Witness Name: Jeremy Hunt
Statement No.: 1
Dated: 20th August 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF THE RT. HON. JEREMY HUNT MP

I, Jeremy Hunt MP, will say as follows: -

1. I make this statement to assist the Inquiry and in response to the Inquiry's rule 9 request. I understand from this rule 9 request that the Inquiry is particularly interested in my views on the role and purpose of public inquiries, whether they achieve their aims, and, if not, where accountability lies. To this end, I am asked not to provide lengthy comment on the reports and recommendations of the three inquiries I have been asked to consider. The brevity of this statement reflects my pursuit of this aim.

2. I would like to start my statement by offering my sincerest condolences to the families affected by this unspeakable tragedy. No parent should ever have to bury their child. So it is absolutely essential we now identify any ways that some or all of these horrific murders could have been prevented.

Career history

3. When I left university, I worked for a management consultancy firm then spent two years in Japan teaching English and learning Japanese. On returning to the UK, I set up my own educational publishing business, which I no longer own, and a charity to help AIDS orphans in Africa.

4. I was elected as the Conservative Member of Parliament for South West Surrey in May 2005 and held that role until the election of 4 July 2024, when the constituency of South West Surrey. On 4 July 2024 I was elected as the Member of Parliament for the newly formed constituency of Godalming and Ash.

5. On 6 December 2005 I was appointed Shadow Minister for Disabled People and, on 2 July 2007, Shadow Secretary of State for Culture, Olympics, Media and Sport. After the

2010 General Election, I became Secretary of State for Culture, Olympics, Media and Sport and served in this role from 12 May 2010 until 6 September 2012.

6. I served as Secretary of State for Health from 6 September 2012 to 8 January 2018 and, when the Department's responsibilities expanded, as Secretary of State for Health and Social Care from 8 January 2018 to 9 July 2018.

7. On 9 July 2018 I was appointed Secretary of State for Foreign and Commonwealth Affairs and held this position until 24 July 2019.

8. From 29 January 2020 until 16 October 2022, I was Chair of the House of Commons Health and Social Care Select Committee. The Select Committee examines government policy, spending, and administration on behalf of the electorate and the House of Commons. As Chair, I was responsible for chairing public evidence sessions and private meetings held to discuss our inquiries and reports.

9. I was appointed Chancellor of the Exchequer on 14 October 2022 and remained in this role until 5 July 2024 when I became the Shadow Chancellor of the Exchequer, a position I still hold.

10. To assist the Inquiry in understanding how the Department of Health ("the Department") functioned during my time as Secretary of State, it is necessary to briefly address the division of responsibilities within the Department between Ministers. As Secretary of State for Health (then Secretary of State for Health and Social Care), I held overall responsibility for the work of the Department, including financial control and oversight of NHS delivery and performance and, latterly, oversight of social care policy. In this role, I was responsible for the NHS which was the largest employer in Europe. I had ultimate responsibility for both the provision of healthcare (ensuring everyone can access good healthcare) and for the delivery of healthcare services through hospitals that are largely state-owned. Given the breadth of these responsibilities, delegation was essential to ensuring the Department ran in an efficient and effective manner.

11. In my work, I prioritised issues where I hoped to make immediate and impactful change. As Secretary of State, my focus was chiefly on safety and quality issues and my priorities at various times included dementia, mental health, maternity, technology and

integration. As the senior Minister, I also led on the management of major crises, including by responding in Parliament and to the media on topical matters as they arose.

