Witness Name: Duncan Burton

Statement No.: 3

Exhibits: DB3/1 – DB3/4

Dated: 7 March 2025

THIRLWALL INQUIRY

THIRD WITNESS STATEMENT OF
DUNCAN BURTON

I, Duncan Burton, will say as follows: -

1. I am the Chief Nursing Officer of England, having been appointed to this position on 25 July 2024. This is my third statement in connection with the Thirlwall Inquiry ("the Inquiry") and is made on behalf of NHS England in response to the supplementary questions asked by the Inquiry in its Rule 9 letter dated 22 January 2025. I responded to the second, third and fourth of these questions in my second witness statement dated 6 February 2025. This statement responds to the first and fifth questions concerning oversight of the use of insulin and the use of CCTV/live streaming technology on neonatal wards.

2. This statement has been drafted on my behalf by the external solicitors acting for NHS England in respect of the Inquiry, with my oversight and input. As some of the questions in the Rule 9 letter go beyond matters which are within my own personal knowledge, this statement is the product of drafting after communications between those external solicitors and senior individuals within NHS England in writing, by telephone and video conference.

Oversight of the use of insulin in neonatal wards

3. In NHSE/2 [**INQ0014552**], we set out the ongoing work the Chief Pharmaceutical Officer for England had been commissioned to undertake by the then Minister for Mental Health and Women's Health Strategy relating to the safe management of insulin on neonatal wards. This work encompassed a survey sent out on 17 January 2024 to facilitate an in-depth assessment of the current safe and secure handling procedures regarding the use of insulin across all neonatal units.

4. The review focussed on current practice, based on the Royal Pharmaceutical Society's safe and secure handling of medicines standards, which apply to all medicines and patient settings, not just insulin and neonates. We provided an update to the Inquiry on the analysis of the results from this survey in NHSE/4 [**INQ0107908**]. In summary, the survey identified overall good practice in the safe and secure handling of insulin in neonatal units in England, with some expected variation in practice based on the type and size of unit, patient acuity levels and the number of babies admitted at any one time. The results did not demonstrate any systemic failures that require a change in practice, although some areas could be improved such as (i) regularity of training and maintenance of competence, (ii) access to specialist clinical pharmacy services and (iii) use of electronic prescribing, However, there was no evidence that such quality improvement actions would reduce or prevent the risk of deliberate misuse of insulin in this setting.

5. In his oral evidence to the Inquiry on 17 January 2025, NHS England's National Medical Director explained further how the variation mostly related to: (1) the presence of a pharmacist on the units to check and to aid in those processes around insulin; and (2) training. As a result, he was exploring with the Chief Pharmaceutical Officer how to improve and promote best practice in these areas.

6. By way of further background, it is important for the Inquiry to understand that each NHS trust is required to have a Medication Safety Officer. This role was introduced in 2014 following the publication of a stage three directive patient safety alert from NHS England titled 'Improving Medication Error Incident Reporting and Learning'. Since April 2023, it has been a contractual requirement in the NHS Standard Contract to have a Medication Safety Officer.[1]

7. In most cases this role is performed by a senior pharmacy professional, although it can be performed by any qualified healthcare professional. The role was reviewed in 2022 and a revised job specification was produced following consultation. The responsibilities of the Medication Safety Officer will generally include at least the following:

   - Monitoring systems and provision of information to support a reduction in avoidable harm resulting from inappropriate medicines use across the Trust.

[1] NHS Standard Contract 2024/25, Service Conditions (Full Length), See page 54.

- Leading reviews of patient safety incidents where appropriate and provide a quality assurance function for incident reviews involving medicines.

- Supporting multidisciplinary teams to investigate incidents to enable causes to be understood and appropriate plans to be established to mitigate future risks.

- Designing and developing systems and processes alongside clinical colleagues to mitigate the risk of incidents recurring.

- Reviewing safety alerts and national safety documents and preparing appropriate plans to deliver compliance.

