Witness Name: Louise Weaver-Lowe

Statement No.: 1

Exhibits: See Index to Exhibits

Dated: 26 April 2024

**THIRLWALL INQUIRY**

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**WITNESS STATEMENT OF LOUISE WEAVER-LOWE**

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I, Louise Weaver-Lowe, will say as follows: -

## Background

### Qualifications

1. I commenced my general nurse training in 1987, qualifying as a Registered General Nurse in 1991. I then completed midwifery training and qualified as a Registered Midwife in 1993.

2. I have been a neonatal nurse since 1993. I completed neonatal Qualified in Specialty (QIS) in 1995, and Enhanced Practice Course in Neonatal Care in 1998.

3. I completed a BA honours degree in Nursing Practice in 2007 and a master's degree in Health Service Management in 2014.

### Roles

4. I started my neonatal career working as a staff nurse, progressing to sister, Matron, and Lead Nurse within the neonatal specialty at Central Manchester University Hospitals NHS Trust, which became part of Manchester University NHS Foundation Trust in 2017.

5. I became Head of Nursing at Saint Mary's Hospital, part of Manchester University NHS Foundation Trust in April 2018. This post provided professional leadership for nursing and midwifery in neonatology, gynaecology, obstetrics and gynaecology theatres, and genetics. This was a new role for Manchester University NHS Foundation Trust, as the Head of Midwifery had previously covered both maternity and nursing and I had been supporting them from a neonatology perspective within my Lead Nurse role. My responsibilities as Head of Nursing included two of the Greater Manchester neonatal units: the Neonatal Intensive Care Unit at Saint Mary's Hospital, which is a tertiary intensive care and surgical service, and the Local Neonatal Unit at Wythenshawe Hospital.

6. My roles as Lead Nurse, and then Head of Nursing at Manchester University NHS Foundation Trust involved engagement with the North West Neonatal Operational Delivery Network ("**NWNODN**") at a local level, i.e. within Greater Manchester.

7. Since August 2019, I have been the Network Director of the NWNODN, which covers the three North West localities of Greater Manchester, Lancashire and South Cumbria, and Cheshire and Mersey. As the Network Director, I provide overall leadership, strategic direction, and management of the NWNODN. My responsibilities include encouraging effective engagement of patients, professionals, and constituent organisations in network activities that support the delivery of national outcome ambitions in line with local needs and resources. It is a full-time role, reporting into the Specialised Commissioning team in the North West, although I am formally employed by Alder Hey Children's Hospital NHS Foundation Trust, as it "hosts" the NWNODN and therefore the employment. I provide further details at paragraph 33 – 34 of this statement.

8. Since May 2023, I have been seconded from my role as Network Director of the NWNODN, to the national role of Neonatal Nursing Lead at NHS England. As it is a secondment arrangement, my substantive employer remains Alder Hey Children's Hospital NHS Foundation Trust. In summary, my role is to provide clear leadership to promote local to national level support and enhance the voice of neonatal nursing by working with NHS England's Maternity and Neonatal Transformation Team and national Specialised Commissioning team. The role's aim is to support safer neonatal care, with the aim that every family whose baby needs neonatal care, no matter where they live in England, is provided with care in accordance with national standards and national best practice guidelines. The role therefore has a focus on delivering the perinatal aims of NHS England's Three-Year Delivery Plan for Maternity and Neonatal

Services **[INQ0012643]**. I cover this role in further detail in paragraphs 15 – 25 of my statement.

Wider Experience in addition to substantive roles

9. I was a member of NICE's "Preterm labour and birth and neonatal guideline development committee" in 2015 which led to the publication of the NICE guideline titled "Preterm labour and birth – Full guideline: methods, evidence and recommendations" in June 2015 and in 2018 I was a member of NICE's "Specialist neonatal respiratory care in babies born preterm guideline committee" which led to the publication of the NICE guideline titled "Specialist neonatal respiratory care for babies born pre-term" in April 2019.

10. Since October 2021, I have sat on the executive committee of the British Association of Perinatal Medicine ("**BAPM**") as network representative for all neonatal networks. Executive committee members take a hands-on role in planning and delivering BAPM's strategic plan and represent the organisation at relevant events and committees. It is a three-year post which will come to an end in October 2024.

11. I am a member of the Neonatal Critical Care Clinical Reference Group. Details of this group can be found in NHS England's Corporate Witness Statement ("**NHSE/1"**) at paragraphs 113 – 117.

12. I am also undertaking the Professional Nurse Advocate Course, which is a masters level course to enhance my support for colleagues and enable me to provide restorative supervision. I provide at paragraph 71 of this statement further details as to the purpose of Professional Nurse Advocacy. Once the course is complete, it will be a role that I intend to undertake in addition to my substantive role.

13. Further details as to my career history and experience can be found in my CV of March 2024 **[Exhibit LWL/0001 [INQ0018035]]** which was drafted for the purpose applying for a place on the Professional Nurse Advocate course.

Definitions

14. The following definitions are not intended to be a comprehensive explanation, but merely to assist the reader in their understanding of some of the terms used in this witness statement:

    a. 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.

b. Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries ("**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. Further information on the MBRRACE-UK surveillance data collection system can be found at **Exhibit LWL/0002 [INQ0018037].**

c. The "Perinatal Mortality Review Tool" ("**PMRT"**) is a standardised tool for investigating and reporting stillbirths and neonatal deaths, with data collated centrally as well as producing reports at a local level. 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 LWL/0003 [INQ0017919],** and **Exhibit LWL/0004 [INQ0018036].**

d. The Child Death Overview Panel ("**CDOP**") is a multi-agency review of all child deaths (a person up to the age of 18 but excluding stillbirth or late foetal loss). It includes representatives from the wider community including police and social services. Statutory guidance was published in 2018 **[Exhibit LWL/0005 [INQ0012367]].**

e. The Perinatal Quality Surveillance Model ("**PQSM"**) is a governance structure that seeks to provide a consistent and methodical oversight of all perinatal services. The current model was published in 2020 to proactively identify trusts that require support before serious issues arise. It is not limited to mortality **[Exhibit LWL/0006 [INQ0018013]]**.

