



# Report for the Thirlwall Inquiry

Analysis of questionnaires  
from 120 NHS trusts

April 2024

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# Executive Summary

## Purpose and scope of report

This report compiles and presents the analysis of responses to a questionnaire that was sent to all 120 NHS trusts with neonatal units in England in Autumn 2023 (except for two trusts which are engaged with an inquiry process). The report aims to provide an overview of the organisation of neonatal care, and draws on previous work by the Nuffield Trust along with wider research and guidance relevant to neonatal care. Trusts were asked to provide separate responses from medical and non-medical leaders, although in some cases single or shared responses were provided. Additional documents were provided in support of responses by some organisations. In the analysis we have used examples from responses to illustrate common themes identified, as well as less common responses, and examples where trusts identified good practice or challenges. We have not been able to follow-up with trusts to validate responses.

## Key points and Nuffield Trust reflections relating to each topic

### Governance and accountability

Governance and accountability for NHS organisations is based on a combination of legislation and guidance and differs depending on whether the organisation is an NHS Foundation trust or not. Some aspects of governance are set out in law while others are within the remit of the trust to organise. This variation was reflected in trusts' responses to the questionnaire which described a range of governance arrangements, ways of configuring clinical services, and organising committees.

Trusts noted that they, or their Board, are accountable to a range of organisations for different things. This included in relation to performance, finances and quality. Trusts provided variable amounts of detail with regards to accountability but many noted the role of NHS England (or its regional teams), their Integrated Care Board or Integrated Care System, the Care Quality Commission, and Parliament/ the Secretary of State/ the Department of Health and Social Care. The key difference observed related to whether a trust is a foundation trust or not, with the former also noting the role of the Council of Governors.

### Trust policies

About half of the respondents (61 trusts) reported they had reviewed their policies during 2023. For most of those (39 trusts), their reviews of policies were triggered by the Letby case. But another 10 trusts reported reviews being triggered by changes national guidance on safeguarding and/or the introduction of the new national Patient Safety Incident Response Framework.

25 trusts reported making recent changes to at least one policy. For a small number of trusts this meant introducing new neonatal specific policies where these did not previously exist. But for most trusts, policy changes included clarifications around escalation in safeguarding processes, new checklists and flowcharts when investigating neonatal deaths, updated language and signposting in line with the national Freedom To Speak Up policy. Among the trusts that had not reviewed or made changes to their policies, many respondents suggested they were awaiting the outcome and recommendations of the Inquiry.

In addition to describing their policies, trusts described actions they had taken once they heard the initial case outcome, which included: offering immediate support to staff and families, re-iterating routes to raising concerns among staff and families, reviewing processes to look for improvements, undertaking trust board briefing and training, strengthening governance processes, and taking action and making plans to improve the monitoring and triangulation of the various data sources across the trust.

## **Staffing**

Monitoring and scrutiny of neonatal staffing is greater than for many areas of NHS activity, and there is established guidance on staffing requirements for neonatal units, along with regional and national reporting, audit, and oversight, from several national bodies. Requirements vary between level of care provided and this was reflected in responses from trusts.

However, most trusts reported challenges with meeting staffing requirements, relating to the number, skill mix and qualifications of staff. For example, 99 trusts reported that they had nursing vacancies, and 68 trusts reported that they did not meet staffing standards for nurses. Trusts were using a range of strategies to address staffing gaps, including training existing staff, developing different roles, and international recruitment. On a day to day basis trusts described how they monitored staffing levels relative to how busy they were and the needs of babies, and brought in additional staff if needed, or in some cases changed admission criteria to maintain safe staffing levels.

## **Culture**

Responses to the questionnaire indicate that culture across trusts and neonatal units is complex, can vary and is dependent on local and national context. While some trusts described particular challenges (either in the neonatal unit or trust as a whole), many described features of their trust which they considered demonstrated a good culture. Some also reflected on changes and improvements over time, the impact of previous incidents and reviews, and organisational priorities to improve culture, noting that culture was not static and developing a good culture requires continuous attention.

Features of positive cultures described by trusts included multi-disciplinary team working and leadership, communication and visibility, equality, diversity and inclusion, staff wellbeing and effective mechanisms for raising concerns. Features of challenging cultures described included siloed working, experiences of bullying, harassment or lack of diversity, and hierarchies. Some trusts also referred to the impact of local and NHS context such as service pressures, staffing levels and neonatal reporting requirements. These themes are reflective of wider evidence, as well as findings from previous investigations. Developing a 'positive safety culture' is one of the objectives of the three-year delivery plan for maternity and neonatal services and this sets out actions for NHS England, trusts and ICBs respectively. Responses from trusts indicate

that many trusts have these processes in place already, are actively working to put them in place and/or are working to cultivate this type of culture.

Several trusts noted that they had been involved in reviews of either culture or neonatal services. These were both proactive (for example as part of organisational development programmes) and reactive (in response to particular incidents). Some were required by particular processes or investigations while others had been initiated by the trust.

Overall, we did not observe marked differences between medical or operational respondents' answers with both staff groups identifying similar themes regarding culture.

### **Working relationships**

Describing working relationships within neonatal units across the NHS as a whole is complex, and dependent on the particular context. Responses to the questionnaire indicate several features which are considered to be important to enable individuals and teams to work together. This included multi-disciplinary team working and leadership, mechanisms to support communication and visibility (such as listening events, huddles and walkarounds) and forums for raising or discussing issues (such as Committees). Guidance and quality standards refer to aspects of team-working which are important for neonatal services and trusts provided several examples in their responses which referred to these elements. Many trusts also reported that they were taking part in the NHSE Perinatal Leadership programme as set out in the three-year delivery plan for maternity and neonatal services. Some trusts referred to challenges with working relationships which included differences in opinion, the impact of staffing or service pressures such as industrial action and hierarchies.

Trusts described a range of routes at NHS and trust level by which they can receive feedback about staff working relationships. This included the NHS Staff Survey or maternity and/or neonatal specific initiatives such as Operational Delivery Network reviews, as well as staff routes such as Freedom to Speak Up guardians, safety champions and walkarounds.

Overall, we did not observe marked differences between medical or operational respondents' answers with both staff groups identifying similar themes regarding working relationships.

### **Reporting and managing concerns and complaints**

#### **Processes for raising concerns/complaints**

There was broad consistency in how respondents described their processes for reporting and investigating concerns/complaints. Staff and families were encouraged to raise their concerns/complaints in the unit, where they felt comfortable doing so. Patient Advice and Liaison Services were widely cited as available to families, and the Freedom to Speak Up guardians as available to staff. Anonymous routes were described for staff raising concerns about other staff in 9 trusts. Incidents were recorded in internal risk monitoring systems, but some trusts described not having systems or processes for recording informal or lower risk concerns/complaints. Multiple teams were described as responsible for investigating concerns/complaints based on the issue.

Most respondents (108 trusts) reported having at least one concern/complaint in the previous year, and most of those (97 trusts) had investigated at least one concern/complaint. Of those, 67 trusts had upheld at least one concern/complaint (that is they found the concern/complaint to be supported by evidence following investigation). The two most frequently described actions taken on the back of concerns/complaints were communication about the issue to staff for learning purposes and making changes to clinical practice or processes.

Where the investigation teams deemed concerns/complaints as necessary to be escalated to external bodies, the process and organisations contacted depended on the nature of the issue. 24 trusts stated they had reported matters to a professional regulator in the last year, over half of which involved contacting the Nursing and Midwifery Council.

### **Factors inhibiting and encouraging raising and acting upon concerns**

Respondents described a range of factors inhibiting staff from raising concerns, which included a lack of a reporting culture, low staffing levels and resourcing leaving little time to raise and investigate concerns/complaints, complex and bureaucratic reporting routes, and ongoing public scrutiny of maternity and neonatal care amplifying reporting requirements. Enabling factors included continuous encouragement for reporting, training programmes and psychology services for people speaking up, visible FTSU guardians, leadership being visible and building in mechanisms to listen.

For families, inhibiting factors described by respondents included a lack of awareness about how to raise a concern and complex reporting routes and language barriers. Enabling factors included multiple possible routes being available, widespread public information on raising concerns/complaints, and ongoing encouragement from staff.

27 trusts suggested they had factors inhibiting the ability of managers to act upon concerns. Common factors mentioned were financial strain and understaffing, lack of capacity of managers and leaders, and the personal and professional isolation risks involved.

### **Reviewing evidence after a death**

There are multiple routes for reviewing evidence after a death including local governance processes and external review and reporting processes. Many respondents reported how such processes aim to support local and broader learning, provide explanations to families, maintain accountability and transparency, oversight and assurance, and benchmark against national and regional standards. However, several respondents reported several influencing factors, such as the service having an open culture, thoroughness of the investigation, triangulation and communication across services and processes, and capacity to embed learning into practice. Several respondents focused on the benefits and opportunities that the new incident reporting framework brings.

Capacity of perinatal pathology services poses a challenge for some trusts. Wide variation was evident in the timeframe for receipt of post-mortem reports and some respondents reported long delays, that were often cited as related to the broader national shortage of perinatal pathology expertise. Established processes for post-mortem request and processing were reported, including pathways to discuss queries or concerns.

Most respondents reported routine medical examiner scrutiny of neonatal deaths, although this was still being put in place in some trusts, ahead of the national requirement for medical examiner review of all deaths. Most respondents reported medical examiner processes to identify themes or patterns, although some described relatively informal mechanisms. Respondents typically reported positive working relationships between medical examiner and coronial services. Many reported regular communication to discuss cases, concerns or queries and identify areas for learning. However, variation was reported in the pathway for referral of cases.

Many respondents reported attendance at child death overview panels, however frequency of attendance varied across trusts, as did the frequency with which the panels were held and existence of dedicated neonatal panels. Respondents described panels were effective in supporting local, regional and national learning, facilitating multi-agency external scrutiny, working alongside other review processes and providing a standardised framework for reviewing deaths. However, some respondents did cite factors that can limit their effectiveness, such as the time delay in reviewing cases, availability of specific neonatal expertise, and reliance on information from other processes.

### **What safety nets exist**

#### **Parental involvement**

There are established approaches and initiatives in neonatal care for involving parents. Many respondents reported the adoption of a family integrated care approach towards neonatal care. Most cited established processes for parental involvement in ward rounds, the sharing of discharge summaries, engagement in care activities and ensuring 24-hour access to the unit. A range of other initiatives were also reported by respondents to varying extents, for example: support to enable parents to stay on the ward; educational opportunities related to care offered to families; mechanisms and opportunities for families to feedback about the service and make suggestions to improve care; and other forms of support offered (for example psychological and peer support).

#### **Data collection and use of data**

There are established national reporting and monitoring requirements relating to neonatal care, and trusts used data for operational management and monitoring staffing, reviewing quality of care and quality improvement, for national and local benchmarking and audit, and financial and contracting requirements. Monitoring and reporting is impacted by wider trust infrastructure particularly use of electronic health records, as well as trust culture, in terms of how the data is reviewed and actioned locally. Several trusts provided examples of how positive change had been enabled following analysis of care outcomes.

#### **Presence of CCTV**

While most respondents reported the presence of CCTV within or outside services, this was usually located at entrances and exits (and some communal areas) for the purpose of ensuring the security and safety of staff and patients. No respondents reported CCTV to be located within clinical areas with the purpose of monitoring babies and few reported its presence in medication storage areas. However, several respondents did report planned upgrades relating to the installation of CCTV in medication storage areas. Few respondents reported live remote access for families and some cited concerns related to privacy of such access. However, some respondents did report providing facilities for video calling or portals for families to access to pre-recorded videos.

## **Management, storage and administration of medication**

The management, storage and administration of medication within maternity and neonatal services was determined by national guidance and local trust policies. While most respondents reported established processes, differences were evident across trusts in relation to the digital capabilities of storage facilities (such as presence of automated electronic storage units), the availability of electronic systems for records of access and administration, and the frequency with which regular audits were carried out for the safe and secure storage and administration of medication.

## **Support for bereavement**

A wide range of bereavement support services were described as available with common services including access to a bereavement midwife, Perinatal Mortality Review Tool review with consultants, referrals to specialist bereavement counselling services where needed, and referral to a perinatal mental health midwife or a clinic for future pregnancies dedicated to parents who have experienced baby loss.

Most respondents described recording neonatal deaths in on-site maternal electronic medical records, which is in line with the national bereavement pathway. Most trusts also described either actively sending or sharing information to local health systems, via a letter to the GP or notification to local health visitors and community midwives. Many described placing electronic alerts, flags or physical stickers on physical and electronic medical records. There were no clear descriptions of how the non-birthing parent's record was updated to enable sensitive discussions the event in future pregnancies – the maternal record appeared to be the only source.

## **Learning and making improvements**

Some trusts provided specific reflections on lessons learned regarding neonatal and perinatal services. These included the importance of data (and ensuring it is visible at board level), processes and cultures which enable people to raise concerns, integrated working between neonatal and maternity services, and relationships between professionals.

Some trusts suggested that there could be improvements made to management and governance structures. These included streamlining the various processes (for example for investigating deaths or reporting) and strengthening the relationship between neonatal units and maternity/ paediatric services. Some however noted that culture, leadership and support should be the main focus rather than changing structures or processes.

More generally, trusts described a number of recent actions they had undertaken. Some were in response to the Lucy Letby case, or other reviews while others were taking place anyway. This included: reviewing and adapting policies and processes for raising concerns, incidents and deaths; enhancing governance and oversight; improving culture and raising awareness of routes for raising concerns; providing support to staff, parents and families and improving family involvement in processes; additional investment or changes in staffing, new roles and changes to service design; improving how data is used and reported and increasing visibility at board level, and implementing recommendations from previous trust and NHS reviews.

## Regulation of senior managers

Respondents expressed a range of views regarding regulating senior managers. Some expressed a clear position either in support of regulation or against it, some expressed a more qualified position and others were neutral or undecided on the topic. Several respondents reflected that – regardless of the overall desirability or otherwise of regulation – they did not consider that it would have made a difference in the Lucy Letby case.

Key themes which were identified by both medical and operational respondents included the purpose of regulation (for example, to support professional development and consistency of manager roles), the interrelatedness and effectiveness of existing processes (such as the fit and proper persons test), the appropriateness of the solution as a way to improve patient safety, and providing consistency with other regulated professions.

## Differences between trusts providing different levels of neonatal care

Overall we did not find systematic differences between trusts providing different levels of neonatal care, apart from where there are different operating requirements, for example for staffing.

# Overarching themes

For almost all the areas covered in the questionnaire there are existing regulations, mechanisms or guidance in place in the NHS. Within neonatal services there are additional reporting routes and requirements to take into account over and above those which apply across the NHS as a whole. In a small number of areas (for example use of CCTV) we found limited guidance.

The infrastructure within trusts affected the processes they have in place to manage safety and risks. For example, there was variation between trusts in the availability of electronic systems to support access to medical records, medicines management and storage facilities, the maturity of systems for data collection, reporting and triangulating information, and ease of access to the ward for parents.

However, policies, structures and processes on their own are not sufficient to ensure services are safe and effective. A wide body of research indicates that culture and leadership are critical, and a positive culture is needed for systems and processes to achieve their aims. Where there is variation in how trusts manage issues, this will reflect a combination of the circumstances of the organisation and the leadership approach to addressing issues.

Some organisational circumstances are unique but there are many factors affecting the whole NHS, or neonatal care specifically, for example resource and workforce pressures. Culture and leadership at an organisational level are also impacted by national leadership and management of the NHS.

In some cases the quantity of guidance, reporting requirements, number of external regulators, and the frequency with which these change, leads to a risk that responding to external scrutiny takes precedence over learning and action within the organisation.

Respondents reported the value of triangulation of the multiple sources of data on complaints, safety issues, informal concerns. In the report we highlight examples where trusts reported positive examples of culture, learning and good practices, as well as examples trusts provided of where there could be improvement.

We were not able to validate the information provided by trusts. Through the course of the inquiry there may be opportunities to triangulate the findings from this report with other sources of information. The responses we examined were from senior leaders at trusts and triangulating with staff on wards (as part of the staff survey which the inquiry has commissioned) will be a helpful exercise to gain a more comprehensive view from within neonatal services. In addition, there may be benefit in understanding how trusts follow through in acting on local policies and national guidance. For example, how information is presented to trust boards, and the actions taken by the board in response to reports or issues escalated to them.

# Abbreviations

AHP – Allied Health Professional  
ANNP – Advanced Neonatal Nurse Practitioner  
ATAIN – Avoiding term admissions into neonatal units  
CEO – Chief Executive Officer  
CMO – Chief Medical Officer  
CNO – Chief Nursing Officer  
CNST – Clinical Negligence Scheme for trusts  
CQC – Care Quality Commission  
ED – Executive Director  
EDI – Equality, Diversity and Inclusion  
EPR – Electronic Patient Record  
FPPT – Fit and Proper Person Test  
FTSU – Freedom to Speak Up  
GIRFT – Getting It Right First Time  
HRG4 – Healthcare Resource Group version 4  
ICB – Integrated Care Board  
ICO – Information Commissioners’ Office  
ICS – Integrated Care System  
IG – Information Governance  
LED – Locally Employed Doctor  
LMNS – Local Maternity and Neonatal System  
MatNeoSIP - Maternity and Neonatal Safety improvement programme  
MBBRACE – Mothers and babies: Reducing risk through audits and confidential enquiries  
MDT – Multidisciplinary team  
ME – Medical Examiner  
NDAU – Neonatal Data Analysis Unit  
NED – Non-executive director  
NHSE - Neonatal transformation Review  
NICU – Neonatal intensive care unit  
NIHR – National Institute for Health and Care Research  
NIPE - New-born infant physical examination data  
NNAP – National Neonatal Audit Programme  
NNRD - National Neonatal Researcher Database  
NPEU – National Perinatal Epidemiology Unit  
OD – Organisational Development  
ODN – Operational Delivery Network  
PMRT – Perinatal Mortality Review Tool  
PSED – Public Sector Equality Duty  
PSIRF – Patient Safety Incident Response Framework  
QIS – Qualified in Specialty  
SCU/SCBU – Special Care Baby Unit  
SI – Serious Incident  
WRES – Workforce Race Equality Standard

# Introduction

This report compiles and presents the analysis of responses to a questionnaire that was sent to all 120 trusts with neonatal units in England in Autumn 2023 (except for two trusts which are currently engaged with an inquiry process). Nuffield Trust researchers (Appendix 1) have identified and summarised key issues and themes arising from the questionnaire responses, including: the culture and nature of working relationships in neonatal units in hospitals; the ability for staff and patients to raise concerns; the level and manner of staffing on neonatal units; and how to make improvements. This report presents observations rather than any findings of fact and highlights relevant contextual documents to assist the Chair in situating themes in line with the letter of instruction (Appendix 2).

## Our approach

Nuffield Trust researchers transcribed questionnaire responses into a single database and analysed each question separately (see Appendix 3 for the full questionnaire). This involved reading all responses to each questionnaire question, categorising responses in order to address questions in the letter of instruction, and grouping similar responses into themes. Where relevant and possible, we counted how many hospital trusts responded in the same way. The analysis aimed to describe the similarities and differences across responses. Quotes from survey responses are also used to illustrate themes and highlight thorough responses, and shown in italics. Some aspects of quotes are redacted, for example, hospital and unit names, or trust specific programmes, and codes are used to ensure trusts remain anonymous (for example, trust 032).

For certain questions (5, 8, and 42), differences in the responses between professional role of respondents were examined. This analysis involved examining whether medical directors and non-clinical trust operational managers responded in the same way. For these questions, quotes have been labelled with A or B to indicate medical or operational respondents respectively. In these sections, if trusts provided a single response the quote has been labelled with “SR” after the trust code and if they provided a joint response it has been labelled “JR” – see [Description of individual respondents](#) for further information on the types of responses.

Where possible, sub-group analysis was also carried out to determine whether there were differences between neonatal units that care for babies with differing levels of complexity. Notable variation is included in the main text within the relevant section, with further detail in Appendix 4.

NHS trust internal policy documents, such as the policy on ‘how to make a complaint’ or ‘raise a safeguarding concern’, were submitted to the Inquiry. These were searched for examples of clear wording of how to raise concerns and complaints.

To accompany the analysis, relevant literature was collated and summarised to point the Inquiry team and Chair to key pieces of evidence on the topics covered in the

report. Relevant literature is included and discussed within each section, and in addition, Appendix 5 summarises relevant Nuffield Trust research and analysis.

## Limitations

The analysis of the questionnaires was carefully designed by an experienced research team, and the results internally cross-checked and reviewed by the Nuffield Trust research team. Notwithstanding, there are potential limitations.

The questionnaires were directed to the medical director and a non-clinical senior manager with responsibility for the trust's neonatal services, with a request to complete the questionnaires separately. However, many trusts submitted a response that had been written by numerous staff members with specialist knowledge, or provided two identical/similar responses. This limited the scope to examine differences between the two main respondent types in many instances.

In our assessment, due to the wording of some questionnaire questions, some respondents have interpreted questions differently. For example, many questions cover more than one concept, or are unclear whether the question relates to the neonatal unit or the trust as a whole. This has made it challenging to concisely summarise the breadth of responses in some cases. As an example, in the section on culture, it was not clear from the questionnaire questions whether respondents were being asked to provide an objective view, or their perception. Given the range of types of interpretation of culture, and variation in responses, it has been difficult to draw conclusions or paint a comprehensive picture of culture in neonatal services.

There were some differences between the letter of instruction and content of the questionnaire, such that the responses did not cover all topics in the letter of instruction. We have indicated where this is the case in relevant sections, and also where we have drawn on data from multiple questions in order to summarise trust response, for example in the section on staffing.

## Structure of the report

This report covers the following topics, which are drawn from the main areas covered in the questionnaire:

- [Summary of survey respondents](#)
- [Governance and accountability](#)
- [Trust policies](#)
- [Staffing](#)
- [Culture](#)
- [Working relationships](#)
- [Reporting and managing concerns and complaints](#)
- [Reviewing evidence after a death](#)
- [What safety nets exist](#)
- [Support for bereavement](#)
- [Learning and making improvements](#)

There is overlap in the content and themes covered across topics. Respondents provided similar content, repeated content, or signposted to other questionnaire responses across different parts of the questionnaire.

To enable consistency across topics, each topic section starts with a description of which questions are being summarised, and bullet points providing context relevant to issues raised in the responses (rather than providing an exhaustive discussion of the issue). A summary of questionnaire responses relevant to the topic follows. Each topic section ends with reflections from the research team on the topic, and where relevant, additional references that may be of interest to readers are provided. All [abbreviations](#) are explained at the start of the report and a [glossary](#) with definitions of common terms drawn from questionnaire responses is available at the end of the report.

***I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true.***

Sarah Scobie, Acting Director of Research, Nuffield Trust  
29 April 2024

# Summary of survey respondents

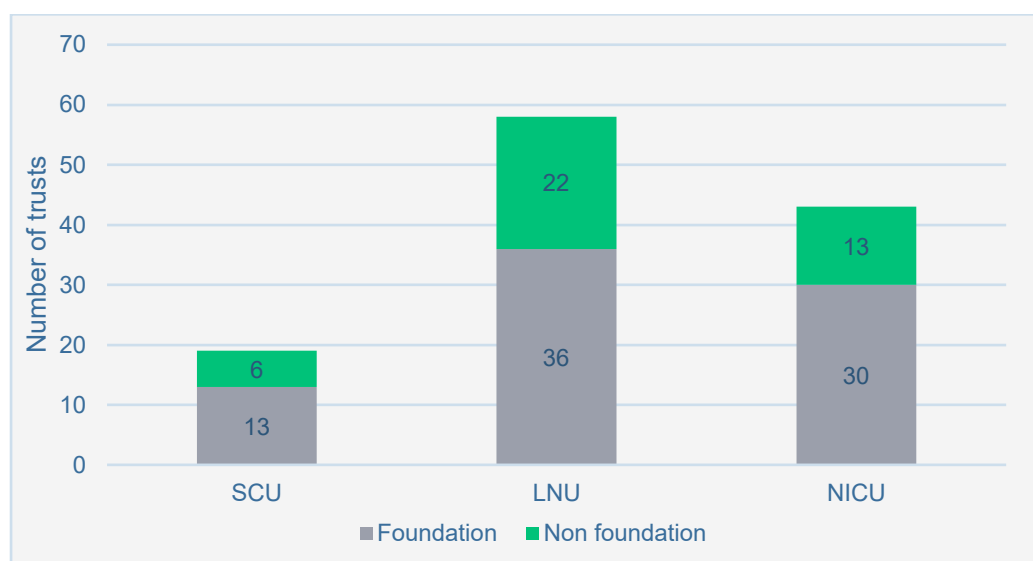
This section of the report describes who responded to the questionnaires at both the trust and respondent level.

Neonatal units are categorised based on the level of care they can provide<sup>1</sup>. Special care units (SCU) support babies with less intensive needs, local neonatal units (LNU), provide a higher level of support, and neonatal intensive care units (NICU), care for babies requiring more intensive support, over longer time frames. Almost all NHS trusts that run acute hospitals provide some form of neonatal care. Smaller, less specialised neonatal units work as part of a network with more specialised centres, who will care for babies with highest levels of need. Some NHS trusts will provide neonatal care at more than one hospital. NHS Trusts with larger and more specialised units will also provide care to babies with less intensive needs.

## Description of trusts

Questionnaires were received from 120 NHS Trusts, of which 79 were [foundation trusts](#), and 41 non-foundation trusts. The distribution of trusts based on the level of care they provide is shown in Figure 1 below. Three trusts are specialist trusts (093, 022, 017) while the remainder are general acute trusts.

Figure 1: Trusts included in the study by level of care and type of NHS trust



<sup>1</sup> Bliss (no date). 'How does neonatal care work?' <https://www.bliss.org.uk/parents/in-hospital/about-neonatal-care/how-does-neonatal-care-work>

More specialised units have a consistently higher number of cots, although there is variation in size within each type of care (Table 1). The questionnaire responses are in line with data on bed days reported by the national neonatal audit<sup>2</sup>, and reflect the guidelines for volumes of activity<sup>3</sup> which require more specialised units to care for a larger number of babies.

Table 1: Distribution of number of cots across trusts by type of care provided

Type of care	Number of trusts	Minimum number of cots	Maximum number of cots	Average number of cots/trust
SCU	19	6	22	11.6
LNU	58	10	44	22.7
NICU	43	10	109	41.7
<b>All trusts</b>	<b>120</b>	<b>6</b>	<b>109</b>	<b>27.7</b>

## Description of individual respondents

Trusts were asked to provide separate questionnaire responses from the trust medical director and a non-clinical director with responsibility for the trust's neonatal services.

Three quarters of trusts did provide two separate questionnaires, while 16 provided a joint response (a questionnaire signed by two or more respondents) and a further 13 provided a single questionnaire. Trusts with a NICU were most likely to provide two separate responses (Table 2).

Several trusts noted that additional insights had been provided by other colleagues in the trust, including neonatal service specialists or clinicians, and trust wide roles covering governance, patient safety, patient advice and liaison, chaplaincy, and human resources. Among the trusts which provided a single response, three were completed by the medical director, four by a non-medical role, and the respondents from six trusts were not identified.

Even when trusts provided two questionnaires, the responses to most questions were identical or very similar. We examined questions on culture, working relationships and regulation of managers to ascertain if there were differences between respondents. This is discussed within the relevant sections in the report.

<sup>2</sup> National Neonatal Audit Programme 2022 Data: Extended Analysis Report. RCPCH: London [rcpch.ac.uk/sites/default/files/2023-10/nnap\\_2022\\_data\\_extended\\_analysis\\_report\\_v1.0.pdf](https://rcpch.ac.uk/sites/default/files/2023-10/nnap_2022_data_extended_analysis_report_v1.0.pdf)

<sup>3</sup> British Association of Perinatal Medicine (2022) 'Service and Quality Standards for Provision of Neonatal Care in the UK' [Service and Quality Standards for Provision of Neonatal Care in the UK | British Association of Perinatal Medicine \(bapm.org\)](https://www.bapm.org/)

Table 2: Questionnaires received by level of neonatal care

<b>Response</b>	<b>SCU</b>	<b>LNU</b>	<b>NICU</b>	<b>Total</b>
2 distinct survey responses	13	40	38	91
Joint response - two or more signatories	2	11	3	16
Single response - single questionnaire	4	7	2	13
<b>Total</b>	<b>19</b>	<b>58</b>	<b>43</b>	<b>120</b>

The medical responses were from primarily from chief medical officers or medical directors (Table 3).

Table 3: Roles of medical respondents

<b>Role type</b>	<b>Number</b>
Chief medical officer	63
Medical director	38
Executive or group medical director	8
Deputy medical director	1
Single response or role unclear	10
<b>Total</b>	<b>120</b>

Respondents in non-medical roles were more varied, covering 45 different job titles. Types of role are summarised in Table 4 below.

Table 4: Roles of non-medical respondents

<b>Role type</b>	<b>Number</b>
Operations or chief operations director or deputy director	68
Divisional manager or director with responsibility for neonatal care	19
Specialist manager or director (such as governance, finance, nursing)	12
Chief or deputy chief executive	9
Non-executive director	3
Single response or role unclear	9
<b>Total</b>	<b>120</b>

Trusts were asked to provide copies of policy documents (see [Trust policies](#)) and some also provided additional information in support of their answers. A total of 1,112 documents were received from trusts. In addition, some trusts embedded policy or other documents within their questionnaire.

# Governance and accountability

In this section we report on responses about governance and accountability. It responds to questions 2 and 4 in the questionnaire.

## Questions asked of trusts:

2. Please describe, in general terms, the management and governance structures within the trust, the role of the trust board, committees that report to the trust board and, where relevant, NHS Governors.

4. Please explain to whom the trust board is accountable?

## Context for this section

- Governance and accountability for NHS organisations is based on a combination of legislation and guidance and differs depending on whether the organisation is an NHS foundation trust or not. While all trusts will have a board, NHS foundation trusts also have a Council of Governors, which is an elected body which holds the non-executive directors to account.
- The 'Code of Governance for NHS provider trusts' sets out "a common overarching framework for the corporate governance of trusts, reflecting developments in UK corporate governance and the development of integrated care systems." It applies to both foundation and non-foundation trusts. Trusts are required to comply with the code and in cases where they do not, explain why.<sup>4</sup>
- Some aspects of governance are required by legislation (such as needing committees for appointments and remuneration and audit), while others are decisions for the trust (such as how to configure clinical services).
- Integrated Care Systems (ICSs) are local partnerships which were legally established in 2022.<sup>5</sup> There are 42 ICSs in England. Each ICS has an Integrated Care Board (ICB) which is a group of leaders of local NHS organisations responsible for planning health services for the local population.<sup>6</sup>
- Neonatal services are commissioned directly by NHS England, based on a national service specification<sup>7</sup>.

<sup>4</sup> NHS England (2022) 'Code of governance for NHS provider trusts' <https://www.england.nhs.uk/publication/code-of-governance-for-nhs-provider-trusts/>

<sup>5</sup> NHS England (no date) 'What is integrated care?' <https://www.england.nhs.uk/integratedcare/what-is-integrated-care/>

<sup>6</sup> NHS England (no date) 'What is integrated care?' <https://www.england.nhs.uk/integratedcare/what-is-integrated-care/>

<sup>7</sup> NHS England, Service specification: neonatal critical care <https://www.england.nhs.uk/publication/service-specification-neonatal-critical-care/>

## Structures for management and governance

In their responses to this question trusts mostly described 'corporate governance' structures and referred to management and governance of the trust as a whole, rather than the neonatal unit specifically.<sup>8</sup> Some trusts referred to additional documents such as policies and organisational charts they had submitted alongside their questionnaire responses. For the purposes of this report, we have not analysed those supplementary documents.

The level of detail provided in response to this question was variable. Some respondents focused mainly on describing the role of the board, executive and non-executive directors, and governors, while others provided more detail about the layers of governance sitting under the board (such as committees), what they were responsible for and how frequently they met.

A key difference in responses related to whether the trust was a foundation trust or not, and therefore whether it had a Council of Governors.

*"[The trust] is not a foundation Trust and therefore does not have NHS Governors. The Trust operates a standardised operating model in line with other acute healthcare providers." (084)*

All respondents discussed the board and its members such as the role of the chair, executive and non-executive directors, and how they work with an executive team. Some also described how often they meet (whether in public or privately). A few referred to the board as being 'unitary' and therefore its members having equal voting rights. A couple of trusts noted that they operated a 'board in common' model and also meet with other trusts (080, 115).

The role and responsibility of the board was described in various ways including:

- *"...strategic development, approving policy and monitoring performance and setting culture" and... "ensuring the delivery of effective financial stewardship, high standards of clinical and corporate governance and promoting effective relations with the local community served by the Trust." (020)*
- *"...to design and then implement agreed priorities, objectives, and the overall strategy of the NHS foundation trust..." (055)*
- *"...to govern effectively and in doing so build patient, public and stakeholder confidence that their health and healthcare is in safe hands." (064)*
- *"At an overall level, responsibility for governance is held by the Board. The Board is accountable for ensuring that the right culture, systems, and procedures are in place to enable appropriate governance, including establishing committees of the Board as required." (095)*
- *"...to set the strategic direction of the Trust; to govern the organisation effectively and to ensure that the Trust is providing safe, high quality, patient-centred care." (005)*
- *"To set strategy, lead the organisation, oversee operations and be accountable to stakeholders in an open and effective manner. The Trust Board therefore has a role in holding the organisation to account for delivery of the strategy as*

<sup>8</sup> 'Corporate governance' is "the means by which boards lead and direct their organisations so that decision-making is effective, risk is managed and the right outcomes are delivered." NHS England (2022) 'Code of governance for NHS provider trusts' <https://www.england.nhs.uk/publication/code-of-governance-for-nhs-provider-trusts/>

*well as seeking assurance that the systems of control are robust and reliable.”*  
(073)

Most trusts also referred to committees in their responses. Their role was described as providing support, insight, and assurance to the board. As noted above, committees such as, ‘*Audit and Remuneration*’, are required by legislation whereas others are for the trust to organise. As such, the exact number and organisation of committees varied as did the frequency of which they met and who acted as the committee’s chair. Other committees referred to by several included ‘*Quality and Safety*’, ‘*People and Organisational Development*’, ‘*Research*’. Those committees referred to by a smaller number of respondents included ‘*Integration*’, ‘*Safeguarding*’, ‘*Equality, Diversity and Inclusion*’ and ‘*Patient and Carer Experience*.’

Some respondents described recent changes that had been put in place, which they considered strengthened governance arrangements, such as additional governance committees and groups.

*“To support delivery of the entirety of the obligations of the Board, the Board has six committees acting with delegated authority. The committees are Quality, Audit, Remuneration, Charitable Funds, Finance, and People. Each committee has terms of reference approved by the Board and reports to the Board on the work that it undertakes.”* (025)

*“The Trust’s governance structure was strengthened during 2022-23 to provide a greater focus on culture, patient safety and quality through three assurance committees of the Board: Insight Committee with a focus on operations, finance and organisational risk; Involvement Committee on people and organisational development and Improvement Committee on quality, patient safety and change management.”*  
(058)

*“The Maternity Assurance Group was set up in response to the second Ockenden report and its recommendations. The group covers matters relating to maternity and neonatal services. It is chaired by the Trust Chair and attended by the CMO and CNO (together, the three Board Level maternity and neonatal safety champions).”* (016)

Several trusts also provided detail on how their clinical areas were organised. The exact terminology and how this was divided varied (for example ‘*Divisions*’, ‘*Clinical Service Units*’, ‘*Clinical collaboratives*’ or ‘*Care Groups*’). Where the location of neonatal services was specified, this included ‘*Women and Children’s*’, ‘*Paediatrics and Neonates*’, ‘*Family Care*’ and ‘*Family Health*’. Some trusts provided detail on their leadership model within their clinical structures, referring to a ‘triumvirate’ model including clinical, nursing, and operational staff. A few referred to adopting a ‘quadrumvirate’ leadership model within these divisions, and some trusts also referred to their corporate divisions.

Some trusts provided detail on governance regarding quality and safety, with some referring to a ‘ward to board’ assurance model. This aims to ensure that NHS boards are connected with service delivery.<sup>9</sup> Some trusts provided information about how the neonatal unit fits within the wider governance structure in the trust noting the role of meetings or individuals, how this information is fed back up to the board and the role of board level Maternity and Neonatal Safety Champions. Further information is provided

<sup>9</sup> NHS Providers (2015) ‘Ward to Board assurance’ <https://nhsproviders.org/media/1162/preproq-ward-to-board-2.pdf>

in the sub-section [Structures and processes for reporting and investigating concerns/complaints](#).

*“The Neonatal Units are part of the Directorate of Paediatrics and Neonates. There are Paediatric and Neonatal Governance meetings that feed into the Paediatric Board Meeting. The Neonatal Service provides an update at the Paediatric Board meeting quarterly.” (119)*

*“For Neonatal service, the local governance and risk meeting feeds into the Maternity / Neonatal Scrutiny committee which then feeds up into the Board Quality Committee which is chaired by a Trust Board [non-executive director].” (038)*

*“The Women, Children and Young Peoples care group was created by the amalgamation of the Women’s services and Children and Young people management teams. This merger creating a single management team led by a Triumvirate of Managing Director, Director of Midwifery and Associate Medical Director has provided the opportunity for more collaborative working.” (068)*

## Board accountability

Trusts referred to a range of external organisations in their responses relating to accountability for different aspects of their work. This included – for example: commissioning, performance, finances, quality and/or safety (see for example 056). Some distinguished between accountability at national and local levels, and others also distinguished formal from informal forms of accountability (see for example 091).

*“We consider NHS trust boards to be accountable to several stakeholders and entities. They include:*

- Secretary of State for Health and Social Care: Ultimately, NHS trust boards are accountable to the Secretary of State for Health and Social Care. The Secretary of State has overall responsibility for the functioning of the NHS and holds ultimate authority over its policies and operations.*
- NHS England: NHS England is the body responsible for overseeing the commissioning of healthcare services in England. Trust boards are accountable to NHS England for the delivery of services outlined in their contracts and for meeting performance targets and standards.*
- Care Quality Commission (CQC): The CQC is the independent regulator of health and social care services in England. NHS trust boards are directly accountable to the CQC for the quality and safety of the services they provide. The CQC conducts inspections and assessments to ensure that healthcare providers meet regulatory standards.” (056)*

*“Our accountability as an NHS Trust Board is multifaceted, involving oversight from national and local bodies, as well as active engagement with patients, the public and staff.” (080)*

*“All NHS foundation trusts and their Boards are accountable to their local communities through their members and governors. They are also accountable to their commissioners (ICBs etc) through contracts. Nationally, they are accountable to Parliament, the Care Quality Commission (CQC), NHS England and the Department of Health.” (020)*

*“Fundamentally the Trust Board is accountable to the population who rely on the Trust for their health care needs. This relationship should form the basis for any decision made that relates to providing health care and Board members should always have this in mind. Formally and structurally, the Board is accountable to the department of health through NHS England. In this way, the DOH’s and NHSE’s relationship with government and through them the electorate creates an alignment of accountability.” (091)*

*“The population we serve. We are held to account by NHSE and our regulators (CQC and others).” (103)*

Given this, trusts referred to several organisations and/or individuals in their responses. These were not mutually exclusive, and unlikely to be comprehensive, given the variable levels of detail provided. Though the majority focused on the trust as a whole, four trusts noted the role of the Local Maternity and Neonatal System in their response, and two referred to the Operational Delivery Network (ODN). One (a specialist trust) described their relationship with specialised commissioning.

Organisations or bodies (and the number of trusts which mentioned them) included:

- NHS England and/or NHS regional teams (90/120)
- Council of Governors (and or members) (74/120)
- Integrated Care Boards and/or Integrated Care Systems (57/120)
- The public/ patients/ local population/ community (57/120)
- Care Quality Commission (53/120)
- Parliament (27/120)
- Secretary of State for Health and Social Care (21/120)
- Department of Health and Social Care (18/120)

18 trusts referred to being accountable to other external organisations in the health system. These included: professional regulatory bodies; Local Maternity and Neonatal System (LMNS); the Operational Delivery Network (ODN); the Health and Safety Executive; the Parliamentary and Health Service Ombudsman; Healthwatch; Information Commissioners’ Office (ICO); the Medicines and Healthcare Products Regulatory Agency (MHRA); the Human Tissue Authority; local provider collaboratives; and the press.

Differences in responses mostly related to the level of detail provided, with some providing single word or phrase responses, such as “regulators”, “all relevant statutory agencies” or “our commissioners” without further detail. Further, some trusts focused on briefly describing the board’s accountability depending on its status as a Foundation trust or not. Alternatively, others provided more detail on the interaction between Integrated Care Boards and NHS England, and between NHS England and Parliament/ Secretary of State with regards to how responsibility is “delegated” between these bodies or using words like “via” or “through”.

Examples of responses illustrating the range of accountabilities and organisations which trusts described, and varying levels of detail are provided below:

*“NHS Foundation Trusts Boards are accountable to their local communities through their members and governors, their commissioners (now the Integrated Care Board or ICB) through contracts, Parliament, the Care Quality Commission (CQC Registration) and NHSE (Provider Licence).” (055)*

*“The Secretary of State for Health has statutory responsibility for the health of the population of England and uses statutory powers to delegate functions to NHS authorities and Trusts Boards, who are accountable to the Secretary of State and to Parliament. The Board shapes the strategy and holds its staff to account for delivering this and is responsible for assuring that risks are managed and mitigated effectively. Performance and oversight is provided by the ICB and NHS England.” (071)*

*“The Board is accountable to the Trust’s public and service users, and to its staff and other stakeholders, through a membership model. Public and staff members elect (and stakeholder organisations appoint) governors. Collectively, the Governors meet as a Council to hold the Board – through the Non-Executive Directors – to account, four times per annum. Four sub-committees support the Council in this work. The Foundation Trust (and therefore the Board) is also accountable to the ICB, as our commissioner, for delivery of services in line with specified service levels, quality standards and agreed plans (including financial plans). In regulatory terms, the Trust has an operating license from NHS England and is overseen by both the ICB and NHS England with respect to adherence to that license and sound stewardship of services, governance and finance, in line with a national oversight framework. The Care Quality Commission inspects and monitors the quality of services provided by the Trust and registers the Trust to undertaken specific services.” (043)*

## Nuffield Trust reflections

Governance and accountability for NHS organisations is based on a combination of legislation and guidance and differs depending on whether the organisation is an NHS Foundation trust or not. Some aspects of governance are set out in law while others are within the remit of the trust to organise (See [Additional references](#) below for examples). This was reflected in trusts’ responses to the questionnaire, which described a range of governance arrangements, ways of configuring clinical services, and organising committees.

Previous work has shown that accountability in the NHS is a complex question, particularly following structural reorganisations.<sup>10</sup> This complexity was reflected in the responses to the questionnaire with trusts describing numerous organisations and routes for which they are held to account for different aspects of the services they provide.

Overall, the level of detail provided was variable, but the majority referred to NHS England and/or its regional teams, and almost half referred to local Integrated Care Boards/ Systems and/or the local population or community. Foundation trusts also noted role of the Council of Governors. Almost half of trusts also referred to the Care Quality Commission.

<sup>10</sup> Dayan (2016) ‘Who is accountable in the NHS?’ <https://www.nuffieldtrust.org.uk/news-item/who-is-accountable-in-the-nhs>

## Additional references

- NHS England (2022) 'NHS England Standing Orders' <https://www.england.nhs.uk/wp-content/uploads/2016/06/standing-orders-approved-march-2022.pdf>
- NHS England (2023) 'NHS Oversight Framework' <https://www.england.nhs.uk/nhs-oversight-framework/>
- NHS England (2023) 'NHS Provider Licence' <https://www.england.nhs.uk/wp-content/uploads/2023/03/PRN00191-nhs-provider-licence-v4.pdf>
- Care Quality Commission (2024) 'What is registration?' <https://www.cqc.org.uk/guidance-regulation/providers/registration/what-registration>
- Monitor (2013) 'Your statutory duties A reference guide for NHS foundation trust governors' [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/284473/Governors\\_guide\\_August\\_2013\\_UPDATED\\_NOV\\_13.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/284473/Governors_guide_August_2013_UPDATED_NOV_13.pdf)

# Trust policies

This section covers questions 30-32 in the questionnaire, in which respondents were asked for copies of policy documents related to: Safeguarding policies for babies; Investigating a neonatal death; Freedom to Speak Up Guardians and/or any other policies relating to the escalation of concerns; Whistleblowing; and Complaints.

## Questions asked of trusts

30. Please provide copies of the trust's current policies in relation to the following: a. Safeguarding policies for babies; b. Investigating a neonatal death; c. Freedom to Speak Up Guardians and/or any other policies relating to the escalation of concerns; d. Whistleblowing; and e. Complaints.

31. In relation to the provision of incidents, concerns or complaints relating to the neonatal service how often have these policies been used between 19 October 2022 and 19 October 2023 and with what effect?

32. Have those policies been reviewed in light of the Lucy Letby case at any point and, if so, what changes, if any, have been recommended and or implemented?

## Context for this section

- NHS England issued a letter<sup>11</sup> to the NHS in response to the verdict of the trial of Lucy Letby on 18 August 2023. The letter described recent national safeguarding policies and actions, such as the national roll out of medical examiners in 2021, the strengthened guidance on the Freedom to Speak Up national policy in 2022, and the on-going improvements that were being made to the national safety reporting system with the introduction of Patient Safety Incident Response Framework (PSIRF)<sup>12</sup>, which replaced the Serious Incident Response Framework<sup>13</sup>.
- The letter encouraged actions on governance, which could have been incorporated into policy reviews and updates – particularly within the Freedom to Speak Up policy. The letter specified that NHS leaders and boards ensure the following:
  1. All staff have easy access to information on how to speak up.
  2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
  3. Approaches or mechanisms are put in place to support those members of staff who may have cultural or other barriers to speaking, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with

<sup>11</sup> NHS England, 2023, Verdict in the trial of Lucy Letby, <https://www.england.nhs.uk/long-read/verdict-in-the-trial-of-lucy-letby/>

<sup>12</sup> NHS England (no date) Patient Safety Incident Response Framework' <https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/>

<sup>13</sup> NHS England (no date) Serious Incident Framework <https://www.england.nhs.uk/patient-safety/serious-incident-framework/>

staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
  5. Boards are regularly reporting, reviewing and acting upon available data.
- Complaints policies are meant to enact The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009<sup>14</sup> and often reflect the Parliamentary and Health Service Ombudsman's Principles of Good Complaint Handling Guidance<sup>15</sup>
  - At the time of the survey in autumn 2023, all trusts were expected to have transitioned to the Patient Safety Incident Response Framework (PSIRF<sup>16</sup>).<sup>17</sup> This is the NHS's new approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving. PSIRF encourages a systems-based view of patient safety (rather than looking for a single cause or point of failure, which is common in the root cause analysis typically work done during patient safety investigations). The PSIRF is a contractual requirement under the NHS Standard Contract and as such is mandatory for neonatal services.
  - In 2022, NHS England strengthened the national Freedom to Speak Up (FTSU) policy, providing a clear template for NHS organisations' own policies.<sup>18</sup> All organisations providing NHS services were expected to have adopted the updated national policy by January 2024 at the latest.

## Description of five requested policies

Many of the policies submitted by respondents were lengthy and spanned numerous sections. As most policies were meant to cover the entire trust or larger groups of patients beyond neonates (for example all children and young people), the topics covered in the policies were generic but comprehensive. For example, a safeguarding children and young people (including unborn babies) policy was 56 pages long and covered any potential safeguarding concern from parents with a learning disability through to children and young people that have sustained a dog bite through to female genital mutilation (046). That said, there were succinct examples of policies, most of which were Freedom to Speak Up or whistleblowing policies. See for example, trust 027's Freedom to Speak Up policy, which was six pages long and included clear language and visuals.

It is noteworthy that many trusts reported their whistleblowing and Freedom to Speak Up documents were one in the same. One trust that sought advice on the matter reported the National Guardian's office (NGO) advocate had reviewed their Trust Freedom to Speak Up Policy and said the trust did not need a separate whistleblowing policy (059).

<sup>14</sup> The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 <https://www.legislation.gov.uk/uksi/2009/309/contents/made>

<sup>15</sup> Parliamentary and Health Service Ombudsman (2009) 'Principles of Good Complaint Handling' <https://www.ombudsman.org.uk/about-us/our-principles/principles-good-complaint-handling>

<sup>16</sup> 'NHS England (no date) Patient Safety Incident Response Framework' <https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/>

<sup>17</sup> 'NHS England (no date) Patient Safety Incident Response Framework' <https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/>

<sup>18</sup> NHS England (2022) 'The national speak up policy' <https://www.england.nhs.uk/publication/the-national-speak-up-policy/>

Table 5 below summarises the key sections of policies and what was included in them. The table draws from the sample of trusts that reported they made changes to their policies (and these policies were accessible), rather than the full sample of submitted documents. The sources of policies we examined included:

- Safeguarding (018, 046, 073, 119)
- Investigating a neonatal death (008, 018, 027, 031, 034, 073, 107)
- Freedom to Speak up / Whistleblowing (018, 031, 035, 067, 069, 080, 118)
- Complaints (001, 012, 018, 020)

Table 5: Common features of the five requested policies

	Safeguarding policies for babies	Investigating a neonatal death	Whistleblowing / Freedom to Speak Up Guardians	Complaints
<b>Introduction and purpose of policy and policy objectives</b>				
<b>Legal underpinning or national guidance</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Children Act (2004)</li> <li><input type="checkbox"/> Working Together to Safeguard Children (2018, updated 2020)</li> <li><input type="checkbox"/> RCPCH Child Protection Companion</li> <li><input type="checkbox"/> National Institute for Clinical Excellence (NICE) 'When to suspect Child Maltreatment' (July 2017)<sup>19</sup></li> <li><input type="checkbox"/> The Health and Social Care Act 2008 (Registration of Regulated Activities) Regulations 2014: Regulation 13 sets out clear standards for the safeguarding of vulnerable children.</li> <li><input type="checkbox"/> CQC 'Guidance for providers on meeting the regulations' – March 2015<sup>20</sup></li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> National guidance on learning from deaths<sup>21</sup></li> <li><input type="checkbox"/> National Guidance on Learning from Deaths for Trusts (2018)<sup>22</sup></li> <li><input type="checkbox"/> Working Together to Safeguard Children statutory guidance (2023)<sup>23</sup></li> <li><input type="checkbox"/> NHS England: National medical examiner system<sup>24</sup></li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Employment Rights Act (1996)</li> <li><input type="checkbox"/> Public Disclosure Interest Act (1998)</li> <li><input type="checkbox"/> NHSE national 'raising concerns' (whistleblowing) policy</li> <li><input type="checkbox"/> Public Disclosure Interest Act (1998)</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Local Authority, Social Services and National Health Service Complaint Regulations 2009</li> <li><input type="checkbox"/> Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2009 and 2014 Regulations)</li> <li><input type="checkbox"/> Parliamentary and Health Service Ombudsman (detailed) guidance<sup>25</sup></li> <li><input type="checkbox"/> Local Government Ombudsman, Healthwatch and PHSO 'My expectations for raising concerns and complaints'<sup>26</sup></li> <li><input type="checkbox"/> NHS Complaint Standards: Model Complaint Handling Procedure for providers of NHS services in England (2022)</li> </ul>

<sup>19</sup> National Institute for Health and Care Excellence (2009) 'Child maltreatment: when to suspect maltreatment in under 18s' <https://www.nice.org.uk/guidance/CG89>

<sup>20</sup> The CQC sets out requirements for organisations to minimise the risk of abuse by having effective systems and processes in place, which are subject to both internal and external scrutiny. See Regulation 13: Safeguarding service users from abuse and improper treatment. <https://www.cqc.org.uk/guidance-regulation/providers/regulations>

<sup>21</sup> [nqb-national-guidance-learning-from-deaths.pdf \(england.nhs.uk\)](https://www.nhs.uk/england/national-guidance-learning-from-deaths.pdf)

<sup>22</sup> NHS England 'National Guidance on Learning from Deaths' <https://www.england.nhs.uk/publication/national-guidance-on-learning-from-deaths/>

<sup>23</sup> <https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>

<sup>24</sup> <https://www.england.nhs.uk/patient-safety/patient-safety-insight/national-medical-examiner-system/>

<sup>25</sup> <https://www.ombudsman.org.uk/organisations-we-investigate/nhs-complaint-standards>

<sup>26</sup> [https://www.ombudsman.org.uk/sites/default/files/Report\\_My\\_expectations\\_for\\_raising\\_concerns\\_and\\_complaints.pdf](https://www.ombudsman.org.uk/sites/default/files/Report_My_expectations_for_raising_concerns_and_complaints.pdf)

<p><b>Other linked trust policies</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Safeguarding Children and Young People – Roles and Competencies for NHS Staff Intercollegiate Document 2006, 2010, updated 2019.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Neonatal Bereavement Guideline</li> <li><input type="checkbox"/> Paediatric Palliative Care in Proven or Suspected COVID-19 infection</li> <li><input type="checkbox"/> Sudden Unexpected Deaths in Infancy and Childhood (0-18 years)</li> <li><input type="checkbox"/> When a Child or Young Person Dies Expectedly in the Community</li> <li><input type="checkbox"/> Policy for the Management, Reporting and Investigation of Adverse Incidents (including Serious Incidents)</li> <li><input type="checkbox"/> Process for Reporting the Death of a Child or Young Person,</li> <li><input type="checkbox"/> Being Open and Duty of Candour Policy</li> <li><input type="checkbox"/> Policy for the Care of the Body After Death (Last Offices)</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Grievance Policy and Procedure</li> <li><input type="checkbox"/> Fraud Policy and Response Plan</li> <li><input type="checkbox"/> Disciplinary Procedure</li> <li><input type="checkbox"/> Dignity &amp; Respect at Work</li> <li><input type="checkbox"/> Policy On Standards Of Business Conduct And Ethical Standards</li> <li><input type="checkbox"/> For Commercial Sponsorship</li> <li><input type="checkbox"/> Social Media Policy</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Incidents including Serious Incidents</li> <li><input type="checkbox"/> PALS guidance</li> </ul>
<p><b>Explanation of terms / Definitions</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Child</li> <li><input type="checkbox"/> Child maltreatment</li> <li><input type="checkbox"/> Child protection</li> <li><input type="checkbox"/> Significant harm</li> <li><input type="checkbox"/> Child and young person</li> <li><input type="checkbox"/> Child in need</li> <li><input type="checkbox"/> Child Subject to a Child Protection Plan</li> <li><input type="checkbox"/> Child protection</li> <li><input type="checkbox"/> Early Help</li> <li><input type="checkbox"/> Safeguarding</li> <li><input type="checkbox"/> Significant harm</li> <li><input type="checkbox"/> See 018 p9 for links to other key words (such as neglect, domestic abuse)</li> <li><input type="checkbox"/> See 046 p7 'Management of child/young person safeguarding concerns'</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Adverse incident</li> <li><input type="checkbox"/> Avoidable death</li> <li><input type="checkbox"/> Case record review</li> <li><input type="checkbox"/> Child</li> <li><input type="checkbox"/> Child Death Overview Panel</li> <li><input type="checkbox"/> Datix</li> <li><input type="checkbox"/> Electronic death certifications (EDC) form</li> <li><input type="checkbox"/> Hospital standardised mortality ratio (HSMR)</li> <li><input type="checkbox"/> HSIB</li> <li><input type="checkbox"/> Incident Review Group</li> <li><input type="checkbox"/> Joint Agency Response</li> <li><input type="checkbox"/> Learning disability</li> <li><input type="checkbox"/> MBRRACE-UK</li> <li><input type="checkbox"/> Medical Examiners</li> <li><input type="checkbox"/> Morbidity</li> <li><input type="checkbox"/> Mortality</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Anonymity</li> <li><input type="checkbox"/> Anonymous</li> <li><input type="checkbox"/> Member of staff</li> <li><input type="checkbox"/> Serious Concern</li> <li><input type="checkbox"/> Whistleblower</li> <li><input type="checkbox"/> Whistleblowing</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Carer</li> <li><input type="checkbox"/> Complainant</li> <li><input type="checkbox"/> Complaint</li> <li><input type="checkbox"/> Datix</li> <li><input type="checkbox"/> Litigant in Person</li> <li><input type="checkbox"/> Local Resolution Meeting</li> <li><input type="checkbox"/> Parliamentary and Health Service Ombudsman</li> <li><input type="checkbox"/> Patient</li> <li><input type="checkbox"/> Patient Advice and Liaison Service (PALS)</li> <li><input type="checkbox"/> Patient Experience Officers / Leads (complaint handlers)</li> <li><input type="checkbox"/> Patient Safety Incident</li> <li><input type="checkbox"/> Quality assurance</li> </ul>

		<ul style="list-style-type: none"> <li><input type="checkbox"/> Mortality lead</li> <li><input type="checkbox"/> Mortality outlier</li> <li><input type="checkbox"/> Neonatal death</li> <li><input type="checkbox"/> Perinatal death</li> <li><input type="checkbox"/> PMRT</li> <li><input type="checkbox"/> Safeguarding practice review</li> <li><input type="checkbox"/> Severe mental illness</li> <li><input type="checkbox"/> SI</li> <li><input type="checkbox"/> Stillbirth</li> <li><input type="checkbox"/> Structured judgement review</li> <li><input type="checkbox"/> Sudden unexpected death in infancy (SUDI)</li> <li><input type="checkbox"/> Summary hospital-level mortality indicator (SHMI)</li> </ul>		
<p><b>Roles and responsibilities</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Approving group (for example, Integrated Safeguarding Committee)</li> <li><input type="checkbox"/> Associate Director of Safeguarding</li> <li><input type="checkbox"/> Chief executive officer</li> <li><input type="checkbox"/> Chief people officer</li> <li><input type="checkbox"/> Clinical lead for Paediatrics / Clinical Director for Paediatrics</li> <li><input type="checkbox"/> Designated Doctor and Designated Nurse for Safeguarding Children</li> <li><input type="checkbox"/> Director of Nursing</li> <li><input type="checkbox"/> Divisional operations directors / Divisional Director of Nursing</li> <li><input type="checkbox"/> Lead nurse for safeguarding</li> <li><input type="checkbox"/> Local authorities</li> <li><input type="checkbox"/> Local Safeguarding Children's Partnership</li> <li><input type="checkbox"/> Named doctor, nurse, and midwife</li> <li><input type="checkbox"/> Other executive directors</li> <li><input type="checkbox"/> Paediatric clinical effectiveness committee</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Timeframes and responsibilities (for example, within 1-2 hours of death, before the family leave or within 24 hours)</li> <li><input type="checkbox"/> Bereavement office</li> <li><input type="checkbox"/> Discharging consultant</li> <li><input type="checkbox"/> All consultants</li> <li><input type="checkbox"/> Care group patient outcome leads</li> <li><input type="checkbox"/> Site management teams</li> <li><input type="checkbox"/> Clinical directors</li> <li><input type="checkbox"/> Mortality monitoring committee</li> <li><input type="checkbox"/> Chief nursing officer</li> <li><input type="checkbox"/> Trust executive directors</li> <li><input type="checkbox"/> Trust non-executive directors</li> <li><input type="checkbox"/> Trust board</li> <li><input type="checkbox"/> Corporate medical director – patient outcomes</li> <li><input type="checkbox"/> Patient outcomes team</li> <li><input type="checkbox"/> Trust lead for adult safeguarding</li> <li><input type="checkbox"/> Trust liaison psychiatry lead</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Chair and Deputy Chair of the Governance Committee</li> <li><input type="checkbox"/> Chair of the trust,</li> <li><input type="checkbox"/> Chief executive officer</li> <li><input type="checkbox"/> Chief Finance Officer</li> <li><input type="checkbox"/> Chief Medical Officer</li> <li><input type="checkbox"/> Chief Nursing Officer</li> <li><input type="checkbox"/> Director of Governance</li> <li><input type="checkbox"/> Director of People</li> <li><input type="checkbox"/> Employees/Staff</li> <li><input type="checkbox"/> Freedom to Speak Up Guardians</li> <li><input type="checkbox"/> Governance Committee</li> <li><input type="checkbox"/> Investigating officer / Investigating team</li> <li><input type="checkbox"/> Line Managers</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Chief Executive</li> <li><input type="checkbox"/> Medical Director/Director of Nursing and Patient Experience</li> <li><input type="checkbox"/> Investigating Officer</li> <li><input type="checkbox"/> Complaints Manager</li> </ul>

	<ul style="list-style-type: none"> <li><input type="checkbox"/> Safeguarding children working group</li> <li><input type="checkbox"/> Safeguarding children's partnership</li> <li><input type="checkbox"/> Specialist professionals for safeguarding children</li> <li><input type="checkbox"/> The trust board</li> <li><input type="checkbox"/> Trust staff who have contact with children and their families</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Business Intelligence Unit</li> <li><input type="checkbox"/> Electronic Patient Record team</li> <li><input type="checkbox"/> Coding department</li> <li><input type="checkbox"/> Complaints team</li> <li><input type="checkbox"/> Patient safety team</li> <li><input type="checkbox"/> Clinical matrons/Clinical nurse managers</li> <li><input type="checkbox"/> Nursing staff, medical staff</li> <li><input type="checkbox"/> Consultant paediatrician/neonatologist</li> <li><input type="checkbox"/> Child death review facilitator</li> <li><input type="checkbox"/> Trust named doctor for child death review</li> <li><input type="checkbox"/> Medical examiner</li> <li><input type="checkbox"/> Key worker</li> <li><input type="checkbox"/> Neonatal unit manager</li> <li><input type="checkbox"/> Neonatal family support sister</li> <li><input type="checkbox"/> Neonatal staff</li> </ul>		
<p><b>Main content (including key internal contact details)</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Procedure for reporting safeguarding concerns</li> <li><input type="checkbox"/> Concerns about a child requiring early help response</li> <li><input type="checkbox"/> Safeguarding information sharing</li> <li><input type="checkbox"/> Child protection information sharing</li> <li><input type="checkbox"/> Bruising or injury in non-mobile infant or child</li> <li><input type="checkbox"/> Concerns about a child's welfare because of domestic abuse</li> <li><input type="checkbox"/> Concerns about the welfare of an unborn baby</li> <li><input type="checkbox"/> Identifying alerting features of child maltreatment</li> <li><input type="checkbox"/> Postnatal care of babies on a child protection plan</li> <li><input type="checkbox"/> Concerns about members of staff harming children</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Bereavement support, which is based on The National Bereavement Care Pathway</li> <li><input type="checkbox"/> Procedures (before death and after death)</li> <li><input type="checkbox"/> Multi-disciplinary communication</li> <li><input type="checkbox"/> Process for recording deaths in care</li> <li><input type="checkbox"/> Approaches for reviewing deaths: case record review and serious incident investigations</li> <li><input type="checkbox"/> Process for specific cases: infant or child deaths, stillbirths (for example, requirements for CDOP, reporting through PMRT, and submission to MBRRACE-UK online reporting system)</li> <li><input type="checkbox"/> Trust-level mortality monitoring and surveillance</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> How to raise a serious concern</li> <li><input type="checkbox"/> Key contacts</li> <li><input type="checkbox"/> What can I speak up about? Examples of concerns you should speak up about<sup>27</sup></li> <li><input type="checkbox"/> A safe culture of openness / our assurances to you</li> <li><input type="checkbox"/> What will happen once a concern has been raised?</li> <li><input type="checkbox"/> Who can speak up?</li> <li><input type="checkbox"/> Confidentiality (Anonymous concerns, confidential concerns)</li> <li><input type="checkbox"/> Management guidelines</li> <li><input type="checkbox"/> Investigation required</li> <li><input type="checkbox"/> Investigation process</li> <li><input type="checkbox"/> Trust Contact Details – Executive Directors, Non-Executive Director and Freedom to Speak Up Guardian</li> <li><input type="checkbox"/> Useful Contacts and Web Addresses</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> How to manage informal concerns</li> <li><input type="checkbox"/> How to manage formal complaints</li> <li><input type="checkbox"/> Time limits on initiating formal complaints</li> <li><input type="checkbox"/> Receipt and acknowledgement processes (for example, how often the board receives complaints reports vs. how often the 'Quality and Safety Committee' or the 'Experience and Engagement Group' reviews complaints)</li> <li><input type="checkbox"/> Registering a complaint</li> <li><input type="checkbox"/> Disseminating the complaint</li> <li><input type="checkbox"/> Categorisation and investigation of the complaint (for example, low, medium, high)</li> <li><input type="checkbox"/> Action to be taken by Investigating Officer</li> <li><input type="checkbox"/> Monitoring of complaints</li> </ul>

<sup>27</sup> NHS England Workforce, Training and Education 'Raising concerns' <https://www.youtube.com/watch?v=zjau1Ey0di8>

	<ul style="list-style-type: none"> <li><input type="checkbox"/> Difference of professional opinion</li> <li><input type="checkbox"/> Contact details for roles including extensions and bleep numbers</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Mortality outlier identification and investigation</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Where to speak up if you cannot talk to anyone in the trust (for example, CQC, NHSE, HEE, NHS Whistleblowing Helpline, Public Concern at Work advice service, National Guardian's office)</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> How to enact policy in-hours vs. out-of-hours (119)</li> </ul>
<b>Visual aids and tools</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> See trust 018 p5 'Key points of this policy' and p6 'Bruising and Injuries in non-mobile infants – what to do'</li> <li><input type="checkbox"/> See trust 046 p34 'What to do if you see a safeguarding flag'</li> <li><input type="checkbox"/> See trust 119 for helpful tips on how to deal with criminal investigations</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> See trust 018 p11 flowchart</li> <li><input type="checkbox"/> See trust 018 p4 'Key points of this policy'</li> <li><input type="checkbox"/> See trust 027 p2 'When a baby dies flow chart'</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> See trust 018 p5 'Key points of this policy' and p6 'Anonymous whistleblowing procedure'</li> <li><input type="checkbox"/> See trust 035 p16 for an investigation template to used for FTSU investigation reports</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> See trust 001 for flow chart</li> <li><input type="checkbox"/> See trust 020 for a decision tree</li> </ul>
<b>Aspects of policy likely rarely put into practice</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> There were a range of types of cases, some of which were likely very rare.</li> </ul>		<ul style="list-style-type: none"> <li><input type="checkbox"/> Right of appeal / further advice</li> <li><input type="checkbox"/> Still concerned, or worried about what will happen to you if you speak up (options to meet guardian outside of work)</li> <li><input type="checkbox"/> Dissatisfaction with investigation/outcome/FTSU Service</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> When a complainant remains dissatisfied</li> <li><input type="checkbox"/> Vexatious complaints</li> <li><input type="checkbox"/> Complaints involving other organisations</li> <li><input type="checkbox"/> Disciplinary procedures</li> <li><input type="checkbox"/> Complaints and litigation</li> <li><input type="checkbox"/> Risks of non-compliance</li> <li><input type="checkbox"/> Ensuring complainants, relatives and carers are not discriminated against</li> </ul>
<b>Learning, training, and staff support</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Training and supervision (levels 1-4) + provision of training</li> <li><input type="checkbox"/> Supervision and support for staff</li> <li><input type="checkbox"/> Child protection training within the Trust reflects the guidance within the Intercollegiate Document 2019, the Local Safeguarding Children Board/Partnerships' training strategies and Working Together 2018.</li> <li><input type="checkbox"/> Any Trust policies relating to working with children are informed by the same documents.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Capturing learning from deaths and ensuring improvement</li> <li><input type="checkbox"/> Supporting staff through the occupational health and wellbeing services, employee assistance programme</li> <li><input type="checkbox"/> Structured judgement review training offered by the Royal College of Physicians</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Training</li> <li><input type="checkbox"/> Monitoring and Compliance of the policy</li> <li><input type="checkbox"/> Health and wellbeing support</li> <li><input type="checkbox"/> NHS England Speaking up support scheme<sup>28</sup></li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Escalation of complaints</li> <li><input type="checkbox"/> Closing the loop – learning and implementing for change</li> <li><input type="checkbox"/> Training on handling complaints (for example, investigation skills, report writing skills, root cause analysis investigation)</li> <li><input type="checkbox"/> Monitoring compliance with policy (for example, titles and named review times, such as quarterly)</li> <li><input type="checkbox"/></li> <li><input type="checkbox"/></li> </ul>

<sup>28</sup> NHS England (no date) 'Speaking Up Support Scheme' <https://www.england.nhs.uk/ourwork/freedom-to-speak-up/speaking-up-support-scheme/>

	<input type="checkbox"/> Education/training and plan of implementation <input type="checkbox"/> Supporting staff			
<b>Patient support and patient rights</b>		<input type="checkbox"/> See bereavement policy above	<input type="checkbox"/> Advice and support (for example, mental health services for NHS staff) <sup>29</sup> <input type="checkbox"/> NHS Constitution	<input type="checkbox"/> Support for complainants (for example, reference to MIND, Mencap, Age UK) <input type="checkbox"/> Support for staff including those called as a witness <input type="checkbox"/> NHS Constitution
<b>Policies also typically ended with the following sections:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Processes for monitoring compliance with and effectiveness of the policy</li> <li><input type="checkbox"/> IG: Archiving arrangements, retention of files</li> <li><input type="checkbox"/> Equality impact assessment tool</li> <li><input type="checkbox"/> References</li> </ul>				

<sup>29</sup> NHS England (no date) 'Support available for our NHS people' <https://www.england.nhs.uk/supporting-our-nhs-people/support-now/>

## Use of trust policies

Regarding the use of policies during the timeline specified in the survey (Q32), respondents typically responded three ways:

- citing the numbers of incidents which had occurred and their type (for example, ‘*we used the FTSU policy once*’),
- reporting that policies are often or always used when required (for example, “*The above policies are effectively in use at all times to inform responses in the areas they cover.*” (035)), and/or
- reporting the information around policy use is not recorded (for example, “*We do not record the specific policies used when responding to a complaint, concern or incident.*” (025))

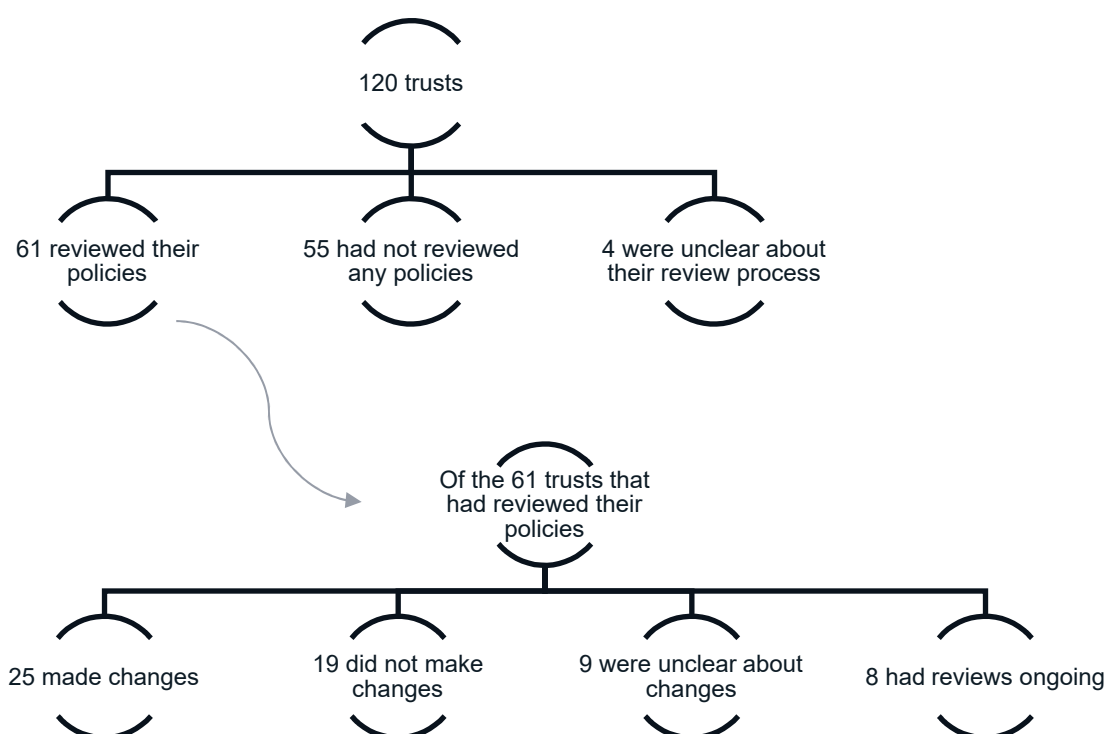
The responses to this question were not sufficiently similar to enable further analysis.

