

Witness Name: Duncan
Burton

Statement No.: 1

Exhibits: DB/0001 to
DB/0060

Dated: 26 April 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF DUNCAN BURTON

I, Duncan Burton, will say as follows:

1. There is approximately one baby born every 55 seconds in England. I have seen the happiness and joy this can bring to women and families. I have also sadly seen and heard the pain, harm and loss that can be experienced by some women, babies, parents and families. For some, this is pain, harm and loss that could have been avoided and is the result of failures within the quality of care; failures to learn, by error or omission; or in the rarest circumstances, by deliberate act. For some, tragedy is made considerably worse when there is a lack of timely openness and transparency. This Inquiry is investigating the rarest and most unimaginable of circumstances of deliberate acts of harm by an individual perpetrator, at a time of the greatest vulnerability for babies and their families. As a registered nurse for over 25 years, one of my most fundamental reasons to come to work each and every day is to care for and safeguard the wellbeing of people and make the lives of those we care for and work with better.
2. The Three Year Delivery Plan for Maternity and Neonatal Services ("Three Year Delivery Plan") that I detail in this statement was not created on the expectation of malign individuals' intent to cause harm, but to recognise, as all legacy reports do,

the importance of greater care and compassion, especially when things go wrong. This should be done with openness and transparency so that there are: cultures and systems of learning when harm has occurred; sharing and learning when improvements are made; and early detection and action upon signals which indicate that additional attention, intervention or action is required.

Background

3. I trained as a nurse at Swansea University between 1995-1998 and registered with the Nursing and Midwifery Council ("NMC") as a Registered Nurse (Adult) in September 1998. I also have a Bachelor of Nursing (Hons) degree from the University of Wales, Swansea [1998]. Although my clinical nursing background has been in adult care, within my various leadership roles detailed below, I have been responsible for neonatal and maternity services, so have a good understanding of this specialism.
4. Before September 2019, when I joined NHS England, I held the following roles:

Organisation	Role	Dates
Frimley Health NHS Foundation Trust	Director of Nursing and Quality	September 2017 - September 2019
	Director of Operations	July 2019 - September 2019
Kingston Hospital NHS Foundation Trust	Director of Nursing and Patient Experience	February 2013 - September 2017
	Chief Operating Officer	July 2015 – September 2015
University College Hospitals NHS Foundation Trust ("UCLH")	Deputy Chief Nurse Specialist Hospitals Board	September 2010 - February 2013
	Deputy Chief Nurse – Medicine Board	May 2009 – August 2010
	Divisional Senior Nurse – Emergency Services	2007 - 2009

	Matron - Infection and Pathology	2004 - 2007
	Deputy Charge Nurse then Charge Nurse Acute Admissions ward	2002 -2004
Royal United Hospitals, Bath	Junior Charge Nurse – Neurology Unit	2001-2002
	Staff Nurse – Respiratory Unit	1998-2001

5. I have a MSc in Healthcare Practice from Bath Spa University College (2001-2004).
6. I am a member of the Royal College of Nursing.

Current role: Deputy Chief Nursing Officer for England

7. Since April 2021, I have been the Deputy Chief Nursing Officer for England – Clinical Delivery, employed full time by NHS England. Prior to 26 February 2024, the job title was Deputy Chief Nursing Officer for England – Delivery and Transformation. The role remains the same, it is just a different name.
8. I am one of four Deputy Chief Nursing Officers, who together with the Chief Midwifery Officer, deputise for and report to the Chief Nursing Officer for England and support her in her broad role **[Exhibit: INQ0017936]**¹. We each have different focuses to cover that overall nursing portfolio. My own portfolio includes:
 - (a) Maternity and Neonatal Programme (before 2023 this was called the Maternity Transformation Programme. This was the same programme, just by a different name. For ease of reference, I will refer to both as the Maternity and Neonatal Programme throughout this statement).
 - (b) Children and Young Peoples Transformation Programme

¹ Please note that where INQ0017936 states "DCNO: People and Communities", this should read "Director: People and Communities" as this is not a Deputy Chief Nursing Officer position

(c) Nursing Workforce – includes safer staffing team; nursing workforce insights team, international nurse recruitment programme

(d) Infection Prevention and Control

9. Before I started my role as Deputy Chief Nursing Officer, I was the Director of International Nurse Recruitment. I was appointed to this position in February 2019 and held this position in addition to my Regional Chief Nurse – South East role. I led the programme of work to recruit international nurses on behalf of the Chief Nursing Officer as Senior Responsible Officer as part of the Government's commitment to have 50,000 more nurses working in the NHS in April 2024 compared to September 2019. Responsibility for international nurse recruitment transferred in April 2024 to the Workforce Training and Education directorate as part of the organisational change programme at NHS England. I also led, from March 2020 to September 2023, the Healthcare Support Worker recruitment programme for NHS England. Responsibility for this was transferred on 1 October 2023 to the Workforce Training and Education Directorate in line with the organisational change programme at NHS England. Further details for this role can be found in the job description for Director of International Nurse Recruitment **[Exhibit: INQ0017933]**.
10. I work with the Chief Nursing Officer, the other Deputy Chief Nursing Officers and senior nursing and midwifery teams to ensure the delivery of key objectives related to national nursing policy, strategy, and professional priorities. I work with other officers of NHS England to support the delivery of national objectives in these areas. Additionally, for functions outlined in paragraph [8], above, for which I am accountable, I ensure the necessary constitutional, governance, and development arrangements are in place to meet NHS England's duties and responsibilities.
11. Each of the Deputy Chief Nursing Officers have networks and contacts with whom we work, which enables us as the Chief Nursing Officer team to consider policy implications and stay connected, with the views of patients, the public and colleagues working across different components of the NHS.
12. My role entails working with multiple stakeholders including the Department of Health and Social Care ("DHSC"), the NMC, Royal College of Nursing, and Royal College of Midwives ("RCM") and the Royal College of Obstetricians and Gynaecologists ("RCOG"). As part of my role, I undertake regular clinical visits to

services, which includes maternity and neonatal units in England, to hear from frontline staff, test the effectiveness of our work, and to share good practice.

13. My team comprises five direct reports whom I line manage, including the director for Maternity, Children and Young People. A team of approximately 130 people support me on all of the programmes within my role. I exhibit an organisation structure, showing the teams and roles that fall under the Deputy Chief Nursing Officer – Clinical Delivery's role **[Exhibit: INQ0017937]** (though I note that due to organisational restructuring, the organogram does not reflect that the Neonatal Nursing Lead now reports to the Chief Midwifery Officer as opposed to the Deputy Director of Children's nursing).
14. I am not responsible for the 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 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.
15. 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. Ruth May is the executive lead in NHS England for the Three Year Delivery Plan, working alongside Sam Allen. I support her in this role alongside others including Kate Brintworth, Chief Midwifery Officer for England; Professor Donald Peebles, National Clinical Director for Maternity; Ngozi Edi-Osagie, National Clinical Director for Neonatology; and Louise Weaver-Lowe, Neonatal Nursing Lead. Further information as to my role can be found in my job descriptions **[Exhibit: INQ0017935; Exhibit: INQ0017934]**.

Career history: September 2019 – April 2021

16. From September 2019 to April 2021, I was the Regional Chief Nurse – South East England. I am employed by NHS England and before the merger I was jointly employed by NHS England and NHS Improvement. In this role I had multiple professional and delivery responsibilities, one of which was for maternity, including

line management of the regional chief midwife and her team, and the delivery of the Maternity and Neonatal Programme at a regional level. Regional Specialised Commissioning from NHS England was and remains at regional level responsible for delivery of neonatal services.

17. Within this role, I was involved with the response to maternity quality issues at East Kent Hospitals University NHS Foundation Trust which led to the Kirkup Independent Investigation into East Kent Maternity Services, commissioned in February 2020. I was interviewed by the Kirkup investigation and for completeness I attach the agreed summary of my interview **[Exhibit: INQ0017940]**.
18. In December 2020, in addition to the Regional Chief Nurse – South East and Director of International Nursing Recruitment Roles, I was asked by the Chief Nursing Officer for England to support the Maternity and Neonatal Programme and NHS England's response to "Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust" ("the First Ockenden report") which was the interim report of Donna Ockenden **[Exhibit: INQ0017920]**. This was in the capacity of an operations director to the national maternity team and was to provide additional operational leadership capacity to the Maternity and Neonatal Programme, working alongside the then Chief Midwifery Officer for England, the then National Clinical Director for Maternity and Women's Health and the then Chair of the Maternity and Neonatal Programme Board.
19. I have retained the responsibilities for the Maternity and Neonatal Programme nationally into the Deputy Chief Nurse role and have been involved in NHS England's responses to "Final findings, conclusions and essential actions from the Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust" ("the Final Ockenden report") which was the final report of Donna Ockenden into the Shrewsbury and Telford Hospital NHS Trust published in March 2022 **[Exhibit: INQ0012641]** and "Reading the signals Maternity and neonatal services in East Kent – the Report of the Independent Investigation" ("the Kirkup report") published in October 2022 **[Exhibit: INQ0012366]**.
20. In my role as Deputy Chief Nurse Specialist Hospitals Board at UCLH (September 2010 - February 2013) I held a number of corporate responsibilities and provided professional nursing leadership across seven hospital sites – this included the Elizabeth Garrett Anderson Wing at University College Hospital – which includes

maternity and neonatal services. I should note that in this role, I was involved in the incident response to a significant neonatal incident in early 2012, regarding the unexplained deterioration of babies in the neonatal unit at University College Hospital. This was subsequently found to be an issue with the intravenous feed at the manufacturer level. Given my role, I supported the initial incident response at UCLH when this was identified and reported to the police and a number of national agencies. Multiple staff were interviewed by the police (not including myself). I do not hold any records related to this. I would say that some of my insights into neonatal safety and the particular vulnerabilities of neonates come from my experience of dealing with this incident.

Voluntary work

21. Since 2019, I have been a volunteer at Princess Alice Hospice in Esher, acting as an advisor on their Clinical and Community Quality Assurance Committee. I am currently going through the process to become a trustee for the charity.

The Three Year Delivery Plan for Maternity and Neonatal Services

22. I have been asked to assist the Inquiry in relation to the Three Year Delivery Plan for Maternity and Neonatal Services which was published in March 2023 [**Exhibit: INQ0012643**]. It is accompanied by technical guidance to provide clarity on the data sources and the outcome measures in the Three Year Delivery Plan [**Exhibit: INQ0017938**].
23. I propose to split this statement into three areas:
- (a) Context
 - (b) Creation of the Three Year Delivery Plan
 - (c) Progress Against the Three Year Delivery Plan
24. Much of this statement, in setting out the context, creation and progress of the Three Year Delivery Plan, will be factual in nature and refer to reports, key national actions, organisational restructuring and investment as well as monitoring and oversight. However, throughout the statement I have endeavoured to offer my own view on the process of developing and implementing the Three Year Delivery Plan, as well as providing insight on the progress made to date and the challenges we face.

Context

25. Antenatal, intra partum and postnatal care can be daunting; women and families need compassion, kindness, and for their voices to be heard so that care can be personalised, and choices respected. When a baby requires neonatal care, this is extremely stressful, and compassion must be at the heart of the neonatal services that we provide to women, babies, parents and families. It is the responsibility of all maternity and neonatal healthcare workers to ensure that women, babies, parents and families receive the standard of care that they deserve.
26. When explaining my roles and experience above, I have referred at paragraph [19] to the Kirkup report, the First Ockenden report and the Final Ockenden report, which were published between 2020 and 2022.
27. By way of background, I set out below some further details as to each of these reports, and work initiated by NHS England in response ahead of the Three Year Delivery Plan, which expands on information set out in NHS England's Corporate Witness Statement ("NHSE/1") in the table at paragraph 674.
28. In her letter of 30 March 2022 to the Secretary of State for Health and Social Care, providing a copy of the Final Ockenden report, Donna Ockenden referred to the significant investment in maternity services that the Government had introduced since the First Ockenden report, noting that this focus and funding (much of which was for workforce expansion) was a significant stride in the right direction. She noted that the estimated cost, cited in a recent Select Committee report, for full expansion of the maternity services workforce would be £200m to £350m². The letter added that:

"Workforce planning, reducing attrition of maternity staff, and providing the required funding for a sustainable and safe maternity workforce is essential. Continuing progress on funding the maternity multi-professional workforce requirements now and into the future will mean that we can continue to ensure the safety of mothers and their babies, and meet the Government's key commitment to halve the 2010 rates of stillbirths, neonatal and maternal deaths, and brain injuries in babies occurring soon or after birth by 2025."