f. Specialised Commissioning refers to specialised services that NHS England are involved in commissioning. Specialised Services are grouped into six national programmes of care. Neonatal services are one such specialised service under "Specialised Commissioning" within NHS England. I understand that further details can be found within **NHSE/1**, at paragraphs 93 – 112.

g. Clinical Reference Groups ("**CRGs**") are groups of clinicians, commissioners, public health experts, patients and carers who advise the national programmes of care on how specialised services should be provided. The Neonatal Clinical Reference Group is one of the CRGs which sit within the Women and Children national programme of care.

h. Operational Delivery Networks ("**ODNs**") are a managed network of neonatal providers focused on coordinating patient pathways between neonatal units over a wide area to ensure access to specialist resources and expertise.

i. The term "units" is used in this statement to refer collectively to neonatal units. Neonatal units are generally split into three classifications: Special Care Baby Units ("**SCUs**") which are low dependency units, Local Neonatal Units ("**LNUs**") for babies who need a higher level of medical and nursing support, and Neonatal Intensive Care Units ("**NICUs**") which treat babies needing the highest level of support.

**Role of Neonatal Nursing Lead**

15. I am the first person to hold the newly created role of Neonatal Nursing Lead for NHS England, which helps to deliver the Three-Year Delivery Plan for Maternity and Neonatal Services **[INQ0012643],** which brings together the work being done as a result of the Shrewsbury & Telford Report by Donna Ockenden **[INQ0012641],** the East Kent Report by Bill Kirkup **[INQ0012366],** and the Recommendations of the Neonatal Critical Care Review **[INQ0012352].** I do not set out any further detail as to each of those documents within this witness statement, as I understand that they are explained and discussed in **NHSE/1,** and a high-level summary is provided at **NHSE/1** paragraph 674.

16. My role sits within the nursing directorate of NHS England. I previously reported to Kate Pye, the Deputy Director for Children and Young People's Nursing, under the portfolio of the Deputy Chief Nursing Officer for Delivery and Transformation, Duncan Burton. However, I now report directly to Kate Brintworth, Chief Midwifery Officer for England. I am responsible for reporting progress on certain actions assigned to me as outlined in my performance objectives **[Exhibit LWL/0007 [INQ0018039]].**

17. The NHS England roles of Neonatal Nursing Lead and National Clinical Director for Neonatology were both created with an aim of creating closer links between neonatal ODNs and national teams, and to provide expert clinical advice to Specialised Commissioning nationally, and to the Maternity and Neonatal Programme. Therefore, as Neonatal Nursing Lead, I connect with other specialist advisory leads across nursing, maternity, and neonatology. NHS England's Maternity and Neonatal Leadership Group has a weekly meeting, including: Duncan Burton (Deputy Chief Nursing Officer), Phoebe Robinson (Director of Maternity, Children and Young People), Kate Brintworth (Chief Midwifery Officer), Dr Ngozi Edi-Osagie, (National Clinical Director for

Neonatology), Steve Anderson (Deputy Director for the Maternity and Neonatal Programme), other NHS England senior leaders, and the Service User Voice Representatives for each of maternity and neonatal services. I work closely with the Neonatal Service User Voice Representative, and she sits on various committees in relation to the work we do. She is also my link to the Maternity and Neonatal Voices Partnerships across the country. Further information as to Service User Voice Representatives can be found at **Exhibit LWL/0008 [INQ0018025]** and **Exhibit LWL/0009 [INQ0018018].**

18. My role involves providing strategic nursing leadership and professional advice, supporting governance for neonatal services in England, and promoting high-quality and safe care for neonates and their families. I work with other interdependent maternity and children and young people's teams within NHS England, such as those set out above at paragraph 17 above, to provide neonatal expertise on health promotion, health prevention, and education matters that improve the quality of neonatal health provision, drawing on national and international best practices, ultimately to support the UK Government's target of reducing stillbirths, neonatal and maternal deaths, brain injuries, and pre-term births by 2025.

19. As part of the NHS Long-Term Plan **[Exhibit INQ0009252**] and subsequent NHS England Neonatal Critical Care Review, I support the development of neonatal nursing workforce data to assist with meeting staffing standards. This has involved working with the workforce and education leads within the neonatal ODNs to collect quarterly data on nursing and Allied Health Professional workforce in neonatal units. I also support the Maternity and Neonatal Programme and Specialised Commissioning in their work under the NHS Long-Term Plan regarding the design and expansion of neonatal critical care services to improve the safety and effectiveness of services and enhance the experience of families. For example, this has involved supporting discussions around capital spend to increase neonatal cots where required.

20. My role started on a part-time basis of 0.4 Full Time Equivalent, which was increased to 0.8 Full Time Equivalent in August 2023. This increase was made in anticipation of the verdicts in the LL cases, as NHS England expected that neonatal nurses, neonatal services, and families, would need more support (including pastoral) as a result of the media attention and impact on the profession. The verdicts left many neonatal nurses feeling vulnerable in their roles, with many struggling with the identity of being associated with their specialty, and they found that parents were naturally feeling more

nervous about leaving their babies under the care of neonatal nurses. From April 2024, the role has returned to 0.4 Full Time Equivalent.

21. Further information as to my role as Neonatal Nursing Lead can be found in the original Job Description / Person Specification for the role **[Exhibit LWL/0010 [INQ0018031]],** which has recently been updated as a result of a change in my line manager **[Exhibit LWL/0011 [INQ0018045]].**

22. I see part of my role as being to bring people together across neonatology, with the aim of ensuring that the right people are involved in any matter being discussed, by signposting people to the right place to address an issue. Neonatal nursing is not a big speciality (in staff numbers) meaning that I am able to be well connected within the specialty, so I always know someone who has the expertise to assist, and my role connects those people into pieces of work so that the right people are answering the right questions, and the right voices are heard. For example, I work with the neonatal network workforce and education leads who are connected to managers in units, so that I have a connection and insight to the ward level. I liaise with ODN managers on a regular basis, to find out what is going on within their region, and to build a picture nationally. Sometimes, an organisation or advisory group may ask me to suggest an expert who can undertake a review for them. I think it is important to not just pick up issues, but to make sure that the right people are involved in addressing that issue, which is where my contacts across the networks help to make sure that the units are heard, via their ODNs, on a national level. I see my role as bringing ODNs together, enhancing ODNs' voices on a national level, identifying good practice and sharing it across the ODNs, knowing who to engage to address any issues, and bringing people in from every level of the service so that ideas and solutions generated are operationally functional at Trust and ward level. I work with Dr Ngozi Edi-Osagie (National Clinical Director for Neonatology) in this respect, who performs a similar role from a medical perspective.