- Supporting the development of education and training programmes to enable multidisciplinary teams to discharge their responsibilities relating to the prescription, procurement, supply and administration of medicines.

- Contributing to the national agenda with respect to medication safety liaising with national, regional, and local groups to minimise medication errors.

8. The Care Quality Commission assures this requirement and in 2021 conducted a national survey regarding the performance of this role [**Exhibit DB3/1, INQ0108913**].

9. The British Association of Perinatal Medicine medicines safety group, in response to a request from the Chief Pharmaceutical Officer, has recently agreed to consider providing further advice on the use of insulin, including storage and pharmacy support. There will be involvement from the National Neonatal and Paediatric Pharmacy Group (NPPG) who published co-produced Pharmacy Staffing Standards for Neonatal Services in September 2022.[2]

10. Following NHS England's oral evidence to the Inquiry, the General Pharmaceutical Council published new regulatory standards for the conduct of Chief Pharmacists on 20 January 2025.[3] The new standards include:

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[2] https://nppg.org.uk/wp-content/uploads/2022/10/NPPG-Neonatal-Staffing-Standards-V2.pdf

[3] https://www.pharmacyregulation.org/about-us/news-and-updates/gphc-launches-new-standards-chief-pharmacists#:~:text=The%20standards%20that%20Chief%20Pharmacists,are%20clear%20lines%20of%20accountability.

- Standard 1: Provide strategic and professional leadership, for example in the sourcing and management of medicines across the organisation.
- Standard 2: Be aware of the knowledge, skills and experience needed to deliver safe and effective services which includes fostering a culture where staff feel confident about raising concerns.
- Standard 3: Delegate responsibility with clear lines of accountability, only delegating to people with the relevant skills, knowledge and experience and who are confident about assuming the extra responsibility.
- Standard 4. Maintain and strengthen governance to ensure safe and effective pharmacy services, having arrangements for managing risks, receiving feedback about interventions, errors and incidents.

11. The introduction of the above seeks to assure the highest standards for the safe and secure handling of medicines by ensuring that Chief Pharmacists understand their responsibilities for the management of medicines across their organisation in line with the guidance published by the Royal Pharmaceutical Society of Great Britain in 2018 on the safe and secure handling of medicines.[4]

12. The combined effect of the above regulatory standards, the NPPG staffing standards, the obligations set out in the Standard Contract and the job specification of the Medication Safety Officer role, ensures that each hospital has a Chief Pharmacist who has oversight of the safe and secure handling of medicines and a Medication Safety Officer with the knowledge, skills and experience to be delegated the responsibility to anticipate, identify and manage risks, and respond compassionately and proportionately to safety incidents within strengthened governance arrangements. The strengthened governance arrangements include the statutory duties laid out by the Controlled Drugs Regulations and the contractual responsibility to implement the new Patient Safety Incident Response Framework.

13. In relation to the additional training that NHS England has identified may be necessary, NHS England provides support for medicines safety through a contract with the NHS Specialist Pharmacy Services. NHS England has commissioned the publication of on-line resources and educational materials that support the safe use of medications relevant to neonatal units. The first of these was in June 2024 on Managing complexities of medication use across care boundaries which provided education and training in the complexities of dosing of paediatric medication. The second, to be published shortly in

[4] Professional guidance on the safe and secure handling of medicines

March 2025[5], is on the safer use of insulin. By the end of 2025 further guidance will be published that supports medication safety officers to deliver improvements in safety through the Patient Safety Incident Response Framework and its relevance to neonatal care.

14. NHS England also recognises that developments in digital infrastructure, automation and use of data provide an opportunity to enhance medicines management, with connected technologies supporting the traceability of medicines from supply to administration, and lead to improvements medicines security and safety. This is something NHS England will keep under ongoing review.