² N.B. although the version of the letter published by Department of Health and Social Care cites £200m to £250m, the Final Ockenden Report, and the version of the letter produced within it cites £200m - £350m. this figure is taken from a Select Committee Report dated 6 July 2021, which cites £200m - £350m, therefore I believe that to be the correct figure.

“Only with a robustly funded, well-staffed and trained workforce will we be able to ensure delivery of safe and compassionate maternity care locally and across England.”

29. Therefore, in the section below, I particularly recognise and set out further information on how we sought to address a funding need identified by the Ockenden reports, recognising that funding can be a lever for change.

Ockenden Reports

30. Donna Ockenden's reports on maternity failings at Shrewsbury and Telford Hospital NHS Trust highlighted themes common to the inquiries, investigations and reviews set out in NHSE/1, including concerns around leadership and teamwork, listening to and supporting families, provision of bereavement care, escalation of concerns and provider board oversight.
31. The First Ockenden report was published on 11 December 2020. It was at this point that I commenced my role with the national maternity and neonatal team. Alongside the Chief Nursing Officer, National Clinical Director, Chief Midwifery Officer, and Maternity and Neonatal Programme team, I convened NHS England's action in response to the report, including identifying and prioritising areas requiring additional policy, assurance, improvement and investment.
32. The report set out failings in relation to leadership, listening to and supporting women and families, provision of bereavement care, escalation of concerns and provider board oversight. It set out both local actions for learning specific to Shrewsbury and Telford NHS Trust, and seven immediate and essential actions for national implementation to redouble efforts to bring forward lasting improvements in maternity services. Following the publication of the report, NHS England wrote to all Trusts instructing them to implement the full set of seven immediate and essential actions **[Exhibit: INQ0017921]**. The letter also identified 12 urgent clinical priorities from the seven immediate and essential actions which Trusts were required to confirm they had implemented within a week. These were 12 specific and targeted actions under the headings of the seven immediate and essential actions. For example, under the immediate and essential action related to “staff training and working together”, the letter asked that Trusts “implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days a week”. Trusts were additionally required to complete and take to their board an assurance assessment tool, which

drew together the immediate and essential actions, National Institute for Health and Care Excellence guidance relating to maternity, compliance against the Clinical Negligence Scheme for Trusts³ safety actions and a current workforce gap analysis.

33. The urgent clinical priorities from the immediate and essential actions focus on enhancing service user safety through implementing the Perinatal Quality Surveillance Model, listening to women and families, and pathways of informed consent. In addition, they included a requirement to complete a risk assessment at every contact throughout pregnancy and monitoring foetal wellbeing through a second lead so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support.
34. Following the publication of the First Ockenden report, the NHS England response included a £95.6m investment into maternity services. This funding was aimed at ensuring that Trusts had in place the mechanisms, staffing levels and oversight to deliver the highest quality of maternal and neonatal care. Staff training, support and retention was essential in ensuring best practice.
35. The £95.6m investment included funding for 1,200 additional midwifery roles, 100 Whole Time Equivalent consultant obstetricians, international recruitment programme for midwives, and support to the recruitment and retention of midwives and maternity support workers. This was in addition to the existing international nurse recruitment programme which provided Trusts with funding support to recruit nurses.
36. NHS England also invested in additional regional maternity infrastructure to complement existing regional chief midwives and regional teams. This was to enhance the support and oversight of Trusts and Integrated Care Boards (“ICBs”) and included funding for every region to appoint a Regional Lead Obstetrician, a Deputy Chief Midwife, and project management support. NHSE/1 Annex 8 explains the role of ICBs and ICSs in greater detail. In addition, an increase in Maternity Improvement Advisors was funded to support the Maternity Safety Support Programme.

³ The Clinical Negligence Scheme for Trusts (CNST) handles clinical negligence claims against member NHS bodies. Although membership of the scheme is voluntary, all Trusts in England currently belong to the scheme. It operates a Maternity (and Perinatal) Incentive Scheme, which is a financial incentive programme designed to enhance maternity safety within Trusts and includes ten safety actions.

37. The NHS Long Term Plan also committed investment to support neonatal nursing establishment. In 2021/22, £5.1m was invested, with new Education and Workforce Lead Nurses introduced. In 2022/23, a further £24m was allocated to recruit over 500 additional neonatal nurses.
38. In 2021/22 NHS England also invested £52m in digital maternity, which was aimed at addressing the varying levels of digital maturity within Trusts across England. This included a Digital Maternity Fund award of £40.82m which was made available to provider organisations across England to further the digital aims of the Maternity and Neonatal Programme.
39. NHS England wrote to Trusts in January 2022 requiring them to discuss progress towards the implementation of the immediate and essential actions at board level before the end of March. Progress was then to be reported to the regional maternity team by April 2022 **[Exhibit: INQ0017922]**. This information was then presented in a report to the NHS England Public Board **[Exhibit: INQ0017924]**.
40. The Final Ockenden report was published in March 2022. As referenced in the table at paragraph 674 of NHSE/1, the report highlighted key themes relating to neonatal care:
- (a) Listening to and supporting families
 - (b) Bereavement care
 - (c) Importance of Local Maternity Systems
 - (d) Multidisciplinary training
 - (e) Escalation of concerns
 - (f) Provider board oversight
 - (g) Implementation of NHS Saving Babies Lives
 - (h) Endorsed recommendations of the Neonatal Critical Care Review.
41. The Neonatal Critical Care Review is explained in more detail in paragraphs 679-694 of NHSE/1, but in brief, it was commissioned following the “National Maternity Review: Better Births Improving outcomes of maternity services in England, A Five Year Forward View for maternity care” (2016). This report, known as ‘Better Births’ highlighted several challenges facing neonatal medicine, nurse staffing, nurse

training, the provision of support staff and cot capacity. Better Births recommended that a review be undertaken, and therefore NHS England commissioned the Neonatal Critical Care Review.

42. The Final Ockenden report set out a list of 15 immediate and essential actions, to be considered by all Trusts in England providing maternity services, that were needed to improve maternity services across England as well as over 60 local actions for learning for Shrewsbury and Telford Hospital NHS Trust.
 - (a) .
43. In March 2022, following the publication of the Final Ockenden Report, NHS England wrote to Trusts and Integrated Care Systems ("ICS") leaders setting out the expectation on boards to prevent the failings found at Shrewsbury and Telford Hospitals NHS Trust happening within Trusts and local systems **[Exhibit: INQ0017923]**. It was also expected that the Final Ockenden report should be taken to the next public board meeting and shared with all relevant staff. After reviewing the report, boards were required take action to mitigate any risks identified and develop robust plans against areas where services needed to make changes, with particular attention paid to the report's four key pillars:
 - a. Safe staffing levels
 - b. A well-trained workforce
 - c. Learning from incidents
 - d. Listening to families
44. The letter also set out expectations on every trust board to have robust Freedom to Speak Up training for all managers and leaders and a regular series of listening events.
45. In March 2022 NHS England announced a £127m funding boost for maternity services to help ensure safer and more personalised care for women and their babies **[Exhibit: INQ0017962]**. Of that funding, more than £50m was provided for Trusts to boost staffing numbers in maternity and neonatal services. Around £34m was invested in Local Maternity and Neonatal Systems ("LMNS"), in culture and leadership development programmes, and in supporting staff retention roles. In addition, £45m of capital funds was made available to hospitals over three years to increase the number of neonatal cots. This new funding built upon the £95m package of support announced in response to the First Ockenden report.

Reading the signals: maternity and neonatal services in East Kent

46. The Kirkup Report was published in October 2022. This report was the result of the independent investigation into maternity services in East Kent.
47. Following the publication of the report, NHS England wrote to the chairs of Trusts, LMNSs and ICBs to reconfirm the requirement for their boards to remain focused on delivering personalised and safe maternity and neonatal care, and to take steps to assure themselves, and the communities they serve, that the leadership and culture across their organisation(s) positively supported the care and experience provided **[Exhibit: INQ0017927]**.
48. The letter highlighted the four areas of action outlined in the report:
- (a) Identifying poorly performing units through identifying valid maternity and neonatal outcome measures and improving data
 - (b) Giving care with compassion and kindness
 - (c) Teamworking with a common purpose
 - (d) Responding to challenge with honesty.
49. Specifically, every Trust and ICB was expected to review the findings of the Kirkup report at its next public board meeting, and boards were to be clear about the action they would take, and how effective their assurance mechanisms are at 'reading the signals'.
50. The letter informed Trusts that NHS England was developing the Three Year Delivery Plan which would bring together action required following the Kirkup report, the Ockenden reviews, the NHS Long Term Plan and Maternity and Neonatal Programme deliverables. However, Trusts were told that this should not delay their actions in responding to either the Kirkup report or the Ockenden reviews.
51. There were therefore two important reviews of maternity and neonatal services published within a short space of time, each highlighting significant concerns about unimaginable loss, harm and suffering of women, babies and families, and each requiring urgent action.
52. There were also increasing concerns from families regarding maternity and neonatal care at Nottingham University Hospitals NHS Trust resulting in the commissioning of

an independent review of maternity services at the trust, chaired by Donna Ockenden, in May 2022.

Overview of key maternity and neonatal reports/reviews

53. NHSE/1 paragraphs 611-620, the table at paragraph 674 and paragraphs 675-692 set out the history and objectives of the key reports concerning maternity and neonatal care, including the Morecambe Bay Investigation, Better Births, the Maternity and Neonatal Programme, and the Neonatal Critical Care Review.
54. Better Births which was published in 2016 had set out a five year forward view for maternity services, and the NHS Long Term Plan which was published in 2019 had reaffirmed the commitment to implement its vision **[Exhibit: INQ0014626]**. With over five years from the publication of the Better Births review, colleagues and I considered it time to review the next phase of priorities for maternity and neonatal services.
55. NHS England had published "Implementing the Recommendations of the Neonatal Critical Care Review" in December 2019 **[Exhibit: INQ0012352]** which contained a number of neonatal specific improvements to be implemented across neonatal services.
56. In April 2022, Getting It Right First Time published a national report into neonatal services across England, which built on the Neonatal Critical Care Transformation review **[Exhibit: INQ0014731]**. This made recommendations to improve the outcomes and experiences for babies and their families. One of the recommendations, for example, was to increase the number of critical care cots which is why I, and others, worked with Specialised Commissioning colleagues to achieve an additional £45m capital investment which was announced in March 2022. I will set out progress at paragraph [171], below.
57. In July 2022 the Care Quality Commission ("CQC") announced a programme of inspections of all maternity services which had not been inspected and rated since April 2021 **[Exhibit: INQ0017951]**. This resulted in additional insight into maternity services both locally and nationally, and highlighted variation between maternity services.

The need for an overarching plan

58. In light of the above, there was therefore a lot being asked of maternity and neonatal services in a relatively short space of time, and a need to address the national recommendations arising from the Kirkup and Ockenden reviews.
59. I, and others across NHS England, were getting feedback from services and Trust leaders that they were struggling with the volumes of recommendations, actions and assurance requirements from multiple organisations. Services were in a position of multiplication of different aims, objectives and recommendations that were often quite similar. I used clinical visits and meetings with regional, ICB and Trust colleagues to test out and confirm the feedback we were receiving. For example, in June 2021, NHS Providers held a listening event for the Chief Nursing Officer, Chief Midwifery Officer and me to hear from nursing and midwifery leaders in the NHS. This was to enable participants to share their experience of the challenges they faced locally and the impact of national level initiatives, as well as an opportunity to reflect on where there may need to be new or different approaches in place to meet the specific needs of maternity services and users.
60. Maternity and neonatal services receive many recommendations for improvement and best practice from national audits and reports, including those published by DHSC and arm's length body-commissioned reports. Within the Maternity and Neonatal Programme team, we use a recommendations register to keep track of these. This provides a single access point for all published perinatal related recommendations. It contains a searchable database of maternity and neonatal recommendations for users with the aim of providing all stakeholders with a tool to view recommendations that have been developed.
61. The recommendations register is currently available to Trusts and ICBs in an excel spreadsheet via the Maternity and Neonatal hub on NHS Futures and is accompanied by a user guide **[Exhibit: INQ0017968]**. There are currently 798 recommendations dating between 2015 and May 2023 on the register. These recommendations are targeted at different organisations including maternity and neonatal services in Trusts. The volume of recommendations makes it challenging for those involved in maternity and neonatal services to manage, prioritise and implement the recommendations.
62. NHS England has a programme of work to digitise the recommendations register to make it more accessible and searchable, and therefore easier for maternity and

neonatal services to navigate. It is expected that this work will be complete by quarter 1 of 2024/25.

