. I also have line management responsibility for the Chief Midwifery Officer who is responsible for the professional leadership of midwives, and NHS England's Director for People and Communities. Details of the areas of responsibility for each member of my central team are set out at Annex 1 of this statement.

10. I am not responsible for the strategic commissioning or day-to-day delivery of neonatal services. As outlined in the NHS England's Corporate Witness Statement ("**NHSE/1**"), NHS England is accountable for the commissioning of neonatal services under statute as part of its Specialised Commissioning function. These services are almost entirely commissioned and assured on a regional basis, with Operational Delivery Networks ("**ODNs**") being used to coordinate patient pathways between providers. The structures for national oversight through the regions to our national specialised commissioning function are outlined in paragraphs 87 - 112 of NHSE/1.

11. There has always been a clear interface between maternity and neonatal services; this

was consistently reflected in the work of the Maternity Transformation Programme and its board, chaired by Sarah-Jane Marsh from April 2016 until the end of 2022, following the publication of Better Births in 2016 [**INQ0014626**].

12. A key development in this period in relation to neonatal services was the publication in December 2019 of "Implementing the Recommendations of the Neonatal Critical Care Transformation Review" [**INQ0012352**]. This work outlined ten actions to deliver improvements in neonatal care, with the Neonatal Implementation Board, co-chaired by the Clinical Programmes Director and Chair of the Neonatal Critical Care Clinical Reference Group (both within Specialised Commissioning) established to lead this as a workstream of the Maternity Transformation Programme, with joint reporting to the national Specialised Commissioning Delivery Group. Further details of this work and the supporting neonatology speciality reviews which were published by Neonatology Getting It Right First Time in 2022 can be found at paragraphs 679 – 692 and 720 - 725 of NHSE/1.

13. This relationship between maternity and neonatal services has been strengthened in our work to deliver the Three Year Delivery Plan for Maternity and Neonatal Services, published in March 2023 ("**Three Year Delivery Plan**") [**INQ0012643**]. The actions set out in the Neonatal Critical Care Review report have been incorporated into the Three Year Delivery Plan, with neonatal ambitions now integral to each of its workstreams. At a regional level, closer working between regions and ODNs have also supported service delivery. Further details are provided in paragraphs 695 - 700 of NHSE/1.

14. Sam Allen, Chief Executive of North East and North Cumbria Integrated Care Board, was appointed in November 2023 as the Chair of NHS England's Maternity and Neonatal Programme Board, overseeing the delivery of the Three Year Delivery Plan. I am executive lead in NHS England for the Three Year Delivery Plan, working alongside Sam Allen. In this role I am supported by: Duncan Burton, Deputy CNO for Clinical Delivery; Kate Brintworth, Chief Midwifery Officer for England; and Professor Donald Peebles, National Clinical Director for the Maternity and Women's Health. The Maternity and Neonatal Programme (formerly the Maternity Transformation Programme) is one of the focuses within the portfolio of the Deputy CNO for Clinical Delivery. Duncan Burton has therefore been integral to the creation and progress of the Three Year Delivery Plan. In this respect, he reported to the Chair of the Maternity and Neonatal Board and myself. The Maternity and Neonatal Board and the weekly Maternity and Neonatal Leadership Group oversaw the development of the plan. I understand that Duncan is therefore providing the Inquiry with a statement focussing

on the Three Year Delivery Plan, so I would refer to that statement for further detail on this area.

15. To strengthen the programme's neonatal specialist capacity, with the support of my Deputy CNO for Clinical Delivery, we worked with other teams such as Specialised Commissioning and the National Medical Directors office to secure additional senior leadership through the creation of two new roles: a Neonatal Nursing Lead, to which we appointed Louise Weaver Lowe in May 2023 (0.4 whole time equivalent); and a National Clinical Director for Neonatal care, Dr Ngozi Edi-Osagie, who was appointed in January 2024 (0.4 whole time equivalent), although she had been providing her expertise to NHS England before this as Chair of the Neonatal Critical Care Clinical Reference Group (within Specialised Commissioning) and National Speciality Advisor.

16. In terms of my links to NHS England's regions, I work closely with NHS England's seven regional teams through their regional chief nurses. I provide professional leadership to NHS England's seven regional chief nurses, to complement their direct line management relationship with NHS England's regional directors, who in turn report at a national level to NHS England's Chief Operating Officer.

17. One of the roles of the regional chief nurses is to provide professional leadership and support to chief nurses in Integrated Care Systems, which includes trusts. Each NHS organisation is a statutory organisation, with their own accountable officers, usually their Chief Executive, who are responsible for the stewardship of their organisation, reporting to their own organisation's board.

18. Chief nurses (or Directors of Nursing) are board members of their trust or commissioning organisation's boards and are responsible for the leadership and in many cases line management arrangements of nurses and midwives within their own organisations. More details on the responsibilities of these organisations are available in NHSE/1 at paragraphs 134 – 153 in relation to provider trusts, and at paragraphs 279 - 282 in relation to Integrated Care Boards ("**ICB**").

19. As the CNO for England and an executive director and board member of NHS England, I am a member of the National Quality Board ("**NQB**") along with NHS England's Quality and Performance and Executive Quality Committees, the latter of which I co-chair with the National Medical Director. The governance structure for these committees is outlined in NHSE/1 at paragraphs 364 - 368.

20. My Deputy CNO for Quality and Patient Safety attends the bi-monthly National Joint

Strategic Oversight Group ("**JSOG**") on my behalf. As outlined in NHSE/1 at paragraphs 376 - 377, this Group provides a national forum for intelligence sharing among national partners, including the General Medical Council, the Nursing and Midwifery Council ("**NMC**") and the Care Quality Commission ("**CQC**"). It is jointly chaired by the CQC's Chief Inspector of Hospitals and NHS England's National Medical Director. As the JSOG has multi regulator membership, it does not formally report into an NHS England committee. However, information is shared as appropriate by NHS England members to the relevant NHS England committees, including executive committees.

21. The National Perinatal Safety Surveillance and Concerns Group is co-chaired by the Chief Midwifery Officer and National Clinical Director for Maternity. This group formally reports on a quarterly basis into the Quality, Performance and Surveillance sub-committee of the Maternity and Neonatal Programme Board. It also provides updates to the JSOG to ensure appropriate sharing of information with external stakeholders. I am made aware of relevant issues discussed at the National Perinatal Safety Surveillance and Concerns Group through my membership of the Maternity and Neonatal Programme Board, or directly by my clinical team. Issues specific to neonatal services are escalated to NHS England's Specialised Commissioning team.

22. In my role as CNO for England, I meet regularly with a range of external organisations to discuss strategic matters relating to the nursing and midwifery professions and other areas of healthcare within my executive responsibilities. This includes representative bodies such as the Royal College of Nursing ("**RCN**"), the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists; charities such as The Queen's Nursing Institute, Cavell Trust and Florence Nightingale Foundation; and the NMC, which is the independent regulator of nurses and midwives in the UK, and nursing associates in England (this role only exists in England).