12. I was supported by a team of junior Ministers to whom I delegated responsibility for the day-to-day management of all other issues. To be effective, delegation must be meaningful. I would, of course, assist if they required a decision from me or wanted my input or advice. Equally, it remained my decision whether to delegate, what to delegate, and to whom a matter should be delegated. The ministerial team supporting me consisted of:

    a. Norman Lamb, Minister of State for Care and Support (6 September 2012 – 8 May 2015);
    b. Anna Soubry, Parliamentary Under Secretary for Public Health (6 September 2012 – 07 Oct 2013);
    c. Daniel Poulter, Parliamentary Under Secretary for Health (6 September 2012 – 30 March 2015);
    d. Earl Howe, Parliamentary Under Secretary for Quality (in post from before my appointment until 11 May 2015);
    e. Jane Ellison, Parliamentary Under Secretary for Public Health (7 October 2013 – 15 July 2016);
    f. George Freeman, Parliamentary Under Secretary for Life Sciences (15 July 2014 – 17 July 2016);
    g. Alistair Burt, Minister of State for Community and Social Care (8 May 2015 – 13 July 2016);
    h. Ben Gummer, Parliamentary Under Secretary for Care Quality (14 May 2015 – 14 July 2016);
    i. Lord Prior of Brampton, Parliamentary Under Secretary for NHS Productivity (14 May 2015 – 21 December 2016);
    j. Philip Dunne, Minister of State (16 July 2016 – 9 January 2018);
    k. Nicola Blackwood, Parliamentary Under Secretary (17 July 2016 – 3 May 2017; returning as Parliamentary Under Secretary in 2019);
    l. David Mowat, Parliamentary Under Secretary (17 July 2016 – 3 May 2017);
    m. Lord O'Shaughnessy, Parliamentary Under Secretary for Health (21 December 2016 – 31 December 2018);
    n. Steve Brine, Parliamentary Under Secretary (14 June 2017 – 25 March 2019);
    o. Jackie Doyle-Price, Parliamentary Under Secretary, Care and Mental Health (14 June 2017 – 26 July 2019);

p. Steve Barclay, Minister of State (9 January 2018 – 16 November 2018); and

q. Caroline Dinenage, Minister of State (9 January 2018 – 13 February 2020).

The Mid-Staffordshire NHS Foundation Trust Inquiries

13. On 21 July 2009, the then Secretary of State for Health, Andy Burnham, announced an independent inquiry commissioned to examine the failings at the Mid-Staffordshire NHS Foundation Trust ("the Mid-Staffordshire Trust") between 2005 and 2009. It was chaired by Sir Robert Francis KC. His report was published on 24 February 2010 (I exhibit Vol.1 as **JH/1**). **INQ0107928**

14. Reading Sir Robert's initial report was one of the first things I did when I was appointed Secretary of State for Health and I still recall the profound sense of shock I felt at learning of these events.

15. In his report of February 2010, Sir Robert recommended that the Department consider undertaking an independent examination into the role of the commissioning, supervisory, and regulatory bodies who monitored the Mid-Staffordshire Trust between January 2005 and March 2009, with a view to evaluating the wider system for detecting and correcting deficiencies in service. In February 2010, Mr Burnham accepted this recommendation.

16. Following the General Election of 6 May 2010, Andrew Lansley was appointed Secretary of State for Health. On 9 June 2010, he announced that this investigation would take the form of a full public inquiry. I exhibit as **JH/2** the terms of reference for that inquiry. **INQ0107929**

17. The Inquiry reported in February 2013, five months into my tenure as Secretary of State for Health. I was not involved in deciding the terms of reference for this Inquiry and have no special insight into what Mr Lansley expected or hoped to achieve through them. However, I have reviewed the terms of reference for the purpose of producing this statement and am aware that they include a requirement to identify lessons learned and to make recommendations. In my view, this was likely to have been the principal purpose in setting up the Inquiry. In my foreword to the Government's initial response to the Inquiry report '*Patients First and Foremost*' **[INQ0012436]**, which I presented to Parliament on 26 March 2013 and discuss more below, I noted that although the Inquiry focused on failings in one hospital between 2005 and 2009, "the whole health and care system needs to listen, reflect and act to tackle the key challenges of culture and

behaviour that the report makes so clearly." Given the systemic nature of the problems Sir Robert was tasked with investigating, it was essential to understand how these events fitted into the system as a whole and reasonable to expect that wider learning and recommendations could be identified which would be of value well beyond Mid-Staffordshire.