63. There were other external factors which were adding to the issues that maternity and neonatal services were facing. Maternity and neonatal services were already working towards the National Maternity Safety Ambition to halve the rates of stillbirths, neonatal death, maternal death and brain injury between 2010 and 2025, however the Covid-19 pandemic had a direct and indirect impact on women and babies, and on the progress towards this safety ambition. Covid-19 was the biggest cause of maternal deaths in 2019/21 as stillbirth risk was around double in women with Covid-19 and preterm birth rates were higher in women with Covid-19 infections.
64. Covid-19 also affected the interaction of women and families with maternity services and impacted on staff's ability to continue to provide care in the same way as pre-pandemic and to make time to spend on improvement. Leaver and turnover rates for midwives consistently rose between April 2021 and August 2022. Through focused work, including investment in a 'retention midwife' in every Trust, this is a trend which has been reversed, but it underlines one of the reasons the workforce was and continues to be a critical focus of the work we are doing to drive improvement across services.
65. Maternity and neonatal services were therefore in a challenging position coming out of the Covid-19 pandemic, which had resulted in increased staff sickness and staff leaving maternity services post-pandemic, like many other professional groups. Maternity services had previously been making good progress and, although the pandemic impacted all services, it hit maternity and neonatal services particularly hard. For example, during the pandemic there was variation in women being allowed to be accompanied to antenatal appointments, which required oversight and support from NHS England to restore in every unit. Women were also reported as being fearful to come to appointments due to the risks of contracting Covid-19 for themselves, or their babies.
66. The NHS England Maternity and Neonatal Programme team and regional maternity and neonatal colleagues also had to refocus time and resources in responding to the Covid-19 pandemic. For example, activities such as supporting the production of additional national guidance focused on Covid-19, support to the vaccine programme and its impacts, and monitoring and responding to the Covid-19

maternity situational reports. Furthermore, to provide capacity elsewhere, some staff were redeployed from improvement work to support clinical services, or other pandemic response activities. This meant pausing or delaying improvement activities on a national and local level. For example, in August 2021 we wrote to Trusts asking them to focus on eight immediate and medium term actions in response to managing the pressures on maternity and neonatal services **[Exhibit: INQ0017946]**.

67. Having held a number of posts and responsibilities concurrently during the pandemic I am acutely aware of the impact that the pandemic had on colleagues across the health and social care sector, including myself. I, like many others, had to work in ways that meant taking on additional responsibilities and finding ways to address a rapidly evolving and uncharted global health emergency. This includes colleagues in maternity and neonatal services. As Regional Chief Nurse – South East, I had to redeploy my regional team into the various Covid-19 response cells, and some into supporting frontline clinical care. I am truly grateful for the efforts of my team and all colleagues across the NHS and social care, and the work of the Royal Colleges and stakeholders for their significant flexibility and tireless work in responding to such an unprecedented global health emergency. For me personally this included leadership at both a regional and national level across a whole range of issues, some examples of which include: supporting Trusts to create additional critical care capacity; creating and responding to rapidly changing guidance; deployment of Covid-19 testing; infection prevention and control training for care homes; leading programmes of work to increase the nursing, midwifery and Healthcare Support Worker workforce – including across multiple stakeholders to enable ongoing and substantial international nurse and midwife recruitment; supporting the emergency registration of thousands of international nurses; undertaking Covid-19 vaccine shifts in a vaccine centre; taking a leading role in preparing for the 2021 increases in Respiratory Syncytial Virus and impact for children; and providing significant professional advice, guidance and pastoral care to senior nursing leaders across the NHS. As outlined in this statement at paragraph [19], I was also working with the national maternity and neonatal team in response to the Ockenden and Kirkup reviews which were published during the pandemic period. Working on the response to these two reports demonstrates that one of my roles as a leader during this time was to ensure that the focus was not only on the pandemic response, but on balancing and managing the risks associated with the wider needs of patients and services.

68. Feedback that I and others in NHS England consistently heard from services and stakeholders was that maternity and neonatal services were struggling with the volume of asks and capacity to drive improvement, as it was difficult to know where to focus their efforts and that there was a lot of variation between organisations in terms of their capacity to do so. There was recognition that a lot of actions needed to be implemented, but there were concerns about services' abilities to implement them and getting the right balance between improvement and assurance activities. We also recognised the variation in clinical outcomes and experience for women, babies and families. This variation is particularly stark in outcomes for women and babies from Black, Asian and Minority ethnic groups and those living in the most deprived areas. In order to address any inequalities, we knew that we needed to free up time for services to focus on key actions and driving improvement, whilst also delivering care, in order to get the balance right.
69. This is not a criticism of the reviews or previous recommendations, which each act within their terms of reference, and the Ockenden and Kirkup reviews have both acted as powerful turning points for maternity and neonatal care. However, an overall structure or overarching plan was needed to help translate the recommendations into action on the ground and be rooted in the national context.
70. NHSE/1 paragraphs 275-304 set out the changes to the NHS as a result of the reforms under the Health and Care Act 2022, to bring about more integrated ways of working. This included the creation of ICBs and a roadmap for the delegation of specific commissioning functions and creating the new NHS England. The NHS England Operating Framework 2022 set out how NHS England should operate in the new structure created by the Health and Care Act 2022, describing the roles that NHS England, ICBs and NHS providers play, and showing how accountabilities and responsibilities are allocated to improve local health and care outcomes. This follows the principles of devolution of services, whereby both ICBs and NHS providers' primary relationship with NHS England would be through their relevant regional team and the arrangements between regional teams, ICBs and providers are to be confirmed locally. Maternity and neonatal units and LMNS' would therefore need to operate within the new NHS England Operating Framework [**Exhibit: INQ0017926**]. This is equally true of the way in which the teams I am responsible for would need to discharge their functions. We needed to bear this in mind in the creation of the Three Year Delivery Plan, to ensure that NHS England's role under the Three Year Delivery Plan, including in relation to monitoring and oversight,

remained within its accountabilities and responsibilities under the Operating Framework, and that ICBs and provider trusts retained the autonomy envisaged by the framework.

71. As a clinician, I know only too well the importance of working together collaboratively as a multidisciplinary team with the patient and family at the centre of care provision, and how this leads to positive outcomes. I also know the impact on patients and families when this does not happen, which can have devastating consequences. My own experience as a nurse leader in various roles, including with maternity and neonatal services, is that working together as a team, with the right sets of values and culture, is critical to successful outcomes for women, babies and families. This is true at the level of care for an individual, and in the approach that is taken across, between and within teams, when focused on driving service improvement. Equally critical is a shared sense of purpose and focus and so the development of the Three Year Delivery Plan was important for setting direction for NHS England's national and regional teams. This is one of the reasons we have clearly set out responsibilities at all levels within the delivery plan and the letter announcing the Three Year Delivery Plan makes clear the ask to work together to deliver the four themes of the plan **[Exhibit: INQ0017930]**.
72. Maternity and neonatal services are also needing to respond to demographic changes resulting in increased complexity of women and babies. This is demonstrated, for example, in changes in rates of caesarean and instrumental deliveries, increased induction rates and reductions in rates of spontaneous onset of labour. One factor behind these increases is likely to be the increasing number of patients who are of advanced maternal age (aged 35 years and over). One in four births in 2021 were to women of 35 years and above compared to one in five births in 2010. There are also serious concerns about the effects of recent increases of obesity and diabetes among women of reproductive age. Neonatal services are caring for more babies born extremely preterm, for example there has been a three-fold increase in provision of care and an almost four-fold increase in neonatal unit admissions to babies born at 22 weeks gestation following British Association of Perinatal Medicine ("BAPM") guidance in 2019 to extend survival focused care to this group of babies.
73. NHS England is monitoring changes in complexity and demographics in the women and babies who use neonatal services. With that in mind, it is likely that, at the conclusion of the Three Year Delivery Plan, NHS England will review, and a next

steps delivery plan will need to be developed. This will have to reflect the evolving clinical situation and shifting complexities and demographics.

74. In light of the context set out above, and in response to listening to feedback from women, families, staff and stakeholders, it was clear we needed to review and reset what we were asking services to do in making the improvements required to enhance maternity and neonatal safety and experience. The aim was to produce a new plan that provided structure, consolidated and prioritised the existing recommendations, and made targeted actions that were achievable and impactful, and continued to support maternity and neonatal services to achieve the National Maternity Safety Ambition to halve the rates of stillbirth neonatal death, maternal death and brain injury between 2010 and 2025. We wanted the actions to be ambitious, but not to overwhelm already struggling services and were mindful of potential resource requirements. The aim was not to add another layer of assurance and reporting, but to consolidate what was already out there and to assist services with clarity of where to start.
75. In May 2022 the NHS England Board confirmed its intention to develop a delivery plan for maternity and neonatal services by the end of 2022 **[Exhibit: INQ0017925]**. The Board paper confirmed the purpose of this plan was to:
- (a) set clear priorities to continue to deliver our maternity and neonatal safety ambitions (i.e. to halve the rates of stillbirths, neonatal death, maternal death and brain injury between 2010 and 2025) and provide more personalised care.
 - (b) to bring together actions required following the Final Ockenden report, the Kirkup report and NHS Long Term Plan and Maternity and Neonatal Programme deliverables.
76. NHS England also confirmed that the plan would be informed by a new working group which the RCM and the RCOG will share responsibility of leading and alternate chairing of the meetings. This is known as the Independent Working Group whose current terms of reference are exhibited **[Exhibit: INQ0017952]**. The Independent Working Group was jointly commissioned by the DHSC and NHS England following a recommendation to the Secretary of State by Donna Ockenden on publication of the Independent Review of Maternity services at Shrewsbury and Telford Hospital NHS Trust. The Independent Working Group will guide the

Maternity and Neonatal Programme around implementation of the Ockenden immediate and essential actions and the recommendations of other reports.

77. The Three Year Delivery Plan was originally planned to be in place by the end of 2022 but owing to the fact the publication of the Kirkup Report was delayed until October 2022, additional time was required to fully reflect the findings of that report, and it was therefore published at the end of March 2023.
78. My role was to put together a team and oversee the plan to create the Three Year Delivery Plan for maternity and neonatal services. Members of the Maternity and Neonatal Programme team were allocated to lead on this work. I reported to the Chief Nursing Officer and the Chair of the Maternity and Neonatal Programme Board. The Maternity and Neonatal Programme Board and the weekly Maternity and Neonatal Leadership Group oversaw the development of the plan.
79. One of the main objectives in developing the Three Year Delivery Plan was to increase the visibility and importance of the neonatal element of the perinatal journey for women, babies and families. This was in many ways the culmination of a growing and deliberate move to fit the profile and parity of neonatal services within the Maternity and Neonatal Programme, building on steps taken in this direction previously.
80. I was therefore keen to deliberately and purposefully make changes to the name of the Maternity Transformation Programme, particularly as this terminology was used in outward facing communications to the NHS and external partners. In 2023 the Maternity Transformation Programme therefore became the Maternity and Neonatal Delivery Plan, and the Maternity Transformation Board became the Maternity and Neonatal Board, whose terms of reference are exhibited **[Exhibit: INQ0017949]**.
81. I also believed that the national programme needed more neonatal clinical voices from a neonatal nursing perspective and to complement the National Specialty Advisor role which was held by a neonatologist. During 2022 members of my team and I worked with the Clinical Programme Director, National Specialised Commissioning and Chief Nursing Officer to create the first national Neonatal Nursing Lead role. This was established to provide expert neonatal nursing advice to the Maternity and Neonatal Programme and Specialised Commissioning functions.