23. In terms of the NMC, its core role is to protect the public by regulating and supporting the nursing and midwifery professions, which it does by maintaining a register of professionals eligible to practise, providing education and professional standards, and investigating concerns raised with them regarding professionals.

24. As the NMC is an independent regulator, I have no role in relation to its oversight or accountability. The NMC is accountable to the Health and Social Care Committee in Parliament, with oversight of its activities being provided by another statutory body, the Professional Standards Authority for Health and Social Care. I understand that the

DHSC has no formal oversight or accountability role in relation to the NMC but is responsible for legislation relating to its activities and can, I understand, exercise powers of last resort to direct them through the Privy Council if they are failing to deliver their statutory duties.

25. I meet with the Chief Executive of the NMC approximately every two weeks. Our discussions are usually focused on important national strategic matters, such as the development of regulatory standards and codes of practice and areas of concern such as the fitness to practise backlog. The Chief Executive of the NMC also occasionally joins the fortnightly UK CNO calls when an issue relating to their responsibilities across the UK requires discussion. The UK CNO calls are meetings with my four UK (plus Republic of Ireland) CNO colleagues to discuss issues relating to our professions, covering matters within our own areas of responsibility and UK-wide as well as international nursing matters, with a rotating chair arrangement. I continue to find these meetings extremely helpful and productive forums for discussion of UK-wide nursing and midwifery issues.

26. The RCN is a nursing trade union and professional body, representing nurses, student nurses, healthcare support workers (HCSWs) in the UK and nursing associates in England. It is completely independent of the NHS and works to support and represent the interests of its members, engaging with DHSC, NHS England and the devolved administrations on improving working conditions and campaigning on issues to raise the profile of the nursing community.

27. Similarly to the NMC, I meet with the General Secretary and Chief Executive of the RCN on a monthly basis to discuss national and strategic issues related to the nursing and nursing associate professions. We meet on a more frequent basis when issues, such as the operational implications of industrial action, require more intensive discussions. My Deputy CNOs engage with other senior leaders within the RCN on specific areas relevant to their portfolios.

Chief Nursing Officer role in local workforce matters

28. In all of my national leadership roles, I have always felt that being closely connected to NHS organisations and the nurses, midwives, nursing associates and healthcare support workers within them is vital to enable me to understand and deliver on the issues facing our professions.

29. I engage formally with national and regional nursing and midwifery leaders through a

series of meetings, including my weekly CNO calls with this group and regular 1-1 meetings. As outlined above, I meet regularly with leaders from external organisations, including regulators, nursing and midwifery representative organisations, trade unions, charities and Royal Colleges.

30. I also meet regularly with directors of nursing from trusts as part of my CNO Strategic Advisory Group. This group was developed during the Covid-19 pandemic as a forum for the discussion of strategic nursing and midwifery issues with some of the most experienced and senior nurses from trusts and post-pandemic, it has continued to meet on a monthly basis to provide me with a wide range of views and advice.

31. As well as this, I also meet with a range of nurses representing the diverse nursing and midwifery workforce of the NHS through the CNO and CMidO Black and Minority Ethnic (BME) Advisory Group. This group provides me with valuable feedback and acts as a sounding board for national work, as well as working on initiatives to support and develop the ethnic minority nursing and midwifery workforce. It is also particularly helpful in communicating national messages to its network, offering engagement events and webinars, as well as support spaces for ethnic minority colleagues.

32. I also engage with nurses at all levels through the National Shared Professional Decision Making Council, a body I established in 2020 consisting of a wide range of frontline nurses (with a separate group being established for midwives) to enable a non-hierarchical approach to collective leadership and discussion of key issues affecting all nurses. In addition to this, I undertake visits to NHS organisations on a weekly basis and I engage with nurses, midwives, nursing associates, HCSWs and local leaders on these visits to discuss issues that are important to them.

33. Although this engagement and connection with nurses and midwives from across the system is vital to me, it is clear that my role at a national level is to take overarching themes affecting our professions and ensure that they are reflected in wide-ranging national programmes or specific pieces of work. It is for individual organisations to act on specific local issues as they are both responsible and accountable for these and best placed to deal with them. It would only be in exceptional circumstances of systemic or service failure where direct national action on a specific local issue would be necessary, and this would only take place following a formal escalation process.

34. For example, concerns about the conduct of individual nurses are a local management issue and would be managed through the local staff management processes within

their employer organisation. Where serious concerns are raised about a nurse, midwife or nursing associate's fitness to practise which could place patients at risk, or negatively impact public confidence in the professions, these would be reported to the NMC, in their role as the independent regulator, through their fitness to practise process.

35. Concerns about individuals that are raised through either of these processes would not be raised or reported to me as a matter of course. However, if there were instances where the concerns were sufficiently serious or would have a wider implication on nursing or midwifery practice, I would expect to be kept informed of local action being taken in response through the regional chief nurses, based on their professional judgement of the individual situation. On occasion, when matters are in the public eye, I will comment, from my professional leadership role perspective.

36. Issues relating to local management, leadership and safe working practices are organisational rather than nursing specific issues, so these would be routinely escalated through the NHS operational management structures, via NHS England's regions and onwards to NHS England's Chief Operating Officer at a national level.

37. As outlined above, in discharging my executive director functions, I sit on the quality committees of NHS England, which report to the NHS England Executive and Board. My role is to ensure professional nursing and midwifery oversight and input into quality issues that have been escalated to these committees. This would also include any improvement plans that have been escalated via the same process from regional to national level, particularly relating to organisations which form part of the national Recovery Support Programme.

38. In addition to NHS England's formal operational management reporting lines through regional directors to NHS England's Chief Operating Officer, the NHS England regional chief nurses have a reporting line to me on professional matters. Relevant issues related specifically to nursing and midwifery may be raised with me through this route. In these cases, I would be updated on any plans at a regional level to offer support to the local organisation in question and discuss whether any national support would be required by the local organisation to help it to deliver its services in line with its responsibilities.

39. There have been a number of instances of national action being required in response to significant local issues. I have been Senior Responsible Officer (**"SRO"**) for NHS

England and before that NHS Improvement for a number of independent investigations into failings at NHS organisations, including "Right First Time: independent review into Southern Health NHS Foundation Trust", "Reading the signals: maternity and neonatal services in East Kent – the Report of the Independent Investigation" **[INQ0012366]** (both alongside the National Patient Safety Director) and most recently the ongoing "Independent maternity review - Nottingham University Hospitals NHS Trust".

Recruitment and Retention

40. Ensuring that the NHS can recruit and retain sufficient staff has been a longstanding challenge for all services and one of my main areas of focus in my national leadership roles.

41. As Executive Director of Nursing at NHS Improvement, I developed the Retention Direct Support Programme, which started in 2017 in partnership with NHS Employers. This was a national programme focused on increasing nurse retention in trusts. It involved intensive working with trusts with a high turnover rate on a cohort basis, with trusts being supported as one of five cohorts to develop their own retention strategies in an action plan, which was agreed upon with NHS Improvement. We then monitored each trust's progress in the subsequent 12 months and provided targeted support where needed.