23. Patient safety, good governance structures, and escalation of issues are important parts of my role. For example, one current workstream is looking at neonatal mortality. In my view, if there is a peak in mortality, the most likely cause is that there is a care or system problem (or a care or system problem that has exacerbated an external problem (see paragraph 48, below)), and deliberate harm is extremely rare, but must be considered. I therefore work with ODNs, which pick up the mortality data first and we look at data sets to see how the ODN and Trusts can improve, such as supporting staff with the PMRT (which is discussed in more detail at paragraphs 53 - 54). Neonatal

services sit within two potential avenues of escalation: one through the local maternity system Integrated Care Boards ("**ICBs**"); the other through NHS England Specialised Commissioning. Historically, if ODNs pick up an issue, they escalate through Specialised Commissioning routes who commission and oversee the service. We are looking at how to bring the two pathways together so that the right information is conveyed to the right people, at the right time, and the correct action is taken.

24. As a result of the additional time granted to my role in August 2023, I had more opportunities to meet with ODN lead nurses and neonatal nurse associates. During these meetings, I provided support for the Professional Nurse Advocate roles to be more embedded within neonatal nursing. I also spent a significant amount of time talking to groups of nurses and addressing the workforce issues, which had become more intense after the verdicts. Historically, I have found that neonatal services have had a good recruitment rate. However, since LL's arrest, those I speak to at network level have noted a decrease in applicants to the specialty and a reluctance from existing neonatal nurses to progress into management roles. As a result, I have been in discussions with retention leads within maternity services to address this staffing issue and develop retention plans. Neonatal staff have been devastated that someone in their area of practice could have committed such terrible acts and they remain anxious that they may be judged poorly because of their association with the same specialism. Staff talk of being anxious that the publicity and the possible impact that significant recommendations from the Inquiry in relation to neonatal services will have on retention and future recruitment. I would say that the Three-Year Delivery Plan for Maternity and Neonatal Services **[INQ0012643]**, which brought together key recommendations of previous inquiries, has been positive - and I think that if any future recommendations could be aligned with the plan, that would be the best way to support staff in relation to any new recommendations.

25. My overall view as to the importance of the role of Neonatal Nursing Lead for NHS England is that I think that neonatal services, particularly neonatal nursing, needs its own voice at a national level. As set out above, much of my work is focussed on strengthening neonatal nursing and the wider neonatal voices within the system.

**Neonatal ODN – Overview**

26. ODNs were launched in April 2013 following the publication of the NHS England's strategy to sustain and develop clinical networks. ODNs were created to focus on coordinating patient pathways between providers over a wide area to ensure access to specialist support in some complex and specialist areas of care, such as neonatal

intensive care, adult critical care, burns and trauma. Details as to the establishment of ODNs and why they were created can be found in the NHS Commissioning Board paper of December 2012, "Developing Operational Delivery Networks: The Way Forward" **[Exhibit LWL/0012 [INQ0018010]]**. The Operational Delivery Network Memorandum of Understanding 2015 **[Exhibit LWL/0013 [INQ0018040]]** also sets out the principles of ODNs in the North West (not specific to neonatology). Both of these documents pre-date my time as Network Director of the NWNODN, but I include them here for context.

27. Developing Operational Delivery Networks: The Way Forward, sets out the purpose of ODNs, namely that an ODN will:

a) Ensure effective clinical flows through the provider system through clinical collaboration for networked provision of services

b) Take a whole system, collaborative provision approach to ensure the delivery of safe and effective services across the patient pathway, adding value for all its stakeholders

c) Improve cross-organisational, multi-professional clinical engagement to improve pathways of care

d) Enable the development of consistent provider guidance and improved service standards, ensuring a consistent patient and family experience

e) Focus on quality and effectiveness through the facilitation of comparative benchmarking and auditing of services, with implementation of required improvements

f) Fulfil a key role in assuring providers and commissioners of all aspects of quality as well as coordinating provider resources to secure the best outcomes for patients across wide geographical areas

g) Support capacity planning and activity monitoring with collaborative forecasting of demand, and matching of demand and supply.

28. I understand that responsibility for assuring governance arrangements for ODNs sits with NHS England regional Specialised Commissioning teams which contract with the host provider to commission the ODNs whereas the responsibility for 'hosting' the ODNs is agreed with a local provider organisation **[Exhibit LWL/0014 [INQ0018033]].**

29. The Neonatal Critical Care Clinical Network Specification[1] of June 2023 sets out that networks have a central role in delivering the recommendations of the Neonatal Critical Care Review and the agreed recommendations of other relevant national reports, including those of Getting it Right First Time **[Exhibit LWL/0015 [INQ0018034]].** Further details as to networks' functions in relation to quality, as set out in the Network Specification are set out at paragraph 59, below.

## North West Neonatal ODN

Overview of the NWNODN

30. The North West Neonatal ODN ("NWNODN") serves a population of circa 7 million people and has a birth rate of approximately 74,000 per annum. There are 22 units within the ODN (across 20 Trusts), with a total of 474 cots. Approximately 7,500 infants are admitted into a neonatal unit per year. The NWNODN is organised into three localities: Cheshire and Merseyside; Greater Manchester; and Lancashire and South Cumbria. The 20 Trusts that provide neonatal services across the North West are members of the NWNODN and are required to participate and engage with the network.

31. The NWNODN is hosted by Alder Hey Children's Hospital NHS Foundation Trust. As set out in the NWNODN's Operational policy 2023 [**Exhibit LWL/0016 [INQ0018024]]**, the host's role is to manage the arrangements to establish the ODN by creating a supportive framework with clear lines of responsibility and reporting arrangements. The host provider is not responsible for the compliance of other ODN member organizations, and accountability for this rests with the ODN Board and the Assistant Director of Specialised Commissioning in NHS England's North of England Specialised Commissioning Team (North West Hub). Further details of the contractual arrangements between commissioners and the host provider, and the host provider's responsibilities in relation to the NWNODN, can be found within the ODN Memorandum of Understanding between NHS England North West Specialised Commissioning and North West Acute Provider Trusts [**Exhibit LWL/0017 [INQ0018042] and [INQ0018043]]**, and Appendix – Clinical Networks **[Exhibit LWL/0018 [INQ0018041]].**

32. The NWNODN's work programme for 2023 – 2024 can be found at **Exhibit: LWL/0019 [INQ0018020]].**

[1] N.B. the Specification refers to "Clinical Networks" as opposed to "Operational Delivery Networks" as most other specialised services use the term "Clinical Networks" to describe their network arrangements, however Neonatology continues to use the term "Operational Delivery Networks".