82. As NHS England reviewed National Clinical Director roles in 2023, my team worked with colleagues across Specialised Commissioning and in the National Medical Director's office to support the Chief Nursing Officer in changing the existing neonatal National Specialty Advisor role to a National Clinical Director for Neonatology role. This was to elevate its parity of importance with the National Clinical Director role for maternity. The National Clinical Director role for maternity was also changed as it had previously included women's health more broadly. This was in recognition of the expansion of workload in the Maternity and Neonatal Programme and growing focus of women's health from the DHSC women's health strategy for England. This has therefore increased the overall capacity for both maternity and women's health.
83. Another example of the change in direction to enhance the role of neonatal services was in May 2022 when we set out Next Steps towards LMNS [**Exhibit: INQ0017928**]. Previously the approach was focused on Local Maternity Systems. Although some systems had already begun to move to LMNS the document set out plans for greater integration of maternity and neonatal transformation at local system level, and in response to the changing NHS architecture. It therefore sets out how for those not currently operating as an LMNS should beginning work towards these principles. In assessing progress of the plan below I will also touch upon how this move for greater integration between maternity and neonatal is reflected in the approach to hearing and working with service users.

Creation of the Three Year Delivery Plan

84. We began to plan out the work and the workstreams that resources would be allocated to. This included pulling together existing evidence and actions, staff and stakeholder engagement, the drafting and publication of the plan and our ongoing progress towards the Ockenden and Kirkup report recommendations.
85. The 2022 Operating Framework set out that NHS England's purpose is to lead the NHS in England to deliver high quality services for all, and one of the ways that the framework sets out that we will achieve that is by enabling local systems and providers to improve the health of their people and patients and reduce health inequalities. It also showed how accountabilities and responsibilities are allocated between NHS England, ICBs and provider trusts. Therefore, in creating the Three Year Delivery Plan, we needed to ensure that NHS England was undertaking work that would add value and help the organisations to whom the majority of

recommendations were addressed. We therefore made engagement a high priority. We were also mindful of how to align providers' performance against the objectives of the plan, in light of the new system's allocation of accountabilities and responsibilities: the spirit of which was that NHS England should support performance and delivery by setting clear objectives, ask system and provider leaders to identify how they will best achieve them in their local context, and provide or facilitate access where needed to address particular challenges. However, providers and ICBs would retain agency and autonomy to identify the best way to deliver the agreed priorities.

Engagement

86. Engagement with service users, staff, and stakeholders was therefore central to the work, and I made sure I was closely involved. This included working with the team to monitor and ensure we were achieving timelines on engagement activities, understanding the emerging themes, advising on additional engagement requirements, and personally presenting to stakeholders on the plan and receiving feedback, for example from the Independent Working Group. To achieve a framework that services could work to, we knew we needed to see what was important to them. For example, we undertook a survey including families and the public, a stakeholder listening exercise with charities and the Royal Colleges, we sought internal views within NHS England, and held engagement events.
87. Since July 2022 the maternity and neonatal team held or attended over 50 events or meetings with service users, members of the workforce, LMNS, ICS, and boards, and stakeholders, reaching over 1,100 people. This included 191 service users, 419 workforce members, 329 supervisors and 106 stakeholders. The feedback received from these events was collated to help guide the drafting of the plan.
88. To further support the engagement, we launched an online survey for three weeks in November 2022 which received over 2,128 responses. This included 782 responses from service users, 1,133 responses from the maternity and neonatal workforce, 105 responses from supervisors and 108 responses from stakeholders. The survey consisted of both qualitative and quantitative questions. Respondents were asked what the most important things to them were in receiving or providing maternity and neonatal care. An external research agency, Solutions Research was then commissioned to analyse the qualitative responses to identify themes while the quantitative data was analysed by NHS England. The questions are exhibited at

[Exhibit: INQ0017963]. The four themes of the Three Year Delivery Plan were drafted using this feedback.

89. As would be expected, the different groups of participants and respondents had different areas of specific focus but there was a broad agreement about the key priorities. An overview of the engagement and the themes drawn out is exhibited at **[Exhibit: INQ0017969]**.

Development and Key Themes

90. The creation of the plan was an iterative process taking feedback and input internally at NHS England and with external stakeholders in order to refine, agree and publish the final plan on 30 March 2023. Throughout the period we kept the NHS Board, and the Maternity and Neonatal Programme Board apprised of the progress with the production of the delivery plan. We also used the oversight group meetings (sub committees of the Maternity and Neonatal Programme Board) to discuss in greater detail and make decisions on key areas of content. Examples of this include specific discussions on personalised care and postnatal care.
91. An example of the Maternity and Neonatal Programme Board engagement is the Single Delivery Plan Draft, Engagement and Publication Plan which was discussed at the Maternity and neonatal Programme Board on 9 Feb 2023 **[Exhibit: INQ0017947]**. This provided an opportunity to set out an update on progress, and on specific the issues that were, at that point, still in play and how we were resolving them.
92. As a result of the various engagement, the messages that were coming back clearly centred around four key themes, which therefore provided the main structure for the plan:
- (a) Listening to and working with women and families with compassion
 - (b) Growing, retaining, and supporting our workforce
 - (c) Developing and sustaining a culture of safety, learning, and support
 - (d) Standards and structures that underpin safer, more personalised, and more equitable care
93. We also established a “clinical and operational” task and finish group which was co-chaired by the National Clinical Director for Maternity and Women’s Health and the

Chief Midwifery Officer for England. This group also included the RCOG and the RCM. It met a number of times during Autumn 2022. Its purpose was to review all actions from the Ockenden and Kirkup reviews and provided views to NHS England and to the Independent Working Group, helping to inform content of the delivery plan.

94. During January to March 2023, we shared a draft of the plan in confidence with a range of key internal and external stakeholders such as the RCM, RCOG, DHSC, NHS Resolution, the Chief Medical Officer for England, the NMC, Maternity and Newborn Safety Investigation programme, National Guardian's Office, Dr Bill Kirkup, Donna Ockenden, and Baroness Julia Cumberledge (Chair of the Maternity and Neonatal Programme Stakeholder council). We used the feedback from stakeholders to further refine the plan.
95. The creation of the delivery plan does not mean that Trusts or ICBs cannot continue to focus on particular issues that are locally important, such as in response to CQC inspections, experience survey results, and feedback from Maternity and Neonatal Voices Partnerships and staff. For example, CQC inspections have identified in a number of Trusts the need to improve triage of women attending maternity services, and NHS England regional maternity teams have been providing support to Trusts where required.
96. Areas which have not been prioritised for focus in the current delivery plan will need to be reconsidered nationally when the Three Year Delivery Plan comes to an end and the next iteration of a national plan is considered. Alternatively, if new priorities emerge during the Three Year Delivery Plan period which are assessed as requiring immediate action, we will of course need to respond to this, and this may reprioritise existing objectives and associated resources or seek additional resources.
97. I anticipate that maternity and neonatal services will, by working through the four key themes and actions within the Three Year Delivery Plan, be on a stronger footing to address additional and future areas of focus.
98. Out of the four themes, we then looked at how best to practically implement the plan. Each theme set out its ambition, key commitments, and then detailed objectives. The objectives set out the actions and responsibilities required of Trusts, ICBs, and NHS England. Each theme ends with how success would be measured. This means that the plan specifically describes how objectives will be actioned, with

responsibilities assigned to Trusts, ICBs, and NHS England, and sets out how success will be determined. The Kirkup report referred to accountability at different levels, and the structure of the plan makes clear what each level of the system should be doing.

Publication of the Plan

99. The Three Year Delivery Plan was published on 30 March 2023, after being approved at a public session of the NHS England board, which set out that the proposed plan would bring together actions from recent reports into maternity and neonatal services, the Long Term Plan and the Maternity and Neonatal Programme, and would continue to support maternity and neonatal services to achieve their ambition of safer, more personalised and more equitable care **[Exhibit: INQ0017929]**. NHSE/1 paragraphs 699-719 set out the commitments of the plan which are most relevant to neonatal services, so I will not repeat them here.
100. NHSE/1 paragraphs 155-185 and 279-283 also sets out NHS England's role in the governance and oversight of ICBs and Trusts, which is the same operating model which is followed for maternity and neonatal services.
101. The Three Year Delivery Plan sets responsibilities for each part of the NHS:
 - (a) Trusts are the main operational unit of maternity services in the NHS and the employer of most staff. Trust boards have a statutory duty to ensure safety of care, including ensuring staff have the resources they need.
 - (b) ICBs commission most maternity services. Each ICB will be a partner in an ICS. ICSs are a partnership of organisations that plan and deliver joined up health and care services. The LMNS is the maternity and neonatal arm of the ICS. ICBs commission Maternity and Neonatal Voice Partnerships which are designed to facilitate participation by women and families in local decision-making.
 - (c) NHS England provides national leadership for the NHS in England. NHS England operates through regional teams which are responsible for relationships with individual ICBs. NHS England has statutory responsibility for commissioning neonatal services, through regional Specialised Commissioning teams and Operational Delivery Networks.
102. The plan was deliberately developed in such a way as to set out the objectives for every maternity and neonatal service to achieve over the Three Year Delivery Plan

lifespan. With the exception of some key commitments which have specific timelines to achieve, we did not mandate every element to be achieved by specific dates within the three years. This was in recognition that, through feedback during creation of the plan, we understood that there was variation between Trusts and ICBs and they would therefore need to decide locally the timeline on achieving different elements of the plan. This approach was also consistent with the new NHS England Operating Framework.

103. Upon the launch of the Three Year Delivery Plan, the Chief Nursing Officer for England, National Medical Director and the then Chief Operating Officer wrote out to Trusts, ICBs, Regional teams, Operational Delivery Networks, LMNS, and clinical networks. This letter set out expectations of working together to embed and deliver the four themes of the plan and emphasised the critical role that Trust and ICB boards had to play in working with maternity and neonatal leaders to improve services (see paragraph [71], above).

Progress Against the Three Year Delivery Plan

104. In this section, I will set out progress with the Three Year Delivery Plan since its publication on 30 March 2023, although it is worth noting that this work is part of a continuum of work already commenced through the Maternity and Neonatal Programme, and responses to the Ockenden and Kirkup reports.
105. Maternity and neonatal services remain a top priority for NHS England and this is demonstrated in the recently published 2024/25 priorities and operational planning guidance which sets out that to improve patient outcomes and experience, the NHS must continue to “maintain the collective focus on the overall quality and safety of our services, particularly maternity and neonatal services and reduce inequalities in line with the Core20Plus5 approach”. It specifically asks that for 2024/2025 and the following two years, systems and services should implement the key actions related to the Three Year Delivery Plan’s four high-level themes and use the success measures to monitor outcomes and progress. The objectives for maternity, neonatal and women’s health are to “continue to implement the Three Year Delivery Plan for maternity and neonatal services, including making progress towards the national safety ambition [to halve the rates of stillbirths, neonatal death, maternal death and brain injury between 2010 and 2025] and increasing fill rates against funded establishment” and to “establish and develop at least one women’s health hub in

every ICB by December 2024, working in partnership with local authorities". Key actions for systems in maternity and neonatal services and women's health are to:

- (a) make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
- (b) reduce inequalities in experience and outcomes for the groups who experience the greatest inequalities (Black, Asian and mixed ethnic groups and those living in the most deprived areas)
- (c) increase fill rates against funded establishment by growing and retaining the maternity and neonatal workforce, and continue to invest in the skills and capacity to provide high-quality care
- (d) agree safe staffing levels for the obstetric workforce in Trusts, and support Trusts to achieve them through action on recruitment and retention
- (e) ensure all women and families have personalised and safe care, with every woman offered a personalised care plan and being supported to make informed choices
- (f) consistently implement best practice, including the revised National Maternity Early Warning Score (MEWS) and Newborn Early Warning Trigger and Track (NEWTT-2) tools
- (g) Continue to develop a positive safety culture, including regular board level review of a focused plan to improve and sustain culture **[Exhibit: INQ0017944]**.