42. As well as this targeted support, the programme also featured a universal offer to all trusts involving the dissemination of best practice and masterclasses relating to recruitment and retention. By the time this work was passed to NHS England's Chief People Officer[1] in February 2020, national turnover rates for nursing staff were at their lowest in five years with the turnover rate reduced from 7.2% at the start of this programme to 6.4%.

43. As CNO for England, I was SRO, supported by my Deputy CNO Duncan Burton, for the International Nurse Recruitment workstream of the 50,000 nurse programme, which started in late 2019, with an original target date of September 2024. My responsibilities for international nurse recruitment complemented those for nurse retention programmes led by NHS England's Chief People Officer[2] and those for domestic nurse supply led by the Chief Nurse of Health Education England. The

[1] The Chief People Officer role within the People Directorate is now the Chief Workforce, Training and Education Officer, within the Workforce, Training and Education Directorate)
[2] As above

50,000 nurse programme met its target early, in November 2023 and international recruitment accounted for over 90% of the increase in overall nursing workforce in that period.

44. In spite of these successes, we know that growing the nursing workforce remains a significant challenge; as of January 2024, although the nursing workforce increased by over 62,000 full time posts since September 2019 (including an increase in neonatal nursing from 5,604 in 2019 to 6,802 in 2023, a total increase of 21.4%), there were still over 34,700 nursing vacancies, over 800 of which were for neonatal nurses. The NHS Long Term Workforce Plan **[INQ0012644]** published in June 2023 builds on the previous programmes and outlines our national initiatives to attract and retain staff as the complexities and demands on our healthcare system continue to increase.

45. To enable successful delivery of national programmes such as these, close working is required with local NHS organisations, which we provide through NHS England's regions and in turn ICBs. This close working and understanding of local issues ensures that my team can establish structures and systems which enable all NHS organisations to benefit from access to registered nurses to help with their individual staffing needs.

46. Although we have supported trusts through these national programmes, responsibility for recruitment and retention at an organisational level are a local issue, handled through operational management processes at that organisation. However, where there are any specific local recruitment and retention issues which require escalation, this would be done through the NHS organisational structure at regional and then, if necessary, national level. I am represented by my Deputy CNO for Clinical Delivery or one of his team at NHS England's national retention board, which is a body that provides oversight on strategic actions on retention issues informed by analysis of current retention data.

Involvement with employees of the Countess of Chester Hospital NHS Foundation Trust

47. In 2016 and 2017, I was the Nurse Director at Monitor (until April 2016) and then Executive Director of Nursing for NHS Improvement, a role which I held until 2019. NHSE/1 paragraphs 166 – 175, 218 – 230, and 238 - 244 outline in detail the oversight role that each of these organisations had.

48. My role at Monitor was Nurse Director, which was not a board-level role. My role as

Executive Director of Nursing at NHS Improvement from April 2016 was a board level position. In this role, I led on national nursing issues relating to trusts, such as the nursing workforce. However, as my roles were nationally focused rather than regional, I had no direct involvement with any employees of the Countess of Chester Hospital NHS Foundation Trust in 2016 and 2017.

49. I first became aware of the concerns about neonatal services at the Countess of Chester Hospital on 9 May 2017 when the NHS Improvement Regional Medical Director forwarded to me a note originally sent to others in NHS England, NHS Improvement and the CQC by NHS England's then Chief Nurse for the North Region earlier that same day **[Exhibit RM/0002 [INQ0018059]]**. This update was shared with me as a nursing leader within a national NHS organisation to keep me informed of the situation.

50. This note outlined the proposals for a police investigation into the unexplained deaths, to be announced the following week. It also outlined that NHS England's Chief Nurse for the North Region would be the contact for NHS England on this incident and that NHS Improvement's Regional Medical Director would play the same role for NHS Improvement from a patient safety perspective.

51. On 17 May 2017 I received a further update on the matter (referred to in Emergency Preparedness, Resilience and Response (**"EPRR"**) structures as an incident) from NHS England's then Chief Nurse for the North Region, which she had on the previous day sent to the then CNO for England **[Exhibit RM/0003 [INQ0018057]]**. This note outlined that the police had decided, on that day, to fully investigate the events at the trust. I liaised with my team at NHS Improvement to ensure I was informed of the known details of the incident and police investigation in advance of this being announced on 18 May 2017. I received a further brief on the day of the announcement from NHS England's Chief Nurse for the North Region, which I shared with other NHS Improvement executive directors **[Exhibit RM/0004 [INQ0018058]]**. A further update was provided by NHS England's Chief Nurse for the North Region on 1 June 2017 **[Exhibit RM/0005 [INQ0018052]]**.

52. As outlined in section 2 of NHSE/1, oversight of the investigation at the Countess of Chester was provided by senior officials within NHS England and NHS Improvement. In my role at NHS Improvement, I led a programme of work on maternity safety, the national Maternity Safety Support Programme (**"MSSP"**), which began in September 2017. This programme was developed from the then Secretary of State for Health's

proposal in the summer of that year to create a list of NHS organisations whose maternity services would benefit from targeted intensive support. Supporting delivery of the DHSC national maternity ambitions in the most challenged organisations was the impetus for this programme.

53. In light of the news coming out of the Countess of Chester Hospital NHS Foundation Trust, I had asked my team in July 2017 to consider whether the trust could be offered any support as part of one of the existing maternity support programmes. Once the MSSP work started to be developed in August 2017, the option to be part of the developing MSSP work was explored. I was informed by the regional team that the issues at the Countess of Chester Hospital were only within neonatal services rather than maternity services and given the ongoing police investigation and enhanced oversight from NHS England as the commissioner of specialised neonatal services, intensive support would be better targeted elsewhere. Therefore, the Countess of Chester Hospital NHS Foundation Trust did not feature on the list of trusts to receive intensive support when the programme was officially launched in September 2017.

Involvement with Alison Kelly

54. I have had no direct involvement with Alison Kelly, in either her role as Chief Nurse at Countess of Chester Hospital NHS Foundation Trust or her subsequent roles. My only contact with her will have been as part of the wider profession, through my communications relating to national nursing matters sent to all NHS trust and commissioning organisation chief nurses, sometimes directly and at other times via regional chief nurses, in my roles as NHS Improvement Executive Director of Nursing and thereafter as CNO for England in NHS England.

55. Examples of these include directly communicating updates to national policies for which I have executive responsibility, such as nursing workforce, or making senior nurses aware of other national initiatives that may have an impact on nurses. This direct communication with chief nurses within the system increased greatly during the pandemic as NHS England's role changed in line with the management of a national incident. I held fortnightly webinars with NHS chief nurses on issues relating to the pandemic, which were often co-hosted with NHS England's National Medical Director and also involved medical directors from NHS organisations. I also attended meetings for NHS chief nurses across each region, organised by regional chief nurses at this time. Alison Kelly may have been among the attendees at these meetings. She may have also attended one of my CNO Summits, which are annual in-person conferences

involving approximately 400-500 nursing leaders from across England. My records show that she did not attend in either 2022 or 2023, but she may have attended in earlier years.