## Review of trust policies

Of the 120 trusts that responded to the questionnaire, about half (61 trusts) described having undertaken a review of at least one policy (or having an ongoing review underway during survey submission) since the verdict of the case in August 2023, whereas 55 reported not having done so (and four provided unclear responses or didn’t respond at all).

Of the 61 that had reviewed their policies, 25 trusts reported they had made changes, 19 reported they hadn’t made changes, nine were unclear in their responses about whether they had made changes and eight had ongoing reviews (and thus could not yet report on any changes). Figure 2: Breakdown of trusts that had vs. had not reviewed and changed policies below summarises the breakdown of trusts that had versus had not reviewed and changed at least one of their policies.

Figure 2: Breakdown of trusts that had vs. had not reviewed and changed policies



Regarding trusts having undertaken reviews of their policies, it is noteworthy that among the 61 trusts where reviews had taken place or were underway, 39 of them (64%) said their review was triggered by the Lucy Letby case. Their responses were often brief, but included explicit reference to the case:

*“All our policies and procedures are reviewed on a regular basis against current government legislation. The SFHFT Safeguarding Lead conducted a review of these policies (as listed in paragraph 30) as part of the Letby learnings.” (014)*

However, ten said their reviews of their policies were unrelated to the case and had instead been triggered by a cyclical review process or changes in national guidance. Another 12 were unclear in their response about their rationale for a review. An illustrative quote describing that guidance (rather than the case) had triggered a review follows:

*“Changes and amendments to the Children’s Safeguarding policy have been made in response to National, Regional and Local changes to procedures aimed to improve the safeguarding of children and young people.*

*Other policies are due to be reviewed as part of the transition to PSIRF, changes to our Risk reporting platform, PHSO standards and recommendations of early resolution and advocating meeting the client early where possible. All policies are within their review dates”. (018)*

Among the 55 trusts that had not yet reviewed their policies, some respondents alluded to being aware of the Lucy Letby case and/or explicitly mentioned keeping the inquiry's recommendations in mind during their next review process, writing that 'reviews would occur at an appropriate time later'. For example:

*"None of these policies have been reviewed since the outcome of the Lucy Letby case, however, the policy review process that the trust conducts with staff side and management colleagues will have this case in mind in the rolling review of our policies." (021)*

*"The Trust has not reviewed policies specifically since the Lucy Letby case. All policies are reviewed and updated regularly, and when any recommendations related to this case are released, they will be incorporated." (055)*

### **Instances of where no changes were made to policies**

The 19 respondents that reported they had reviewed their policies but not made any changes said that the policies were appropriate as they were. Respondents wrote:

*"All policies have been reviewed in light of the Lucy Letby case and no changes have been required." (110)*

*"The Child Death Policy was reviewed in light of the Lucy Letby case and was felt to be fit for purpose. The complaints policy was reviewed in November 2023 but no significant changes were made." (098)*

*"All policies attached in Q30 have been reviewed and updated since 2018 - no changes have been made in light of the Lucy Letby case." (090)*

*"There has been initial discussion through the neonatal network and no changes were felt to be necessary urgently given the degree of external scrutiny and review that has and is in place as a result of the Kirkup review. The consensus view was to continue to discuss this issue and ensure any changes to be considered are applicable and consistent across the network." (068)*

*"Recently updated guidelines are felt to provide an adequate level of oversight and therefore haven't been altered. The service had an existing robust process for review of incidents and neonatal deaths. There was already routine internal review of all neonatal deaths, with further review in [Perinatal Mortality Review Tool] and [Child Death Overview Panel] and the Neonatal Death Clinical Guideline for Neonatal Staff was updated in September 2023." (102)*

It is noteworthy that some of those 19 respondents went further to report that despite no changes being made at present, they would review their policies again once more information was available from the inquiry or further guidance or recommendations were made.

*"According to the Trust's version control processes, outlined within each policy, no policies have yet been reviewed specifically in light of the Lucy Letby case findings, but it is pertinent to comment that any key findings, outcomes or recommendations*

*from the Inquiry or any other relevant routes would likely be considered / included in policy amendments.” (026)*

*“Following receipt of information from NHS England in relation to the Lucy Letby case the Trust Freedom to Speak Up Policy and processes was reviewed and no changes made. As more information becomes available relevant policies and processes will be reviewed.” (008)*

*“All staff have been contacted and asked to be vigilant and to report anything untoward or which doesn't look right to their manager. There have not been any changes to policies at present although this will be kept under review.” (004)*

### **Instances where changes were made to policies**

25 trusts described the changes they had made to their policies, a summary of which are described below. It is noteworthy that the policies that underwent change extended beyond the five policies that were requested in the questionnaire.

#### **Safeguarding babies**

- introduced as a new policy (018)
- added a paragraph regarding escalations of concern and the role of the local authority designated officer (LADO) (046)
- clarified use of Child Protection Information Sharing system use for midwives (073)
- added indications about the point when antenatal or postnatal care should be engaged (073)

#### **Investigation of neonatal death policy**

- updated to allow one of three people to raise a concern following a neonatal death that is unexpected and unexplained, which will trigger an immediate Child Death Review Meeting (CDRM) (107)
- updated to include MBRRACE-UK guidance on signs of life following spontaneous birth before 23 weeks gestation (018)
- updated flowcharts, referral process and links (018)
- added requirements to note the names of professionals who cared for the baby in the 24 hours prior to their death (031)
- developed a new Neonatal death checklist to ensure all the correct procedures are followed and people identified (034)
- included the requirement to have oversight by the medical examiner and also the Child Death Overview Process (027)
- changed governance structure/ internal reporting processes to enable more detailed summaries and trends to reach the trust board (073)

#### **Additional changes made to policies relating to investigation of neonatal death policy:**

- produced a specific Trust Neonatal Death and Bereavement Guideline that describes the processes to support bereaved families on pages 4-5 (008)
- changed wording of 'Sudden Unexpected Death in Infants and Children (SUDIC) under 18 Operating Procedure' to ensure clarity of the process, and added clear guidance for key workers, and introduced a paediatric lead within the trust to answer clinical questions the family may have had about the care prior to point of death of the child (028)

- updated trust mortality policy to include a section on an immediate escalation pathway to the senior leadership team and executive medical director. Examples where this pathway may be triggered include: immediate safety concern related to death that cannot be resolved in the department or requires a trust-wide response; suspicious circumstances to death related to a single or group of deaths requiring possible immediate escalation; departmental concerns for specific themes or care related to death. (088)
  - adapted the 'Learning from deaths policy' to strengthen alignment of the maternity and neonatal death process, including the perinatal mortality review tool (PMRT) process, and the Learning disability mortality review (LeDeR) and Child death overview panel (CDOP) processes with overall mortality review governance processes (115)

### **Freedom To Speak Up (FTSU)/ whistleblowing**

- developed a standalone policy for FTSU that is based on the national template (061, 080)
- strengthened the safeguarding section to make it clear that any type of abuse of harm would go via safeguarding pathway and made the interface generally clearer (067)
- updated the overall language to clarify how understand to speak up and what staff can expect as a result of doing so (018, 035, 069)
- added a quick reference guide, which simplified flow charts for raising and handling concerns, as well as added a hyperlink to relevant policy and well-being hub (004)
- updated to increase awareness of the ways to raise concerns (118)
- added signposting to support groups for those who are less likely to feel able to raise concerns, including those early in their clinical careers or may have cultural barriers (118)
- introduced a new "Allegation against staff" policy (031)

### **Complaints**

- updated to include changes to process such as variable timeframes, escalations, working with other organisations and handling correspondence from PHSO (018)
- adopted the PHSO's six principles for handling concerns and complaints (012)

### **Position of the trust policy**

- updated with an action to 'inform the police' (028)
- strengthened the message that staff are aware they can escalate a concern (028)

### **Fit and proper persons policy**

- improved information about board members and Regulation 5 Directors on the NHS Electronic Staff Record (080)
- updated the governance processes to enable the Chairs Annual Submission on FPP (080)
- updated to incorporate FPP as part of the audit plan every three years (080)

## Other actions taken by trusts in response to the Lucy Letby verdict

When describing the policy review process they undertook, many trusts also described the actions they had carried out because of the Lucy Letby verdict. Some of these were described by trusts in their responses to other parts of the questionnaire – see *Changes to neonatal and perinatal services – Actions*.

The actions respondents reported were carried out in trusts included:

### Offered psychological support for staff

- CEO and Director of Nursing visited the neonatal ward to offer reassurance and make plans to implement the NHS England recommendations (038)
- organised local group and individual briefings and provided support from the unit's psychotherapist (038)
- developed a guideline to support staff in collaboration with the London Neonatal Operational Delivery Network (038)

### Supported families

- neonatal staff spoke directly with parents on a regular basis to acknowledge that parental concerns may be heightened given the publicity surrounding the case, and that there were routes available to express concerns (043)
- provided comprehensive face-to-face communication with patients and staff (049)
- wrote to patients with offers of support from neonatal counsellors from the NNU and trust (049)
- shared the NHSE letter on the outcome of the case with patients, parents, and staff (024)

### Communicated routes to raising concerns to families

- undertook communications drive to ensure that patients and their relatives know how to provide feedback and raise concerns following work with local Healthwatch - this included providing updated information on trust website, use of [local area] Radio, signposting to PALS in clinical areas. (119)

### Reviewed policies, tools, and unit

- reviewed internal data and policies to ensure adequate safeguards were in place to identify unusual spikes in deaths or patterns of incidents using varied data sources (for example, quality and safety governance data, mortality surveillance, freedom to speak up policy) (066)
- commissioned an external learning review of the trust's formal employee relations processes and the way it manages Freedom To Speak Up arrangements. This included consideration of the number and type of concerns raised and the organisation of the network of Freedom To Speak Up 'champions' (092)
- undertook a deep dive on the neonatal unit (060)
- reviewed the reporting processes from the neonatal unit to trust (013) and the use of DATIX to manage FTSU cases to ensure this provides adequate support, whilst also adhering to the recording criteria set by the NGO (097)

### **Board briefing / training**

- discussed speaking up and taking action / Letby, regulating managers / fit and proper persons during a board development session (011)
- discussed the case, its implications and the patient safety framework, and Freedom to Speak Up processes at a Trust Board Study Session: “The main action that came out of this discussion was the need for an annual report that triangulates patient outcomes, clinical incidents, staff survey results, FTSU and HR data” (092)

### **Strengthened governance processes**

- strengthened the role of the group quality team to identify group themes and take action (118)
- introduced a new neo natal improvement board (reporting to the clinical governance committee), which reviews all incidents of moderate harm and above (033)
- introduced twice weekly incident review panels (033)
- introduced new processes and functions of the Specialty Mortality and Morbidity meetings with a new SOP being implemented and a monitoring process agreed (115)

### **Took action to improve monitoring**

- extension of existing monitoring processes to include reviews of unexplained deterioration (006)
- developing a dashboard that contemporaneously flags spikes in mortality by department/ consultant across the Trust to allow for timely investigation into possible trends (025)
- developing plans to “Improving our reporting and analysis of FTSU through better triangulation of information and data.” (080)
- highlighted in board papers the risks that themes and patterns might be missed if information from the different reporting routes are not effectively triangulated (079)
- prior to the Letby verdict, a new process was implemented to identify any members of staff that have been identified in more than three concerns or complaints within a 12-month period. All of these cases will be shared with the relevant executive lead (065)

### **Changed clinical processes**

- moved storage of medication (such as insulin) to a secure neonatal ITU fridge and vials are single use only (027)

### **Offered training**

- implemented the National Guardians Office Training modules to all staff, developing additional materials re our FTSU Culture for our overseas recruitment, and strengthening central and local induction regarding FTSU (080)

In summary, a range of actions were carried out, some with immediate effect after the outcome of the case was announced (for example, offering psychological support to staff and families), while others are still underway (for example, improved processes for triangulating data sources to improve investigations).

## Nuffield Trust reflections

About half of the respondents reported reviewing their policies. Most reviews were triggered by the Letby case, and a small proportion by changes national guidance. After having reviewed their policies, 25 trusts reported making changes to at least one policy. The changes were not significant for most, involving clarifications and new visuals. But for a few trusts, changes meant introducing new neonatal-specific policies where these did not previously exist. Respondents wrote that additional changes would be made based on the Inquiry. There is no known literature base on policy changes that occur in trusts after an inquiry.

In addition to describing their policies, trusts described actions they had taken once they heard the verdict, which included initial reactions such as offering immediate support to staff and families, through to plans to strengthen governance processes and improve the monitoring and triangulation of the various data sources across the trust. Some of these actions were also described in the section on ['Learning and making improvements'](#).

# Staffing

In this section we report on responses about staffing in neonatal units, including vacancies, adherence to staffing guidelines, cover arrangements and the use of locum, bank or agency staff. It responds to questions 1d, 1e and questions 28 and 29 in the questionnaire. There was overlap in the responses between these questions, and the summary draws on responses from multiple questions.

## Questions asked of trusts:

1. Please provide a short description of the neonatal services in the trust including:
  - d. the staffing structure for the unit; and
  - e. the current number of vacancies within the staffing structure.
  
28. Are the required staffing levels and ratios for the neonatal unit at the trust in line with The British Association for Perinatal Medicine Framework for Practice Service Standards for Hospitals providing Neonatal Care (3<sup>rd</sup> Edition) 2010, the NICE Quality Standards, the DHSC Neonatal Toolkit and NHS England's Special Commissioning specifications for neonatal care?
  
29. If not, why not? If so, does that require the use of bank staff and locums? Does that have a financial consequence for the trust?

## Context for this section

- The British Association of Perinatal Medicine (BAPM) produces service standards for neonatal services across the UK, including guidance on structure and organisation of neonatal units and staffing<sup>30</sup>.
- In 2020 the BAPM published a tool<sup>31</sup> to support neonatal units to calculate safe nursing staff levels, based on the type of unit, the number of cots and occupancy, and the proportion of nursing staff with specialist qualifications.
- Levels of medical staffing are defined based on level of expertise, from trainee roles (Tier 1 and 2), through to consultant roles (Tier 3). Posts in the medical rota

<sup>30</sup> British Association of Perinatal Medicine (2022) 'Service and Quality Standards for Provision of Neonatal Care in the UK' [https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file\\_asset/file/1494/BAPM\\_Service\\_Quality\\_Standards\\_FINAL.pdf](https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/1494/BAPM_Service_Quality_Standards_FINAL.pdf)

<sup>31</sup> British Association of Perinatal Medicine (2019) 'Calculating Unit Cot numbers and Nurse Staffing Establishment and Determining Cot Capacity A BAPM Framework for Practice - Supplementary Guidance' [https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file\\_asset/file/101/BAPM\\_Guidance\\_on\\_Cot\\_Capacity\\_and\\_use\\_of\\_Nurse\\_Staffing\\_Standards\\_24-10-19.pdf](https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/101/BAPM_Guidance_on_Cot_Capacity_and_use_of_Nurse_Staffing_Standards_24-10-19.pdf)

can be filled by Advanced Neonatal Nurse Practitioners (ANNPs), as well as by doctors.

- Medical Tier 1 and Tier 2 rotas include doctors in training, who are allocated to trusts by the relevant local education and training board (formerly called deaneries)<sup>32</sup>. Doctors early on in their career may spend short periods of time in neonatal units as part of a foundation programme<sup>33</sup>. Specialised training programmes for paediatrics and neonatal care are organised in conjunction with the Royal College of Paediatrics and Child Health<sup>34</sup>.
- Neonatal units are part of Operational Delivery Networks (ODNs)<sup>35</sup> which cover a defined geographic area. ODNs should ensure that there is sufficient neonatal capacity across their area, working with trusts to develop their service to align with demand, and ensure resources are allocated across the region to maximise availability of cots.
- ODNs coordinate the allocation of babies to neonatal units, including transfers between units and repatriating babies back to local hospitals, balancing the aim for babies to receive specialist care when needed, close to home, but also ensure capacity in individual units is within safe staffing levels.
- In 2019 the Neonatal Critical Care Transformation Review<sup>36</sup> recommended that ODNs review capacity within neonatal units, based on the level of care they provide, and develop a plan, in conjunction with all key stakeholders, to address any mismatch between the criteria relevant to the unit and the existing capacity and demand.

## Staffing structure and vacancies

Trusts provided information on staffing structure to varying levels of detail and in different formats. For example, some included only medical or only nursing staffing, others including a range of other roles, including outreach and non-clinical roles, as well as allied health professionals. Numbers of staff were included in some cases but not all, with others describing levels of cover rather than numbers of staff, as required by the national neonatal audit<sup>37</sup>.

Information on vacancies was provided more consistently for nursing staff than for medical staff (Figure 3). For 52 trusts it was unclear whether or not there were medical vacancies as these were not mentioned. 13 trusts reported that they did not have medical vacancies, while nine reported they had no nursing vacancies.

<sup>32</sup> NHS England 'Local Office and Deanery information' <https://medical.hee.nhs.uk/medical-training-recruitment/medical-specialty-training/inter-deanery-transfers-idt/local-office-and-deanery-information>

<sup>33</sup> UKFP 2024 Applicant Handbook <https://madeinheene.hee.nhs.uk/Portals/12/UKFP%202024%20Applicant%20Handbook%20.pdf>

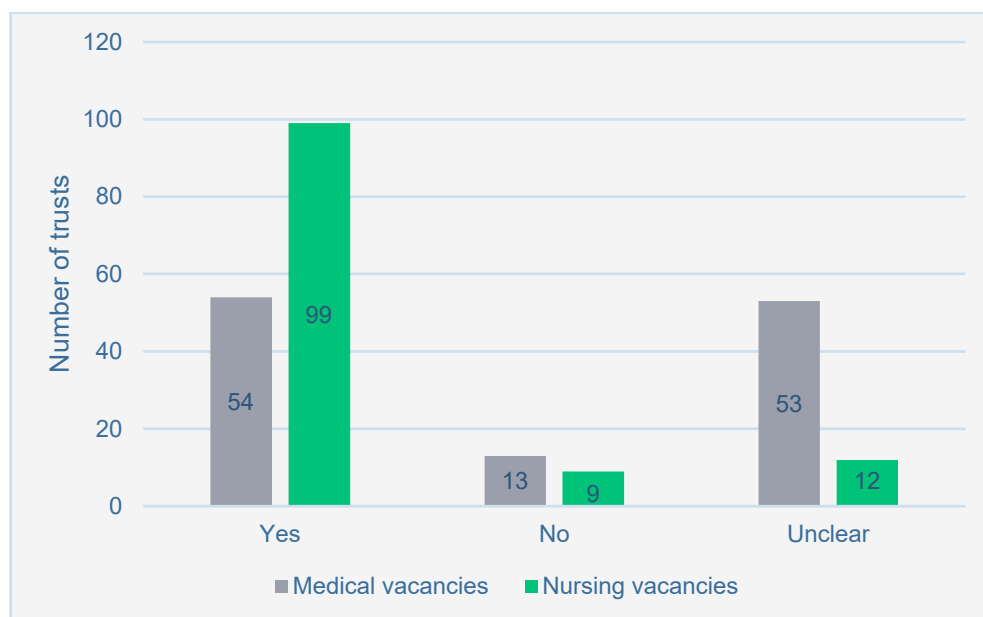
<sup>34</sup> Royal College of Paediatrics and Child Health 'RCPCH Progress+' <https://www.rcpch.ac.uk/education-careers/training-assessment/progressplus>

<sup>35</sup> NHS England (2019) 'Implementing the Recommendations of the Neonatal Critical Care Transformation Review' <https://www.england.nhs.uk/wp-content/uploads/2019/12/Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf>

<sup>36</sup> Ibid.

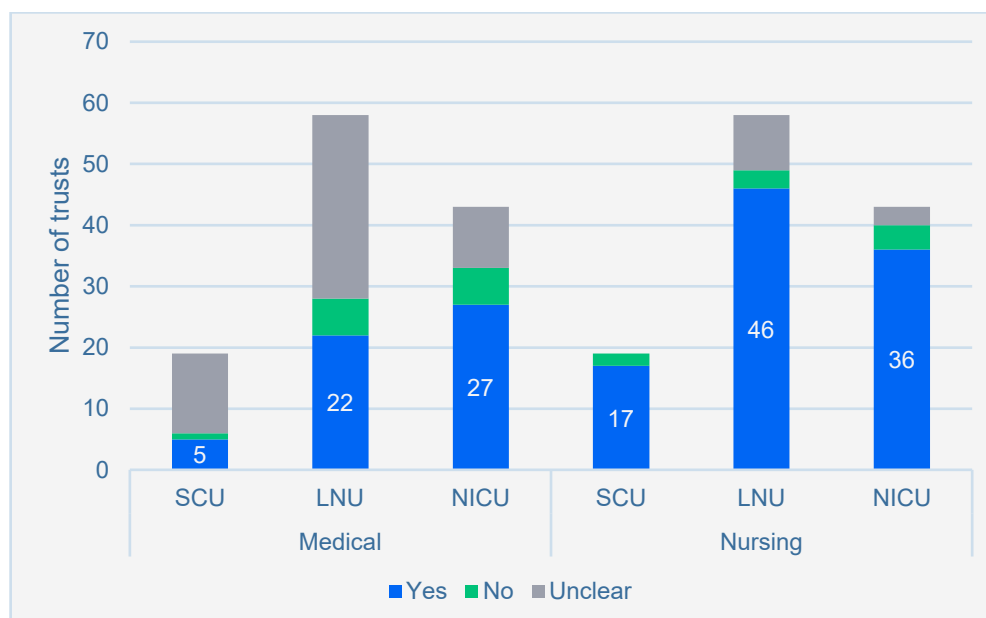
<sup>37</sup> Royal College of Paediatrics and Child Health 'National Neonatal Audit Programme' <https://www.rcpch.ac.uk/work-we-do/clinical-audits/nnap>

Figure 3: Number of trusts reporting vacancies for medical or nursing staff



The proportion of trusts with medical vacancies was highest for trusts with NICUs; the medical staffing requirements for these units are more stringent since these units care for the sickest babies. Overall, 83% of trusts reported vacancies for nursing staff. This was consistent across trusts with all types of units (Figure 4).

Figure 4: Vacancies for medical or nursing staff by level of care



Respondents described how the staffing establishment was reviewed in response to changing demand or new requirements and what was being done to address vacancies.

In some cases, neonatal units have budget for additional staff but reported that they were struggling to recruit and retain staff, due to lack of qualified staff nationally, and long timelines needed to train up staff to more qualified roles, or to recruit internationally (062).

*“The neonatal unit is funded to deliver staffing to BAPM... The Trust is working towards delivering this and we are on an improvement trajectory. A recruitment lead for nursing has been recruited to target nursing vacancies and training. A number of actions are in place including Nursing Associates and International recruits.” (062)*

In other cases, trusts have reviewed their staffing against requirements, in discussion with the ODN, and have identified that additional staff are needed to meet guidelines. They have then put forward a business case within the trust, or externally, for additional funding, after which they can then commence recruitment (102). This can be a lengthy process and some trusts report recruitment and training plans covering two years or more (008).

*“There is not currently funding in place to ensure a dedicated registrar (or equivalent). There are also unfilled deanery rotational posts. An action plan is in place, but this requires significant investment and funding is not available to completely address the shortfall in staffing required. There is a risk on the risk register.” (102)*

*“Phased implementation for full Tier 2 compliance is in place spanning 22/23-27/28 due to the recruitment of qualified and suitably experienced Advanced Neonatal Nurse Practitioners (ANNP) to staff this rota. Budgeted gaps at Tier 2 are being used to finance trainee ANNPs as part of the implementation plan.” (008)*

Information on staff groups other than medical and nursing was limited. However, trusts described the role of the Allied Health Professionals (AHP) (for example 069) and challenges in provision (for example 100, 083).

*“The neonatal unit has a dedicated specialised Allied Health Professional (AHP) workforce in place, including two occupational therapists, two physiotherapists and two neonatal pharmacists.” (069)*

*“Allied Health Professionals: We do not meet the expected numbers, there has been a recent allocation of money towards establishing a LMNS wide AHP workforce (hosted by [organisation name]) which would provide a fraction of physiotherapy, occupational therapy, dietician and speech and language therapist required for the unit. There is minimal pharmacy support to the unit, not enough for the number of available cots on the unit.” (100)*

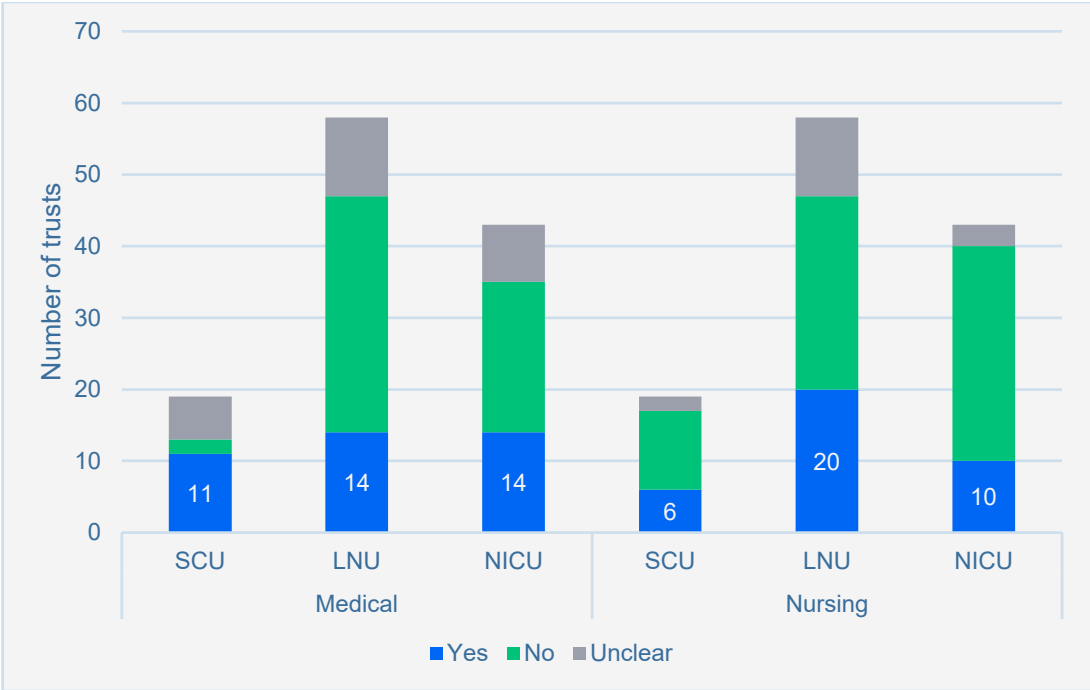
*“We have access to Physiotherapy, SALT, dietician and pharmacy service support within the SCBU. We do not have Occupational therapy cover for the SCBU but can be accessed as outpatient after discharge. We do not have psychology support for parents on the SCBU or as outpatient post discharge.” (083)*

# Meeting staffing guidelines

Most trusts provided unambiguous responses to indicate whether or not the BAPM guidelines were met for medical (95 of 120 trusts) and nursing staff (104 of 120 trusts). Over half of trusts (68 of 120) reported that they were not compliant with nursing guidelines, and just under half (56 of 120) were not compliant with medical guidelines. Trusts referred to the 2010 BAPM guidelines, and also to subsequent guidance. This section focuses on the BAPM guidelines, but some trusts also noted other staffing guidelines and reporting requirements for these, for example for the Maternity Incentive Scheme<sup>38</sup> (028, 052, 059, 097, 038).

Trusts with all types of unit reported challenges with meeting nursing guidelines, while this was a particular challenge for LNUs and NICUs for medical staffing (Figure 5). Trusts reported using the BAPM safe staffing tool to monitor nurse staffing levels, and some provided examples of recently completed assessments (for example 017, 020).

Figure 5: Trusts reporting meeting BAPM guidelines for medical and nursing staff, by level of care



Reasons for not meeting medical staffing requirements included insufficient numbers of staff overall and not having the right skill mix to cover requirements for different types of shift (for example weekday, evening or weekend) (Table 6). Cover requirements were most challenging for LNUs.

<sup>38</sup> NHS Resolution 'Maternity (and perinatal) Incentive Scheme Year Six' <https://resolution.nhs.uk/wp-content/uploads/2024/04/MIS-Year-6-guidance.pdf>

Table 6: Reasons for not meeting BAPM guidelines for medical staffing, by level of care

	SCU	LNU	NICU	Total
Cover requirements	1	22	10	33
Number of staff	1	7	7	15
Number and cover		2	2	4
Unclear		2	2	4
<b>Total</b>	<b>2</b>	<b>33</b>	<b>21</b>	<b>56</b>

Examples of cover arrangements which were challenging included covering rotas at nights or at weekends (071), how frequently weekend cover was required for individuals, ensuring the right mix of staff for each tier (097), and ensuring that neonatal and paediatric rotas were separate (102 and 116).

*“The consultant workforce covers 2 neonatal units (level 1 and level 3) when on call at the weekend. These on call shifts are for 24 hours at a time, there are separate rotas in the week. This is not compliant with BAPM guidelines for consultant cover... The Trust has supported a business case that would enable workforce expansion to create a team of 18 WTE consultants (from the current 13 WTE), to be implemented over a 3-year period. This would enable the on call rotas to be separated out and also provide resident cover over night to the NICU in line with the standards for units delivering 4000 ICU days per year.” (071)*

*“...The rota will need to transition to 1 in 8 with weekend cover if it is to become BAPM compliant and meet CNST standards. We are in the process of changing the rota to 1 in 8 at the Tier 1 and 2 level following the transition of Advanced Neonatal Practitioners (ANNPs) from 8a to 8b and the recruitment of Tier 2 registrars through the ORDER program (Overseas registrar development & recruitment), a Trust initiated program equivalent to Medical Training Initiative (MTI). For the rota to be compliant at Tier 3, there is need for recruitment of 2 further consultants. The requirement to increase the establishment of neonatal medical consultants has been presented to Finance and performance committee in October 23 and there is a plan to collate a business case going forward to uplift funded establishment to meet BAPM workforce requirements. In order to meet the requirements of CNST year 5 an action plan for achievement of BAPM neonatal medical standards has been collated and shared with the Trust Board of oversight as part of the Maternity and Neonatal Service Update Paper. There is a risk recorded on the risk register for this.” (097)*

*“There is a risk on the corporate risk register around Paediatric medical staffing, which impacts neonates. A tier 2 agency locum is currently being employed at cost to the Trust. There is also an increased requirement for locums from existing tier 2 or act-down from consultants at cost to the Trust.” (102)*

A number of trusts mentioned that an increasing number of part-time posts made it more difficult to meet staffing requirements, as well as the trust being allocated low numbers of

training posts, or trainees with limited experience (057). Several trusts mentioned employing or training Advanced Neonatal Nurse Practitioners (ANNPs) to fulfil Tier 1 and 2 rotas (as noted above, 008 and 097). Respondents reported that this enabled the trust to have a more consistent staffing rota, with more continuity in the team, than was possible by relying on rotational or training roles only (057).

*“...in common with many other LNUs and SCBUs, the doctors that fill the Tier 1 Rota are predominantly GP trainees who have never done paediatrics/neonates before and have a limited interest in developing skills in this area as they will likely never use these skills following their 4-6 month placement with us (which only includes a few days on the neonatal unit anyway). They therefore are, in general, unable to carry out even basic procedures like IV canulation and would certainly never get involved in endotracheal tube placements or adjustment of ventilation. Therefore, we feel that to deliver that increase in quality we need to deliver this cover, especially out-of-hours when there is skeleton senior presence around, with career paediatricians and ANNPs (Advanced Neonatal Nurse Practitioners). This is what we are working towards... In terms of career paediatricians, there are only small numbers sent to us by Deanery (2 [trainees]) and recruiting to junior trust grade posts is problematic as most colleagues will be working towards a run-through training post (meaning they only stay with us for a short period of time) or we have to invest time and effort for international graduates and again, once settled and able to progress, they quickly move to tertiary centres or apply for run-through training. Like many other units in this position, we have opted to cover, at least partly, this area with ANNPs. Given that all units across the country are trying to do pretty much the same thing, we are all trying to recruit ANNPs from the same, finite pool. Therefore, after trying unsuccessfully to recruit to ANNP roles, we are now training our own neonatal nursing staff.” (057)*

One trust (037) reported that additional funding supported the medical rota to be split between paediatrics and neonatal cover over the winter (when there would be greater demand for paediatric care):

*“Medical – There is a split rota for neonates and paediatrics at Tier 1, middle grade and consultant level during day. At night-time, a middle grade rota is occasionally shared with Paediatrics. There is some funding provided by Neonatal Network to support split reg rota overnight over winter period.” (037)*

Reasons for trusts not meeting nurse staffing guidelines are summarised in Table 7 below.

Table 7: Reasons for not meeting BAPM guidelines for nursing staffing, by level of care

	SCU	LNU	NICU	Total
Insufficient qualified staff	2	11	9	22
And insufficient staff overall	1	5	6	12
<b>Insufficient staff overall</b>	1	7	11	19
No supernumerary shift coordinator	5	3	1	9
Unclear	2	1	3	6
	<b>11</b>	<b>27</b>	<b>30</b>	<b>68</b>

Half of trusts that were not meeting the guidelines reported that they had insufficient nurses with a Qualification in Speciality (QIS), including 12 trusts which also had insufficient staff overall. BAPM guidelines recommend that 70% of nursing staff are QIS trained. Respondents described steps their trust was taking to increase the number of qualified staff, including recruiting additional staff at a lower band, and providing training for them in house, as well as international recruitment (090). Respondents mentioned that new staff, particularly those just qualified and international recruits, may need time in post working on a supernumerary basis while they gain sufficient practical experience in their roles. For less specialised units, specialty training requires staff to spend time working in a different trust which provides specialist care, thus reducing capacity within the local team during training (010).

*“We have almost constant Band 6 neonatal nursing adverts out and we invest in and train these staff so that they can have the opportunity to be promoted to Band 7 posts. In the longer term it is easier to recruit Band 5 nurses and then train them internally, being financially able to provide Qualified in Speciality courses. After a consolidation period, competencies completed, they undertake an interview to be sent on the neonatal ITU course and they are then promoted to a Band 6 post when this is achieved. However, these are long term strategies and take time.” (090)*

*“...There is also an impact when staff undertake the FiN (Foundation in Neonates) course and QIS (Qualified in speciality) when staff need to attend placements in tertiary centres. Clinical safety of patients is always the priority and so escalation to enable safe staffing levels to be at the correct levels is essential, this includes the use of bank staff (who are often staff from the unit) and locum medical staff (wherever possible staff familiar to the service are used).” (010)*

A further 19 trusts reported that they had too few nursing staff overall. Nine trusts reported that they were not able to have a supernumerary nurse coordinator role, with day-to-day responsibility for managing nursing on the unit, without clinical responsibility for individual babies. Meeting this requirement was more challenging for SCUs (Figure 5, above) and was reported to be more difficult for smaller units (119).

*“Providing a supernumerary shift coordinator for the size of our unit and the average occupancy is not an affordable option.” (119)*

Respondents from three trusts (004, 069, 090) mentioned particular challenges with recruiting and retaining qualified staff in London, because of insufficient trained staff nationally, and more competition for staff in London. The higher cost of living in London was also mentioned as a challenge to recruitment. One trust outside London (083) reported that recruiting staff was more challenging because they were competing with trusts able to pay the London weighting.

## Relationship between staffing structure, vacancies and staffing guidelines

Trusts highlighted that having a full complement of staff did not mean that guidelines were always met, and vice versa.

Respondents provided information about how they assess staffing requirements on a shift-by-shift basis, and the proportion of shifts which are compliant for staffing (for example, 104, 107 and 094). Several trusts indicated that staffing risks were added to the risk register, and in some cases reported at board level (for example 094, 107 and 048).

*“...there were 3 days in Q1 of 2023 where [unit name] did not meet BAPM standards” (104)*

*“Quarter 2 [unit name] has been fully compliant, [unit name] has had 6 occasions in 92 days non compliant” (094)*

*“Neonatal Qualified in Specialty (QIS) = 14.92 WTE = 59.9%. National requirement= 70%. Dedicated medical rota. On average, 69% of shifts are staffed to British Association of Perinatal Medicine (BAPM) requirements with the expectation of overnight Tier 2 cover which includes: 3 ANNP on Tier 1 rota. This is reflected in the maternity/neonatal risk register.” (107)*

*“In September 2023 the nursing staff on the Neonatal Unit collectively sent a letter to NCIC’s Chief Executive, Executive Chief Nurse, SCBU Management team and their union representatives, escalating their concerns around the staffing issues on the unit. As a result of this escalation the Board of the trust were briefed and since that time the issue has had proactive executive oversight to stabilise the current staffing challenges and produce a more robust staffing model moving forward.” (094)*

Respondents (for example 094, 104, 113) reported that sickness, maternity leave, or other absences meant that even if they had a full establishment that was compliant, they may need to bring on temporary staff on a shift-by-shift basis or for longer periods to meet staffing guidelines.

Staffing requirements are calculated based on expected level of occupancy of cots - 60% (015, 018) and 80% were both mentioned (032, 029, 115, 049, 030) - and on an expected level of acuity of babies (029). Trusts reported sometimes needing to bring in extra staff when they were busier than usual or had more babies with a high level of need (for example 002, 111). Further, respondents noted that the designation of the level of units is

based on expected number of cot days occupied by babies with each level of need, and fluctuations in demand mean that trusts' level can increase (for example from a SCBU to an LNU), which will also change the staffing thresholds they are required to meet. In exceptional cases, the gestational age of babies admitted to the unit is reviewed, in order to enable care to be provided safely (026):

*“The Neonatal Nurse staffing levels are monitored by the [region] Neonatal ODN, the quarterly information is submitted onto the futures platform.[Site name] neonatal nurse staffing achieves standards, this is occasionally impacted by short notice sickness and increased acuity or occupancy above cot base numbers where network beds are also not available or appropriate. The unit will then utilise their own staff via bank systems, or on occasions look to agency staffing, this is not frequent.” (002)*

*“Nurse staffing - Each shift we have a minimum of 3 staff members on duty 1 x B6 and 2 x B5 with minimum of 1 x qualified in speciality on each shift, this is compliant with BAPM standards. If acuity/capacity is high then we look to manage staffing on a shift by shift basis, with additional bank and agency staff if necessary. We have a full time B7 sister providing leadership for the ward and a paediatric matron providing oversight.” (111)*

*“The service is working with the Operational Delivery Network to review establishment in line with British Association of Perinatal Medicine (BAPM) workforce standards which are based on 80% occupancy” (029)*

*“In 2018 constraints were placed on the unit [name], in response to a crisis in medical staffing numbers leading to removal of trainees from the Hospital. Whilst the services was deemed safe to continue the gestational age for admission was moved to 34 weeks. This was formally moved back to normal 32 weeks (SCBU) in Autumn 2022 (supported by ODN and Trust Board).” (026, Q8)*

Several trusts provided examples of reporting and monitoring methods including: board papers providing an overview and action plans (017), monitoring charts tracking actual and required staffing measures over time (026), a snapshot of monitoring reports (035), and a completed example of nursing workforce calculator (020). Monitoring and reporting are discussed in more detail in relation to [data collection and use of data](#).

Most trusts (99 of 120) reported that they used bank, agency, or locum staff at times to meet staffing levels. This was unclear for 19 trusts and only two trusts reported that they did not use bank, agency or locum staff (066 and 080). Respondents used terms in different contexts, for example using agency when referring to bringing in medical roles, and the NHS Professionals temporary staff providers sometimes being referred to as agency and sometimes as bank. As a result, it is not possible to split out temporary medical staff from temporary nursing staff.

Trusts indicated that they used temporary staff to ensure that on a shift-by-shift basis staffing guidelines were met, where they had vacancies (049 and 119), and when they were unusually busy (for example 111). Some respondents (for example 091) also noted that if their staffing levels were at capacity they may also not take in more babies.

*“Yes the unit requires bank/agency daily to sustain safe staffing numbers... This ensures that, while the substantive staffing does not meet the QIS target, actual on the day shifts are filled almost to or at the required QIS level. The trust uses ‘safe care’ tool to assess whether a unit is safely staffed on a shift-by-shift basis. (unit name] rarely declares a ‘red flag’ for staffing (approximately 1 a month). The shortfalls of staff per shift is addressed by non-clinical staff such as practice educators working clinically, or non-essential study days being rescheduled. There is also a band 4 who checks the roster daily and ensures shifts are put out to staff bank and agency in advance.” (049)*

Use of bank, locum or agency staff was recognised as an option for ensuring staffing requirements were met, but was only one of a range of options considered:

*“Following on from the response to Question 28, on any occasion where there is a shortfall in nurse staffing, meaning that safe ratios cannot be maintained, the following options are explored by the Trust:*

- *Cancellation of training/non-clinical activity (to release staff to undertake clinical duties)*
- *Shift swaps*
- *Redeployment of staff from the Neonatal Unit on the opposite site (if that site is better staffed to allow the redeployment)*
- *Redeployment of staff from other paediatric inpatient services*
- *Use of additional hours from substantive staff*
- *Use of bank staff*
- *Use of agency staff*

*On any occasion where there is a shortfall in medical staffing, meaning that safe ratios cannot be maintained, the following options are explored:*

- *Shift swaps*
- *Use of step down (including consultants “acting down” into junior doctor vacancies)*
- *Use of locum medical staff*

*Use of bank, agency, step down or locum staff does have a financial consequence for the Trust. However, the Trust will always actively prioritise patient safety and clinical risk over any adverse financial implications, and do so in this circumstance.” (026)*

For nursing staff, respondents mentioned that bank staff were preferable to agency staff from a quality perspective, as they were often already nurses in the unit or elsewhere in the trust undertaking extra shifts and would therefore be familiar with the work of the unit. Likewise for medical staff, respondents (008, 071, 102) mentioned that existing staff may do overtime, and that consultants may “act-down” to provide the cover needed for weekend and evening rotas.

Limited information was provided by respondents about financial impacts of using bank and agency staff. Some respondents (for example 029) stated explicitly that there was minimal impact, because the cost was covered by vacancies, particularly in the case of bank staff. Some respondents (for example 035) did state that there was a financial impact, without giving further information.

## Nuffield Trust reflections

Staffing guidelines for neonatal services have been established for some time and are monitored nationally by the NNAP and locally on an operational basis by ODNs. In order to meet NHS Resolution requirements, the trust board needs to receive a review of staff on a bi-annual basis. The survey responses indicate that trusts are actively working towards meeting guidelines. For many trusts this is an ongoing process, and changes in guidelines and wider challenges with recruitment and retention of staff mean that this will continue to be the case. However, relative to many areas of NHS activity, there is a high level of monitoring and scrutiny of staffing for neonatal care<sup>39 40</sup>.

At a unit level, staffing requirements change on a day to day basis and the focus for trusts is ensuring individual shifts have safe staffing levels which meet the care needs of babies and the number of cots in use. Respondents described a wide range of management approaches used to achieve safe staffing levels on an operational basis, including closing cots when staffing levels could not be increased in line with demand. They also described how they monitor risks and escalate concerns.

The responses cannot be directly compared with other sources of data on neonatal staffing, but the overall picture from respondents is consistent with audit reports showing gaps in staffing within neonatal services. The 2022 NNAP<sup>41</sup> reported that almost 30% shifts do not have the number of nursing staff required to meet the guidelines. They note particular concern about the wide variation in staffing, with 13 units (including 12 NICUs) meeting nursing numbers in fewer than 40% shifts. A 2020 snapshot survey by the RCPCH found that 10% of neonatal units had gaps in medical staffing with 5% of these shifts covered by locums<sup>42</sup>.

Trusts reported long-standing challenges with recruitment, also identified in earlier studies<sup>43</sup>. Trusts were using a range of strategies to address staffing gaps, including training existing staff, developing different roles, and international recruitment. These steps can take considerable time to put in place and require additional capacity to implement.

<sup>39</sup> National Quality Board 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time' <https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf>

<sup>40</sup> The King's Fund (2017) 'Understanding NHS financial pressures: How are they affecting patient care?' [https://assets.kingsfund.org.uk/f/256914/x/b866c0a98e/understanding\\_nhs\\_financial\\_pressures\\_2017.pdf](https://assets.kingsfund.org.uk/f/256914/x/b866c0a98e/understanding_nhs_financial_pressures_2017.pdf)

<sup>41</sup> Ibid

<sup>42</sup> Royal College of Paediatrics and Child Health 'A snapshot of neonatal services and workforce in the UK' [https://www.rcpch.ac.uk/sites/default/files/2020-09/a\\_snapshot\\_of\\_neonatal\\_services\\_and\\_workforce\\_in\\_the\\_uk\\_2.4.pdf](https://www.rcpch.ac.uk/sites/default/files/2020-09/a_snapshot_of_neonatal_services_and_workforce_in_the_uk_2.4.pdf)

<sup>43</sup> The King's Fund (2017) 'Understanding NHS financial pressures: How are they affecting patient care?' <https://www.kingsfund.org.uk/insight-and-analysis/reports/understanding-nhs-financial-pressure>

## Additional references

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- British Association of Perinatal Medicine (2022) 'Service and Quality Standards for Provision of Neonatal Care in the UK' [https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file\\_asset/file/1494/BAPM\\_Service\\_Quality\\_Standards\\_FINAL.pdf](https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/1494/BAPM_Service_Quality_Standards_FINAL.pdf)
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# Culture

This section provides a description of culture(s) within trusts and neonatal units. This section covers questions 7, 8 and 39d in the questionnaire.

Trusts responded to question 8 in a variety of ways. This included listing words to describe culture, describing processes or structures in place, listing trust documents (such as strategies), or referring to external assessments (such as the NHS Staff Survey). The process by which the question was answered also varied. Some respondents provided answers based on their own personal experience or observations, whereas others had consulted with colleagues or done specific staff engagement to answer the questions (see for example 083B, which included responses from the Chief of Service, midwifery, neonatal and nursing staff members). The extent to which trusts interpreted the question as requiring objective, or subjective responses was also variable. It is important to bear these factors in mind when considering the analysis.

There was overlap between the answers to questions 7 and 39d, although no timeframe was specified in question 7. Given the overlap we have summarised the responses to these questions together. However, caution must be exercised with regards to the timeframe in question 39d as this was also reported variably (for example, such as 'last six years' and 'post-Covid').

## Questions asked of trusts:

7. Have there been any external reviews undertaken on culture at your trust, including the neonatal unit?

8. How would you describe the culture of the trust, generally and in particular of the neonatal unit? If you consider that the different professions have different cultures, please set that out briefly. Please note that we will issue a separate questionnaire on culture to be completed by staff within the neonatal service at the trust.

39d. Has the trust commissioned any external reviews of neonatal services in the last 5 years?

## Context for this section

- "Culture" is a term which is both widely used and difficult to define. Aspects of culture include '*organisational*,' '*just*,' '*safety*,' '*reporting*,' and '*learning*.' Further details and definitions of these terms can be found in the *Glossary*.

- Numerous investigations and inquiries into NHS services have identified a range of issues and recommendations in relation to culture. This includes the Francis report (2013)<sup>44</sup> and Ockenden review (2022).<sup>45</sup>
- The NHS People Plan is the workforce strategy accompanying the NHS Long Term Plan.<sup>46</sup> The NHS People Promise, which accompanies the People Plan contains seven aspirations one of which is a culture which is “positive, compassionate and inclusive.”<sup>47</sup>
- The NHS Staff Survey has been undertaken annually since 2003 and provides a snapshot of staff experience in the NHS.<sup>48</sup> In 2021, the questions were aligned with the seven aspirations in the NHS People Promise to track progress.
- The Perinatal Culture and Leadership Programme forms part of the NHSE three-year plan for maternity and neonatal care.<sup>49</sup> The aim is “to support perinatal leadership teams develop the conditions for a positive culture of safety and continuous improvement.” According to NHS England, as of 5<sup>th</sup> October 2023, 98 perinatal leadership teams (out of 152 maternity and neonatal sites) had started the programme. The aim is for all trusts to have enrolled onto the programme by November 2023, with every site having completed the programme by September 2024.<sup>50</sup>
- The Freedom to Speak Up review (2015) set out 20 principles and actions aimed at creating the right environment for NHS staff to speak up.<sup>51</sup> The National Guardian’s Office, and role of Freedom to Speak Up guardians were created in response to this.<sup>52</sup> The national speak up policy (2022) sets out the “minimum standard for local freedom to speak up policies across the NHS.”<sup>53</sup>

## Culture in NHS trusts

Several respondents noted that it was difficult to describe the culture of a trust at a general level, for example due to the size and complexity of NHS organisations.

*“In many ways, this is the key question for the Inquiry, and NHS regulators. In replying, it is important to note the context the NHS is working in and that the hospital will not have one culture but a series of microcultures which can be quite different even in adjacent units.” (003A)*

<sup>44</sup> Mid Staffordshire NHS Foundation Trust Public Inquiry 2013 ‘Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry’ (2013) <https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry>

<sup>45</sup> Department of Health and Social Care (2022) ‘Final report of the Ockenden review’ <https://www.gov.uk/government/publications/final-report-of-the-ockenden-review>

<sup>46</sup> NHS England (2020) ‘NHS People Plan’ <https://www.england.nhs.uk/ournhspeople/>

<sup>47</sup> ‘Our NHS People Promise’ <https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/>

<sup>48</sup> NHS Staff Survey <https://www.nhsstaffsurveys.com/>

<sup>49</sup> NHS England (2023) ‘Three year delivery plan for maternity and neonatal services’ <https://www.england.nhs.uk/wp-content/uploads/2023/03/B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf>

<sup>50</sup> NHS England (2023) ‘Update from the Maternity and Neonatal Programme’ <https://www.england.nhs.uk/long-read/update-from-the-maternity-and-neonatal-programme/>

<sup>51</sup> Report on the Freedom to Speak Up Review (2015) <http://freedomtospeakup.org.uk/the-report/>

<sup>52</sup> National Guardian’s Office <https://nationalguardian.org.uk/>

<sup>53</sup> NHS England (2022) ‘The national speak up policy’ <https://www.england.nhs.uk/publication/the-national-speak-up-policy/>

*“Providing a generalised answer to this question is difficult and does not feel appropriate given the complex range of different services we provide, across a range of teams formed from 5,000 colleagues.” (058A)*

*“It is difficult to describe the Trust culture briefly without making general or sweeping statements regarding a large complex organisation with many different cultures and experiences within it... The Trust has not undertaken a survey specific to neonatal services and a description of the culture in the service will be best described by staff within the questionnaire submitted by the inquiry.” (120A)*

Where respondents felt unable to comment (for example, because of a lack of knowledge on the culture in neonatal units or a difficulty in answering the question for the trust as a whole), some referred to other assessments to answer the question. This included reflecting on the NHS Staff Survey, trust vacancy rates and retention figures, CQC inspections, accreditations, the NHS Workforce Race Equality Standard (WRES)<sup>54</sup>, or specific culture reviews, as indications or proxies of what the culture is like, and because these were seen as providing more of an objective view.

Given the complexity outlined above, some respondents used words such as “*generally*” or “*in general*” in their responses acknowledging that issues could arise with specific individuals or circumstances, that it is important to not be complacent and that there is always room for improvement. As such, culture was considered not to be static.

*“The culture of the trust is going through a transformational phase of growth and acceptance.” (103A)*

*“The culture within the Trust and the neonatal unit is generally good with an open and honest culture which is promoted and supported from the Trust Board down. There are occasional tensions between groups of staff across the organisation and this has been particularly the case over the last year or so with the impact of Industrial Action in a number of staff groups, system wide financial pressures and the recovery from the Covid-19 pandemic.” (053A)*

In trusts with multiple sites, respondents acknowledged that factors such as geography and size can impact on culture in a trust as a whole. In these cases, respondents provided reflections about culture across the different sites.

*“It is therefore important to acknowledge and value individual site identities and diversity, whilst seeking to develop our shared positive culture for the Trust as a whole, based on our Trust Values & Behaviours.” (030 - SR)*

Respondents referred to a range of cultures in their answers. Some specifically referred to “*just and learning culture*”, “*safety culture*” and “*organisational culture*.” Words used by respondents to describe culture included ‘*open*’, ‘*transparent*’ and ‘*honest*.’ These were illustrated with examples which included ensuring visibility of different staff members (particularly senior leadership), communication, confidence to raise issues, multi-disciplinary leadership, and a focus on learning and reflection.

<sup>54</sup> NHS England (no date) ‘NHS Workforce Race Equality Standard’  
<https://www.england.nhs.uk/about/equality/equality-hub/workforce-equality-data-standards/equality-standard/>

Some respondents also described the processes and structures in place which they considered enabled this culture, such as incident reporting processes, policies such as Freedom to Speak Up and their approach to complaints. These were also described in [Structures for reporting concerns and complaints](#) and [Factors inhibiting and encouraging raising concerns](#). Some respondents referred to work they were doing to embed a “just” culture, reflecting the ambitions set out within the NHS People Plan. A small number of trusts mentioned the Letby case (for example 036A, 079B).

*“[The trust] has a strong culture of dedication, cooperation and mutual support but I am also aware that post Lucy Letby it is fragile and needs to be nurtured” (036A)*

*“The MDT support offered by NICU leadership to the whole department in the wake of the Lucy Letby case verdict demonstrates an open and supportive culture; acknowledging that they would be supported by management if they raised concerns, but also confident that management would highlight any changes in mortality levels.” (079B).*

Some respondents also described the working environment for staff more generally. Words used to describe the organisational culture commonly included: ‘collaborative’, ‘friendly’, ‘respectful’, ‘kind’, and ‘collegiate,’ and respondents also indicated that they had shared priorities around delivering the best care or outcomes for patients. Several also referred to equality, diversity and inclusion in their response and reflected on the extent to which their workforce was diverse. Some respondents also referred specifically to the relationship between culture and quality improvement. Many trusts described their organisational values and behaviours.

Some respondents referred to the impact of context including NHS pressures on culture. Examples included waiting lists, burnout and low morale, staff sickness, staffing shortages, industrial action, and the impact of Covid-19. These were highlighted as important context for understanding culture within services, with respondents recognising that this could place pressure on services and individuals, even in a culture that was generally considered to be good. Eight respondents referred to industrial action in their answers although this was both in relation to illustrating the context, and to evidence how teams worked together.

*“Recent CQC inspection indicated that there was a positive, safety culture where staff felt able to raise concerns without fear. Whilst this is encouraging, it is the minimum that we should aim for and I am cognisant that our staff like all staff across the NHS are working under pressure (associated with growth in demand and increase in acuity, shortage of trained staff and financial challenge) and have done for a number of years, are fatigued following the pandemic and feel undervalued as evidenced by industrial action across numerous professional groups over the last year.” (060B)*

*“The Neonatal Unit has a very integrated way of working, with all staff valued and a good working relationship between the medical and nursing staff with junior doctors being supported in their work by Advanced Neonatal Nursing Practitioner (ANNPs). This was clearly evident in the recent periods of industrial action.” (102A)*

*“In times of industrial action we have all worked hard to ensure no one felt discriminated against for their choices and that these were respected by all.” (036B)*

Some respondents provided a more general description of culture at the trust as a whole without providing detail on neonatal services.

*“I am not able to comment specifically on the culture of the neonatal unit, but I confirm that nothing has been brought to my attention and there has been nothing that I have experienced in my visits to the neonatal unit that lead me to believe that the culture of our values is not demonstrated.” (021B)*

*“The Trust puts patients at the centre everything we do. There is a positive, learning culture across the whole Trust which is reflected in our Neonatal units. The Trust prides itself on our focus on continuous quality improvement and patient safety. There are close working relationships between professional groups with a culture of support and collaboration with the purpose of delivering outstanding patient care.” (110A)*

## Culture in neonatal units

Where respondents did provide specific answers in relation to the neonatal unit, most considered that the neonatal service was aligned with, or reflected, the culture of the trust as a whole. In some cases, respondents noted that challenges had been identified in other services, although not within neonatal services, while some trusts who had experienced challenges with other services reported that the culture in neonatal services was actually better. Some respondents did note that they had experienced challenges with regards to culture in the neonatal unit. This is summarised in more detail in [Challenges with culture](#).

Some respondents noted that the reporting pressures on neonatal services can be particularly significant and cause strain within teams. Other wider contextual factors were also thought to have an impact such as workload, staffing levels and industrial action, although these were also issues which were noted to be present across the trust as a whole.