18. Although I did not set the terms of reference for this inquiry, I had and continue to have enormous respect for Sir Robert and have always been very impressed with his work. If he was tasked with identifying learning and making recommendations, I would be confident that he would carry out that task carefully and well and provide what was asked of him.

19. I have been asked whether I intended to implement the recommendations Sir Robert was asked to make. Of course I hoped to but it was not possible to make a commitment to implement them before seeing them. Although I fully anticipated that Sir Robert's recommendations would be carefully considered and reasonable, as Secretary of State, I was responsible to parliament for the actions of the Department - and in particular the costs to taxpayers of implementing any recommendations so it was right that I took ultimate responsibility for deciding what to implement and when.

20. I was certainly committed to giving full and careful consideration to any recommendations he made but there are none the less sometimes good reasons why a recommendation should not or cannot be accepted. In part, this is a result of the necessary distance between a recommendation-maker and the person to whom a recommendation is made. An integral feature of public inquiries is that the Chair is entirely independent of the Government and the Secretary of State. This independence ensures a thorough, fair, and objective investigation and facilitates public trust in the process and findings. However, because it is essential that the Government does not, and does not appear to, intervene or attempt to influence the outcome of such an inquiry, there is little opportunity to pre-empt or respond to recommendations before they are made. As such, it not always possible for the recommendation-maker to know in advance whether a recommendation is practical or possible, what other impact it may have in the broader system, what costs it will entail, or indeed whether the Government has the resources to implement it in light of policy and budgetary constraints (which are constantly changing in response to wider factors).

21. After the report was published I worked closely with Sir Robert throughout the implementation process. In my view, successful implementation requires a good level of openness and engagement between the recommendation-maker and the person to whom the recommendation is made. This allowed me to understand the spirit and aims of his recommendations and to identify alternative measures in cases where a particular recommendation posed unforeseen difficulties.

22. As Sir Robert noted in his letter of 5 January 2013, which introduces his report of February 2013, the story is "first and foremost of appalling suffering." He identified many serious failings within the Trust, in the wider NHS system of checks and balances, and on the part of a large number of agencies, scrutiny groups, commissioners, regulators, and professional bodies who should have identified and prevented such serious systemic failings from occurring but failed to do so. The Government accepted these findings and the then Prime Minister, David Cameron, apologised on behalf of the Government that the systems in place had permitted such horrific abuse to go unchecked for so long.

23. Sir Robert made 290 recommendations in his report, each of which received careful consideration. The Government's initial response '*Patients First and Foremost*' (discussed in paragraph 17 above) **[INQ0012436]**, set out a raft of immediate actions to start tackling the wider issues identified. These included appointing a new Chief Inspector of Hospitals, simplifying the Care Quality Commission ratings system, and writing personally to the Chairs of all NHS Trusts asking them to hold events to obtain the views of staff on safeguarding matters and report their findings to me.

24. Although some immediate action was both necessary and possible, the process of determining which specific recommendations should be accepted and how to implement those was an important task which required significant work. I have been asked to explain this process and say whether I consider it to have been effective.

25. When recommendations are made they are first reviewed by the civil servants within the Department who consider them in light of the expertise available to the Department and wider Government, consulting with associated healthcare bodies or other Government Departments where necessary. There is no one team who do this process because the best person or team to evaluate a recommendation will depend on what the recommendation concerns. Often input will be required from several different teams or

individuals, or from external bodies or other Government Departments. Before accepting a recommendation, it might be necessary to carry out wider consultation or seek further information. Once accepted, implementation will often require action or support from other bodies or changes to legislation or regulatory frameworks. These processes can be lengthy and complex. However, for acceptance to be meaningful rather than tokenistic, it is necessary to identify what further work is required and be clear-sighted as to whether and how the aims of a given recommendation can be achieved.

26. Once this process of considering recommendations is complete, the Secretary of State will receive advice on whether to accept or reject a recommendation or, if further information is required before a decision can be made, what further work needs to be done. The Secretary of State remains the decision-maker but will draw upon the advice and input of many individuals inside a department to conduct research and enquiries so that a fully informed decision can be made.