56. I was involved in work within NHS England, led by NHS England's then Chief Operating Officer, from summer 2023 onwards in the light of the trial of LL and its implications. I was a member of the Project Columbus Strategic Oversight Group, which included an assessment of whether Alison Kelly and others who were subject to scrutiny during the trial of LL, were employed within the NHS as at July 2023 and what action, if any, NHS England should take regarding them. The work of Project Columbus is set out in further detail in annex 3 of NHSE/1. As part of these discussions, Alison Kelly's then role at the Northern Care Alliance NHS Foundation Trust ("**NCA**") was considered and in a meeting I attended on 11 July 2023, NHS England came to the view that in the event of a guilty verdict, NHS England's Regional Chief Nurses for the North West (at that point this was a jointly held post) would make contact with the NCA to seek assurance that they were appropriately implementing the fit and proper person regulations in regards to Alison Kelly. Given the situation, and the fact that there was an ongoing NMC referral in relation to Alison Kelly, whilst a matter for the trust to decide, our view was that it was important for the NCA to carefully consider all options including her either standing down voluntarily or being suspended from her role.

57. To support clinicians at the Countess of Chester Hospital NHS Foundation Trust following the outcome of the trial, NHS England's National Medical Director and I visited the trust on 28 September 2023 to tour the neonatal unit and to speak to staff. In the course of these discussions, we met with two clinicians who shared their views over the escalation of issues in 2016 to Alison Kelly and other senior leaders within the trust. I exhibit my notebook entry from this date **[Exhibit RM/0006 [INQ0018061]]**.

58. Separately to the above discussions, I have been made aware of concerns from within the NMC over its handling of a referral relating to Alison Kelly. The NMC's newly appointed (since March 2023) Executive Director of Professional Practice copied me and the CNO for Wales into a letter to the NMC's Chair of Council dated 1 October 2023 raising her concerns over internal processes within the organisation **[INQ]**. These concerns were shared with me in my capacity as the head of the nursing profession in England; I play no role in the NMC's internal complaints process.

59. Among the issues raised in this letter was the handling of a referral to the NMC of

Alison Kelly by I&S from the Countess of Chester Hospital NHS Foundation Trust, which was focused on Alison Kelly's role in relation to responses to concerns raised over the trust's neonatal unit.

60. Both the CNO for Wales and I were copied into a response to this letter from the NMC's Chair, which was sent on 14 November 2023, outlining the actions being taken by the NMC in response to these concerns **[INQ].** I spoke to the Chair on 28 November, who informed me that these concerns were being dealt with in line with the NMC's internal processes.

61. Following a request for a meeting from the NMC's Executive Director of Professional Practice, the CNO for Wales and I discussed the NMC's Executive Director of Professional Practice's ongoing concerns with her on 1 March 2024. We were clear that these issues remained for the Chair of the NMC to deal with and to support this we sent a letter to the Chair of the NMC on 4 March 2024 to notify him of these discussions and reiterated this point, copying this correspondence to the DHSC for their awareness **[Exhibit RM/0007 [INQ0018056]].** I have been informed by the Chair of the NMC in a subsequent phone call on the same day that the NMC understands that these are issues which they are responsible for dealing with. I am aware from being copied into subsequent correspondence that the NMC are in active discussions with their Executive Director of Professional Practice.

Views on the effectiveness of NHS management and governance structures

62. Throughout my career in senior nursing roles, my main focus has been on enhancing the capacity and capability of the nursing and midwifery professions. I outlined my priority for building the nursing and midwifery professions, and those who support them such as HCSWs, in my first CNO Summit after assuming the role of CNO for England in 2019.

63. During my first year as CNO for England, my work on making the case for the importance of nursing and midwifery at a national level supported significant steps to improve nursing and midwifery workforce numbers, such as:

- the introduction of at least £5,000 a year funding support for all nursing, midwifery and allied health professional (AHP) students;
- £150m funding for continuing professional development for NHS nurses, midwives and AHPs which equates to £1,000 for each individual every three

years; and,

- the Government's pledge to deliver 50,000 more nurses.

64. This has been my main focus because I feel very strongly that having sufficient numbers of registered staff is key to ensuring the delivery of high-quality care. However, the increasing demand for healthcare services, driven by the demographics of an ageing population with ever more complex needs, means that this work needs to continue. The NHS Long Term Workforce Plan published in June 2023 outlines our national initiatives to train and retain our NHS staff as well as reforming working and training practices. The NHS England's Workforce, Training and Education Directorate leads work on the NHS Long Term Workforce Plan.

65. Whilst the number of staff is important, and is a necessary building block for safe staffing, it is one piece of the safe staffing jigsaw. Safe staffing is not purely about numbers, it is also about looking at the composition of the team (having the right mix of roles, skills and experience) and ensuring the right quality of nursing provision, plus leadership, supervision, management and training. As important is having the appropriate support staff to enable nurses and midwives to fulfil their safety critical roles.

Neonatal nurse qualifications

66. As per the NMC standards for education for the profession, all nurses, including neonatal nurses, will have undertaken a nursing or midwifery degree, which entails 2,300 hours of in practice-based learning and 2,300 academic hours. To work as a nurse, they will need to meet the NMC requirements to join the register and to remain on the register all nurses are required to undertake the NMC revalidation process every three years and demonstrate that they have maintained their competence (further details of revalidation process are outlined below in paragraphs 112 and 119).

67. The NMC does not mandate any post registration education for the neonatal nurse workforce. However, as outlined in the NQB guidance on "Safe, sustainable and productive staffing: An improvement resource for neonatal care", (published June 2018, more details in paragraph 96 below) national standards for appropriate staffing levels in neonatal care are well established through publications by DHSC (Toolkit for high quality neonatal services (2009)), the National Institute for Health and Care Excellence (**"NICE**") (quality standard (QS4) for neonatal specialist care (2010)) and the British Association of Perinatal Medicine ("BAPM").(third edition of the BAPM Service standards for hospitals providing neonatal care (2010)).

68. Neonatal units should be staffed by an appropriate staff mix and one vital element of this which has been recommended since the 2009 DHSC guidance and supported in subsequent guidance is that 70% of the nursing staff need to demonstrate achievement of neonatal nurse qualification in speciality (**"QIS"**), and consequent competency in practice. This should include the following:

- Period of preceptorship including defined foundation learning (special/transitional care) within the neonatal speciality
- Completion of a programme of post registration education/training which demonstrates the competencies and core clinical skills as a Neonatal Nurse/ Midwife QIS.