Monitoring and reporting

- 106. The Better Births report in 2016 recommended that a nationally agreed set of indicators should be developed to help Local Maternity Systems to track, benchmark and improve the quality of maternity services. In response, NHS England produced a National Maternity Services Dashboard.
- 107. The National Maternity Services Dashboard, which is publicly available, enables clinical teams in maternity services to compare their performance with their peers **[Exhibit: INQ0017970]**. Two sets of measures have been made publicly available via the National Maternity Dashboard:

1. The Clinical Quality Improvement Metrics, which are derived from the Maternity Services Data Set for quality improvement purposes.
 2. The National Maternity Indicators, which are derived from a range of sources, including MBRRACE-UK, CQC Survey, National Maternal and Perinatal Audit and staff surveys.
108. Both sets of measures are at Trust level and show national benchmarks. The Clinical Quality Improvement Metrics provide a regular monthly source of clinical activity data for maternity services to make quality improvements. The National Maternity Indicators provide a holistic picture of the performance of maternity services and are split into five domains: mortality and morbidity, clinical care and health promotion, choice and continuity of carer, user experience and organisational culture.
109. In addition to the National Maternity Services Dashboard, and to complement the Three Year Delivery Plan, technical guidance was published on 31 May 2023, which sets out the metrics that are being monitored against the plan, gives details on the construction of each outcome and progress measure so that LMNS and ICBs are clear on how progress will be measured, and provides clarity on the data sources for these measures. These data sources include:
- (a) CQC National Maternity Survey
 - (b) Regional returns (see paragraphs [110 - **Error! Reference source not found.**], below)
 - (c) NHS Staff Survey
 - (d) NHS Workforce Statistics
 - (e) Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK ("MBRRACE-UK") Perinatal Mortality Surveillance⁴.
 - (f) Office for National Statistics Child and Infant Mortality Statistics

⁴ MBRRACE-UK is a shared national programme of data collection and analysis for maternal, stillbirth, perinatal and infant mortality data via an online reporting system.

- (g) National Neonatal Research Database/ Neonatal Data Analysis Unit Reports
 - (h) Badgernet⁵
110. Every quarter, the national maternity and neonatal team report to the Quality, Performance and Surveillance Committee of the Maternity and Neonatal Programme Board on progress against the plan's metrics **[Exhibit: INQ0017960]**⁶. An example of the data that is tracked and reported in line with the Three Year Delivery Plan technical guidance is exhibited **[Exhibit: INQ0017948]**⁷. This report summarises the national and regional trends across the success measures for the Three Year Delivery Plan. It includes:
- (a) A summary of the latest national position, trends and variation for measures updated since the last report
 - (b) An overview of trends for all of the progress and outcome measures in the delivery plan, including those for which recent data updates are available and those that have not had a recent update.
111. The Maternity and Neonatal Board also receive regular updates on progress with the Three Year Delivery Plan objectives and "plan on a page" and "highlight report" which represents all current projects being undertaken in the maternity and neonatal delivery programme **[Exhibit: INQ0017942]**.
112. In addition to the quarterly Quality Performance and Surveillance report, a Beta version of a Three Year Delivery Plan Oversight Tool is available to NHS Users via the Maternity and Neonatal Hub on Future NHS. The tool is an interactive dashboard and which includes analysis of trends and variation in the success measures at national and sub-national levels across the four themes in the plan. The tool is intended to enable oversight of the delivery of key objectives/commitments in the Three Year Delivery Plan at all organisation levels, in line with the Operating Framework's allocation of accountabilities and responsibilities, and principles of devolution to services, ICBs and regions.

⁵ Badgernet is an electronic record system for maternity and pregnancy, and for neonatal care. It is a key data source used by all neonatal units to collect data for multiple purposes

⁶ This exhibits the Three Year Delivery Plan Quarterly Oversight Report as presented to the Quality, Performance and Surveillance Committee of the Maternity and Neonatal Programme Board.

⁷ This exhibits the Three Year Delivery Plan Quarterly Oversight Report itself.

113. Through this, and the National Maternity Services Dashboard, the aim is that Trusts will be able to benchmark themselves; to hold themselves and others to account, with oversight from ICBs. Regional teams at NHS England will be involved at escalation points. Nationally, the information will allow NHS England to identify whether the interventions we make, such as funding, are having an impact, but the more detailed monitoring to services remains at trust and ICB level, in accordance with the autonomy envisaged by the Operating Framework. The system will therefore assist with maintaining safe patient care, and accountability by providing greater transparency. Development of the tool is ongoing and has been informed by feedback from users. The latest update from February 2024 incorporates an overview of the measures at ICB level, enabling benchmarking of all of the success measures in a single view. An equivalent analysis of the success measures at trust level will be incorporated into the tool imminently, for users from trust to national level. The final Oversight Tool will therefore be one dashboard, which can be used at every level from trust to NHS England, to assist with their respective purposes and responsibilities.
114. There is some overlap between the National Maternity Indicators and the Three Year Delivery Plan measures on outcomes. However, there are some Three Year Delivery Plan measures that are not National Maternity Indicators and some National Maternity Indicators that are not Three Year Delivery Plan measures. NHS England would not advocate the use of one tool over the other since they have been developed for different purposes, albeit with some crossover between the content, and organisations may therefore need to use both. The Three Year Delivery Plan measures on the Oversight Tool will help the local NHS understand how it is doing against delivery of the plan. The Clinical Quality Improvement Metrics on the dashboard are intended to support maternity services with regular data on clinical activity to help them make specific improvements to the clinical quality of care and are still valid for this purpose.
115. In terms of next steps, the National Maternity Indicators on the National Maternity Services Dashboard will be aligned to the Three Year Delivery Plan by the end of the current financial year in April 2025. The Maternity Services Dataset Data Quality Steering Group chaired by Donald Peebles, National Clinical Director for Maternity, is building consensus around what needs to be included, as some National Maternity Indicators may be retained if services find them useful. The Three Year Delivery Plan oversight tool also contains management information that could not

be published on the National Maternity Services Dashboard, so it is likely that both the tool and dashboard would continue to operate. Therefore, by April 2025, the published National Maternity Dashboard will include:

1. Clinical quality improvement metrics; and
2. The outcome measures of the Three Year Delivery Plan oversight tool, combined with the potential for some National Maternity Indicators which would be retained.

Progress against themes

116. Given the extensive nature of the Three Year Delivery Plan and associated programmes, this section will set out key areas of progress we are monitoring at national level and is not an exhaustive list of all elements of work, impact and evaluation. Similarly, as it is only one year on from the publication of the plan, some of the steps taken in relation to maternity and neonatal care will take time to come to fruition and their tangible effect on services has not yet been fully realised. Some of the investment into maternal and neonatal services set out below has already delivered progress, but in other cases we will only be able to ascertain progress in the longer term and as this translates into impact on outcome and experience measures. Monitoring progress and taking effective action to drive improvement, as referenced earlier in the Three Year Delivery Plan and NHS Operating Framework, is the responsibility of all parts of the NHS including Trust boards and ICBs. In reporting progress to date, we have split this section up into the four themes of the Three Year Delivery Plan:

- (a) Listening to women and families with compassion
- (b) Growing, retaining, and supporting our workforce
- (c) Developing culture of safety, learning, and support
- (d) Standards and structures that underpin safer, more personalised, and more equitable care

Listening to women and families with compassion

117. Listening and responding to all women and families is an essential part of high quality, compassionate care. The latest maternity survey highlights progress made in relation to the experience women have in their interactions with staff and the support they receive throughout pregnancy.

118. In the latest CQC maternity survey, most women had a better experience of maternity care last year compared with 2022. Importantly, most women were positive about their interactions with staff and the advice and support they received during labour. The findings of the survey are exhibited **[Exhibit: INQ0017967]**. The 2023 survey results show a statistically significant improvement across many aspects of women's experience since 2022. The responses to 38 out of 54 evaluative questions showed a significant improvement in the top positive response option between 2022 and 2023, the responses to 15 questions showed no significant change and the response to one question showed a significant deterioration. The responses where improvements were seen cover several elements of women's experience that had showed deterioration from 2019 to 2022, including the pandemic period. While the 2023 results indicate that women's experience of maternity services broadly remains below 2019 levels, some results are now equivalent to, or have surpassed the pre-pandemic level.
119. In the same survey, most people surveyed (81%) said they were 'always' given enough time to ask questions or discuss their pregnancy at antenatal check-ups (up from 77% in 2022), and 83% of responders said that midwives providing antenatal care 'always' listened to them (an increase from 80% in 2022). The survey results also indicated that support for maternal mental health had improved in 2023. Three-quarters (75%) said their midwife 'definitely' asked about their mental health during antenatal check-ups (compared with 71% who said this in 2022) and 88% felt they were given enough support for their mental health throughout pregnancy (up from 85% in 2022).
120. The survey does indicate that there remains much scope for improvement, such as women having enough time to discuss mental health and physical health with their GP at the 6-8 week check. The only survey question that showed a significant deterioration between 2022 and 2023 related to the availability of staff during postnatal care in hospital as 55% of women said they were 'always' able to get a member of staff to help when they needed it. This was down 1.4% compared to 57% in 2022. The response to this question reiterates why the workforce elements of the Three Year Delivery Plan continue to be critical to the improvement of maternity and neonatal services, and experience of women and families.
121. NHS England is on track to commence procurement during quarter 1 of 2024/25 for a national neonatal parent experience survey which, subject to the procurement

being successful we expect that two consecutive surveys will run for all Trusts with neonatal services; one in 2025 and 2026.

122. In December 2023 “GP six to eight week maternal postnatal consultation – what good looks like guidance” was published for all GPs to support them to fulfil their contractual requirement to offer a postnatal consultation to all women. This is a universal offer and should be offered to all women, including those whose baby has sadly died or does not reside with them for any reason **[Exhibit: INQ0017956]**.
123. The Three Year Delivery Plan includes a commitment for a Patient Reported Experience Measure (PREM) for maternity and neonatal care to be created by 2025 **[Exhibit: INQ0017955]**. This will provide timely and robust, feedback from users of maternity and neonatal services to better understand service users’ quality of care. A nationally accepted measure of experience would facilitate comparisons with different models of care, provide baselines to identify if an intervention made a difference, and highlight where focus should be given to improve services. The Policy Research Unit at the National Institute for Health and Care Research have selected a supplier for the work. The contracted work will begin in July 2024 with an anticipated 18-24 month project duration.
124. In November 2023 national Maternity and Neonatal Voices Partnership guidance was published, to support ICBs and Trusts to properly embed and coproduce services with the communities who use them. As part of this guidance, NHS England sets out the approach to integration of neonatal voices within Maternity and Neonatal Voice Partnerships. To support LMNSs to move towards implementing these actions, the document sets out suggestions for the addition of neonatal care to their remit and how to engage and involve neonatal families in quality and safety surveillance at provider and system level. **[Exhibit: INQ0017954]**.
125. This coproduced guidance supports ICBs and Trusts to fulfil their statutory obligations around involving people and communities in the planning, proposals and decisions regarding NHS maternity and neonatal services in England, keeping service users at the heart of our work.
126. Service User Voice representatives are an important part of the Maternity and Neonatal Programme due to their lived experience and connections with Maternity and Neonatal Voice Partnerships. They were also an important component in creating the Three Year Delivery Plan. There are 15 maternity and neonatal Service

User Voice representatives supporting the national Maternity and Neonatal Programme, including within the Maternity and Neonatal Board, sub-committees and stakeholder council. In September 2023, recognising their important involvement in the programme and our commitments to service user voice in the Three Year Delivery Plan, Service User Voice representatives were also added to the weekly Maternity and Neonatal Leadership Group meeting **[Exhibit: INQ0017945]**. There are two Service User Voice representatives on the Group – one for neonatal and one for maternity.