27. In the case of Sir Robert's report, from the outset I accepted all the recommendations in principle. However, there were several areas where further investigation was necessary. In the introduction to volume 1 of the Government's detailed response to Sir Robert's inquiries, '*Hard Truths: the Journey to Putting Patients First*' published in January 2014 **[INQ0012437]**, I explained that the Government had commissioned six independent reviews to conduct work in relevant areas:

    a. The 'Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England,' led by Professor Sir Bruce Keogh, the NHS Medical Director in NHS England;
    b. The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings, by Camilla Cavendish;
    c. A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England, by Professor Don Berwick;
    d. A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture, by Rt Hon Ann Clwyd MP and Professor Tricia Hart;
    e. Challenging Bureaucracy, led by the NHS Confederation; and
    f. The report by the Children and Young People's Health Outcomes Forum, co-chaired by Professor Ian Lewis and Christine Lenehan.

28. Although there certainly can be good reasons to seek further information before deciding to accept or reject a recommendation, it was important to me that the Department be open and transparent about what was accepted, what was rejected, and the reasons for these decisions, and to keep Sir Robert and the public abreast of what work was being done.

29. In November 2013, the Government published its response to the House of Common's Health Committee Third Report of Session 2013-2014 '*After Francis: Making a Difference*' which I presented to Parliament on 19 November 2013 (**JH/3**). This provided an update on the progress made since publication of Sir Robert's report. **INQ0107930**

30. This was followed in January 2014 by '*Hard Truths: the Journey to Putting Patients First*' (which I have referred to above), volume 2 of which responded in detail to the 290 recommendations **[INQ0012438]**. For each recommendation, the report indicated whether it had been accepted (in full or in principle) or rejected and, for those which were accepted, what work had been done on implementation. The overwhelming majority were accepted either in full or in principle. For the nine which were not accepted (recommendations 19, 61, 64, 137, 145, 183, 209, 212, and 213) the reasons for this were explained. Where it was nonetheless possible to identify an alternative approach considered likely to achieve the outcome sought, this was set out.

31. In February 2015, the Government published '*Culture Change in the NHS: Applying the Lessons of the Francis Inquiries*' **[INQ0012439]**. This report considered the longer-term impact of Sir Robert's report, evaluated the work done so far in response, and set out the key areas where further action was needed. Annexed to the report was a detailed update on progress in respect of each of the 290 recommendations which identified further work done since the report of January 2014.

32. I have been asked to comment on whether I consider this process to be effective. In my view, the system works well provided the Secretary of State remains in contact with the recommendation-maker during the implementation process and both sides cooperate to achieve the spirit and overall objectives of the recommendations, even if not every recommendation is accepted. I have great respect for Sir Robert and worked closely with him and I sought to be proactive in my approach. My sense was that he was happy with the action taken and understood the reasons behind the decisions not to accept recommendations where that was the case.

33. I am asked where responsibility lies when a recommendation by a public inquiry is not accepted or implemented. Where a recommendation is directed at a Government Department, as mentioned above, it can only be the duty of the relevant Secretary of State, who is ultimately accountable to Parliament and the public, to decide whether or not it should be accepted or implemented. The Secretary of State bears the ultimate responsibility for such decisions as they do for the action of the Department more widely. I do not consider that there is a relevant difference in respect of this responsibility between statutory and non-statutory inquiries.

34. During my tenure as Secretary of State of Health (then Health and Social Care), the responsibility for implementing the recommendations of the Mid-Staffordshire NHS Foundation Trust Inquiry lay with me. When I left the Department in July 2018, the responsibility for continuing the work on implementation passed to my successor, Matt Hancock MP. Each Minister and Government must respond to the unique challenges they face and each will have their own areas of focus and priorities, informed by circumstances and wider policy and strategy objectives. However, the serving Secretary of State will bear responsibility for their decisions, including in respect of continuing or not continuing implementation.