69. Currently QIS is delivered through a variety of methods including in-house/hybrid/HEI programmes at level 5 or 6 of the Skills for Health NHS career framework. Work undertaken as part of the Neonatal Critical Care Review identified concerns over this variation of provision, and Health Education England (**"HEE"**) were commissioned by the Neonatal Implementation Board in 2020 to review neonatal QIS education across England. This review, undertaken on behalf of HEE by RSM UK Consulting LLP, was published by HEE in June 2021 and found that there was a lack of standardisation across QIS education, with variations in the hours, content and cost of these courses.

70. In response to this, I understand that NHS England's Workforce, Training and Education Directorate (who assumed responsibility for this work from HEE in April 2023) is currently developing a set of QIS standards to provide uniformity of the QIS qualification, with anticipated publication by Autumn 2024. My Neonatal Nursing Lead, Louise Weaver Lowe, is supporting colleagues in the Workforce, Training and Education Directorate with this work. I set out below at paragraphs 118 - 125 my views as to job plans and mandated access to continuing professional development (CPD).

<u>Advanced practice</u>

71. In terms of advanced practice, this has been an established area within nursing and midwifery, including the neonatal workforce, since the early 1990s, outlining a level of clinical expertise underpinned by the four pillars of advanced practice:

- clinical practice
- leadership

- facilitation of learning
- evidence, research and development

72. It is my view that Advanced Nurse Practitioners should be educated to master's level and assessed as competent in advanced level practice. As clinical leaders, they have the freedom and authority to act and accept the responsibility and accountability for those actions.

73. However, I have concerns over the inconsistent use of the term 'advanced practitioner' within the nursing and midwifery professions and the lack of specific regulation of advanced practice. There are examples of practitioners using the 'advanced practice' title despite not having completed master's level studies. Also, whilst I understand the retention dilemma, there are instances of organisations inappropriately using the term as a retention tool for experienced nurses. Conversely, there are also believed to be many nurses and midwives working at advanced practice levels without any formal or informal recognition.

74. The NMC has been aware of concerns in the area of the regulation of advanced practice for some time and signalled in its 2020-25 strategy that it would explore this issue to see whether regulation of this element of the nursing and midwifery workforce was required. Further details of this proposal were provided in their corporate plans published in 2022 and 2023. To support these plans, the four UK CNOs jointly wrote to the NMC on 26 April 2022 asking the NMC to undertake a programme of work to develop formal recognition of advanced practice **[Exhibit RM/0008 [INQ0018054]]**. The NMC's reply dated 4 May 2022 confirmed their intention to work with the four UK CNOs to agree the way forward on post registration qualifications **[Exhibit RM/0009 [INQ0018055]]**.

75. The NMC has been working on its review of advanced practice over the past two years, engaging extensively with professionals, wider stakeholders and the public. I wrote to the NMC again on 15 March 2024 to restate my continued support for the formal recognition of advanced practice for the nursing and midwifery professions **[Exhibit RM/0010 [INQ0018060]]**. At the NMC Council meeting on 27 March, a proposal to develop standards of proficiency for advanced level practice and associated programme standards was agreed. I support this and will be working with the NMC to ensure consistency and appropriate regulation of advanced practice in nursing and midwifery, and I believe that this should address my concerns in this area.

Standards for medicines management

76. In terms of clinical guidance for medicines management, NHSE/1 paragraphs 884 - 901 outline in detail the guidance and legislation in this area. Nurses, as with all responsible clinicians, should follow appropriate guidance in this area of clinical practice. Professional Standard 18 of the NMC's Code, under the theme of preserving safety, outlines what is expected of registered nursing and midwifery professionals in relation to the prescribing, supplying, dispensing and administering of medicines.

77. The NMC adopted the Royal Pharmaceutical Society's (**"RPS"**) Prescribing Competency Framework in 2018, which provides a framework for all prescribers to demonstrate and maintain competence. I understand that as part of this process the NMC worked with the RPS to ensure that the Competency Framework covered the areas outlined in the NMC's existing guidance "Standards for Medicines Management", which was then withdrawn in 2019.

78. I have not been made aware of any specific concerns relating to medicines management for nurses following the withdrawal of the NMC's Standards for Medicines Management in 2019. I note that not only does the NMC's website point to the RPS framework, but the RCN's medicines management clinical resource outlines the information required to support nurses in this area of professional practice.

79. Supervision and guidance are also important in medicines management, and I would suggest that when units are staffed to BAPM levels, which includes a 25% uplift for nursing time over and above direct clinical care, there should be time for supervision and CPD, which should include medicines management training.

Closed loop medicines management

80. In relation to the potential use of closed loop medicines administration, I feel that greater use of digital technology to ensure that the right drug is being dispensed and administered to the right patient could potentially offer improvements in both patient safety and efficiency.

81. I have previously discussed this issue with my Neonatal Nursing Lead, and we are in agreement that the benefits in terms of patient safety are primarily around reducing errors through ensuring end to end tracing of drugs, but having systems where drugs can only be dispensed or made available to an individual clinician via a personally identifiable means would also act as a deterrent in the rare instances where an

individual seeks to harm vulnerable patients.

82. I would welcome further work on rolling out these types of systems across all of the NHS, not just neonatal units, as not only would there be patient safety benefits, but the efficiency gains would allow nurses and other clinical staff more time for direct patient care. I appreciate that there would need to be more investment required in digital infrastructure to implement this across the NHS.

CCTV in neonatal units

83. As outlined in NHSE/1 at paragraphs 870 - 883, the use of CCTV within neonatal units is covered in estates related guidance published by NHS England Estates and previously by the DHSC. This is largely focused on the use of CCTV in relation to the security of access to neonatal units, with the aim of preventing unauthorised access to these settings.

84. In relation to the installation of CCTV throughout neonatal units, as outlined in NHSE/1, there are considerations relating to privacy, human rights and data protection regarding the use of CCTV within clinical areas and the use of CCTV will form part of NHS England's forthcoming review of the technical guidance notes for maternity and neonatal settings.

85. My own view on any proposal in this area is that for CCTV to be used as an effective deterrent to criminal activities in neonatal settings, it would need to be continuously monitoring the setting and sufficiently closely focused on the babies. This would entail the recording and storing of millions of hours of footage each year, the vast majority of which would show babies and families at very vulnerable and emotional moments, ranging from the delivery of lifesaving treatments to babies being breastfed and receiving skin to skin contact.

86. As well as these privacy concerns, further expansion of CCTV into neonatal units would entail additional considerations for NHS staff relating to ensuring that patient consent processes are completed, plus information management and monitoring. In the context of competing resources, this could lead to resources being diverted away from front line care, which in itself could have wider implications for patient safety. Finally, we would also need to consider that if the introduction of CCTV were deemed to improve safety, whether this should only be implemented in neonatal settings when there are a range of other settings within hospitals where vulnerable patients are receiving care.

87. Overall, I feel that the introduction of measures which can be deemed as intrusive would have a detrimental effect on the bond between patients, their families and healthcare workers which supports the delivery of high quality, personalised healthcare.

Safe nurse staffing levels

88. In relation to safe nurse staffing levels, this is an area of nursing and midwifery practice which I have had a long-standing focus on and commitment to.