NWNODN Team

33. As Network Director I am responsible for delivering the whole system of work program for neonatal services across the North West of England, working collaboratively with commissioning leads and national outcome leads. I provide overall leadership, strategic direction and management for the NWNODN, supporting neonatal services in the region to meet national, local, and Trust standards and optimize resources to improve services. Maternity and neonatology services work closely with each other. For example, the Senior Responsible Owners for maternity for each of the three local maternity systems (ICBs, formerly CCGs) sit on the NWNODN board. Each of those localities has a Local Maternity and Neonatal System Board which is attended by both maternity and neonatal representatives from that area, and as Network Director of the NWNODN, I sit on all three of those Local Maternity and Neonatal System Boards This cross over promotes joint working and communication between the specialisms. I understand that other regions may have slightly different ways of achieving this cross-over, but it is present across the country. My role is to help all stakeholders to work together to provide safe, fair, and effective specialised services. This includes encouraging patients', professionals', and constituent organisations to be effectively engaged in ODN activities that align with local needs and resources, and support the delivery of national outcome ambitions.

34. I have held the role of Network Director of the NWNODN since August 2019 and further details can be found within the job description for Network Director **[Exhibit LWL/0020 [INQ0018032]].** As this sets out (and reflecting the fact that the NWNODN is hosted by Alder Hey Children's Hospital NHS Foundation Trust), I am responsible to the Chief Executive and Chief Operating Officer of the host Trust, i.e. Alder Hey Children's Hospital NHS Foundation Trust. The organisation chart shows that my role sits jointly beneath the Board of the host Trust, and NHS England Specialised Commissioning. Although I am substantively employed by the host Trust, my role is funded by NHS England.

35. The NWNODN team acts as a resource, coordinator and facilitator for all of the ODN's stakeholders (service users and service providers i.e. the units and Trusts) to achieve a collaborative approach to safe and effective specialised services. As Network Director I am supported by various people, including the Clinical Lead for each of the three localities, the Senior Lead Nurse, a Quality Improvement Lead Nurse, a Parent & Families Engagement Lead, and a Workforce & Education Lead. Since I have been seconded to NHS England, Kelly Harvey, Quality Improvement Lead Nurse and Lead

for Governance, has been acting up into the role of Network Director but I have continued to support in the periods of time when I am not fulfilling the Neonatal Nursing Lead role for NHS England.

36. The current structure of the NWNODN can be found at page 7 of the NWNODN Operational Policy of June 2023 **[Exhibit LWL/0016 [INQ0018024]]**, together with further details as to the various roles within the NWNODN team.

37. The NWNODN team is overseen by the NWNODN Board and is accountable to NHS England Specialised Commissioning.

NWNODN Governance

38. The NWNODN Operational Policy **[Exhibit LWL/0016 [INQ0018024]]** and Governance Process **[Exhibit LWL/0021 [INQ0018021]]** sets out the current[2] governance framework to monitor progress against the NWNODN's governance arrangements. The structure comprises:

    a. NWNODN Board (Terms of Reference can be found at **Exhibit LWL/0023 [INQ0018014])**
    b. NWNODN Senior Management Team (Terms of Reference can be found at **Exhibit LWL/0024 [INQ0018023])**
    c. A Neonatal Steering group for each locality
    d. A Clinical Effectiveness Group for each locality
    e. A NWNODN Data Group (Terms of Reference can be found at **Exhibit LWL/0025 [INQ0018017])**
    f. The NWNODN Programme Board (Terms of Reference can be found at **Exhibit LWL/0026 [INQ0018015])**
    g. NW Expert Education group (established in 2022)
    h. NW Neonatal Transport Steering Group.

39. The NWNODN publishes its guidelines and processes on its website. I include a list of these documents as an Annex to this statement. Those which I consider are potentially more relevant to the Inquiry have been highlighted on the annex.

## Personal involvement in matters relating to the Inquiry

Wider Network Involvement pre-2019

40. Prior to taking up the role of Network Director of the NWNODN in 2019, my involvement with the NWNODN was limited to service-specific matters that were part of my roles as

[2] See also 2020 version, "NWNODN Governance Framework Final 2020" [**Exhibit LWL/0022 [INQ0018038]**]

Lead Nurse for Neonatology and then Head of Nursing (including neonatology nursing) at Manchester University NHS Foundation Trust. In these roles, I would attend NWNODN meetings for the Greater Manchester locality, along with managers from other neonatal units within the locality. Trusts tended to send their most senior neonatology nurse and their clinical lead to these meetings. I imagine that it was a similar arrangement in the other two localities of Cheshire and Merseyside, and Lancashire and South Cumbria, but I was not involved directly with them until 2019. The locality meetings would be chaired by the Network Director of the NWNODN who at that time was Julie Maddocks, plus the ODN's lead nurse for Greater Manchester, and the ODN's Clinical Lead. There were different types of locality meetings, such as the quarterly Greater Manchester steering group which I would attend, and the Governance Clinical Effectiveness meetings, which my Governance Lead would attend. Occasionally at the meetings I attended, we may hear about news from the other localities, such as if key personnel had left, or significant incidents, or if there were lessons learned that the NWNODN felt it appropriate to share with the Greater Manchester locality because they were relevant to our units. There were also some meetings for the whole ODN, where all three localities would be invited, but I do not specifically recall whether I attended these, or if my Lead Nurse attended on my behalf. I do not recall hearing anything in relation to LL or mortality rates at the Countess of Chester Hospital through the NWNODN whilst I was at Manchester University NHS Foundation Trust.

41. Before I joined the NWNODN in 2019, I was not aware of whether the ODN was involved in CDOP. I cover in greater detail at paragraphs 48 – 62 the current Mortality Review Process at NWNODN and how it interacts with CDOP.