*“Due to the focus on scrutiny of practise in the neonatal unit and the scrutiny of outcomes staff can feel that they are constantly being assessed. Being a level 3 unit, they deliver care to the very sickest of babies. If there is an incident some staff do take it personally if an element of the care they provided is called a safety incident. The leadership within the service are working with staff to reinforce the no-blame culture and to assure staff that if they make an error that they will be treated fairly in accordance with the ‘Fair and Just Culture’ methodology.” (017A)*

A few respondents noted the impact of increased scrutiny on maternity services on neonatal units. One noted that certain configurations could lead to neonatal services being perceived as the “*poor relation*” to the rest of maternity, particularly given the national focus on maternity services following the Ockenden Review (096B).

*“With the national scrutiny on Maternity in the last few years it is fair to say that they [the neonatal unit] have felt that their issues are not seen as being as important.” (055A)*

Given the wide variation in how services are configured it is not possible to see whether this is a consistent view, although when discussing factors which facilitate working relationships, several respondents noted there were things which support working between neonatal, and wider maternity and paediatric services (See [Facilitators of working relationships](#)) Some reflected on changes they had made to facilitate these relationships (See [Changes to neonatal and perinatal services - Actions](#)).

Some respondents also referred to the visibility of the neonatal unit in their response, however a range of views were provided. Some noted that compared to other parts of the trust, neonatal services were less visible, and this could result in them being more disconnected or overlooked (see for example 016A, 040A, 002A). On the other hand, the attention placed on these services recently had been considered to raise their profile (083A).

*“On occasion, services including maternity and neonatal services can sometimes operate in a way which is somewhat insular - as the rhythm of the organisation inevitably becomes focused on flow within the emergency department and the adult wards at times of general operational pressure.” (016A)*

*“In terms of the Neonatal Unit, I believe that the culture is open and responsive. Inevitably, a small unit has less visibility to the whole organisation than e.g. the Emergency Department.” (040A)*

*“The Neonatal unit on occasion feel isolated and disconnected from the rest of the acute trust they do not always feel that their challenges are appreciated within the trust external to child health.” (002A)*

*“The level of scrutiny and national attention maternity and neonatal services have received over the last couple of years has increased the profile and visibility of the services, however, this often overshadows other services with as much need.” (083A)*

## Positive culture

In their responses, respondents provided examples to illustrate the “positive” culture they had described. These often applied across the trust as a whole, as well as within the neonatal unit. These have been grouped into themes: transparency/ reporting, workforce roles, communication and engagement, equality, diversity and inclusion, staff wellbeing, trust-wide initiatives and policies, and accreditations and benchmarking. Examples relating to each of these themes are provided in Table 8.

Table 8: Examples provided by trusts which they reported were 'positive' aspects of culture

Themes	Examples
Transparency/ reporting	<ul style="list-style-type: none"> <li><input type="checkbox"/> Events to mark national Speaking Up Month (021)</li> <li><input type="checkbox"/> Improving incident reporting rate (115)</li> <li><input type="checkbox"/> Maternity and Neonatal Safety Champions at board level (executive and non-executive) (for example 058, 016, 087)</li> <li><input type="checkbox"/> Freedom to Speak Up Guardians (for example 064, 118, 076)</li> <li><input type="checkbox"/> Risk and governance process – GIRFT complaints (048)</li> <li><input type="checkbox"/> Mandatory 'Speak Up, Listen Up, Follow Up' training for all senior leaders and line managers (064)</li> <li><input type="checkbox"/> 'Civility saves lives' training<sup>55</sup> (101)</li> <li><input type="checkbox"/> Use of Datix system (for example 084, 098, 009)</li> <li><input type="checkbox"/> Adopting the Patient Safety Incident Response Framework (for example 069, 058, 010)</li> </ul>
Workforce roles	<ul style="list-style-type: none"> <li><input type="checkbox"/> Flat hierarchies (for example 087, 102)</li> <li><input type="checkbox"/> Appointing allied health professionals and adopting MDT working groups (025)</li> <li><input type="checkbox"/> Appointing dedicated children's/ neonatal/ maternity clinical leaders (for example 087, 026, 007)</li> <li><input type="checkbox"/> Moving neonatal from paediatrics into maternity (058)</li> <li><input type="checkbox"/> Professional nurse advocate role (098)</li> <li><input type="checkbox"/> Role of the lead paediatric consultant in maintaining morale (036)</li> <li><input type="checkbox"/> Visibility of maternity matrons (075)</li> <li><input type="checkbox"/> Amending medical rota to provide full neonatal week (075)</li> </ul>
Communication and engagement	<ul style="list-style-type: none"> <li><input type="checkbox"/> Reintroduction of an in-person executive welcome at weekly staff induction days (021)</li> <li><input type="checkbox"/> Board breakfasts (025)</li> </ul>
Equality, diversity and inclusion	<ul style="list-style-type: none"> <li><input type="checkbox"/> Freedom from Racism programme (021)</li> <li><input type="checkbox"/> Dedicated EDI roles and EDI strategies, BAME Network (055)</li> <li><input type="checkbox"/> Celebrating events, such as International Nurses Day, disability awareness, Black History Month and religious festivals (049, 110)</li> <li><input type="checkbox"/> Inclusive recruitment and retention processes (048)</li> </ul>
Staff wellbeing	<ul style="list-style-type: none"> <li><input type="checkbox"/> Compassionate leadership programme (025)</li> <li><input type="checkbox"/> Onboarding and exit interviews (048)</li> </ul>

<sup>55</sup> Civility Saves Lives <https://www.civilitysaveslives.com/>

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Trust-wide initiatives and policies	<ul style="list-style-type: none"> <li><input type="checkbox"/> Relationship with parent-led charity 'First touch' which supports events and breakfasts (049)</li> <li><input type="checkbox"/> Organisational values (for example 046, 066, 077, 111, 112)</li> <li><input type="checkbox"/> Role modelling behaviour from CEO and board (106, 010, 013)</li> <li><input type="checkbox"/> Focus on quality improvement (074, 110,</li> <li><input type="checkbox"/> Culture and organisational development programme for Maternity and Neonates (092) and improvement programmes (045)</li> <li><input type="checkbox"/> 'People Strategy' (092) and 'Just Culture Pledges' (116)</li> <li><input type="checkbox"/> Developing values and behaviours specific to the neonatal team (071)</li> <li><input type="checkbox"/> Culture dashboard (091)</li> <li><input type="checkbox"/> Focus on innovation (036)</li> </ul>
Accreditations and benchmarking	<ul style="list-style-type: none"> <li><input type="checkbox"/> NHS People Pulse survey (064)</li> <li><input type="checkbox"/> NHS Staff Survey (for example 119)</li> <li><input type="checkbox"/> Trust-wide awards (042)</li> <li><input type="checkbox"/> SCORE survey (for example 047, 113, 109)</li> <li><input type="checkbox"/> Perinatal Culture Leadership NHSE Programme (for example 092, 058, 034)</li> <li><input type="checkbox"/> Family Integrated Care (FiCare) green award (110)</li> </ul>

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In their responses to questions on governance and accountability, several trusts referred to the role of the board in setting or role modelling culture across the trust as a whole (See [Structures for management and governance](#)).

It was not possible to compare different features of the trusts themselves and how this related to their culture given the variation described above. However, a few respondents noted the impact of size and/or being multi-site as introducing complexity, making it difficult to ensure a consistent culture across the trust as a whole. One respondent noted that the size of the trust allowed a more “*close knit feel*” (095B).

## Challenges with culture

Several trusts reported some negative response regarding culture either in the trust as a whole or relating to the neonatal unit specifically. This included describing past or ongoing issues, and areas requiring improvement.

In many cases where respondents were describing challenges, they cited specific circumstances affecting the trusts. This included: the impact of mergers (see for example, 013, 113, 108), geography and size of the trust and relationships between different sites (see for example 088, 034, 102, 013) impact of previous investigations and reviews (see

for example 068, 055), CQC inspections and subsequent ratings (091), NHS Staff Survey results (094) and implementation of trust projects such as new EPR systems (024).

*“I would say that the organisation is still finding its feet post-merger and consequentially there are many staff who feel disengaged, distant from management and disempowered to lead change. I think there is a suspicion of management by some teams who are suspicious of motives and think that managers are looking for an excuse to close services and hence don’t necessarily want to raise concerns. I think morale is poor and this a general thing across the NHS with many staff burnt out, significant vacancies, high levels of sickness and high acuity. Paediatrics has been exceptionally badly hit and by extension neonatology. I think there is frustration about the financial constraints limiting what QI we can do to implement the changes that people want to see. I think there is a something of a culture of suspicion, possibly due to concerns from regulators and a perception therefore that the trust tends to over-declare SIs and other incidents etc. This can sometimes deter people from reporting incidents or grading them correctly.” (013A)*

*“From a personal point of view, I feel that the history of the Trust has contributed to the culture as much as the culture has contributed to the history. Historical issues continue to be brought up nationally quite regularly and it can be hard for staff to get past them. Issues like [findings from previous investigations] still hang over teams and result in risk-averse behaviour at times. We have not got a workplace where all people feel psychologically safe.*

*From a medical point of view, the Trust has historically not addressed incivility and poor behaviours at an early stage but has then undergone a large number of formal processes to deal with these issues; this has led to mistrust, disengagement and an unwillingness for people to put their head above the parapet. There is a lot of hard work and application being undertaken to try and regain trust and develop engagement between the medical leadership and the doctors in the Trust and to allow them to feel pride in their organisation, because there are areas of excellent practice and patient care.” (055)*

Examples of ‘negative’ aspects of culture reported by respondents are described in Table 9. Themes included: working relationships, the impact of national or local context and reporting and safety.

Table 9: Examples provided by trusts which they reported were ‘negative’ aspects of culture

Theme	Example
Working relationships	<ul style="list-style-type: none"> <li>□ Poor leadership and working relationships between staff groups, siloed working and/or existence of cliques (056, 033, 055)</li> <li>□ Low staff engagement (such as with the NHS Staff Survey) (for example 007, 115)</li> <li>□ Bullying, harassment and discrimination (for example 011, 032, 061, 055, 069) and evidence of racism (035)</li> <li>□ Challenges with specific staff groups (for example “consultants adopting a command and control’ style of leadership” (073), and with “a small group of nursing staff” (091)</li> </ul>

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	<ul style="list-style-type: none"> <li><input type="checkbox"/> Poor implementation of Electronic Patient Record project (024)</li> <li><input type="checkbox"/> Lack of equality in progression opportunities (004)</li> <li><input type="checkbox"/> Performance management culture resulting in fear or blame (056)</li> </ul>
The impact of national or local context	<ul style="list-style-type: none"> <li><input type="checkbox"/> Suspicion of management due to anxiety around service closure and historical experience where poor behaviour had not been addressed (013)</li> <li><input type="checkbox"/> NHS pressures – staffing shortages, sickness, industrial action, low morale (for example, 060, 053, 056)</li> <li><input type="checkbox"/> Impact of historical issues and investigations (055)</li> <li><input type="checkbox"/> Too much focus on operational delivery or financial pressures compared to quality or building relationships (056)</li> </ul>
Reporting and safety	<ul style="list-style-type: none"> <li><input type="checkbox"/> Pressure of external assurance in neonatal services (024)</li> <li><input type="checkbox"/> Lack of confidence in speaking up, or that action would be taken if they did (056)</li> <li><input type="checkbox"/> Non-compliance with trust policies (013)</li> </ul>

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Some trusts also referred to the working relationships between different professions with some stating that they had observed different cultures *between* professions, which could be exacerbated by context such as service pressures.

*“Barriers to living the culture we want often arise due to perceived operational pressures and what has often been a drive to focus on operational delivery and finance without as clear a focus on Quality or taking the time to build trusted working relationships in teams. This in my view needs re prioritising. Cultural maturity varies across the trust with pockets of excellence accompanied by areas which are not as strong and are being directly supported. I think there is a difference between professions in terms of culture. Again this varies in different areas of the trust and we are actively trying to break down professional silos to have a one team ethos. This needs to be built into education and training and team building from undergraduate to retirement (including managers).” (056A)*

*“There continues to be evidence of cultural divides between professional groups which can show in the times of stress and adversity (eg in times of significant external pressures from external reviews, police enquiries and Coronial cases). During these stressful periods additional support is needed (and provided) to help professional groups remain strong together, to understand each other’s concerns and contributions to processes and to show cooperative and compassionate team working.” (032A)*

## Areas for improvement

As outlined above, even where respondents reported the culture was generally positive, many also recognised that there was always room for improvement and that culture change could take a long time to embed.

Some respondents specified areas of work they were focusing on. This included work on equality, diversity and inclusion, promoting civility and respect, embedding a “just” culture and strengthening collaborative working. A few respondents also referred to action they had put in place in response to previous issues being raised, reflecting that the situation had improved. Trusts also discussed these in their responses on [Working relationships](#) and [Suggestions for improvements to management and governance structures](#).

*“In terms of the Neonatal unit, there has been a significant amount of work undertaken over the last 6 months to address the culture in the unit. Whilst we know we have more to do, we have seen a much more open culture across the team where staff are feeling much more confident to challenge each other. We are also seeing greater respect across the disciplines when challenge is received.” (035B)*

*“There is always more that we can do, and key areas where there are improvements required. Generally our consultants report lower levels of engagement than other staff groups; we are seeking to improve this via a medical leadership and workforce programme and have regular consultant forums in place where they can ask questions or raise concerns, which are chaired by me, or one of our associate medical directors.” (115A)*

*“Neutral evaluation revealed a great deal of commitment and dedication but found a number of key priorities for action that were connection, clarity, consistency, communication, psychological safety, focus and performance. Trust leadership is working with the staff to address these priorities.” (091A)*

*“The culture of the staff on the Neonatal Unit now is excellent. Almost 3 years ago there were 3 incidents which were investigated as SIs. The openness and immediate learning demonstrated by the staff was exemplary. The investigations and findings were reviewed externally and independently by another large Trust out of Region. Their review was extremely complimentary. There was learning which came out of the investigations around culture. At the time (early 2021) we were in the middle of the pandemic, and staffing numbers were challenged. Staffing has improved significantly since then, and much work has been done around culture. In the wider Trust, we recognise the need for an open and just culture.” (001A)*

*“The Trust acknowledges that the joint working with Neonates and Maternity does require strengthening. Actions are being taken to address this with a Quadrumvirate leadership programme, safety huddles, joint clinical Director appointment, perinatal forum engagement and the development of a perinatal improvement programme.” (109A)*

*“The Neonatal unit has previously experienced challenges with working relationships which led to a culture review in 2017/18. Since that review,*

*considerable time and effort has been invested in building relations and improving working relations. Whilst some challenges remain within the nursing workforce, steady improvements are continuing to be made, particularly with committed nursing leadership in place.” (107A - SR)*

## External reviews of trust culture and neonatal services

With regards to reviews of culture at the trust generally, trusts provided examples of initiatives or reviews they had been involved in which had not been specifically commissioned by the trust. Some examples occurred following a specific incident and may be part of a standard process when such incidents occur although limited detail was provided. Given this variation, we have not calculated a numerical answer to this question.

Examples described by trusts fell into five broad categories, which are summarised in Table 10. This included NHS-wide initiatives, neonatal or maternity specific initiatives, required trust reviews, reactive trust reviews, and proactive trust reviews.

Table 10: Examples of reviews provided by trusts

Type of review	Example
NHS-wide initiatives	<ul style="list-style-type: none"> <li><input type="checkbox"/> NHS Staff Survey</li> <li><input type="checkbox"/> CQC inspection or visit</li> </ul>
Neonatal or maternity-specific initiatives	<ul style="list-style-type: none"> <li><input type="checkbox"/> SCORE survey<sup>56</sup></li> <li><input type="checkbox"/> Visit from the Neonatal Operative Delivery Network</li> <li><input type="checkbox"/> NHSE Perinatal Culture and Leadership Programme</li> <li><input type="checkbox"/> Royal College of Paediatric and Child Health visit</li> <li><input type="checkbox"/> Getting it Right First Time visit<sup>57</sup></li> <li><input type="checkbox"/> MATNEO culture survey</li> <li><input type="checkbox"/> Maternity and Neonatal Voices Partnership visits</li> <li><input type="checkbox"/> Operational Delivery Network peer reviews</li> <li><input type="checkbox"/> An assessment visit from BLISS as part of Gold Accreditation<sup>58</sup></li> </ul>

<sup>56</sup> Health Innovation Oxford & Thames Valley ‘SCORE survey’ <https://www.patientsafetyoxford.org/clinical-safety-programmes/safety-in-maternity/past-projects/maternal-and-neonatal-health-safety-collaborative/score-survey-2/>

<sup>57</sup> Royal College of Paediatrics and Child Health ‘A snapshot of neonatal services and workforce in the UK’ <https://www.rcpch.ac.uk/resources/snapshot-neonatal-services-workforce-uk>

<sup>58</sup> Bliss ‘Going further with the Bliss Baby Charter’ <https://www.bliss.org.uk/health-professionals/bliss-baby-charter/what-is-the-bliss-baby-charter-1/going-further-with-the-bliss-baby-charter>

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	<ul style="list-style-type: none"> <li><input type="checkbox"/> Maternity and Neonatal Voices Partnership visit ('15 steps')<sup>59</sup></li> <li><input type="checkbox"/> MMBRACE report into mortality<sup>60</sup></li> <li><input type="checkbox"/> Kirkup review</li> <li><input type="checkbox"/> Ockenden visit/ Ockenden review</li> <li><input type="checkbox"/> Maternity Improving Performance in Practice (IPiP)</li> <li><input type="checkbox"/> MatNeoSip culture score survey</li> </ul>
Required trust reviews (for example following incidents)	<ul style="list-style-type: none"> <li><input type="checkbox"/> Internal audits</li> <li><input type="checkbox"/> Internal and external reviews following serious incidents, deaths or due to mortality outliers</li> </ul>
Reactive trust reviews (for example into behaviour)	<ul style="list-style-type: none"> <li><input type="checkbox"/> Investigations into other trust services (not neonatal) such as surgery or maternity</li> <li><input type="checkbox"/> External review of whistleblowing case</li> <li><input type="checkbox"/> Freedom to Speak Up review</li> <li><input type="checkbox"/> External inquiry into bullying and harassment</li> </ul>
Proactive trust reviews (for example as part of organisational development programmes)	<ul style="list-style-type: none"> <li><input type="checkbox"/> Commissioned reviews from external organisations or individuals, CQC well-led review, trust values refresh, 'culture conversations,' culture audit, cultural readiness survey as part of Virginia Mason improvement work</li> </ul>
Other (not clear if initiated internally or externally, or proactive or reactive)	<ul style="list-style-type: none"> <li><input type="checkbox"/> External quality governance review, leadership and culture needs analysis, Family Integrated Care (FIC) external review, internal culture review</li> </ul>

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Trusts were not asked for reasons for why reviews took place. Where respondents did provide reasons, these were both proactive (as part of wider programmes) and reactive (in response to specific issues or concerns) and included:

- Responding to concerns raised about behaviour by individual team members (115)
- As part of a trust-wide culture programme (025), as part of internal reviews/ audits (071) or as part of board development programme (095)
- To inform work post-merger (008) or "*as part of the transaction process*" (110)
- To resolve "*conflict*" within maternity and neonatal services (048)

<sup>59</sup> National Maternity Voices (2022) '15 steps for maternity' <https://nationalmaternityvoices.org.uk/toolkit-for-mvps/mvps-in-action/gathering-feedback/15-steps-for-maternity/>

<sup>60</sup> MBRRACE-UK 'Perinatal Confidential Enquiry: A comparison of the care of Asian, Black and White women who have experienced a stillbirth or neonatal death' <https://www.npeu.ox.ac.uk/mbrpace-uk/reports>

- Following concerns raised to the CEO by consultants regarding leadership in paediatrics, and culture in paediatrics and neonates (013)
- Following concerns raised about “*lived experience of colleagues*” (055) and “*lack of collaborative working between paediatrics and A&E*” (084)
- As part of a whistleblowing case (058)
- As part of programmes of improvement work (116)
- To “*establish a foundation for understanding staff perceptions as an organisation and to determine how the experience of work influences staff health and well-being*” (117)
- Due to the trust being an ‘outlier’ for neonatal mortality (033)

There was, however, variation in the extent to which trusts described reactive and proactive reviews, with some interpreting the question as relating to reviews which had been commissioned in response to particular issues.

*“No external reviews have been commissioned as data has not demonstrated sufficient concern to do so.” (112)*

## Comparison between respondents with different roles

In this section we compare responses from medical directors (or other clinicians) and non-clinical managers where trusts submitted two different responses.

Respondents mostly described the culture at a high level across the trust, and their responses were subject to the complexities and interpretations of the question described earlier. We did not observe any examples where there were clearly opposing views between two respondents of the same trust, although some expressed diverging views. For example, responses varied in the level of detail provided, and the issues they focused on. In some cases, respondents from the same trust drew on different sources of evidence or examples to illustrate their responses or reflected on their personal experience of working at the trust. Even where responses within trusts were different, it did not necessarily mean that they were incompatible or mutually exclusive. Consequently, we have grouped responses into three categories:

- Aligned – similar content, examples or sentiment expressed
- Neither aligned nor divergent – different content but not necessarily incompatible
- Divergent – content which indicates different views, experience or evidence

Examples illustrating these differences are provided in Table 11 below.

Table 11: Examples from trusts illustrating different responses to Question 8

Trust	Response from 'A'	Response from 'B'
<b>Aligned</b>		
063	<p><i>"Following the COVID pandemic the Trust has entered a difficult period with staff advocacy engagement turnover and retention metrics deteriorating. Large scale interventions around the people promise (...), continuous improvement, and investment in leadership development mean that the[y] are starting to see recovery of these areas."</i> (063A)</p>	<p><i>"The culture of the Trust has been more difficult in the last few years in the context of a high staff turnover, high vacancies and retention metrics deteriorating. Some of this reflects the wider NHS however there have been challenges specific to [the trust] including offering staff appropriate training and development to further their careers.</i>  <i>The Trust has been working hard on the NHS People promise improving recruitment rates, reducing the level of vacancies across nursing in particular.</i>  <i>More training and development opportunities have been put in place."</i> (063B)</p>
077	<p><i>"Over the last two years, since the new executive leadership team started in post, the Trust's culture has been changing. We have introduced new Trust values. We are aiming to be more open, encouraging "speaking up" through our Speaking Up Guardian, and are promoting the importance of civility and kindness through an initiative which includes a film for staff that is shown at all staff inductions.</i>  <i>In the cultural readiness survey, the scores for the neonatal unit were more positive than other areas. The highlighted areas of focus are; work/life balance, communication and collaboration.</i>  <i>In respect of the neonatal unit, it consists of a well-functioning multi-disciplinary team of clinicians and managers who work cohesively to deliver excellent care."</i> (077A)</p>	<p><i>"Trust generally: welcoming, improvement focussed; learning to speak up and increasingly doing so; kind, enjoy pulling together (eg in Covid ...); processes not always well embedded. Some teams exhibit a degree of learned helplessness, although that is starting to wane.</i>  <i>Over the last two years, since the new executive leadership team started in post, the Trust's culture has been changing. We have introduced new Trust values. We are aiming to be more open, encouraging "speaking up" through our Speaking Up Guardian, and are promoting the importance of civility and kindness through an initiative which includes a film for staff that is shown at all staff inductions.</i>  <i>In the cultural readiness survey the scores for the neonatal unit were more positive than other areas. The highlighted areas of focus are: work/life balance, communication and collaboration.</i>  <i>In respect of the neonatal unit, it consists of a well-functioning multi-disciplinary team of clinicians and managers who work cohesively to deliver excellent care."</i> (077B)</p>
020	<p><i>"Generally a positive, supportive and safety focused culture throughout the Trust. As might be expected, there is variation in culture and the experience of staff members between</i></p>	<p><i>"My view of working in the Trust for over 20 years is that there is generally a highly motivated and positive workforce, striving hard to do a good job as well as being caring and supportive to each</i></p>

	<i>different departments and there are some departments which have needed additional support in this respect.” (020A)</i>	<i>other. As within any organisation employing such high numbers of staff there will also be pockets of staff feeling less motivated and engaged and as an organisation we try to address these areas with organisational development support but on occasions we will manage poor behaviours where this is required.” (020B)</i>
035	<i>“Following the National Staff Survey and internal Pulse Check results over the past year, the Trust is committed to developing a culture that can be described as open, which shows mutual respect for each other and people’s views. There is a commitment to improving racism in our Hospital which has been reflected as a challenge through the staff surveys and WRES data.” (035A)</i>	<i>“It is fair to say that the culture across the organisation is not where we wish it to be, although there are pockets or good practice in some teams where the culture is considered to be open and supportive. We know that we have an issue with racism and respect and this plays out in both the Pulse check and National staff surveys. The Board aware and are committed to changing this, and have a whole program of work in place to address.” (035B)</i>
<b>Neither aligned nor divergent</b>		
029	<i>“Prior to merger there were two separate trusts. Merger took place on [date] which was at the 1st peak of the Covid pandemic. The trust has developed its values which are a framework to nurture a healthy culture through embedding our values and associated behaviours... As examples we have twice yearly staff engagement events (on each hospital site) and monthly all staff briefings (MS Teams) attended by all executives where challenging issues and questions are addressed.” (029A)</i>	<i>“As noted above, the Trust’s commitment to an open and learning culture and leadership at the level of individual service line are well reflected in our neonatal and paediatric services and these is frequent and purposeful communication between service leaders, front line staff and senior leaders including the executive team across the trust. I believe that the structure and approach we take promotes honesty and a shared purpose, breaking down both hierarchies and inter-professional differences. Twice yearly Trust wide engagement events run for a week on each site and are open to all staff. We actively promote the staff survey and ask leadership teams to evidence their use of the intelligence from this source in their objectives.” (029B)</i>
031	<i>“My description of the Trust culture is that there is a “can do attitude” to anything related to the patient with a willingness to go the extra mile to achieve good outcomes. I do not feel it is appropriate to offer what would be observations about culture in different staff groups as this would be subject to a wide variety of biases. However I am aware that my personal opinions in relation to this are not objective and thus evidence</i>	<i>“[The] [Trust values] are [...] at the heart of everything that we do. These were developed with considerable input from staff and the public and I think accurately describe the culture that we are trying to develop at [the trust]. Staff are generally very proud to work at [the trust] and proud of our international reputation, particularly for research. Where there are issues these often arise from financial pressures or workforce shortages. At times</i>

	<p><i>such as our staff survey provide better evidence about the culture within [the trust].</i></p> <p><i>My personal experience is that there is a strong culture of patient centred care in our neonatal services and good multi-disciplinary process. As previously described I have not seen any evidence to suggest otherwise but the planned questionnaire on culture will provide more objective evidence about the culture in our neonatal unit.” (031A)</i></p>	<p><i>there are tensions between tertiary and local secondary care work, but this is less apparent in neonatal services.” (031B)</i></p>
032	<p><i>“Trust culture is one of being caring and prioritising people first (patients and staff) with all staff indicating through feedback and direct consultations that they want to work in an inclusive, kind, compassionate, patient and staff-centred workplace. This is also true of the neonatal unit where staff express their priority is the care of the baby and family and working in a team that include and respect each other.” (032A)</i></p>	<p><i>“The Trust has a history of not being inclusive and of bullying from leaders at all levels. This has been changing significantly in the last 3 years and the culture is now very much more inclusive, transparent and open. The senior leadership is much more visible that previously and staff of all grades are able to ask questions of the leadership in a variety of forums. There is still more for us to do and cultural work is continuing across the organisation.” (032B)</i></p>
056	<p><i>“The trust has a continued focus on improving culture with recognition of the need for a trust culture to be lived by all comprising positive safety culture, compassionate/kind, culture of continuous improvement. In discussing this at a whole staff webinar recently a high proportion of staff on the call indicated they felt safe to raise a concern however less staff felt that a concern would be responded to. We therefore recognise the need to continue to make sure staff are responded to when they raise concerns at all levels of management and not just getting a response because there is escalation to board members or the FTSUG.</i></p> <p><i>Different work streams exists including [values] and the PSIRF implementation which we hope will help move culture in a positive direction. Barriers to living the culture we want often arise due to perceived operational pressures and what has often been a drive to focus on operational delivery and finance without as clear a focus on Quality or taking the time to build trusted working relationships in teams. This in my view needs re prioritising. Cultural maturity varies across the trust with pockets of excellence accompanied by areas which</i></p>	<p><i>“I would describe the culture of the Trust as evolving. There is a legacy culture that still exists which is very performance management driven which resulted in a culture of fear and blame (lingering from a decade ago). Thus, it is taking time to build trust amongst staff and shift the culture to openness and transparency.</i></p> <p><i>The culture in the neonatal service is also evolving. The structures in place aim to strengthen the safety first culture.” (056B)</i></p>

	<p><i>are not as strong and are being directly supported. I think there is a difference between professions in terms of culture. Again this varies in different areas of the trust and we are actively trying to break down professional silos to have a one team ethos. This needs to be built into education and training and team building from undergraduate to retirement (including managers).” (056A)</i></p>	
<b>Divergent</b>		
013	<p><i>“I think that culture across a large multi-trust site is difficult to define and varies greatly across the organisation. I would say that the organisation is still finding its feet post-merger and consequentially there are many staff who feel disengaged, distant from management and disempowered to lead change. I think there is a suspicion of management by some teams who are suspicious of motives and think that managers are looking for an excuse to close services and hence don't necessarily want to raise concerns. I think morale is poor and this a general thing across the NHS with many staff burnt out, significant vacancies, high levels of sickness and high acuity.” (013A)</i></p>	<p><i>“There has been a recent change of Chief Executive at the Trust. The culture [they are] role modelling is one of civility, responsibility, patient focus and openness. I have no concerns about a culture of issues being ignored or disputed. The new CEO commissioned the external culture review referenced above. Overall there has been a culture where non-compliance to Trust policies has been accepted and where poor behaviour has been tolerated – this is beginning to change. There are slightly different cultures at each of the hospital sites. These site based cultures are mirrored by the cultures in the Neonatal units, mostly by the Consultant teams.” (013B)</i></p>
078	<p><i>“I would describe the culture as one of openness and a willingness to work as part of multi-disciplinary teams. There are always individuals who work less well in this way but the vast majority embrace this way of working. We have encouraged all grades of staff to participate in MDTs. We are very conscious of the Staff Survey noting that some colleagues experience bullying and harassment at work and although this is not uncommon in the NHS are working hard to reduce this. The Freedom to Speak up service has been boosted with champions across the Trust and from a diverse range of backgrounds.” (078A)</i></p>	<p><i>“I would describe the Trust as having a positive culture. This has been evidenced in our recent staff survey results, from our Freedom to Speak Guardian and external feedback from regulators. Colleagues generally feel supported in their work and new starters consistently describe the Trust as one of the most welcoming they have been part of.” (078B)</i></p>
115	<p><i>“The Trust’s culture, and that of neonatology, is generally collaborative and patient-centred and based on MDT working between medical staff, nursing staff and managers at all levels, including leadership. There is a focus on facilitating</i></p>	<p><i>“. The merging of the neonatal unit with the Maternity directorate on [date] has had a positive impact. There has been a positive emerging perinatal culture in the neonatal service with the multidisciplinary team</i></p>

<p><i>joint working as demonstrated in many of our processes, including incident investigation reports, development of clinical guidelines, response to complaints and concerns (both from patients and from staff) and through the impressive breadth of research which is undertaken across the organisation.</i></p> <p><i>I would say there has been a significant improvement in how it feels to work here over the last few years with a focus on just culture, support for our colleagues, putting patients at the heart of what we do, and on living our Trust values (...). We have focused on encouraging people to speak up when they have concerns and on ensuring appropriate action is taken when they do. One of the key areas in which this focus is visible is our improving incident reporting rate.</i></p> <p><i>There is always more that we can do, and key areas where there are improvements required.</i></p> <p><i>Generally our consultants report lower levels of engagement than other staff groups; we are seeking to improve this via a medical leadership and workforce programme and have regular consultant forums in place where they can ask questions or raise concerns, which are chaired by me, or one of our associate medical directors.” (115A)</i></p>	<ul style="list-style-type: none"> <li><i>· New leadership structure in place since [date] (head of specialty, 2 medical site leads, a dedicated Lead Nurse and a Business manager) has improved stability, collaborative working and effective engagement with the entire team</i></li> <li><i>· There is collaborative working across [t]he two sites and different staff group</i></li> <li><i>· There is an open culture where staff feel safe to raise concerns.” (115B)</i></li> </ul>
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Across staff groups as a whole, we did not observe any clear differences between the responses of the respective staff groups. The themes raised above were consistent between the respondents.

## Nuffield Trust reflections

Culture is a term widely used in healthcare but is difficult to define and is used as both a remedy and culprit for issues within healthcare.<sup>61</sup> Understandings of culture in the NHS tend to come from reports into high-profile patient safety failures.<sup>62</sup> Different aspects of culture include organisational culture, safety culture, learning culture and just culture (more detail on these terms is provided in the glossary). This range was reflected in the responses to the questionnaire.

Responses to the questionnaire indicate that culture across trusts and neonatal units is complex, can vary and is dependent on particular contexts. While some did describe particular challenges, many described features of their trust which they considered demonstrated a good culture. Some also reflected on changes and improvements over time, the impact of previous incidents and reviews, and organisational priorities to improve culture, noting that culture is not static and developing a good culture requires continuous attention.

Features of positive cultures were described by trusts to include multi-disciplinary team working and leadership, communication and visibility, equality, diversity and inclusion, staff wellbeing and effective mechanisms for raising concerns. Features of challenging cultures described by trusts included siloed working, experiences of bullying, harassment or lack of diversity, and hierarchies. Some trusts also referred to the impact of local and NHS context such as service pressures, staffing levels and reporting requirements. These themes are reflective of wider evidence, as well as findings from previous investigations with several pointing to culture as a reason for why people were unable to raise questions or concerns, why poor standards are accepted and to explain individual behaviour (see for example Kirkup (2022)).<sup>63</sup>

Developing a 'positive safety culture' is one of the objectives of the three-year delivery plan for maternity and neonatal services. This sets out actions for NHS England, trusts and ICBs respectively.<sup>64</sup> For trusts, this includes for example:

- ensuring maternity and neonatal leads have the time, access to training and development, and lines of accountability
- regularly reviewing progress and supporting implementation at board level of a focused plan to improve and sustain culture, including alignment with their FTSU strategy, and

<sup>61</sup> Machen, S. (2021). 'Assuring medication safety from board to ward – the role of governance and local cultures'. UCL PhD thesis. Available at UCL Explore.

<sup>62</sup> Machen, S. (2021). 'Assuring medication safety from board to ward – the role of governance and local cultures'. UCL PhD thesis. Available at UCL Explore.

<sup>63</sup> Kirkup (2022) 'Reading the signals: Maternity and neonatal services in East Kent – the Report of the Independent Investigation'  
[https://assets.publishing.service.gov.uk/media/634fb083e90e0731a5423408/reading-the-signals-maternity-and-neonatal-services-in-east-kent\\_the-report-of-the-independent-investigation\\_print-ready.pdf](https://assets.publishing.service.gov.uk/media/634fb083e90e0731a5423408/reading-the-signals-maternity-and-neonatal-services-in-east-kent_the-report-of-the-independent-investigation_print-ready.pdf)

<sup>64</sup> NHS England (2023) 'Three-year delivery plan for maternity and neonatal services'  
<https://www.england.nhs.uk/long-read/three-year-delivery-plan-for-maternity-and-neonatal-services/>

- ensuring that staff are supported by clear and structured routes for escalating clinical concerns and ensuring all staff have access to FTSU training modules and a FTSU guardian.

Responses from trusts indicate that many trusts have these processes in place already, are actively working to put them in place and/or are working to cultivate this type of culture.

Ascertaining the culture across the NHS as a whole is complex given the multitude of organisations, teams and individuals who work within it. However, the national results of the NHS Staff Survey can provide some insight.<sup>65</sup> With regards to clinical safety specifically, the percentage of staff who feel secure raising concerns is at its lowest point in five years, with medical and dental staff consistently less likely to report feeling secure than registered nurses and midwives. Across all staff groups, 71% reported feeling secure raising concerns about unsafe clinical practice and 57% reported feeling confident that their organisation would address their concern.

With regards to the working environment generally, the 2023 results showed improvements on four measures relating to workload and resources, following notable declines between 2020 and 2021. Findings on burnout also improved since the 2022 survey, although 30% of respondents still reported feeling burnt out because of their work.

<sup>65</sup> NHS Staff Survey (2024) 'National Results' <https://www.nhsstaffsurveys.com/results/national-results/>

# Working relationships

This section provides a description of working relationships within neonatal units. This section covers questions 5 and 6 in the questionnaire.

The questions about working relationships were answered in a variety of ways. Most respondents provided descriptions of relationships between healthcare professionals in general, rather than broken down by different staff groups. Some respondents provided answers based on their own personal experience, perceptions, or observations; whereas others had consulted with colleagues to answer the questions.

## Questions asked of trusts:

5. Describe the working relationships in your neonatal service within each of the groups of professionals set out at (a), (b) and (c) below. Are these relationships in the neonatal service typical of the trust generally?

- a. doctors and managers (clinical and non-clinical);
- b. nurses, midwives and managers (clinical and non-clinical) and
- c. between medical professionals (doctors, nurses, midwives, and neonatal nurse practitioners)

6. In respect of each group set out at (a), (b) and (c):

- a. How does the trust seek to facilitate an effective working relationship within the groups of staff identified above?
- b. When has the trust received any staff feedback about the working relationships in the neonatal service?
- c. What was the response rate to the NHS Staff survey in respect of the neonatal unit and did this provide any feedback in relation to culture & leadership within the unit?

## Context for this section

- The BAPM Service and Quality Standards (2022) note the importance of effective multidisciplinary team (MDT) working in delivering excellence in neonatal care. This includes establishing mechanisms to improve team working and communication, developing a perinatal culture and regular staff engagement.<sup>66</sup> These standards also describe “network pathways” which discuss the interaction between neonatal units and maternity services.

<sup>66</sup> British Association of Perinatal Medicine (2022) ‘Service and Quality Standards for Provision of Neonatal Care in the UK’ [https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file\\_asset/file/1494/BAPM\\_Service\\_Quality\\_Standards\\_FINAL.pdf](https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/1494/BAPM_Service_Quality_Standards_FINAL.pdf)

- As well as the NHS Staff Survey (see [Culture – Context for this section](#)), several other regular surveys exist. The General Medical Council run the national training survey every year to capture the experiences of doctors in training and trainers.<sup>67</sup>

## Working relationships between all staff groups

Most respondents reported positive working relationships between staff groups. Words used to describe relationships commonly included ‘good’, ‘strong’, ‘close’ and ‘excellent,’ ‘supportive’ and ‘inclusive’ although in a few cases, these words were listed without further information or reasons for why respondents classified relationships in this way. As described in [Culture in NHS trusts](#), respondents noted that there could be pockets of issues even if working relationships were generally good. In some cases, respondents referred to relationships across wider trust divisions or departments (such as paediatrics and maternity) and not just within neonatal services, and some also described relationships as a whole rather than between specific roles. A few noted that they were unaware of concerns being raised.

*“This response spans all of the groups above and does not separate them out, as focus is placed on good team dynamics and effective working practices across all disciplines.” (010 – SR)*

Respondents noted a range of features which demonstrated these relationships. Common themes raised by respondents in their answers included a multi-disciplinary approach to teamworking, leadership, and ensuring communication between teams and individuals, and visibility of senior staff (both clinical and managerial). One respondent specifically noted that given babies in NICU have multi-speciality needs, good relationships with other specialty teams (such as cardiology or respiratory) are also important (069A). Several respondents also reported that the relationships and approaches to working were reflected across the trust more widely. As described in [Culture in NHS trusts](#), some reported that working relationships could change over time or be impacted by local or national context as with culture as a whole.

*“The working relationships are healthy and evolving.” (060B)*

*“Relationships between professionals are generally good although in such a large team and with such operational and clinical pressures there can be personal differences and some disagreement but focus is always on providing consistent safe and effective care to babies and families.” (069 – SR)*

*“This is not to say that the relationship could not be improved further, and I am always aware that maintenance of these relationships does not happen by accident.” (036)*

Where challenges with working relationships were noted, these were commonly a result of specific trust circumstances (as described in [Challenges with culture](#)). This included the impact of previous investigations in the maternity units or trust as a whole, perceived hierarchies between staff groups, and difficulties with individual behaviour. One trust (013)

<sup>67</sup> General Medical Council (no date) ‘National training survey <https://www.gmc-uk.org/education/how-we-quality-assure-medical-education-and-training/evidence-data-and-intelligence/national-training-surveys>

reported some challenges with specific sites; this was reported to be specifically between medical staff at some sites and the wider trust management due to concerns surrounding a merger.

## Working relationships between doctors and managers (clinical and non-clinical)

Where respondents described relationships between doctors and managers specifically, these were mostly described positively. Words used by respondents in relation to these relationships included: ‘professional’, ‘supportive’, ‘mutually respectful’, ‘healthy’, ‘fruitful’, ‘collaborative’, ‘friendly’, ‘open’, ‘honest’, ‘approachable’, ‘communication’ and ‘shared ambition.’

A small number of respondents noted that part of the reason for positive working relationships was that they adopted a “medically led” model, where clinicians were responsible for decision-making, both at the trust level and within particular services. As described in [Positive culture](#), many respondents referred to multi-disciplinary leadership which included management and clinical staff, as well as informal and formal routes for facilitating communication, feedback, and collaboration between these staff groups.

Where challenges were mentioned and reasons given, respondents referred to the wider context around NHS pressures, historical issues within the neonatal service, and specific areas of contention such as decisions around particular care approaches. Some also noted that where challenges did arise, teams worked together constructively to discuss and address them.

*“Working relationships between doctors and managers within the neonatal team are generally good partly because we have a medically led model – the head of specialty is a consultant who works very closely with the general manager and the lead nurse. This is typical of the wider Trust generally where this structure is also in place...” (115A)*

*“These relationships are usually good, but there has been a need to pay particular attention to good teamworking recently due to challenges within the management team around capacity, vacancies and the capability to newly recruit staff.” (049 - JR)*

*“Working relationships within the neonatal service between doctors and managers are very good. Across the wider general paediatric medical staff it becomes a bit more mixed, but in the main the relationships are generally good. There are a minority of general paediatric medical staff who do not feel their views are represented by management teams.” (116A)*

*“There is always discussion, sometimes with differing views, on how funding, investment or efficiencies should be delivered, but generally these are healthy discussions that also exist in nearly all NHS services between doctors and managers.” (080B)*

*“Inevitably, there will also be episodic frustrations between clinicians and managers. The current industrial relations context is a challenge to working relationships in*

*some areas in the Trust, given the opportunity cost presented by recurring periods of medical staff industrial action and consequent impact on transformation agenda, working time, and financial position.” (040A)*

*“Managers are visible and accessible albeit there are a number of conflicting priorities in the NHS as a whole that can mean managers are not always as visible as they’d like. This is typical of the trust generally and is usually linked to capacity of competing priorities rather than lack of engagement or poor relationships.” (040B)*

## **Working relationships between nurses, midwives and managers (clinical and non-clinical)**

Where respondents described relationships between nurses, midwives and managers, themes included the importance of regular communication through meetings and other forums, clear lines of accountability to senior nursing roles (such as the Head of Nursing or Chief Nurse roles), multi-disciplinary team working, and respect for each other’s expertise. A few respondents noted that in their neonatal units their leadership was “*quadrumvirate*”, including senior midwives as well as doctors, nurses and managers. Several respondents described the relationship between the neonatal unit and wider divisions such as maternity, or paediatrics and described the ways in which communication and collaboration is facilitated between staff across these units.

*“Traditionally midwives and nurses have worked quite independently of each other but our learning from our independent maternity review has brought all teams closed together. The work we have done on transitional care and in training in neonatal life support has emphasised the shared skills that our midwives and neonatal nurses have and has helped us in developing workforce plans. Having been through a major maternity review and with maternity and neonatal care always and understandably being a focus for inquiry, there are professional anxieties in relation to management of conduct and capability that can create tensions between clinical staff and their managers.” (091A)*

*“Since March 2023 they have begun meeting as five leaders (Chief of Service for Paediatrics/Neonates, Chief of Service for Obstetrics & Gynaecology, Director of Midwifery, Head of Nursing for Paediatrics and Neonates, and Associate Director for Women’s and Children’s. This ensures good communication flows between departments and there is a current focus on culture.” (119B)*

*“Across Maternity significant improvement has been evidenced in the improvement of working relationships between Midwives and Managers. There is a clear management structure across Maternity with lines of escalation to the midwifery matrons through to the Associate Director of Midwifery. The Matrons, Quality and Safety lead, General Manager and the Associate Director meet weekly to review the delivery of maternity services and resolve factors that may impact on service delivery that specific week. The relationship between midwives and Neonatal nurses and the current management structure is one that is in forming stage. Whilst there has been stability in Maternity between midwives and Managers, the Neonatal relationship with Managers is in its early stages following a change of structure.” (094 - SR)*

*“There is evidence of respectful challenge, innovation and cross-discipline support to achieve goals. This is reflected in the wider Trust culture. As a smaller Trust with proportionately smaller teams there are more opportunities for staff of all disciplines to meet and talk both informally and formally which engenders an interested and innovative approach to the work as well as growing supportive relationships.” (036 - SR)*

A few trusts reported issues regarding working relationships between nurses, midwives and managers. This included concerns regarding relationships between senior leadership and nursing teams in lower bands. One respondent noted that there was a disconnect between how the relationships appear and concerns that had been raised:

*“The working relationships appear good outwardly. However, the Freedom to Speak Up Guardians again suggest there are cliques in the units and they are not as cohesive as would initially appear.” (068A)*

## **Working relationships between clinical professionals (doctors, nurses, midwives, and neonatal nurse practitioners)**

Where respondents described relationships between clinical professionals, themes raised included the importance of mutual respect between professional groups, multi-disciplinary working, and collaboration. Respondents gave examples of regular meetings and opportunities for communication which support working relationships.

Some respondents noted that while relationships were generally positive, there could be instances of disagreement between staff members. It was not always clear from responses who these staff were or what the disagreement was about, although a few mentioned issues around professional disagreement between staff groups. One respondent noted there could be professional challenge between nursing/ midwifery and medical teams, and between obstetricians and paediatricians regarding individual cases (063A). In one case, while the respondent noted that there were good relationships between neonatal doctors, nurses and midwives, they stated that work was required to improve relationships between consultant obstetricians and midwives (116B). Another noted that action was taken with regards to behaviour by a “*small number of consultant colleagues*” (115A).

One respondent gave a specific example of where there had been disagreement between groups over the most appropriate course of care. This related to how to configure certain pathways (who is responsible for escalation at certain points) and how to allocate staffing (for example whether to improve flow, or to improve staff mix) (096). One respondent noted that the impact of frequent rotation of doctors in training can mean there is less opportunity for building personal relationships (029B). One also noted that there has been an issue with trainees or more junior staff feeling less well supported, which the trust was undertaking specific work on (032 - SR)

Some respondents also noted that wider contextual pressures could place strain on working relationships.

*“There are professional working relationships between all these groups, although there are differences between the sites and differing perspectives between professional groups.” (023 -JR)*

*‘As one might expect in a high-pressure environment, tensions arise from time to time but are sympathetically and effectively handled by the various service leads working cooperatively and it is very rarely necessary for COO, CNO or CMO to be involved.’ (036A)*

A few trusts noted challenges in the working relationships between senior medical professionals and junior or trainee doctors, and one also noted issues which had been raised regarding locally employed doctors and Advanced Neonatal Nurse Practitioners.

*“There are reports from trainees and more junior staff of sometimes feeling marginalised and left out of key communications, or more senior staff showing less supportive behaviour towards them particularly in busy and stressful cases. This is the area identified for the culture and engagement strategy work being undertaken by the Division and Trust.” (032 -SR)*

*“Within the wider workforce, there is generally good mutual respect for all clinical professionals. Specific instances have been raised about support for the development of locally employed doctors (LEDs) and Advanced Neonatal Nurse Practitioners (ANNPs) with the suggestion that they are not always encouraged to practice at their highest level of training. This is being addressed by defining role and responsibilities more precisely through a recent business case and creating a more supportive professional environment among clinicians. In addition, there have been specific accusations of an unsupportive working environment for junior doctors which have been escalated through medical management and form part of the current investigation.” (073A)*

## **Facilitators of working relationships**

Respondents described a combination of formal and informal mechanisms and or/ approaches to facilitate working relationships. These are summarised in Table 12 – many of these are also discussed later in the report in [Factors encouraging raising concerns](#). Given that many respondents described examples which operate across whole teams, we have not separated these by staff group. Themes included team working, leadership, communication and visibility, and trust policies and processes, and there was a strong focus on mechanisms which support multi-disciplinary team working. Several trusts noted that their staff were participating in the NHS England Perinatal Leadership Development Programme.

*“The importance of strong multi-disciplinary working relationships between clinical and managerial roles is integral to the functioning of the organisation and utilises multi-disciplinary clinical and non-clinical team meetings, multi-disciplinary training opportunities, multi-disciplinary handovers between clinical teams and multi-disciplinary core huddles and briefings to ensure that all staff, regardless of role, have common purpose with clear and direct communication. There are also multidisciplinary team (MDT) wards rounds, MDT Perinatal Mortality Reviews (PMRT), staff away days and*

*MDT wellbeing activities, which all support the integration of team working and strengthen the relationships between disciplines.” (030 -SR)*

*“The premise that a collaborative, multi-disciplinary team results in improved care and safety is adopted and supported within the Trust. The Trust encourages an inclusive ‘bottom up’ approach being patient and staff centred. The inclusion of all disciplines within the leadership team, governance and specialty meetings aims to foster effective working relationships. Practically, relationships are strengthened through multi-disciplinary training and joint managers meetings between the neonatal and maternity services.” (056B)*

Table 12: How trusts facilitated working relationships

Theme	Examples of how trusts facilitated working relationships
Team working within the neonatal unit and between other clinical areas	<ul style="list-style-type: none"> <li><input type="checkbox"/> Using Team Engagement and Development Tools</li> <li><input type="checkbox"/> Improving medical leadership or engagement/use of medical champions</li> <li><input type="checkbox"/> Multi-disciplinary team working and collaboration, ‘flat’ hierarchies</li> <li><input type="checkbox"/> Regular meetings between healthcare professionals and managers</li> <li><input type="checkbox"/> Co-locating neonatal and maternity services/ offices being on the same corridor</li> <li><input type="checkbox"/> Multi-disciplinary approach to improvement programmes, training, and away days</li> <li><input type="checkbox"/> Encouragement of MDT working from executive level</li> <li><input type="checkbox"/> Ensuring 24/7 consultant cover on paediatric rotas</li> <li><input type="checkbox"/> Clinical supervision and group psychological support</li> <li><input type="checkbox"/> Cross-site roles</li> </ul>
Leadership	<ul style="list-style-type: none"> <li><input type="checkbox"/> Leadership development programmes (for example, such as NHS England’s Perinatal Leadership Development Programme)</li> <li><input type="checkbox"/> Representation of neonatal services at a senior level (for example on the board)</li> <li><input type="checkbox"/> Cross-site leadership</li> <li><input type="checkbox"/> Triumvirate leadership within clinical divisions between managerial, medical, and nursing staff</li> <li><input type="checkbox"/> Creating new roles such as Director of Midwifery/Head of Paediatric Nursing</li> <li><input type="checkbox"/> Clear lines of accountability to senior nursing roles</li> <li><input type="checkbox"/> Maternity and Neonatal Safety Champions at board level</li> <li><input type="checkbox"/> Medically-led model (at the trust and in the neonatal unit)</li> </ul>
Communication and visibility	<ul style="list-style-type: none"> <li><input type="checkbox"/> Listening events and programmes</li> <li><input type="checkbox"/> Website contact forms allowing staff and the public to contact the CEO directly</li> <li><input type="checkbox"/> Huddles and walkarounds</li> <li><input type="checkbox"/> NHS Staff Survey and trust surveys</li> </ul>

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Trust policies, processes and initiatives	<ul style="list-style-type: none"> <li><input type="checkbox"/> Staff forums</li> <li><input type="checkbox"/> Open door policies (for example of senior nursing and medical staff and managers)</li> <li><input type="checkbox"/> Senior clinical and non-clinical support and presence on the unit</li> <li><input type="checkbox"/> Drop-in sessions (for example with matrons, the board and other senior leaders)</li> </ul>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Freedom to Speak Up policies</li> <li><input type="checkbox"/> Regular senior leadership forums/reviewing values</li> <li><input type="checkbox"/> Committees and forums for raising issues</li> <li><input type="checkbox"/> Routes to resolve conflict such as mediation and workshops</li> <li><input type="checkbox"/> 1:1s, appraisals, line management, 360 feedback</li> <li><input type="checkbox"/> Taking action in response to NHS Staff survey feedback</li> <li><input type="checkbox"/> Promoting a diverse workforce – recruitment programme and medical staff representation</li> <li><input type="checkbox"/> Making human factors and staffing integral parts of investigating clinical incidents</li> <li><input type="checkbox"/> Embedding teamwork within organisational values</li> <li><input type="checkbox"/> Providing a range of informal and formal feedback routes to raise issues</li> <li><input type="checkbox"/> Separating paediatric and neonatal consultant rotas</li> <li><input type="checkbox"/> Celebration events</li> <li><input type="checkbox"/> Specific learning sessions following the Lucy Letby verdict to support staff</li> <li><input type="checkbox"/> Action plans in response to specific reviews</li> </ul>

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## Feedback about working relationships

Respondents interpreted “feedback” in question 6b in a variety of ways. Some respondents focused on concerns raised by staff, while others referred to avenues for parents as well. Some respondents interpreted the question as being about whether specific concerns or issues had been raised (for example by the CQC, via Freedom to Speak Up Guardians or employee relations) while others provided answers which described the general routes through which feedback had been received or could be given. There was also variation in the extent to which respondents interpreted this question as being about formal or informal feedback, or positive or critical feedback. For example, one respondent noted that while individual issues had been identified, there were no systemic themes or concerns (105). Example responses which illustrate this variation are provided below:

*“There was a Freedom to Speak Up concern raised around fairness, transparency and bullying. This was investigated and actions from these were undertaken and reviewed by the divisional leadership team.” (049)*

*“The Trust has reviewed its records for the time period suggested and has not found any formal feedback or concerns recorded regarding the neonatal services.” (064)*

*“The staff have a yearly staff survey, which is fed back to the unit and team, the staff have had the opportunity to complete the SCORE survey which is part of the national perinatal cultural Annual General Medical Council (GMC) trainee survey, Health Education England (HEE) / NHS England (NHSE) (Education) reports and informal educational surveys conducted by the Medical Education Department. Human Resources (HR) exit interviews, quarterly staff pulse surveys and annual survey. Monthly CQC engagement sessions and internal mock CQC reviews.” (014)*

Where respondents described feedback which had been given, or routes where it could be received, the examples provided broadly fell within two categories: (1) NHS-wide initiatives, and (2) trust-organised initiatives. These are summarised in Table 13 below:

Table 13: Routes for receiving feedback on working relationships in neonatal services

Type of initiative	Examples
NHS-wide	<ul style="list-style-type: none"> <li><input type="checkbox"/> NHS Staff survey</li> <li><input type="checkbox"/> CQC inspections</li> <li><input type="checkbox"/> SCORE survey as part of the NHSE Perinatal National Culture and Leadership programme</li> <li><input type="checkbox"/> General Medical Council survey for doctors in training</li> <li><input type="checkbox"/> Operational Delivery Network annual service reviews/ annual parent and staff feedback survey</li> <li><input type="checkbox"/> London School of Paediatrics Survey</li> <li><input type="checkbox"/> Clinical accreditation scheme reviews</li> <li><input type="checkbox"/> BLISS charity surveys</li> <li><input type="checkbox"/> Ockenden visits</li> <li><input type="checkbox"/> Friends and Family Test</li> </ul>
Trust-organised	<ul style="list-style-type: none"> <li><input type="checkbox"/> Regular team/ ward meetings and team away days</li> <li><input type="checkbox"/> Listening events and board walkarounds</li> <li><input type="checkbox"/> Maternity Safety champions, Freedom to Speak Up guardian, Datix process</li> <li><input type="checkbox"/> Annual trust/ team/ pulse surveys</li> <li><input type="checkbox"/> Appraisals/ exit interviews/ HR drop-in sessions/ grievances</li> <li><input type="checkbox"/> Unit parent questionnaires/ Friends and Family Test</li> <li><input type="checkbox"/> Social media</li> <li><input type="checkbox"/> Specific internal or external reviews of culture</li> <li><input type="checkbox"/> Regular thematic reviews of Freedom to Speak Up issues</li> <li><input type="checkbox"/> CQC assurance rounds</li> <li><input type="checkbox"/> Debriefing sessions following the Lucy Letby case</li> <li><input type="checkbox"/> Reviews of individual cases</li> <li><input type="checkbox"/> Anonymous staff boxes</li> </ul>

Given the variation described above, respondents mostly described the processes by which feedback could be given rather than the content of this feedback. Some respondents described the action they had taken or were taking as a result of feedback that had been provided. One noted that they were developing a “*culture ambition*” as part of a wider culture programme (023).

*“The GMC [national training] survey results have improved year-on-year since 2021. In the results published in 2023, there were green flags (positive outliers) for the domains of workload and educational governance. There were no pink or red flags (negative outliers). In response to the 2021 results, an action plan was implemented which has delivered sustained improvement in trainee experience.” (115)*

*“Following receipt of the results and an external facilitator will talk the triumvirate through the results then will work with staff groups to contribute towards a post survey action plan.” (119)*

## NHS staff survey

A detailed analysis of trusts’ responses regarding the NHS Staff Survey has not been undertaken because this was not described consistently. Some respondents only provided answers on the survey response rate, while others provided more analysis (sometimes in the form of tables or charts). Some provided broader comments comparing results within the neonatal units to the trust as a whole or national average while others provided a detailed breakdown of results on different topics (such as the NHS People Plan promises).<sup>68</sup> Some provided a broad comment on whether the results were positive (such as in relation to previous years), and others referred to free text comments.

Where a response rate for neonatal services was not provided, this was due to an inability to break down the responses at this level due to the risk that individuals would be identifiable. In this case, the trust would not receive data for the neonatal service, and it would be aggregated with feedback from a larger unit.

Some respondents noted specific actions which had been taken to address issues raised within the staff survey such as commissioning culture programmes or reviews. However, it was not always clear whether action was always taken following a staff survey, or only if concerns were raised. One respondent described how they use the staff survey results as part of their organisational development work:

*“As part of our Organisation Development (OD) work, staff survey data is used to identify our highest and lowest scoring teams. These teams are then prioritised for focused interventions. For the lowest scoring teams, a diagnostic discussion is held to identify the most appropriate interventions to help improve staff experience which is supported by our People team. For highest scoring teams, they are given the opportunity to be signed up for the TED (Team Engagement Development) tool, which supports experienced leaders of performing teams to increase their engagement with self-directed use of OD tools.” (085)*

<sup>68</sup> NHS England (no date) ‘NHS People Plan’ <https://www.england.nhs.uk/ourhsppeople/>

*“We have been working hard over the last 2 years to ensure a more open culture where colleagues feel empowered and able to raise concerns. We used the free-text comments from the 2022 staff survey to develop a programme of work called RISE (Recognised, Included, Supported & Equipped). Alongside this, we engaged with an external organisation to refresh our strategic goals and organisational values – some 12,000 staff were involved in this process.” (007)*

## Comparison between respondents with different roles

In this section we compare responses from medical directors (or other clinicians) and non-clinical managers where trusts submitted two different responses. Where different responses were provided, these were largely due to:

- The level of detail
- Reflections based on the individual's own experience
- The extent to which they answered about the trust as a whole or neonatal unit

But, even where responses within trusts were different, it did not necessarily mean that they were incompatible or mutually exclusive. Consequently, we have grouped responses into three categories:

- Aligned – similar content, examples or sentiment expressed
- Neither aligned nor divergent – different content but not necessarily incompatible
- Divergent – content which indicates different views, experience or evidence

Some respondents described relationships across staff groups as a whole, rather than particular groups as specified in question 5. When describing this, many respondents provided descriptive answers on the team structure, and mechanisms in place such as meetings. Alternatively, some respondents provided more of a reflection on the quality of these relationships.

A sample of responses relating to relationships as a whole and between particular staff groups is provided in Tables 14-16. The themes described in [Working relationships](#) were present across the responses from each staff group and there was little variation in the responses between the staff groups as a whole.