89. This issue was a particular focus of the Francis Inquiry into the failings at Mid Staffordshire Hospitals NHS Foundation Trust **[INQ0012382],** published in February 2013, and Don Berwick's independent report "A promise to learn – a commitment to act: improving the safety of patients in England" published by DHSC in August 2013.

90. The Francis Inquiry stated that

    (a) "The procedures and metrics produced by NICE should include evidence-based tools for establishing the staffing needs of each service. These measures need to be readily understood and accepted by the public and healthcare professionals"

    (b) "The NHS Litigation Authority should introduce requirements with regard to observance of the guidance to be produced in relation to staffing levels, and require trusts to have regard to evidence based guidance and benchmarks where these exist and to demonstrate that effective risk assessments take place when changes to the numbers or skills of staff are under consideration. It should also consider how more outcome based standards could be designed to enhance the prospect of exploring deficiencies in risk management" (recommendation 93)

91. In the Government's response to the Francis recommendations "Hard Truths – The journey to putting patients first" published in January 2014, it set out that:

    (a) "The [NQB] and the [CNO] are publishing a guidance document that sets out the current evidence on safe staffing. This clarifies the expectations on all NHS bodies to ensure that every ward and every shift has the staff needed to ensure that patients receive safe care.

    (b) "The [NQB] and the [CNO] are publishing new guidance on safe staffing

levels in hospitals and the National Institute for Health and Care Excellence has been commissioned to provide authoritative independent advice on evidence based tools to ensure the right levels of staff on every shift on every ward on every day in the NHS"

92. The Government had therefore outlined the requirement for trusts to publish ward level information on whether they are meeting their staffing requirements, with a detailed review of staffing levels taking place every six months. In setting their staffing levels, trusts were required to take into account available evidence, local circumstances, as well as the acuity (severity of illness) and dependency (the level of care and assistance) of the patients being cared for.

93. These requirements are underpinned by legislation, specifically regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The CQC's inspection regime for trusts includes whether they have appropriate staffing arrangements in place, both in terms of capacity and capability. The NHS Standard Contract also specifically stipulates that trusts must adhere to regulation 18 and also regulation 19 in relation to ensuring sufficient staff and their education and skills development to enable service provision[3].

94. A range of action was taken at a national level to support trusts with their safe staffing responsibilities. In my then role as Regional Chief Nurse for East of England, I led on safe staffing improvement work developed from the then CNO's "Compassion in Practice" strategy published in December 2012, specifically action area 5: 'Ensuring we have the right staff, with the right skills, in the right place'. Following sector-wide consultation, including with the Royal Colleges and unions, this work was published by the NQB in November 2013 titled "How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability". This sets out 10 expectations and a framework within which organisations and staff should make decisions about staffing that put patients first. The first of these expectations sets out that "Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability".

95. The DHSC and NHS England asked NICE to produce safe staffing guidance, which was published for nursing in adult inpatient wards in acute hospitals in July 2014,

[3] See section 5.2 of the NHS Standard Contract 2023/24, General Conditions (Full Length) Version 1, March 2023

followed by safe midwifery staffing for maternity services in February 2015.

96. NHS England built on this via its work with partners on the NQB's "Safe Sustainable and Productive Staffing" guidance in July 2016, which in turn was followed by seven specialty specific safe staffing guides in 2017-2018, including one for neonatal care in June 2018, along with a complementary resource, Developing Workforce Safeguards. As Executive Director of Nursing at Monitor and NHS Improvement, I jointly led the work on the specialty specific safer staffing guidance on behalf of the NQB with Dr Mike Durkin, NHS England's National Director for Patient Safety who was the SRO for this work.

97. Each of the specialty specific guides was led by an independent expert in the field, supported by evidenced based reviews by academic teams. Working closely with Sir Robert Francis, particularly securing his sign off for each of the specialty guides, ensured that they were aligned with and supported the recommendations from his review of Mid Staffordshire Hospitals NHS Foundation Trust.

98. Under the overarching safe staffing guidance, trust chief nurses need to assure their organisation's board that their nursing and midwifery staffing is safe and complies with the NQB guidance. The neonatal care safe staffing guidance outlines staffing requirements for the different levels of care within neonatal units, based on detailed expert work from the BAPM. This guidance recommends a 1-1 nursing/patient ratio for neonatal intensive care, 1 nurse for every two babies in neonatal high dependency care and one nurse for every 4 babies in neonatal special care. These staff should be complemented by an appropriate mix of registered and non-registered staff to ensure safe delivery of services.

99. On my appointment as CNO for England, to further embed the principles of safe staffing within NHS organisations, I established the CNO Safer Staffing Fellowship programme, which is a MSc accredited education programme in healthcare workforce planning, delivery and assurance. The programme aims to have a CNO Safer Staffing Fellow in all trusts. The safer staffing fellows provide the knowledge and skills to ensure nursing and midwifery staffing establishment setting and review follows an evidence-based approach. The programme launched with its first cohort in February 2019, and it became accredited to MSc level in 2021. To date 164 individuals have completed the PG Certificate level of the programme. I understand that one fellow from the Countess of Chester Hospital NHS Foundation Trust completed the programme in 2022.

100. To ensure the NQB guidance was updated, strengthened and aligned with changes in practice as a result of the pandemic restrictions and new patterns of care delivery, NHS England was commissioned by the NQB in February 2022 to lead a review and refresh of the seven existing specialty focused safe staffing resources (including for neonatal care) and the complementary resource, Developing Workforce Safeguards, as well as produce a range of new guides for areas such as adult and children's critical care, operating theatres, virtual wards and community services. Further, as part of the settlement agreed with all staff-side unions on industrial action in May 2023, the Government's offer included non-pay measures to support the NHS workforce and stated that it would ask NHS England to review the existing arrangements on safe-staffing. My team is working on bringing together both of these workstreams, which are led on my behalf by the Deputy CNO for Policy and Strategy.

101. My long experience of leadership in the area of safer staffing has greatly influenced my priority as CNO for England to increase the nursing workforce in the NHS. Safe staffing will always depend on having enough staff; my advocating for a national programme to deliver additional nurses, along with the £5,000 funding support for nursing students to encourage domestic supply and the CPD funding for registered nurses to increase retention, has always had delivering safe staffing as one of its many motivations.

102. I set out above the reasons why the NQB has been the body which has advised on safe nurse staffing levels for the last ten years. The NQB champions the importance of quality and drives system alignment across health and by bringing together bodies including NHS England, CQC, NICE, the Health Services Safety Improvement Body, DHSC and a range of Government agencies. As set out at paragraph 367 of NHSE/1, the NQB is jointly chaired by NHS England's National Medical Director and the CQC's Chief Inspector of Hospitals. Its membership offers a spectrum of clinical and wider expertise, such as senior clinical and professional leaders from the member organisations, as well as lived experience experts supporting the development of its work **[INQ0009272].**

103. When I became CNO for England in 2019, my view on legislation in relation to safer staffing was that this would not, on its own, increase the safety of NHS services if there were not sufficient staff to implement it. Five years later, I feel that we are in a much better position in terms of capacity, with over 62,000 more nurses in the NHS, although I recognise there are still c.34,700 vacancies (because establishment has grown) and variations between individual trusts and services.