127. Following work undertaken by the maternity and neonatal team, in the Government's Spring Budget 2024, it was announced that almost £35m will be invested to improve maternity and neonatal safety across England which will include additional funding to support Maternity and Neonatal Voice Partnerships to improve how women, parents and families' experiences and views are listened to and acted on to improve care.
128. As of February 2024, 39 Maternal Mental Health Services have been established, which combine maternity, reproductive health and psychological therapy for women experiencing mental health difficulties related to their maternity experience. Services in each ICS area are planned to be operational in 2024.
129. The latest national data shows that the number of women accessing specialist perinatal mental health services has risen. 55,873 women were reported to have accessed specialist community Perinatal Mental Health services and Maternal Mental Health Services in the 12 months to end of January 2024.
130. The Three Year Delivery Plan sets out the requirement to act on findings from the Maternity and Neonatal Independent Senior Advocate (“**MNISAs**”) pilots. The First Ockenden Report proposed the MNISA role to ensure that women and families voices are heard. Individuals in these roles report to Trusts and LMNS. There are currently eight ICBs who have received clearance to begin piloting the role and where the MNISA has begun to work with women and families. We are expecting more MNISAs to be given clearance soon. NHS England published operational guidance for the MNISA pilot phase in November 2023. Due to longer periods of time required to recruit and commission the pilot MNISAs, and in recognition of the need for sufficient time to assess the impact of the pilots, the Maternity and Neonatal Programme Board have extended funding for the pilot ICBs and evaluation through to the end of 2024/25. Decisions on the future direction for

MNISAs will need to be made in the spring of 2025 following the results of the pilot evaluations.

131. Tackling health inequalities is a key priority for all our services, to address the stark disparities in maternal, perinatal and neonatal health outcomes for women from Black, Asian and ethnic minority backgrounds, and to ensure care and experience is equitable for all mothers, babies and families. In 2021 NHS England published national Equity and Equality guidance for LMNS's. This was to support each ICS to develop robust, coproduced Equity and Equality guidance for LMNSs, to ensure that women and babies, no matter what their ethnic background or where they live, get safe, personalised, and equitable care. In 2023/24 ICSs are required to publish their equity and equality action plans setting out evidence-based action plans which reflect the needs of their local population. These action plans therefore set out how the national guidance will be implemented locally. Every LMNS has produced a plan, and as of March 2024, 37 out of 42 LMNSs have published their plans.
132. All maternity and neonatal staff now have free access to cultural competence and cultural safety training, which has been developed in partnership with Health Education England (now part of NHS England) in collaboration with the RCM and updated in 2023.
133. The NHS Race and Health Observatory, in partnership with the Institute for Healthcare Improvement and supported by the Health Foundation, has established an innovative 15-month, peer-to-peer Learning and Action Network to address the gaps seen in severe maternal morbidity, perinatal mortality and neonatal morbidity between women of different ethnic groups. Across England, nine Trusts and ICSs are participating, and it is due to run until June 2025.
134. In quarter 4 of 2023/24, 140 Trusts in England with maternity and neonatal services have applied for a set of clinical training aids to support care for women and babies from Black, Asian and ethnic minority backgrounds.
135. NHS England has provided funding to support Trusts to set up Enhanced Midwifery Continuity of Carer teams, which have additional staffing to provide more holistic support for women living in the 10% most deprived areas of England, who are more likely to experience adverse outcomes during pregnancy and birth. 29 teams were operational by January 2024, while a further 29 teams are expected to become operational in the near future. For 2024/25, funding will increase to provide up to

210 teams in the most deprived neighbourhoods. Where staffing levels do not yet allow for establishment of further Enhanced Midwifery Continuity of Carer teams, systems are recommended to consider increasing the capacity of other (non-continuity) teams caring for women from the most deprived areas, to increase clinical time available for these women. Where this is not possible, systems should progress specific actions in their equity and equality action plans and put steps in place to prepare for enhanced continuity of carer rollout when staffing levels allow.

Growing, retaining, and supporting our workforce

136. I chair the Maternity and Neonatal Workforce, Training and Education Committee with the Director of Operations and Oversight, Workforce, Training and Education directorate as co-chair. The group brings together colleagues from across NHS England; the Workforce Education and Training Directorate; and the Maternity and Neonatal Programme, as well as the wider Nursing Directorate and service users. External stakeholders include RCOG, RCM and BAPM. The Workforce, Training and Education Committee is a sub-committee of the Maternity and Neonatal Board and oversees and scrutinises progress in relation to theme two of the Three Year Delivery Plan 'Growing, retaining, and supporting our workforce'. This includes progress updates on maternity and neonatal workforce recruitment, retention, strategy and education and training, as well as workforce metrics.
137. Our ambition of safer, more personalised, and more equitable care can only be delivered by skilled teams with sufficient capacity, which is why growing, retaining and supporting our workforce is the second theme of the Three Year Delivery Plan. Workforce is a key enable to achieving all elements of the Three Year Delivery Plan. This is why I have played such an active role in driving workforce elements and since my involvement in the national programme in December 2020. Since the £95m additional investment in 2021, this has now grown through the last three years to £186m a year from 2024/25. This will be enhanced further with the Spring Budget announcement of an additional £35m over the next three years. These investments have supported increases in establishments and workforce related programmes. For example, NHS England funding in 2021 allowed the creation of an additional 100 obstetrician posts and 1,200 midwifery posts. Trusts continued to build on this investment locally.
138. Specific support has been provided and enacted nationally since the First Ockenden report which the Three Year Delivery Plan continues to build upon. For example, since 2022/23, NHS England has provided access to non-regulatory, clinically led, direct workforce support to all trusts with a maternity service and

delivered it to 96 Trusts. This direct support offer was an enabling programme to support workforce growth by building workforce capability, spreading best-practice and fostering collaboration across the system. Other actions nationally include support for Trusts to increase and support the maternity support workforce; and increased places and funding for Trusts to access the shortened midwifery course for registered nurses in 2023/24 and 2024/25 leading to the registration of over 1,000 more midwives by 2026.

139. The midwifery international recruitment programme has supported the arrival of 1,074 internationally educated midwives across England since September 2021. NHS England aims to continue delivering midwifery international recruitment in the coming year to support Trusts to mitigate midwifery shortfalls with a further arrival of 750 internationally educated midwives. Trusts were able to recruit internationally educated neonatal nurses as part of the NHS England international recruitment programme with funding support since 2020. The programme has supported with the pastoral care of these nurses and midwives to assist with their transition to working for the NHS.
140. Overall, evidence demonstrates that NHS England is making progress on growing and retaining the maternity and neonatal workforce, which demonstrates the benefits of earlier investments, national and local targeted support programmes and policy interventions are starting to deliver improvements. However, although we are making progress, the influence of increasing complexity and demographic changes as set out earlier in the statement, remaining workforce gaps, and variation between services, and how improvements in workforce are consistently experienced by both patients and staff working in services, all remain drivers for ongoing progress. We know from our feedback mechanisms that not all services and staff have yet felt the benefits of the additional investment in workforce.
141. A paper presented to the Maternity and Neonatal Board in March 2024 sets out progress to date and links to the NHS Long Term Workforce Plan **[Exhibit: INQ0017943]**.
142. The Three Year Delivery Plan sets out the requirements on Trusts to undertake regular local workforce planning, following the principles outlined in NHS England's workforce planning guidance. It is the responsibility of Trusts to undertake regular local workforce planning, following the principles outlined in NHS England's workforce planning guidance. Where Trusts do not yet meet the staffing

establishment levels set by Birthrate Plus⁸ or equivalent tools it is their responsibility to do so and achieve fill rates by 2027/28.

143. In February 2024 there was an increase of more than 1,200 more full-time equivalent midwives working in maternity services compared to the previous year, which is the highest number of midwives reported to be working in the NHS to date.
144. The required midwifery staffing establishment to deliver the Birthrate Plus standard for maternity services nationally is currently 27,500 full time equivalent midwives. The Birthrate Plus methodology is based on an assessment of clinical risk and the needs of women and their babies throughout the maternity pathway **[Exhibit: INQ0017917]**. The latest funded establishment data to February 2024, when compared to March 2021, shows that staffing establishments have increased by 2,758 full time equivalent midwives (a 11.4% increase), to 26,906 full time equivalent midwives, which shows continued progress on reducing the funded staffing establishment gap. The Government's Spring Budget 2024 announcement included funding for an additional 160 full time equivalent midwives over the next three years, therefore we are currently working through the timing and detailed allocation approach for Trusts and ICBs.
145. Leaver rates for midwives have continued to improve, as they reduced to 5.0% in January 2024, compared to a peak of 7.3% in August 2022. This has been supported with retention midwives in every unit.
146. The number of midwifery courses increased by 4,096 over the four years up to 2023, exceeding by more than 400 the target of a 3,650 increase over that period, and we are now seeing the benefit of these increases coming through into registered midwifery roles. Going forward, the NHS Long Term Workforce Plan sets out a further expansion of midwifery training places to support a growth of 1.8-1.9% in midwives each year. The NHS Long Term Workforce Plan, as referenced in NHSE/1 at paragraphs 647 and 649, sets out the workforce plan for the NHS over the next 15 years. Maternity and neonatal services are part of this plan, and the focus on maternity and neonatal workforce through the Three Year Delivery Plan aligns with the ambitions of the NHS Long Term Workforce Plan. There are of course challenges and risks that will continue to be faced and require ongoing

⁸ Birthrate Plus is a midwifery-specific, national tool that provides intelligence and insights to model midwifery numbers, skill mix and deployment and to inform workforce decision making about safe and sustainable services

flexing of approach, for example we are currently reviewing and working with NHS England's Workforce Training and Education directorate colleagues on mitigating potential risks from the reduction in applications to nursing and midwifery undergraduate courses.

147. There has been growth in the neonatal nurse workforce, rising from 5,604 full time equivalent Neonatal Nurses in 2019 to 6,802 in 2023, an increase of 1,198 full time equivalent (21.4%). BAPM standards are used to determine neonatal nurse staffing levels. Additional funding was allocated for neonatal cot side nurses in 2022/23 and significant progress has been made in recruiting to these roles. In November 2023 there was an increase of 559 full time equivalent cot side neonatal nurses compared to 2022/2023. Neonatal nurse quality roles, to support cot-side clinical training and clinical governance, received funding for 98 full time equivalent roles. The national recommendation for Qualification in Specialty nurses is 70%. Currently the national position shows 62.5%. NHS England is currently developing a national standard for Qualification in Specialty training.
148. Funding of £6.3m was allocated by NHS England in 2022/23, rising to £12.7m full year effect, to establish 182 new Allied Health Professional roles in neonatal services. The latest quarterly data shows that 124 Neonatal Allied Health Professionals roles have been recruited to, but there is variation between units in the vacancy rates for different Allied Health Professionals.
149. Funding was approved for three years from 2022/23 as part of the spending review settlement to expand training places in obstetrics and gynaecology by 40 per year. Additional NHS England funding allocated since 2021, combined with local investment, has led to increases in obstetric consultants. The data suggests that the obstetrician consultant workforce increased by 5.1% to 1,861 full time equivalent roles over a 12-month period to February 2024 with over 90 full time equivalent posts created over the same period. When comparing February 2024 to March 2021 data, this shows that establishments for obstetricians have increased by 448 full time equivalent roles (a 29.3% increase). However, the number of vacancies has also increased, reflecting the increased establishment. In addition, as part of NHS England's commitment to ensure obstetric teams are consistently able to provide key aspects of safe care, NHS England has provided £7m in additional investment in obstetricians in 2023/24 rising to £15m from 2024/25 onwards **[Exhibit: INQ0017950]**. This funding supports existing expectations of the obstetric workforce to help to ensure safer, more personalised, and more equitable care.

NHS England is keen to ensure that obstetric teams are consistently able to provide key aspects of safe care such as pre-term birth prevention clinics and twice-daily consultant ward rounds as well as consultant capacity for leadership and quality improvement to ensure robust quality governance. NHS England is monitoring the impact of this funding increase at a local level through monthly Provider Workforce Return data. Collecting data on obstetrician numbers is more challenging due to the gynaecological elements of the specialty.