35. I have said that, for acceptance to be meaningful, it is essential to understand the impact and viability of a recommendation. More work may be necessary before a decision can be made. Equally, even where a recommendation is accepted, it may take time to implement, particularly if the mechanisms required to implement it are lengthy and unpredictable, for example, where legislative or regulatory change is necessary.

36. In some cases, recommendations can take many years to implement. Sir Robert made several recommendations (275-281) in respect of death certification and medical examiners. Implementing these required changes to legislation, trial systems tested at different locations across the country, local authorities needed to recruit and appoint sufficient numbers of medical examiners, and a programme of training was prepared by the Royal College of Pathologists, which those appointees then had to undertake. Reforming the death certification process and introducing medical examiners ultimately took many years to bring into effect.

37. I am asked to explain the effect of a decision not to implement recommendations and the consequences for the Government and Government Departments concerned. To my knowledge, there are no formal sanctions for deciding not to implement a given recommendation but there can (appropriately) be considerable political and reputational pressure to act and consequences for failing to act. Amongst many other things, inquiries are very effective tools for casting light on important matters and generating public awareness and interest. They can also serve to require Ministers to publicly explain and justify their decisions, which is of significant value. However, they cannot force a Minister to act.

38. For the reasons discussed above, I do not consider that formal sanctions or a legal obligation to accept or implement recommendations would be appropriate. Not every recommendation can or should be accepted. Further consideration or investigation may be necessary. Even for recommendations which are accepted, there may be resource constraints or changes in the wider system which prevent implementation or make available better ways of achieving the desired outcome.

39. Recommendations made as a result of careful, independent investigation are of significant value, however, the decision to act or not act must lie with the person who bears responsibility for those actions. The Secretary of State is accountable to Parliament and, ultimately, the public, for the decisions that they make. The consequences of committing to a recommendation and failing to implement it are political: the public will weigh the actions and decisions of the Minister and vote accordingly.

40. I have already said that I consider openness and transparency of decision-making to be vital to successful implementation. I also consider it essential to ensuring that this accountability functions effectively. For Ministers to be held accountable in Parliament and by the public for the decisions they make, those decisions must be clearly and publicly stated so that they can be subjected to proper scrutiny. Although there may be good reasons why action cannot immediately be taken, decisions should not be deferred indefinitely. Where it is necessary to take further action before deciding, it is still essential to report on progress.

The Freedom To Speak Up Review

41. On 24 June 2014, I announced that the Government had commissioned the Freedom to Speak Up Review ("FSUR"), an independent review led by Sir Robert to examine the treatment of NHS staff who raise concerns about safety and other matters of public interest, the handling of such concerns, and how best to create an open and honest reporting culture in the NHS. I set up the FSUR in response to wider concerns about the reporting culture within the NHS and the ways that NHS bodies were dealing with concerns raised by staff. These issues were clear from the events at Mid-Staffordshire and the extent of the problem had become even clearer still through the implementation work we had carried out in response.

42. There were many cases where sub-standard care and treatment had occurred but staff were afraid to speak out or were treated inappropriately when they did. The 2013 NHS staff survey identified that only 72% of respondents felt safe raising concerns. Far too many people felt unsafe or unsure about raising concerns. However, not raising concerns can cost lives.

43. I hoped the FSUR would assist me by providing independent advice and recommendations for measures to ensure (i) that NHS workers could make disclosures about the quality of care, malpractice, or wrongdoing; (ii) that such disclosures would be considered and acted upon appropriately; (iii) that those who made disclosures would not suffer detrimental treatment as a result; and (iv) that access to appropriate remedies would be available if they were subjected to such detriments and those who did this would be held to account.

44. Given his previous work, Sir Robert was extremely well placed to conduct this further review and I was confident he would do an excellent job - and he did. The FSUR was informed by the experiences of individual NHS workers who said they had suffered detriment as a result of raising legitimate concerns, as well as by employers, trade unions, professional and system regulators, and professional representative bodies. Many of the individual cases had been litigated and determined by courts and tribunals. In such cases, the FSUR concluded it would not be possible or practical to attempt to reopen or unpick such decisions. This was inevitably disappointing to many whistleblowers.