104. Safe staffing legislation has already been introduced in Wales and Scotland, so there is a variation of approach within the UK. In Wales, this legislation was enacted in March 2016, with its duties to ensure sufficient nurses to care for patients introduced in April 2017 and further duties to calculate and maintain the nurse staffing level for adult acute medical inpatient wards and adult acute surgical inpatient wards coming into force from April 2018 (this was later complemented by paediatric wards in 2021, but neonatal units are not included). The latter duty encountered issues in implementation due to a lack of uniform provision of e-rostering software.

105. In Scotland, similar legislation was enacted in 2019 and came into force on 1 April 2024. This places duties on healthcare providers to ensure that at all times suitably qualified and competent individuals, from such a range of professional disciplines as necessary, are working in such numbers as are appropriate for:

    (a) the health, wellbeing and safety of patients,

    (b) the provision of safe and high-quality health care, and

    (c) in so far as it affects either of those matters, the wellbeing of staff.

106. It must be noted that in the case of both countries, the legislation does not state specific nurse ratios or numbers; rather it places duties on health organisations to maintain what they deem to be safe staffing levels. In practice, this approach is similar to the above process outlined for England in terms of there being a contractual responsibility for trusts to adhere to the NQB guidance which outlines the requirements for safe staffing; the only difference is that this guidance is not underpinned by specific legislation in England.

107. Getting nurse staffing right at every level from ward to board is crucial to patient safety and patient experience. Significant progress has been made in the last five years in increasing the nursing workforce numbers in England by 62,000.

108. In my view we are therefore now at the appropriate juncture for there to be formal consideration of safer staffing being underpinned by legislation. This of course would be the responsibility for the government to take forward in consultation with the organisations represented on the NQB, Trade Unions and the Royal Colleges.

<u>Nursing roles 'from ward to board'</u>

109. In relation to the need for nursing specific roles from 'ward to board', all trusts have a

board-level chief nurse or director of nursing, and their teams typically consist of a hierarchy of nurses responsible for a range of quality, operational and professional functions across different areas of the delivery setting, as well as management responsibilities for nursing, midwifery and HCSW staff.

110. My own career is an example of this; I started as a student nurse then worked in clinical settings such as theatres before moving into nursing leadership roles, eventually at board level within local NHS commissioning and provider organisations before taking on regional and national leadership positions.

111. As in my own case, a central requirement for all of these roles within the nursing structures in NHS organisations would be for the nurse to be registered with the NMC. As mentioned above to maintain a valid registration, each nurse must undergo a process of revalidation every three years. This process entails meeting a range of revalidation requirements set out by the NMC to show that your skills and knowledge are up to date and that you can maintain safe and effective practice. This must be demonstrated on each nurse's application via evidence that they are meeting set criteria, include a number of practice hours, continuing professional development and feedback. Each application must be confirmed by an appropriate person, who would normally be a line manager or another nursing or midwifery professional.

112. One of the core requirements of nursing revalidation is demonstrating a minimum of 450 practice hours over the three year revalidation period. These practice hours are defined by the regulator as those in which an individual relies on their skills, knowledge and experience as a registered nurse - including time spent providing direct care to patients, managing teams, teaching others or running or shaping a care service.

113. Many senior nurses will choose to undertake clinical work. In my own case, I worked on the frontline in NHS organisations on 29 occasions between March 2020 and January 2022 to support the response to the Covid-19 pandemic and found this work extremely beneficial in supporting my national level decision making. I encourage all senior nurses to work alongside their colleagues and engage regularly across their organisation(s) to ensure that they remain close to their teams.

114. The connection that senior and executive nurses have to the frontline is essential. Work done by the Kings Fund and Burdett Trust in their publication "From Board to Ward" in 2009, which was followed by their publication "Putting quality first in the boardroom" in 2010, led to their production of the Nurse Executive's Handbook.

Building on this, I led work in NHS Improvement on the Executive Nurse Handbook, published in March 2019 which succeeded the Burdett Trust publication and supports executive nurses to use their influence at board level to ensure that safeguarding, quality of care, patient safety and experience remain the guiding priorities for their organisation. This focus on leadership throughout the nursing profession was complemented when I became CNO for England by the publication of the Matron's Handbook in January 2020.

115. I feel that both of these publications, along with our wider work on supporting nurse leadership, including our leadership programme for nurses, has strengthened nursing leadership within NHS organisations. NHS England's mandating of a Director of Nursing to be an executive member of every ICB has further embedded nursing leadership with the NHS system.

116. Another way in which senior nurses can maintain their direct links with their teams is to establish structures to ensure that a full range of voices are heard. As CNO for England, one of my main objectives has been to build a collective leadership and shared vision for nursing, ensuring that the voices of all nurses are heard. An important element of this has been the establishment of shared decision-making councils to enable a non-hierarchical approach to collective leadership and discussion of key issues affecting all nurses. I feel that this has been a particularly effective tool and I find my regular council meetings bring fresh perspectives and viewpoints to national issues.

117. It is vital that as well as engaging with all levels of the nursing, midwifery and HCSW workforce, that senior nurses understand different perspectives from the full range of our diverse workforce. An important forum for giving me this perspective is my CNO BME Strategic Advisory Group, who I meet with regularly to discuss nursing and midwifery issues. I also greatly value the feedback I receive from the international nursing and midwifery associations that have been established, particularly as international nurse recruitment has greatly increased since 2019. I encourage all senior nurses to continue to engage with similar groups within their own organisations and across their ICB areas.

Job plans and mandated access to continuing professional development (CPD)

118. It is vital that nurses, midwives and nursing associates have the right skills and training to do their jobs effectively and to develop their careers. A co-ordinated approach to

education and training that provides opportunities for our professionals at all stages of their career is needed to ensure this. From when I became CNO for England in 2019, this work has been led by HEE and is now within the responsibilities of NHS England's Workforce, Training and Education Directorate.

119. As part of the revalidation process, every nurse and midwife must demonstrate that they have undertaken 35 hours of CPD relevant to their field of practice over the previous three years to ensure that they maintain safe and effective practice. This learning is in addition to any mandatory or statutory training that the employer provides.

120. In 2019, I worked with the government to secure £150 million recurrent funding for continuous professional development, which created a personal training budget of £1,000 for each nurse, midwife and AHP over a three year period. This commitment to national CPD funding was restated in the NHS Long Term Workforce Plan in 2023 and now also covers nursing associates.

121. This funding is allocated to each NHS organisation via NHS England's regions on a per capita basis (i.e. based on the number of nurses, midwives, nursing associates and allied health professionals recorded as being within that organisation). This funding is an investment solely for CPD and cannot be used for funding backfill or mandatory training. Clinicians are able to access this funding through local processes within their own organisation.