Table 14: Examples from trusts illustrating **aligned** responses to Question 5

Trust	Response from 'A'	Response from 'B'
058 – general	<p><i>“This is a challenging question to address as there will be a range of opinions and perceptions. From my standpoint, as both Medical Director and Executive Maternity Neonatal Patient safety champion, I have experienced strong working relationships between all the staff groups listed, including, but not limited to doctors and managers, nurses/midwives and managers and between medical professionals. The divisional structure in the Women and Childrens Division is strong, with excellent working relationships within the triumvirate. The ADO, Clinical Director and Director of Midwifery attend all the full meetings of the Board meeting in person and present as a strong, unified senior leadership team. I would suggest that these strong relationships are typical of the Trust generally, accepting that there are inevitable tensions at times in areas of high pressure and high demand.” (058A)</i></p>	<p><i>“With regard to 5. a, b, and c above it is my experience that the working relationships between all professional groups relative to neonatal services are professional, collegiate, and collaborative across the multi-professional spectrum. While I am not able to comment on relationships right across the Trust, I would say that my view of this is reflective of those relationships across the whole of the Women's and Children's services division that sit within my portfolio.” (058B)</i></p>
033 – general	<p><i>“The staff survey does not highlight a significant deviation from the Trust figures in the relationships within the neonatal service. However, concerns have been raised through patient safety walk rounds and via the freedom to speak up guardian. As a result of these concerns a freedom to speak up review to place in the neonatal unit and the themes from this were shared with Executive Directors and the Divisional Leadership team. An action plan to respond to concerns raised was developed but the divisional team and compliance with this is monitored on a regular basis.” (033A)</i></p>	<p><i>“Through FTSU and other direct dialogue with the Unit there are some cultural issues across professionals in the Neonatal Unit. This has been discussed with the teams and professional groups and an action plan is in place. The Trust has also been working with an external company to support some cultural work, whilst not specific to the Neonatal Unit a Trust-Wide survey in relation to Harassment was undertaken. Over 1200 staff responded, some listening events were arranged, which circa 450 staff attended. A plan for short, medium and longer term actions is now in place.” (033B)</i></p>
056 – general	<p><i>“The neonatal unit at the trust is considered to be a well-functioning and governed unit. This has improved over the last few years as Neonates has moved under the governance of Maternity from paediatrics. Overall, I would say that there are very healthy lines of communication between neonates, midwifery and management. Neonatal ward staff participate on daily labour ward huddles; there are frequent daily correspondences between teams as to</i></p>	<p><i>“In terms of neonatal governance and management arrangements the Division has operationally and strategically moved neonatal services from Paediatrics to join the new Neonatal and Maternity team. Neonatal services now receive the same level of scrutiny through the perinatal quality surveillance programme as maternity do. There are several tangible benefits because of the joining of neonatal and maternity services including, the ‘voice’ of the</i></p>

	<p><i>workload, staffing and potential impending deliveries. There is a very robust online neonatal alert system where midwifery and obstetrics alert neonates to maternity problems in pregnancies so we can form management plans. The situation that neonates is overseen by maternity has improved communication lines between teams particularly midwives and Nurses.</i></p> <p><i>I think there is varying degree of true MDT working across the trust. The team in Neonates and midwifery have taken strides to improve and we are actively trying as a trust to focus on the MDT rather than professional silos. A common theme of incidents and SIs in some areas has been a lack of escalation to a deteriorating patient due to perceived hierarchies.</i></p> <p><i>PROMPT training in Maternity is a good example of the train together work together ethos we are trying to build. This needs to be in place throughout careers (Undergraduate to retirement and including in some aspects NHS managers) so teams can be built around the use of skills for the patient not around a professional bias.” (056A)</i></p>	<p><i>neonatal service is now being heard alongside the maternity voice; improved communications regarding staffing and care planning; senior professional oversight of daily safe staffing huddles.</i></p> <p><i>The arrangements across the organisation mirror that of neonates/maternity as a multi-disciplinary leadership structure working collaboratively.</i></p> <p><i>Feedback from an Ockenden Assurance visit was complimentary regarding the proactive approach to embracing neonatal services within maternity.” (056B)</i></p>
054 – doctors and managers	<p><i>“Neonatal consultants and managers share the same administrative corridor and meet often in an informal manner where necessary. In addition, we also have monthly meetings that involve the neonatal clinical lead, Matron and the General Manager for Paediatrics – Paediatric business meeting; this is followed by a monthly paediatric service line review – with our divisional leadership team. The neonatal consultant team meets every 4 – 6 weeks to discuss various clinical and administrative issues, sometimes with attendance from the Matron.</i></p> <p><i>In the last 12 months we have had a formalised perinatal quad meeting which involves the Head of midwifery, Deputy director of ops, lead for neonates and the obstetric specialty director.” (054A)</i></p>	<p><i>“There are good working relationships across all of the above staff groups with regular formal and informal meetings which provide opportunity for concerns/issues to be raised.” (054B)</i></p>
020 – doctors and managers	<p><i>“There are positive working relationships between Drs and managers within the neonatal service and more broadly within the Trust. The neonatal service has a triumvirate of Clinical Lead (Dr), Service Manager and nursing Matron who are collectively responsible for the service. This approach is</i></p>	<p><i>“[The trust] prides itself on its friendly open working culture, operating fairly but with accountability. As our location is equidistant between [two cities] and in a semi-rural location, our recruitment strategy is all based around being ‘a good place to work’. This openness and visibility of staff working together</i></p>

	<p><i>replicated at divisional level. The divisional teams have recently attended the NHSE perinatal culture and leadership programme to further develop these relationships. Maternity and neonatal staff leads attend daily huddles to share any concerns re staffing or emerging issues. Maternity and neonatal unit are co located for ease of transfer which facilitates visibility and communication between teams.” (020A)</i></p>	<p><i>crafts an integrated self-respecting approach to positivity, enabling us to develop services and maximise opportunities for the organisation as a whole to move forward. Within the Neonatal services, I evidence strong working relationships between our doctors and managers, both recognising the symbiotic role they contribute to each other to ensure that we strive to provide the very best services to our patients and families.</i></p> <p><i>The neonatal service directorate is within the Women and Childrens Division and each Division has a triumvirate of Associate Medical Director (Dr), Divisional Director and Head of Nursing. This then cascades to each directorate (ie Neonatal) who have a Clinical Lead (Dr), Service Manager and matron who are collectively responsible for the service they provide. Both formal and informal meetings and open-door culture within the Trust aids integrated working and positive relationships across these professional groups.” (020B)</i></p>
016 – nurses, midwives and managers	<p><i>“The relationship between neonatal nurses and midwives is felt to be good, with both teams undertaking MDT education sessions together. There are twice daily huddles involving both neonatal and maternity teams to discuss any potential admissions, capacity and staffing issues. We feel that the neonatal team can (and do) approach clinical managers (lead consultant and matron) with any concerns.” (016A)</i></p>	<p><i>“The relationship between nurses and midwives is also good, and demonstrated through MDT education sessions together. There are twice daily huddles between the neonatal and maternity teams to discuss any potential admissions, capacity and staffing issues. I believe the neonatal team feel they can approach clinical managers with any concerns, non-clinical managers don’t attend clinical areas on a regular basis.” (016B)</i></p>
013 – medical professionals	<p><i>“Site 1: There is a good relationship between doctors, nurses, midwives and NNPs based on mutual respect and they perform highly as a result. They have strong leadership and function well as a team.</i></p> <p><i>Site 2: There has been some difficulty with the midwives and the neonatal leadership when trying to resolve some issues with some of the pathways. We have some strong personalities and I and the SLT have had to intervene on occasion to ensure things remained on track. The head of midwifery and the clinical lead have a good relationship based on respect and everyone has the patient at the heart of what they are doing. Similarly the</i></p>	<p><i>“Site 1: Working relationships are positive and typical of the rest of the site.</i></p> <p><i>Site 2: Working relationships are generally positive but sometimes under pressure due to demand outstripping capacity.</i></p> <p><i>Site 3: Working relationships are reasonable but with some poor behaviours which have caused tension.” (013B)</i></p>

	<p><i>doctors and the nurses on site have a good working relationship and the unit functions at a high level because of it. There is a more difficult relationship with nursing leadership at SLT, again, not necessarily welcoming the external oversight or the questions being asked.</i></p> <p><i>Site 3: The relationship between medical professional, nurses, midwives and managers has at times been very strained with allegations that are currently being looked at of bullying, undermining and poor workplace culture. Much of this is historical and there has been a failure, previously to hold people to account for this poor behaviour. We are starting to see some green shoots of improvement, addressing behaviours, setting expectations and taking things forward.” (013A)</i></p>	
043 – medical professionals	<p><i>“As the Medical Director for the Trust, I am not close to the detailed operational workings of the unit; however, I have made enquiries and I am advised of the information summarised in the paragraphs below. To the best of my knowledge and belief, I am not aware of any significant issues with relationships between medical professionals in our neonatal services.</i></p> <p><i>The day-to-day relationships between senior and junior doctors, the nursing team and the Associate Paediatric Nurse Practitioners – who are based in our Paediatric Service but support the work of the neonatal service - appear positive and supportive; an openness exists that maintains effective clinical care. The nursing team are comfortable in reporting incidents on the system when there are errors in process, and these are considered and acted upon by the medical team. There is a culture of learning from incidents rather than affecting relationships.</i></p> <p><i>Generally fewer incidents are reported by the medical team as the support from nursing colleagues is good. Our medical teams also cover many areas while nursing teams are based more exclusively within the service and “ownership” of the areas is helpful and supportive.</i></p> <p><i>The nursing and midwifery teams have a supportive relationship across the maternity and neonatal services.” (043A)</i></p>	<p><i>“The day-to-day relationships between senior and junior doctors, the nursing team and the Associate Paediatric Nurse Practitioners – who are based in our Paediatric Service but support the work of the neonatal service - appear positive and supportive; an openness exists that maintains effective clinical care. The nursing team are comfortable in reporting incidents on the system when there are errors in process, and these are considered and acted upon by the medical team. There is a culture of learning from incidents rather than affecting relationships.</i></p> <p><i>Generally fewer incidents are reported by the medical team as the support from nursing colleagues is good. Our medical teams also cover many areas while nursing teams are based more exclusively within the service and “ownership” of the areas is helpful and supportive.</i></p> <p><i>The nursing and midwifery teams have a supportive relationship across the maternity and neonatal services.</i></p> <p><i>As the Associate Director of Operations for the Family Health Care Group I presently do not feel that there are any challenges in relationships that would prevent discussion and escalation of issues of concern.” (043B)</i></p>

Table 15: Examples from trusts illustrating **neither aligned nor divergent** responses to Question 5

Trust	Response from 'A'	Response from 'B'
017 – nurses, midwives and managers	<p><i>“The relationship between the nurses is perceived on the whole to be good. There are emerging concerns regarding the relationship between some of the band 6 nurses in leadership roles and those of a lower band. The Deputy Director of Nursing and the Deputy Chief People Officer are undertaking listening events to define and further understand the issue prior to resolution plan being put in place. The relationship between the nurses and midwives is good and facilitated by both maternity and neonatology being in the same division. The head of nursing for neonatology is part of the same senior leadership team as the head of midwifery. There is strong nursing leadership with a real focus on career development and emotional well-being. The same operational (non-clinical managerial team) team supports both the maternity service and the neonatal service allowing for consistency of approach. The relationship is good.” (017A)</i></p>	<p><i>“I believe the relationships to be positive and professional based on the information I have received through my role as Chief Operating Officer and my visits to the Unit. I receive the results of staff surveys, the biannual “big conversation” and reports on complaints and incidents and there is nothing that causes me cause for concerns. The relationships are typical of the organisation, and I would even say are better and more positive in the neonatal unit than in other areas.” (017B)</i></p>
056	<p><i>“The neonatal unit at the trust is considered to be a well functioning and governed unit. This has improved over the last few years as Neonates has moved under the governance of Maternity from paediatrics. Overall, I would say that there are very healthy lines of communication between neonates, midwifery and management. Neonatal ward staff participate on daily labour ward huddles; there are frequent daily correspondences between teams as to workload, staffing and potential impending deliveries. There is a very robust online neonatal alert system where midwifery and obstetrics alert neonates to maternity problems in pregnancies so we can form management plans. The situation that neonates is overseen by maternity has improved communication lines between teams particularly</i></p>	<p><i>“In terms of neonatal governance and management arrangements the Division has operationally and strategically moved neonatal services from Paediatrics to join the new Neonatal and Maternity team. Neonatal services now receive the same level of scrutiny through the perinatal quality surveillance programme as maternity do. There are several tangible benefits because of the joining of neonatal and maternity services including, the ‘voice’ of the neonatal service is now being heard alongside the maternity voice; improved communications regarding staffing and care planning; senior professional oversight of daily safe staffing huddles. The arrangements across the organisation mirror that of neonates/maternity as a multi-disciplinary leadership structure</i></p>

	<p>midwives and Nurses. I think there is varying degree of true MDT working across the trust. The team in Neonates and midwifery have taken strides to improve and we are actively trying as a trust to focus on the MDT rather than professional silos. A common theme of incidents and SIs in some areas has been a lack of escalation to a deteriorating patient due to perceived hierarchies. PROMPT training in Maternity is a good example of the train together work together ethos we are trying to build. This needs to be in place throughout careers (Undergraduate to retirement and including in some aspects NHS managers) so teams can be built around the use of skills for the patient not around a professional bias.” (056A)</p>	<p>working collaboratively. Feedback from an Ockenden Assurance visit was complimentary regarding the proactive approach to embracing neonatal services within maternity.” (056B)</p>
<p><b>040 – Nurses, midwives and managers</b></p>	<p>“Again, I have no concern about these relationships. There is a new Divisional Nurse Director to bolster the leadership provided by the Director of Midwifery and Matron.” (040A)</p>	<p>“Response: The working relationships between nurses, midwives and managers the neonate service are supportive and respectful of each other’s areas of expertise. Managers work closely with nursing teams to provide high quality, responsive services. At times there can be challenges between competing priorities, but this is infrequent and resolved by working closely together. This is typical of the trust generally.” (040B)</p>

Table 16: Examples from trusts illustrating **divergent** responses to Question 5

Trust	Response from ‘A’	Response from ‘B’
<p>040 – Medical professionals</p>	<p>“I believe these are for the most part effective and respectful. Within the maternity service, there is ongoing team development work and teams “coaching” to support the medical and midwifery team through the significant set of assurance actions resultant from Donna Ockenden’s national recommendations. This is one of the most scrutinized services locally and nationally, with a huge assurance requirement. In terms of safety culture and willingness to speak up, I have confidence that interprofessional concerns about conduct or capability would be escalated as we lived experience of this happening within the women’s and children’s directorate.” (040A)</p>	<p>“The teams are on a journey of improvement. Historically, teams have been protective of their areas and less integrated than they are now. They were less open to changing ways of working. As a team they work together to resolve issues and lead improvements jointly as a multi-disciplinary team and have adopted a much more open and transparent learning culture. These relationships are typical of the Trust generally – with the majority of areas working jointly, openly, and transparently for the care they provide.” (040B)</p>

<p>017 – nurses, midwives and managers</p>	<p><i>“The relationship between the nurses is perceived on the whole to be good. There are emerging concerns regarding the relationship between some of the band 6 nurses in leadership roles and those of a lower band. The Deputy Director of Nursing and the Deputy Chief People Officer are undertaking listening events to define and further understand the issue prior to resolution plan being put in place.</i></p> <p><i>The relationship between the nurses and midwives is good and facilitated by both maternity and neonatology being in the same division. The head of nursing for neonatology is part of the same senior leadership team as the head of midwifery.</i></p> <p><i>There is strong nursing leadership with a real focus on career development and emotional well-being. The same operational (non-clinical managerial team) team supports both the maternity service and the neonatal service allowing for consistency of approach. The relationship is good.” (017A)</i></p>	<p><i>“I believe the relationships to be positive and professional based on the information I have received through my role as Chief Operating Officer and my visits to the Unit. I receive the results of staff surveys, the biannual “big conversation” and reports on complaints and incidents and there is nothing that causes me cause for concerns. The relationships are typical of the organisation, and I would even say are better and more positive in the neonatal unit than in other areas.” (017B)</i></p>
<p>073 – medical professionals</p>	<p><i>“Within the wider workforce, there is generally good mutual respect for all clinical professionals. Specific instances have been raised about support for the development of locally employed doctors (LEDs) and Advanced Neonatal Nurse Practitioners (ANNPs) with the suggestion that they are not always encouraged to practice at their highest level of training. This is being addressed by defining role and responsibilities more precisely through a recent business case and creating a more supportive professional environment among clinicians. In addition, there have been specific accusations of an unsupportive working environment for junior doctors which have been escalated through medical management and form part of the current investigation. Shift safety huddles ensure all disciplines are aware of daily issues, changes to practice or to the service. Training and development opportunities are shared through all disciplines, and multidisciplinary attendance is encouraged. Events such as Simulation Training encourage all disciplines to work and learn together.</i></p> <p><i>Information and updates are shared through forums such as:</i></p>	<p><i>“There is an atmosphere and culture of mutual respect between the wider teams where ideas and suggestions are listened to, respected and discussed with a view to finding solutions.</i></p> <ul style="list-style-type: none"> <li><i>•Shift by Shift safety huddles ensure all disciplines are aware of daily issues, changes to practice or to the service.</i></li> <li><i>•Training and development opportunities are shared through all disciplines, and multidisciplinary attendance is encouraged. Events such as Simulation Training encourage all disciplines to work and learn together.</i></li> <li><i>•Information and updates are shared through forums such as: email, WhatsApp, notice boards and closed face book pages.</i></li> <li><i>•The NICU encourages inclusive social events, where all staff are invited to participate in unit activities and celebrations within the unit, or at external venues.</i></li> <li><i>•Where working relationships within the nursing establishment become challenged, resolution is quickly sought, with informal interventions or escalation to formal management through the Trust and HR Services.” (073B)</i></li> </ul>

*email, WhatsApp, notice boards and closed Facebook pages. The NICU encourages inclusive social events, where all staff are invited to participate in unit activities and celebrations within the unit, or at external venues. Senior management are invited to these events and an open, celebratory atmosphere exists on these occasions.*

*Where working relationships within the nursing establishment become challenged, resolution is quickly sought, with informal interventions or escalation to formal management through the Trust and HR Services.*

*There is good communication between nursing leads and doctors, especially when there are concerns. These relationships extend from the specialty, through the division, to the executives. Recent examples illustrate that the executive team (including the Medical Director) respond promptly to concerns from the matron in Neonates.” (073A)*

## Nuffield Trust reflections

As with [Culture](#), describing working relationships within neonatal units across the NHS is complex, and will be dependent on the particular unit and trust context. Although it is difficult to summarise the shape of working relationships across all neonatal units, respondents described several features which were considered important to enable individuals and teams to work together. This included multi-disciplinary team working and leadership, mechanisms to support communication and visibility of senior clinical and managerial staff, as well as board members (such as listening events, huddles and walkarounds), and forums for raising or discussing issues (such as Committees).

BAPM guidance states that team-working is particularly important for neonatal services and the quality standards refer to a number of aspects of this such as mechanisms to support team working and communication, developing a perinatal culture (for example, through huddles or safety briefings), regularly engaging with staff about their experiences and access to specialists.<sup>69</sup> Trusts provided several examples in their responses which referred to these elements. Many trusts also reported that they were taking part in the NHS England's Perinatal Leadership programme as set out in the three-year delivery plan for maternity and neonatal services. Previous Nuffield Trust research also showed that the most common initiatives used to improve relationships between managers and clinicians specifically included collaboration on quality improvement or innovation projects, and additionally joint discussion and training events - although it also found there was mixed awareness on the availability of these services within trusts.<sup>70</sup>

Previous research relating to doctors and managers' relationships specifically noted that relationships within organisations are often dependent on the approach taken by individuals at board level and how well they work together.<sup>70</sup> Some respondents to the questionnaire referred specifically to the culture which was being set or role modelled by members of the board, including different approaches when new leadership was in place. Some also specifically noted the role of the board in setting trust culture in their responses to the questions on governance.

Given the questionnaire was targeted at those in senior leadership positions, the responses may reflect different perceptions to those working more closely with the units. Some respondents acknowledged this in their responses and either drew on input from others, noted that they felt unable to comment, or considered that the separate questionnaire would be more useful. Previous research found that clinical directors held views that diverged from and were less positive than those of the other groups studied (i.e. Chief Executives, Medical Directors and Directorate managers) – they were less likely than other groups to have confidence in managers' abilities, or believe they shared common goals.<sup>70</sup> This was not something we observed in trusts' responses to the questionnaire. Though, given that it was not anonymous, and many were completed as joint or identical responses, it was not surprising. Overall, we did not observe marked differences between medical or operational respondents' answers with both staff groups identifying similar themes regarding working relationships.

<sup>69</sup> British Association of Perinatal Medicine (2022) 'Service and Quality Standards for Provision of Neonatal Care in the UK' <https://www.bapm.org/resources/service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk>

<sup>70</sup> Powell and Davies (2016) 'Managing Doctors, Doctors Managing' <https://www.nuffieldtrust.org.uk/research/managing-doctors-doctors-managing>

# Reporting and managing concerns and complaints

This section provides a description of how trusts said they responded to concerns and complaints, which covers questions 3, 10-19, 39abc, and 40 of the questionnaire. In their responses some trusts described different types and levels of severity of concerns and complaints. The language used to describe concerns and complaints was inconsistent. Some respondents used “concerns” for staff and “complaints” for patients, but others used “concerns” for what might be described as low-severity level or informal patient complaints. To avoid inappropriate comparisons, we have used the term “concern(s)/complaint(s)” to describe any and all references to concerns and complaints.

Some of the content covered in this section, for example on incidents is also discussed in the section titled [Unexplained deaths and unexpected patient safety incidents](#), and information related to the Freedom to Speak Up guardians are mentioned in the [Culture](#) and [Working relationships](#) sections.

## Questions asked of trusts:

3. What are the arrangements for reporting concerns in the neonatal services to the trust board and to other trust management and governance structures?
10. What are the processes within the trust for investigating concerns or complaints (whether raised by staff or parents/guardians) about neonatal care?
11. What board level oversight is in place in respect of concerns or complaints that are received?
12. How many complaints, formal or otherwise, and concerns were raised between 19 October 2022 and 19 October 2023 by staff, parents or guardians? If records are not kept of any complaints made, please explain why.
13. How many investigations into complaints and concerns have taken place between 19 October 2022 and 19 October 2023?
14. How many complaints, formal or otherwise, have been upheld?
15. What action has been taken in respect of concerns?
16. What processes are in place for reporting incidents, concerns or complaints about neonatal services and/or staff members to external bodies?

17. How often have those processes been used between 19 October 2022 and 19 October 2023 and, if reports have been produced, to whom have these been made?
18. What are the policies of the trust for reporting concerns or complaints to professional bodies such as the Nursing and Midwifery Council (“NMC”), the General Medical Council (“GMC”), the Health and Care Professions Council (“HCPC”) or the General Pharmaceutical Council (“GPC”)?
19. How often have matters relating to the neonatal unit and/or staff working within that unit been reported to any of the Regulators either regulator directly or through the Responsible Officer between 19 October 2022 and 19 October 2023?
39. Look at your answers to the questions at 2 to 7 above. Are there features of the management structure, the governance structure, the culture at the trust, which:
- You think may inhibit people from raising concerns about the care of babies?
  - You think encourages people to raise those concerns. Please briefly explain your answer.
  - Have any issues been escalated to the trust board since 19 October 2022 in respect of neonatal services?
40. Is there anything within those structures, the culture or the conditions in which the trust operates which may inhibit managers (clinical or non-clinical) from acting upon concerns raised?

## Context for this section

- There are numerous routes through which patients and staff can raise concerns/complaints about NHS services. National guidance has been produced for the public by NHS England<sup>71</sup> but most trusts direct patients, their families, and carers to their local Patient And Liaison Service (PALS) as a first point of contact for confidential advice, support and information on health-related matters.<sup>72</sup> The first point of contact for staff can vary based on whom the staff member feels comfortable raising the concern with.
- Staff who are registered professions, including doctors, nurses, midwives and nursing associates, pharmacy professionals, and have professional duties to raise concerns where they believe that patient safety or care is being compromised by the practice of colleagues or the systems, policies or procedures in the organisations they in which they work.<sup>73,74,75</sup>

<sup>71</sup> NHS England (no date) ‘Feedback and complaints about NHS services’ <https://www.england.nhs.uk/contact-us/feedback-and-complaints/complaint/>

<sup>72</sup> NHS UK (no date) ‘What is PALS (Patient Advice and Liaison Service)’ <https://www.nhs.uk/nhs-services/hospitals/what-is-pals-patient-advice-and-liaison-service/>

<sup>73</sup> General Medical Council (no date) ‘Raising a concern’ <https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/raising-and-acting-on-concerns/part-1-raising-a-concern>

<sup>74</sup> Nursing and Midwifery Council (2023). ‘Raising concerns: Guidance for nurses, midwives and nursing associates’ <https://www.nmc.org.uk/standards/guidance/raising-concerns-guidance-for-nurses-and-midwives/>

<sup>75</sup> General Pharmaceutical Council (2023). ‘Reporting concerns’ <https://www.pharmacyregulation.org/reporting-concerns>

- Professions registered with the Health and Care Professions Council — including professions such as Dietitians, Occupational therapists, Paramedics, Physiotherapists, Practitioner psychologists, Radiographers, and Speech and language therapists — have a responsibility to put the safety and wellbeing of service users and carers first.<sup>76</sup>
- Staff have numerous routes through which to raise concerns/complaints and report incidents, depending on the type of concern/complaint, for example, whether related to a patient safety incident, a serious incident, or safeguarding concern. To report whistleblowing staff are encouraged to contact their trust's Freedom to Speak Up guardian. Following from the Francis Review it was recommended that every healthcare provider in England across the acute, mental health, community health and ambulance sectors have a 'Freedom to Speak Up Guardian'. The Guardian role was intended 'to act as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation'.<sup>77</sup>
- In autumn 2023, the new Patient Safety Incident Response Framework (PSIRF) was introduced and was described by NHS England as representing a significant shift in the way the NHS responds to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.<sup>78</sup> Alongside that change, the Learn From Patient Safety Events (LFPSE) service was introduced starting from 2021. NHS organisations are being asked to switch to recording patient safety events onto the new LFPSE service, rather than the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS) it is replacing. All NRLS users should have made the switch to LFPSE by the end of September 2023.<sup>79</sup> Provider regulators, such as the Care Quality Commission, have access to this safety data.
- The processes and external bodies involved depend on whether the concern/complaint are linked to disciplinary processes of a professional, serious incidents, deaths, safeguarding concerns.

## Structures and processes for reporting and investigating concerns/complaints

The most cited starting points for families raising concerns/complaints were unit-based senior staff and/or Patient Advice and Liaison Service (PALS). Respondents described

<sup>76</sup> Health and Care Professionals Council (2019) 'Standards in practice: how to report concerns about safety' <https://www.hcpc-uk.org/news-and-events/blog/2019/standards-in-practice-how-to-report-concerns-about-safety/>

<sup>77</sup> The National Guardian's Office (no date) 'The National Guardian' <https://nationalguardian.org.uk/>.

<sup>78</sup> NHS England (18 August 2023) 'Verdict in the trial of Lucy Letby' <https://www.england.nhs.uk/long-read/verdict-in-the-trial-of-lucy-letby/>

<sup>79</sup> NHS England (no date) 'Learn from patient safety events (LFPSE) service' <https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-patient-safety-events/learn-from-patient-safety-events-service/>

PALS as physically signposted throughout the hospital and information being available on the trust's website. For staff, the most common starting point for raising concerns/complaints was a unit-based staff (for example with a line manager, matron, or senior clinician) or the Freedom to Speak Up (FTSU) guardian. Information about the FTSU was described as available via intranet-based policies. Respondents described that complainants – whether families or staff – could choose with whom to raise their concerns/complaints.

Respondents often described processes for raising concerns/complaints that exist across the trust, rather than reporting processes unique to the neonatal unit (with a few exceptions, for example 023, 048, 055, 062, 119). When describing the process at a trust level, respondents often reported something along the lines of:

*“Both hospital sites have a PALS team who will address any queries or concerns from parents and direct to the most appropriate person for response – there is an MDT approach to this. The Trust has a Complaints, Concerns and Compliments Policy which is available on both hospital sites’ Intranet. Posters are available in all clinical areas advising patients/relatives/carers how they are able to raise a concern at any point...For staff concerns the trust has two Freedom to Speak up Guardians (one per hospital site) and seven Freedom to Speak up Champions from both clinical and non-clinical backgrounds.” (029)*

When describing the raising concerns/complaints process within the context of neonatal care, responses included mentions of service-specific contact points, such as the neonatal safety champion, and the neonatal outreach team. For example,

*“Staff have multiple channels to raise concerns, including reporting to their line manager, utilizing HR processes, contacting the FTSU guardian, reaching out to the neonatal safety champion, engaging with the whistleblowing policy, participating in team meetings, holding one-to-one meetings with their line manager, and discussing concerns during appraisal meetings.*

*In addition, staff can raise concerns through the Trust's incident reporting system, and they have the option to raise concerns on behalf of the family using the same system.” (112)*

and

*“The Trust has processes in place for both staff and/or parents/guardians to raise concerns or complaints across all services. These would then be investigated accordingly. Please refer to question 30 and the provision of these policies.*

*At a local level, families are encouraged to speak to a member of the senior clinical and operational team if they have any concerns. This includes the senior nursing team, cross site Matron, Head of Nursing, Neonatal Lead, Chief of service or Associate Director if they want to raise concerns. The Trust's PALS and Complaints Teams are also easily accessible. Once the patient is discharged from the neonatal unit, they have key contacts with the neonatal outreach service.*

*For babies that have died there is a key worker allocated to the family, who they can contact with concerns. These concerns are brought to the perinatal mortality review group and these concerns are addressed and fed back to the parents. If parents wish to meet with the allocated consultant, that can be facilitated.*

*A Freedom to Speak Up (FTSU) Guardian has been in post since 2017 and recruited following the National Guardians office fair recruitment guidance and is a full-time position and covers across the Trust including neonates. FTSU is part of corporate induction and accessible for confidential and anonymous reporting via the Trust's intranet for all staff groups. Staff who raise concerns to FTSU are supported to report them openly, confidentially, or anonymous and staff supported or taken to be investigated via the appropriate team such as patient safety/HR/counter fraud to follow appropriate guidelines.” (119)*

In addition to unit-based staff, PALS, and the FTSU guardian, some respondents highlighted alternative starting points for both families and staff who want to raise concerns/complaints with bodies outside of the trust. For example:

*“There are several ways in which complaints or concerns might be received from service users.*

*Typically these would be through the PALS service as outlined in other sections above. This service has a visible office on the top landing (main reception of hospital) in addition to contact being possible by telephone, email, social media et cetera. Concerns parents/guardians may be directed to the service by staff members. On occasion, they may come directly to the Medical Director, Chief Nurse, or Chief Executive Officer.*

*Staff themselves have the opportunity to raise concerns directly with line managers, with clinicians within the team, through the freedom to speak up route, and by speaking directly to other colleagues with managerial responsibilities. The Chief Nurse and I encourage that colleagues should be able to come directly to us should they have concerns which are not being addressed. This is reinforced in our presentations to new starters at corporate induction.*

*The other possible vehicles are through MPs, the Care Quality Commission, the Integrated Care Board, or through legal contact. In those circumstances, it is likely that directors would be notified and/or involved immediately.*

*Complaints are managed in line with the trust complaints policy. A meeting with complainants is usually established to agree key lines of enquiry, and the divisional team oversee the complaint response which is signed by the chief executive. There is a Divisional complaints lead. Complainants are advised of their opportunity to involve the Ombudsman should they be dissatisfied with the response.” (040)*

Nine trusts described there being anonymous routes for reporting concerns/complaints both internally and externally. In most of those trusts, the Freedom to Speak Up guardians could be reached anonymously via the trust intranet or by using the internal incident reporting software. Only one trust mentioned the National Whistleblowing hotline as an anonymous route to reporting. See the quotes below for examples.

*“Staff are able to raise concerns in a number of ways. They are able to complete an incident report via a risk management system. They are also able to contact our Freedom to Speak up Guardian confidentially directly or via a dedicated mailbox number. In addition, there is the facility via a risk management system to raise an anonymous concern with our Freedom to Speak up Guardian.” (002)*

*“...staff can call the National Whistleblowing Helpline for free safe in the knowledge that everything they tell them is strictly confidential and anonymous. They offer legally compliant, unbiased support and guidance. Contact details are provided on the Trust website for the National Whistleblowing Helpline.” (056)*

Once a concern/complaint was identified, many trusts mentioned the incident being logged in Datix or Ulysses (or a similar system), which are compulsory online risk and incident information management software systems that aim to capture incidents and their learning points. The logging of an incident on such a system typically triggered several actions, including an investigation. A few descriptions of how staff use Datix and the processes triggered are provided below.

*“The Trust’s complaint procedures include mechanisms for staff to raise concerns. This identifies the need to complete a DATIX for any incident the staff member believes to be a risk to patients, staff or the Trust. These incidents are shared trust-wide with formal actions required and reporting of responses via internal governance routes. Staff members are also encouraged to escalate concerns to their Lead Nurse, Matron or Associate Director of Nursing. These will then be actioned via formal routes and there is feedback to the staff member.” (009)*

*“Suspected patient safety incidents are reported using the Datix system which is accessible by all staff. All Datixes which are initially classified as moderate or above harm are seen by the executive team. An initial investigation is carried out by the relevant team with divisional governance team oversight, and incidents that remain as moderate or above harm are sent to the Serious Incident Review Group which meets on a weekly basis and which is attended by senior clinical executives and deputies and the Trust patient safety team. This group sees an initial 48 hour report which outlines the incident, tracks Duty of Candour processes and identifies any immediate actions that have been taken. Next steps are decided by the group using the 2015 SI framework, noting that the Trust is currently transitioning to using the Patient Safety Incident Response Framework. (PSIRF). If an SI is declared, an investigation team is identified and relevant parties notified and reporting systems are completed.” (035)*

Where an incident or concern/complaint was categorised as informal, respondents suggested a unit-based staff might follow up on the concern/complaint and respond to the complainant. For example,

*“Informal concerns raised via PALS or direct contact are managed at ward manager level.” (020)*

and

*“Informal concerns are dealt within the neonatal department. If unresolved, parents/staff will be advised on the formal complaint procedure.” (038)*

and

*“The complaints policy has the option to record concerns as formal or informal, working towards an end goal of providing resolution for all parties and a genuine message of learning and improvement where services have failed to deliver a best level of care. The Trust encourages active liaison with the complainant to work through to the resolution, offering the opportunity to meet and work through the concerns together.” (023)*

Where an incident or concern/complaint was considered more serious than ‘informal’, multiple groups of staff at varying levels of the hospital were described as involved depending on the nature of the incident. The groups involved: the triumvirate at a directorate or division level, staff on a specialty team (for example, patient safety, or complaints team), or at the whole hospital/trust level (for example, governance board, trust board). These groups were described using many names, which highlighted their main purpose such as the ‘*patient safety team*’, ‘*internal patient safety panel*’, ‘*executive review group*’, ‘*decision-making group*’, ‘*safeguarding team*’, ‘*quality committees*’, and ‘*patient experience*’ team. The membership of these groups was described as multi-professional in many cases, but membership was not always clear in responses. Investigations also often involved the unit level governance teams, such as a ‘*neonatal governance team*’ and/or involvement of the Directorate (for example Paediatric, Maternity and Neonatal) Triumvirate (027). Other individuals (rather than groups) who might be involved in investigating incidents, possibly as members of the groups mentioned above included peer reviewers (responsible for quality and safety assurance (020)), peer listeners (distinct from FTSU guardians) (029), and neonatal safety champions (who had a similar role to FTSU guardians but were specific to neonatal care) (035).

The groups responsible for investigations were often described as being charged with reporting information about the incident to the trust board. While some respondents reported that the board reviewed on all concerns and complaints (and their proposed resolution), others stated the board had sight of only some (often higher risk or formal) concerns/complaints (and if available, their proposed resolution).

*“Complaints that are registered are always forwarded directly to the Triumvirate irrespective of the issues, to ensure that the directorate senior team are sighted on the concern and can support a response. The lead Matron and ward Manager will take the complaint forward and will often offer a meeting to the family. The Chief Nursing Officer is copied in on all registered complaints for Trust Board oversight. Complainants who remain unhappy with the Trust’s formal response are given the contact details and process for the Ombudsman. There is a monthly complaints report compiled for the directorate which details all complaints received in month by the complaints service and these complaints are discussed at the monthly W&C Governance meeting. Copies of directorate governance meeting minutes are presented monthly at the Operational Quality and Safety Meeting (OQSG) for oversight. This meeting is chaired by the Chief Medical Officer and Chief Nursing Officer.” (064)*

*“The formal complaints received are reviewed and investigated at business unit and divisional level. The Chief Executive personally reads and signs all of the Trust responses. Informal concerns are managed locally within the business unit. Both informal and formal statistics are shared at business unit and divisional level governance meetings and themes are identified for improvement work.” (023)*

*“Incidents and concerns (managed on the Trust’s digital reporting system) are reviewed by the Neonatal Governance Team and by the Paediatric Triumvirate. These are reviewed as per Trust processes and risk graded issues related to the neonatal unit are discussed with the ODN and also with relevant NHSE bodies as they arise. At a Trust level all incidents are reviewed by the central patient safety team and potential serious incidents (regardless of the initial graded level of harm) are reviewed on a weekly basis against the 2015 patient safety framework by an Executive chaired review panel. The Trust’s Executive Team have oversight of the complaints and incident management performance, themes and trends via the Trust’s internal quality governance reporting structure which is also overseen by the Integrated Care board (ICB) via the quarterly Provider Quality Committee.” (027)*

If an incident or concern/complaint investigation pointed to the need to refer the case externally, questionnaire respondents described the process for contacting the appropriate organisations. This process is described in the section below called [Reporting concerns/complaints and incidents to external bodies](#).

However, where incidents or concerns/complaints were ready to be brought to a close because the investigation(s) (internal and/or external) had come to decision, there was a process of drafting a written response to complainants and signing off that response. Chief Executives, Executive Directors, or Committee Chairs/Leads were described as those responsible for signing off. A particularly detailed response describing the process of raising and responding to incidents and concerns/complaints is provided below:

*“The Trust’s complaint procedures include mechanisms for staff to raise concerns. This identifies the need to complete a DATIX for any incident the staff member believes to be a risk to patients, staff or the Trust. These incidents are shared trust-wide with formal actions required and reporting of responses via internal governance routes. Staff members are also encouraged to escalate concerns to their Lead Nurse, Matron or Associate Director of Nursing. These will then be actioned via formal routes and there is feedback to the staff member.*

*Neonatal complaints and concerns raised by service users are processed and investigated in line with the Trust’s complaints Policy. All concerns, complaints or feedback from service users are registered on Datix and allocated to a member of the team. Concerns are shared with the leads for the Neonatal service and/or relevant staff for the issue to be looked in to and the neonatal service make direct contact with the service user to discuss the concern and any action/learning arising from this. The outcome is then logged in datix. If necessary the concern will also be logged as an incident or escalated to formal complaint investigation.*

*Formal complaints are investigated by the complaints investigation team in liaison with the neonatal service. The medical records are reviewed alongside local and national policies and guidance, the family are spoken to for their*

*statements/recollections, involved staff are spoken to for their statements/recollections. Where it is felt that there is a patient safety issue or harm has occurred the complaint and investigation is escalated to the weekly Patient Safety Panel (PSP).*

*Following investigation, service users are offered a face to face meeting with a complaints investigator and senior staff from neonates to discuss their experience and the investigation findings, and a written response is also provided. Written responses are shared with involved staff, [division] triumvirate, Director of Nursing, Midwifery and [Allied Health Professionals], and then reviewed and signed off by CEO.” (009)*

## Neonatal concerns/complaints

### Trusts citing concerns/complaints

108 trusts reported at least one concern/complaint had been raised in the timeline specified in the questionnaire. Those without any concerns/complaints were trusts 010, 016, 037, 044, 053, 056, 058, and 111. We excluded four trusts because of non-response or responses being provided at a trust rather than neonatal level (033, 098, 100, 108).

Respondents rarely provided details about the concerns/complaints. For example, about half of respondents (59 trusts) were unclear about whether their concern(s)/complaint(s) had been raised by a patient or staff member. There was also little consistency in describing the ‘level’ of concerns/complaints (for example, formal vs informal, high risk vs low risk). In some responses, respondents did not explicitly mention staff concerns or complaints at all, solely discussing patient concerns/complaints, which made it unclear whether there were no staff concerns/complaints at all or whether information about staff was not available or recorded. Despite these issues, a small sample of respondents provided further detail about the source and content of concerns/complaints. See illustrative examples of both ‘clear’ and ‘unclear’ responses below (Table 17).

*Table 17: Examples of clear and unclear responses about concerns/complaints*

<b>Response type</b>	<b>Examples</b>
Clear responses	<p><i>“1 concern was received relating to neonatal services and no formal complaints</i></p> <ul style="list-style-type: none"> <li><i>•117 incidents were reported by staff relating to neonatal services (115 low/no harm and 2 moderate harm)</i></li> <li><i>•4 concerns were raised through the Freedom to Speak Up Guardian route in relation to neonatal services.” (002)</i></li> </ul> <p><i>“In relation to the Neonatal Unit: Three Formal Complaints were received. Eleven PALS were received, one of which was positive.</i></p>

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*There was one FTSU concern raised in September 2023. The issues raised had previously been responded to however the individual remained dissatisfied and was advised to raise with FTSU which they did, and the Chief Executive is giving personal oversight of the response to these issues.” (073)*

*“Neonatal specific complaints/concerns:  
On behalf of Patient 10  
On behalf of Staff 0” (017)*

Unclear  
responses

*“The total number of complaints/concerns or otherwise raised between the 19 October 2022 to 19 October 2023 was 2,224 (this includes concerns raised via PALS)” (004).*

*“There were no formal complaints for NNU during this time period. There is one relevant PALS concern relating to lack of information and lack of facilities. There have been no formal root cause analysis or Serious incident investigations undertaken for neonates.” (011)*

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Very few trusts provided rationales for their cited numbers of concerns/complaints, but one trust reported their low number of concerns/complaints was attributable to a new initiative, which they believed had been a success to date:

*“In our experience of NICU, we have found with the introduction of an open-door policy for families where we actively promote to families to raise any concerns real time to our onsite senior nurse and matron this is potentially part of contributing to these numbers of complaints being low. In addition, over 18 months ago our ‘ask the matron’ initiative was launched where families can complete an enquiry form and speak or meet with our matron to raise any compliments of concerns whilst in hospital or after being discharged, we have had excellent feedback on this as an initiative. The funded wrap around support food, accommodation in addition to the above has contributed to our BLISS accreditation.” (114)*

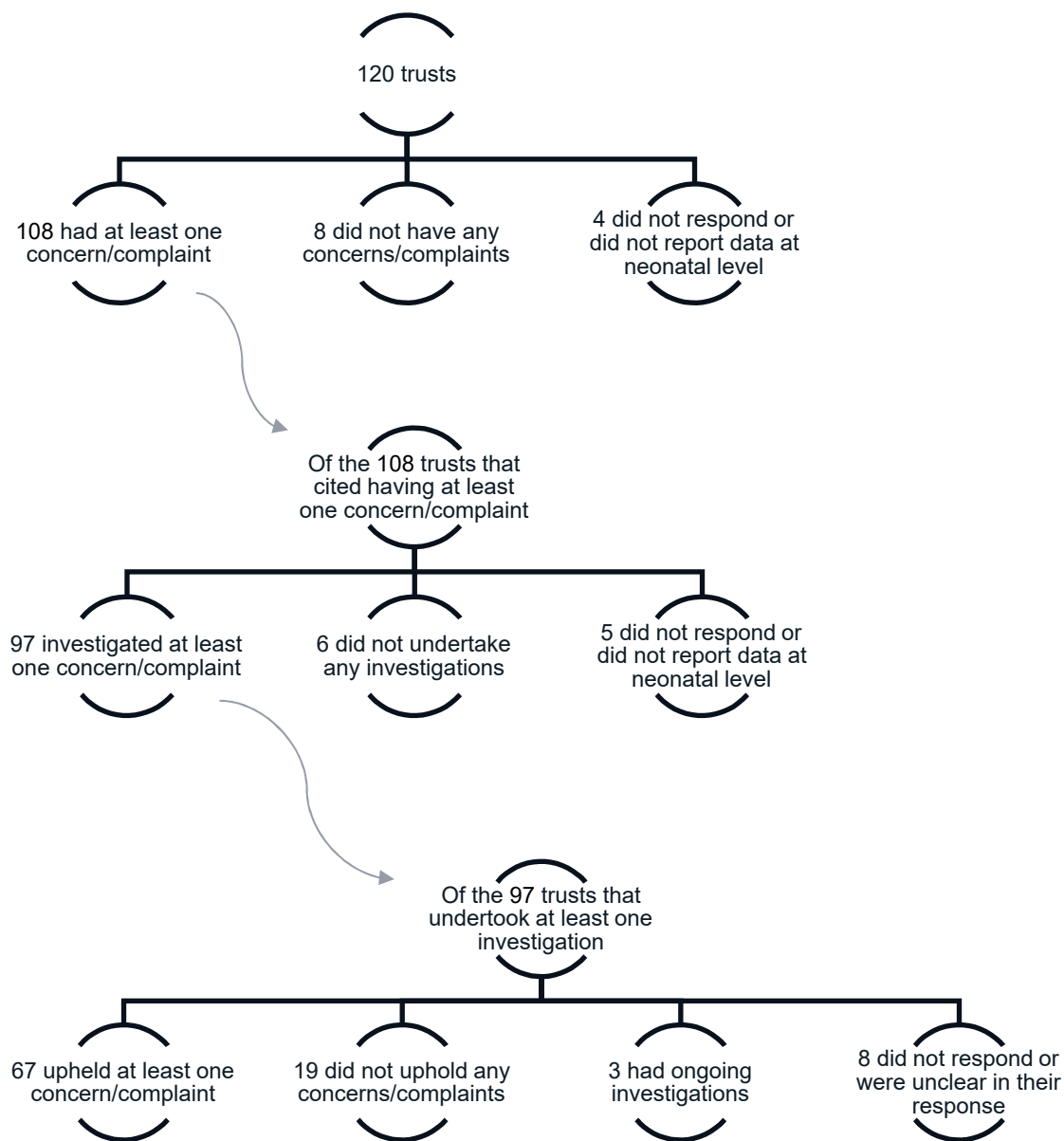
### **Investigations into concerns/complaints**

Of the 108 trusts that had a concern/complaint raised, most (97 trusts) had carried out at least one investigation during the timeline specified in the questionnaire. Few respondents made it clear that their trust investigated *all* concerns/complaints, and others that they investigated *some* concerns/complaints (for example, formal complaints). However, for the majority of trusts, their processes for investigation were not clear.

Of all the 97 trusts that reported undertaking at least one investigation during the specified timeline, 67 reported that at least one concern/complaint was fully or partially upheld (for instance, found the concern/complaint to be supported by evidence following investigation), 19 trusts reported not having any complaints upheld, three had ongoing investigations, and eight respondents provided no or unclear responses.

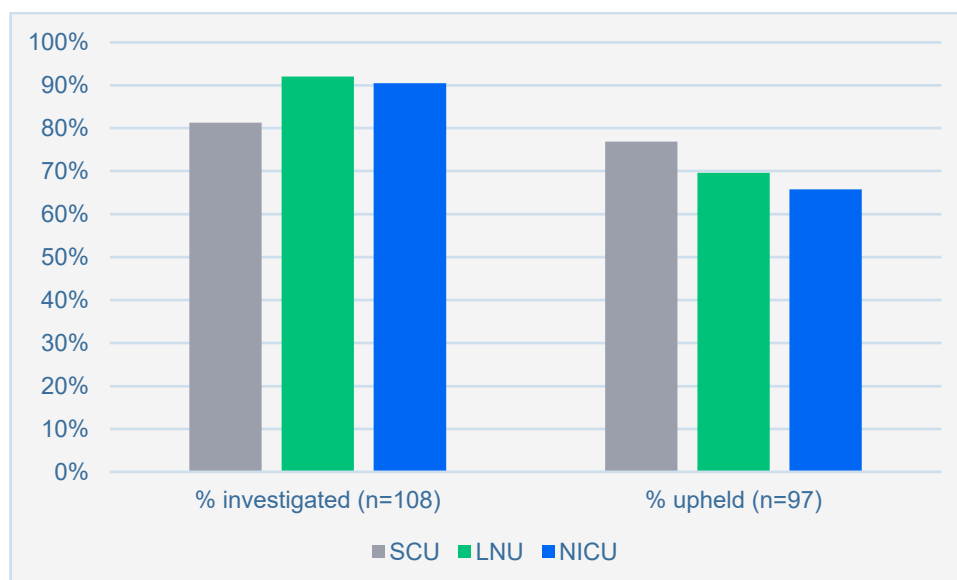
Figure 6 summarises the numbers of trusts that cited concerns/complaints, investigations and concerns/complaints being upheld or not.

Figure 6: Breakdown of trusts that had vs. had not investigated and upheld concerns/complaints at the NNU level



Among the 108 trusts which had at least on concern/complaint, a slightly lower proportion of SCUs investigated those complaints than trusts providing more specialised care (Figure 7). However, among those that had investigated complaints, a slightly higher proportion of SCUs reported that they had upheld complaints, with NICUs being least likely to have upheld complaints.

Figure 7: Proportion of trusts investigating complaints and upholding concerns/complaints, by level of care provided



Regarding terminology, respondents from three trusts (035, 038, 049) described moving away from the term 'upheld', instead using terms such as 'review' and focusing on learning (rather than gathering evidence to uphold complaints or not).

*"The Trust no longer use the term upheld. 4 cases responded with actions/learning." (038)*

*"The main focus of the complaints process is to provide an adequate explanation to the complainant and to identify learning and areas for improvement." (035).*

Regarding informal concerns/complaints, respondents from several trusts commented they did not have systems in place to record informal concerns or their outcomes (often managed on the ward) or that staff concerns are recorded at the department level (rather than unit level) making it difficult to review past concerns (042, 045, 073, 079, 102, 106, 115). Another respondent alluded to limited detail in recording systems on site (041).

*"We do not centrally record (patient) issues which are raised and resolved directly on the ward." (provided by the patient experience team) (102) and,*

*"Complaints are logged as formal or informal. In November 2023, the Trust started logging concerns. There is no record of concerns before this time. Between 19 October 2022 and 19 October 2023, there were three complaints about the neonatal service. Since 2016, all complaints have been logged on the Trust's Datix system and are kept indefinitely. Staff concerns are usually raised directly with a manager, in which case they are addressed as part of normal day-to-day working and a record is not kept. During this time period, no staff concerns were escalated outside the department." (079)*

*"There were 64 formal requests for resolution/grievances raised by staff during*

*this time period, unfortunately due to the way that this is recorded we are not able to confirm if any of these relate to neonatology. Nineteen of these required investigation – none of these related to neonatology.” (115)*

*“No concerns have been raised via the Trust’s PALS function between 19 October 2022 and 19 October 2023. It is however likely that low level informal concerns may have been raised to staff on each neonatal unit and had local resolution, but details of these have not been formally recorded if they were successfully resolved at that level.” (026)*

*“All concerns and complaints are investigated. This number will be the same as the number of concerns and complaints raised. We only note an ‘outcome’ i.e. upheld, partially upheld, not upheld to formal complaints. The one case logged was handled as a concern (less formal, response with 7 working days), so this case does not have a recorded outcome, in line with our processes.” (045)*

*“Between 19 October 2022 and 19 October 2023, there were:*

- 3 formal complaints made by patients/guardians to the Neonatal Unit*
- 82 Freedom to Speak Up (FTSU) contacts across the Trust (data not easily available by clinical unit)” (042)*

*“In relation to the Neonatal Unit: 3 Formal Complaints, 11 PALS. Nil [were upheld] (information only held for formal complaints).” (073)*

*“One - (this is all that is registerd.[sic] No specification on whether it's staff or parent)” (041)*

The quotes above illustrate how a lack of processes in recording some types of concerns/complaints had made it difficult for respondents to provide detailed answers to the questionnaire.

## Action taken on concerns/complaints

81 trusts described the actions they had taken in response to concerns/complaints they described in Q12. Actions are summarised in Table 18 below. Almost all actions were described addressing patient concerns/complaints rather than those raised by staff.

Table 18: Actions taken on concerns/complaints

Theme (number)	Illustrative example
Communication of learning to all staff (often via a team meeting/huddle or in writing (for example,	Trust 062 described a comprehensive approach to internal communications around lessons learnt. Their responses describe using a range of approaches to embed lessons including: ‘lesson of the month’ comms, patient safety notices, ward safety boards, screen savers.

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<p>in a newsletter)) (40 trusts)</p>	<p><i>“A recent change in practice as part of a national drive means that all complaint and patient safety events give rise to a Patient Safety Learning Summary, which is shared via relevant Divisional governance meetings to ensure a wide breadth of learning. These are entered as evidence against the actions that are captured on Datix as part of the Actions module on RLDatix.” (026)</i></p>
<p>Making changes to clinical practice on the unit (for example, only attempting to insert a cannula three times before seeking assistance) (29 trusts)</p>	<p><i>“In relation to the two informal concerns raised by service users, the following action has been taken: a) Breastfeeding advice given on transitional care A meeting took place between the parent, neonatal matron and neonatal lead consultant to hear the feedback directly. This has been fed back to transitional care teams and infant feeding teams. We now have an established infant feeding team and are working towards baby friendly initiative accreditation. In this respect, all staff involved in the care of women and newborn babies will have to undergo specific training on breastfeeding. This parent has been invited to the MNVP meeting so that her story can be shared with a wider group of staff members.” (025)</i></p> <p><i>“Specific incident relating to a missed opportunity to identify a potential biliary atresia which resulted in an appropriate referral to a tertiary centre (intervention could have been undertaken earlier). Learning fed back into the clinical teams and review of the clinical pathway relating to this clinical presentation.” (050)</i></p>
<p>Holding a private meeting with parents, which sometimes included the staff member involved in the concern/complaint during which an apology was verbally provided, or apology letter provided (18 trusts)</p>	<p><i>“All concerns and complaints are investigated. Complainants and or families are invited to face to face meetings with the relevant individuals to discuss their concerns and to hear any learning or actions that the Trust has initiated. If this is not the preferred method of communication by the family then formal written responses are also always provided.” (020)</i></p>
<p>Providing direct feedback to the staff member(s) involved and encouraging reflection (17 trusts)</p>	<p><i>“A Neonatal consultant has spoken with the individuals concerned and re-iterated that cannulas should be attempted a maximum of three times before asking someone else to try and that if it looks like it is going to be difficult then it would be good practice to warn the parents of this and then they can be given the opportunity as to whether they would like to be present for the procedure or not..” (038)</i></p>

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<p>Advising on changes to staff behaviour (for example, manner of speaking while on ward, use of mobile phones, tone of delivery of diagnosis) (15 trusts)</p>	<p><i>“Communication issues in relation to complaint number 2 and this has been addressed with those involved. The importance of good communication / documentation is raised at risk meeting, team meetings and message of the week at handovers.” (015)</i></p>
<p>Introducing new training and accreditation (11 trusts)</p>	<p><i>“Baby Friendly Initiative accreditation which includes a programme of training and education that will address some of the concerns raised regarding feeding support. Audit checks were put in place to monitor staff progress in this area. This audit is part of the baby friendly accreditation work which is reviewed annually to ensure the unit is maintaining the standards.” (119)</i></p>
<p>Undertaking a review and creating action plans (11 trusts)</p>	<p><i>“Instigate Human factors training for all staff” (109)</i></p> <p><i>“Actions have been taken from the complaint investigation reports and discussed between services/divisions. For example, action from complaint 7216 – “babies on CPAP should have their forehead examined along with nasal care in view of pressure from CPAP headgear. By the end of October 2022 [Name] Lead Nurse for the Neonatal Unit, will ensure that the care plan for CPAP will be amended to include inspection of the forehead as routine practice. These actions are created to ensure learning from complaints in order to reduce the number of raised concerns we see within the Trust and to mitigate repeated concerns being raised via both PALS and the Complaints Department. Data is produced to highlight what the Trust’s actions are in regard to concerns raised. Meetings are being held with divisions in order to develop a better way of how we record and close actions”. (004)</i></p>
<p>Increasing the involvement of and feedback from parents (8 trusts)</p>	<p><i>“Parents are encouraged to offer parental feedback before they are discharged via anonymous feedback. Feedback is collated and reviewed at the Monthly Neonatal Quality Forum. Positive feedback is disseminated to staff and negative/concerns are reviewed and solutions to issues raised are sought. Feedback to parents is disseminated using our ‘You said, We did’ boards.” (076)</i></p>
	<p><i>“• Improved engagement and communication between staff and parents/ families</i></p>

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- *Asking a parent if they prefer another family member to be present during examination of their child. Ensure there is sufficient privacy, and the location is comfortable and as calm as possible.*
  - *To listen carefully to parents' questions and provide them with appropriate answers and/or information on how to pursue their requests.” (101)*
- 

It is not possible to provide comment on whether the actions were adequate or effective, as respondents did not provide comments on this.

## Reporting concerns/complaints and incidents to external bodies

Following internal investigations, which are described in [Structures and processes for reporting and investigating concerns/complaints](#), trusts reported being obligated to report certain concerns/complaints and incidents to external bodies depending on the type and grade of the concern/complaint or incident. It was understood from the responses that the most senior staff members undertook referrals:

*“The Patient Relations Team would not undertake the reporting to external bodies but would highlight any significant concerns/complaints to Chief Nurse/Medical Director plus Deputy Chief Nurse/Director of Nursing Workforce (for nursing/AHP) and designated consultant lead for serious medical/GMC issues, plus legal and safeguarding where appropriate.” (062)*

There was a range of external bodies and reporting systems with which trusts were required to engage regarding incidents and concerns/complaints. The two quotes below name many of the commonly cited bodies and systems:

*“Incidents:*

*All serious incidents are reported to StEIS which is the NHS England web based serious incident management system. Our commissioners, NHSE regional and national teams and the Care Quality Commission have access to StEIS and see all reported serious incidents. In addition, under the SI framework we are required to directly report to commissioners where a serious incident indicates an issue or problem that has (or may have) significant implications for the wide healthcare system, or where an incident may cause widespread public concern. The relevant commissioner will then consider the need to share information throughout the system, with NHS England sub-regions and regions and other partner agencies as required.*

*HSIB/MNSI:*

*All early neonatal deaths, where the baby dies within the first week of life of any cause and the pregnancy had reached 37+0 weeks gestation or more, are referred to Maternity and Newborn Safety Investigations for investigation. Information*

*regarding the referral to HSIB/MNSI is included in our duty of candour letter to the family. Following completion of the investigation, the report is shared with the family and the Trust and once it is finalised, a joint meeting is offered between the family, the Trust and HSIB/MNSI to discuss the findings and recommendations. In response to the recommendations, the Trust will develop an action plan which is presented at SIRP for approval.*

#### **MBRRACE/PMRT**

*For neonatal deaths which meet the MBRRACE/PMRT criteria this process is followed. The patient safety and risk managers attend the PMRT weekly reviews and if any patient safety concerns are raised through the PMRT process these are escalated to the governance team which triggers discussion at an MDT panel and if a patient safety concern is agreed this would lead to the case being taken to SIRP.*

#### **Disclosure and Barring Service (DBS)**

*I have produced the Trust 'Allegation of abuse policy' as exhibit RFL/3. The Trust process is to refer to the Disclosure and Barring Service (DBS) when an employer, volunteer manager or personnel supplier has dismissed or removed a person from working with children or adults (or would or may have if the person had not left or resigned etc.) because the person has: Been cautioned or convicted for a relevant offence; or Engaged in relevant conduct in relation to children and/or adults at risk i.e., an action or inaction (neglect) that has harmed a child or adult at risk or put them at risk of harm]; or Satisfied the harm test in relation to children and/or adults at risk [i.e., there has been no relevant conduct (i.e., no action or inaction) but a risk of harm to a child or vulnerable adult still exists.*

*Child Death overview panel (CDOP) All deaths of children and young people are reported to the CDOP. Parents are informed of the purpose of the CDOP and a key worker is identified who brings the wishes and views of the family to the process.”  
(021)*

and

*“All clinical incidents are reported to the National Reporting Learning System (NRLS) and all incidents-triggering an investigation as per the national incident investigation framework are reported on the Transfer of Strategic Executive Information System (StEIS), hosted by NHS England.*

*The Patient Relations Team would not undertake the reporting to external bodies but would highlight any significant concerns/complaints to Chief Nurse/Medical Director plus Deputy Chief Nurse/Director of Nursing Workforce (for nursing/AHP) and designated consultant lead for serious medical/GMC issues, plus legal and safeguarding where appropriate.*

*It may be necessary to refer a member of staff to their appropriate professional body, e.g., NMC, HCPC, GMC. The Trust may also provide relevant information to external agencies, e.g., Police, the Disclosure and Barring Service or the Information Commissioner's Office. Patients are a/so advised they can speak to the Health Service Ombudsman if they remain dissatisfied with the complaint response.*

*Where concerns are raised relating to staff conduct these are dealt with in line with the Trusts associated Policies and where required staff will be referred to their professional bodies e.g, NMC and GMC.” (062)*

More detail about the varied processes leading to contacting external bodies is described below.

### **Disciplinary processes**

Respondents indicated that if disciplinary processes are required as part of the investigation and reporting of concerns/complaints or incidents, the process often involves engaging Human Resources and the trust’s Responsible Officer (Chief Nurse/Chief Nursing Officer, Medical Director/Chief Medical Officers), sometimes alongside a local employer liaison advisor from the General Medical Council (GMC) or the Nursing and Midwifery Council (NMC) (whichever relevant). This group would often review the case and decide on what action to take next. One trust specified actions can include interventions to maintain safety (for example, restriction or exclusion), fact finding exercises, formal investigations, discussion with regulators, or formal fitness to practice referrals to a professional body (for example GMC, NMC)<sup>80</sup> (091). Respondents described how this process is guided by the Maintaining High Professional Standards (MHPS)<sup>81</sup>, as well as internal human resources or disciplinary policies.

*“Conduct or capability concerns in relation to medical staff would be addressed through the responsible officer advisory group of which I am a member. Such concerns are also discussed with NHS Resolution, and with the [General Medical Council (GMC)] where the [Responsible Officer] considers that formal referral is indicated. There is an informal quarterly meeting between the GMC [Employer Liaison Advisor] and the Trust [Medical Director]/ [Responsible Officer].” (040)*

*“If there are any concerns raised about a member of the nursing staff they are escalated via the nursing leadership structure and any decision on whether a referral is required to the Nursing Midwifery Council (NMC) are made with the relevant Head of Nursing and the Director of Nursing. If of concern this will also be discussed with the Trust Chief Nurse. A referral is made to the NMC by the Head of Nursing for the relevant directorate – in the case of Neonatology this is the Medicine and Neonatology Directorate after review by the Director of Nursing for the clinical group (in this case the [trust] clinical group). The Chief Nurse’s Office keeps a database of all the NMC referrals, historical, currently live and ongoing. Any communication from the NMC is via the Chief Nurses’ Office so there is a consistent process across the Trust and Trust level oversight of the process which is managed at a clinical group level.” (069)*

*“Concerns regarding medical staff are discussed at the Responsible Officer Advisory Group and if required would be discussed with the GMC Local Employer Liaison Advisor and if appropriate referred to GMC.” (096)*

<sup>80</sup> General Medical Council (2024) ‘Fitness to practice guidance – How we make decisions’ <https://www.gmc-uk.org/concerns/information-for-doctors-under-investigation/how-we-make-decisions>

<sup>81</sup> NHS Resolution (2023) ‘Maintaining High Professional Standards in the NHS’ <https://resolution.nhs.uk/covid-19-and-business-continuity/practitioner-performance-advice/maintaining-high-professional-standards-in-the-nhs/>

*“All MHPS investigations are discussed with the Trust’s GMC Employer Liaison Adviser in quarterly meetings.” (116)*

One trust mentioned that in some circumstances a request for a health professional alert notice (HPAN)<sup>82</sup> may be requested from NHS Resolution. This is typical if the concern relates to fitness to practice and a referral to a regulator is being considered but the individual has left the organisation (091). The Disclosure and Barring Service (DBS) was also mentioned by some trusts. For example,

*“If, following an investigation a Person in a Position of Trust is removed, by either dismissal or permanent redeployment, to a non-regulated activity, because they pose a risk of harm to adults with care and support needs, (or would have, had the person not left first), then WUTH, has a legal duty to refer the person to the Disclosure and Barring Service (DBS).” (065)*

Other trusts mentioned innovations and gaps in regarding disciplinary processes. For example, one trust mentioned being in the process of developing a Professional Registration Policy, which will compliment NMC Registration Policy and cover all registered staff (090). On a related note, another reported not having a specific policy/process in place for raising concerns regarding Pharmacy professionals, but instead relying on General Pharmaceutical Council (GPC) guidance on raising concerns (055). They described relying on external advice from the Practitioner Performance Advice service<sup>83</sup> (which provide a liaison officer to discuss ongoing cases) for advice on how to manage and resolve concerns raised in line with the Maintaining High Professional Standards about the practice of individual doctors, dentists, and pharmacists. The same trust recently set up a Professional Standards Group (PSG) where concerns regarding doctors are picked up at an early stage. The PSG was described as collectively discussing concerns and advising the Responsible Officer for future actions. It also met with Nursing/Advanced Care Practitioner teams meet every two weeks as part of “Just Culture case reviews<sup>84</sup> to discuss and progress any issues and to identify if referral to the NMC or the Health and Care Professions Council (HCPC) needs to be undertaken.

## **Serious incidents**

Respondents reported that if categorised as a serious incident, the escalation process to commissioners and regulatory authorities often involves being guided by the National Serious Incident Framework<sup>85</sup>. Serious incidents are discussed at regular meetings with the Integrated Care Board (which for some trusts occur weekly, and for others monthly). One trust specified that all internal SIs are signed off by the divisional and trust executive teams. All external SIs are signed off at divisional, Trust and ICB level (046). ICBs each

<sup>82</sup> NHS Resolution (2024) ‘Health Professional Alert Notice’ <https://resolution.nhs.uk/services/practitioner-performance-advice/hpans/>

<sup>83</sup> NHS Resolution (2023) ‘Practitioner Performance Advice service’ <https://resolution.nhs.uk/services/practitioner-performance-advice/>

<sup>84</sup> NHS England (no date) ‘A just culture guide’ <https://www.england.nhs.uk/patient-safety/patient-safety-culture/a-just-culture-guide/#about-our-guide>

<sup>85</sup> NHS England ‘Patient Safety Incident Response Framework (PSIRF)’ <https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/>

coordinate a Maternity and Neonatal Voices Partnership (MNVP)<sup>86</sup> which review incident reporting, scrutinise serious incidents, and mortality reviews (013). There are processes for involving Place level bodies, but these were infrequently mentioned.

Respondents reported that trusts are meant to report incidents to the Learning from Patient Safety Events service (LFPSE)<sup>87</sup>, which is currently in the process of replacing the National Reporting and Learning System (NRLS)<sup>88</sup> and Strategic Executive Information System (StEIS)<sup>89</sup>. One trust noted that the upgrade to the LFPSE system has improved functionality to automatically notify any incident to NHS England, as well as a 'radio' button for if staff consider an incident to be 'CQC notifiable'. Guidance is provided when accessing this system (094). Respondents noted LFPSE data is reviewed by the Care Quality Commission (CQC) and NHS England regional and national teams.

Respondents described how any notifiable safety incidents must be referred to the Maternity and Newborn Safety Investigation (MNSI) programme.<sup>90</sup> Respondents noted its predecessor, Healthcare Safety Investigation Branch (HSIB), had previously produced reviewed which were provided to the organisation, neonatal and maternity services and shared with the family involved.