Arrest and conviction of LL

42. When I took up my position as Network Director for NWNODN in August 2019, the previous Network Director Julie Maddocks, had left so I had a handover meeting with the Acting Network Director, in which we spoke about all units within the NWNODN, to familiarise me with the background and position of the different localities and units. In relation to the Countess of Chester Hospital, I was informed that their admission criteria had been moved from that of an LNU (as per its designation) to that of an SCU. It was important for me to be aware of this as it has an impact on network pathways and patient flow if one unit is not performing to its designation. I therefore knew that babies who fitted the admission criteria for an LNU could not go to the Countess of Chester Hospital despite its LNU designation, and they would need to be directed to an

alternative LNU, which would have an impact on the capacity of that alternative LNU. I was also told that the Lead Nurse was maintaining contact with the Unit Manager at the Countess of Chester Hospital, to provide pastoral support.

43. The NWNODN team advised me that there would be a number of documents in the NWNODN files that pertained to the Countess of Chester Hospital, including some that related of the increased mortality that had been experienced at the unit. In view of the trial and our expectation that a review or inquiry of some capacity would occur I requested Kelly Harvey who was Governance Lead Nurse to collate such documents so that they were together and available should a request be made for them. I did not go through the individual documents other than to assist in filing. I will also disclose the bundle of documents gathered during that review but would note that whilst this exercise was of documents saved to the NWNODN files, emails were not automatically or routinely saved to files, so there are likely to be emails elsewhere that were not part of this exercise.

44. I recall that Dr Eleri Adams, of Neonatology Getting It Right First Time, was due to conduct a review of the Countess of Chester Hospital in January 2022. She contacted me to query why the Countess of Chester Hospital had admission criteria which did not match their designation. I advised that the admission criteria had been changed whilst there were concerns about unexplained mortality rates at the unit. LL had since been arrested, and I understood that the regional Specialised Commissioning team had decided that the admission criteria should remain the same until at least the outcome of the criminal trial of LL.

45. The NWNODN has tried to support neonatology staff at the Countess of Chester Hospital throughout the increased scrutiny and media attention. This has mostly been arranged by Kelly Harvey and has been informal peer to peer support, and psychology support for staff.

46. The team at the Countess of Chester Hospital has expressed to me their desire to start to admit sicker babies and move back to the admission criteria that matches their designation as an LNU, but this is not a decision for the NWNODN and I have advised them to put their case to the NHS England Specialised Commissioning team

47. My impression following conversations with the team at the Countess of Chester Hospital about returning to their previous admission criteria is it that they feel that by not being able to return to LNU admission criteria, they are being punished for the terrible actions of LL, and their view is that the issues which led to the change in admission criteria are no longer present since LL is no longer on the wards.

**Role of ODNS in identifying issues / patterns**

48. Mortality rates and adverse events in any neonatal service cannot be taken in isolation. Neonatal mortality is complex and is affected by small number variation. Peaks in mortality can be impacted by demographic and population factors and determinants which in turn can be exacerbated by care, system and pathway factors, which may have occurred before the baby reaches the neonatal unit. For example, a unit may have a greater number of babies admitted in poor condition and the unit can only do its best to mitigate the issues present at the time of admission. Those babies' outcomes may therefore not be an accurate reflection of the neonatal service, but of an issue in maternity and delivery, or those external factors noted above. It is important to triangulate these outcomes with maternity data, in order to check whether the data is a measure of the maternity service or the neonatal service. As a midwife as well as a nurse, and through my experience in managing neonatal services and networks, I help to support the conversations around this data. If the core issue is with maternity, it needs to be raised and escalated with the maternity service. As mentioned above at paragraph 33, in the North West, there is a cross-presence from each specialism, via the NWNODN board and the Local Maternity and Neonatal Systems' boards, to assist with communication, and networks work with their Local Maternity and Neonatal System to raise any concerns and develop and monitor any actions. I believe that both the Kirkup and Ockenden reviews highlighted that teams which work together and communicate have better outcomes. My work, and the role of ODNs is to support that collaboration.

2024 Service Specification

49. A new Neonatal Critical Care Service Specification was published on 11 March 2024 **[Exhibit LWL/0027 [INQ0018029]]**, updating the previous version which was published in 2013 **[INQ0009232]**. I was involved in the later stages of the drafting of the new service specification. It is an NHS England Specialised Commissioning document, directed at neonatal service providers / units across England, setting out what is expected of them at service level. It therefore includes the expectations for services to engage with ODNs. The updated specification incorporates the most recent guidance (setting out relevant NICE guidance and standards, and BAPM frameworks for practice) and takes into account various national reviews. It specifies the expected gestational ages and numbers of babies that each level of neonatal unit should admit, and how these units collaborate with ODNs and services to provide safe and effective care. In my view, the new specification has greater clarity and focus on governance. The governance section has been strengthened so that Trusts have a contracted duty to have evidence of written clinical procedures and operational policies, which must

include joint maternity and neonatal safety and governance processes. Each neonatal unit must review their data (such as National Neonatal Audit Programme (NNAP), Specialised Services Quality Dashboard (SSQD) and MBBRACE-UK) and develop plans to improve areas that require attention. The role of the neonatal safety champions is strengthened through the 2024 specification and issues are to be shared with the region's ODN. The 2024 service specification requires that:

a. Each provider Trust must have guidelines, policies, and care pathways to ensure consistent and evidence-based clinical management

b. Trusts should adopt ODN approved guidelines, policies, and care pathways.

c. Neonatal units must have written clinical procedures and policies in place, including joint maternal and neonatal safety and governance processes.

d. Each neonatal unit must review their data and develop plans to improve areas that require attention.

e. Neonatal safety champions must work with maternity safety champions to provide a perinatal safety culture and support board level safety champions. Trusts must support the neonatal safety champion in their role.

f. Each provider Trust must have a process for sharing patient safety concerns with their ODN.

g. Trusts must engage with ODN governance processes to raise concerns to the LMNS/ICB/NHS England region.

50. The 2024 service specification is accompanied by an Engagement Report, setting out the feedback received by NHS England during the development of the service specification and how this feedback has been taken into account **[Exhibit LWL/0028 [INQ0018028]]** and an Equality and Health Inequalities Impact Assessment **[Exhibit LWL/0029 [INQ0018030]]**.