122. In terms of mandating access to CPD, I understand why this option is favoured by some, because nurses, nursing associates and midwives can find it difficult to undertake this ongoing learning at times when they are under pressure at work. In my view, the best organisations have made the link between enabling CPD and delivering high quality care and with the ongoing national funding all NHS organisations should enable staff access to CPD. The NHS Long Term Workforce Plan advises organisations to address local learning and development inequalities and ensure that line managers discuss ongoing learning opportunities with their team members.

123. I feel that while it is of course important to continue to support organisations and individuals to enable access to CPD, my own view is that greater investment is required in our NHS staff to support not only their skills and competencies, but also to develop their career pathways and increase job satisfaction and therefore retention. For example, on average a place on a level 6 neonatal QIS course costs over £2,000 –

far above the £1,000 allocated every three years for each nurse.

124. This is indicative of the need for increased investment to ensure that we have the right workforce to meet future challenges. With increased investment, I feel that the addition of mandated access to CPD would be a reasonable step as the right incentives would then be in place to overcome any financial and access barriers.

125. In relation to job plans for nurses, as outlined in our recently updated "E-job planning the Clinical Workforce" the NHS Long Term Plan **[INQ0009252]** expectation that the clinical workforce would have an e-job plan does not extend to purely ward-based staff, which would include the majority of nurses, nursing associates and midwives. However, the benefits of e-rostering for nurses and midwives are clear and outlined in our guidance "Nursing and midwifery e-rostering: a good practice guide", published originally by NHS Improvement in 2018. This guidance helps nurse leaders to make informed decisions to ensure safe staffing levels and efficient deployment of staff and should be implemented across all trusts.

Other measures to keep babies safe

126. Finally, in relation to the structures, processes and external scrutiny which help to keep babies in hospital safe and well looked after, NHS England's letter of 18 August 2023 **[INQ0014761]**, of which I was a co-signatory, outlined the systems and improvements that have been implemented to help us make the NHS a safer place.

127. As outlined in the letter, our recent improvements in patient safety, particularly the new Patient Safety Incident Response Framework, led by NHS England's National Director for Patient Safety, have the potential to deliver a step change in how we respond to patient safety incidents. It is vital that we continue to improve by using data to understand how incidents happen and to deliver changes to make patients safe.

128. A consistent theme in national independent investigations into NHS organisations has been how staff have been unable to challenge what they felt were unsafe practices or poor care within organisations.

129. This is why one of the main themes in our Three Year Delivery Plan is to develop and sustain a culture of safety, learning, and support across all maternity and neonatal services. As part of this, we will:

    - Offer a perinatal culture and leadership programme to all maternity and

neonatal leadership quadrumvirates including the neonatal, obstetric, midwifery and operational leads;

- Through regional teams, share insights between organisations to improve patient safety incident response systems and improvement activity.

- Provide targeted delivery of the maternity and neonatal board safety champions continuation programme to support trust board assurance, oversight of maternity and neonatal services, and a positive safety culture.

130. This national level work will complement the work being led by NHS trusts to support the culture within maternity and neonatal services. This drive is supported by all NHS organisations having adopted the strengthened national Freedom to Speak Up ("FTSU") policy published in June 2022, which requires all NHS organisations in England to adopt NHS England's mandated policy on FTSU as the minimum standard, strengthen their assurance processes for enabling and supporting whistle-blowers, and reviewing relevant data and acting upon it. It is also vital that boards and senior leaders are aware of and prioritise their statutory responsibilities for safeguarding of vulnerable patients.

131. In addition to these, the terrible events at the Countess of Chester Hospital NHS Foundation Trust demonstrate the vital importance for each NHS organisation to embed a positive culture in relation to whistle-blowers and all staff who raise concerns, making sure that concerns can be raised and guaranteeing that they will be heard and acted on at the highest level of the organisation, with further escalation if required.

132. A key element of supporting a positive culture to enable staff to raise concerns is to give them the psychological support needed to make their voices heard. My directorate has led the development and implementation of Professional Nurse Advocates (**"PNAs"**) across the NHS since 2020. This role, which developed from the impact on our staff of managing the Covid-19 pandemic, offers psychological support delivered by specially trained nurses to their colleagues.

133. PNAs support staff by talking to them about their concerns and the pressures that they are facing. They are able to offer a safe space for NHS staff to discuss issues in an informal way. This approach has been shown to improve staff wellbeing and retention, as well as improving patient outcomes. It can also support staff where they have concerns about quality and help them to make these concerns heard formally.

134. This work started as a critical care initiative and was expanded due to its success. As of March 2024, over 4,4000 PNAs have completed training. 10,033 PNA training places have been commissioned by NHS England between 2021-2024, supported by £8m funding from my Directorate. Since April 2022, PNAs have delivered 54,363 sessions of restorative clinical supervision and 34,105 career conversations. They have also been involved in over 2,700 quality improvement projects each month.

135. In August 2023, we announced funding of £4m for Professional Midwifery Advocates and Professional Nurse Advocates to support staff wellbeing and provide restorative clinical supervision in maternity and neonatal services. I am driving the expansion of this work across the NHS and would like to see this become integral within all services, aiming for a 1:20 ratio by the end of 2025 in NHS commissioned services.

136. As we know, the tragic events at the Countess of Chester Hospital were intentional acts perpetrated by a malign individual. Even with improvements in patient safety monitoring and reporting, a culture change across all organisations in relation to whistleblowing, and a culture of safety, learning and support, it will always be difficult to prevent a malign individual intent on harm from acting in this way.

137. What we can learn from these terrible events is that the possibility of criminal acts needs to be actively considered from the outset of any incident. This needs to be embedded within the process of examining any unexpected neonatal (or any other) death, harm or near miss. Staff who raise concerns in relation to this possibility need to be listened to and a low-risk, but 'no-blame' approach needs to be taken in response to these concerns until investigation processes can be completed. This approach could quickly identify situations where other children or vulnerable adults may be at risk and enable swift preventative action.

138. I have outlined above my views on how further progress could be made: additional investment from Government in the numbers of nurses within our workforce; increased resource and mandated CPD; greater use of closed loop medicines systems; governmental consideration of safe staffing legislation and the continued delivery of and investment in the Three Year Delivery Plan and any additional requirements arising from this Inquiry.

139. As I said at the time of the guilty verdicts, Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her. My thoughts remain with the families affected, who have experienced pain and suffering that few of us can imagine, and I

want to reiterate my profound apologies on behalf of the NHS for all that they have been through.

140. All nurses and midwives were shocked and sickened to learn what Lucy Letby did; it was a betrayal of all the hard work the nursing and midwifery profession do each day to save lives and care for patients.

141. I also want to recognise that all staff at the Countess of Chester NHS Foundation Trust will have felt let down, particularly those who raised concerns and the NHS must learn from this.

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: _____01/05/2024_____

ANNEX 1: NHS England Nursing Directorate