Respondents cited CQC requirements guiding action on notifiable safety incidents (as part of the Duty of Candour regulation)<sup>91</sup>, which indicates that serious concerns or complaints should be actively reported. Respondents reported that information could be submitted using a CQC template for recording and tracking concerns and/or raised at meetings between the trust and the CQC relationship manager. Respondents described variation in the frequency with which these meetings occur. Some noted meetings can occur monthly for trusts (see 055) or 'regularly' as part of the Executive Well Led relationship meetings (see 020). Respondents also noted CQC requirements advised sending a duty of candour letter to parents including information on where external referrals were made.

*"[Trust 023] has a good relationship with the CQC relationship manager / inspector, and the Trust Associate Director of Governance and Patient Safety would actively notify them of any serious concerns or complaints raised or themes coming from one specific area for awareness. Likewise, the CQC approach the Trust directly should any concerns or complaints be raised directly to them. This type of communication is followed up at the monthly relationship meeting and captured in the governance report presented to the Quality and Performance Committee." (023)*

## Incidents involving perinatal or neonatal death

<sup>86</sup> NHS England (2023) 'Maternity and Neonatal Voices Partnerships' (MNVPs)

<https://www.england.nhs.uk/long-read/maternity-and-neonatal-voices-partnership-guidance/>

<sup>87</sup> 'Learn from Patient Safety Events' (LFPSE) <https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-patient-safety-events/learn-from-patient-safety-events-service/>

<sup>88</sup> 'National Reporting and Learning Service (NRLS)' <https://report.nrls.nhs.uk/nrlsreporting/>

<sup>89</sup> 'Strategic Executive Information System (StEIS)' <https://steis.improvement.nhs.uk/>

<sup>90</sup> 'Maternity and Neonatal Safety Investigation programme' <https://www.mnsi.org.uk/>

<sup>91</sup> CQC (2022) 'Duty of Candour: notifiable safety incidents' <https://www.cqc.org.uk/guidance-providers/all-services/duty-candour-notifiable-safety-incident>

Respondents described that if the incident involved a neonatal death, a report was made to the coroner and reviewed using the National Perinatal Mortality Review Tool<sup>92</sup> and referral made to the MNSI. These cases were then also reviewed by the Child Death Overview Panel. These are described in detail in a later section of this report titled [Reviewing evidence after a death](#). Respondents also noted that mortality data is reported via the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) audit,<sup>93</sup> which is reviewed at trust level and by the relevant regional Neonatal Network.

## Safeguarding concerns

Respondents reported that if categorised as a safeguarding issue, the escalation process is guided by the Local Authority Designated Officer (LADO)<sup>94</sup> process for safeguarding complaints about staff. The process was described by a respondent in detail:

*“The Trust also adheres to the LADO (Local Authority Designated Officer) Process, which in summary is set below:*

### *LADO Process Summary*

#### *Management of Allegations against a Person in a Position of Trust (POT)*

*Referral/Consultation - A person in position of trust is anyone who carries out work, paid or unpaid on behalf of an agency, which has access to children or privileged information about children as a part of their work.*

#### *Criteria for a LADO Referral:*

- Behaved in a way that has harmed a child, or may have harmed a child*
- Possibly committed a criminal offence against or related to a child*
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children*
- Behaved or may have behaved in a way that indicates they may not be suitable to work with children*
- Behaved or may have behaved in a way that indicates that they may not be suitable to work with children.*

*Safeguarding: Concerns can also be raised to the Trust Safeguarding team via a multitude of pathways, concerns can be received from but not limited to:*

- Staff members declaring concerns*
- Police*
- Children's Social care*

*Once information received, concerns are shared proportionately with line management and HR. Information is considered at a Round Table.*

*LADO meeting (see above) held, all partner agencies are in attendance to share relevant information and consider the transferrable risk.*

*LADO may continue to be involved or handover to HR process if investigation or ongoing internally processes need to be followed.*

<sup>92</sup> 'Perinatal Mortality Review tool' <https://www.npeu.ox.ac.uk/pmrt>

<sup>93</sup> 'MBRRACE audit tool' <https://www.npeu.ox.ac.uk/mbrance-uk>

<sup>94</sup> 'National LADO Network' <https://national-lado-network.co.uk/the-role-of-the-lado-local-authority-designated-officer/>

*All LADO information is held within the trust by the Safeguarding Team.” (062)*

### **External bodies and reporting systems where reports and referrals were made**

During the timeline specified in the questionnaire, 56 trusts reported they had employed the ‘reporting concerns/complaints or incidents to external bodies’ processes described above. However, some trusts also noted that they would not always know when a report is made, for example, if instigated directly by the public (013).

Reports or referrals were sent to a range of bodies and external reporting systems, the most cited of which was the Maternity and Newborn Safety Investigation programme (MNSI), previously Health Services Safety Investigations Body (HSIB) (16 trusts), StEIS/PSIRF (13), NMC/GMC (9), Perinatal Mortality Review Tool (6), and the Integrated Care Board (ICB) (6 trusts). Organisations or systems mentioned five or fewer times included contact with the CQC, Child Death Overview Panels (CDOP), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE), Local maternity and neonatal system (LMNS), Regional Neonatal Networks, Operational Delivery Network (ODN), Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), an employee union, StEIS/PSIRF, PMRT, NRLS/LFPSE, and the Serious Hazards of Transfusion (SHOT) registry via the Medicines Hazards Regulatory Agency.

*“Between 19th October 2022 and 19th October 2023, the trust made 9 referrals to HSIB relating to neonatal incidents for babies transferred for therapeutic cooling and early neonatal deaths.*

*3 of these cases have been rejected, 6 are proceeding; only one has received a draft report to date, which when finalised will be shared with trust, family and redacted for national learning.*

*All HSIB referrals are automatically investigated as being a serious incident.*

#### *PMRT referrals*

*There have been 22 PMRT reviews between October '22 and October '23 (though not all were eligible). 6 of these infants were born <24 weeks. Of the remaining 16 infants born at or over 24 weeks gestation, there were 6 neonatal deaths and 10 still births.*

*PMRT reports are shared with CDOP and are automatically shared with MBRRACE.*

*Findings are often discussed with parents at the debrief meetings.*

*NNAP reports are received quarterly and action plan in place to address any outlying areas of care.*

*Quarterly network reports received with data for unit benchmarked to other units across the [Region].*

*HSE/RIDDOR – one incident reported during the period relating to a staff member who sustained a fall.” (054)*

Only a few respondents described how external reporting was fed back to staff and parents:

*“MNSI reports received across the maternity and neonatal service during the time specified four reports. All reports are shared with the families, the staff involved, available to staff via a secure channel on MS teams, findings recommendations and action plans are shared*

*with the specialty and division via governance meetings, the board of directors as part of the quarterly Quality report, the Integrated Care Board and the LMNS for shared learning.” (087)*

*“There has been 1 incident (December 2022) declared as a serious incident (neonatal transfer/ unexpected death). The final report was shared with care group, division, and Trust Executives internally and externally to the ICB as part of the serious incident process. The statutory Duty of Candour was provided to parents and again following the completion of the investigation report.” (101)*

## Reporting to professional and provider regulators

With specific regard to professional and unit regulation with professional bodies (for example, GMC, GPC, HCPC, NMC) or the provider regulator (such as CQC), 24 trusts stated that they had reported matters to a regulator directly or through the Responsible Officer. These included:

- 15 trusts only made referrals to the NMC (001, 003-006, 017-018, 025, 032, 039, 067, 071, 090, 098, 106) \*Note that 032 made 4 NMC referrals during the specified timeline, which was the highest reported number of referrals made of any trust.
- 6 trusts only made referrals to the GMC (027, 030, 033, 070, 073, 080)
- 1 trust made a referral to both the NMC and the GMC (113)
- 1 trust made a referral to the CQC (056)
- 1 trust made a referral to the LMNS (110)

It should be noted that respondents rarely mentioned the HCPC or GPC, and instead they mostly referred to the GMC or NMC or medical and nursing staff – even if they were reporting that no referrals had been made. For example,

*“There have been no referrals have been made to the GMC or the NMC during this time period” (035)*

and

*“Medical staff – no matters reported. Nursing staff – no matters reported.” (116)*

Respondents also discussed referrals made about the unit level (rather than the individual professional level described above). For example,

- Trust 056 noted that two referrals had been to the CQC – one from a family and the other from a whistleblower. Both were closed within the timeline specified.
- Trust 104 noted they had discussed issues with their ICB regarding cot closures and the development of a workforce plan to ensure safe staffing.

It is noteworthy that several trusts referenced tools and organisations that are no longer in service (or transitioning out). For example, there were mentions of the NRLS and STeIS, which have now been replaced by the Learning from Patient Safety Events (LfPSE) service. Furthermore, there were mentions of HSIB independent single case investigations, which since 1 October 2023 have been carried out by MNSI.

# Factors inhibiting and encouraging raising concerns

Several features of the management structure, governance structure, and the culture at trusts were described by respondents as either inhibiting or encouraging staff from raising concerns about the care of babies. Very few respondents provided views on inhibiting or encouraging factors from patient/family perspectives.

Most trusts indicated they had at least one encouraging factor present. 25 trusts said they had at least one inhibiting factor present. Where respondents from the same trust disagreed about the presence of inhibiting factors, we counted the trust as having them present.

We have organised respondents' descriptions of factors related to staff into themes including reporting culture, staff voice, escalation routes, leadership, resources, public scrutiny, and quality improvement. This is followed by a brief section on factors relevant to families.

## Staff factors - Reporting culture

Respondents reported that a lack of a culture of reporting at a trust inhibited concerns from being raised. For more information on reporting cultures, see [Culture](#). In the context of culture inhibiting raising concerns, Some respondents described:

- incident reporting being perceived as punitive and infrastructure feeling accusatory and individually exposing ('a blame culture rather than just and learning culture') (055)
- raising concerns not being seen as normal or a normal duty of professionals (055)
- previous poor handling of whistleblowers or people who had raised concerns inhibiting current reporting culture (055)
- competitive cultures between trust sites leading to underreporting

Two respondents from the same trust described cultures and 'legacy cultures' that are far more likely to inhibit reporting than governance structures or processes:

*"I don't think there is anything specific in the reporting structures/governance which prevents concerns being raise about the care of babies. The most likely reason that somebody would not escalate a concern is due to culture either having a fear that by raising a concern it will cause them a detriment or that they won't be listened to obtain appropriate action." (056A)*

*"To some extent the legacy culture still plays an important role in potentially inhibiting reporting generally. There is a lingering perception that staff may be punished for raising issues, that there is a blame culture and a fear of reporting. The Trust and the specialities have worked hard to dispel these beliefs. There appears to be a concern that people will not be heard when reporting concerns and nothing will be done as a result. The Trust is working to understand why some staff still have these views." (056B)*

And the process of changing cultures was described as a long journey involving multiple strategic actions:

*“From the Trust Board down, it is my observation and assessment that a lot of effort has been made over the last 5 years to create an open and listening culture; to promote and facilitate patients, staff and family members to raise concerns; to ensure that robust policies, processes and training are in place to support this; and to respond rapidly and appropriately to concerns that are raised to increase confidence in these systems and processes and thereby further strengthen this culture.*

*Although I believe a lot of progress has been in this respect as outlined under question 8, responses to the staff survey and the external report into culture and leadership in neonatology described above demonstrate that some staff are still reluctant to report concerns through the various channels provided. Efforts are ongoing to overcome these barriers across the Trust and in the neonatology service. In the last few weeks a further opportunity has been provided for staff in the neonatal unit to provide confidential external virtual or face to face feedback as part of the ongoing work arising out of the external culture and leadership review (see questions 5 and 6 for further information on the external culture and leadership review and Newborn Care Development Programme).” (042)*

*“The approach in maternity has positively encourages staff to raise concerns and report issues. This has taken a number of years to embed and is a real shift in culture. It takes time and trust to be in this position.” (056)*

To encourage reporting and create a positive reporting culture, respondents noted the importance of continuously encouraging reporting, and that being anonymous if desired by the person raising the concern. The actions related to culture described by respondents included:

- the trust having a culture encouraging staff to raise parents/carers' concerns and potential solutions (029, 035), a 'strong FTSU culture', an 'open-door policy / culture', or a 'positive culture of clinical risk reporting'
- the trust working hard to continuously build a culture which offers psychological safety to all its staff or the promotion of just and learning cultures and the use of quality improvement methodologies (in the trust's strategy, priorities, staff induction, and on-going training) (010, 054, 091)
- staff being supported to raise concerns and thanked when they do so (060)
- senior leadership regularly emphasising the importance of raising concerns and citing examples in which the raising of concerns has led to positive change (015)
- staff regularly being reminded to use the risk information management system (004)
- all trust leaders undergoing training in compassionate leadership to facilitate an open culture (096)
- opportunities for anonymised escalation via Datix, Professional Nurse Advocates and the FTSU guardians (085)
- division nursing leaders giving a presentation on just culture on a study day (116)

- the trust spoke about the Letby case with the wider organisation at daily meetings and with the divisional leadership meetings
- communications at a Trust level around the value of speaking up and how to do it
- the development of a 100-member FTSU Champion network

One trust additionally detailed a communications-push they had following the Letby case:

*“Following the Lucy Letby case and as part of Speak Up Month 2023, the Trust’s Chief Executive focussed on speaking up in his weekly newsletter to all staff on 2 October 2023 saying, “Fostering a culture of openness and psychological safety where everyone can feel confident and safe to speak up is business critical”. The Chief Executive encouraged any member of staff to raise concerns or ideas for improvement to their manager or Freedom to Speak Up Guardian. The newsletter also directed staff to the “Raising concerns at [trust 079]” intranet page, where information is given about whom to approach to discuss concerns (HR services, Patient Safety Team, Clinical Governance Team, Counter-Fraud Specialist, Joint Union Office, Freedom to Speak up Guardians, Staff Governors, Trust Chaplains, Staff Network Groups, and the Patient Support and Complaints Team).” (079)*

### **Staff factors - Voice**

Linked to the above around reporting cultures, we grouped respondents’ descriptions of issues inhibiting staff from using their voice. These included inbuilt hierarchy and different professional groups stifling hearing everyone’s voice, and the executive team being perceived as not listening to the division clinical leadership team. One respondent also noted staff found it particularly challenging to speak up when their concern was about staff of a different gender, race, and/or hierarchy (007).

*“Any NHS trust, by its design, has an inbuilt hierarchy and different professional groups. People can sometimes feel inhibited by speaking up about issues if people are ‘higher in the hierarchy’ or in a different professional group. I think this is inherent within NHS organisations to some extent.” (116)*

Alternatively, numerous encouraging actions were described by respondents to increase staff using their voice, including the introduction of training programmes (for example ‘Empowering Voices’ (007)/‘Speak Up’ or similar, Active Bystander (038)), the introduction of a new psychology service for staff to encourage speaking out, and an ‘active staff council’. Continuous work on diversity and inclusion was also mentioned as enabling.

### **Staff factors - Escalation routes**

Respondents described several features of reporting structures and processes that inhibited concerns being raised, including complex, bureaucratic, and hierarchical reporting routes for staff, often without ‘loop closure’. One respondent noted there might be a lack of awareness on how to raise a concern among staff. Another respondent noted the management structure created a challenge in the flow of information from the unit to the division. While two noted strained relations were the causes of reporting challenges.

Alternatively, some respondents argued that structures were well designed to ensure concerns were appropriately investigated, staff were aware of escalation routes for concerns (including informal, formal and FTSU routes). Two respondents noted their trusts

used flattened hierarchy which created visibility of senior leaders, as well as executives with visibility of the unit and directorate triumvirate (058, 102). While others flagged that effort had been put into building personal relationships, and good relationships existed at all levels, which encouraged reporting.

Respondents indicated there were numerous opportunities for staff to raise concerns. These included through a 'visible FTSU team' and 'many FTSU guardians and champions' being available who held 'regular drop-in sessions' (020). One respondent said their trust additionally developed a confidential FTSU service delivered by an independent provider to encourage reporting (025). Another encouraging feature was that it was not necessary to go through a line manager (by going to middle management) or using the incident reporting system to raise a concern, and others noted discussion around concerns were a regular part of staff appraisals (048).

### Staff factors - Leadership

Respondents described the importance of their leadership teams building in mechanisms to listen to staff and being visible on the wards. Respondents described encouraging features of cultures including:

- **Ward rounds:** inclusive ward rounds allowing for feedback from parents/ carers and the multi-disciplinary team (004, 019, 078)
- **Visible leadership:** Visible leadership within the unit and easily accessible leaders.
- **Walkarounds:** CNO and CMO or Non-Executives and Executive Directors regularly undertaking walkarounds (076) – sometimes including a patient safety theme or drawing on the IHI Patient Safety toolkit (036)
- **Events:** regular listening events with divisional and/or executive leadership (036), a weekly patient safety summit held within the Trust with an open invitation (020), a monthly online "Executive Question Time" meeting (where it was described staff recognise that their questions and concerns are being listened to in real time Q&A and in followed up afterwards) (015)
- **Surveys and reporting tools:** surveys to gain info about concerns and following up with actions promptly and a staff psychology service which reported themes from support sessions to the Executive team (while maintaining staff confidentiality). The respondents reported that "[the psychology service] is an incredibly helpful way of identifying at an early stage any areas that need addressing" (058).
- **Patient and staff stories:** Neonatal patient and staff stories being shared at board meetings (102)

Other encouraging features described by respondents included leadership being perceived by staff as credible, well-established, and effective in escalation of incidents and concerns. And the unit governance team being proactive in their approach with clinical teams. New neonatal trust-wide posts had also been established in a small number of trusts focused on encouraging reporting and safety.

Some respondents described the importance of having a clinically led divisional structure, "clinically credible, well established team members who are recognised within the wider

organisation as being effective in their escalation of incidents and concerns” (113), and clinically-led management structure and triumvirate leadership teams at all levels.

### Staff factors - Resources

Respondents described several features of trusts creating challenges in reporting. This included incident reporting software being clunky and digital data integration being challenging. Respondents also indicated that their units were not fully recruited to (and not in compliance with BAPM standards), despite extensive efforts. This is discussed further in [Staffing levels](#). Low staffing levels were reported to leave no headroom or time to raise concerns, and one trust cited a need for investment in protected PA time for clinicians who are investigating incidents and developing risk management support.

Respondents described some aspects of resources as encouraging reporting. For example, where software was helpful, one respondent noted using action logs to provide an audit trail and feedback to staff on where changes had been made. Physical design also helped with reporting, whereby the maternity governance team (and safety champions) were in the SCU. One respondent described how additional senior level resources had been recruited in to lead recovery and improvement actions identified.

A respondent described resources being important (among other factors such as culture) to collecting data and taking a proactive quality improvement approach:

*“At [trust 039] we have a very open culture, and the management structure is democratized through the Divisional arrangements and specialty teams. I have spent time talking to the teams and I know that they are very comfortable talking about both their successes and their challenges. The Freedom to Speak Up culture is now strong, and we have a sensitive and dedicated team that deals with the issues raised. When appropriate those concerns are escalated and investigated. As a Board member I see upward reports regularly and always have an opportunity to challenge and enquire. As Chair of Patient Safety, I have adequate resources to collect data and both a reactive focus (for all serious incidents and near misses) and a proactive team (for quality improvement). I am impressed by the work of HSIB and regularly receive reports and detailed investigations following neonatal death. We always take time to read and respond to these reports. Our perinatal mortality surveillance program is mature. We were one of the first Trusts to embrace the work of the Medical Examiner.” (039)*

Another important resource described by respondents included modern quality management systems:

*“I think having a modern quality management digital system would help to look for any quality issues across the trust. Using technology to flag areas of concern if data points where outlying from an outcome perspective. I am sure there would be the ability to correlate this with metrics such as staffing numbers or staff on duty to look for themes and trends if there was some system integration. A lot of this triangulation is done manually at present. One cannot always rely on data to make judgement as there are well known examples of how data error has led to the wrong assumptions being made but it could help to flag areas of concern automatically.” (056)*

## Staff factors - Public scrutiny

Some respondents described the public scrutiny of maternity and neonatal services as inhibiting reporting (091). For example, respondents noted there were numerous reporting requirements to report the same data in different formats (such as, in response to the Ockenden review, CQC, NHSE, ICS, and ICBs) (024). Feelings of excessive public scrutiny was said to risk having an impact on reporting and psychological safety:

*“As a level 3 unit there is a lot of scrutiny on the outcomes of the babies that are cared for on the unit. The staff working on the unit need to be able to balance that scrutiny with the psychological safety to make decisions and potentially mistakes.” (017)*

*“There is significant focus on maternity services which draws more attention to the clinical teams which in turn increases pressure on individuals. This may change behaviours in terms of raising concerns about colleagues either – people raising more, or teams more reluctant to raise.” (063)*

*“If anything, I would take some confidence that following the Letby considerations, colleagues should feel more comfortable in raising concerns about the care of babies in the Trust. Similarly, the focus on Ockenden reports has led to a focus on midwifery services. There is always a risk of excess scrutiny can lead to more closed culture, and it is important therefore that we balance this out with our just culture and learning approach as a trust.” (040)*

Public scrutiny and data reporting are also discussed in the following sections: [Data collection and use of data](#) and [Suggestions for improvements to management and governance structures](#).

## Staff factors – Quality improvement

Quality improvement projects and meetings were described as encouraging factors by a small number of respondents.

*“I don’t think that there are any obvious inhibitors but I am conscious that the barriers to reporting are often subtle rather than overt and so continuous improvement needs to be universal in ensuring staff feel psychologically safe, connected and empowered.” (060)*

For example, two respondents noted that continuous improvement methodology had encouraged their leaders to empower those that do the work to improve the work, which had been perceived by the respondent to have built confidence in individual staff members and in teams. Staff celebrating the achievements which have a positive impact on patient care was also perceived as enabling.

A particularly comprehensive reply, which referenced many of the supportive features described above is provided here:

*“We think there are a number of factors that would encourage people to raise concerns, which are as follows:*

- *Recent media coverage covering the care quality in these services (as described above).*
- *Strong communication initiatives in neonatal services following the Letby case, proactively engaging with parents, families and colleagues to encourage reflection and where appropriate raising concerns.*
- *Colleagues feedback to service group leadership that the incident reporting systems in both sites are user-friendly.*
- *Trust culture as evidenced by annual staff surveys*
- *Our triumvirate leadership structure which brings together clinical and operational leaders to work as a single team and in the case these services, Director of Maternity Services, Associate Medical Director & Service Group Director*
- *A quality and performance monitoring regime that is built around balancing challenge with support and where statistical performance information is used within a continuous formal dialogue*
- *Our promotion of key national initiatives such as the ‘Duty of Candour’ and ‘Freedom To Speak Up’*
- *The ongoing process of a positive merger and integration where two high performing Trusts have come together to integrate and develop services under a new service group leadership team*
- *The strong interest from our Board in these services and associated with this, frequent visits to these services and walkarounds by Executive Directors and Non-Executive Director Safety Champions*
- *Close involvement of our Somerset Maternity Voices Partnership” (005)*

### **Inhibiting and encouraging factors for families**

As mentioned above, very few respondents offered views on inhibiting or encouraging factors from family perspectives. However, the few responses are summarised here.

Inhibiting factors included:

- a lack of awareness on how to raise a concern among staff and patients
- language barriers among families wishing to make a complaint and the need for interpreters being available to families (098)
- complex reporting routes and governance structures for families (036)

One respondent provided a view not only of their own trust’s reporting structure, but of all trusts across the NHS:

*“I think the governance structures of all Trusts are complex and somewhat opaque to the general public, which may inhibit raising concerns or an understanding of what is being done about any concerns that are raised.” (082)*

Encouraging factors included:

- multiple routes being available to patients using written or verbal (and anonymously, if preferred) including tools such as a local patient concern reporting app (036, 047), and a QR code for reporting directly to the Operational Delivery Network (047), chaplaincy services (040, 072)

- widespread public facing information about how to raise concerns and provide feedback
- encouragement from trust staff to families about raising concerns, however minor the concern (004) and encouragement to take part in wards rounds (019, 078)

## Factors inhibiting managers from acting upon concerns

27 trusts identified at least one feature present that was inhibiting the ability of managers from acting upon concerns, although many also referenced back to their overall response on factors inhibiting concerns being raised. However, the illustrative quotes below highlight some of the differences from question 39a.

The most common inhibiting factors mentioned were financial strain and understaffing, which were often described in a linked way:

*“The predominant limitation on the Trusts ability to respond has been due to the financial position of the organisation and wider NHS, which has meant that they have not been able to fully support all business cases and investment requests. This has limited the services ability to address certain national standards, such as BAPM medical and AHP staffing.” (102)*

*“The trust operates in a very financially constrained environment where managers have massive competing pressures put upon them including managing complex services across a wide geographical area. There has not been a huge amount of strategic direction for the trust. Much time is spent day-to-day firefighting staffing shortages and very high patient demand. All of this in an environment where they are constantly under pressure to cut costs. We are also under huge amounts of regulatory scrutiny from the CQC etc which can mean that staff are terrified about covering things up so over-declare and investigate incidents or the opposite and don’t declare things.” (013)*

Other inhibiting factors raised included the capacity, capability, and sustainability (and fatigue) of managers and leaders. Two respondents noted there was potentially a lack of clear understanding of the governance processes, neonatal services, and a lack of experience in dealing with complex concerns, particularly among new managers who are not given training in handling complaints, which could be impacting reporting. Linked to the above, one trust noted managers and leaders were not regularly present on all sites, which was leading to teams feeling disconnected from their leaders. Concerns around the capacity and capability of leaders and managers are described in the quotes below:

*“The management/leadership team are dealing with a huge number of asks (potentially too many) at any one time, and this can influence how they are able to act. It is at times difficult to unpick what the actual concern or issue is and what the ask/expectation of the person who is bringing that to you is... There are occasions where there is ‘learned helplessness’ or ‘wilful blindness’ from leaders – that may be*

*due to a knowledge gap or just feeling that ignoring it will mean it becomes someone else's problem." (055)*

*"It is also a matter of fact that the NHS has been under exceptional operational demand for the last 4 years since the pandemic. Both clinical and non-clinical managers have 'bandwidth' challenges with competing pressures, such that there is a risk of delay or even failure to recognise early signs that concerns are being raised." (030)*

*"The lean and new leadership is spread thinly across multiple sites and this has an impact on the accessibility of the clinical and non-clinical managers and the resources they have to respond. The implementation of a new clinical operating model with sufficient leadership resources would make a difference to this although the strengthening organisational financial pressures may have an adverse impact on this. The lack of required training, development and support for new joiners means a paucity in the depth of leadership, career and experience development. To act on concerns then falls to the personal values of any given leader rather than being developed as a standard supported way of leading. A culture from the executive to enable open reporting and supported reaction is vital. One that is focused on only hearing 'good news' and moves to a blame culture is one that will inhibit managers or clinical staff from alerting to low level and major risks." (083)*

And these bandwidth issues are tied to all staff, not just managers, and associated with trust financial positions and activity levels in the following quote:

*"One concern I have is around the deeply constrained NHS financial position, and the urgent care demand which we are seeing in emergency departments in acute organisations. This has also resulted in an uptick in paediatric activity and the admission of complex young people with challenging behaviour and/or mental health considerations to acute settings. All of these have the potential to act as distractions from quality neonatal service provision, and without being tackled can lead to compassion fatigue and/or learned helplessness from staff in relation to escalation of concerns. These are regional and national issues." (040)*

A small number of respondents also reported that the specialised nature of neonatal care made it difficult for managers to raise and act on concerns. For example, one respondent said:

*"Neonatal care is one of many specialised areas at [trust 030] where managers (particularly those not directly involved in a neonatal unit) may be less familiar with the clinical and non-clinical aspects of neonatal care; and it may therefore be more difficult for them to raise legitimate challenge." (030)*

Respondents from a trust also highlighted that acting upon concerns came at a significant expense and risk to managers. One respondent drew on an example of managers at their site five years ago who had suffered significant stress and professional isolation as they tried to act on concerns:

*"There is nothing that I can think of specific to our structure however in my experience I am aware that those who act on concerns raised often do so at*

*considerable personal cost usually in terms of stress but occasionally in terms of professional isolation. That the current process can be very onerous perhaps because there is a tendency for those whom concerns are raised about experience huge stigma even before any allegations are proven and so the reporter or manager will want to be absolutely sure before they even commence an investigation which could be an inhibitor. Reporting concerns and making a decision to act needs to be entirely objective, that's probably unrealistic hence my earlier comment related to the importance of an inclusive culture where biases are understood and acknowledged.” (060)*

Another respondent described a lack of options to move careers as a risk to raising concerns (especially if professional relationships broke down):

*“The relatively small and specialist team in NNU may make it more difficult to raise concerns about colleagues as there are fewer alternative places of work should relationships deteriorate (set against, for example, an adult nurse who could seek to work in any one of a number of teams).” (016)*

Thus, factors inhibiting action appeared to be linked to a lack of resources, leadership and management being stretched or inexperienced, and the potential personal stress, risk, and burden of evidence associated with taking action. Respondents emphasised regular surveys and reviews as important sources of data on reporting culture.

Finally, while unrelated to inhibiting factors, multiple respondents noted in their responses to this question that they used the NHS staff survey, other internal surveys, and CQC and FTSU reviews to determine how staff felt about reporting. Getting regular views was used to track progress, as explained in this quote:

*“Discussions around the results of the NHS staff survey were undertaken alongside regular meetings with the team for any areas highlighted to ensure improvement is noted. Previous repeat surveys have demonstrated an improved position within the division. This work has been included within the Trust and divisional strategy.” (117)*

## **Raising issues with the trust board**

50 of the 107 trusts that replied to question 39c reported having escalated at least one issue to the Trust Board since 19 October 2022 (13 trusts did not reply). The issues discussed with the trust board repeat many of the themes described above but are summarised in Table 19 below.

Table 19: Types of issues raised with the trust board

Category	Specific issues discussed with the trust board during the specified timeline in the survey
Staffing	Neonatal staffing gaps (102) (094) (089) and the need to meet BAPM framework levels (102) (025) or QIS standards (054)
Incidents	Serious incidents and external investigations (064, 060) Safety incidents (for example external transfers of baby for cooling, and for sepsis care) (020) Coroners' inquests (072) Infection and contamination issues (021, 054)
Whistleblowing	Whistleblowing disclosures (013) and challenges to doing so clinicians not feeling listened to by the executive team (024)
Transformation projects	Centralisation of neonatal services across sites (071) [Local] Integrated Care Board have been developing a case for change for women and children's services with a view to potential public consultation. (021) Reassignment of the Local Neonatal unit to a Special Care Unit (035)
Backlogs	Backlogs of PMRT cases caused by a pause in the review process during the pandemic (115)
Estates reviews	Review of estates and space for neonates/cots (025) Digital data integration (025)
Thematic discussions	A paper detailing the Lucy Letby case and learning from it, a deep dive into the neonatal service (060) <i>"The outcome of the Lucy Letby trial and its implications for our own hospital were discussed at a special session of the Trust Board."</i> (045)
Funding for quality and safety initiatives	Funding for Neonatal Safety Champions (102) Infant feeding support for families on the neonatal unit (102)

## Nuffield Trust reflections

Respondents described numerous routes to raising concerns/complaints – both within a trust as well as with external bodies. As the questionnaire did not ask respondents about their perceptions of the effectiveness of the reporting and response to concerns or complaints, it was not possible to comment on the adequacy of the processes and procedures. However, it is worth noting that recent research has identified serious issues

with reporting concerns and complaints across the English NHS. Martin and colleagues (2021) argued that mechanisms for raising complaints and concerns (across a range of specialties) often disappointed those who used them, or failed to produce a resolution that met their expectations. Many of the study's participants (from across 6 NHS trusts) suggested the systems they had encountered were poorly designed and poorly realised, which led to scepticism about the value of the process.<sup>95</sup>

UK-based research, before the introduction of the Freedom to Speak Up guardian role, found common themes around hesitancy to speak up:

- 2007: a study involving 142 nurses from three NHS trusts found that they feared repercussions, retribution, labelling and blame for raising concerns, about which they predicted nothing would be done.<sup>96</sup>
- 2010: a study found that nurses would not challenge doctors if they perceived that this would result in conflict or stress, if they were afraid of the doctor, or if they feared reprisal.<sup>97</sup>
- 2012: a study found that five of the 22 (26%) UK-based anaesthetic assistants and consultant anaesthetists indicated they would not speak up<sup>98</sup>

Within the current context where Freedom to Speak Up guardians play such a pivotal role in staff raising concerns, studies have attempted to understand their effectiveness. However, researchers have warned that the FTSU guardian role looks different across trusts, and concluded in a 2021 evaluation that comparison and assessment of the effectiveness of the role at a national level would only be possible or meaningful only when variability could be properly accounted for.<sup>99</sup> Despite this variation, they and others have identified common practical challenges faced by FTSU guardians, including:

- a lack of available resources, especially time scarcity, which negatively and significantly affected their ability to effectively respond to concerns; their opportunities to collect, analyse and learn from speaking-up data; and, more generally, the extent to which they developed their role and speak-up culture.<sup>100</sup>
- challenging categorisations of concerns, very few of which reached a threshold for whistleblowing, and many were not obviously quality and safety-related, while others appeared to be signals of issues that were much more complex and wide-ranging than they first appeared. This means the role involved helping those with lower-level worries to construct their concerns and knowing what to do with them (rather than solely supporting whistleblowers).<sup>101</sup>

<sup>95</sup> Martin GP, Chew S, Dixon-Woods M. Why do systems for responding to concerns and complaints so often fail patients, families and healthcare staff? A qualitative study, *Social Science & Medicine*, Volume 287, 2021,

<sup>96</sup> Attree M (2007) 'Factors influencing nurses' decisions to raise concerns about care quality' *Journal of Nursing Management* 15: 392–404. Pp 95

<sup>97</sup> Churchman JJ, Doherty C (2010) 'Nurses' views on challenging doctors' practice in an acute hospital' *Nurs Stand*.

<sup>98</sup> Rutherford JS, Flin R, Mitchell L (2012) Teamwork, communication, and anaesthetic assistance in Scotland. *Br J Anaesth.*

<sup>99</sup> Jones A, Maben J, Adams M, et al (2022) Implementation of 'Freedom to Speak Up Guardians' in NHS acute and mental health trusts in England: the FTSUG mixed-methods study. National Institute for Health and Care Research, Southampton (UK). <https://europepmc.org/article/nbk/nbk583156>

<sup>100</sup> Ibid: Jones et al (2022)

<sup>101</sup> Martin GP, Chew S, Dixon-Woods M (2021) 'Uncovering, creating or constructing problems? Enacting a new role to support staff who raise concerns about quality and safety in the English National Health Service' *Health*.;25(6):757-774.

To improve the FTSU guardian role, researchers suggest:

- work being done to reimagine and re-present the work of raising concerns, so that it is infused less by the connotations of whistleblowing;
- keeping their FTSU guardian role broad in nature, allowing them to be available for discussion around all types of concerns/complaints rather than narrowing to more serious issues, which will help them understand and intervene in the localised cultures that might lead to quality issues in trusts; and
- ensuring the role is close and embedded within the organisation and with colleagues – rather than distant and independent – to develop a role that is relational rather than procedural.<sup>102</sup>

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<sup>102</sup> Ibid Martin et al (2021).

# Reviewing evidence after a death

This section provides a description of how trusts reported they reviewed evidence after a death, including pathology requests, role of the medical examiner and Child Death Overview Panels.

This section covers questions 20-27 in the questionnaire. There was overlap in the responses between these questions, and the summary below draws on responses from multiple questions.

## Questions asked of trusts

20. How many Child Death Overview Panels has the trust participated in relating to neonatal deaths at the trust between 19 October 2022 and 19 October 2023?
21. Do you consider these panels are an effective way to investigate a neonatal death? Please explain why you take that view?
22. Does your trust have a Medical Examiner Office?
- When was this established? Please provide a history of appointments.
  - Do Medical Examiners have in place processes to be able to identify themes or patterns such as clusters of cases displaying similar characteristics?
  - Have any neonatal deaths been reported to the Medical Examiner?
  - Have Medical Examiners ever escalated any concerns about care to, for example, local clinical governance teams?
  - Have Medical Examiners ever identified any themes or patterns?
  - What is the interaction between the Medical Examiners and coronial system and have Medical Examiners referred any cases to the coroner?
23. How many perinatal pathology requests has the trust made since 19 October 2022?
- What time frame did the trust receive results in respect of those requests?
  - How are requests processed and questions/challenges made?
  - Are there appropriate data sharing arrangements in respect of pathology requests?
24. How many unexplained deaths or unexpected patient safety incidents within neonatal services at your trust have been reported between 19 October 2022 and 19 October 2023?
25. Please explain the trust's process for reporting, reviewing and responding to unexplained, unexpected and/or reportable deaths and patient safety incidents? Please describe how parents are involved and able to participate in the process?

26. What do you consider is the purpose of these processes?

27. In your experience do these processes achieve that purpose/those purposes?

## Context for this section

### Perinatal pathology request

- Perinatal post-mortem examinations are specialist medical examinations undertaken following the death of a foetus or baby, in which the pathologist reviews clinical and post-mortem findings to suggest a mode and (where possible) cause of neonatal death. The perinatal period for post-mortem examination refers to period from 12-40 weeks gestation and after (up to the first 28 days of life).<sup>103</sup>
- Perinatal pathology protocols within the UK are published by the Royal College of Pathologists (RCPATH) and their implementation overseen by the UK Accreditation Services (for example, guidelines on autopsy practice for neonatal death<sup>104</sup>). See [additional references](#) section for further guidelines.
- In October 2022 NHS England published an urgent policy statement<sup>105</sup> which set out criteria for perinatal post-mortem investigation of fetal and neonatal deaths, the aim of which is to support greater standardisation in access to perinatal post-mortem investigations and placental examinations, and to prioritise available perinatal pathology capacity.

### Unexplained deaths and unexpected patient safety incidents

- As described in the [reporting and managing complaints section](#), the NHS is undergoing a transition from the Serious Incident Framework (SIF)<sup>106</sup> to the Patient safety incident response framework (PSIRF)<sup>107</sup> as an approach to responding to patient safety incidents (it was expected the transition would be completed by Autumn 2023). PSIRF is a key part of NHS patient safety strategy<sup>108</sup> and described by NHSE as a significant shift in the way that the NHS responds to patient safety incidents.
- There is numerous national guidance for reviewing evidence after a neonatal death and reporting requirements, much is specific to neonatal and maternity services.

<sup>103</sup> NHS England (2022) 'Perinatal post-mortem investigation of fetal and neonatal deaths (England, Scotland and Wales)' <https://www.england.nhs.uk/long-read/perinatal-post-mortem-investigation-of-fetal-and-neonatal-deaths-england-scotland-and-wales/>

<sup>104</sup> Royal College of Pathologists (2019) 'Guidelines on autopsy practice: Neonatal Death' <https://www.rcpath.org/static/0a7c073e-c773-4941-a1e998df666e17e3/G168-Guidelines-on-autopsy-practice-Neonatal-death.pdf>

<sup>105</sup> NHS England (2022) 'Perinatal post-mortem investigation of fetal and neonatal deaths (England, Scotland and Wales)' <https://www.england.nhs.uk/long-read/perinatal-post-mortem-investigation-of-fetal-and-neonatal-deaths-england-scotland-and-wales/>

<sup>106</sup> NHS England 'Serious incident framework' <https://www.england.nhs.uk/patient-safety/serious-incident-framework/>

<sup>107</sup> NHS England 'Incident Response Framework' <https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/#new-approach>

<sup>108</sup> NHS England 'The NHS patient safety strategy' <https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/>

For example, MBRRACE-UK (Mothers and babies: reducing risk through audits and confidential enquiries across the UK) reporting requirements include surveillance of causes of maternal deaths, still births and infant deaths<sup>109</sup> and Perinatal Mortality Review Tool (PMRT)<sup>110</sup> supports standardised perinatal reviews across NHS maternity and neonatal units.

- The Maternity and Newborn Safety Investigations<sup>111</sup> (MNSI) was established as a national initiative to improve maternity safety across the NHS in England by investigating specific patient safety incidents which all NHS trusts are required to report.

## Medical Examiner

- Medical examiners are senior doctors who provide independent scrutiny of the cause of death.
- The National Medical Examiner's good practice guidelines<sup>112</sup> set out expectations for medical examiner operation.
- A statutory medical examiner system is being rolled out across England and Wales to provide independent scrutiny of all deaths.<sup>113</sup> From September 2024, it will be mandatory for all deaths in any health setting (not investigated a coroner) to be reviewed by a medical examiner (as per Department of Health's Death Certification Reforms<sup>114</sup>).
- Coroners are independent judicial officers (either doctors or lawyers) appointed by the local authority responsible for investigating cause of deaths, operating in accordance with legislation (for instance, Coroners and Justice Act (2009)<sup>115</sup> and Coroners (Investigations) Regulation 2013<sup>116</sup>).

<sup>109</sup> MBRRACE-UK (2022) 'Perinatal Mortality Surveillance Report' <https://www.birthcompanions.org.uk/resources/mbrrace-uk-perinatal-mortality-surveillance-report-for-births-in-2020>

<sup>110</sup> NPEU Sheer (2023) 'Perinatal Mortality Review Tool (no date)Tool' <https://www.npeu.ox.ac.uk/pmrt>

<sup>111</sup> Maternal and newborn safety investigations (no date) Maternity and Newborn Safety Investigations 'About us' <https://www.mnsi.org.uk/about/>

<sup>112</sup> NHS England (2020) Implementing the medical examiner system: National Medical Examiner's good practice guidelines NHS England (2020) Implementing the medical examiner system: National Medical Examiner's good practice guidelines [https://www.england.nhs.uk/wp-content/uploads/2020/08/National\\_Medical\\_Examiner\\_-\\_good\\_practice\\_guidelines.pdf](https://www.england.nhs.uk/wp-content/uploads/2020/08/National_Medical_Examiner_-_good_practice_guidelines.pdf)

<sup>113</sup> NHS England: The national medical examiner system <https://www.england.nhs.uk/patient-safety/patient-safety-insight/national-medical-examiner-system/>

<sup>114</sup> DHSC (2024) Death certification reform and the introduction of medical examiners <https://www.gov.uk/government/collections/death-certification-reform-and-the-introduction-of-medical-examiners>

<sup>115</sup> National Archives (2009) Coroners and Justice Act 2009 Department of Health and Social Care (2023) 'Death certification reform and the introduction of medical examiners' <https://www.legislation.gov.uk/ukpga/2009/25/contents>

<sup>116</sup> The Coroners (Investigations) Regulations 2013 <https://www.legislation.gov.uk/uksi/2013/1629/contents/made><sup>116</sup> National Archives (2013) The Coroners (Investigations) Regulations 2013 <https://www.legislation.gov.uk/uksi/2013/1629/contents/made>

## Child death panels

- The Child death review: statutory and operational guidance<sup>117</sup> sets out the full process that follows the death of a child who is normally resident in England. It builds on the statutory requirements set out in Working together to safeguard children<sup>118</sup> clarifies how services and organisations should contribute to child death reviews.
- Child death overview panels (CDOP) form part of the child death review process. Panels conduct multi-agency independent case reviews of deaths of children in the area, and includes representatives from public health, local child and social care services, the police, with the aim of preventing further deaths.

## Perinatal pathology requests

It is challenging to calculate the number of perinatal pathology requests that trusts have made since 19 October 2022 due to the variation in responses. While some respondents were broad in their interpretation and included figures for all perinatal requests (such as placental histopathology, postmortems), others included only postmortem figures, and in some cases a number was provided but it is not clear what it referred to. It should also be noted that different reporting periods have been used by respondents, some have reported numbers for a one-year period from 19 October 2022, others have used a cut-off date somewhere between October to December 2023, and others have not specified the time period for which the data refers to.

It should also be noted that some respondents reported challenges with extracting data relating to perinatal requests from their systems (for example 019, 066, 067, 087). Instead, some respondents reported having employed other criteria or search parameters to help identify perinatal requests, such as providing data for perinatal deaths defined as from pregnancy to one year after delivery (008), completing a search for paediatric pathology requests under the age of one year (019), or providing data based on relevant clinics and wards (076).

### Time frame for receiving perinatal pathology request results

Understanding the timeframe for trusts receiving the results of perinatal requests is challenging due to varied responses. For instance, some respondents (for example 037, 056) provided an approximate time frame, others (for example 008, 039, 059, 071) provided a median, average or range for the perinatal pathology requests for the specified time period. Timeframe can also be impacted by type of pathology request, complexity of the case and whether any additional testing is required (for example 001, 006). While some respondents cited different time frames for each type of request (for example 049, 055), for others it isn't clear the type of pathology request that the cited time frame refers

<sup>117</sup> Department for Education and Department of Health & Social Care. (2018) 'Child death review: statutory and operational guidance' <https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england>

<sup>118</sup> Department for Education (2015) 'Working together to safeguard children' <https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>

to (for example 064, 069, 084). A few respondents (for example 088, 117) reported that they do not hold this information as reports are returned to the requesting clinician.

In focusing on perinatal post-mortem time frame specifically (when reported) substantial variation was evident between trusts. For example, some respondents reported a turnaround time of approximately six to eight weeks (for example 011, 013, 024, 056), while others reported a much longer timeframe, such as exceeding nine months (101) or up to 12 months (for example 005, 045, 100). Some reported broad windows for turnaround, such as four to eight months (114) or three to nine months (028). Several respondents (for example 039, 108) cited delays with receiving such reports. Numerous respondents (for example 005, 045, 100) reported it to take up to 12 months to receive post-mortem reports and one trust (111) reported full reports taking six to ten months, although received preliminary results within one to two weeks. Several respondents (for example, 039, 093, 094, 100, 113) cited staff shortages as an explanation for such delays.

*“Results from PM reports are available from anywhere between 8 weeks to 25 weeks. Currently there is a delay with processing PM examinations and reports due to a national shortage of perinatal pathologists.” (094)*

*“The target for availability of post-mortem (PM) reports is 3 months, but due to staff shortages this is currently taking 6-9 months in more complex cases.” (113)*

*“In terms of provision of reports for both placenta and or post mortem we have over recent years struggled to recruit and as a consequences turnaround times have been longer that we would like. However, in terms of post mortems we do provide a provisional report before the final report can be completed. Currently there is a nationwide deficiency in perinatal pathologists, such that perinatal centres are working with NHSE to identify both local short-term and longer term solutions.” (093)*

Some trusts reported that they have set targets relating to timeframes for receipt of results. For example, one trust (110) reported a service level agreement in place to receive 90% of post-mortem results within a pre-specified timeframe of 56 days. And one trust (055) reported that pathology turnaround times are reviewed and reported on a monthly basis at trust level. However, many trusts did not mention whether they have pre-specified timeframes for receipt of reports and whether these are monitored, reviewed and reported on.

### **Processes for making pathology requests**

Processes vary with type of pathology request. While many respondents focused on processes for post-mortems specifically, others focused more broadly on pathology requests or other types of requests. The focus here will be on post-mortem requests.

Respondents (for example 037, 089, 116) reported that gaining consent for post-mortem is usually undertaken by individuals trained to do so (for instance, perinatal post-mortem consent trained), such as member of the clinical team who cared for the baby (072), neonatal consultant (038, 092) or other trained member of staff such as midwives or clinicians (037, 058, 116). Some respondents reported (for example 007, 025) that families

are provided with information, given the opportunity to discuss with the team and to make an informed decision.

Several respondents (for example 037, 012) reported a cooling off period (following parental consent) prior to the transfer of the baby, with transfer only being initiated once the period has expired. Some respondents reported that documentation (for example consent and request form) is sent to mortuary and pathology services via paper or hardcopy forms (for example 056, 093), others reported the use of electronic forms/email (for example 012, 079, 107), and others reported that requests can be made within electronic patients records systems (for example 060, 078, 119).

Respondents varied in their accounts of who receives the post-mortem report. For example, the bereavement team (096, 102, 115), requesting clinician (014, 061, 088) or named consultant (113). Several respondents (for example 078, 119) reported the post-mortem report to be returned via electronic patient records. Several respondents (for example 088, 096, 115) reported that the post-mortem report (once received) is discussed with family members (for example, a bereavement appointment is scheduled).

Respondents reported several opportunities to raise challenges during the request process and/or following receipt of the report. Some (for example 069, 107) reported that questions or queries from the clinical team can be documented on the consent or referral form at the time of making the request. Two trusts (089, 101) also reported that parents can document questions or concerns for the pathologist on the relevant forms.

Many respondents (for example 016, 032, 079, 097, 098) reported direct contact (by email or telephone) between trust clinicians or bereavement teams and pathology services to discuss queries or concerns, where more clarity or additional information is required. A number of respondents (for example 028, 112) also reported that the pathologist may request further information directly from the referring clinical team or family as required.

Once received, several respondents (for example 030, 049, 102) reported that the post-mortem report is reviewed by relevant clinicians or bereavement team, and that cases are often presented and discussed at wider trust meetings. If any clarification is needed regarding the report or concerns raised clinician to pathologist liaison is initiated (for example 032, 087).

### **Data sharing arrangements in respect of pathology requests**

In discussing data sharing arrangements some respondents referred to general trust information governance or data protection policies, while other respondents discussed how data is transferred. Given these differences, it is not possible to state whether trusts reported such processes were appropriate.

A number of respondents (for example 016, 026) broadly reported data sharing arrangements to be in line with Trust IG policy for data sharing or that appropriate data sharing arrangements/agreements were in place but did not provide further details. Some respondents (for example 010, 037, 109, 111) reported that a contract or formal data sharing agreement with partners or organisations was in place for pathology requests, such as service level agreement that covered data sharing arrangements. For trusts in

which pathology services were inhouse, data sharing agreements were not required (for example 001, 041).

However, two trusts (006, 073) reported that they do not have specific or appropriate formal data sharing agreements in place for pathology requests or services. One trust (054) reported data sharing to be a challenge with pathology services and that they often do not receive reports and one trust (056) cited that reporting is not routinely shared with maternity and neonatal services.

Where respondents focused on data sharing processes, some (for example 010, 023, 030, 041) reported that data is shared via electronic patient records, through a connected electronic pathology test-requesting and results reporting system or similar, in which results can be transferred and reviewed, while other respondents reported reliance on secure email (for example 005, 093).

## Unexplained deaths and unexpected patient safety incidents

It is not possible to calculate the number of unexplained deaths or unexpected patient safety incidents within neonatal services in the specified time period (19 October 2022 to 19 October 2023) due to the variation in responses. Respondents reported '*unexplained*', '*unexpected*' or '*unintended*' deaths, neonatal deaths, '*unexpected patient safety incidents*', '*incident reports*', '*patient safety incidents*', '*serious incidents*', '*safety events*' or '*never events*'.

### Processes for reporting, reviewing and responding to unexplained deaths and unexpected patient safety incidents

Respondents reported established processes based on national guidance such as the [Serious Incident Framework](#) (044, 078), [patient safety incident response framework](#) (067, 110) and [statutory and operational guidance for child death review](#) (067, 071) and several respondents cited following the [National Bereavement pathway](#) (087, 108). Many respondents cited local trust policies and guidance, such as child death review policy (056, 116), mortality review/learning from deaths policies (026, 042, 093) and trust incident reporting or incident management policies (002, 024).

### Local governance processes and incident reporting

Respondents (for example 038, 111) commonly cited incident reporting processes and policies, with patient safety incidents investigated in line with trust incident reporting policy and national guidance (i.e. SIF or PSIRF). Some respondents (for example 067, 110) reported having already transitioned to PSIRF, however others were using SIF with plans in place to transition (for example 033, 079). Incident reporting processes are described further in [Reporting and managing concerns and complaints](#) section of the report. Several respondents (for example 035, 095) reported that information from the incident reporting

system is triangulated with that other local governance processes such as death review processes and complaints procedures.

### External reporting requirements

Many respondents (for example 080) reported the various national reporting requirements specific to neonatal services, such as the national MBBRACE database, Perinatal Mortality Review Tool (PMRT), Child Death Overview Panel (CDOP) and Maternity and Newborn Safety Investigation (MNSI).

*“For perinatal deaths, notification is made to MEs (all cases locally are referred to coroner regardless of cause of death), to the MBBRACE team and to eCDOP. The death is reviewed in perinatal mortality and morbidity, PMRT and child death review meetings when indicated (death does not occur locally). Cases are referred to Maternity Newborn Safety Investigations (MNSI) when necessary. Where concerns of death arise, an independent review is commissioned. Feedback of findings are reported to clinical governance committees and the perinatal morbidity and mortality meeting. A monthly perinatal mortality report is published and widely circulated highlighting trends and concerns/successes in mortality statistics.” (080)*

Respondents (010, 017, 037) noted that all neonatal deaths are reported to MBBRACE (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries) UK reporting system, which is responsible for collecting national information about maternal deaths, late fetal losses, stillbirths, and neonatal deaths. As part of the reporting system deaths are reviewed using the standardised PMRT.

Respondents (for example 060, 078) reported medical examiner review of deaths and referral to the coroner for investigation (as appropriate). Several respondents (for example 010, 016, 070) cited that eligible cases (for instance, early neonatal death) are independently reviewed/investigated by the MNSI (formerly HSIB), an external reviewing body and learning shared with trusts.

Several respondents (for example 017, 037, 041, 079) reported that the CDOP team are notified of all child deaths through an electronic CDOP system. The multi-agency panel conduct a review of each death and liaise with neonatal team for any clarification. See [Child death panels section](#) for further detail. Several respondents (for example 006, 037, 106) reported that neonatal deaths are discussed, reported, presented at regional neonatal ODN meetings and to Local Maternity Neonatal System (LMNS).

### Parental involvement

Respondents reported various mechanisms for the involvement of parents and families in trust and external review processes (005, 023, 031).

- “All parents are offered a post mortem following the death of their baby and this is discussed at length if it is an option they wish to consider*
- All parents are offered an initial meeting post the death of their baby with a Neonatal Consultant and Bereavement Clinical Nurse Specialist.*

- *All parents are contacted the next working day by Bereavement CNS (family keyworker) to discuss the processes relating to the death of their baby including Post Mortem, coroner's referrals, and discussion with Medical Examiner and funeral arrangements.*
- *Medical Examiners routinely contact all parents to discuss if they have any concerns around the care of their baby*
- *Parents are informed of the Perinatal Mortality Review Tool and NDOP processes and sent a letter to invite their feedback and questions and offer to be involved in the review process*
- *Parents are routinely offered a post bereavement follow up 3-6 months post the death of their baby to meet with a Neonatal Consultant, CNS and other relevant professionals to answer any questions the family may have*
- *Following the PMRT and Child Death Review Meeting reviews, findings are feedback to parents in the chosen format.” (031)*

*“During these processes the parents or guardians are supported by the bereavement midwife and are informed that their care is being reviewed. They are encouraged and supported in thinking of any questions they would like to ask the review team, if they are happy, first names to personalise the reports will be used to personalise the report. The Trust does also have a Family Liaison Office who can provide additional support if it is needed but usually the relationship is maintained with the bereavement midwife and the maternity risk team. The MNIS team will meet with parents or guardians and once they have obtained their consent will directly work alongside them to achieve a report which encompasses the parental questions. They also meet with the families to provide the feedback on completion.” (023)*

Respondents (for example 033, 037, 040, 050, 059, 068, 088) reported engagement with families as part of local governance processes such as incident reporting, such as the opportunity for families to contribute to the investigation, ask questions and raise concerns, contribute to the investigation terms of reference and several cited fulfilling duty of candour. Local mechanisms varied, however. Several respondents mentioned the transition to PSIRF and the goal that it would bring better involvement of families (056).

*“Duty of Candour is carried out either in a face to face discussion, or telephone discussion. This is followed up by a letter. Through this process, parents are able to provide questions they wish to be addressed in the investigation of deaths or patient safety incidents. These questions would be addressed in the investigation report. We offer the opportunity for a face to face meeting to talk through the report. If this offer is not accepted, then the report would be provided in full to the parents.” (037)*

*“For any incident that results in moderate harm or above, the statutory Duty of Candour applies in which patients and/or family members will be made aware that an incident has occurred, an apology made and an explanation of the Trust's intention to undertake an incident investigation. This conversation is then followed up in writing by a letter, and upon completion of an incident investigation a copy of the report is shared with the patient/family member and an invite is extended for*

*the patient/family to meet with the Duty of Candour lead so that the report can be explained in more detail and an opportunity for questions to be raised.” (033)*

*“In principle, defined in our processes (for example in our templates for communication with families about serious incidents), we intend that parents will be offered the opportunity to be involved in all stages of the investigation. In practice we are confident that parents/family are involved at the start of the investigation: the investigation team meet with the family to hear their story and understand their key concerns (if appropriate/preferred by the family they may provide this input through a letter or discussion with another member of the team such as the bereavement team). We are confident that feedback is given to the family at the end of the investigation, with a copy of the report being provided to them and the opportunity to meet the investigation team in order to discuss the findings. The area in which we seek to improve is involvement of the family during the investigation, recognising that for some parents this would not be appropriate or chosen by them, but where parents and families are able and willing we would ideally meet with them during the investigation not just to update them, but to draw on their experience and insight in order to understand lessons and the best responses to those lessons. Before being finally published, the investigation report is reviewed by care group leads (nursing, medical and operational) and the corporate SI team (which is led by the executive team).” (068)*

Several respondents (for example 001, 008, 021, 102) reported the involvement of families in other review processes, such as the PMRT process providing an opportunity to address questions and concerns relating to care, put forward perspectives and findings being shared with families. Several respondents reported parental involvement in child death overview panels, with parents able to submit questions and receive feedback ([see Child Death Panel](#) section). Respondents also reported the involvement of families in MNSI (050), as well as via discussions with the medical examiner and coroner, providing the opportunity to raise concerns.

*“For neonatal deaths which meet the MBRRACE/PMRT families are verbally made aware of the process at the earliest opportunity by the bereavement midwife. They are then offered a letter explaining the process which gives a point of contact for any queries or concerns they may wish to raise within the review. Queries and concerns are addressed as soon as possible by the bereavement midwife. During the regular communication with the family, this is revisited again prior to the follow up meeting that occurs to discuss the results of the review.” (021)*

*“The PMRT specifically seeks and presents the parental voice, including questions and concerns arising around their child’s care. The outcome of the PMRT is then fed-back to the parents by the bereavement team.” (102)*

*“As part of our perinatal mortality review process, the parents’ perspectives about their baby’s care is sought on multiple occasions (this is captured by the PMRT process) and the parents are offered a copy of the PMRT report once it is finalised. The parents are offered multidisciplinary follow up visits with the neonatal team to revisit any concerns and to discuss future implications.” (001)*

## The purpose of processes

When discussing the purpose of such processes, respondents cited supporting organisational and wider learning to improve the quality and safety of care, provide explanations to families, maintain accountability and transparency, provide a robust and thorough process, provide oversight and assurance, and provide opportunity to benchmark local services (see Table 20).

Table 20: Overview of purposes of processes as reported by respondents

Theme	Overview and example
Learning (119 trusts)	<p>Respondents commonly reported the purpose of processes in organisational and wider learning to support improvement in the quality of care, deliver safe and effective services, and identify good practice (021, 019, 081, 102, 115).</p> <p>Some respondents (026, 070, 071, 106) focused on the role of processes in identifying themes and clusters to be investigated.</p> <p>Several respondents (021, 024 064) mentioned the role of such processes in preventing future occurrence or incidents.</p> <p><i>“The purpose of the review is to reflect, generate learning and share with local and regional neonatal team to ensure that if any actions are needed they take place to support provision of high quality, safe and effective services.”</i> (019)</p> <p><i>“To enable effective thematic learning from reviews, to identify specific learning and inform themes and trends at a national level. This enables the identification of mitigating actions that could be implemented to prevent future deaths.”</i> (071)</p> <p><i>“To understand why the incident or death happened and to identify any actions that can be taken to prevent future occurrences.”</i> (021)</p>
Providing clear explanations to families (79 trusts)	<p>Respondents (004, 007, 021) commonly reported the processes to provide answers to families, to address concerns they may have, to make sure their voices are heard, and provide reassurance that learning is made and actions in place to prevent recurrence. Respondents (030, 053) also cited the importance of such processes in fulfilling duty of candour, being open and transparent with families, and providing support to families.</p> <p><i>“The processes are designed primary to support families and to make sure that their questions about what happened are answered and that their voice is heard.”</i> (007)</p>

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<p>Transparency and accountability (52 trusts)</p>	<p><i>“On an individual patient level, the process is in place to support effective and compassionate engagement with families, ensuring fulfilment of the statutory Duty of Candour and a consistent approach to the learning response whenever a patient safety incident is identified.” (030)</i></p>
	<p>Respondents (021, 036, 099) cited the importance of such processes to ensure transparency, accountability and an open and honest culture within the service and trust.</p>
	<p><i>“As a Just Culture, we seek to understand the accountability of an incident without apportioning blame. Understanding the causes behind an incident can also help to bring closure for the family.” (099)</i></p>
	<p><i>“It is vitally important the process is open and transparent, hearing from all involved and ensuring they feel heard and understood.” (036)</i></p>
<p>Allows for a robust and thorough investigation (31 trusts)</p>	<p>Some respondents (013, 038, 056, 110) cited the importance of a robust, rigorous and standardized review process.</p>
	<p><i>“The processes ensure that a consistent approach is maintained in reporting and learning, including the involvement of all appropriate key partners, supported by clear procedures and protocols.” (110)</i></p>
	<p><i>“These processes provide a systematic and robust inquiry into what happened, why it happened, learning and how to reduce the risk of an incident happening again.” (056)</i></p>
<p>Oversight and assurance (26 trusts)</p>	<p>A number of respondents (040, 119) reported the role of processes in ensuring oversight of incidents and providing assurance.</p>
	<p><i>“To provide assurance to the Board of Directors and external agencies of the care that is provided and that there are robust processes that are in place to investigate untoward incidents.” (119)</i></p>
	<p><i>“The governance structures in place ensure there is oversight of all incidents and appropriate learning responses are in place.” (040)</i></p>
<p>Compliance with regulatory and statutory requirements (14 trusts)</p>	<p>Several respondents (036, 055, 119) noted the role of processes in meeting regulatory and statutory requirements and national frameworks.</p>
	<p><i>“There are regulatory and statutory requirements to be met and these processes ensure that we create the good governance practices and adhere to best practice in doing so.” (036)</i></p>

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*“To ensure we are compliant with our legal obligations including to those to HM coroner and the Duty of Candour.” (119)*

Benchmarking and identification of outlier services (10 trusts)

Some respondents (007, 064) reported the role of processes allowing services to be compared nationally and to identify outlier services.

*“Benchmarking and the national reporting processes allows identification of any outlier status that may require further investigation.” (007)*

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Respondents (for example 010, 046, 076, 112) commonly reported that processes achieved the intended purpose or purposes. However, it should be noted that some respondents provided little detail regarding how the purpose(s) were achieved and given the numerous review processes respondents often focused on different aspects or processes. Respondents (for example 010, 042, 060, 067, 069, 081) cited examples of demonstrable change to practice where processes have led to positive change or contributed to learning, and some (for example 004, 025, 075, 112, 117) reported processes to be effective and robust.

*“Yes, there are always learning opportunities as a result of incidents or unexpected events. As an organisation we have been able to demonstrate system improvements which will reduce the likelihood of incident reoccurrence and have a focus on continuous service improvement.” (010)*

*“Yes the current process is robust with excellent senior oversight and valuable contributions from clinicians across the trust. Action plans are tracked and improvements are implemented. New process in place which has made the review of incidents and quality of reviews much better.” (075)*

*“Overall these are extremely effective and provide learning, improvement, oversight and scrutiny. Common themes can be identified locally and nationally. It also provides a framework to eliminate variation of both process and quality of review following neonatal and perinatal death.” (112)*

Some respondents (for example 021, 023, 053, 055, 073) cited factors that impact the relative ‘success’ of processes, such as culture, thoroughness of the investigation, triangulation and communication between review processes and capacity to embed learning (Table 21).