51. The 2024 service specification sets out the obligations on all neonatal units in terms of mortality reporting, such as:

a. All neonatal deaths should be reviewed using the standardised framework of the PMRT and the local CDOP, alongside maternity staff responsible for the care of the mother and with active communication with parents.

b. Each neonatal unit should ensure adequate time in consultant job plans for a named Clinical Lead, a named education/training lead, each consultant providing educational supervision and for PMRT and CDOP reviews.

52. ODNs monitor the services within their network for compliance with the service specification, therefore the enhanced governance provisions for services in the 2024 service specification will mean that ODNs will in future be monitoring services' compliance with these aspects, if they did not do so already.

NWNODN approach to mortality

53. In terms of the NWNODN's approach to identifying issues and patterns in mortality, when I came into the post of Network Director, I reviewed the NWNODN Guideline for Reporting Patient Safety Incidents and Mortality **[Exhibit LWL/0030 [INQ0018011]]**, together with the NWNODN's other existing policies, procedures and guidance. I would say that most deaths in an LNU or SCU are unexpected, but there is no national expected mortality rate so it is difficult to benchmark neonatal mortality. I therefore wanted to make sure that the NWNODN was actively challenging Trusts' data and had an escalation process if it was not satisfied with the unit's explanation. There had also been more recent developments in mortality reporting, such as the PMRT which needed to be incorporated into the process. This review led to the 2020 NWNODN Mortality Reporting Process **[Exhibit LWL/0031 [INQ0018012]]**, which was further updated by the 2023 NWNODN Mortality Reporting Process **[Exhibit LWL/0032 [INQ0018022]]**. The process sets out the NWNODN's monitoring and tracking responsibilities and explains how themes and learning will be identified, disseminated, and escalated.

54. In addition to the various national neonatal mortality reporting requirements, to which all providers must adhere, under the NWNODN Mortality Reporting Process, the NWNODN Clinical Effectiveness Group ("**CEG**") (Terms of Reference can be found at **Exhibit LWL/0033 [INQ0018019])**, meets approximately quarterly to provide a peer review of local mortality reviews, with the aim of sharing learning (the CEG had been established and was already reviewing mortality prior to my arrival at the NWNODN). The current process is set out in a flowchart at Appendix 5 of the 2023 Mortality Reporting Process document, but in summary, all deaths on a neonatal unit should be recorded on the Badgernet system and on MBRRACE-UK by the clinicians at the time of death. This enables the NWNODN data analyst to capture all deaths across the region each month, which are added to a mortality tracker. The provider is then asked to complete a CEG pro-forma, and the PMRT reports are shared with the NWNODN reports. The CEG then undertakes the following process:

a) CEG group members review reports before the CEG meetings and raises any issues with cases

b) Clinical Lead and Governance Lead Nurse highlight cases for discussion.

c) Providers present cases with a focus on learning.

d) Cases with no learning identified are shared but not discussed within CEG, unless there was no external neonatal reviewer present at the local PMRT meeting.

e) Providers are asked if there are cases requiring a more detailed review.

f) Deaths further discussed at CEG are documented on the CEG meeting log with comments on discussion and learning.

g) Issues identified where a further review is recommended, such as an MPR or IR, will be documented on the meeting log and left open on the mortality tracker until the additional review is complete.

h) Reports with action from MPR or IR processes are shared with CEG for learning.

i) Completed CEG mortality reviews are shared with CDOP.

55. The NWNODN has reciprocal working with CDOP because as well as CEG mortality reviews being shared with CDOP after each quarterly CEG meeting, CDOP's administrators also send details of neonatal care deaths to the NWNODN Governance Lead Nurse, and non-identifiable details are cross-referred to the NWNODN mortality tracker. This means that the NWNODN has sight of all deaths within the region.

56. All deaths continue to be reviewed through the NWNODN's CEG, which have been shared with the relevant CDOP since at least 2019. I know that this practice had started under Kelly Harvey as Governance Lead Nurse before I joined the NWODN. All reports from the CEG meeting are included in the papers for CDOP meetings.

57. The NWNODN has a Neonatal Steering Group ("**NSG**") (Terms of Reference can be found at **Exhibit LWL/0034 [INQ0018016])**. A quarterly mortality summary is presented to the NSG with details of themes or learning identified through CEG and mortality data is reviewed through the dashboard at senior management team and NSG meetings. Mortality data is included in quarterly governance reports shared via the NWNODN Board and locality steering groups. Any concerns involving neonatal mortality within a

provider will be escalated via the NSG to the provider and a local review and report will be requested to understand any learning or local requirement for further investigation.

58. I believe that the NWNODN Mortality Reporting Process set out above is robust. In addition to reviewing the unit's internal review for each death (as already occurred), if the NWNODN's reviewers are not assured by that internal review, it triggers greater scrutiny and an escalation that was not previously set out in the process. I believe that this process would pick up a spike in mortality within an organisation. This will be further strengthened by the national work to embed neonatology into the PQSM process, set out below (see paragraph 66 – 68).

59. The Neonatal Critical Care Clinical Network Specification [**Exhibit LWL/0015 [INQ0018034]]** sets out that networks' functions in relation to quality include:

    a. Monitor key indicators of quality across the network and regularly review clinical outcomes across the network.

    b. Share the learning from internal and external investigations of care quality, linking with the other organisations where appropriate.

    c. Use clinical process and clinical outcome measures to compare and benchmark providers.

    d. Undertake audit, and other service improvement activities including reflecting on and responding to suboptimal outcomes, care and patient experience.

    e. Manage risks to the delivery of the network's annual work programme.

    f. Identify service issues and risks and ensure they are managed through regional and system quality structures following agreed escalation processes. Providers or commissioners may ask networks to facilitate the response to risks, but providers and commissioners remain accountable for their services' risks.

    g. Run a regular clinical forum to review mortality and outcomes across the network

60. How each ODN undertakes the functions above will vary across regions. I am aware that following LL's conviction, NHS England Clinical Programmes Director for Specialised Commissioning wrote to each of the NHS England regions to request information regarding various points relevant to reviewing data, identifying trends, and follow up actions (see **NHSE/1** paragraph 997). The responses fed into a paper provided to NHS England's Executive Quality Group on 11 September 2023 and then

to NHS England's Quality Committee on 14 September 2023 **[INQ0014778]** which includes recommendations to:

a. Review the roles and responsibilities of Operational Delivery Networks to ensure compliance with the Operational Delivery Network specification and to strengthen accountability.

b. Continue to identify best practice in terms of Operational Delivery Network and commissioner assurance of perinatal mortality surveillance.