45. Instead, the focus of the FSUR was on the culture of the NHS more broadly, the systems within which disclosures were made and how to prevent the need for whistleblowing by adopting an open and transparent culture. Its scope included all organisations and individuals who provided NHS services in England and enabled Sir Robert to evaluate changes made in light of the Mid-Staffordshire Inquiry, the adequacy of existing legislation (such as the Public Interest Disclosure Act 1998), and the remedies and support available.

46. The Report was published on 11 February 2015 **[INQ0002387; INQ0012434]**. Sir Robert set out 20 principles and associated actions which addressed culture change, improved handling of cases, measures to support good practice, specific measures for vulnerable groups; and extending legal protections.

47. Sir Robert made two recommendations: (i) that all organisations which provide NHS healthcare and regulators should implement the Principles and Actions set out and in line with the good practice described; and (ii) that the Secretary of State for Health should review at least annually the progress made in the implementation of these Principles and Actions and the performance of the NHS in handling concerns and the treatment of those who raise them, and report to Parliament.

48. On announcing its publication, I explained that I accepted all recommendations in principle and would consult on a package of measures in respect of implementation, which included the introduction of 'Freedom to Speak Up Guardians': specified individuals within each organisation to whom concerns could be brought and who would report directly to Trust Chief Executives. I confirmed that I would write that day to every Trust Chair to underline the importance of the report and request they begin implementing the actions identified.

49. On 16 July 2015, the Government published its '*Learning not Blaming*' report **[INQ0012432]**, which I laid before Parliament. It detailed the Freedom to Speak Up consultation work undertaken by the Department in response to the FSUR, and also responded to the Public Administration Select Committee report on investigating clinical incidents and the Morecambe Bay Foundation Trust Investigation, which was led by Dr Bill Kirkup and reported in March 2015 **[INQ0002385]**.

50. The consultation process in respect of the FSUR ran from 13 May 2015 until 4 June 2015 and sought input on measures including the Freedom to Speak up Guardian role, the introduction of a National Independent Officer, and the introduction of a Patient Safety Champion. Respondents (which included Trusts, NHS staff, Royal Colleges, and wider healthcare bodies and regulators) commented on the implementation of Sir Robert's actions at a local level and explained what further national guidance and support would assist them.

51. Their responses informed further actions identified by the Department in its response which were to be carried out by local NHS bodies and national organisations including the CQC, NHS England, Monitor, the NHS Trust Development Authority, and Health Education England. The consultation provided a means of reviewing what progress had been made and served to identify barriers to implementation and ways that the Department could support organisations in making further changes.

52. In respect of ongoing review, on 9 March 2016 I reported again to Parliament, announcing that NHS Improvement had that day published their 'Learning from Mistakes' ranking of NHS Trusts, which used data from staff surveys and patient safety incident reporting to identify those Trusts with strong reporting cultures and those where improvement was necessary. This ranking was to be updated annually through the CQC's ongoing reporting on quality and patient safety.

53. Further updates were set out and reported to Parliament in the Department's Annual Report and Accounts for 2016-2017 (**JH/4**) and 2018-2019 (**JH/5**). In respect of the 2016-2017 report, paragraphs 186-7 and 191-193 noted the establishment in April 2016 of the Healthcare Safety Investigations Branch and the appointment in July 2016 of a new Chief Inspector to oversee the service. In October 2016, Dr Henrietta Hughes was appointed as the National Guardian to assist the individual Freedom to Speak Up Guardians in place in NHS organisations nationwide.

INQ0107931

INQ0107932

54. The 2018-2019 report at paragraphs 274-286 delineated the new Patient Safety Strategy, amendments to the Employment Rights Act 1996 in respect of protected disclosures by NHS staff, the results of the CQC's ongoing monitoring on reporting concerns, and events held in October 2018 as part of the first ever "Speak Up" month to raise awareness of speaking out within the NHS.