CCTV and live-steaming technology

15. In NHS England's oral evidence before the Inquiry on 17 January 2025, the National Medical Director also recognised the potential benefits for parents in connection with the use of technology that allows for the live-streaming of babies in cots on neonatal wards. Professor Powis indicated that he intended to discuss with me whether NHS England should carry out some specific pilot work to explore this further.

16. It is important to note here that we are not strictly speaking about CCTV, which is used within hospitals to control access to buildings and particular units. CCTV is used as a safety measure in this sense to monitor access to units (so as to mitigate the risk of child abduction, for example). Paragraphs 870-878 of NHSE/1 [**INQ0017495**] explain the use of CCTV in this regard. I note that the results of the Nuffield Trust Survey indicated that no NHS trust currently uses CCTV inside neonatal units. Any such use would require careful, context-specific analysis of a range of factors, including around privacy and safeguarding, as well as all applicable legal considerations.

17. A better description of the technology in question is "live-access monitoring". There is no national policy or framework in place governing the use of such technology and deployment would, therefore, be a decision for individual providers, taking into account the needs of their population and following appropriate consideration of applicable legal and regulatory duties. NHS England understands from the Nuffield Survey that 3 Trusts

[5] MSATS – Safer use of insulin – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice

indicated that they have used some form of this technology, although it is not clear if all trusts were applying the same definition.

18. NHS England is also aware that there have been several instances around the world where the use of this technology in neonatal units has been piloted. As far as NHS England is aware, these pilots have all focused on improving parent/patient experience, rather than using this technology as a safety measure. A recent systematic review of these pilots concluded that whilst there are many documented benefits for parental well-being, the use of the technology requires adequate staff training, support and plans for ongoing maintenance [**Exhibit DB3/2, INQ0108912**].

19. Following the evidence given by the National Medical Director to the Inquiry, my team contacted the University College of London to better understand any learnings from their academic research and, in particular, the pilot done by the University College London Hospitals NHS Foundation Trust in 2020 in their neonatal unit which ran for 18-months. In summary, this pilot involved parents having access to live-streaming of their baby's cot via wifi for two hour slots each day, and ended due to issues with the maintenance of the technology.

20. NHS England subsequently reviewed two papers written by researchers at the University College of London on this pilot that explored:

    a. The impact of the new implementation of webcams on nursing workload. This study concluded although the introduction of webcams did not negatively impact nursing workload, nurses reported webcam-related changes to nursing workflow in terms of infant handling, concern for parents and other webcam viewers, and technological difficulties, all of which might be able to be resolved through preparation, staff and parent education and good communication **[Exhibit DB3/3, INQ0108910]**.

    b. Parents' experiences of using the webcam technology. This study concluded that live streaming webcams can reduce the separation imposed on parents when their baby is admitted for neonatal care and parents' experience was mostly positive. The benefits for parents centred around reassurance of their baby's wellbeing, increased bonding, and access to enable family integration, which overall improved parental emotional wellbeing. Again, whilst some challenges were

identified, it was concluded that these could likely be resolved by further education and support **[Exhibit DB3/4, INQ0108911]**.

21. Having considered the above research, and following discussions with the National Clinical Director for Neonatology, NHS England does not consider that the conduct of further pilots would be of assistance at this stage. There are undoubtedly many benefits for parents in relation to the use of webcams in neonatal cots. The challenges are also known: the limits of the currently available technology, the impact on workflows, the need to train staff, patient confidentiality, education for families, ongoing maintenance and cost.

22. NHS England currently has other, higher priority, areas for focus and funding for neonatal experience and safety in line with the Three Year Delivery Plan, as outlined in my first statement. However, we also recognise that, as the technology improves, there will be more options for allowing parents to monitor a neonate remotely and NHS trusts will be able to tailor the use of this technology to enhance the services they provide to parents. Currently, this will remain a matter for each Trust to decide if and when to implement. Any learnings from such pilots will, however, be shared by NHS England through the neonatal networks.

Statement of Truth

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

Signed: **Personal Data**

Dated: 7 March 2025