61. I would agree with NHS England's recognition that there is further work to be done to ensure a standardised approach to mortality surveillance (see **NHSE/1** paragraph 998). I would add that, as set out above at paragraph 52, the enhanced governance provisions for services in the 2024 service specification should strengthen ODN's monitoring of this area.

62. In my experience, both from when I worked in neonatal services and as Network Director, the NWNODN has a good level of communication with the units within the network. I believe that this has improved over the last 10 years, with the contractual, and then legal Duty of Candour being introduced in 2013 and 2014, respectively. As ODNs were also established in 2013, the last decade has seen ODNs mature, with relationships and engagement between ODNs, Trusts, and Specialised Commissioning becoming more embedded. I think that most Trusts appreciate that ODNs are there to support them, which also helps with open conversations.

**Role of ODNs in escalating member concerns**

63. ODNs have a role as a "critical friend" to the units in their regions, and units are encouraged to speak to their ODN about any issues arising. ODNs do not, however, have a mandated role for members to raise concerns about a professional colleague and ODNs are not regulatory bodies. ODNs have a unique insight into culture and relationships within the services in their region, as they go into to all of the region's units and build relationships, but the formal escalation route would be via the employing organisation. I would expect staff to follow their Trust procedures in the first instance, including speaking to their Freedom to Speak Up champions if necessary. If they were not listened to there and it was a practice issue, it would be open for them to go to their ODN for support, but there are other routes also available to them such as the Care Quality Commission, their own professional bodies (such as the GMC or NMC), or NHS England. It is also worth noting that ODN staff remain employed by the host trust, therefore:

a. ODN staff in this context are still registered by professional bodies e.g. NMC and so have probity expectations relating to any concern raised.

b. Organisationally the ODN reports into the hosting trust and the regional Specialised Commissioning team, which is the correct escalation route for an ODN member to escalate concerns.

c. The ODN member of staff can then be supported by commissioners and their employer i.e. host trust to feed back/escalate as appropriate to the particular trust or unit.

64. I believe that culture plays an important role in colleagues being able to raise concerns. In my role as Neonatal Nursing Lead for NHS England, I have undertaken the "NHS England Culture and Leadership Programme" in order to assist me to support the culture and leadership work being undertaken across the organisation and the help me to disseminate it through the ODNs. This is an NHS England programme of a three-day course, with further follow up days. I understand that every Trust in England participated via a quadrumvirate comprising: an obstetrician, midwife, a neonatal representative (medical or nursing) and an operational management representative. I participated in the programme, together with other NHS England senior managers so that we experienced the programme in the same way as the participating Trusts.

**ODN recommendations**

65. In my opinion, there are already many safeguards in place to mitigate risks, but as ever, there are improvements that can be made, some of which are already in progress. I have regular meetings with ODN directors and am therefore anecdotally aware of the areas that they think would benefit from review or improvement.

PQSM

66. As noted above, there is already a Perinatal Quality Surveillance Model (PQSM), which was last updated in 2020. I am supporting the Maternity and Neonatal Programme, and Specialised Commissioning who are working together to update the PQSM by strengthening neonatal quality elements and embed it further into neonatal services. A summary of the current PQSM is set out in a presentation from the quality teams within maternity and neonatology, and Specialised Commissioning [**Exhibit LWL/0035 [INQ0017932]]** which was sent to Regional Specialised Commissioning Teams, Regional Maternity Teams, Neonatal ODNs, Regional Specialised Commissioning DoNs in January 2024 [**Exhibit LWL/0036 [INQ0018027].** This was circulated to provide clarity as to what the current process should look like from a neonatal

perspective, and to remind regions and local systems that they should continue to use the current PQSM whilst work is being undertaken to review it. I am a member of the PQSM Task and Finish Group. Its Terms of Reference [**Exhibit LWL/0037 [INQ0018044]]** set out that:

*"This Group will oversee the review of the Perinatal Quality Surveillance Model, defining the scope of the review and ensuring it encompasses updated guidance and legislation. Namely the following:*

- *Oversight Framework for 2022/23 (2023/24 once published)*
- *Ambitions set out in the NHS Long Term Plan – system led delivery of integrated care (Integrating care: next steps to building strong and effective integrated care systems across England) (Gov. white paper: Joining up care for people, places and populations.)*
- *2022/23 NHS operational planning and contracting guidance.*
- *Health and Care Act 2022 namely the formal establishment of ICBs*
- *NHSE Operating Framework*
- *Early Warning Signs Framework– in development, to be shared by NHSE quality team*
- *National Quality Board guidance on Quality Risk Response and Escalation*
- *MNVP guidance, once published."*

67. I attended the initial meeting of the PQSM Task and Finish Group, in October 2023, which included a presentation covering areas such as developments since the PQSM was launched in 2020, and why a review is necessary **[Exhibit LWL/0038 [INQ0018026]].**

68. I understand that the expected timeframes are for a draft revised PQSM to be available in September 2024, with publication in December 2024, followed by a period to allow support for implementation, such as webinars and supporting regions with what the new model means in practice, prior to implementation in March 2025. From my conversations with networks, I understand that they are supportive of the PQSM being reviewed because they would welcome greater uniformity and guidance.

Pharmacy support

69. Neonatal services and ODNs would welcome greater investment in neonatal-specific pharmacy support to assist with medicines management and neonatal staff training to avoid accidental dosing errors that are a greater risk with the complex drugs often required for very small babies which require conversion of milligrams to nanograms. I understand that Neonatology Getting it Right First Time and BAPM have both

recognised a gap in neonatal pharmacy provision. I am supportive of the work that BAPM and the Neonatal & Paediatric Pharmacists Group have been doing in this area. Within the NWNODN we have supported, on a fixed term contract with non-recurrent funding, a network level pharmacy role. She is working with two other networks to compile a paper on the benefits of increased pharmacy support, with the desire for this role to be considered as a prerequisite for all neonatal ODNs.