Table 21: Factors influencing ‘success’ of review and reporting processes

<b>Theme</b>	<b>Illustrative example</b>
Culture, openness and transparency impacting on willingness to share and learn (021, 023, 096)	<i>“In general, yes but causes of incidents can be multifactorial and investigations must be thorough. They can only achieve the purpose if the process is open, transparent, and safe. The culture has to be a positive learning one where staff feel able to share</i>

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	<p><i>openly and honestly and where there is a willingness to learn.” (021)</i></p>
	<p><i>“There has to be a positive, no blame, safety culture to support this type of investigation as teams have to be able to understand when things have gone wrong without blame to actively engage in developing the correct actions to prevent further incidents occurring.” (023)</i></p>
<p>Thoroughness of the investigation (that it is well-led with relevant multidisciplinary expertise) (053, 095)</p>	<p><i>“Investigations that are well led and ask appropriate questions do achieve their purpose. However, this can be very dependent on the panel investigating and particularly the standard of the panel chair.” (053)</i></p> <p><i>“I would say in the past not always as the operational staff who undertake the investigations are not trained investigators and rarely received any form of training so the quality of investigations was at times lacking (often just case note reviews and an ask from some staff for statements). Investigating anything in itself is a whole different skill set to being trained as a doctor, nurse, midwife or AHP. This has now been recognised at national level (with PSIRF being introduced) and at local level but as with a lot of initiatives organisations are being asked to implement without any extra resources or funding from government or NHSE.” (095)</i></p>
<p>Triangulation across processes and communication across processes/parts of the system (055, 115)</p>	<p><i>“It is the triangulation of complaints, concerns, incidents, data and mortality that is important, not one of these things in isolation. Each of these will provide a small, limited area of reassurance but having an overall process in place to look at all data and intelligence sources gives us a better understanding of a situation and is able to provide assurance if appropriate.” (055)</i></p> <p><i>“We have recently reviewed the mortality processes for maternity and neonatology and how these align with the wider learning from deaths processes within the Trust and made changes to ensure improved visibility of outcomes and alignment of investigation processes, including presentation of appropriate cases at the death review panel for discussion and triangulation of the different investigation processes.” (115)</i></p>
<p>Capacity to embed learning into practice</p>	<p><i>“Learning from cases is complex and often requires systemic change. While clinicians know what should</i></p>

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i.e. investment to embed changes (023, 073)

*occur and what didn't occur, change often involves MDT commitment, process change, monitoring and this can be very difficult due to limited expertise in delivering effective change and resource to enable effective change." (073)*

*"Currently the Trust is on an improvement journey to better link the learning from patient safety incidents with the transformation and quality improvement teams." (023)*

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In addition, some respondents (for example 008, 023, 032, 054, 095) reported scope for improvement of such processes such as a need to strengthen the sharing and embedding of learning, and improved triangulation and communication across processes.

*"The area that require further improvement is the more effective dissemination of learning from individual departments to across the whole Trust and triangulating this with learning from incidents and complaints." (008)*

*"The combination of internal and external reviews provide a robust pathway but need to strengthen the mechanism to piece together all information pertaining to an individual baby and share learning – all reports arrive at different times and to different professionals which may not be shared in a timely manner, which presents challenges to learning from these incidents." (054)*

In reflecting on current processes, many respondents (for example 021, 025, 048, 115) focused on transition from the Serious Incident Framework to the Patient Safety Incident Response Framework (see [policies](#)) and the benefits and opportunities it brings. In particular, respondents noted its role in strengthening engagement with families, emphasising a systems approach and more structured approach to learning, as well as providing a more rapid and timely response.

*"The new Patient Safety Incident Response Framework provides an opportunity to strengthen compassionate engagement with patients and families, to emphasise a systems approach to investigation and to undertake thematic learning." (021)*

*"Our current incident investigation processes are very resource heavy, meaning sometimes more time is spent on undertaking the investigation and drafting and reviewing the report than on engagement and improvement. PSIRF encourages a focus on proportionate incident investigation and removes the 'Serious Incidents' classification and the threshold for it, promoting proportionate approach to better balance the resources we have between learning and delivering improvement. Done well this will reduce the need for multiple actions, duplication of effort and production of detailed reports that sometimes cause more questions and concerns for those involved." (115)*

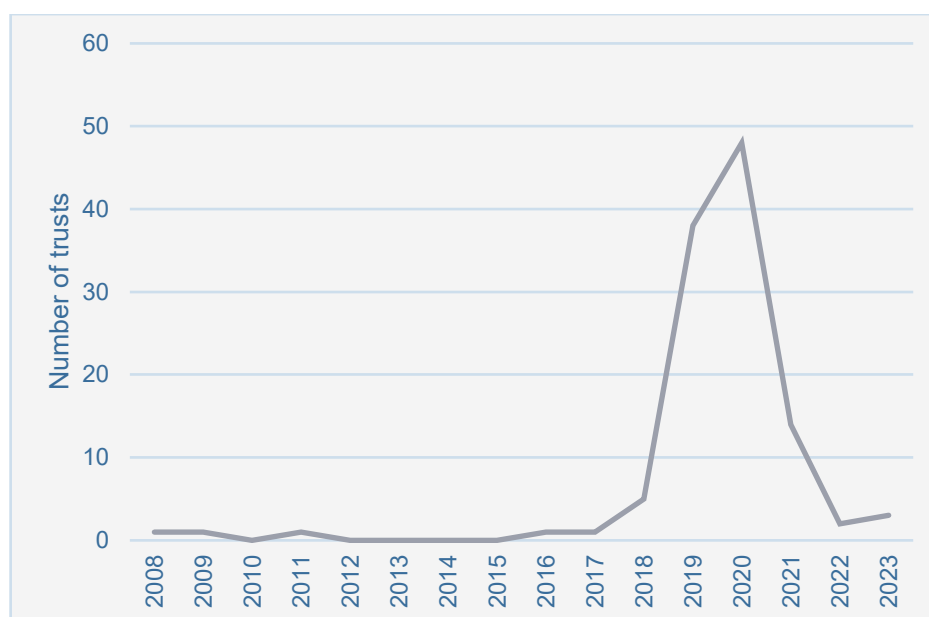
*"Process have recently been strengthened due to the transition to the new Patient Safety Incident Response Framework (PSIRF). Since transition, there has been*

*improved communication with families, more collaboration with Directorates and more efficient escalation processes. Having a standardised robust pathway for reporting, reviewing and responding to incidents ensures that other processes can feed into and follow the incident process which enable oversight and avoids concerns being missed. Having processes for reviewing the data within the Trust and the ICB also allows us to identify areas that may need further exploration. As the PSIRF implementation is relatively new, we will continue to monitor our processes and the outcomes.” (025)*

## Medical examiners

119 of 120 trusts reported having a medical examiner office. Reported dates of establishment of the office ranged from 2008 to 2023. One trust (093) reported that they did not have a medical examiner, rather the medical examiner function was provided by another trust and that they were working towards implementing a service. 100 of 115 trusts reported their establishment between 2019 and 2021 (Figure 8).

Figure 8: Date of establishment of ME office across trusts

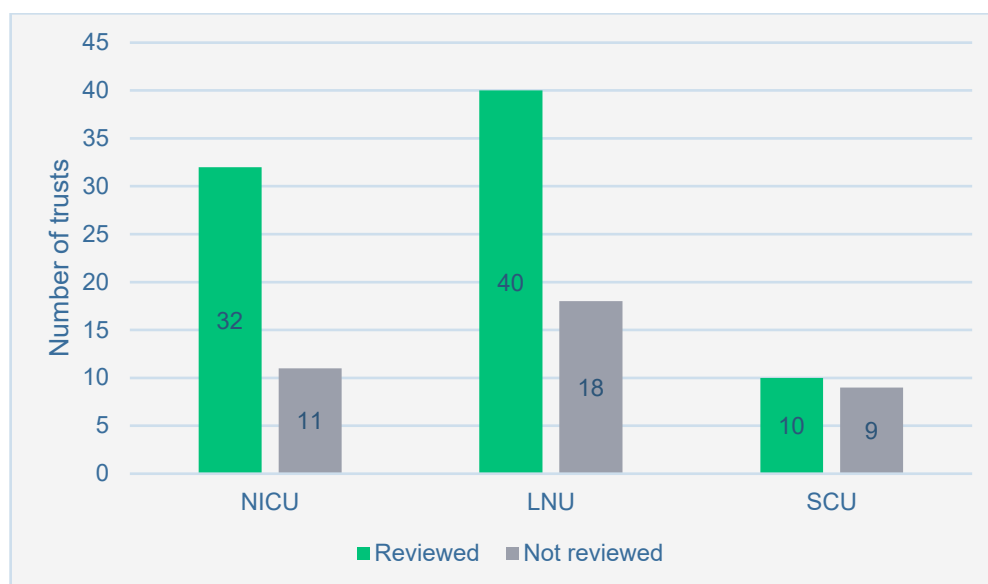


Note. Date of establishment was reported for 115 trusts (for 5 it was not reported or unclear)

### Medical examiner processes in reviewing neonatal deaths

82 of 120 trusts noted that neonatal deaths have been reported to and reviewed by the medical examiner or that neonatal deaths are typically reviewed by the medical examiner (for four trusts it was unclear or not reported). It is, however, important to note that in their responses some reported whether any deaths have been reported in the time since the office was established or in a given time period, whereas others reported whether neonatal deaths tend to be (or are routinely) reviewed by the medical examiner. Medical examiners in trusts with less specialised neonatal units were less likely to review neonatal deaths (Figure 9).

Figure 9: Do medical examiners review neonatal deaths, by level of care



Of the respondents that reported medical examiner review of neonatal cases, it was often noted that medical examiner scrutiny had been put in place relatively recently, often within the last few years (for example 018, 031, 055, 112).

*“We began scrutinising neonatal deaths in October 2022. The majority of neonatal deaths are now scrutinised, but we are not currently at 100%. We are actively working towards to capturing all deaths.” (018)*

*“Yes. This Office first established 100% of adult inpatient deaths before reaching out to Paediatrics and Neonatology. Medical Examiners Offices were instructed by the National team to be scrutinising Paediatric and Neonatal deaths from September 2022. Before then we were engaging collaboratively with the Neonatal Unit to develop understanding of our Service and how we would integrate with the established review processes of PMRT and CDOP For clarity: this Office did not scrutinise any Paediatric or Neonatal deaths between 19/09/21 and 19/09/22 We have been able to fully scrutinise all Neonatal deaths since September 2022.” (024)*

Of the respondents that reported neonatal deaths were not typically reviewed by the medical examiner, some reported only adult cases to be reviewed (for example 070, 095, 116), others mentioned it being local practice to refer neonatal cases directly to the coroner (for example 028, 033, 064, 094, 095). A number of respondents cited that an agreed process was being put in place for medical examiners to scrutinize neonatal deaths. For example, several respondents (for example 010, 037, 056, 094, 108, 116) noted the medical examiner service had been working with relevant services to establish processes for reviewing neonate deaths or that preparations were underway for the medical examiner service to begin reviewing neonatal deaths.

*“The process for reviewing neonatal deaths is in it’s early stages so no formal review has occurred historically. Many of these cases were routinely reported to*

*the local coroner, and the local coroner expects the Medical Examiner to review cases moving forward. The Medical Examiner service has been working with the neonatal service for some time regarding how to standardise the processes to ensure all neonatal and child deaths are reviewed as part of our Medical Examiner process. We are now assured that the process is in place and moving forwards all neonatal and child deaths will be reviewed under our Medical Examiner process and will feed into our routine Mortality Surveillance Group.” (094)*

### **Medical Examiner identification of themes or patterns and escalation of concerns about care**

Many trusts reported the identification of patterns or themes by medical examiner services more broadly (including adult deaths). However, only three (031, 090, 119) reported themes specific to neonatal deaths had been identified. Two respondents (015, 090) cited the relatively small number of neonatal cases making identification of patterns less likely. Among those who did not report medical examiner identification of themes, some respondents (for example 010, 055) focused on the role of medical examiners in feeding into wider clinical governance processes to support the identification of themes.

112 of 120 trusts reported medical examiners having processes in place in order to identify themes or patterns (for 8 trusts it was unclear or not reported). However, it should be noted that many did not specify whether responses related to the broader identification of themes or patterns, adult or neonatal cases. In addition, substantial variation in processes was evident across trusts – some (for example 052, 085, 106, 109, 114) reported established processes, systems, mechanisms, while other trusts (for example 001, 019, 025, 041, 055, 061, 088, 101) reported having no formal policies or processes in place or described relatively informal mechanisms, such as discussions or information sharing between medical examiner office staff or team meetings.

*“There are no formal systems in place in the ME office to identify clusters of cases. It is likely that issues would be identified on a case by case basis, and through discussions between MEs in regular team meetings.” (025)*

*“The Trust have an informal system whereby any concerns identified by any of the MEs or the medical examiner officers (MEO) these are discussed with the lead ME at the office meeting.” (101)*

*“A whiteboard is used in each office currently to allow MEs to see each other’s suggested themes. Consideration is being given as to whether datix or another electronic system can be used to capture this information.” (088)*

Some respondents (for example 010, 015, 037, 062, 065, 076) focused on medical examiner oversight and scrutiny of all deaths through discussion with clinical teams and bereaved relatives. For some respondents (for example 004, 023, 045, 064, 066, 089, 095) the regular internal medical examiner team meetings were seen to support the identification of patterns, by sharing information and available data, discussing cases or issues, for reflection and learning.

*“The Medical Examiners closely scrutinise each death within the trust and discuss the cause of death with clinical teams and the bereaved relatives.” (015)*

*“Through the course of scrutiny, we are indeed able to identify themes and patterns. In line with National ME principles, the cause of death remains the responsibility of the clinicians who were responsible for the patient's care in life, the MEs discuss that cause of death with them. Given the independence of the role the MEs are able to receive any concerns shared by the clinicians or the bereaved relatives and escalate them accordingly.” (037)*

Respondents (for example 004, 064, 071, 106, 109) commonly reported the presence of an inhouse database or spreadsheet, IT recording system, tracker or dashboard for collating data for cases scrutinized. Databases were reported to aid the review of data and conduct of audits in the identification of patterns, and to support regular reporting. Data collected was reported to include concerns raised by clinicians and families, as well as data relating to cause of death and location of death (for example 064, 085, 109). One respondent (031) reported that they have also started recording names of clinical staff present at time of death for all neonatal deaths.

A few respondents (for example 052, 106) reported the use of an IT platform or system that incorporates information from numerous sources, links to other data or feeds into other processes therefore allowing the triangulation of information in identifying themes (for example, linking the medical examiner record to the trust Datix incident reporting system).

*“The Medical Examiner Service maintains an up to date database of all deaths scrutinised, which records data on location of death, consultant in charge of the care, cause of death, concerns, escalation etc. Regular audits are undertaken against the database by the Senior Medical Examiner Officer to ensure it is accurately maintained and any concerns have appropriately been escalated.” (109)*

*“Within the first 3 months we developed an electronic Medical Examiner record utilising the Trust's Datix incident reporting system. This allowed us to link various records to aid visibility for the ME - including for example incident reports, investigations, Coroners referrals and safeguarding alerts. This system also allows easy audit of data. A monthly report is compiled by the ME service and provided to the trust.” (052)*

Regional and national processes were reported to support the identification of themes. Several respondents (for example 004, 032, 039, 046, 113) cited the role of regular regional medical examiner meetings in sharing learning or data submitted for regional medical examiner reporting. Similarly, some respondents (for example 015, 023, 073, 119) cited the comparison of local data with national averages or national reporting requirements (such as quarterly reporting to national medical examiner) as supporting the identification of patterns.

*“All data is also submitted regionally and discussed on a quarterly basis with the regional ME and MEO in order to ascertain the presence of any patterns.” (004)*

*“Data regarding cause of death, coroner referrals and governance issues are collated for all deaths for submission to the National Medical Examiner and any*

*themes or patterns are readily identifiable often before other governance systems within the trust may have identified trends.” (015)*

Many respondents (for example 010, 049, 065, 066, 115) focused on the escalation of concerns through local governance processes and the triangulation of data and/or concerns with other processes. Respondents reported established pathways in which concerns identified by medical examiners are escalated via relevant governance teams and processes (see details below).

**Learning from deaths processes:** many respondents (for example 006, 014, 029, 049, 065) cited the role of learning from deaths teams and processes in escalating concerns (for example quarterly learning from deaths reports or medical examiner attendance at meetings).

**Structured judgement reviews:** some respondents (for example 002, 006, 031, 111) cited the role of structured judgement review in escalating concerns, these being recommended following medical examiner review and often feeding into trust mortality review processes.

**Mortality review processes:** respondents (for example 045, 049, 063, 065) also focused on the role of mortality review processes, with the medical examiner service often reporting to the mortality review group, mortality surveillance group or committee. A few respondents (for example 066, 083) reported the attendance of the medical examiner at trust mortality review meetings to discuss cases or consider patterns.

**Clinical incident reporting:** some respondents (for example 002, 010, 026) cited processes relating to incident reporting if concerns with patient care were identified, such as datix incident reporting system in line with trust governance processes.

**Routine reporting to trust leaders and board:** some respondents (for example 029, 046, 049, 063, 065, 077, 078, 115) cited routine reporting of learning to the trust board or committees (such as quality committee, executive management board) and/or escalation of concerns to trust leaders (for example chief medical officer, medical director)

*“The ME team are only one facet of that Governance oversight system and are integrated into the wider Governance system and associated incident triangulation through attendance at Mortality Review Group, Weekly Safety Oversight meetings and use of the Datix incident reporting system.” (010)*

*“The Medical Examiners review all cases and escalate any concerns or themes to the Deputy Medical Director on a weekly basis. Escalated cases are reviewed through the Mortality Review Group (biweekly) and any learning is collated and forms part of the quarterly Learning from Deaths report that is presented at Trust Board. The lead Medical Examiner is part of the Mortality Review Group and has the opportunity to challenge and feedback any wider concerns/ learning.” (065).*

While many trusts (for example 012, 045, 066) reported that there had been escalation of concerns about care by the medical examiner, only two (083, 085) reported the escalation of concerns specifically related to neonatal deaths. Nevertheless, it should be noted that

some respondents broadly reported escalation relating to both adult and neonatal cases, some provided responses specific to neonatal deaths, and for some it wasn't clear. It is also important to note, as per the [Medical Examiner](#) processes in reviewing neonatal deaths section medical examiners do not routinely review neonatal deaths at all trusts and that processes for escalating neonatal cases often differ to adult cases for example child death review process and PMRT review. Processes relating to escalation of concerns about care are outlined in the [Medical Examiner](#) processes in reviewing neonatal deaths section.

### Interaction between medical examiners and the coronial system

Respondents (for example 007, 024, 054, 079, 092) typically reported positive working relationships between medical examiner services and the coronial system, describing the relationship as “*excellent*” “*strong*” “*good*” and “*collaborative*”. Many described regular interaction between medical examiners and coroners, such as regular meetings, direct conversations or email exchanges to discuss complex cases, specific queries or concerns, process issues and identify themes and areas for learning or improvement (for example 026, 039, 045, 069, 077, 092). Several respondents also reported meetings with other local services. For example, one trust (079) reported a bi-monthly ‘after death working group’ which included a medical examiner, coroner, local council, registrars, cremation services and undertakers. Another trust (002) reported a regular ‘joint service meeting’ attended by the coroner, local registrars, hospital and primary care representatives. Two trusts (007, 118) described coroner involvement in the training of medical examiners/officers.

*“Relationship between the Coroner and ME service is excellent as we have been running our service for over 13 years. The ME function is very well embedded and the coroner requests that all deaths must be reviewed by the ME prior to referral to them.” (054)*

*“MES has an excellent working relationship with the local HM Coroner’s office as well as with the Registrar of Births and Deaths. This is supported by frequent regional ME-Coroner meetings as well as ME-MEO-Registrar meetings where examples of good practice are discussed and any opportunities for improvement and better collaborative working are identified.” (092)*

Most trusts (for example 063, 066, 077, 083, 097) reported that medical examiner office had referred cases to the coroner or that they typically referred cases to the coroner (routinely or occasionally), however only six trusts (015, 031, 036, 039, 084, 120) reported the referral of neonatal cases. It is, however, important to note that when discussing escalation of concerns many respondents did not specify whether referring to neonatal deaths or deaths more broadly.

Among those trusts that reported cases had been referred to the coroner, some (for example 029, 054, 063, 066, 081, 100) reported the direct referral of cases, whereby medical examiners review all deaths and routinely refer cases to the coroner (as appropriate) or complete referrals on behalf of the requesting clinicians. However, for others (for example 009, 071, 114) medical examiners only make referrals when necessary or required (for instance if the clinician is unavailable). In terms of criteria for referral, cases were reported to be referred where the cause of death was not clear (004,

029 102), concerns relating to care and/or concern expressed by family (037, 050, 115) and several respondents (for example 023, 072, 085, 099) cited the referral of cases in accordance with the Notification of Deaths Regulations (2019)<sup>119</sup>. Several respondents (for example 023, 085, 092) cited the use of an online coroner's portal to make the referral.

*“All hospital deaths are reviewed by the Medical Examiner prior to any Coroner’s referral being made. The Medical Examiner’s Office completes the referral on behalf of the referring doctor and include the Medical Examiner’s scrutiny information. The Medical Examiner also refers to the HMC directly as well, but the attending doctors are always sighted on this referral.” (081)*

*“MEs have a direct line of accountability to HM Coroner and will refer cases as appropriate i.e. where there are significant concerns or the cause of death cannot be established.” (029)*

For those respondents who did not report the direct referral of cases between medical examiner and coroner, some (for example 010, 019, 038, 092) reported that the medical examiner service does not routinely refer cases to the coroner, instead the attending medical or clinical teams are encouraged to refer cases with the medical examiner able to offer advice, discuss the case and support decision making. Some respondents reported that the medical examiner has oversight of all cases prior to coronial referral (for example 012, 045). However, in other cases it is not clear whether the medical examiner necessarily has oversight of those cases referred directly by clinical teams (for example 040, 048, 118).

*“It is usually the responsibility of the host clinical team to make a referral to the coroner, and for 'continuity of care' reasons, (i.e., MEs should not usually be called to inquests) the ME team promote that approach, the MEs will advise the host clinical team when the ME feels a Coroner referral is required and has not been completed. However, the ME team will complete the referral if there is any risk of a delayed referral, or if it is felt that the crux of the issue might be missed without ME input. The interaction and triangulation between the ME team, the hospital clinicians, and the coronial team is important and highly valued by the Trust.” (010)*

*“Our service remit is to review non-coronial deaths with the acute and community setting. If it is clear that the case requires a referral to the coroner and this is identified and completed directly by the clinical team, then the referral does not pass through the Medical Examiner system. However, inevitably there are cases which are not picked up by the clinical team as needing a coroner referral, which upon review by our office are identified as requiring one. It is then the responsibility of the clinical team to complete the referral, not the ME.” (040)*

## Child death panels

In reporting their attendance at Child Death Overview Panels (CDOP) in the time period between 19 October 2022 and 2023, some respondents broadly reported the number of

<sup>119</sup> National Archives (2019) The Notification of Deaths Regulations 2019  
<https://www.legislation.gov.uk/ukxi/2019/1112/made>

panels attended (but did not specify whether their attendance related to a trust neonatal case), others reported the number of neonatal deaths reported to or reviewed by the CDOP in the time period, and some respondents reported the number of panels held in the specified time period but did not confirm whether a trust representative was in attendance.

Many respondents (for example 006, 017, 100) confirmed attendance at a panel, however for many cases it was not possible to determine if attendance related to the review of trust neonatal cases and for some it was not clear whether a panel was attended. Few respondents (for example 010, 080) reported that they did not attend a panel in the time period.

Trust attendance at panels varied; some reported that they attend all panels within the given time period (for example 021, 024, 058), a number of respondents (for example 033, 038, 055, 096, 033) reported that they attend panels on a rotational basis such as with other trusts/hospitals, and several (for example 049, 064, 072) reported attendance when invited. The number of panels attended by trusts in the time period ranged between zero (for example 040, 044) and ten (109). The reported frequency with which panels are held varied. For example, panels held monthly (033, 059) or bi-monthly (034, 041, 082), quarterly (045, 063, 088) or six monthly (072). The trust representatives in attendance at panels also tends to vary, covering a broad range of roles and disciplines such as: neonatal expertise, obstetric expertise, safeguarding professionals, bereavement teams, child death leads, midwifery, nursing expertise.

31 trusts (for example 114, 012, 017, 032, 033, 039, 073, 083, 086, 108) reported panels dedicated to neonatal cases or cited neonatal themed panels, however the frequency with which these were reported to be held varied.

Several respondents reported that not all neonatal deaths within the trust would be discussed at the local/regional panel due to cases being reviewed in the area of residence. This is particularly the case with tertiary centres in which babies have been transferred from other areas for specialist care. In some cases, respondents reported still being able to feed into such panels by attending meetings, submitting information, or contributing to other review processes (for example 042, 039, 080). However others reported being unable to contribute (for example 079, 109).

*“All neonatal deaths are notified via the [trust/service name] COOP portal and all 9 [trust/service name] deaths were reviewed by the local COOP during this period. If the baby 'resides' elsewhere (22/31 cases, i.e. the majority of deaths), the information is forwarded to that relevant COOP for final analysis and the Trust makes a major contribution to the analysis through the M&M process.” (042)*

*“Not all the neonatal deaths on the unit are discussed at the local CDOP due to the unit being a tertiary centre. Thus, there are other CDOPs where [trust/service name] NICU deaths are discussed where we do not have access to that information.” (109)*

### **Effectiveness of Child death overview panel**

Most trusts reported panels to be an effective way to investigate a neonatal death (for example 032, 042, 063, 068). The prominent themes in respondents explaining their view

of effectiveness related to the role of the panel in supporting local, regional and national learning (particularly the identification of broader themes) as well as the independent, multi-agency role of the panel in providing a broader scope of review, external objectivity and scrutiny. See Table 22 for factors related to perceived effectiveness of the panel.

However, respondents did report factors that can limit the effectiveness of such panels, including the time delay between the death and the panel taking place limiting its role in generating immediate learning, its reliance on information from other processes, duplication of processes and that it does not necessarily have oversight of all deaths at a given unit.

Table 22: Overview of reasons for effectiveness of CODP reported by trusts

Theme	Example
Learning (64 trusts)	<p>Respondents commonly cited the role of the CDOP in supporting learning at a local, regional and national level (031, 091, 102). In particular, for the identification of wider patterns and themes to prevent future deaths (033, 088), such as submitting data into National Child Mortality Database (005, 010), feeding back learning to trusts (073), following up any actions identified for trusts (043), and for providing a broader scope of review and issues that impact care (018).</p> <p><i>“It also ensures that thematic learning can be undertaken across reviews of multiple deaths, and that this learning can be shared with local, regional, and national organisations.” (102)</i></p> <p><i>“One advantage of this approach is that it allows partner agencies to identify and address modifiable factors at regional and national levels which will reduce neonatal and child mortality. It also can reveal modifiable factors that may not have been evident from single trust reviews.” (091)</i></p>
Independent multi-disciplinary panel providing external, objective scrutiny (57 trusts)	<p>When discussing the effectiveness of the panel, many respondents (022, 050, 084, 088, 103, 115) cited the independent scrutiny and objectivity provided by an external multi-agency or multiprofessional panel and the broad scope of review (for example expertise in neonatology, midwifery, obstetrics, and paediatrics, social care, police, public health).</p> <p><i>“The panels allow a multidisciplinary and broad review to be undertaken with the involvement of appropriate expertise and externality to add value and objectivity to the review, increasing the potential for learning.” (115)</i></p> <p><i>“The panel has power to approach and invite professionals outside of local neonatal service including paramedics, GPs, other hospitals and other agencies, which make it an effective process to investigate neonatal deaths with a 360-degree view.” (084)</i></p>

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Complementary alongside other review processes (22 trusts)

Some respondents (012, 026, 062, 090, 097, 098, 102) reported the panel is effective given it is implemented alongside other robust reviews/processes. For example, its benefit as a final 'sign-off' and being complementary to other processes (for example PMRT) due to its wider scope and identification of themes at a higher level.

*"As a final, comprehensive review, with the benefits of information from the PMRT, postmortems and other relevant information from initial reviews, it is an effective way to ensure a further, semi-independent review of the care." (102)*

*"The CDOP panel provide an effective way to investigate deaths as they can identify themes and trends across a number of hospitals and make recommendations for area to focus improvement initiatives. This complements the work done via HSIB and the use of the PMRT for reviewing deaths." (098)*

Structured, standardised and robust framework for reviewing deaths (16 trusts)

A number of respondents (013, 054) reported the importance of robust processes and a structured, standardised framework for systematically reviewing neonatal deaths.

*"They are effective in the sense that there is a structured standardised framework for reviewing every death, although in isolation each of these processes may not identify all concerns." (054)*

Captures concerns and perspectives of families (14 trusts)

Several respondents cited the role of the panel in capturing the concerns and views of families (024, 032, 108).

*"The panels take care and are respectful of parent's views and opinions, demonstrating care of families through regular and sensitive communication contacts." (032)*

*"Families have an opportunity to voice concerns, contribute to the process and to ask for feedback following the regional panel discussions." (108)*

Time delay (14 trusts)

Several respondents (020, 042, 083, 087) focused on the time lag between deaths and the panel taking place, particularly that the panel is not able to rapidly review care or generate immediate learning.

*"The process is however very lengthy meaning that it does not support the identification of immediate learning and actions which need to be taken, in the same way that our own internal investigations would." (020)*

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Value of neonatal expertise (13 trusts)	<p><i>“The CDOPs panels provide an expert opinion and scrutiny of child/neonatal deaths but there is a significant delay in the review often due to the timeliness of pathology reports. For local learning and scrutiny of local practices, these likely do not provide a timely overview.” (087)</i></p>
More learning is gained from other review processes (12 trusts)	<p>Several respondents (021, 046, 77, 109) noted the importance of neonatal expertise and/or the value of themed panels to ensure external neonatal expert presence.</p> <p><i>“The Panels provide an opportunity for learning by pulling together colleagues across multiple agencies their value could be enhanced if they had a neonatologist on the panel. There may also be a benefit to establishing a dedicated overview panel for neonatal deaths or to ensure there is a neonatal doctor on the CDOP.” (046)</i></p> <p>Several respondents (019, 023, 037) discussed the panel to be less effective than other existing processes that review neonatal deaths for example child death review meeting, ODN network meeting, MNSI, and internal incident review.</p> <p><i>“Whilst the CDOP panel is a very important part of any neonatal death it is felt potentially more learning is gained from the child death review meeting (CDRM) which occurs locally following the death of a neonate (or child). Feedback from the CDOP meeting often takes a period of &amp; can reflect a broader perspective within the system as cases are not discussed until after a PM or local investigations reach their conclusion.” (023)</i></p>
Reliant on information provided by other review processes (10 trusts)	<p><i>“The membership of the CDOP panels is multiagency and they are reliant on the information provided by the Perinatal Mortality and Mortality meeting to carry out their function rather than carrying out the actual investigation of the neonatal death. The ODN network meetings which have neonatologists from different trusts are in a stronger position to investigate and challenge practice that has resulted in neonatal deaths.” (019)</i></p> <p>While some respondents reported that the panel is complementary to other death review processes, several (003, 068, 104, 116) reported that panels are reliant upon the information provided to them through other review processes.</p> <p><i>“The regional CDOP panels are very much reliant on the quality of the local mortality reviews completed in the institutions where an infant has received care.” (104)</i></p> <p><i>“It is difficult to appraise the role of the CDOP panel in investigating the deaths of neonates in isolation to other</i></p>

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	<p><i>processes triggered by the death of a neonate. There is significant internal and multi-agency work that is carried out external to a CDOP panel that influences the ability of the panel to be able to scrutinise, appraise and determine harm or preventable issues within the death of a neonate. Where the structure and processes around the CDOP panel (including the Trust's neonatal death reviews) are robust, the panel are well placed to identify issues of harm and abuse and act accordingly.” (003)</i></p>
<p>Not necessarily oversight of all neonatal deaths on a given unit (7 trusts)</p>	<p>Several respondents (006, 019, 109) reported that a given CDOP does not necessarily review all deaths at a particular unit (instead reviewing deaths of those that reside in a given location) and therefore might not be placed to identify a pattern of deaths arising from a given unit.</p> <p><i>“The Child Death Overview panels (CDOPs) have oversight of deaths for children normally resident (or in the case of neonates whose parents are normally resident) within a geographic location. This means that the discussions of neonatal deaths in one tertiary neonatal unit will be scattered over several CDOPs so no CDOP has oversight of all the neonatal deaths from such a unit. This means they might not identify a pattern of neonatal deaths arising from a unit.” (019)</i></p>
<p>Lack of feedback (6 trusts)</p>	<p>A number of respondents (002, 049, 105, 109) reported seldom receiving feedback from the panel or that feedback mechanisms between the panel and local services and systems for sharing learning need to be improved.</p> <p><i>“Feedback mechanisms need to be improved between CDOP and local services and there should be better involvement of health services in the Child Death Review Processes so that the maximum learning can take place from all child deaths.” (109)</i></p>
<p>Duplication of other processes (6 trusts)</p>	<p>Several respondents (065, 105, 113) discussed the duplication and overlap of the various processes, panels and boards in reviewing neonatal deaths. However, several respondents hoped that the plans to merge PMRT and CDOP might address this issue.</p> <p><i>“At present there is a lot of duplication in reporting a neonatal death. There is seldom feedback from CDOP following a neonatal death. CDOP is due to merge with MBRRACE and PMRT to form the PMRT-CDOP integrated system. This will save duplication of data entry and also ensure a neonatal medical expert is on the panel, and there will be direct feedback.” (105)</i></p>

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# Nuffield Trust reflections

## Perinatal pathology requests

Despite urgent policy guidance<sup>120</sup> being issued by NHSE in October 2022 aiming to achieve greater standardisation in access to perinatal post-mortem investigations and prioritise available perinatal pathology capacity, survey responses indicate continued challenges relating to perinatal pathology capacity for some trusts. While considerable variation was evident between trusts in timeframe for perinatal post-mortem, some reported long delays in receipt of post-mortem reports (in some cases up to 12 months) and some respondents cited delays were due to a national shortage of perinatal pathologists. Respondents did, however, report established processes for post-mortem request and direct pathways for communication between trusts clinicians and pathology services to discuss queries or concerns.

## Unexplained deaths and unexpected patient safety incidents

There are multiple routes for reviewing evidence after a death including local governance processes (for instance incident reporting, learning from deaths processes, mortality review processes) and external processes and reporting requirements (such as MBRRACE-UK, PMRT, MNSI, CDOP). While providing opportunities for triangulation, this is likely to involve a degree of overlap across processes and procedures. Many respondents reported established processes for involving parents in processes, although mechanisms to facilitate such engagement often varied across trusts.

Respondents reported the purpose of such processes to support local and broader learning to improve the quality and safety of care, provide explanations to families, maintain accountability and transparency, provide robust processes, meet statutory requirements, oversight and assurance and benchmark against national and regional standards. Many respondents reported that such processes achieve their purpose, with several providing examples of demonstrable change and learning. However, the relative 'success' of processes were reported to be dependent on the culture (for instance openness and transparency willingness to share and learn), thoroughness of the investigation and expertise, triangulation with other processes and communication across parts of the system, and capacity to embed learning into practice.

In reflecting on current processes for incident reporting, some trusts focused on the recent transition from the serious incident framework<sup>121</sup> to the patient safety incident response

<sup>120</sup> NHS England (2022) 'Perinatal post-mortem investigation of fetal and neonatal deaths (England, Scotland and Wales)' <https://www.england.nhs.uk/long-read/perinatal-post-mortem-investigation-of-fetal-and-neonatal-deaths-england-scotland-and-wales/>

<sup>121</sup> NHS England 'Serious Incident framework' <https://www.england.nhs.uk/patient-safety/serious-incident-framework/>

framework (PSIRF)<sup>122</sup> and the benefits and opportunities that the new framework brings (such as strengthening engagement with families, emphasizing a systems approach and more structured approach to learning, and providing a more timely response). In interpreting survey responses it is, therefore, important to consider the context at the time of reporting, particularly given that trusts were at different stages of transition in responding to patient safety incidents. Some trusts did report that processes could be strengthened, particularly related to sharing and embedding learning and linking/triangulation across processes and parts of the system.

### Medical examiner processes

Most trusts reported medical examiner scrutiny or review of neonatal deaths. For those trusts that did not, some reported it to be local practice to refer neonatal cases to the coroner and several cited that agreed processes were being put in place for medical examiner scrutiny of neonatal deaths (in preparation for the deadline for statutory requirement for medical examiners to scrutinise all deaths). It is, therefore, important to consider survey responses in the context of the ongoing transition towards medical examiner review of all deaths and the impact of the timing of roll-out of medical examiner services at the time of reporting.

Many respondents reported medical examiner processes in place to identify themes or patterns. However, for some such processes were established and mature, while others reported relatively informal mechanisms and processes. Examples included regular team meetings and sharing information, data collection and use of internal databases, platforms or spreadsheets for data collection and to facilitate audits, role of regional and national processes (for example reporting requirements and benchmarking), escalation of concerns through local governance processes and the triangulation of data and/or concerns with other review processes.

Respondents typically reported positive working relationships with coronial services, often citing regular communication to discuss cases, concerns or queries, and identify trends and areas for learning. There was some variation in the pathway for referral of cases to coronial services, some reported direct routine referral from medical examiners, some reported referral from requesting/attending clinicians with medical examiner support.

### Child death overview panel

Child death overview panels form part of the child review process, conducted in accordance with national statutory guidance<sup>123 124</sup>. Many trusts reported attendance at a panel. However, frequency of attendance varied across trusts, as did the frequency with which the panels were reported to be held and whether a dedicated neonatal themed panel had been devised. Many respondents reported panels to be effective, particularly in

<sup>122</sup> NHS England Serious 'Patient Safety insight' <https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/#new-approach>

<sup>123</sup> DHSC (2019) Department of Health and Social Care and Department for Education (2018) 'Child death review: statutory and operational guidance (England)' <https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england>

<sup>124</sup> Department for Education (2024) 2015) 'Working together to safeguard children' <https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>

supporting local, regional and national learning, due to the multi-agency external scrutiny provided by the panel, and for providing a standardised framework for reviewing deaths, this complementing other review processes. However, respondents noted factors that can impact their effectiveness, such as the time delay in which panels review cases, the input of neonatal expertise, reliance on information from other processes. Some respondents reported that other review processes following a neonatal death are more useful for generating learning.

## Additional references

- The Royal College of Pathologists (2017) [Guidelines on autopsy practice: Third trimester antepartum and intrapartum stillbirth](#)
- The Royal College of Pathologists (2017) [Guidelines on autopsy practice: Fetal autopsy \(2nd trimester fetal loss and termination of pregnancy for congenital anomaly\)](#)
- The Royal College of Pathologists (2022) [Tissue Pathway for histopathological examination of the placenta](#)
- The Royal College of Pathologists (2015) [Guidelines on staffing and workload for paediatric and perinatal pathology departments](#)

# What safety nets exist

This section provides a description of how trusts describe what possible safety nets exist on site, including for example, parental involvement in care, the presence of CCTV, processes relating to medicine management, and all data that is collected.

This section covers questions 9, 34, 35 and 38 of the questionnaire. There was often overlap in the responses between questions, and therefore the summary below draws on responses from multiple questions.

## Questions asked of trusts:

9. What are policy and procedures in place in respect of parent/guardian involvement in neonatal care, in particular:

- a. Are parents/guardians included in ward rounds?
- b. Do they have access to a parent portal and/or medical records?
- c. Do they routinely receive copies of discharge summaries?
- d. What other involvement do parents / guardians have?

34. Is CCTV installed to monitor babies within the neonatal and/or maternity units within the trust?

- a. If so: when was it installed and why?
- b. What areas are covered (for example, entrances/exits or wider)?
- c. Does it cover the storage areas for controlled and non-controlled drugs, including insulin?
- d. Does the trust provide remote access for parents via webcam or video footage?
- e. Alternatively, if CCTV is not installed, please explain why?

35. Please explain the security arrangements and policies for the storage and administration of medication (controlled and non-controlled drugs) where babies are cared for within the neonatal and/or maternity units within the trust, including in relation to insulin. In particular:

- a. Whether an electronic record is kept of who accesses drug storage cabinets, when and for what purpose?
- b. Whether the electronic records are stored securely?
- c. When records are destroyed?
- d. Whether there is a process for regular auditing of such records.

38. Please list and briefly summarise the health information requested below.

- a. The categories of data that are collected in relation to each baby and why.
- b. Who, if anyone, has responsibility within the trust for analysing that data and with what frequency?
- c. What is the purpose of the analysis?
- d. What arrangements, if any, are there to submit that data to external bodies (including benchmarking organisations)?

- e. Is the data shared more widely than as described at (d)? If yes, please indicate how and with whom it is shared and for what purpose.
- f. What local, regional, national and international reporting and data systems for perinatal and neonatal care has the trust reported to since 19 October 2022?

## Context for this section

### Parental involvement

- There are established approaches towards parental involvement in neonatal care. In particular, a family-centred or integrated approach has been outlined in national guidance and frameworks.
- The British Association of Perinatal Medicine (BAPM) framework describes a model of family-integrated care (FiCare), providing a structure for implementation in neonatal services. The model promotes a culture of partnership working between families and staff.<sup>125</sup>
- Other such initiatives and programmes include the BLISS Baby Charter,<sup>126</sup> which provides a practical framework for which units can assess themselves against when implementing family-centred care approach (and gain accreditation) and the UNICEF UK Baby Friendly Initiative<sup>127</sup> which sets out standards for care.
- The recently published three-year delivery plan for neonatal and maternity services (NHSE 2023)<sup>128</sup> outlines ambitions for parents to be partners in their baby's care through adoption of a family-integrated care approach and appropriate parental accommodation, to ensure local Maternity and Neonatal Voice Partnerships (MNVPs) have the appropriate infrastructure for service users voice to be central to service improvement and for services to achieve the standard for UNICEF UK Baby Friendly Initiative accreditation or an equivalent initiative.

### Data collection and use of data

- NHS trusts are required to submit data on neonatal units as part of national datasets<sup>129</sup>, national audits<sup>130</sup> and to their ODN.

<sup>125</sup> British Association of Perinatal Medicine (2021) 'Family Integrated Care: A Framework for Practice' <https://www.bapm.org/resources/ficare-framework-for-practice>

<sup>126</sup> Bliss. 'What is the Baby Charter?' <https://www.bliss.org.uk/health-professionals/bliss-baby-charter/what-is-the-baby-charter>

<sup>127</sup> UNICEF UK. 'Baby Friendly Initiative' <https://www.unicef.org.uk/babyfriendly/about/>

<sup>128</sup> NHS England (2023) 'Three year delivery plan for maternity and neonatal services' <https://www.england.nhs.uk/wp-content/uploads/2023/03/B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf>

<sup>129</sup> NHS Digital (no date), Secondary User Service <https://digital.nhs.uk/services/secondary-uses-service-sus>

<sup>130</sup> RCPCH (no date), National Neonatal Audit Programme <https://www.rcpch.ac.uk/work-we-do/clinical-audits/nnap>

- Scope to improve how data is used was identified in the Kirkup review and some actions are in progress including defining better outcome measures to monitor safety<sup>131</sup>
- While the NHS as a whole is aiming to move towards using electronic health records, not all trusts have achieved this<sup>132</sup>, and even where the trust does have an electronic health record it may not meet the specific requirements of neonatal units.
- BadgerNet<sup>133</sup> is an information collection system used by NHS trusts for neonatal and some maternity services, which also enables data to be accessed by ODNs. The underlying software is provided by a number of different suppliers, and the exact term used, and functionality varies between trusts.

## CCTV

- There is no national guidance or framework specifically for use of Closed Circuit Television Systems (CCTV) in NHS settings, however its use is guided by the broader Government's Surveillance Camera Code of Practice<sup>134</sup> which provides guidance on the appropriate and effective use of surveillance camera systems by relevant authorities, Data Protection Act (2018) and General Data Protection Regulations (GDPR).
- The presence of CCTV in hospital settings is usually determined locally by the trust and the relevant trust policies.

## Storage and administration of medication

- The Royal Pharmaceutical Society (RPS) has published guidance on the safe and secure handling of medicines (SSHM) which sets out best practice principles for medicines governance processes.<sup>135</sup>
- Other guidance exists related to the administration of medicines in health settings<sup>136</sup> which has been co-produced by RPS and Royal College of Nursing (RCN) and sets principles/guidance to ensure the safe administration of medicines by health professionals.

<sup>131</sup> Department of Health & Social Care (2023) 'Government response to 'Reading the signals: maternity and neonatal services in East Kent - the report of the independent investigation'  
<https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-report-government-response/government-response-to-reading-the-signals-maternity-and-neonatal-services-in-east-kent-the-report-of-the-independent-investigation>

<sup>132</sup> NHS Digital (2023), News 90% of NHS trusts now have electronic patient records,  
<https://digital.nhs.uk/news/2023/90-of-nhs-trusts-now-have-electronic-patient-records>

<sup>133</sup> See for example <https://www.badgernotes.net/> and <https://www.systemc.com/our-solutions/healthcare/maternity-neonatal/?page=1#changesettings>

<sup>134</sup> UK Government (2022) Update to Surveillance Camera Code of Practice Biometrics and Surveillance Camera Commissioner (2021) 'Update to Surveillance Camera Code of Practice'  
<https://www.gov.uk/government/publications/update-to-surveillance-camera-code>

<sup>135</sup> Royal Pharmaceutical Society (no date) 'Safe and secure handling of medicines'  
<https://www.rpharms.com/recognition/setting-professional-standards/safe-and-secure-handling-of-medicines>

<sup>136</sup> Royal Pharmaceutical Society (2019) 'Professional Guidance on the Administration of Medicines in Healthcare Settings'  
<https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/SSHM%20and%20Admin/Admin%20of%20Meds%20prof%20guidance.pdf?ver=2019-01-23-145026-567>

- Guidelines and procedures for the storage, management and administration of medication (controlled and non-controlled drugs) is usually specified in local trust policies.

## Parent involvement

A summary of the involvement of parents/guardians in neonatal care by attendance at ward rounds and receipt of discharge summaries is shown in Table 23.

### Involvement in ward rounds

118 trusts (out of 120) reported parental involvement in ward rounds (for two trusts it was not clear). Respondents commonly reported that parents are invited and encouraged to attend ward rounds on the neonatal unit, and were encouraged to participate in care planning, ask questions, provide updates from their perspective and contribute to decision making when appropriate (for example 025, 049).

*“Parents are encouraged to join the daily ward rounds and be included in discussions about their baby’s care. Feedback from the parents, in part, informs the update on the baby’s condition and management plan.” (025)*

*“During the ward round parents can listen and receive a detailed update on their baby’s care. Parents are also encouraged to participate as much as they feel comfortable within the ward round. During this time medical and nursing staff will involve the families into the decision regarding their babies care and acknowledging their thoughts and opinions and taking them into account when devising a care plan.” (049)*

Several respondents reported strategies to encourage parental participation in ward rounds. One respondent (014) reported that the timing of ward rounds had been adjusted to facilitate parental engagement and accessibility (for example after school drop-offs) and another respondent (071) cited recent discussions regarding parental involvement between the unit and families to better understand barriers to attendance. Several respondents (for example 024, 069, 110) reported that when parents were unable to attend the ward round, alternatives were offered, such as discussion with a relevant clinician, telephone consultation or remote access such as video calling or virtual attendance (010, 048, 087). A number of respondents (for example 024, 047, 053) also reported offering parent-led ward rounds.

*“Discussions regarding parental participation have been held as a team and through engagement with families to understand some of the barriers to attending and how this can be improved. As part of the improvement work the admission process to the neonatal unit now includes discussion with parents of the timings of ward rounds.” (071)*

*“Parents and guardians are actively encouraged to participate in ward rounds. Presently, the Trust is exploring a digital solution through Microsoft Teams calls to*

*facilitate the involvement of parents who are unable to attend physically. Additionally, the ward round schedule has been adjusted to commence at 11am, allowing parents the flexibility to join after school drop-offs, thereby enhancing accessibility and engagement.” (014)*

*“They [parents] are encouraged to be present for ward rounds; if they are unable to be, updates are provided when they are next on the unit. To increase accessibility options for parental involvement at ward round, there is a tablet on wheels to start offering video conferencing for families who cannot physically be present on the unit during ward rounds. This is one of multiple improvement projects being led by our large multidisciplinary Family Integrated care team.” (087)*

*“Parents and guardians are actively encouraged to attend the ward rounds. They have 24-hour unrestricted access to their baby. The Trust has recently undertaken a piece of Quality Improvement work led by a senior nurse to develop Parent Led Ward rounds – where parents are able to present their baby’s case and update the medical team on the Consultant ward round.” (055)*

Some respondents (for instance 019, 091, 116) also reported that parental involvement in ward rounds is monitored through data reporting systems (for example dashboards or electronic patient records) and that compliance is reviewed through the National Neonatal Audit Programme (NNAP). In instances in which respondents provided data regarding the level of parental involvement in ward rounds, reported attendance at ward rounds varied (for example 058, 070, 071, 091, 116).

### **Receipt of discharge summaries**

116 of 120 trusts reported that parents routinely receive a copy of their discharge summary as part of the discharge process. In two cases it was unclear or not reported (Table 23). Many respondents (for example 004, 021, 055) reported that these are provided via the BadgerNet system and some (for example 065, 091, 103) reported that summaries are provided prior to discharge to give parents opportunity to review, discuss with the medical team and raise any questions or ask for amendments. One trust (087) reported that a member of the team collaboratively produces a discharge summary together with parents by discussing the summary of care and discharge notes. However, respondents at two trusts (030, 071) reported that discharge summaries are not provided to parents consistently across all neonatal and maternity units within a trust.

*“Families always receive a Badgernet discharge summary report whether they received care on the neonatal unit or on transitional care unit. A member of the team will sit and discuss contents of the summary of care and discharge notes with parents, collaboratively make a final discharge summary together. This is shared with health visitor and GP in addition to a parent copy.” (087)*

Table 23: Number of trusts reporting parental/guardian involvement in neonatal care

	Parents/guardians included in ward rounds	Parents/guardians routinely receive discharge summaries
Yes	118	116
No	0	2
Unclear/not reported	2	2
<b>All trusts</b>	<b>120</b>	<b>120</b>

### Parental access to medical records

Few trusts reported that parents had direct access to medical records (or aspects of records) and the method of access varied. 14 trusts (for example 031, 050, 059) reported access to a parent portal through which medical records or aspects of records could be accessed. However, it was sometimes unclear what aspects of medical records were accessible and whether related to maternity or neonatal care. For instance, several respondents (048, 050, 105) reported access to maternity records or notes, while others (010, 031) reported access to neonatal notes or records. Portals were most often reported as providing a means for parents and staff to communicate, for the sharing of information, to receive updates, and sharing photos, videos or messages (for example 054, 065, 071), such as Vcreate and BadgerNet. Several respondents (001, 021) also reported parent access to paper neonatal medical records or notes and several noted (089, 098) that parents have full access to maternity and/or neonatal records but did not specify how these were accessed.

Among those trusts that did not report direct access to medical records, it was often noted that these can be accessed via request as per trust processes such as through PALS, disclosure team, subject access request process (for example 012, 034) or records could be viewed under the supervision of staff (for example 011, 100). In addition, many respondents (for example 009, 054, 094) reported that parents/guardians do have access to cot side clinical or nursing notes and observations. For many trusts it was either not reported or it was unclear from the description provided whether parents had access to medical records, cot side notes, or maternity records.

### Parental involvement in neonatal care

Respondents commonly reported parental/guardian involvement in neonatal care. Many (for example 005, 030, 102, 110) reported adopting a FiCare model of neonatal care (as per the BAPM framework), adopting FiCare principles or a commitment to FiCare, and several respondents described parents as being “*partners in care*” (009, 120). A number of trusts (for example 010, 020, 055, 097) reported the unit being rated or assessed as ‘green’ for adopting the FiCare model and several trusts (for example 015, 029, 062, 064) reported holding accreditation according to the BLISS baby charter for family centred care and UNICEF Baby Friendly Initiative (BFI). Examples of responses are provided below.

*“The unit is implementing a family integrated care report in line with the BAPM Family Integrated Care (FiCARE) model, this includes seeking parents’ opinions and choices in discussions around care, support for feeding choices and highlights the importance of parents as partners in care. The Trust collects direct parent feedback on discharge which is used to inform service development.” (102)*

*“Parents/guardians have full involvement as we consider that they are “partners in care”. They are able to remain resident 24/7 at cot side if they wish. Food is provided and they are fully involved/engaged in the decision-making process for decisions on aspects of care. Time is available for discussions between parents/guardians and clinical staff. Parents/carers have access to care via “V-create”, an electronic virtual system which allows them to access images and videos of their child remotely.” (009)*

*“Parents / guardians are respected as partners in care and can be involved as much as they can /like with their baby’s care. They have 24hr access to their baby. The neonatal unit has recently introduced a learning tool for parents to safely administer naso-gastric tube feeds. Parents have been involved in guidelines, such as home oxygen. They are able to room in with their baby prior to discharge to establish feeding and gain confidence while support is close at hand. How to give oral medication prior to discharge is taught. They have access to the parent support sister to support them through their neonatal journey. There is an active parent support group and parents were invaluable with the unit’s preparation and subsequent re-accreditation for Bliss platinum status.” (015)*

However, variation was evident in relation to the specific initiatives reported to have been adopted to facilitate parental involvement. It should be noted that some of the variation across trusts might also be due to reporting differences. Table 24 presents common themes and examples that emerged in relation to parental involvement in neonatal care.

Table 24: Parental/guardian involvement in neonatal care

<b>Theme</b>	<b>Example</b>
Access to the unit	<p>Respondents (015, 104, 110) commonly reported 24/7, open access for parents/guardians on the unit or unrestricted visiting (for example to remain cot side if they wish).</p> <p>Several respondents (036, 065, 061, 067, 087, 113) reported access to parental accommodation on the unit should they wish to stay – either via cot side recliner chairs or separate accommodation.</p> <p>Respondents differed in the extent of support provided to parents to enable them to stay on the ward - a number of trusts reported how they support and encourage parents to be on the unit. For example access via a biometric fingerprint entry system (104, 115), provision of food while on the unit (009, 073, 101, 109), facilities and groups for siblings on the unit (010, 054), free parking (087, 101), and a dedicated family area (010).</p>

	<p><i>“There are [number] parent bedrooms located directly on the unit, to enable parents/guardians to remain close to their baby. This provision assures parents/guardians that they can leave their baby for short periods of time, to relax, rest and sleep during their neonatal journey, but be close by if they are needed. There are also sleeper chair/beds that are available for parents/guardians wishing to stay at the cot side. Support is also offered with provision of a rest room (food storage and kitchen facilities) privacy, comfortable seating, free meals, free car parking, free wi-fi and comfort rounds. These initiatives are to remove any barriers to parents/ guardians, spending quality time with their baby. Each parent/guardian journey is supported according to individual need and is supported from admission to discharge, or during end-of-life care.” (073)</i></p> <p><i>“Parents and siblings on the neonatal unit have 24 access to their babies. From day 0 parents are encouraged and expected to be with their baby as much as possible. To undertake cares [sic] such as nappies changes, feeding, whilst also spending time to read, hold and undertaking daily skin to skin. On the unit we want to ensure there is a welcoming environment and that families are comfortable. There is a parent's room with a fully equipped kitchen where parents have access to tea, coffee, fridge, microwave and snacks available by our unit charity. There is also an expressing room, quiet area and 4 rooms where families can stay. Within each room on the unit there are expressing pumps and chairs where parents can lay back and have skin to skin or even take a nap if they wish to.” (049)</i></p> <p><i>“Parents are welcome to be resident on the unit and access all our facilities. They are offered breakfast, lunch and dinner whilst visiting their baby on the unit.” (035)</i></p> <p><i>“There are facilities for one or both parents to stay overnight if they wish, although at times not enough for the size of the unit. There are reclining chairs and fold up beds if families wish to stay at the cot side. Rooms are used flexibly to increase space for parents to stay if needed although bathroom access for male parents in particular can be a challenge.” (054)</i></p> <p><i>“Siblings have unrestricted access and there are facilities on the unit for them (play space, tv, access to drinks and books) which supports parent involvement.” (054)</i></p>
Caring activities	<p>Many respondents (004, 064, 092, 096) reported that parents are encouraged to participate in caring for their baby, for example, skin to skin approaches, comforting, nappy change, bathing, feeding (including breastfeeding and nasogastric tube feeding), administration of oral medication. And some trusts (033, 046, 054) cited parental education programmes or training to support the learning of care tasks.</p>

	<p><i>“Parents are encouraged to get involved with all aspects of their baby’s care, including feeding, changing and comforting their child. Where required, parents are provided with training to be able to feed their babies via nasogastric (NG) tubes and are offered breastfeeding support by the nursing teams and infant feeding teams. They are also encouraged to have regular skin to skin contact with their babies and to read and sing to them.” (025)</i></p> <p><i>“The Newborn services teams educate parents to provide care to their baby to develop parental bonding which includes breastfeeding, skin to skin care, naso-gastric tube feeding, stoma care, handling their preterm baby and preparing for discharge, which supports parents’ confidence, and readiness for when they are ready to take their baby home.” (030)</i></p>
Care planning and decision-making	<p>Several respondents (009, 048, 065, 115) reported that parents are engaged in decision making and care planning process.</p> <p><i>“Parents/Guardians are involved in decisions regarding the care of their babies whilst on admission e.g. decision about types of feed (breastmilk or formula), treatments and tests, referrals etc.” (065)</i></p>
Feedback	<p>A number of respondents (021, 090, 102) reported feedback is regularly sought from families about care to enable improvements to be made, such as survey completion prior to discharge. Some respondents mentioned the friends and family test (048, 099), whereas others reported tailored neonatal feedback pathways (027, 101).</p> <p><i>“Parents/carers also have access to a suggestions board on the NICU. All parents/carers on the day of discharge are provided with an I-pad to complete an electronic survey of their experience of the NICU which is submitted to the Neonatal Network. The Neonatal Network send the Trust a quarterly report of the results that are reviewed by the NICU leadership team and in the Unit Clinical Governance Meeting. The Trust has acted on feedback in relation to breast feeding facilities, accommodation and parking.” (008)</i></p> <p><i>“Additionally The team, have very recently introduced bi monthly [meeting] for parents and guardians. These take place on each unit, and are led by the NICU Leadership Team. All Parents are invited to attend and it is a platform to encourage parents to feedback on their experiences of the Neonatal service.” (088)</i></p>
Advisory groups or committees	<p>Some respondents (008, 041, 093) reported the involvement of parents/guardians as representatives in advisory groups (such as neonatal network parent advisory group) or for consultation on strategies (such as redevelopment and other major changes).</p>

	<p>Several respondents (014, 065, 091, 099) cited the development of their Maternity and neonatal voices partnership (MNVP) with the involvement of families.</p> <p><i>“Parents/guardians are involved with family integrated care works, regular feedback, co-production where possible and continued progress to develop our Maternity and Neonatal Voice Partnership.” (099)</i></p>
<p>Support provided to parents</p>	<p>A number of respondents cited providing support to families:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Peer support groups such as coffee mornings with parents of babies previously on the unit (031, 042, 073).</li> <li><input type="checkbox"/> Parent group sessions facilitated by psychologist, access to unit psychologist, psychology support, groups led by other health professionals (030, 054, 115).</li> <li><input type="checkbox"/> Support with caring tasks such as feeding (030, 100).</li> <li><input type="checkbox"/> Parental teaching sessions and preparation for discharge to meet the ongoing needs of their baby, for example, safe sleeping, basic life support, how to manage ongoing conditions (025, 054).</li> <li><input type="checkbox"/> Support from family integrated care team or lead or coordinator or champion (035, 062, 093).</li> </ul> <p><i>“Prior to discharge, parents are given advice on safe sleeping, bathing baby and car safety. They are also advised on how to manage any ongoing conditions, what to do in the event of a worsening illness and are given a demonstration of infant CPR.” (025)</i></p> <p><i>“We have a Family Team which provides family support and includes a Family Integrated Care Lead Nurse, a psychologist, family support workers and discharge coordinators.” (093)</i></p> <p><i>“There is a weekly social round where information about family wellbeing is discussed and plans made if support needed. There is access to a unit psychologist two days per week.” (054)</i></p>

## Data collection and use of data

This section provides a description of how trusts describe the data they collect, how it is used, and how it is shared. Almost all trusts (119 of 120) provided responses on use of data.

### What data is collected and for what purpose

Most respondents interpreted the questions as relating to data systems, rather than the individual categories of data. However, some trusts did describe the different types of data they collect (069). In some cases, trusts referred to the type of system or multiple systems

they used to collect data, for example, paper medical and nursing records, trust electronic health record, or BadgerNet (a neonatal and maternity specific system) (094). In some cases, trusts are able to take data from the electronic health record to meet reporting requirements (069) but in other cases additional data collection is required for this (021).

*“The systems we used changed from a suite of separate applications to a consolidated health record, EPIC in October 2023. All required data for the full medical record is collected on digital systems:*

- *Medical notes by medical, nursing and allied health professionals*
- *Administrative data – admission, discharges, transfers, referrals, clinical coding (ICD10 diagnosis and OPCS4 procedure codes)*
- *Prescription and drug administration data*
- *Physiological trending data from monitors*
- *Clinical laboratory orders and results*

*This is the data needed to support direct patient care, or for mandatory reporting.” (069)*

*“Maternity BadgerNet: Demographic data, clinical data, event data*

*Neonatal BadgerNet: Demographic data, clinical data, event data*

*Silverlink PAS: Demographic data, clinical data, event data*

*RIO: CHIS Record, Demographic data, clinical data, event data*

*Most of the data item [sic] are mandatory to enable us submit the dataset to NHS England, eg. MSDS, CDS, CSDS. We use the data to monitor our activity, clinical performance, operation efficiency and protect patients’ safety and welfare.” (094)*

*“Patient medical records on the unit are paper based currently. Electronic minimum dataset for multiple clinical parameters is collected every day for every baby. This is manually added to the UK neonatal patient data management system provided by BadgerNet. This is in line with most neonatal units nationally. This system is used to create admission and discharge letters for all babies – for the parents and for the GP. This is also used to collate important data for benchmarking in the [Neonatal Audit Project] system.” (021)*

Respondents described how data collected for patient care is then used in different ways to meet a range of purposes (102).

*“Babies who receive Neonatal Care or Transitional Care (which meets the threshold for HRG4 or higher) will have a Badger admission and Discharge created. This includes:*

- *Baseline parental and demographic data from the E3 system;*
- *A daily summary of their level of care and whether carers are present and providing care (which forms the basis of HRG coding);*
- *Documentation of input from the MDT, including specialist reviews, cranial ultrasound results and assessment of growth;*

*This data forms the basis of their written discharge paperwork and is used to capture activity and levels of care. Some of this data is used as part of national audits, including the National Neonatal Audit Project and MBRRACE report. There are local audits, or audits which form part of national quality improvement / patient safety projects which have separate data collection.” (102)*

The purposes of collecting data reported by respondents, apart from for direct patient care, are summarised in Table 25 below.

Table 25: Purpose of collecting data

Category or theme?	Examples of purpose
Operational management and delivery of care	<ul style="list-style-type: none"> <li><input type="checkbox"/> To plan services</li> <li><input type="checkbox"/> To track operational efficiency – monitoring activity. For example, to enable planning of staffing numbers against activity (and staff to patient ratio)</li> <li><input type="checkbox"/> To forecast and business plan, for example for commissioning and funding plans</li> <li><input type="checkbox"/> To ensure the trust receives appropriate income for activities completed</li> <li><input type="checkbox"/> To enable performance monitoring - regular review of performance which is visible to the organisation and network.</li> <li><input type="checkbox"/> To ensure consistency of practice and feed into clinical decision-making</li> <li><input type="checkbox"/> To identify any outlying performance indicators – to be reviewed and shared and action plans developed</li> <li><input type="checkbox"/> To prepare internal reports</li> </ul>
Quality improvement: identifying learning and areas for improvement	<ul style="list-style-type: none"> <li><input type="checkbox"/> To look for patterns of care and outcomes of care, to identify trends or areas for concern, including early identification of complications, incidents and complaints.</li> <li><input type="checkbox"/> To drive change and improvement, by identifying trends and patterns.</li> <li><input type="checkbox"/> To ensure consistency of practice with national standards (identify those that sit outside national standards) and identify unwarranted variation</li> </ul>
Reporting / oversight / Assurance	<ul style="list-style-type: none"> <li><input type="checkbox"/> To report data to Trust, regional and national bodies as required (for example, local dashboard, regional ODN, national level) – particularly statutory/national/regional requirements</li> <li><input type="checkbox"/> To provide assurance for example to board over quality of care, ICS exec leads, Local Maternity Neonatal System</li> </ul>
National, network level and local benchmarking and audit	<ul style="list-style-type: none"> <li><input type="checkbox"/> To benchmark against local, network (such as ODN) and national standards</li> <li><input type="checkbox"/> To help highlight areas of good practice and areas for improvement</li> <li><input type="checkbox"/> To submit to Neonatal Networks and national audits for example NNAP, NHE GIRFT, ATAIN, NHSE Neonatal transformation Review, Mat and Neonatal Safety improvement programme (MatNeoSIP)</li> </ul>

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Other	<input type="checkbox"/> To enable public health surveillance <input type="checkbox"/> To use during trust education and training <input type="checkbox"/> To develop trust policies <input type="checkbox"/> To comply with Clinical Negligence Scheme for Trusts <input type="checkbox"/> To use in research and evidence generation - Data goes into creating the National Neonatal Researcher Database (NNRD)
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Respondents identified a number of common external reporting requirements, as outlined in Table above, in particular mandatory submissions of activity data, the neonatal audit, the Maternity Incentive Scheme, and entering data in the BadgerNet system.