55. On 9 July 2018, Matt Hancock became the Secretary of State for Health and Social Care. I am not able to speak to what further reviews were conducted under his leadership.

Reflections on recommendations to enhance the safety of babies in hospital

56. I am asked to say what recommendations I consider this Inquiry should make to keep babies in hospital safe. I am asked to give particular consideration to any recommendations as to how the NHS is governed and how changes to the healthcare system are implemented.

57. In my view, change requires focus and prioritisation by the Government and relevant Ministers. Each Government and Secretary of State will have their own priorities and these will necessarily be influenced by the particular challenges facing the Government and NHS at any given time. To make change on a particular issue, it must become a priority and an area of focus, and there must be sufficient resources available to generate sustained effort. All of this can be disturbed by unforeseen external events (such as the Covid-19 pandemic), by economic changes, and by shifts in policy and strategy as Ministers and governments change.

58. I consider that even after the efforts made during my tenure, in which maternity safety was a major priority, there are still too many deaths and injuries of babies and mothers within the NHS. On 13 November 2015 I announced the Government's ambition to halve the rate of stillbirths, neonatal, and maternal deaths in England by 2030 **[INQ0012889]**, with an expectation of a 20% reduction by 2020 (the 'Halve it' campaign.) This was supported by significant investment packages for enhancing equipment, reporting, and training.

59. In November 2017, 'Safer Maternity Care, the National Maternal Safety Strategy – Progress and Next Steps' was published **[INQ0012891]**. This identified the work undertaken to date and, based on the progress made, announced that the target date of 2030 would be brought forward to 2025 and expanded to include a reduction in the rate of pre-term birth from 8% to 6%, also by 2025.

60. The work of producing policy guidance on measures and implementation to facilitate these reductions lay with NHS England. Their 'Saving Babies' Lives Care Bundle' guidance was first issued March 2016 and I understand it has been revised on a near

annual basis since. It identifies safety measures, trends in incidents, and ways to better implement changes to achieve the target.

61. I understand that the Department's Annual Report and Accounts for 2022-2023 (for the period ended 31 March 2023) **[INQ0012915]**, indicate that, since 2010, the stillbirth rate has reduced by 23% and the rate of neonatal mortality by 30%. The rate of brain injuries occurring during or soon after birth is 2% lower than the 2010 baseline and rate of pre-term births has been reduced from 8% in 2017 to 7.7% in 2021. However, there was a 26% increase in the maternal death rate. In short, progress has been made against some elements of this ambition but there is clearly much work still to be done.

62. External factors have certainly had an impact, the pandemic perhaps most significantly. However, I consider there would be value in refocusing effort in this area and only through that focus can meaningful change be achieved.

63. I would recommend the Inquiry consider advising the government to restart the 'Halve it' campaign and update the 'Saving Babies Lives' care bundle (**JH/6**) (Version 3.1, July 2023). In particular, it is essential the planned increase in midwives, maternity nurses and obstetricians in the NHS Long Term Workforce Plan are implemented as quickly as possible. INQ0107933

64. I also recommend moving to a No Fault compensation system as operates in New Zealand. This was recommended in one of my Select Committee reports published on 22 April 2022. This is because the threat of litigation leads to a blame culture which makes it very hard for doctors and nurses to speak up when mistakes are made as they inevitably are.

65. Finally, when it comes to the implementation of recommendations made by Inquiries, whether statutory or not, I recommend a beefed up version of the requirements placed on governments to respond in a timely way to Select Committee reports. I believe the government should have an obligation to respond within 60 days to all recommendations with a straight 'yes' or 'no' answer. There should be no 'accepting in principle' or 'under consideration' or other devices that could be used to kick a recommendation into the long grass). Any 'yes' to a recommendation should be accompanied by a date by when a recommendation will be implemented in full.

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 in its truth.

Signed: PD _____

Dated: 20th August 2024