Professional Nurse Advocates and Psychology support

70. Neonatal ODNs are also supportive of greater Professional Nurse Advocate and psychology support. Greater staff access to a Professional Nurse Advocates and / or unit psychologists is an important cultural piece that I believe would assist neonatal services. These resources mean that staff have a safe place to discuss concerns and promote a culture of wellbeing, which in turn improves openness and transparency to enable staff to raise concerns. I am not involved in the detail of the Freedom to Speak Up process, but I would suggest that it is a mechanism to be used where the informal Trust processes have not been successful. It is important for the underlying culture of the organisation to be promoting openness and transparency, such that Freedom to Speak Up is not needed in the vast majority of cases. Professional Nurse Advocates and psychologists can improve that underlying culture, as can good leadership training for unit managers, so that they have the people management skills to instil confidence in staff that they can be open and their concerns will be dealt with.

71. One of my objectives as Neonatal Nursing Lead has been in relation to Professional Nurse Advocacy. The role of Professional Nurse Advocate needed further embedding into neonatal services so NHS England obtained additional funding (£4 million) for Professional Midwifery Advocates and Professional Nurse Advocates to support staff wellbeing and provide restorative clinical supervision in maternity and neonatal services. I am undertaking the Professional Nurse Advocacy course, and I am working to promote its uptake with other neonatal nurses and create a community of Professional Nurse Advocates to support staff at stressful times. Professional Nurse Advocacy is centred on restorative supervision. Their purpose is not to give answers but to enable staff to come to resolutions for themselves, giving staff a space to discuss issues, making them feel cared for and mitigating anxiety. Neonatal units are a stressful place to work in ordinary circumstances, as nurses are caring for families with sick babies, and sadly losing babies in some cases. Various high profile reviews, the tragic circumstances of LL crimes, and resulting prolonged media attention have served to

compound that in my opinion. Professional Nurse Advocates are therefore important for retention and making neonatal nursing a place that people want to work.

Closed loop medicines administration

72. In my personal opinion as a neonatal nurse, I think that there is a case to consider for closed loop medicines administration. For example, registered nurses and midwives could have finger print access to medicines and that access information could be stored, which may have a deterrent effect. In neonatal units we have second checking for administering drugs, but we do not need two nurses just to go into the drugs room, and there are multiple reasons why a nurse would need to go in there. Requiring two nurses to access a drug cupboard would be very difficult to achieve practically and would require increased staffing. I would also note that restricting access to drugs would have an impact on nurses performing their duties, so the practical impact on care of on any new system needs to be fully considered and balanced.

73. I would also note that if this was to be required in neonatal units, it should be considered in other specialisms as well. Adult ICUs, and Paediatric ICUs would be a similar risk level as neonatal units as they also have patients who are also more vulnerable. If this became practice only on neonatal units, and then there were medicines issues in adult care, it would be difficult to justify why the same procedures had not been put in place to protect those patients as well.

CCTV throughout neonatal areas

74. From my experience of working on neonatal wards and with families, I have reservations about CCTV being implemented throughout all neonatal areas, i.e. beyond entry / exit points for the purposes of making the ward a secure environment. I believe that the following are relevant considerations that would need to be balanced against the benefits of additional CCTV:

    a. Cameras would need to be focussed on each cot in order to show the detail required to see each individual baby.

    b. Having a baby in a neonatal unit is a difficult and important time for families, who may feel uncomfortable with such close monitoring. For example, neonatal wards have breastfeeding mothers, and skin to skin contact between baby and parent, both of which are important for babies' wellbeing. I would be concerned that CCTV may put some parents off both of these activities.

c. If the cameras were to be switched off at personal times such as breastfeeding, that in itself would have to be monitored or regulated so that it was genuinely for this reason, and not for people intending to cause harm.

d. Families may need to be asked to sign a consent form to be recorded and there would need to be guidance on what would happen if they refused.

e. Practical considerations would include archiving of the footage as I expect that it would not be possible to have real-time monitoring all of the CCTV in real time. This would make the CCTV more of an evidential benefit than preventative.

f. Similarly to the closed loop medicines point, if this was established in neonatal units then it would also need to be brought in elsewhere, as there are vulnerable patients in other specialities.

Staffing

75. Although nursing recruitment is an issue across the profession, I found that neonatal nursing used to be a specialism that was relatively easy to recruit into compared with other nursing specialisms, however there is a risk that this will not be the case since the various independent reviews and the convictions of LL. There has also been an anecdotal decline in neonatal nurses applying for management posts, for the same reasons. I will continue to monitor any issues and work with networks and national teams if additional interventions are required.

76. I consider that neonatal care is unusual and staffing capacity can risk in some cases falling into a gap, as there is no direct entry into the profession. This is because it is specialised, not all hospitals have a unit, and neonatology is in a strange position within the system as it sits between the two specialisms of maternity and paediatrics. Neonatal nurses therefore come either from paediatric, adult, or maternity specialisms.

77. Improvements in staffing are important for keeping babies in hospital safe for a variety of reasons. A unit which meets BAPM staffing levels will benefit from enhanced supervision, teamwork, morale, and time for staff to undertake professional development, all of which contribute to improved quality of care.

78. Since I came into the role of Neonatal Nursing Lead, we now have quarterly national neonatal staffing data. I have worked with the neonatal ODNs to collate data so that we have granular Trust level data showing how many staff are needed, vacancy rates, budgets and whether specialities meet the service requirements. This data is new and

still being verified but is a significant step forward in workforce data for neonatal services. As set out above, I believe that Professional Nurse Advocacy can play an important role in staff wellbeing and retention.

Clinical Time

79. I believe that it is important for medical professionals to have protected time for governance and PMRT but current pressures means that this is challenging. It is strongly recommended that a PMRT should include an independent external member "to provide a 'fresh pair of eyes' to the review of the care provided and to provide robust challenge where complacency or 'group think' in service provision has crept in, as identified in the Kirkup report" [**Exhibit LWL/0039 [INQ0017918]**. The time commitment for external members to review each death and attend the meeting to discuss is significant, and I note that as set out above at paragraph 51 the 2024 Neonatal Critical Care Service Specification gives more time for clinicians to dedicate to PMRT and governance which will assist in this respect.

**Statement of Truth**

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

**Signed**: PD

**Dated**: 26 April 2024