150. To support neonatal medical staffing establishments in 2023/24 £3m was provided to neonatal services, rising to £6m in 2024/25 onwards. The additional funding is intended for local neonatal units, to support compliance against BAPM workforce standards and core safety activities in relation to safety governance, clinical leadership, and the Perinatal Mortality Review Tool. Similar to obstetricians' overlap with gynaecology, the overlaps between neonatology and paediatrics means that modelling and monitoring the neonatal medical workforce is not straightforward, and further work nationally is required to support this.
151. Although there are specific programmes of work targeted at increasing the maternity and neonatal workforce, this is only one part of the jigsaw of workforce recruitment, retention and training support. Maternity and neonatal services also have access to the wider recruitment, retention, and training support offered by NHS England to all NHS services. For example, there is a wide ranging programme supporting retention, which is led by NHS England's Workforce, Education and Training directorate and works to improve staff experience and the retention of our NHS people [Exhibit: INQ0017964]. The programme works nationally as well as across all seven regions to support and help organisations and systems to achieve improvements in staff retention.
152. NHS England is currently developing more regular collection and interpretation of neonatal staffing data by utilising provider workforce returns in the same way we do for maternity, where we currently have more granular workforce data. This data is collected quarterly via regional Operational Delivery Networks, which work directly with NHS provider neonatal teams to provide additional data quality assurance. This collection has provided a new level of granular neonatal nursing and Allied Health Professional workforce data, which NHS England continues to refine and validate in order to draw accurate conclusions and subsequent recommendations. As set out in the Three Year Delivery Plan, workforce is not just about growing numbers of staff, it is also about valuing and retaining our clinical provision and investing in skills. It is also about having the right quality of nursing provision, the composition of

- the team in terms of roles, skill, experience, and support staff, plus leadership, supervision, management and training.
153. Leadership and culture are important factors within workforce and, as outlined earlier, we have strengthened the national clinical leadership of neonatology with a National Clinical Director for Neonatology and a Neonatal Nursing Lead.
 154. In August 2023 we announced a further £4m investment in Professional Midwifery Advocates (PMAs) and Professional Nursing Advocates (PNAs), who provide educational and psychological support for midwives and neonatal nurses **[Exhibit: INQ0017931]**. PMAs and PNAs are equipped with the skills to facilitate restorative supervision to their own colleagues and teams, in nursing, maternity and beyond. Their training equips them to listen and to understand challenges and demands of fellow colleagues, and to lead support and deliver quality improvement initiatives in response.
 155. On training, in May 2023 we published an updated version of the Core Competency Framework. This sets clear expectations for trusts to address known variation in training and competency assessment across maternity teams.
 156. In February 2024, NHS England launched the Safe Learning Environment Charter **[Exhibit: INQ0017966]**. The Charter was created in response to healthcare learners' feedback on their clinical experiences in maternity services, set out in the Kirkup and Ockenden reports. The Charter was developed through extensive engagement and supports the development of positive safety cultures and continuous learning across all learning environments in the NHS underpinned by principles of equality, diversity, and inclusion.
 157. The Government's Spring Budget announcement in March 2024 includes provision for the training of an additional 6,000 staff in neonatal resuscitation over the next three years. NHS England are currently working on proposals to take this forward.

Developing culture of safety, learning, and support

158. NHS England's Maternity and Neonatal Programme commissioned the codesign and delivery of a national Perinatal Culture and Leadership Programme. Senior perinatal teams from every Trust with a maternity or neonatal service in England have enrolled (150 overall) plus two additional national teams. The Perinatal Culture and Leadership Programme is set out at paragraphs 712-716 of NHSE/1, but in brief, the programme is designed to support leaders and their teams to create and nurture a local safety culture. The programme has three phases:
 - (a) Phase 1: Team 'Quad' leadership development– this brings together the perinatal senior leadership team (midwifery, neonatal, obstetric and

operational representation), responsible for supporting, role modelling and leading the cultural environment.

- (b) Phase 2: SCORE culture survey – an opportunity to gain insight into teams' safety culture 'how it feels to work here', to help the team identify strengths and opportunities. This will cover both maternity and neonatal staff.
- (c) Phase 3: Cultural conversations and planning for improvement – Quads will be supported and by an independent culture coach to have conversations about the culture survey findings with their teams and codevelop an improvement plan based around a small number of identified key themes and linking with other work they are doing.

159. The programme has been commissioned over five intakes. All five intakes have commenced and therefore all Trusts will have completed it by January 2025. The outline for Module One is exhibited **[Exhibit: INQ0017953]**. A full evaluation of the programme has been commissioned, but anecdotal early feedback from participants, which I have tested as part of my connections and visits to frontline clinical services has been positive, in part due to the time and space it enables them to have together as a leadership team, focussing on improving the culture and leadership of their services.

160. The Perinatal Quality Surveillance Model ("PQSM"): "strengthening trust board oversight" was published in 2020 to proactively identify Trusts that require support before serious issues arise. The model seeks to provide consistent and methodical oversight of all services, through the five principles for improving oversight for effective perinatal quality:

- (a) Strengthening trust board oversight of perinatal clinical quality through collaboration between the board level safety champion and non-executive director, monthly review of perinatal safety by the trusts board and collaboration with the LMNS to ensure trust level intelligence is shared and there is early action when needed.
- (b) LMNS and ICS role in perinatal clinical quality oversight – senior LMNS representation at local quality surveillance group, local quality dashboard, concerns are escalated to regional quality committees and timely and proportionate action is taken to address identified concerns.

- (c) Regional oversight for perinatal quality - each region has a quality committee or group which reports to the national Executive Quality Group. Each region also has a joint strategic oversight group, which reports to the national joint strategic oversight group. Regional quality board should include maternity and neonatal quality as a standing agenda item, and the regional chief midwife and regional lead obstetrician are standing members of regional quality oversight groups to avoid perinatal quality being siloed. Concerns should be reported by the regional chief midwife to the executive quality group and by the regional chief midwife and lead obstetrician to the National Perinatal Surveillance Group, where necessary with a request for additional support.
- (d) National oversight for perinatal clinical quality – the National Perinatal Surveillance Group is responsible for the timely identification and escalation of any trust-level concerns by national partners with insights into maternity and neonatal services. At national level, the current highest level of maternity-specific response involves placing trusts on the Maternity Safety Support Programme.
- (e) Identifying concerns, taking proportionate action and triggering escalation - sets out action and support which may be considered when the need for additional intervention has been identified is broken down into each level of the system; provider, LMNS/ICS, Regional, National.

- 161. The five principles for improving oversight for effective perinatal clinical quality are designed to ensure a positive experience for women and their families. They integrate perinatal clinical quality into developing ICS structures and provide clear lines for responsibility and accountability for addressing quality concerns at each level of the system.
- 162. It has been agreed that the National Perinatal Quality Surveillance Model will continue to oversee quality in maternity and neonatal services, in recognition of the specific focus and risks in this area. A summary of the PQSM is exhibited in a presentation from the maternity and neonatology quality teams and Specialised Commissioning **[Exhibit: INQ0017932]** which was sent to Regional Specialised Commissioning Teams, Regional Maternity Teams and Neonatal Operational

Delivery Networks in January 2024. A draft revised PQSM is due to be published in December 2024, followed by a period to allow support for implementation in March 2025.

163. The Three Year Delivery Plan sets out the ongoing need to provide support to Trusts through the Maternity Safety Support Programme (“**MSSP**”). It also articulates the need to improve alignment with the Recovery Support Programme and undertake evaluation of the programme by March 2024. The MSSP is a national support programme provided to maternity services where there are concerns, which was launched in September 2017. Trusts are provided with support from a dedicated maternity improvement advisor. There is an intrinsic link between significant leadership, governance, cultural and patient safety challenges supported via the wider Recovery Support Programme, and maternity safety concerns. Therefore, a paper was taken to the System Oversight Committee in April 2022, setting out the proposals for aligning the MSSP and the Recovery Support Programme and the wider NHS System Oversight Framework (now the NHS Oversight Framework). Building on these steps and further agreement at the NHS England Quality Performance Committee, further interim adjustments to the entry criteria to the MSSP were made in November 2023. The evaluation of the MSSP has been undertaken within the second half of 2023/24, gathering feedback from multiple stakeholders. The final report is currently being finalised with recommendations for consideration through relevant NHS England governance during quarter 1 of 2024/25.
164. NHS England has established and maintained other programmes of work that are applicable to all of the NHS, regarding culture and patient safety, including Freedom to Speak Up and the Patient Safety Incident Response Framework, as well as the specific Perinatal Culture and Leadership Programme.
165. Paragraphs 761-787 of NHSE/1 set out the processes and procedures in relation to concerns that might be raised by an NHS worker, and the processes and policies in relation to freedom to speak up. In brief, in response to a report by Sir Robert Francis KC, “Freedom to Speak Up, An Independent Review into creating an open and honest reporting culture in the NHS, February 2015”, NHS England has published a Freedom to Speak Up policy which provides a minimum standard for local policies across the NHS, and all NHS organisations and others providing NHS healthcare services in primary and secondary care are required to adopt this policy as a minimum standard. Further, the NHS Standard Contract (general condition

5.10) requires providers of NHS services to have one or more Freedom to Speak Up Guardians, who have various duties to work and co-operate with the National Guardian's Office.

166. Paragraphs 815-829 of NHSE/1 describe the Patient Safety Incident Response Framework in full. Implementation of the Patient Safety Incident Response Framework is now required by the NHS Standard Contract and organisations were expected to implement the Patient Safety Incident Response Framework in the autumn of 2023. The Patient Safety Incident Response Framework emphasises the central importance of engagement and involvement in families, ensuring they are able to be a part of any investigation.
167. NHS England consider that it is too early to give a fully informed view as to the effectiveness of the Patient Safety Incident Response Framework, but it has been generally well received by the health and care system. The evidence of effectiveness so far, as well as further considerations, is set out in NHSE/1 at paragraphs 925-931. We have heard some feedback from maternity services that the transition to the Patient Safety Incident Response Framework has been challenging, and this was included in the Programme Delivery Report at the March 2024 Maternity and Neonatal Board. Concerns were discussed and addressed in a session on 6 March 2024, led by the Patient Safety Team (Medical Directorate at NHS England) and facilitated by Health Services Safety Investigations Body. This was an opportunity to share examples, case studies and approaches that services can take in transitioning to the Patient Safety Incident Response Framework and was attended mainly by regional and national colleagues so that they would then be able to support Trusts.
168. NHS England has worked with the Maternity and Neonatal Board Safety Champions from 14 Trusts from across all seven regions (who are on the MSSP). In response to identified needs, specific support has been provided on the identification and use of data for learning and improvement, and in supporting the board with themes and trends. The next stage of this programme will be discussed at the strategy and policy committee (a sub-committee of the Maternity and Neonatal Board), to take this learning into the ongoing work on data, and next phase of Board Safety Champions work.

Standards and structures that underpin safer, more personalised, and more equitable care

169. In May 2023, NHS England published an updated version of the Saving Babies' Lives Care Bundle, aimed at providing best practice for providers and commissioners to reduced perinatal mortality **[Exhibit: INQ0017961]**. This is the third version of the care bundle and builds on the achievement of previous versions (2016 and 2019). It was produced by drawing upon other national guidance and co-developed with service users, clinical experts, and national organisations. A tool to support implementation has also been made available to Trusts and ICBs to help provide baseline compliance with the care bundle, agree local trajectories, and measure improvement against the interventions set out in each element. Responding to the National Pregnancy in Diabetes audit, this new bundle includes a new additional element on management of pre-existing diabetes in pregnancy.
170. The national Maternity Early Warning Score (MEWS) and updated Newborn Early Warning Track and Trigger 2 (NEWTT-2) are tools to improve the detection and care of unwell mothers and babies, enabling timely escalation of care. NHS England has appointed a digital organisation to work on the digital specifications for the Maternity Early Warning Score and Newborn Early Warning Track and Trigger 2 tools. Work has begun and it is expected that specifications will be developed by end July 2024.
171. The £45m capital investment into neonatal cots is funding expansions across London, the South East, Midlands and North East and Yorkshire. Additional cots have already opened in two neonatal units, and all but one scheme is currently expected to deliver the funded increase in costs by March 2025. Due to the complexity of one scheme in London, a change to a later scheme completion date has been requested and is currently under review to approve the later delivery date.
172. Included in the Three Year Delivery Plan was a commitment to convene a taskforce to progress the recommendation from the Kirkup report for an early warning system to detect safety issues within maternity and neonatal services. The Maternity and Neonatal Outcomes Group was set up by NHS England in May 2023 to address the first recommendation in the Kirkup report to "identify valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers". Dr Edile Murdoch has been appointed the Chair of the Maternity and Neonatal Outcomes Group, to lead this programme of work, and Dr Bill Kirkup and Sir David Spiegelhalter, a statistician and Fellow of Churchill

College, Cambridge have been appointed as advisors. The group is developing an early safety signal monitoring tool using more timely outcome data to identify potential issues earlier, which will enable maternity and neonatal teams and Trust boards to investigate, as well as identify the services needing support nationally. The tool will not determine the safety of a service but indicate early changes in signal trends that require further investigation.