Less frequently mentioned systems included:

- International benchmarking (the Vermont Oxford Network) (for example 115, 007, 092, 101, 039)
- Providing data to Bliss, to obtain best practice awards (005, 027)
- The UNICEF baby friendly report (052, 117)
- Research programmes (for example, National Neonatal Researcher Database) or data for specific clinical trials (022, 069, 089)
- Benchmarking tools such as run commercial benchmarking providers (079, 017)
- Systems which are required for specific groups of babies, such as the National Congenital Anomaly Register (096)

#### How is data reviewed and analysed?

Respondents reported that data is analysed externally and within the organisation.

Trusts receive reports back from national and regional systems that they submit data to. ODNs have a key role in analysing data from the BadgerNet system, and providing benchmarked data back to trusts (009).

Respondents described four main functions in relation to how data is used within the organisation:

- Ward clerk or designated member of the team to enter and validate data collected on the ward about individual babies,
- Data analyst or information specialist to analyse data, including preparing internal reports and external submissions,
- Designated medical consultants to review internal and external analysis of data reports to identify action required and provide clinical oversight of information submitted to external audit, and
- Review of data as part of wider governance processes.

Typical examples include:

*“Lead nurse, Neonatal Consultant and Matron review the data quarterly. The Operational Delivery Network review the data and compares to other units. Band 6 sister and ward clerk check data regularly to ensure no data errors. Data is brought to the Maternity- Neonatal transformation group bi monthly for the transfers in and*

*out, deaths, mag sulphate and steroids and off birth pathways. The Mat-Neo transformation group is chaired by either Director of Nursing or Medical Director.” (009)*

*“This data is regularly reviewed and analysed by our neonatal consultant data lead and neonatal information manager, as well as being reviewed through our governance processes. This process includes:*

- overseeing activity, mortality and morbidity data entered on BadgerNet EPR system and validating data on a monthly (activity and mortality data) or quarterly (morbidity data) basis;*
- Mortality and some morbidity data included in the neonatal scorecard and neonatal quality assurance report and discussed at the monthly neonatal quality and safety meetings, with key metrics then reported upwards through the Trust’s governance structure and externally as required (see question d);*
- Vermont Oxford data validated and submitted for international benchmarking yearly in March;*
- Analysis of national audit reports when published (usually annually) undertaken by designated clinical lead and reported to directorate and divisional quality and safety committee, then reviewed at the Trustwide clinical audit and effectiveness group and summarised in reports to EMBQ, EMB and quality committee.” (115)*

Trusts provided positive examples of how monitoring data had enabled issues to be identified and led to positive change:

*“Audits and dashboards help to measure patterns or trends in care that may be occurring. For example, a rise in rates of postpartum haemorrhages was noted on the dashboard, and consequently prompted a thematic review to understand the reasons for this and whether any improvements are required. Doing this regionally also helps to benchmark us against other maternity units, to identify outliers and prompt care reviews where required, to improve safety.” (050)*

*“All stillbirths and neonatal deaths are reviewed at the Maternity Serious Incident Group (MSIG) ideally within 72 hours where the antenatal/intrapartum and postnatal care is reviewed in full by a multidisciplinary team (MDT) so that any care concerns can be addressed immediately, actions put in place and to identify whether an incident requires investigating further. All stillbirths and neonatal deaths are notified to MBRRACE within 7 days of identification and taken to the MDT Perinatal Mortality Review Tool (PMRT) meeting ideally within 8 weeks, where the care provided is reviewed through the Tool. PMRT is attended by an external expert for transparency.*

*All deaths that meet the criteria for MNSI (previously HSIB) are referred to MNSI as soon as possible and if the incident is triaged and accepted, this is then investigated externally by MNSI.*

*Since June all stillbirths and neonatal deaths are entered onto a Thematic Tracker and this enables us to identify any potential themes arising and follow up on actions in place. The tracker is very extensive, looking at the full holistic care*

*provided throughout the antenatal, intrapartum and immediate postnatal period, as well as postnatal results, such as postmortem/placental histology.” (112)*

## CCTV

### Installation and location of CCTV

99 of 120 trusts reported that CCTV covered entrances and exits, and external corridors. 29 trusts reported the presence of CCTV within the unit in communal areas such as corridors and waiting areas. There were no instances in which respondents reported the presence of CCTV in clinical areas (such as wards). For 21 trusts, CCTV was not installed, the location was unclear or not reported.

Eight trusts (for example 020, 024, 066) reported that CCTV covers storage areas for medications, however of these two (009, 039) reported CCTV positioned at external doors to medication rooms and four (035, 055, 066, 109) reported that CCTV did not cover storage areas across all units/wards. However, some respondents reported drug storage areas to be secure, with controlled and monitored access (for example use of swipe cards) that can be reviewed and audited ([see storage and administration section](#)). A number of respondents (for example 005, 036) reported that it was planned for CCTV to be installed in medication storage areas as part of unit upgrades or refurbishments. Although not directly asked about, it is noteworthy that respondents rarely reported whether the CCTV was reviewed, how often, and who had access to the footage.

It is, however, important to note that respondents varied in their interpretation of whether CCTV was installed within the unit. It was not always clear from their responses whether CCTV was positioned internally or externally to the unit. While some respondents focused on the presence of CCTV within the unit with the purpose of monitoring babies only (i.e. in clinical areas), others focused on its presence within the unit more broadly. In some cases, there were differences in the location of CCTV between maternity and neonatal units or sites within a trust. Where possible, given the information available, Table 26 provides an overview of the location of CCTV reported to be positioned on units.

*Table 26: Trust reported locations covered by CCTV*

Area covered by CCTV	Number of trusts
Entrance/exits and external corridors	99
Internal communal areas (such as corridors, waiting area, reception)	29
Storage areas for controlled and non-controlled drugs	5
Clinical areas (such as wards)	0
Unclear / Not reported	21
<b>All trusts</b>	<b>120</b>

Note that it was not always clear whether corridors were internal or external to the unit. Respondents often reported CCTV installation across several areas and therefore categories are not exclusive. In cases in which upgrades or wider CCTV installation has taken place, initial date of installation has been reported.

Many trusts did not provide the date of CCTV installation, stated that it was not applicable or did not know. Of the 47 trusts that provided a date of installation, 41 (for example 070, 106) provided a date more than five years ago and only six trusts (for example 047, 060, 072, 111) reported the date of installation within the last five years. However, several trusts (for example 028, 055) did report that a CCTV upgrade had taken place since the installation.

### Reasons for installation of CCTV

For those trusts that confirmed the presence of CCTV, reasons for its installation are presented in Table 27. Security and safety purposes (for patients and/or staff) were most often cited as reasons for installation. Several respondents reported its installation was linked to facilities upgrades or redevelopments and a number of trusts did not provide a response or did not know.

Table 27: Summary of reasons reported by Trusts for installation of CCTV

Reason	Example
Security and safety (of babies)	<ul style="list-style-type: none"> <li><input type="checkbox"/> To ensure the safety and security of babies. Several respondents mentioned concern relating to infant abduction (040, 050, 112).</li> <li><input type="checkbox"/> Prevent unauthorised access to the unit (076, 119).</li> <li><input type="checkbox"/> Crime prevention/detection (005, 050).</li> </ul>
Security and safety (of staff)	<ul style="list-style-type: none"> <li><input type="checkbox"/> Security and safety of staff (006, 011, 079). One respondent (072) reported incidents of visitors becoming threatening towards reception staff.</li> </ul>
Broader facilities upgrade/development	<ul style="list-style-type: none"> <li><input type="checkbox"/> Installed during unit build, redevelopment or upgrade (009, 046, 088).</li> <li><input type="checkbox"/> Part of ongoing upgrades relating to medication access (090).</li> </ul>
Unknown	<ul style="list-style-type: none"> <li><input type="checkbox"/> Reason is not known (024, 083)</li> </ul>

Table 28 provides an overview of reasons cited by respondents for not having CCTV installed within neonatal/maternity services for the purpose of monitoring babies. Many respondents focused on the potential use of CCTV in clinical areas and the need to protect and respect the privacy of patients and their families.

Table 28: Summary of reasons reported why CCTV had not been installed

Reason	Example
To respect and protect the dignity and privacy of babies and their families	<ul style="list-style-type: none"> <li><input type="checkbox"/> Considered intrusive in clinical areas/cot side where breastfeeding, nappy changing, expressing and skin to skin contact encouraged (029, 055, 119).</li> </ul>
Not considered necessary	<ul style="list-style-type: none"> <li><input type="checkbox"/> No incidents or concerns identified the need for CCTV (115).</li> <li><input type="checkbox"/> Not needed in clinical areas due to presence of staff and parents throughout day and night (090).</li> <li><input type="checkbox"/> Other measures in place such as secure controlled access (016), presence of security staff (090), baby tagging system (007).</li> </ul>
In line with current trust policy	<ul style="list-style-type: none"> <li><input type="checkbox"/> In line with other clinical areas within the trust or trust strategy for implementation of CCTV for example installed in public areas but not within patient care areas to uphold privacy (043, 069, 119).</li> <li><input type="checkbox"/> Not a local requirement (013).</li> </ul>
Broader national policy	<ul style="list-style-type: none"> <li><input type="checkbox"/> Not a national (i.e. BAPM) requirement (019).</li> </ul>

### Remote access for parents and families

Three of 120 trusts were explicit in their response that they provided live remote webcam footage for parents/guardians (010, 048, 090) (Table 29). Thirteen trusts (for example 007, 070) reported providing remote access for parents via webcam or video calling on an ad-hoc basis and 41 trusts (for example 015, 027) reported providing access to pre-recorded video footage (typically through VCreate or another similar platform). It was unclear or not reported for 14 trusts. Several trusts (for example 026, 062, 080, 086) mentioned potential concerns relating to patient privacy and confidentiality of remote access.

*“The Trust offers the opportunity for families to arrange a virtual call with the neonatal unit where their baby is receiving care. This then enables staff to provide webcam footage of their baby. The Trust does not offer 24/7 footage of babies receiving care on the neonatal units, and does not currently permit families to set up their own devices that would allow 'livestreaming' of their baby from our hospital sites. This is to maintain and protect overall patient privacy and confidentiality.”*  
(026)

Table 29: Summary of trust responses for type of parental remote access

Parental remote access*	Number of trusts**
Live, remote webcam	3
Video calling on ad hoc basis (for example if parents unable to attend)	13
Pre-recorded video footage (for example via Vcreate)	41
Unclear / not reported***	14
No	50
<b>All trusts</b>	<b>120</b>

\* Respondents differed in their interpretation of 'remote access' (whether live and/or continuous remote access or streaming, a digital system/portal providing access to recorded videos, video calling on an ad-hoc basis) and several respondents mentioned remote access but did not specify any further details.

\*\*Some respondents reported more than one method of providing remote access and therefore categories are not exclusive.

\*\*\*Cases for which insufficient detail has been provided have been coded as unclear

## Storage and administration of medication

Many respondents reported trust policies or procedures relevant to the storage, management, security arrangements and administration of medication that were applicable to maternity and neonatal units, such as a "medicines management policy", "medicines policy" or "safe and secure handling of medicines policy" and usually a separate "controlled drugs" policy (for example 009, 021, 049). There were no reported instances of policies specific to maternity or neonatal units.

### Storage and management of medication

Respondents commonly reported that drug storage units were key locked (for example 009, 030, 090, 103) or in some cases digitally locked, such as digilock or keypad (for example 017, 079). In many cases, respondents reported (for example 048, 049, 073) that senior staff (such as nurse or midwife or practitioner in charge of ward) were accountable for the safe and secure storage of medicines, responsible for holding keys, which were only available to authorized members of staff. In some cases (for example 015, 041, 064, 081, 117), particularly for controlled drugs, these were double locked for example in a locked/secure access room in a locked cupboard or fridge. However, some respondents (for example 009, 022, 101, 118) reported electronic swipe access (for instance with an electronic security card traceable to the individual) to drug rooms and in some cases, respondents (for example 022, 026, 101) reported being able to access electronic records or undertake reviews of access to drug rooms.

*"The [controlled drugs (CD)] cupboard is a locked cabinet, within a locked cupboard, behind a locked door. The Nurse in charge always carries the keys to the CD cupboard as per the policy Controlled Drugs Policy and Procedures" (064)*

*“The drug storage cabinets room has a swipe access control. This is centrally managed by the Trust IT team. Electronic records can be generated for who has accessed the room when required.” (101)*

19 of 120 trusts (for example 030, 034, 039, 080) reported that an electronic record of who accesses drug storage cabinets on the unit is kept, whether via automated electronic cabinet such as Omnicell (for example 034, 066, 080), swipe access (039), or electronic Abloy key system (for example 035, 059, 094). In most cases, such records were reported to include data for who accessed the drug storage unit and when, but not for what purpose. A few respondents reported an electronic record of access was not available at the time of reporting, but that plans were in place to allow for electronic records in the future (for example 043, 070, 087). See Table 30 for trust responses relating to electronic records of access.

*“Medicines are stored in an automated medicines cabinet (Omnicell) which requires fingerprint access. All transactions including access to medications stored within the Omnicell are recorded electronically. This includes controlled drugs.” (030)*

*“All maternity areas (other than maternity theatres) have Omnicell cabinets installed (including fridge control) including records of who accessed, medicine accessed, amount removed, patient for whom removed.” (080)*

Table 30: Trust responses relating to electronic records of access to drug storage areas

<b>Electronic record of who accesses drug storage cabinets</b>	<b>Number of trusts</b>
Yes*	19
No**	91
Unclear / Not reported	10
<b>All trusts</b>	<b>120</b>

\*Note that several trusts reported electronic records of access at only one site, hospital or ward have been categorised as ‘yes’.

\*\*A number of trusts reported that electronic record of access to drug storage cabinets was not available, however did report that such records for drug rooms/storage areas.

For those who did report electronic records were kept, most reported that these were held or stored securely on the trust server (for example 005, 050, 069, 080, 096) or in security records (for example 020, 115), and several respondents (for example 005, 050) stated that only authorised individuals were able to access records (such as security or pharmacy staff). The timeframe for destruction of such records ranged between six months (005) to ten years (031) and was often five years or more (for example 020, 035, 050, 069, 080). Respondents commonly (for example 020, 066, 115) reported that access to records are not audited regularly but are retrieved and reviewed for specific investigations as required (for example 035, 059, 069, 096) or audited on an ad hoc basis (for example 031, 050, 080).

For those without electronic records, a number of respondents (for example 027, 033, 075, 098) reported that paper records, books or registers of access to drug cupboards/rooms are kept, particularly for controlled drugs (such as paper sign-out book, record book, record of access). Several respondents reported that drugs (particularly controlled drugs) are double checked or countersigned (for example 071, 110, 117). For example, clinicians are required to simultaneously check controlled drugs out of the locked cupboard (071), that cupboards are dual locked and keys held by senior staff (072) or countersigning of the drugs register (110).

Where storage arrangements for insulin were reported, respondents reported insulin to be held in a locked fridge (for example 030, 041, 042, 053, 065, 090, 091, 110) or reported that insulin was not stored on the neonatal unit and would be requested if required (for example 036, 040, 081, 084). One trust (011) reported that it had changed procedures for management of insulin in response to the Letby case.

*“Insulin has recently been made an accountable drug (in response to Letby case), therefore is treated in the same way as a Controlled Drug. It is stored in a locked box in fridge until opened. Once opened it is accounted for in the CD book and any remainder is witnessed and disposed of. It is therefore now a single use ampule. Each ampule has a tamper proof seal which is checked before use. All stock is checked daily and recorded in CD book. The key for the lock box is kept with the CD key by the Nurse in Charge.” (011)*

### **Auditing of medication management and storage**

Several respondents (for example 010, 110) reported that adherence to or compliance with policies and standards related to the safe and secure storage of medicines is assessed through audits, often conducted by pharmacy staff. However, the frequency in which checks/audits were reported to be completed varied across trusts, for example, monthly (113), quarterly (095), and six-monthly (030). Two trusts (010, 030) reported the safe and secure storage of medicines is audited in line with the Royal Pharmaceutical Society standards<sup>137</sup> for safe and secure handling of medicines.

*“Safe storage audits are carried out by the pharmacy team each month to ensure all the medicine cupboards are locked, clinical rooms are locked, no medication is left out (unless in use) and the keys are being held by the nurses, as well as checking controlled drug registers.” (113)*

*“Safe storage of medication is audited twice a year by the pharmacy team and included in the annual medicines management audit that ward managers complete.” (030)*

*“The maternity team undertake monthly audits of safe storage of medicine. Pharmacy undertake a Safe and Secure handling of medicines audits on a quarterly basis.” (095)*

<sup>137</sup> Royal Pharmaceutical Society (no date) ‘Safe and secure handling of medicines’  
<https://www.rpharms.com/recognition/setting-professional-standards/safe-and-secure-handling-of-medicines>

Many respondents reported that drug stocks are checked and audited regularly and a record of this is kept (either paper or electronic). However, checks were reported with varying frequency across trusts, such as twice daily (for example 012, 033), daily (for example 015, 081), weekly (for example 023, 117). In some cases (such as 012, 015) checks were made by unit staff and supplemented by pharmacy audits. Similarly, many respondents reported that controlled drugs registers are routinely audited, with varying frequency. For example, one respondent (078) reported paper records are checked every 24 hours, audited monthly and pharmacy reviewed quarterly, and another (065) reported daily controlled drug checks, weekly ward managers audit, monthly matron audit, and quarterly pharmacy audit. However, it should be noted that respondents were not always clear about what specifically was being audited, whether storage arrangements, stock levels, registers of access to or administration of medications.

*“Balance checks of all restricted drugs are required at the end of each late and night shift and are facilitated and signed by two members of registered nurses/midwives. Balance checks of all controlled drugs are required once within a 24-hour period and are facilitated and signed by two members of registered.” (033)*

*“Controlled drug stock is checked once each shift by two registered nurses and recorded on paper. A pharmacist must check the stock holding of Controlled Drugs against the ward/department Controlled Drug record book every 3 months.” (015)*

### **Administration of medicines**

Respondents typically reported that preparation and administration of all medicines on the unit/to neonates is required to be checked by two authorised members of staff (for example 006, 046, 053, 073, 085, 110).

*“All medications, both controlled and non-controlled (including insulin) are prepared and checked by 2 registered staff members both of whom sign the Medication Administration Record.” (110)*

In terms of records of medication administration, some respondents reported that administration is recorded in paper charts, drugs registers or books (for example 030). For example, one respondent (016) reported a paper record of controlled medications administered and signed by two members of staff and another (109) reported a controlled drug record book of amount of medication given and wasted (if applicable). Other respondents (for example 010, 074, 083, 087, 118) reported an Electronic Prescribing and Medicines Administration (EPMA) system or similar which monitors who administers and checks drugs as well as prescribing details. For example, one respondent (083) reported this to require login/password of both staff members in order to record the administration, while another respondent (065) reported a single sign-on process using a smartcard individualised to each staff member, with these systems capable of producing an audit trail of medications administered.

*“Both the person administering the medication(s) and the witness must sign the CD Record Book. This must only be done when the CD has actually been administered to the patient. The second signature confirms that both the administrator and witness are satisfied that all the requirements were met before the controlled drug was administered.” (030)*

*“Trust has an Electronic Prescribing and Medicines Administration (EPMA) system which monitors who administers and checks drugs as well as prescribing details.”  
(010)*

## Nuffield Trust reflections

### Parental involvement in care

There are established family-centred or family-integrated approaches towards involving families and parents in neonatal care (see [context](#) for this section) and the three-year delivery plan for neonatal and maternity services also includes recommendations relating to parental involvement and the adoption of a family-integrated approach towards neonatal care.<sup>138</sup>

Respondents typically reported the adoption of a family integrated care approach towards neonatal care. Most cited established processes for parental involvement in ward rounds and sharing of discharge summaries with parents, and many reported support for parental engagement in care activities and facilitating round-the-clock access to the unit. It is, however, important to note that national NNAP data capturing parental attendance at ward rounds indicates considerable variation in level of attendance across trusts.<sup>139</sup> Few respondents reported parents/families to have direct access to medical records, which is an ambition set out in the three-year delivery plan for neonatal and maternity services.<sup>140</sup>

There appeared to be some variation relating to the extent of support reported to be offered to parents through initiatives, such as the support available to enable parents to stay on the ward (for example accommodation, parking, food access), the training opportunities offered, mechanisms and opportunities for parents and families to feedback about the service and make suggestions to improve care, and other forms of support offered (such as psychological support). Although, it is important to note that such differences might also be due to reporting differences between respondents.

### Data collection and use of data

Maternity and neonatal units have extensive reporting requirements that they must adhere to (for example national audits, local datasets and to the ODN) and many of these are specific to neonatal and maternity services. Trusts were broadly consistent in their responses and examples given, for example trusts cited submitting/reporting data to regional and national bodies, with external reporting requirements including neonatal networks and national neonatal audits such as NNAP, MBBRACE and the maternity

<sup>138</sup> NHS England (2023) ‘Three year delivery plan for maternity and neonatal services’  
<https://www.england.nhs.uk/wp-content/uploads/2023/03/B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf>

<sup>139</sup> RCPCH (2023) National Neonatal Audit Programme (NNAP) Summary report on 2022 data  
[https://www.rcpch.ac.uk/sites/default/files/2023-12/nnap\\_summary\\_report\\_on\\_2022\\_data\\_version\\_2.pdf](https://www.rcpch.ac.uk/sites/default/files/2023-12/nnap_summary_report_on_2022_data_version_2.pdf)  
RCPCH Audits ‘National Neonatal Audit Programme (NNAP) Summary report on 2021 data’  
[https://www.rcpch.ac.uk/sites/default/files/2022-10/nnap\\_summary\\_report\\_on\\_2021\\_data.pdf](https://www.rcpch.ac.uk/sites/default/files/2022-10/nnap_summary_report_on_2021_data.pdf)

<sup>140</sup> NHS England (2023) ‘Three year delivery plan for maternity and neonatal services’  
<https://www.england.nhs.uk/wp-content/uploads/2023/03/B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf>

incentive scheme. The ability and ease with which trusts are able to fulfil such reporting requirements is impacted by the wider trust infrastructure. For example, variation in methods of data collection were evident across trusts (for instance paper medical and nursing records, electronic health record, BadgerNet, UK neonatal and maternity patient data management system) and some trusts reported that additional data collection was required.

Trusts reported the purposes of collecting data to be for operational management and delivery of care (such as planning services), quality improvement (for instance identifying learning, areas for improvement or trends), reporting and oversight (at a trust, regional and national level), and national and network level benchmarking. The impact of data collected is likely dependent on how trusts use and review the data, as well as how it is acted upon – some trusts provided examples of how positive change had been enabled.

### **Presence of CCTV**

There is no national policy for the use of CCTV in NHS settings, although its use can be guided by the broader surveillance camera code of practice, Data Protection Act (2018) and GDPR, and there is limited published evidence related to its use.<sup>141</sup> The presence of CCTV across maternity and neonatal services is, therefore, broadly in accordance with local trust policy (and this was reflected in trust responses). While most trusts reported the presence of CCTV within or around neonatal and maternity services, it was overwhelmingly reported to be located at entrances and exits (and occasionally communal areas). The purpose of CCTV was primarily reported to ensure the security and safety of staff and patients. There were no trusts that reported the presence of CCTV within clinical areas on the unit for the purpose of monitoring babies and few reported the presence of CCTV in medication storage areas, although several trusts did report planned upgrades for its installation in medication storage areas. It should also be noted that it was rarely discussed by trusts whether CCTV is reviewed, by whom and how often (although this was not a question directly posed to respondents).

Few trusts reported that services provided live remote webcam access for parents and families and some respondents cited concerns related to privacy and confidentiality of such remote access. However, some trusts did report providing facilities for video calling or portals for families to access pre-recorded videos and/or photos.

### **Management, storage and administration of medication**

National guidance relating to the safe and secure handling and administration of medicines in health settings sets out best practice principles and national legislation guides the

<sup>141</sup> UK Government (2021) Biometrics and Surveillance Camera Commissioner (2013) 'Amended Surveillance Camera Code of Practice (accessible version)' <https://www.gov.uk/government/publications/update-to-surveillance-camera-code/amended-surveillance-camera-code-of-practice-accessible-version>

management of controlled drugs.<sup>142 143</sup> The management, storage, and administration of medication within maternity and neonatal services was reported to adhere to several local trust policies. However, no trusts reported any distinct policies specific to neonatal or maternity services.

While most respondents reported established processes for the management and storage of medication, differences were evident across trusts in relation to the digital capabilities of storage facilities (for instance whether electronic or manual lock) and the use of electronic or paper records. Most respondents reported medication storage units were manual key locked or in some cases digitally locked and some reported the use of double-locking and countersigning, particularly for controlled drugs. Few respondents reported the presence of automated electronic cabinets and electronic records of access to medication storage units and where this was the case, it was uncommon for these to be audited regularly. Instead, many respondents reported the use of paper records of access.

Most respondents reported clear processes for the preparation and administration of medication, often using a doublechecking or countersigning arrangement. In some cases, administration was recorded in paper records, and in others, in an electronic prescribing system. While trusts often reported regular established processes for auditing the safe and secure storage of medication, the frequency with which audits were carried out varied.

## Additional references

- NHS England (2019) 'Developing family-centred care in a neonatal intensive care unit: An action research study' <https://www.england.nhs.uk/publication/developing-family-centred-care-in-a-neonatal-intensive-care-unit-an-action-research-study/>
- NHS England (2023) 'Update from the Maternity and Neonatal Programme' <https://www.england.nhs.uk/long-read/update-from-the-maternity-and-neonatal-programme/>
- Department of Health & Social Care (2023) 'Government response to 'Reading the signals: maternity and neonatal services in East Kent - the report of the independent investigation' <https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-report-government-response/government-response-to-reading-the-signals-maternity-and-neonatal-services-in-east-kent-the-report-of-the-independent-investigation>

<sup>142</sup> Royal Pharmaceutical Society (no date) Safe and secure handling of medicines Professional Guidance on the Administration of Medicines in Healthcare Setting <https://www.rpharms.com/recognition/setting-professional-standards/safe-and-secure-handling-of-medicines>

<sup>143</sup> Royal Pharmaceutical Society (2019) Professional Guidance on the Administration of Medicines in Healthcare Settings Setting <https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/SSHM%20and%20Admin/Admin%20of%20Meds%20prof%20guidance.pdf?ver=2019-01-23-145026-567>

# Support for bereavement

This section will provide a description of how trusts describe what support for bereavement is available to families. This section covers questions 36 and 37.

## Questions asked of trusts

36. a-d Please describe the level of bereavement and counselling services provided across trusts? How adequate are services reported to be?

- a. Patient Advice and Liaison Services.
- b. Bereavement counselling.
- c. Perinatal mental health services for future pregnancies.
- d. Any other advice/support offering.

37. Please compile and present responses on whether medical records are annotated in this way (describing what happened, so parents do not need to explain in future).

- a. a mother has suffered a neonatal death and how that is relevant to her care and the care of any subsequent babies she has; and/or
- b. parents have suffered a neonatal death, so they do not need to give their full patient history each time they access NHS services.

## Context for this section

- Sands<sup>144</sup> leads the collaboration of partners who have developed the National Bereavement Care Pathway to improve the quality and consistency of bereavement care received by parents in NHS trusts after pregnancy loss or the death of a baby. The Pathway is based around nine core standards, and the guidance materials cover five experiences including for example on stillbirths and neonatal deaths.<sup>145</sup>

## Bereavement and counselling services provided

Trusts described that PALS was available to all families suffering the death of a baby or a serious health outcome, and the process of supporting a family was informed by the National Bereavement Care Pathway.

*“Local guidelines and checklists are written in accordance with the National Bereavement Care Pathway (NBCP), these ensure and guide staff to give patient*

<sup>144</sup> Sands <https://www.sands.org.uk/> <sup>144</sup> Sands (no date) <https://www.sands.org.uk/>

<sup>145</sup> National Bereavement Care Pathway (2024) <https://nbcpathway.org.uk/>

*information at both a local and national level. All women receive the National SANDS guidance as well as our local information 'Following the Loss of your Baby'. Both these booklets give practical and emotional support/advice." (102)*

To some PALS was proactively offered to parents as part of their welcome to the unit, for example, in a 'unit introduction book given to all parents when their baby is admitted to the unit' (see for example, trust 038). Yet other trusts described mentioning access to PALS when a specific concern/complaint about care arose (see for example trust 019) and/or in the case of a death one trust described sending PALS leaflets sent alongside the Duty of Candour letters (see for example trust 064).

Sites also commonly described providing access to a bereavement midwife who would:

*"when possible, meet the family face to face whilst in hospital and will remain in contact with the family after discharge with regular telephone calls, the frequency of these calls will be dependent on the family's requirements and individual wishes." (058)*

Bereavement midwives would also signpost families to PALS if they have any questions or concerns/complaints regarding their care. Trust 094 described that when a concern/complaint is initiated via the bereavement midwife (on behalf of the family),

*"the department would initially carry out a rapid review of care, which is then taken for discussion at the Quality and Safety Meeting. The Bereavement midwives keep the parents up to date on the review and they are given feedback regarding any findings and actions." (094)*

The ongoing contact with parents varied across trusts, but typically involved face-to-face contact with a consultant, midwives and/or a neonatal psychologist as part of the PMRT process:

*"All families who suffer a death are sent a letter from their lead Consultant at around 6-8 weeks post bereavement, offering them a face to face meeting to discuss any aspects of their baby's care or relay any outstanding results." (029)*

*"Parents are offered both an obstetric and neonatal bereavement follow up appointment within 4-6 weeks as set out in our neonatal bereavement guideline. Depending on the parents wish, this can be arranged jointly or in separate sessions. If requested, this appointment can involve the bereavement midwives or neonatal psychologist." (115)*

*"All families are offered contact from our bereavement midwives and our specialist bereavement nursing team. All families are offered follow up for surviving infants with their named consultant, and bereavement follow up (usually joint with obstetric colleagues) for babies that die. We have access to a trained psychologist on the unit who works with families." (007)*

*"Specialist bereavement midwives will support the family around the death of a baby. Parents will be offered bereavement follow-up appointment 6 weeks after the death of a baby with neonatal consultant and obstetrician. The bereavement team will*

*arrange the appointment date according to the convenience of parents. This meeting will take place in a quiet bereavement office with appropriate seating arrangements and facility for coffee for parents. If parents prefer to meet at a different location, the team will try their best to accommodate parents' preference. The specialist bereavement midwife will always be present at these follow-up meeting. The senior clinicians will discuss and update on details of antenatal, delivery, neonatal care provided, investigation results including post-mortem findings (if parents consented), complications and outcome. All parents' questions will be answered. Parents wellbeing is checked and where further referral is required, appropriate arrangements will be made. If required, a further bereavement follow-up appointment will be made. If the post-mortem report is not available at the time of 1st bereavement follow-up appointment, further appointment will be made on receiving post-mortem report." (038)*

Many respondents also described the option to refer families to bereavement counselling through the baby loss charity 'Petals', or families and/or women with foetal loss to local bereavement services/charities such as Our Angels, Taking Baby Steps, SANDS, Teddy's wish, or Jannah's Children. Chaplains were also described often as sources of support. A few respondents additionally mentioned also having access to a Birth Reflections or Birth Revisited team (007, 019) where women could discuss their birth experience. A description of the referral to Petals service is below, as is a list of types of therapy available in one local area:

*"All families who sadly go through the loss of a baby or have an adverse outcome on the Neonatal Unit are given our PALS information leaflet if they wish and they are offered bereavement counselling through PETALS which is an online service run by trained counsellors. A staff member needs to refer them and this service is offered to both parents. Additionally, we also have the Maternity Trauma Loss Service which supports women after the loss of a baby or traumatic birth. They usually accept referrals from six weeks post-delivery and also provide support in subsequent pregnancies." (004)*

*"We can also refer to maternal mental health who offer a range to treatments for PTSD including EDMR (Eye Movement Desensitisation and Reprocessing), CBT, talking therapy and peer support from other bereaved parents. The bereavement counsellor who specialises in baby loss also attends the trust once per month to see and assess families." (062)*

The duration of support was not always clear in responses but ranged from about a month through to in perpetuity.

*"Our Bereavement Midwife offers continuity of care post-delivery and will see the family in the hospital and provide postnatal care for 28 days. We also have a named Neonatal Bereavement Nurse to help support staff and families on our neonatal unit.*

*"Neonatal family support nurse will maintain contact with the parents for the 1st year following the death of the baby. Throughout this time she directs parents to the different support organisations and supports with the PMRT process. She supports families with funeral arrangements and viewings of the baby until the funeral is held." (077)*

*“Maternity bereavement team will continue to support bereaved families for however long they are needed. They will never discharge completely, and the parents will always have access to the bereavement phone for easy contact details. The bereavement team provide the families with details of all local and national charities” (086)*

Regarding future pregnancies, respondents widely reported that support for future pregnancies was available through referral to a specialist clinic for families who have experienced baby loss, often called a ‘Rainbow clinic’. Where Rainbow clinics were not available, some trusts suggested being able to provide perinatal mental health team access (see for example 057). Another trust described their local specialist mental health midwives undertaking joint antenatal clinics with obstetricians which focused on provided care planning and support for parents who had lost a baby (see for example 095). Where no additional services were available, trusts relied on strong working relationships between maternity and neonatal teams to provide appropriate support to families during future pregnancies (see for example 076).

*“The Neonatal Unit have strong links with the perinatal mental health midwifery services and share information such as mental health plans of perspective neonatal mothers to inform the supportive plan of care made for current and future pregnancies” (076)*

## Medical records

Most respondents described recording neonatal deaths in on-site maternal electronic medical records and 46 specifically mentioned using the online medical record tool called BadgerNet (see [data collection and use of data](#)). Most trusts described either actively sending or sharing information to local health systems, via a letter or notification from the electronic discharge system to the GP, local health visitors, and/or community midwives. But others described placing electronic alerts or physical stickers on medical records. There were no clear descriptions of how the other parent’s record was updated to enable sensitive discussions the event in future pregnancies – the maternal record was the only source mentioned. Descriptions of the letters to the GP did not specify whether they cited both parents or only the birthing parent. One trust highlighted that local interoperability meant that other local hospitals could access electronic medical records. But this same trust did not mention whether GPs or other health providers (not on Cerner EPR) were notified.

*“This information is detailed in the patient records in the structured notes and highlighted in the medical history but there is not a specific field where this is recorded. Now that all [local] hospitals have transitioned to the Cerner electronic patient record this will support with improved access to previous clinical notes and discharge summaries to ensure this information is visible and available on the maternal record when they access services at other hospitals.” (115)*

As mentioned, 37 trusts described using stickers, symbols, flags or alerts in forms of teardrops, rainbows, or doves to highlight bereavement. Stickers were sometimes

described as used on paper notes or in the electronic patient record (see the quotes below). Some trusts also described stickers as located on BadgerNet (in addition to or instead of the trust's own medical record).

*“The SANDS teardrop sticker is also added in electronic form to the Maternity electronic record. Therefore, the Community Midwife will be made aware prior to undertaking the initial booking of a subsequent pregnancy.” (102)*

*“If a woman or childbearing person has a stillbirth a SANDS teardrop is put on the paper records for all to see. The current maternity electronic system does not have the facility to do this though it may be possible in K2 version 6.1. As this is a symbol it would not pull through to any interface that goes to Badger net the NNU system.” (002)*

Trusts using Cerner EPR described the transition from a physical sticker to an electronic alert, and suggested the alert or flag was obvious:

*“Before the recent implementation of the Trust's EPR (Cerner), the booking midwife would usually place a SANDS sticker on the notes with the year of loss so health professionals are aware the patient has suffered a loss. They then would also document in the handheld notes prompting professionals to check the patient's notes to familiarise themselves with the history instead of them having to ask the patient. Following the implementation of Cerner, an alert is put on the system at the time of booking by the booking midwife stating that this patient has had a previous neonatal death. This alert would then appear every time a member of staff accesses the patient's record.” (009)*

*“Cerner has the facility to add a ‘flag’ to the patient's record. This flag appears next to the patient's name so it is very obvious when you open the record. The ‘flag’ function is used when a woman or birthing person has experienced a neonatal death and includes information such as the date the death occurred, gestation and cause of death if known.” (025)*

The challenge with stickers and notes in medical records, as noted by some respondents, was that staff needed to check records before an appointment: *“As long as notes were accessed prior to seeking a history then the information of a previous neonatal death would be conveyed” (023).*

## **Nuffield Trust reflections**

Overall, a wide range of bereavement support services were described as available across trusts with common services including a bereavement midwife, PMRT review with consultants, referrals to Petals where needed, and referral to a Rainbow clinic for future pregnancies. Respondents did not discuss the adequacy of these services in their responses.

# Learning and making improvements

This section provides a description of what improvements could be made to the safety of babies in neonatal units. These responses are reported at the respondent level. This section is drawn from questions 41, 42 and 44.

## Questions asked of trusts

41. Do you have any suggestions about the way management and governance structures might be improved? This is not a request for a general review of structures, but rather of those structures that affect neonatal care.

42. Do you have any reflections on the issue of whether and how senior managers should be regulated?

44. What lessons has the trust learned, if any and/or what changes has the trust put in place, and when, if any, in particular in relation to neonatal perinatal services, since 19 October 2022?

## Context for this section

- There are nine regulators covering 32 professions in health and social care including the General Medical Council, Nursing and Midwifery Council and Health and Care Professions Council (HCPC).<sup>146</sup> Key functions performed by regulators include setting standards of ethics and competence, checking the quality of education and training courses, maintaining a public register of professionals and investigating complaints.
- The Fit and Proper Person Test (FPPT)<sup>147</sup> requires NHS trusts to check that all executive and non-executive directors (or equivalent) roles are suitable and fit to do the role.<sup>148</sup>
- In 2019, the Kark review recommended a series of actions to strengthen the FPPT.<sup>149</sup>

<sup>146</sup> Lewis Pickett (29 September 2017) 'Professional regulation in health and social care'

<https://researchbriefings.files.parliament.uk/documents/CBP-8094/CBP-8094.pdf>

<sup>147</sup> Care Quality Commission (2023) 'Regulation 5: Fit and proper persons: directors'

<https://www.cqc.org.uk/guidance-providers/regulations/regulation-5-fit-proper-persons-directors>

<sup>148</sup> NHS Employers (2021) 'Fit and proper person regulation (FPPR) <https://www.nhsemployers.org/articles/fit-and-proper-person-regulation-fppr#:~:text=The%20regulation%20requires%20NHS%20trusts.fit%20to%20do%20the%20role.>

<sup>149</sup> Department of Health and Social Care (2019) 'Kark review of the fit and proper persons test'

<https://www.gov.uk/government/publications/kark-review-of-the-fit-and-proper-persons-test>

- In response to the Kark review, NHS England developed a Fit and Proper Person Test (FPPT) Framework to improve the implementation of the FPPT.<sup>150</sup>
- The Seven Principles of Public Life ('Nolan' principles) include seven standards which are expected from people who hold public office roles.<sup>151</sup>
- The Messenger Review (2022) examined leadership in health and identified seven recommendations to strengthen leadership and management.<sup>152</sup>
- There are no consistent requirements for people who become managers in the NHS (whether clinical or non-clinical). The support and training which is provided varies between individual trusts. However, the NHS Graduate Management Training Scheme exists for graduates wanting to pursue a career as a manager in healthcare.<sup>153</sup>

## Suggestions for improvements to management and governance structures

Trusts provided a range of answers relating to improving management and governance structures. Some related to the specific structures and processes in their own trust, while others commented more broadly on wider governance processes surrounding neonatal services. Additionally, some of the themes described below were also touched upon in the sections titled ['Factors inhibiting and encouraging raising concerns'](#) and ['Factors inhibiting managers from acting on concerns'](#).

Several respondents indicated that they considered their own internal processes to be “robust” or “fit for purpose,” and noted that they were regularly reviewed to take account of any developments. However, several respondents also reported that while they had no specific suggestions, they had a willingness to learn, would welcome suggestions and were responsive to wider policy changes. Some respondents described specific reviews that they had been involved in previously which had recommended changes with regards to management and governance, and which they were implementing (see [External reviews of trust culture and neonatal services](#)).

While there were several suggestions for improving structures, some respondents highlighted that it was the implementation, or culture around these processes that was important and not the structures themselves.

*“I think what is crucial is the culture and the behaviours of people within the governance and management structures. Management and governance structures can only be robust and safe if there is an open, just and listening culture in the people operating in them.” (021)*

<sup>150</sup> NHS England (20 March 2024) 'NHS England fit and proper person test framework for board members' <https://www.england.nhs.uk/publication/nhs-england-fit-and-proper-person-test-framework-for-board-members/>

<sup>151</sup> Committee on Standards in Public Life (31 May 1995) 'The Seven Principles of Public Life' <https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--2>

<sup>152</sup> Department of Health and Social Care (8 June 2022) 'Health and social care review: leadership for a collaborative and inclusive future' <https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future>

<sup>153</sup> NHS Graduate Management Training Scheme (no date) <https://graduates.nhs.uk/>

Related to this, some respondents noted the importance of training, education, and support for senior leaders (050), as well as ensuring that senior leaders were visible, present and engaged in what is happening within the neonatal service (069). Some specifically noted the need to support a just and learning culture within which wider governance arrangements sit (103, 007). Several respondents referred to implementing the Patient Safety Incident Response Framework, although this was in relation to the trust as a whole and not just neonatal services.

*“Formal governance structures must also be supported by less formal listening and soft intelligence gathering and the Maternity Safety Champion roles are key to this but all senior leaders who manage neonates within their portfolio should spend time in the unit and be a face that staff can recognise.” (069)*

*“Consistent emphasis on psychological safety, just culture and compassionate leadership is vital as is role modelling by senior leadership. I think all managers should be mandated to be trained all three concepts.” (103)*

*“A culture of openness, listening and curiosity is paramount however and would have a greater impact than changing governance or management structures...” (007)*

*“A strong model of leadership encompassing professional and operational leadership working together in a team structure with clear objectives, solid information flows which are shared across all elements of service delivery and quality of care is essential. The principles of being clinically led and operationally supported should be inherent within the team dynamics.” (050)*

Some respondents described how the wider context could make implementing desired improvements challenging. One trust noted that there were financial, and other capacity constraints within NICU which could limit the effectiveness of these processes:

*“Doctor leaders often feel they would like more Programmed Activities dedicated to their leadership roles, citing some other Trusts. The time and resource commitment required, the sometimes high turnover of managers (esp. at less experienced levels) and vacancies/ unfilled management posts, means that support for the neonatal service to make changes and improvements is sometimes more limited in capacity than the Division and department would ideally wish for. There is a risk that limited managerial capacity can slow down the implementation of change...” (049)*

Where respondents did provide suggestions for improvements, many related to streamlining and standardising processes. Some respondents noted that neonatal services were subject to assurance requirements from several organisations, which required different submissions at different times. Respondents noted this could cause confusion, complexity and duplication, and distract from overall ambitions to improve services. Some noted that there needed to be greater clarity of the roles of different governance structures and better integration between them, particularly at a local level. Some commented on specific local initiatives they were involved in related to this (see for example 112).

*“The current governance arrangements in place, scrutinising maternity and neonatal services, are multiple and result in many external agencies demanding*

*assurance in multiple forums. These multiple agencies contain huge experience and expertise, but this capacity is aimed at receiving assurance rather than transforming/improving services.” (024)*

*“Integrating local and network governance would reduce the need to report to multiple services.” (102)*

*“From a central/ national perspective, the plethora of overlapping and duplicative national and local regulatory bodies and processes that cover neonatal care and the wider perinatal pathway could be rationalized. I can see this process is beginning to happen (e.g. MNSI and HSIB) but this should be accelerated, so that waste can be reduced and cost savings delivered, with resources redirected to the front line. This would also enable Trusts to spend more time improving processes and care delivery, rather than ‘feeding the beast’ through often duplicative submissions to multiple different regulatory bodies. From a local perspective, we are undertaking a piece of work to try to streamline our operational reporting processes, building a new set of Directorate digital dashboards which will enable better monitoring of performance and proactive identification of issues before them become risks using leading indicators, enabling intervention to fix problems rather than being reactive.” (112)*

*“Across the system, a range of forums – including LMNS, Neonatal Networks and ICB/ICS all operate across maternity and neonatal services. As part of the developing maturity of the ICS/ICB, we would like further clarification around the role of these networks and how they fit together. Nationally, support could be provided to enable this.” (117)*

*“I consider that having the operational and governance of both maternity and neonatal services aligned is essential in managing the services effectively. Oversight and assurance to external bodies is also essential however this needs to be simplified. For example, neonatal mortality is quantified and benchmarked in many ways. The national and region measure is to use the NNAP data. This compares the neonatal mortality of a particular unit against the national and regional average. As the only level 3-unit surgical unit in [the area], [the hospital] neonatal mortality will always be an outlier. The more useful comparator is with another neonatal level 3 surgical unit such as [another hospital].” (017A)*

*“I do have a concern that the current volume of data and reporting required in maternity services and presented to trust boards may make it difficult for the wood to be seen for the trees. It can feel that assurance is being conflated with receipt of large volumes of data as distinct from intelligence and insight, and that some of the key national drivers on maternity service quality are not being addressed. In particular, the ability to develop training and workplace cultures which have obstetricians and midwives working closely together supported by neonatal colleagues from early stages in training.” (040)*

*“Across all NHS services, there may also be a place for considering the burden of external reporting, and whether this can be lessened for providers without any diminution in the quality of care for service users.” (030)*

This was also referred to by several respondents in relation to the processes for investigating deaths. One respondent noted that *“the PMRT [Perinatal Mortality Review Tool] process should be taken out of the hands of local teams”* (091).

A few respondents also referred to the role of the medical examiner in investigating neonatal deaths, suggesting that they should be involved in all neonatal deaths (069). See the section on [Reviewing evidence after a death](#) for further discussion.

*“I think that there could be greater clarity around the role and responsibility of the LMNS and how it interacts with the individual neonatal units and Trusts in general. I also think that the multiple processes to review perinatal and neonatal deaths when they occur (for example CDOP, PMRT, incident investigation processes) which work well individually, can cause additional distress and confusion for families if not joined up...”* (115)

*“I think including neonatal deaths in the independent ME process would be helpful. However, we would have to train MEs in the scrutiny of neonatal deaths as most are from an adult medicine background. Access to high quality, benchmarked, timely data and the ability to look at trends over a period of time.”* (082)

Some respondents also referred to the relationship between the neonatal unit and other clinical areas, such as maternity and paediatrics both within the trust and the wider system, and a range of views were provided with regards to this. As outlined in [Structures for management and governance](#), how neonatal services are configured in relation to other clinical services varies between trusts (for example whether it is part of maternity/ paediatrics). Regardless of these structures, respondents described the importance of collaborative working between these divisions.

Some respondents referred to a *“perinatal”* model which emphasised continuity between these services and indicated that this was a more desirable approach for patients. As such, respondents indicated that this should be reflected in wider governance structures, and some had already adopted this approach within their own trust.

*“A move towards a perinatal model would provide clarity on internal and external management and governance structures. Streamlining this structure would provide more efficient processes and expedite feedback.”* (054)

*“The combination of neonatal services with maternity services in a unified Perinatal Division is a recent structural change. The aim is a more focused approach in neonatal governance and case reviews across maternity and neonate services being more streamlined.”* (113)

*“I think increasing oversight of neonatal activity as part of our overall maternity oversight would improve some of the governance processes and general oversight of this critical area. Given the significant national focus on maternity over the last few years there is a challenge in potentially crowding out neonatal work which is something we are conscious of and need to ensure does not happen and actually rebalance the focus to have more discussion on neonatal activity.”* (078)

*“We do not have any concerns however on a positive note the Trust has recently restructured the divisional structure creating a Women’s, Children’s and Young*

*People Division which will provide direct communication to the Executive Team.” (047)*

*“Inclusion of the Neonatal Clinical Lead within the Maternity and Perinatal Directorate Leadership team and amendments to the governance structure to ensure a clear line of reporting from the Neonatal unit and board. These should be in place in all Trusts.” (116)*

*“Nationally in the NHS there are a lot of disjointed initiatives between Maternity and Neonatal Care that require individual focus rather than focus on the whole Mother and Baby. The national Women’s Health Strategy goes some way to addressing this and the 3 Year Maternity and Neonatal Transformation Plans. There needs to be more cohesion at national level on setting strategic direction for governance and assurance on these services. Reviews are often conducted in isolation.” (017)*

*“Neonatal care interfaces with maternity and with paediatrics. It is therefore important that there is clarity on the governance processes for both clinical care and management of staff. This is more important in Trusts where staff rotate between or work across paediatric and neonatal services, rather than in units where a defined group of staff only work within neonatal services. Developing more neonatal metrics for inclusion on quality dashboards, together with improving visibility of those that are already included e.g., NNAP data to Trust Boards would improve governance and oversight (for example, metrics and performance indicators used for adult services are not applicable to neonatal units or indeed to paediatric care).” (030)*

However, some respondents noted that the disadvantage of this was that it could mean governance processes were duplicated. They also noted that neonatal units need to have their own profile to ensure they do not get lost within other services. One respondent noted that while they did not think this was the case in their own trust, there was a perception that neonatal services were less well integrated or understood in comparison to adult services, and the wider running of the hospital. A couple of trusts however stated the opposite and noted:

*“clear delineation and interrelationships between service delivery (maternity and neonatal) and associate governance structures” (036) and the need for*

*“dedicated operational and governance support for Neonates - currently shared with Maternity” (054).*

A few also referred to ensuring that neonatal services are visible at board level:

*“In my experience Neonatal services, which tend to be small and discrete, can often be overshadowed by either Maternity Services, Children’s Services, or both. On a very simple level, disentangling small-volume discreet Neonatal data from the myriad Maternity and Children’s data has been difficult and onerous...” (055)*

*“In my opinion the profile of neonatal services should receive parity of esteem with maternity. This is likely to improve as the maternity neonatal improvement programme has been launched.” (097)*

*“An annual slot for the NNU team, at the board to present their issues.” (032A)*

Some respondents also reflected on the relationship between neonatal and maternity services in the local governance system, with some seeing this as a positive while again also recognising the importance of aligning different processes.

*“The transfer of Neonatal governance at a system level into the same forum as maternity governance, as part of the Local Maternity and Neonatal Systems, is providing huge benefit in ensuring continuity of care. HSIB, now MNSI, has provided a very helpful level of oversight into neonatal and maternity clinical incidents and the appropriate level of review of these cases... The delegation of commissioning responsibility for Specialist Commissioning which is due to take place imminently must ensure a harmonisation of processes for Neonatal, Maternity and Gynaecology commissioning processes.” (084)*

One respondent noted that the role of the Operational Delivery Network could be strengthened:

*“That ODN playing a greater role, and having more levers, in determining how neonatal care is best delivered is an opportunity... It, alongside its peers, could also be given a greater voice nationally in policy and resource allocation decisions. Neonatal ODNs could also become a formalised and recognised route for speaking up regarding neonatal care concerns outside of a specific organisation’s boundaries; whilst still ensuring the escalation process involves subject matter experts and feels ‘safe’ to those raising concerns.” (069)*

One respondent referred to the need to consider “interdependencies” between hospital-based care and the wider system, and the consequences for funding models:

*“The focus on maternity services has been helpful in so much as funding followed acknowledgment of poor staffing or weak governance structures. However, by viewing hospital based maternity systems alone risks the wider interdependencies, such as socio-economic factor influencing choice and health inequalities (which is then seen in variable outcomes as measured at hospital levels), and the perinatal outcomes/ care pathways becoming more vulnerable. It would be important moving forward to be more focused on the interdependencies, the elements pre and post of the service in question and to ensure the increased funding to one aspect is not at the expense of another. The later is important as this is not the case currently with fixed budgets and a regulatory focus on increased funding at one point will lead to inevitable cuts to other services.” (083)*

As discussed elsewhere in this report (See [Culture](#) and [Working Relationships](#)), leadership was noted as integral to ensuring safety and governance. Some respondents reflected on specific roles they had put in place, or changes they had made to strengthen governance arrangements, both within clinical divisions and overall trust leadership in their own organisation, as well as further improvements that could be made.

*“Improvements have been made following the external review [such as] inclusion of the Neonatal Clinical Lead within the Maternity and Perinatal Directorate Leadership team.” (096)*

*“There is now a senior sister role to support governance in neonatology.” (015)*

Other suggestions for improvements raised by respondents included:

- More timely reporting of National Neonatal Audit Programme (NNAP) data (029)
- Mentorship for leaders (025)
- Collaboration and involvement with families/ more family representation in neonatal governance processes (039)
- Support and education for neonatal staff (118)
- Ensuring corporate services support neonatal staff (for example IT/ procurement) (118)
- Splitting SCBU and paediatrics in local governance discussions (019)
- Board considering a standalone report on quality, safety and performance within neonatal services, as well as maternity (094)
- Develop a National Child mortality database and align with National Making Data Count Programme, resolve delays at CDOP, develop a national job plan for the CDOP designated Neonatal Consultant with recommended PA allocation (113)
- Split neonatal consultant rota to ensure compliance with BAPM guidelines and provide continuity of care (011)
- Appointing a neonatal governance post (002) (Note that this was something that (056) has done)
- Adopting a peer review process for neonatal units (016)

## Changes to neonatal and perinatal services

Trusts provided several examples of changes and ‘lessons learned’ with regards to neonatal and perinatal services. It was not always clear whether these were a specific response to the Lucy Letby case, or previous investigations (whether inside the trust or outside), or changes that were being made anyway. Similarly, it was not clear whether all of the changes described had taken place in the timeframe provided. There was some overlap between the responses trusts provided here, and elsewhere in the questionnaire (See for example [Working Relationships](#), [Trust Policies](#) and [Suggestions for Improvements to management and governance structures](#)).

Several trusts provided detailed descriptions of the work they were doing and which covered multiple themes (see for example, 073). This included trusts who had been the subject of prior reviews into maternity services. Some trusts reflected that they adopted an approach of “continuous learning and improvement” sometimes as part of longer-term programmes of work, or in response to feedback.

*“We are a large University Trust with an active research and training profile. We are continually learning from incidents. Alongside this we continue to undertake work to improve culture and colleague experience of working in maternity & neonatal units through externally supported programmes of work; and to further improve workforce recruitment and retention. More generally as a Trust, we have also reviewed our Freedom to Speak Up Service and are now using an external independent Guardian Service. All of the above was already in train and was not specifically undertaken as a result of the Lucy Letby case.” (077)*

*“...we aim to be a learning organisation and have a continuous improvement strategy which follows a lean methodology and provides training and coaching to support staff to learn and make improvements at all levels.” (119)*

*“Staff in the neonatal unit were obviously very distressed to hear the outcome and the narratives from the Lucy Letby trial and it did cause us all to stop and think regarding our own services. There have not been any changes to how we manage our neonatal service specific to the Lucy Letby case but as illustrated in answer to this questionnaire, both the neonatal and maternity service are continually developing in response to feedback from both staff and patients/families. This has included participation in a Perinatal leadership course by neonatal and maternity leadership team (clinical and non-clinical), strengthening of the midwifery leadership, ensuring regular maternity (and neonatal) reports to the Trust Quality & Performance Board Committee, work to improve our facilities in both the neonatal unit and maternity and consideration as to whether neonatal services might be better managed together with women’s services as a directorate.” (069)*

*“The Trust has put in place a series of changes since October 2022. It is important to note that this was not because of lessons learned but rather by way of building on and continuing developments that were underway prior to that date. By way of example, there are daily Trust safety huddles led by Executives and attended by colleagues representing all aspects of the Trust’s business. This enables any areas of concern to be identified and addressed quickly. Listening events have been held with colleagues in the Women and Children’s department to enable issues/concerns to be discussed in an open and safe space and to provide an opportunity to reiterate the Trust’s ‘safety first’ position. There is excellent engagement ‘from ward to Board’, backed by robust Board assurance processes and a very clear and strong accountability framework. There is good triangulation between the members of the Executive team responsible for the various aspects of the business who meet monthly. Clinical and operational leads meet with the Executive bi-monthly to report on compliance with KPIs and be scored across a number of domains. In terms of individual performance, any colleague about which three or more concerns or complaints are made will be reported to the relevant Executive lead.” (065)*

## **Lessons learned**

Some trusts provided reflections on lessons they had learned. These are summarised in Table 31.

The most common theme raised was the importance of culture, with trusts also mentioning the importance of working relationships, effective processes for identifying and raising concerns, and review processes. A few trusts provided examples of recent incidents and how they had responded to them to illustrate how they had put in place previous learning or recommendations (see for example 099 and 101).

## **Actions**

Examples of actions which trusts described in their responses are provided in Table 32. These actions broadly fell within the following categories: reviewing and adapting policies

and processes for raising concerns, incidents and deaths; enhancing governance and oversight; improving culture and raising awareness of routes for raising concerns; providing support to staff, parents and families and improving family involvement in processes; additional investment/ changes in staffing, new roles and changes to service design and improving how data is used and reported and increasing visibility at board level, and implementing recommendations from previous trust and NHS reviews.

Some trusts also described specific actions undertaken following the Lucy Letby case such as board level discussions or reviewing and amending policies (See [Review of trust policies](#) for further information). One trust had conducted a review of insulin storage and dispensing although concluded that greater security would be disproportionate (041).