173. To date, three outcome measures have been identified and a methodology (currently using R software) is being validated against trusts placed on the MSSP. Testing so far has been done using anonymised historical data from MBRRACE-UK and the National Neonatal Research Database covering a 31-month period between June 2019 and December 2021. Development of a Beta version of a visualisation tool is at an early stage, as are discussions with stakeholders on what standard operating procedures might look like for the interpretation of a signal using the tool, and the action and escalation that should take place as a result.
174. The final tool will be reliant on a real-time data feed from Trusts on a focussed set of measures. These will be extracted from a single notification portal to make it easier for Trusts to notify national organisations of specific incidents. This is now referred to as "SPEN" (Submit a Perinatal Event Notification). The development of SPEN is a complex project involving bringing together stakeholders such as Maternity and Newborn Safety Investigations Programme, CQC, NHS Resolution⁹ and MBRRACE-UK. The build is progressing; however, due to the complexity of the work, it is now increasingly likely to be delivered by winter 2024 rather than summer 2024 which was the ambition sets out in the Three Year Delivery Plan. Escalation on this issue has been discussed at the March 2024 Maternity and Neonatal Board, and additional mitigations are being explored to support the delivery including potential alternative options to provide live data feeds to the Beta version of the tool as an interim solution to enable testing in a small sample of trusts.
175. To further reduce serious brain injury during or soon after birth, and to meet the National Maternity Safety Ambition to halve the rates of stillbirths, neonatal death, maternal death and brain injury between 2010 and 2025, the DHSC established the Brain Injury Reduction Programme, which has its origins in a collaboration between the RCOG, the RCM and The Healthcare Improvement Studies Institute. Phase one

⁹ NHS Resolution is an arm's-length body of Department of Health and Social Care, providing expertise to the NHS on resolving concerns and disputes, sharing learning for improvement, and preserving resources for patient care.

of this programme has been completed, which has developed tools for monitoring foetal deterioration, and developed a consensus definition for impacted foetal head and pathway for management. Phase two now requires clinical validation of these resources and pilot rollout within a small number of ICBs. Invitations for tender have closed for phase two and were awarded to a consortium led by the RCOG in April 2024. Once work begins, we expect that phase two will require 9-12 months to complete, likely to be by spring 2025. Subject to sufficient evidence of clinical impact, phase three will follow with a full national roll out. NHS England will organise the delivery of phases two and three of the brain injury programme within the NHS and are currently recruiting to additional temporary posts to support delivery. Funding for this programme was announced as part of the £35m Spring Budget 2024 funding for maternity and neonatal services. The programme aligns with existing NHS England work on Perinatal Deterioration including NEWTT2 and MEWS.

176. Since December 2022, 14 Maternal Medicine Networks have been established across England, with 17 new centres of excellence that help women with pre-existing medical conditions, or conditions that arise during pregnancy, to receive additional specialist care. These are particularly important as maternal deaths are often caused by medical conditions that pre-date or develop during pregnancy, which can be missed or misattributed to pregnancy. The development of these centres is supported by obstetric physicians and a component of the £35m funding announced in the Government's Spring Budget 2024 provided is to train more obstetric physicians.
177. As set out above at paragraph [150], the Perinatal Mortality Review Tool ("PMRT") is one of the areas for which the additional investment for neonatal medical establishment (£3m in 2023/24 rising to £6m in 2024/25 onwards) is intended.
178. The PMRT is a standardised tool for investigating and reporting stillbirths and neonatal deaths, with data collated centrally as well as producing reports at a local level. It was introduced in 2018, to review perinatal deaths from 22 weeks gestation until 28 days from birth. It is recommended that the PMRT review team includes the involvement of a professional external to the Trust, as a "fresh pair of eyes" and the review team grades the quality of care provided. It is a national standardised reporting tool and is integrated to the MBRRACE-UK national perinatal mortality surveillance data collection system. Further information about PMRT can be found at **[Exhibit: INQ0017919; Exhibit: INQ0017918]**.

179. The Three Year Delivery Plan made a commitment to undertake a national maternity and neonatal unit infrastructure compliance survey and report, to determine the level of investment needed for an environmentally sustainable development of the maternity and neonatal estate across England. The guidance to the survey is exhibited **[Exhibit: INQ0017958]**. The survey has three objectives:
- (a) Assess the current condition of the maternity and neonatal estate across England
 - (b) Identify future needs of the maternity and neonatal estate, considering population growth and technological change
 - (c) Inform recommendations and to enable service improvement
180. On 29 February 2024, NHS England estates and facilities team wrote to Trusts asking them to complete this survey for submission to the national team and local ICBs by 8 April 2024 **[Exhibit: INQ0017959]**. The results of this survey will be collated during the quarter 1 of 2024/25 in order to form a national view of the objectives set out at paragraph [179] and identify next steps in response to the findings.

National Maternity Safety Ambition

181. As set out at various points within this statement, the aims of the Three Year Delivery Plan were to: bring together actions from recent reports into maternity and neonatal services, the long-term plan and the maternity programme; and continue to support the National Maternity Safety Ambition to halve the rates of stillbirths, neonatal death, maternal death and brain injury between 2010 and 2025. The overall measures for this ambition show that there has been progress in reducing stillbirth and neonatal mortality, but that inequalities persist, and the pandemic had an adverse impact. Maternal mortality remains a concern and we continue to investigate what more might need to be done to make improvements here. The current available statistics show the following:
- (a) **Stillbirth rate:** 3.9 per 1000 live births, 23% lower than 2010 in 2022 and down after an upward shift in 2021 linked to pandemic impact. We expect the next set of rates for 2023, to be available in summer 2024.
 - (b) **Neonatal Mortality rate:** 1.4 per 1000 live births, 30% lower than 2010 in 2021, having increased during the pandemic. The 2022 rates are expected in May 2024.

- (c) **Maternal Mortality rate:** UK rate per 100,000 maternities has risen from 11.66 in 2019-21 to 13.41 in 2020-22. Excluding deaths due to Covid-19 the latest rate is 11.54 per 100,000 maternities, a rise from 10.06 in 2019-2021. We expect the next update to these rates in early 2025.
- (d) **Rate of serious brain injury during or soon after birth:** 4.25 per 1000 live births, 9% lower than 2014 in 2019. The next update will provide rates for 2020 and 2021 and are awaiting confirmation from DHSC on when this will be available.
- (e) The latest preterm birth rate available from ONS was 7.7% in 2021 up from 7.6% in 2020. ONS data to be published in the spring which will confirm the 2022 rate.
- (f) The perinatal mortality rate for black and Asian babies was 9.3 per 1000 births in 2021, compared to 5.7 per 1000 births for white babies. Black and Asian babies were at 1.6 times higher risk of perinatal mortality than white babies in 2021, a small improvement from 1.8 in 2017. For babies from the most deprived quintile, the perinatal mortality rate was 8.7 per 1000 births in 2021 compared to 5.0 for babies from the least deprived quintile. This again reflects the importance of the actions at all levels of the NHS within the Three Year Delivery plan and particularly the steps being taken to address inequalities.

Independent Review of Maternity Services at the Nottingham University Hospitals NHS Trust

182. On 5 February 2024, NHS England presented an update to the Secretary of State for Health and Social Care on our progress in relation to maternity and neonatal care **[Exhibit: INQ0017957]**. This outlined progress to date and some of the challenges we are facing. It also set out that, in addition to the Three Year Delivery Plan objectives, one of our main focuses this year would be to continue to support Nottingham University Hospitals NHS Trust, and wider NHS to learn from the ongoing Ockenden led independent review into maternity services in Nottingham University Hospitals NHS Trust. This is part of the agreed approach to the review, using identified learning for improvement throughout the review period and ahead of the final report in September 2025.
183. In relation to this last point, I chair the Learning and Review meeting as part of the Independent Review by Donna Ockenden of Maternity Services at Nottingham

University Hospitals NHS Trust. As part of this, there are bi-monthly learning and improvement meetings with the Trust's executive team. The meetings also include Donna Ockenden as the Review Chair, and with regional and national representation, including the Chief Midwifery Officer, the National Clinical Director for Maternity, and NHS England Improvement Directors. In addition to providing oversight in the region and ICB, it has been agreed that the emerging themes should be shared across maternity and neonatal care systems, in order to support their collective continuous improvement. The aim is that any learning emerging from the review can be fed into the Trust in real time rather than waiting for completion of the report before all the lessons are fed back. I exhibit a copy of the terms of reference for this group **[Exhibit: INQ0017965]**.

184. The emerging themes are exhibited in a paper presented in March 2024 to the Quality, Performance and Surveillance Committee and Maternity and Neonatal Board **[Exhibit: INQ0017941]**.
185. The forward plan for the learning and improvement meetings will identify areas for ongoing focus and will be agile to themes that emerge through the review. Alongside informing and supporting the implementation of timely responses by the Trust, it will allow for national learning to be shared with services and stakeholders before publication. The NHS England Public Board in May 2024 is due to discuss maternity and neonatal services and progress against the Three Year Plan. This will include an update on the review in Nottingham and its key emerging themes. We have seen that the emerging themes broadly align with the Trust's Maternity Improvement Plan and, as we continue to work with the review team. We have seen that the emerging themes broadly align with the Trust's Maternity Improvement Plan, and as we continue to work with the review team, we will assess the ongoing alignment with the Three Year Delivery Plan.

Conclusion

186. Overall, and in keeping with the evidence I have available, I would say that progress has been made in relation to the Three Year Delivery Plan, but there remains a lot to do, especially in terms of variation between services, perinatal mortality rates, experience of care and work on "reading the signals" to identify potential safety issues sooner. From my own experience of working within the NHS, I can see that the NHS had made significant strides in terms of a culture of openness and transparency, but there is more to do. Maternity and neonatal services are not alone

in this journey and are part of wider efforts to improve openness and transparency across the NHS, as set out in NHSE/1. We have had lots of positive feedback from services and stakeholders on how helpful the Three Year Delivery Plan has been for them. We have also recently achieved a £35m additional investment to support maternity and neonatal services over the next three years **[Exhibit: INQ0017939]**.

187. The Three Year Delivery Plan was launched in March 2023, which will therefore last until March 2026. With the anticipated publication of the Ockenden review into Nottingham University Hospitals NHS Trust in September 2025 and the outcome of this Inquiry, ongoing progress of the Three Year Delivery Plan will have to take into account any new or emerging recommendations or actions from these. Emerging trends will need to be considered in the development of future plans for maternity and neonatal services. This will also need to include any lessons learnt from the implementation of the existing Three Year Delivery Plan.
188. As set out earlier in this statement at paragraph [74] the need for an overarching plan was to create national direction and prioritisation for maternity and neonatal services. It is recognised that during the implementation of the Three Year Delivery Plan, NHS England, ICBs and Trusts need to remain agile and be able to respond and adapt to inevitable new evidence and clinical developments, feedback from women, families and staff, organisational changes and resource availability. That means being able to prioritise and de-prioritise in response to real-time developments that were not envisaged in the creation of the plan and NHS England will have to respond to change, update best practice, and amend national programmes in response to feedback and outcomes, as well as working to reduce variation on the ground between Trusts and ICBs. Any changes in current direction will need to be substantial in order for us to make any significant changes or updates to the Three Year Delivery Plan, to avoid the risk of the service having an overwhelming volume of actions to implement. This will lead to elements of the plan having different timelines based on locality as, while all providers are working towards the same objectives, there has to be a recognition that there is variance between the stages Trusts and ICBs are at locally.
189. The first of the four themes of the Three Year Delivery Plan is 'listening to and working with women and families with compassion' because of the importance of this in driving improvement across our services. It is the voices and experiences of women and families through past and current investigations into maternity and neonatal care, which will continue to drive me and my team. As I hope has also

been clear in this statement, listening and feedback from staff and stakeholders is also important, particularly in delivering the themes of “growing, retaining, and supporting our workforce” and “developing a culture of safety, learning and support” and this will also continue to drive me and my team as we continue to support the NHS in the delivery of the Three Year Delivery Plan.

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.

Personal Data

Signed: _____

Dated: 26 April 2024