Table 31: Examples of 'lessons learned' provided by trusts (in response to Question 44)

Theme	Example
Culture	<p data-bbox="521 312 1865 411"><i>“The key lesson learned for us is that we need to continue to challenge ourselves and our behaviour to ensure we are creating the right environments for the right discussions and how we are enabling an organisational wide culture of openness.” (103)</i></p> <p data-bbox="521 443 1865 647"><i>“The Lucy Letby incident has definitely highlighted the need to promote the FTSU service and has provoked significant reflection as to how would we, as a large Trust, assure ourselves that a similar issue would not happen here. Whilst it is difficult to completely mitigate, promoting a strong, open culture through compassionate leadership is key to allowing staff at all levels to feel comfortable raising concerns and importantly feeling that the concerns raised will be listened to and acted upon where appropriate.” (106)</i></p> <p data-bbox="521 679 1865 1225"><i>“External events have reemphasised the importance of culture and creating the environment where staff know how to speak up if they have concerns, that they feel safe to do that and that they are listened to with action. This is not just applicable to Neonatal services and applies at all tiers of any organisations structure not just between the board and the frontline staff. The NHS has a structure (FTSU) because the patient safety culture is not endemic at all tiers. The involvement and response to patients/families when their concerns are raised is also critically important and has received additional focus in the trust. Events such as those at the Countess of Chester, Martha’s law, the Kirkup report amongst others re iterate how important this is and structures need to be in place, resourced/prioritised appropriately to respond to concerns identified by both staff and patients/families. There is a continual balance between competing pressures of operational delivery, quality and finance amongst constraints in the NHS of workforce gaps and what feels like an inability to invest in services to maintain and improve standards of care in line with societal expectations and demands. The pressures of continual operational delivery and financial balance/waste reduction can take precedence over the quality and safety agenda including response to complaints/concerns raised by service users. I feel there needs to be a reflection on the focus of NHSE and the influence this has on the wider NHS resulting in the “work as done” across the country. How does the “as designed” NHS safety culture thrive?” (056A)</i></p> <p data-bbox="521 1257 1865 1393"><i>“It is important to view safety through different lens and by different people to avoid a single point of failure. Multi-disciplinary relationships are crucial. A culture of openness, challenges and scrutiny is essential. External scrutiny should be welcomed. The learning from maternity incidents should be applied across many other services. Empowered and engaged staff make a difference.” (056B)</i></p>

	<p><i>“All trusts nationally have been shocked by the unfortunate events which have occurred. Our response has been proportionate, and in keeping with the associated challenges colleagues in maternity services have been through with Ockenden and Kirkup in recent years. The main learnings, which are shared at a regional and national level, are the importance of cultural development and shared accountability between both Exec, Non-Exec and Quadrumvirate members leading Neonatal services. Ensuring that there is an open and trusting culture is critical to managing risk appropriately.” (084)</i></p> <p><i>“a) The importance of actively demonstrating attitudes and behaviours to encourage a culture of openness and transparency, listening and taking action when concerns are raised. b) Since August 2023 - the importance of regular meetings of the Executive Triumvirate (Chief Operating Officer, Chief Medical Officer and Chief Nurse) to share soft intelligence. To conduct regular walk arounds in all areas (much easier in a smaller hospital) to gather intelligence from all grades of staff and encourage open discussion. c) Ensure governance processes are actively followed and actively maintained. d) Review of HR data in relation to staff concerns and triangulation of data between HR, Chief Medical and Chief Nursing Officers. e) The role of Safety Champions within both the Maternity and Neonatal Services. f) The importance of recognizing similar concerns could happen in any service across the organization and are not limited to Neonatal Services.” (036)</i></p> <p><i>“The Trust has reinforced the need for all colleagues to retain professional curiosity, within a just and learning culture. Unusual patterns in care should be flagged, openly questioned and considered – this was the learning in the Shipman enquiry and also in the post Letby analysis.” (040)</i></p>
Working relationships	<p><i>“The Trust has learned the importance of integration between maternity and neonatal services, and so has brought them together into a newly formed “Perinatal Division” with joint divisional leadership.” (113)</i></p> <p><i>“...although the details of the Lucy Letby crimes have only been made available through media and formal court verdicts, lessons that we have already considered have been the importance of the relationship between different healthcare professionals. Safety of babies requires doctors, midwives and nurses to work collaboratively so that if there ever is another sophisticated murderer in another neonatal unit, or potentially any other part of the health service, that relationships do not impede professional inquiry and timely action. This needs to start with Trust leaders like myself demonstrating the importance of this through demonstrating this working relationship with their immediate peers and through intervening to support any professional, whatever their background, where these relationships break down. This also means that all health care professionals need to recognise the risks associated with being siloed in their own professional space.” (091)</i></p>

Governance and process for raising concerns	<p><i>“Ensure we have sight of any concerns, ensure there is transparency, act early and seek advice when unsure. Provided board assurance with what we are following and lessons learnt.” (075)</i></p> <p><i>“The Letby case has been a reminder of the importance of ensuring clinical governance is effective and robust.” (118)</i></p>
Use of data and reviews	<p><i>“Lessons learned: importance of mortality review and identifying any pattern of death. To be aware of unexpected death of a stable baby, occurrence pattern and robust investigation including parent and staff involvement.” (038)</i></p> <p><i>“The importance of mortality data at department / diagnosis level. The importance of objective structured scrutiny of unexplained mortality.” (060)</i></p> <p><i>“The retaining of rotas of post graduate students who undertake the Qualified in Specialty (QIS) training. That all accidental extubations must be incident reported, ensuring that the team have line of sight on trends, issues with equipment, processes etc. (in place since 2020). Extreme preterm pathway - only experienced QIS nurses look after extreme preterm babies in the first 72hrs of life (in place since October 2021). Swipe access added to the pharmacy room – (implemented in December 2019 (new unit opened March 2020 and this practice was retained)). For Serious Incidents consideration is given who was involved in the incidents and are there any names that repeated and if necessary, rotas are checked (in place since 2018 and aligned to the Trust’s Fair and Just approach). Two consultants to agree cause of death for death certificates (implemented in 2019).” (017)</i></p>

Table 32: Actions described by trusts

Theme	Examples of actions
<p>Reviewing and adapting policies and processes for raising concerns, incidents and deaths</p>	<p>Implementing the PSIRF (for example, 027, 034)</p> <p><i>“In the light of Letby, we have taken action and have now ensured that all neonatal and child deaths are being reviewed through the Trust’s robust Medical Examiner service.” (094)</i></p> <p><i>“The InPhase system has been implemented incorporating incidents, complaints, risk and audit review within one data base that managers and staff have access to. The new patient safety incident review framework (PSIRF) is currently being rolled out across services.” (027)</i></p> <p><i>“We have updated our Mortality policy to place emphasis on an immediate route for escalation for deaths where there are immediate safety concerns.” (088)</i></p> <p><i>“In Q4 2022/2023 the neonatal service introduced a quarterly report to supplement the neonatal death review process and supplement the previous process of rapid review, detailed notes review, and further case review using the perinatal mortality review tool. Learning from the Q1 2023 report highlighted learning that was fed back to [...]. A review of the perinatal mortality review tool process including the parents involvement in the process was undertaken in May 2023 to strengthen the process of review and clearly define responsibilities for the reporting and management of the process. This process is now enacted on a weekly basis and attended by neonatal leads to ensure rigorous review and oversight of all cases of neonatal loss. This is supplemented by the quarterly review of all cases of neonatal loss and identification of lessons learnt.” (076)</i></p>
<p>Enhancing governance and oversight</p>	<p><i>“We established the Maternity and Neonatal Committee in 2023, bringing together neonatal with maternity services into the same reporting, oversight and governance structure in recognition of the benefits of so doing. This committee is chaired and led by our Chief Nursing Officer, with our Board level champion (a clinical non-executive director) as vice-chair.” (105)</i></p> <p><i>“Whilst not directly in response to the Issues at the Countess of Chester Hospital, the trust has put the following changes in place which the team feel offer better leadership and oversight of the care group - The appointment of an Associate Director of Nursing for Children and Young People has brought expertise to the service. Along with that, there is increased scrutiny, more challenge and increased direct involvement with the care group. - There has been reinvigoration of the Professional Leader’s Forum which has increased discussion, challenge and engagement. - The appointment of a Clinical Director for Children and Young People has signalled the importance of such services to the trust and</i></p>

	<p><i>has improved morale a little within the teams. - The development of a neonatal dashboard with the Business Intelligence team will bring visibility to the service for all staff.” (055)</i></p> <p><i>“The Trust completed a self-assessment of the arrangements in place for staff to raise concerns. This self-assessment reiterated that there are established systems and process in place, and they are effective. In addition, the following further actions were taken:</i></p> <ul style="list-style-type: none"> <li><i>a) We have remodelled the Trusts Freedom to Speak Up (FTSU) policy, based on the model FTSU policy, published by NHSEE June 2022.</i></li> <li><i>b) The Trust has appointed an additional Freedom To Speak Up post, below Board / Associate Director Level, and we have strengthened the systems and processes for reporting and managing any concerns escalated, by creating a single reporting structure and a standardised reporting template to better capture themes and feedback.</i></li> <li><i>c) We have focussed on increasing staff awareness of the FTSU guardian, through increased communications.</i></li> <li><i>d) Implemented Board Safety Champions with regular meetings in place for oversight and monitoring.</i></li> <li><i>e) Worked to further strengthen the good relationship between senior managers and ward / unit staff, by increasing visibility through daily ‘check in’s’ and team listening events.” (110)</i></li> </ul>
<p>Improving culture and raising awareness of routes for raising concerns</p>	<p>Participating in the Perinatal Culture and Leadership programme (for example 025, 095, 079) and SCORE survey (for example 090, 112, 116)</p> <p>Promoting and increasing engagement with the NHS Staff Survey (for example 109, 059) Increased FTSU training and providing a culture where people feel safe to raise concerns (064) Developing values and behaviours (116)</p> <p><i>“There has been a significant amount of awareness raising in general across the organisation and to the Trust Board. The structures before October were already relatively strong in terms of governance.” (007)</i></p> <p><i>“The service has made changes to its training programme to include escalation, human factors and civility.” (095)</i></p> <p><i>“The Trust Board held a board development workshop called “Let’s talk culture” on the [date] to discuss culture within our own organisation.” (003)</i></p>

	<p><i>“The Trust has reinforced the need for all colleagues to retain professional curiosity, within a just and learning culture. Unusual patterns in care should be flagged, openly questioned and considered – this was the learning in the Shipman enquiry and also in the post Letby analysis.” (040)</i></p> <p><i>“There has been a large amount of awareness raising and increased communications led by the CEO to reiterate the importance of raising concerns and for leaders to listen and respond. One of the initial aims in response to the events surrounding this inquiry has been for the Executive to promote completion of the staff survey. We expect to have increased our response rate ...” (109)</i></p> <p><i>“As mentioned previously, no policies have specifically been updated since October 2022. However, there has been a large amount of awareness raising and increased communications led by the CEO to reiterate the importance of raising concerns and for leaders to listen and respond.” (059)</i></p> <p><i>“The planned review of the review of the Freedom to speak up: raising concerns (whistleblowing) policy was delayed to consider the outcomes of the Lucy Letby case. The policy was subsequently ratified in November 2023. The freedom to Speak Up Policy now includes a flow chart at the front of the policy outlining the process for staff to follow when raising a concern. An additional appendix has been included advising managers how to handle concerns with practical tips. Having made these changes the learning is that it is incumbent upon the Trust to consider what further work needs to be taken to encourage staff across all disciplines and specialties to speak up if they have concerns about care and / or witness unacceptable behaviour from colleagues.” (112)</i></p> <p><i>“In my current position it is hard to find a detailed answer to this question my feeling is the national picture has raised the awareness across the whole trust in relation to speaking up and safe practice, this also led to a governance review. We now have 3 FTSU Guardians who are actively out and about in the Trust. The CEO is introducing a executive "Buddy" system that is designed to get the senior managers out there in the organisation to allow issues to be openly discussed. The Culture is shaping to be a very open on under this CEO and hopefully any issues are exposed and addressed in a professional and constructive way.” (012)</i></p> <p><i>“One ED named as culture development lead for the neonatal service.” (073)</i></p>
<p>Providing support to staff, parents and families; improving family</p>	<p><i>“Following the outcome of the Letby court proceedings further steps have been taken to support staff and re-emphasise the multiple ways in which concerns can be raised, either formally, informally or anonymously. Additionally, support has been provided to families who may have felt anxious as a result of information in the media. This is in conjunction with our existing priority to ensure we continue to</i></p>

involvement in processes	<p><i>provide active encouragement and participation of a family in the management of their baby's care.” (090)</i></p> <p><i>“Support to families if concerns raised following Countess of Chester incident.” (070)</i></p> <p><i>“Our Board regularly hears from patients directly, via patient stories. Comprehensive reporting via our governance processes provides a route for formal patient experience reporting with thematic analysis relating to complaints and concerns. Additionally, we have established groups that facilitate interaction between patient groups and specific services, including links with maternity and perinatal groups. These enable the leadership of the Trust to hear directly from service managers and service users.” (117)</i></p> <p><i>“One of the key areas for improvement we have identified is how we involve patients and families in our investigations processes, including incidents, mortality reviews and complaints. This applies Trustwide, but also to neonatal and perinatal services. This is something we are already working on, and in 2022 we implemented an escalation process, including regular meetings chaired by the medical director to discuss and review complex cases and where there are family concerns to better understand these. As I have described elsewhere in this document, our new compassionate engagement process which we will implement as part of PSIRF will help support us to do this even better. We are also working to align the complaints approach and processes with PSIRF starting immediately with more coordinated management of joint SI/complaints cases and fortnightly meetings to review response letters and trouble shoot issues.” (115)</i></p> <p>Involving patients and families in investigations processes (115)</p>
Additional investment/ changes in staffing, new roles and changes to service design	<p><i>“We have put in place additional investment to fund a dedicated Matron post to cover our neonatal provision, and have allocated additional operational management to support Gynaecology and Maternity services to provide support to clinical colleagues.” (084)</i></p> <p><i>“Establishment of Neonatal Risk Management Lead Nurse March 2023. Establishment of Digital neonatal nurse specialist.” (104)</i></p> <p><i>“Appointed more staff and taken active steps to address the shortfall in paediatrics radiology Service - appointed 2 more consultants. Trust had supported neonatal department to increase establishment to ensure aligned with BAPM standards (9th consultant).” (047)</i></p> <p><i>An internal staffing review has taken place (this is not unique to Neonatal department and is part of the Trusts safer staffing review process). This has resulted in a requirement to increase our neonatal staffing. A business case is currently being developed in light of this. (050)</i></p>

	<p><i>There has been a reconfiguration of the workforce to move towards the British Association of Perinatal Medicine (BAPM) standards for nursing and medical staffing, including applying for external funding, which has been successful. (079)</i></p> <p><i>“I am now more conscious than ever that any such re-organisation should not impact on the open and transparent cultures that have evolved over the years. Letby gives us a further lens through which to consider the risks of transformation projects such as NICU re-organisation.” (039)</i></p> <p><i>“As a new women and children's division (2022) we have acted to give neonatal services a stronger identity and voice within the multisite services, with better leadership arrangements and a divisional and organisational focus on perinatal issues rather than maternity and child health. (083)</i></p> <p><i>“One change made, but prior to 19 October 2022, was to create a standalone Care Group for Women’s and Children’s services to ensure sufficient oversight of these services. Previously, these services had been within a much larger Care Group which was also responsible for the running of the [site]. I believe that this led to insufficient attention on these services and, in particular, their culture which has been one of three separate hospitals and not one merged organisation.” (013)</i></p> <p><i>“One main change the Trust initiated was the merge of the Neonatal and Maternity services into the same Directorate in April 2023. Governance pathways and processes were reviewed and aligned in the new Directorate. The neonatal medical leadership team was extended – a new Head of Specialty was appointed in April 2023 along with two neonatal site leads and a dedicated Lead nurse, this improved stability and functionality of the team.” (115)</i></p>
<p>Improving how data is used and reported and increasing visibility at board level</p>	<p><i>“The importance of mortality data at department / diagnosis level. The importance of objective structured scrutiny of unexplained mortality.” (060)</i></p> <p><i>“We have changed the way in which we report to the board of directors on our perinatal mortality data in recognition of the misalignment/ delay in national benchmarking. As a level 2 unit our internal mortality data vs our stabilised and adjusted rate reported by MBRRACE may differ following data triangulation to account for those babies transferred post birth for an increased level of care requirement who subsequently die in another provider. The decision to change the reporting was made in Quarter 2 of 2023 in recognition of the misalignment of internally reported mortality rate (babies who died at the (trust) and the MBRRACE stabilised and adjusted rate (babies who were born and died at the (trust) and Babies who were born at the (trust) but died elsewhere). This is to ensure our data is truly reflective of the mortality rates for the trust ahead of the formalised MBRRACE reporting which is often a year behind. We have also begun to present our mortality figures as a rolling average for internal year to</i></p>

	<p><i>year comparisons, and national benchmarking to ensure we are progressing towards our ambitions to reduce perinatal mortality in line with the national driver to reduce stillbirth/NND by 50%. As a secondary outcome this will allow us to identify any anomalies or outlying values/incidents which are not in keeping with national or local trends/rates to try and give an indication of continued improvement over time not just a snap shot in time.” (087)</i></p> <p><i>“The trust has increased the reporting of perinatal quality indicators to the Board and has established a perinatal quality assurance council. Perinatal information is included in the quarterly maternity/perinatal services reports to Board. Perinatal mortality is included in the Trust wide weekly safety panel.” (074)</i></p> <p><i>“The Letby case serves as a reminder that vigilance around morbidity and mortality in neonatology is of utmost importance. We have added neonatal, infant and childhood mortality to the regular ‘learning from deaths’ paper that goes to our quality and safety committee and to board. We have also had a board presentation on neonatal safety.” (077)</i></p> <p><i>“We also recognise the need to improve how we triangulate data within and across the quality and people domains. We have started work to review the data and soft intelligence we have for each specialty to identify areas which may need enhanced support. Meetings have occurred with our executive medical director and divisional leadership teams to review the current actions underway and identify any gaps or additional support required. Quality review meetings will be triggered for specialties where on-going concerns are confirmed.” (115)</i></p>
<p>Implementing recommendations from previous trust and NHS reviews</p>	<p>Ockenden/ Kirkup/ CQC inspections/ Getting it Right First Time (for example 068)</p> <p><i>“The Ockenden report has provided the Trust with a directive to improve the working relationships between ante, peri- and post-natal services, creating a “quadrumvirate” working management structure between neonatal, obstetric, midwifery and nursing teams. The Trust is working to replicate the quadrumvirate structure from operational through to board level relationships. This can be evidenced through various work streams including the ATAIN and MatNeoSafety working groups.” (107)</i></p> <p><i>“The Trust has initiated a cultural review with an external agency delivering a report with comprehensive recommendations. There is an allocated OD lead to support the NNU to deliver the required changes, which is routinely reported and monitored.” (032)</i></p> <p><i>“The Lucy Letby verdict has been reached in the middle of a maternity transformation programme that includes 210 recommendations from our independent maternity review. Many of the recommendations relate to perinatal services and include recommendations to improve antenatal, intrapartum and</i></p>

	<p><i>postnatal care with particular focus on listening to families and supporting them through often tragic circumstances...” (091)</i></p> <p><i>“We have put place assurance around neonatal simulation training, neonatal life support training and advance neonatal airway skills for doctors, which were highlighted as areas for improvement from the external review.” (033)</i></p>
<p>Actions trusts have taken following the Lucy Letby verdict – see <a href="#">Other actions trusts took in response to the Lucy Letby verdict</a> for further information</p>	<p>Board papers and discussions (for example 021, 069, 022, 002)</p> <p><i>“There has been considerable discussion and review of services post the Lucy Letby case. Discussions have been had with the neonatal network around service changes but these are currently on hold whilst we await further guidance as part of NHS planning.” (078)</i></p> <p><i>“... the Trust and the Trust Board have actively discussed the information available to us as a result of the Letby case, which has been largely limited to that which is in the public domain. A letter was provided to all parents on the SCBU at the time of the verdict providing information as to how concerns could be raised. There were also Executive visits, briefings and listening sessions with SCBU staff as a result of the verdict. Staff were also reminded of the FTSU Guardian role and other pathways for raising concerns within the Trust.” (053)</i></p> <p><input type="checkbox"/></p> <p><i>“The trust undertook a session with the board to discuss the initial issues that the Lucy Letby case highlighted. This included a review of reporting structures, how data is used to review safety and encouraging speaking up. One key lesson is the importance of presenting data in a manner that can be understood by the board and is benchmarked. A deep dive was undertaken to look at all neonatal deaths over the last 2 years to look for any patterns or themes. None were identified.” (098)</i></p> <p><i>“More and open discussion about the Letby case has empowered staff and patients to raise concerns and be more vigilant.” (100)</i></p> <p><i>“We have asked ourselves collectively and individually whether the acts undertaken by Letby could occur within our Trust. We have had open and honest conversations within Executive meetings and with our clinical staff. We have challenged each other and have subjected the SIs we had to detailed internal and external review. We have commissioned external opinion on the SIs and have run through the detail of SIs at Board. We hold a daily Exec huddle and run through the operational and safety events of note from the previous day. We have been heavily investing in our workforce in expanding numbers but also creating the right culture for individuals and the organisation to Thrive.” (001)</i></p> <p><input type="checkbox"/></p>

*Although I am relatively new to the Trust, starting after the conclusion of Lucy Letby's trial, I can evidence the Board has actively responded to the appalling crimes committed at the Countess of Chester Hospital and taken steps to ensure that [the trust] learns all possible lessons and acts in response. The Trust has put in place a number of changes since October 2022 which impact on the neonatal and perinatal services, although are not specific to them. A paper outlining the Trust response to Lucy Letby's conviction was presented and discussed at Public Board in October 2023. Due to changes in leadership, the Trust has undertaken a governance review during this time, including strengthening its risk management and alignment from ward to board. The CEO has introduced an executive buddy to all wards and departments to increase visibility and we have three FTSU guardians who are accessible and out in the organisation. This reflects the changes in culture and openness under the new CEO. These include the updating of key policies including FTSU and strengthened Fit and Proper Persons Test (FPPT) framework in line with national guidance. The Trust introduced a Workplace Culture Group in 2023 which has a specific remit to look at all the soft intelligence around services from different perspectives, as historically these had been held in professional and specialty silos, to improve early detection and intervention when indicated.” (012A)*

*“The Trust Board has discussed the implications of the Letby case at a Private Board meeting. It is introducing a programme to develop Leadership Behaviours. Other than [e]nsuring that policies and procedures are known to all clinical areas in respect of clinical concerns there has not been any specific intervention in Neonates. The Neonatal unit is currently developing a case for expanded consultant staff to enable a split rota with Childrens which will increase capacity in the service.” (045)*

□

*“There have been two briefings to Board on this important subject. There has been a strengthening of the Board Safety Champion arrangements with a Non-Executive Director (NED) who has a Medical background appointed into this role to support oversight. The Board have undertaken a visit to the Neonatal department as part of the Board Visibility and Safety Programme to provide support to staff and opportunity to discuss concerns in light of the Lucy Letby outcome. The Trust have also been strengthening our Freedom to Speak Up arrangements in light of the outcome of this case and this has led to an increased focus and oversight of cases and themes at the Raising Concerns Group.” (097)*

*“Our Trust and Board have reflected on the outcomes from the Lucy Letby case, recognising that complacency has no place in any organisation. Our reflections have to date not resulted in any direct changes to our neonatal perinatal services but a review of the information (and questions answered in this response) support our plans to strengthen our FTSU processes by having a wider network of individuals undertaking this role.” (020)*

*“There has been a significant amount of discussion around the Lucy Letby case and though significant changes have not been identified as needing to be made it has put the raising of and responding to of concerns around neonatal care at the forefront of the minds of all.” (003)*

*“Staff in the neonatal unit were obviously very distressed to hear the outcome and the narratives from the Lucy Letby trial and it did cause us all to stop and think regarding our own services.” (069)*

*“The circumstances behind the need for the Inquiry have provided us with a further lens to look through for improvement, tightening of process, identification of gaps and to hear from staff and patients how this has affected them and their feelings about the service provision at [the hospital]. We have introduced new roles, staffing reviews, strengthened training and opportunities for staff to talk openly or in confidence about how it has affected them and how we can support. It has allowed a specific focus on the needs of the Neonatal Service and we have been able to promote its standing within the larger service to ensure their voice is not lost in the wider provision.” (036B)*

# Regulation of managers

79 trusts provided separate and different responses to this question. Most respondents answered this question based on their own, reflecting on their own careers and experiences. Therefore, where individual responses were provided these typically reflected different responses.

## Overview of responses

Respondents expressed a range of views in relation to the regulation of managers. This included:

- Those who expressed a clear position on regulation (either supportive or not supportive)
- Those who expressed a qualified position (that whether or not they would be supportive would depend on the purpose or how it was done, or that they were unsure whether regulation was necessary considering other things in place)
- Those who expressed a neutral position (neither supportive nor unsupportive)
- Those who stated that they did not have enough information to comment

Table 33 provides examples which illustrate the variation in position expressed by respondents. These points were expressed by both clinical and operational respondents, and we did not observe clear differences between these staff groups in their position.

Table 33: Examples provided by respondents which illustrate the range of positions expressed about regulating managers

Type of response	Examples
Clear position suggesting they were either supportive or not supportive of regulation	<p><u>Supportive</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <i>“I am in favour of regulation of senior managers. It needs to be fair and transparent with the focus on learning lessons and improving performance. Regulation could be used to set the highest standards but offer support and mentoring to achieve these. It needs to be pragmatically and fairly implemented, with credible and transparent management administering it. We need to make senior management in the NHS a more attractive role than it currently is to attract the brightest and best people in our society to want to improve the NHS. Regulation cannot just be a route to target and blame individuals when and if things go wrong (unless serio[u]s misconduct is found).” (027B)</i></li> <li><input type="checkbox"/> <i>“I personally welcome regulation of senior managers and I think it should involve clear records of professional development, external appraisal, performance with a specific focus on openness, transparency and upholding the Nolan principles, as well as personal reflection and development. This will encourage increased professional development of leaders and managers but</i></li> </ul>

*this will add cost to Trust's and the NHS, as will the act of regulation itself." (024B)*

- "It is my view that the regulation of senior managers in the provision of health care (not only NHS but also private provision) would be a very welcome development. The development of a regulatory framework should be a highly considered, well researched and evidence based process. A good regulatory framework should not only give a basis on which to identify and deal with poor or negligent practice, but also to actively promote outstanding, brave and honest leadership, including service innovation. The managerial environment is very different from the clinical environment, and the comparative basis for a regulatory approach to senior managers is unlikely to be best served by starting from the position of adapting a clinical regulatory model; a better route to a starting point may be to look to legal or financial industries as a point of comparison." (053B)*
- "Whilst we are currently aligned with the professional standards code of conduct, I believe that regulation would promote consistency across roles, helping to improve the quality of senior managers, and also provided recognised support for individuals and organisations." (110B)*
- "As Medical Director and responsible officer, I undergo appraisal and revalidation external to the trust as well as an internal appraisal. This could be further strengthened but a similar system could be adopted by for the other executives and NEDS – as this would allow reflection, external review and an understanding as to whether ongoing learning has been in place. It would not only enable scrutiny of the senior managers, but it would be supportive in the development of these complex and challenging roles." (024A)*
- "Yes, there is no reason why senior managers should not be regulated in a similar way to other professional groups including doctors and nurses. However, I would not that both the Medical Director and Chief Nurse are already regulated members of the Trust Board as are the Medical and Nursing members of Divisional and Departmental management triumvirates. Therefore the introduction of regulation for other senior managers may not have the effect that seems to be expected from this introduction of further regulation." (053A)*

*Not supportive*

- "My personal opinion is no, there is no need for this. Overall the issue is more how we reward and treat our managers to ensure that we recruit and retain the best that we can." (116A)*
- "Senior managers who belong to some professions (doctors, nurses, pharmacists, allied health professionals, clinical psychologists, solicitors, and accountants) are already regulated. All senior managers, whether regulated or not, are subject to*

	<p><i>robust Trust policies (including but not limited to: performance, capability, conduct). Therefore non-clinical managers do not need regulation as they act within Trust policies.” (079B)</i></p>
<p>Qualified response – depending on purpose and what it was trying to achieve</p>	<ul style="list-style-type: none"> <li data-bbox="443 427 1350 864">□ <i>“As a senior operational manager, I feel it depends what such registration would seek to achieve and what the requirements would need to be to achieve and maintain registration. Managers aren’t directly involved in hands on patient care and have a wider role of ensuring the mechanisms within the services are appropriate to allow safe care and to support the clinical staff to do that. There is some potential to regulate tangible skills such as resource management, NHS targets and protocols and improvement techniques but it would be difficult to regulate the complimentary skills that are required to support services at a senior level. There are sufficient traditional managerial supervision routes within the organisation, and we are subject to requirements such as mandatory training etc.” (106B)</i></li> <li data-bbox="443 869 1342 1003">□ <i>“As a senior / executive non-clinical manager who has had no regulation in 20+ years of NHS service, I do believe that regulation could be beneficial if done in the right way and aligned to other health professional models.” (016B)</i></li> <li data-bbox="443 1008 1289 1104">□ <i>“It feels there needs to be real clear pathways of careers development within ops like it is in nursing, how this could be regulated is harder to understand or envisage.” (037B)</i></li> <li data-bbox="443 1108 1350 1373">□ <i>“The senior managers I have worked with in my 9 years as a Medical Director have generally been of a very high standard with strong values to provide high quality patient care and an open culture where colleagues feel psychologically safe to raise concerns. I remain to be convinced as to what value regulating senior managers beyond what already exists, such as the fit and proper persons test, will bring forward further meaningful improvement.” (007A)</i></li> <li data-bbox="443 1377 1350 1877">□ <i>“My personal view is that regulation of senior managers is a reasonable thing to put in place, noting that such regulation is already in place for clinical executives who maintain their professional registration. Having said this, I believe it is important to be clear why such regulation is necessary and, in my view, this should not be used as a vehicle to identify scapegoats when things do not turn out as expected. I am not aware of any evidence that supports apportioning blame to individuals solves safety issues and I believe there is evidence to the contrary. Furthermore, if regulation for senior managers is to be introduced, better training and development needs to be put in place for potential senior NHS leaders and more robust selection processes also need to be in place. This also applies to senior leaders who are already regulated by their professional regulator.” (035A)</i></li> <li data-bbox="443 1881 1318 1980">□ <i>“I think that some form of regulation of senior managers should be considered, but I think it would be very difficult in practice given the wide range of backgrounds and roles. Instead I think</i></li> </ul>

	<p><i>the wider and better application of the ‘fit and proper persons’ test might be more effective.” (031B)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <i>“It depends on what this looks like; I think we need to ensure there is management accountability, however there are mechanisms already within organisations which, if applied correctly, should enable monitoring of performance (appraisal, HR processes). A strengthening of these existing mechanisms may be more effective.” (082B)</i></li> <li><input type="checkbox"/> <i>“There seems to be a general consensus that this is required and I don’t disagree providing it is done properly; which will require investment, support, education and training standards and programmes, a funded regulator with resources and the ability to be apolitical. It should be done in a supportive way rather than penal, where senior managers are given time to improve organisations. When a senior leader is expected to influence the culture of an organisation it must be recognised that culture development in itself takes several years.” (069B)</i></li> </ul>
<p>Neutral – did not express a clear preference either way</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> <i>“Senior managers should be provided with specific training and development to support them in their roles. This should be based on core competencies and assessment, reviewed through the annual appraisal process.” (071A)</i></li> <li><input type="checkbox"/> <i>“Training and development for senior managers is important to support them in their work.” (071B)</i></li> <li><input type="checkbox"/> <i>“This is a point of much variance in opinion, and I am not sure where I stand. Though currently non-clinical I do hold Nursing and Midwifery Council Registration and therefore am governed still by a professional body. I cannot see that a regulatory body would have any benefit over a robust internal management system within individual organisations.” (003B)</i></li> <li><input type="checkbox"/> <i>“I do not hold a personal view on this matter but would expect all senior managers to hold high professional values and act in the best interests of the patients that they serve.” (094A)</i></li> <li><input type="checkbox"/> <i>“I think there are many moving parts to providing assurance that senior managers are competent, capable and exhibiting the values we aspire to in the NHS. I am not sure that regulation would add significant value over ensuring robust performance management and creating an open culture NHS wide. Many senior managers have a clinical background and are therefore already regulated.” (019A)</i></li> <li><input type="checkbox"/> <i>“I do not have strong views on this... I believe that it is important that we are able to attract, train and retain the best and the most interested and supportive managers. I am not sure that regulation is the answer and whether a better focus might be looking at how senior managers are developed, supported, trained and incentivised as well as their what might support better interaction with and understanding of clinical services and patient needs.” (115A)</i></li> </ul>

- |  |
|--|
| <input type="checkbox"/> <i>"I do not hold a personal view on this matter but would expect all senior managers to hold high professional values and act in the best interests of the patients that they serve." (094B)</i> |
|--|

Within the range of views provided by respondents, four key themes were identified. These were:

- the purpose of regulation,
- other existing processes in place,
- whether regulation is the appropriate response in the current context, and
- how regulation would work in practice.

As described above, these themes were raised by both medical and operational respondents.

### **Purpose of regulation**

Many respondents reflected on what the purpose of regulation would be. This included those who were supportive, and those who provided a view suggesting that their opinion would depend on what that purpose was. The purpose of regulation fell within three broad categories:

- To ensure accountability and oversight
- To align with the processes already in place for clinical staff
- To standardise roles, and support professional development and training

### **Accountability and ensuring parity with clinical staff**

One purpose of regulation described by respondents was to ensure that managers are held accountable, and to provide parity with clinical staff (who are regulated and held to account through their respective regulators). Responses included:

- *"to provide greater credibility" (078B)*
- *"no reason why senior managers should not be regulated in a similar way to other professional groups" (053A)*
- *"anomaly that there is not a professional regulator for senior managers" (058A)*
- *"reassurance for medical colleagues if managers held responsible in the same way as medics" (078A)*

Some noted that regulation was what the public expect, and that it would improve public confidence. This appeared to both be in terms of accountability, but also by having a consistent set of expectations around skills. However, respondents also reflected that the focus should not be on blaming individuals or *"as a vehicle to identify scapegoats"* (035A).

*"I feel this [regulating managers] would be helpful. A regulated body whereby equal accountability with other registered professionals would benefit the management profession and provide greater assurance of accountability." (020B)*

*“I personally believe that regulating senior managers is the right way forward and would bring them into line with clinical colleagues who have to maintain their professional registration. It is important that senior managers are supported to learn and develop which I don’t believe happens in every organisation. Managers are often overlooked when it comes to development and study leave, but regulation would hopefully ensure that senior leaders are given access to solid training in key leadership areas which will support them to do what are often very difficult role.” (035B)*

*“I am in favour of regulation of senior managers. It needs to be fair and transparent with the focus on learning lessons and improving performance. Regulation could be used to set the highest standards but offer support and mentoring to achieve these. It needs to be pragmatically and fairly implemented, with credible and transparent management administering it. We need to make senior management in the NHS a more attractive role than it currently is to attract the brightest and best people in our society to want to improve the NHS. Regulation cannot just be a route to target and blame individuals when and if things go wrong (unless serious misconduct is found).” (027B)*

*“Whilst we are currently aligned with the professional standards code of conduct, I believe that regulation would promote consistency across roles, helping to improve the quality of senior managers, and also provided recognised support for individuals and organisations.” (110B)*

*“As a senior manager within the NHS who has a background in Nursing and has therefore felt the benefit of reporting through to a regulatory body, I would very much support the regulation of senior managers. This would create parity with the clinical teams within the NHS and provide assurance to the public and our governing bodies that there is some consistency in skills and competencies for those staff working at a senior level in management.” (091B)*

## **Professionalisation, learning and development**

A common theme raised by many respondents related to professional development. Some respondents reflected on the lack of training and development opportunities for managers (especially ‘middle managers’), the lack of a clear career pathway, and the need to ensure that staff feel respected and valued. Some considered that a desirable purpose of regulation would therefore be to support a more consistent approach to skills, training and development for managerial roles.

*“I strongly believe that the case for regulation has been made more than once and that the managerial contribution to the NHS would be given greater value by a regulated adherence to a code of practice which gives the service to our patients’ primacy, acknowledges constraints, establishes responsibilities to work collaboratively with colleagues of all disciplines and which enables challenge by expecting us to actively empower teams.” (026B)*

*“The Messenger report resonated with general managers in the NHS. They are an undervalued resource who are motivated by public service, score very highly on altruism and carry a high degree of risk working in complex reactive systems for relatively small recompense. There is little, if any, structured training, and the span*

*of control is often so large that meaningful oversight can be difficult. Added into this is the almost daily distraction of operation issues often working in a reactive and crisis management mode and the difficulty of the job is amplified. This is a classic human factors issue.” (003A)*

*“Managerial regulation should be implemented positively, focused on personal development and career progression, and not based on a negative perception of regulation. The framework for regulation must carefully consider how it also avoids pushing highly skilled clinical leaders from positions of senior management. Processes should be in place to aid and support clinicians entering these roles rather than pushing them away from them, which will in turn impact on the imperative of being a clinically led organisation.” (084B)*

*“It would be unhelpful if this were to be seen as a punitive step, however, some form of regulation would support assurance for the public that managers have been quality assessed. I believe it would be helpful to establish a professional body of NHS management and to ensure managerial staff are regulated against an agreed framework. I believe this would help us also in being protected by a body and supported with training and frameworks that would put more realistic expectations in place and encourage management as a career path.” (108B)*

*“It is worth noting, however, that senior operational managers – both for a service such as neonates, and generally, are not required to follow any core training programme, acquire qualifications or meet formal registration requirements to provide evidence that they can meet the standards expected of their role.” (043A)*

As part of this, some respondents reflected that recruiting and retaining non-clinical managers in the NHS was a challenge, and that having a clearer career pathway could support with this. However, not all respondents considered that regulating managers was the way to achieve this. Some also reflected that ‘regulation’ would also not achieve the purpose of supporting professional development.

*“I would not characterize the ‘lack of regulation’ inferred from the question as a problem. This is a highly skilled, trained and dedicated bunch of people who are often making the active choice to receive a much lower salary than comparable roles in the private sector, in order to serve in the NHS. Furthermore, there is always a risk that if you over-regulate this space then the NHS will become more siloed, preventing managers from outside the NHS, with relevant skills, to enter the service and add value due to access to senior management positions becoming a ‘closed shop.’ (112A)*

*“Formalising regulation for NHS managers would likely create barriers to entry, add additional administration and may not confer increased accountability. It would also likely reduce the diversity of background of those within the NHS leadership... it is a personal view that there are already significant consequences for senior managers, including the risk of criminal charges, for decision making. There is certainly scope for agreeing codes of conduct or charters of behaviour and responsibilities. However substantial processes are already in place to hold colleagues accountable for their actions – we should strengthen their use rather than introduce new ones.” (113A)*

*“I believe that it is important that we are able to attract, train and retain the best and the most interested and supportive managers. I am not sure that regulation is the answer and whether a better focus might be looking at how senior managers are developed, supported, trained and incentivised as well as their what might support better interaction with and understanding of clinical services and patient needs. Linking managers with the quality and safety outcomes of their units and holding whole teams accountable for these might have a greater impact and be more supportive.” (115A)*

*“I am unsure as to whether regulation would allow future health service managers to be better equipped with the tools and behaviours that allow the running of complex organisations. Over regulation risks removal of the diversity of thought and experience that (in my experience) add to the management talent within the NHS.” (063A)*

### **Other processes already in place**

Many respondents reported that a lot of senior managers are already regulated by other bodies, and/or are subject to other processes which hold them to account. This included:

- Their own professional or clinical regulatory bodies such as finance or HR
- Fit and Proper Person test (several including 118, 076)
- Code of Conduct for NHS managers and employees (092)
- Nolan principles (110)
- CQC
- Contracts of employment
- Trusts' own processes for identifying and addressing concerns about individuals (090)

As such, some respondents were unclear what regulation for managers would add. Of those who referred to other processes, several referred to the Fit and Proper Person Test, and a few indicated this could be strengthened further (for example by not only applying it to board-level positions). Some respondents said that trusts have a responsibility to ensure that their own internal processes and cultures are robust enough to ensure that concerns are identified and individuals are held to account for their actions.

*“When applied correctly the fit and proper persons test is an important safeguard. All organisations have policies that support management of poor performance and conduct that should be used to address poor practice.” (034A – JR)*

*“Regulation is a very blunt and expensive instrument for applying safety principles. When you already have at least one regulated nurse/midwife and a doctor on a trust board, it's unclear what regulating the chief operating officer or chief executive would achieve. I think a clear and perhaps more prominent national framework for the fit and proper person test would be helpful.” (091A)*

### **Whether regulation is an appropriate response in the current context**

Despite the discussion outlined above, some respondents – even those who were supportive of regulation, in principle – were unsure whether it was the appropriate solution. This was particularly the case if it was assumed that the purpose was to improve patient

safety. A few were concerned that this could lead to ‘over-regulation’ and bureaucracy, with a small number also noting that regulation would be costly and not an appropriate use of public money.

Several respondents referred to the Lucy Letby case in their response and indicated that – based on their knowledge and understanding of the case – regulation would not have resolved or prevented the issues, and that many of the individuals involved were already subject to regulation by their own professional bodies. A few responses solely commented on the fact that they did not believe regulation would have affected the situation in the case, without providing further views on the subject as a whole. Some referred to other cases (such as Shipman), or more general reflections that other professions (such as doctors) are already regulated and that does not prevent issues occurring.

Some indicated that there was a concern that the conversation was being driven by a desire to have someone to blame. Words used to describe this included “red herring” (060B), “a distraction” (105A) and “reactionary” (038A).

*“As CMO I am a doctor first and therefore already regulated. Regulation does not automatically lead to a high quality of practice, whether in the clinical or managerial sphere. I don’t believe formal regulation of senior managers would lead to a better or safer standard in the running of a hospital. If a senior manager is not performing, their tenure tends to be short-lived anyway.” (001A)*

*“I am generally positive in relation to regulating managers, but I think it’s the wrong conversation in relation to this case. The reason it’s being called for in relation to this case is as far as I can see is to create an ability to have a manager ‘struck off’ rather than simply sacked... It’s related to punishment rather than learning and improvement and the fact that its being called for in relation to this case undermines all the evidence we have about the importance of a no blame culture. I don’t think that regulation would have meant that the managers behaved differently.” (060A)*

*“Nobody should be absolved from accountability when evidence of serious misconduct is discovered amongst any member of NHS staff, but we know that most clinical staff are regulated, and serious misconduct still occurs on a regular basis. This leads me to believe that simply introducing a more robust regulatory framework for managers won’t in and of itself prevent these terrible events from happening again. As such I do not think regulation per se is the answer. Rather, the money spent on introducing what is likely to be a highly bureaucratic regulatory system, would be better spent on investment in NHS managers (both clinical and non- clinical). Additionally, more needs to be done to shift from a blame culture in the NHS which incentivizes a lack of transparency and buck passing, to one of openness and responsiveness. This would encourage more to speak up and raise concerns.” (095B)*

*“I think we need to consider what the problem is that requires a solution before jumping to the conclusion that regulation is the answer. If the question is – would having regulated senior managers stopped what happened at the Countess, then I would suggest the answer is no, as many of the senior team were already regulated. If the question is – would the regulation of non-clinical senior managers, as well as clinical (already regulated) senior managers, bring about a culture of greater accountability and stop individuals being passed round the system, then yes, it would*

*be of benefit. However that solution would require more than the regulation of senior managers to be introduced.” (095A)*

Several respondents considered that instead, the focus should be strengthening existing processes and ensuring that there is a culture in which people can raise concerns. This included the importance of fostering a good culture, leadership, training and development. Some noted that regulation (if driven by a desire to punish individuals), was counter-productive to the wider efforts to adopt a just and learning culture in the NHS.

*“We would reflect that there is already extensive regulation within the NHS and some would see it as over-regulated. The launch of the patient safety incident response framework seeks to address this in some respects and focus on improvement, learning and support of patients families and staff. We would reflect that this maybe a more constructive approach for the future than additional regulation of managers.” (061A – JR)*

*“A system that develops an open culture whilst also ensuring boards can achieve assurance would seem crucial to me. A system with visible leadership embedded within, where anyone can speak up and be listened to.” (080A)*

*“I worry that an over-reaction to introduce additional significant layers of regulation will be a distraction from where the real focus should be, which is on ensuring good multi-professional team-working, consistent clinical leadership and a culture of respect, civility, openness and transparency across a Trust, and in all clinical areas.” (105A)*

*“Reactionary regulation may not add value at present. The focus should be on appropriate open, no blame culture which fosters learning, appropriate and encouraged implementation of PSIRF.” (038A)*

*“Guidelines, recommendations and regulation cannot compensate for a poor culture and a poor culture cannot be corrected by them, so leadership training is to me the most essential basis of all of this.” (036A)*

*“My personal view is that regulation of managers alone will not help to prevent a disaster. Training standards and standardisation would be helpful, especially for middle managers who tend to be the forgotten layer and are the senior managers of the future... More emphasis on organisational development and cultural change, ensuring that all levels of seniority are included is needed.” (027A)*

*“Many managers are already regulated by their professional body – in fact those managers who were perhaps most culpable in the LL case were regulated by the GMC and NMC. The same has been true of previous serious quality and safety incidents in the NHS. I think regulation risks adding a layer of bureaucracy when what is needed is training, development, a good appraisal system and a supportive culture to work in.” (082A)*

*“I think that some form of regulation of senior managers should be considered, but I think it would be very difficult in practice given the wide range of backgrounds and roles. Instead I think the wider and better application of the ‘fit and proper persons’ test might be more effective.” (031B)*

*“In terms of reflections, I can see both the pro’s and con’s of regulating senior managers. However, it depends on what issue is trying to be addressed. Greater use of the existing performance management rules should be deployed first line if its competence and capability that is to be addressed.” (010B)*

*“... more regulation may not necessarily lead to fewer bad things happening - but it is vital we do something to maintain the highest standards in hospital managers. NHS directors must meet the fit and proper person test, including an assessment of senior managers’ qualifications, competence, skills, and experience that are considered necessary for their position. However, it is equally important that we improve the accountability of NHS managers. We need to create a culture of openness, honest and blameless discussion of mistakes (or near mistakes) or errors in handling of incidents. We need fair and transparent accountability of individual and group actions and that would be much more promising for higher levels of care quality, better management of healthcare services, and preventing incidents affecting patients and staff...” (040B)*

One respondent did however note that the opposite could also be the case, for instance if it is dependent on the culture of individual organisations there is likely to be variation and therefore less of a standardised approach to accountability for managers (106). A small number of respondents pointed to other issues, such as recruitment within trusts, and education, addressing more structural issues rather than just focusing on regulation.

*“Before any instant measures re regulation are introduced there are many steps to be considered beforehand. Starting point is the recruitment process at Trust and local levels. Policies do not always provide opportunity to advertise externally for posts above a certain level eg Band 8a which can result in recycling of “problem” individuals and a restriction in accessing new talent. This lends itself to the thought it is easier to get someone in rather from within even though there may be concerns than go out externally, as it saves time in filling the post. Reference policies which only ask for minimal information i.e name of individual; confirmation of tenure and nothing more in terms of performance must be made to be more robust and subject to a national template.” (112A)*

*“I think that professionalising medical and other leadership has not been considered when medical education has been designed. As a result, people fall into it ad hoc from lots of different routes and are prepared to varying degrees. The medical profession culturally also needs to respect leadership roles (medical and otherwise). There is still a “them and us” narrative. It needs to be said that if doctors don’t choose to be part of leadership, then someone else will have to take on that role. I would like to see the term “manager/management” replaced with “leader/leadership” as this is really what “very senior manager” roles are – they are not purely a technical role, but a leadership role. It demeans what senior managers are in the NHS.” (055A)*

### **How regulation might work in practice**

Respondents commented on issues relating to how regulation would work in practice, and in some cases their view on regulation depended on how it was implemented. This included how to define roles and skillsets, who would be covered (and how to define a ‘senior manager’), how to consider the particular context or aspects of managers’ roles, the interaction with other processes and the potential for dual regulation.

*“Given that senior management deals a lot with making difficult and finely balanced decisions based on risk, difficult to see how a regulator would deal with these issues. Moreover, management and leadership involves learning from mistakes.” (076A)*

*“Thus any adverse judgements of NHS managers’ actions made by regulators – with reputational and professional consequences - would need to take into account the context in which they were made including local and national directions or influence that the manager in question may be under.” (015A – JR)*

*“It is my view that the regulation of senior managers in the provision of health care (not only NHS but also private provision) would be a very welcome development. The development of a regulatory framework should be a highly considered, well researched and evidence-based process. A good regulatory framework should not only give a basis on which to identify and deal with poor or negligent practice, but also to actively promote outstanding, brave and honest leadership, including service innovation. The managerial environment is very different from the clinical environment, and the comparative basis for a regulatory approach to senior managers is unlikely to be best served by starting from the position of adapting a clinical regulatory model; a better route to a starting point may be to look to legal or financial industries as a point of comparison.” (053B)*

*“I believe there should be regulation of senior managers. This needs to carefully involve senior managers and their unions in design of it and to be well thought through. It should not be rushed. It will be slightly different to regulation of other healthcare professionals given the indirect impacts that senior managers can have, and it will need to encompass different elements of leadership. Many senior managers are already regulated as they [are] also in clinical roles and how this will work will need to be considered to avoid dual regulation.” (007B)*

*“There seems to be a general consensus that this is required and I don’t disagree providing it is done properly; which will require investment, support, education and training standards and programmes, a funded regulator with resources and the ability to be apolitical. It should be done in a supportive way rather than penal, where senior managers are given time to improve organisations... Thought and clear definition should be given to what levels of management this applies, how it relates to those from clinical and non-clinical backgrounds and how it relates to substantially clinical or non-clinical senior manager roles...” (069B)*

## **Nuffield Trust reflections**

The question of whether or not NHS managers should be regulated is not a new issue and has been the subject of debate for several years. It has also been raised in the context of other reviews and inquiries such as the Kark review of the Fit and Proper Person Test, which recommended improvements to strengthen the test in relation to the recruitment of NHS directors.<sup>154</sup> The Messenger review into NHS leadership and management also

<sup>154</sup> Department of Health and Social Care (2019) ‘Kark review of the fit and proper persons test’ <https://www.gov.uk/government/publications/kark-review-of-the-fit-and-proper-persons-test>

recommended – amongst other things - consistent management standards delivered through accredited training, a simplified appraisal system and creating a new career and talent management function for managers.<sup>155</sup>

Consistent issues which arise in these debates include the effectiveness of existing processes, how to ensure accountability without apportioning blame, and providing consistency with other regulated professions. This variety of perspectives was reflected in trusts' responses to the questionnaire, with trusts providing a range of perspectives on the purpose of regulation, whether it would improve accountability and whether it would support greater consistency and professional development for senior managers in the NHS.

There is currently a limited evidence base on the impact of regulating managers in the NHS, with much of what has been published opinion pieces or commentary. A recent study by the Health Foundation did however note that regardless of positions on regulation, greater consistency was desirable in relation to personality-led management (that which is contingent on the personality, style, interests and preferences of the individual) and training and development.<sup>156</sup>

## Additional references

- Smith and Chambers (2011) 'Mid Staffordshire Public Inquiry Seminar on the development and training of trust leaders - 18 October 2011 The regulation and development of NHS managers: a discussion paper'  
[https://pure.manchester.ac.uk/ws/portalfiles/portal/33714114/FULL\\_TEXT.PDF](https://pure.manchester.ac.uk/ws/portalfiles/portal/33714114/FULL_TEXT.PDF)

<sup>155</sup> Department of Health and Social Care (2022) 'Leadership for a collaborative and inclusive future'  
<https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future/leadership-for-a-collaborative-and-inclusive-future#findings>

<sup>156</sup> Jones, Horton and Home (2022) 'Strengthening NHS management and leadership: Priorities for reform'  
<https://www.health.org.uk/publications/long-reads/strengthening-nhs-management-and-leadership> .

# Further information for the inquiry provided by trusts

This section summarises information that trusts provided regarding further information for the inquiry. It is drawn from question 43 in the questionnaire.

## Question asked of trusts

43. Are there any other matters which you consider are relevant to the Terms of Reference, and which would be of assistance to the Inquiry. If so, please set these out in the section marked “further information”?

94/120 trusts either provided no response to Question 43 or reported that they had nothing further to add. Some referred to answers given in other parts of the survey, or signposted to their response to Questions 41 and 44.

In 26/120 trusts, at least one respondent provided further comments.

Trusts provided responses on the wider NHS context such as the use of data, staffing and culture which reflected other parts of the questionnaire (see 054, 055, 076, 032, 017, 118, 116, 060 and 084). A few trusts referred to work that they had been involved in or undertaken which they considered may be of interest to the inquiry (038, 081, 067 and 026).

There were 13 comments related to the scope and approach of the inquiry (such as issues to consider or be aware of, individuals to consult or recommendations):

*“I was surprised that although the medical director and a non-clinical senior manager were asked their views, the Chief Nurse was not specifically asked for their views.” (024A)*

*“We support the views of the Royal Statistical Society that have been presented to the Chair of the inquiry in a letter sent 23rd September 2023. This has been discussed at the regional mortality group that the Medical Director attends and we believe very relevant for the enquiry to take into account.” (008A)*

*“Yes, I would strongly suggest looking at what HR processes were used during this time and whether managers had tried to take action but were stymied by these processes. In my view, managers often know who the poor performers are or the ones about which there are concerns but struggle to collect sufficient evidence to act. I would like to see this looked at. I think we also need to look at exactly how we can pick up individuals associated with multiple incidents such as the above given we are supposed to be working in a no blame type environment. Whether this is*

*some kind of database that records individuals involvement in incidents and so can flag early warnings or some mechanism that introduces a pause in an investigation to ask whether there is anything that is possible deliberate. Lastly, I would look at exactly how we are supposed to check for possible criminality: at what point are we supposed to involve the police. Is it as soon as we are asking the possible question or do we need a certain amount of evidence, how does this fit in with a no-blame culture.” (013A)*

*“Recognising the longevity of this process [the inquiry], it would be important to ensure that the Terms of Reference include the ability to minimise hindsight bias in consideration of the facts.” (014A)*

*“It is important that any measures which come forward are proportionate to the level of risk that any trust faces, which is in keeping with appropriate risk management techniques. Ensuring that safeguards are built. A plea would be that any central recommendations that emerge from this enquiry must be accompanied with the appropriate recurrent funding streams if it is recognised there is a deficit in funding, or a need to bring all services to a level not previously commissioned formally. The new NHS funding framework, both for capital and revenue streams, make responding to central directives extremely challenging. CNST [Clinical Negligence Scheme for Trusts] is a very clear example of this, where annual safety standards are released requiring investment to deliver them, but this investment given via the CNST rebate is non-recurrent which incurs a growth in the trusts cost base without any additional funding streams. This must be considered as this brings a clinical risk to all areas of the hospital as we are required to deliver within an ever more constrained cost base.” (084A)*

*“What is not clear from the questions is if the Inquiry yet understands the impact of obstetric care on neonatal outcomes and how this is considered. There are some broad parallels with the Kennedy Inquiry with the interdependency of cardiology and cardiothoracic surgery. In addition, the network of care needed across level 1, 2 and 3 units with the complexity of transfers and appropriate resource also needs to be considered.” (003A)*

*“My only suggestion is to press further on issues around leadership training (of all senior MDT staff) and culture within units and teams. I believe this is likely to prove the most productive avenue of inquiry.” (036A)*

*“Whether involvement of the Safeguarding team was considered early on? Whether anyone considered the Local Authority Designated Officer (LADO) process for managing allegations against staff who work with under 18s?” (085A/B)*

*“The Inquiry may wish to consider including in question 5 the working relationships of other allied health professionals (AHPs) such as pharmacists, physiotherapists and wider members of the MDT who work alongside the doctors, nurses and midwives and have different roles. An example would be the work of pharmacist & pharmacy technicians in terms of both medicines’ optimisation and the safe and secure storage of medicines.” (030A/B)*

*"I am not close to the detail of the sequence of events in the case that has sparked this enquiry but I struggle to understand why the data alone in terms of mortality did not generate significant and prompt review of safety at the highest level in the Trust. The need to speak up and raise concerns is in my experience often more important when the data alone doesn't generate the right attention and yet in this case I don't understand why that alone was not sufficient. Where were the external bodies looking at this data also in this and I believe this should form part of the review." (068B)*

*"No. I would not feel it appropriate to pass opinion until further evidence is known, the Inquiry completed and people have been provided the right to reply." (086A)*

*"Some of the issues arising out of the Letby case around the raising of concerns and building a safety culture within a Trust are similar to those raised within Ockenden, East Kent and Kirkup report, as well as the Patterson report. Therefore, I think that by limiting this Inquiry to neonatal services it is missing the opportunity to think about the systems and processes NHS wide. I also believe that the quality roles within neonatal and maternity services that would support a safety culture have been eroded as the financial climate in the NHS has become increasingly challenged. The scrutiny on perinatal services is complex and this has an impact on the capacity of the governance team, and it is not clear what added value this has in terms of increasing the safety of perinatal services. The tariff for maternity services does not cover what it costs to deliver a baby and this resource has been concentrated on front line services. Correct funding of maternity and neonatal services is imperative." (017A)*

*"Main thing is how decisions were made with regards to concerns being raised? Was it individuals making decisions or as Multi-professional. Did they seek advice externally? Where was the professional curiosity?" (075A)*

# Concluding remarks

This report presents descriptive analysis of responses from 120 NHS trusts which responded to the questionnaire sent to organisations with neonatal units.

We found that responses were completed largely from an organisational perspective, rather than reflecting individual respondents' views. As a result, we have focused on a trust level analysis in the report. We also examined any differences in responses within trusts for selected questions relating to culture, working relationships and regulation of managers.

The responses were free text, based on differing interpretations of the questions (which often had multiple elements), and were completed to varying levels of detail. As a result, while we have quantified responses for a small number of topics, we have primarily summarised themes in the responses, along with presenting example responses. Some respondents provided detailed and clear examples, which we have drawn on to illustrate themes: however, because the level of detail and clarity was variable, it cannot be assumed that other respondents have different views or experiences. Where we have been able to quantify responses we have examined differences between trusts based on level of care provided.

In our analysis we have grouped together responses to questions which have similar themes, but also note that there is overlap between sections (for example, between reporting and managing concerns and complaints, and culture). We also bring together overarching themes, and contextualise our findings within previous Nuffield Trust research.

We have not been able to validate the responses from trusts. More in depth research with trust boards, for example, could provide insights into the topics covered in the report.

# Glossary

<p>Culture</p>	<p>While the term ‘culture’ is used widely in health care, it is also poorly understood.<sup>i,ii</sup> This is due to both the concept being difficult to define academically, and the concept being used as both a remedy and a culprit across healthcare arbitrarily.<sup>iii</sup> Conceptualisations of culture in the NHS tend to come from reports into high-profile patient safety failures.<sup>iii</sup></p> <p>‘Organisational culture’ represents the shared ways of thinking, feeling, and behaving in healthcare organisations and acts as a metaphor for some of the softer, less visible, aspects of health service organisations and how these become manifest in patterns of care. It is <i>“the way things are done around here”</i>, as well the way things are understood, judged, and valued.<sup>iv</sup></p> <p>‘Safety culture’ refers to the way safety is thought about and implemented within an organisation.<sup>v</sup> Patient safety culture, defined as ‘the product of individual and group values, attitudes, perceptions, competencies, and patterns of behaviour that determine the commitment to, and the style and proficiency of, an organisation's health and safety management’, and has been used worldwide to describe healthcare organisations’ commitment to patient safety.<sup>vi</sup></p> <p>Additionally, Waring (2005)<sup>vii</sup> suggests that ‘safety culture’ is driven by a ‘learning culture’ that actively seeks out previous experiences of error in an effort to ensure they do not happen again. This is underpinned by a ‘reporting culture’ where staff routinely document and communicate their experiences of error to enable this learning. Accordingly, it is suggested that high levels of reporting are secured through the creation of a ‘just culture’ that recognises human fallibility but importantly establishes clear expectations of responsibility and does not unfairly or routinely blame or punish those who make mistakes.</p>
<p>Governance</p>	<p>Corporate governance is “the means by which boards lead and direct their organisations so that decision-making is effective, risk is managed and the right outcomes are delivered.”<sup>viii</sup></p> <p>Clinical governance is “a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish”. It involves monitoring systems and processes to provide assurance of</p>

	patient safety and quality of care across the organisation. <sup>ix</sup>
Local Neonatal Unit	Local Neonatal Units are those which provide babies with skilled staff but the ratio of nurses to babies is fewer than in intensive care. It provides care for babies who do not meet the requirements to be provided by an Intensive Care Unit but do meet another set of requirements such as receiving a form of non-invasive respiratory support. <sup>x</sup>
Neonatal Intensive Care Unit	Neonatal Intensive Care Units provide the most unstable/unwell babies and have the greatest needs with relation to staff skills.
Maternity unit / Maternity care	The unit which specialises in care and treatment of women and babies during maternity episodes. A maternity episode is the period of and around labour and delivery of babies and is often where a mother with give birth. <sup>xi xii</sup>
Medical director or chief medical officer	A Medical Director is a member of the board of an NHS organisation with a clinical background. They report to the Chief Executive and along with the Director of Nursing, are the only clinicians on the board. The role was formerly a strictly medical one, but now includes wider managerial duties, and bridges the gap between management and doctors in the NHS. <sup>xiii</sup>
Multidisciplinary team	Teams which draw upon various disciplines or consist of team members with different backgrounds are known as multidisciplinary teams. Bringing together different backgrounds and disciplines aims to more holistic care and better use of resources. <sup>xiv</sup>
Neonatal unit / Neonatal care	A neonatal unit provides care for babies who are born: prematurely, with a medical condition, or develop an illness after birth. <sup>xv</sup> There are different levels of neonatal care as described in the summary of survey responses.
Non-Executive Director	<p>Non-executive directors work alongside the members of the board sharing responsibility for strategy judgements, ensure accountability, and shape culture. They use their skills and personal experience as community members.</p> <p>It is also role which provides expert support and looks “at the organisation’s activities from a health and wellbeing perspective and act as a critical friend”. All NHS organisations have a non-executive wellbeing guardian. They sit in the integrated care boards (ICBs).</p>

NHS Staff Survey	<p>An annual workforce survey conducted each autumn of all staff working for the NHS in England. It collects data on the working lives of NHS staff and provides both a national and regional picture. It aims to assist improving working conditions and allow comparison of regional organisations with the national picture.</p> <p>It has been running every year since 2003. The Survey Coordination Centre at Picker Institute Europe supports NHS England and Staff Survey Advisory Group in its implementation.<sup>xvi</sup></p>
Perinatal	<p>Describes the period surrounding birth, and traditionally includes the time from fetal viability from about 24 weeks of pregnancy up to either seven or 28 days of life.<sup>xvii</sup></p>
Patient advice and liaison (PALS)	<p>PALS is a point of contact for patients, their families and carers. It can provide assistance for health-related questions and help resolve concerns or problems with using the NHS.</p> <p>It also can provide information about the complains procedure, support groups and more general guidance about the NHS.<sup>xviii</sup></p> <p>The service was fully implemented in 2002.</p>
Quadrumvirate	<p>The clinical directors for neonatology and obstetrics, Director, or Head of Midwifery (DoM/HoM) and operational lead.<sup>xix</sup></p>
Safeguarding	<p>NHS defines safeguarding as ‘protecting a citizen’s health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect’. Children and young people, and at-risk adults such as those receiving care or those with learning difficulties are the most in need of protection. All staff have a duty to safeguard children and adults at risk in the NHS.<sup>xx</sup></p> <p>The term ‘safeguarding’ was introduced under Labour in “an attempt to broaden ‘child protection’ to include multi-agency support for families in need, rather than simply concentrating on investigating incidents of abuse once something bad had happened”.<sup>xxi</sup></p>
Special Care Unit	<p>Special Care Units (also called Special Care Baby Units) provides babies who require additional care delivered on the neonatal unit or in a transitional care area with the primary carer resident with the baby.<sup>xxii</sup></p>
Transitional Care	<p>Transitional Care Units assist resident mothers as primary care providers for their babies who have needs in excess of normal care requirements but do not, however, care of a neonatal unit.</p>

	This usually applies to newborns with moderate additional care needs (such as late preterm babies) or older babies transitioning from between a neonatal unit and home. <sup>xxiii</sup>
Triumvirate	A triumvirate is a group of clinical service lines led by a clinical lead, operational lead and a nursing lead. <sup>xxiv</sup>
Trust/ Foundation trust	<p>An NHS Trust are organisations and legal entities set up by the Secretary of State under section 25 of, and Schedule 4 to, the National Health Service Act 2006, to provide goods and services for the purposes of the health service. They are overseen by NHS England.</p> <p>Trusts provide hospital services, community services and/or other aspects of patient care, such as patient transport facilities.<sup>xxv</sup></p> <p>The key difference with an NHS Foundation trust is that they also have a Council of Governors, an elected body which holds the Non-Executive Directors to account.</p>
Whistleblowing	Whistleblowing is the term used when a worker provides information to their employer or a prescribed person relating to wrongdoing. The wrongdoing will usually, though not always, relate to something they have witnessed at work. This is also known as making a disclosure. <sup>xxvi</sup>

<sup>i</sup> Mannion, R., & Davies, H. (2018). Understanding organisational culture for healthcare quality improvement. *BMJ: British Medical Journal (Online)*, 363 doi: <https://doi.org/10.1136/bmj.k4907>

<sup>ii</sup> Mannion, R., Davies, H., and Marshall, M. (2005). *Cultures for performance in health care*. Open University Press. <https://www.york.ac.uk/che/publications/books/cultures/>

<sup>iii</sup> Machen, S. (2021). *Assuring medication safety from board to ward – the role of governance and local cultures*. UCL PhD thesis. Available at UCL Explore.

<sup>iv</sup> Mannion, R., & Davies, H. (2018). Understanding organisational culture for healthcare quality improvement. *BMJ: British Medical Journal (Online)*, 363 doi: <https://doi.org/10.1136/bmj.k4907>

<sup>v</sup> The Health Foundation. 2011. *Measuring Safety Culture*. Accessed 12 Feb 2024 <https://www.health.org.uk/publications/measuring-safety-culture>

<sup>vi</sup> Gleeson, L.L., McNamara, J., Donworth, E., Crowley, E.K., Delaney, A., Sahn, L., O'Mahony, D., Russell, N.E. and Byrne, S., 2023. Healthcare provider perceptions of safety culture: A multi-site study using the safety attitudes questionnaire. *Exploratory Research in Clinical and Social Pharmacy*, 9, p.100228. doi: 10.1016/j.rcsop.2023.100228

<sup>vii</sup> Waring, J.J., 2005. Beyond blame: cultural barriers to medical incident reporting. *Social science & medicine*, 60(9), pp.1927-1935. <https://doi.org/10.1016/j.socscimed.2004.08.055>

<sup>viii</sup> NHS England (2022) 'Code of governance for NHS provider trusts' <https://www.england.nhs.uk/publication/code-of-governance-for-nhs-provider-trusts/>

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- ix NHS England (no date) 'Matron's handbook: governance, patient safety and quality' <https://www.england.nhs.uk/mat-transformation/matrons-handbook/governance-patient-safety-and-quality/>
- x NHS England (2024) Neonatal Critical Care Service Specification Neonatal-critical-care-service-specification-March-2024.pdf (england.nhs.uk)
- xi NHS Data Model and Dictionary (no date) Maternity Service [https://www.datadictionary.nhs.uk/nhs\\_business\\_definitions/maternity\\_service.html?hl=maternity](https://www.datadictionary.nhs.uk/nhs_business_definitions/maternity_service.html?hl=maternity)
- xii Ibid. (no date) Maternity Episode. [Maternity Episode \(datadictionary.nhs.uk\)](https://www.datadictionary.nhs.uk/nhs_business_definitions/maternity_episode.html?hl=maternity_episode)
- xiii Good Governance Institute (2017) GGI board insights paper 2: the role of the Medical Director in the NHS. <https://www.good-governance.org.uk/wp-content/uploads/2017/04/The-Role-of-the-Medical-Director-in-the-NHS.pdf>
- xiv Working differently together: Progressing a one workforce approach [PowerPoint Presentation \(hee.nhs.uk\)](#)
- xv NHS England (2024) Neonatal Critical Care Service Specification Neonatal-critical-care-service-specification-March-2024.pdf (england.nhs.uk)
- xvi NHS England (no date) Working together to improve NHS staff experiences | NHS Staff Survey (nhsstaffsurveys.com)
- xvii Perinatal Institute. (no date). Perinatal Mortality Definitions. Available at: <https://www.pi.nhs.uk/pnm/definitions.htm>
- xviii NHS UK (no date) What is PALS (Patient Advice and Liaison Service)? [What is PALS \(Patient Advice and Liaison Service\)? - NHS \(www.nhs.uk\)](#)
- xix NHS Resolution. (2023). Maternity Incentive Scheme – year five. Available at: <https://resolution.nhs.uk/wp-content/uploads/2023/07/MISyear5-update-July-2023.pdf>
- xx NHS England (no date) About NHS England Safeguarding <https://www.england.nhs.uk/safeguarding/about/>
- xxi Copperman, J., & Brown, H. (2021). Managing safeguarding across health and social care. In Leading, Managing, Caring: Understanding Leadership and Management in Health and Social Care (pp. 377-400). Routledge.
- xxii NHS England (2024) Neonatal Critical Care Service Specification Neonatal-critical-care-service-specification-March-2024.pdf (england.nhs.uk)
- xxiii British Association of Perinatal Medicine (2017) Neonatal Transitional Care - A Framework for Practice [https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file\\_asset/file/2472/TC\\_Framework-20.10.17x.pdf](https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/2472/TC_Framework-20.10.17x.pdf)
- xxiv Health Foundation (2022) Strengthening NHS management and leadership: Priorities for reform <https://www.health.org.uk/publications/long-reads/strengthening-nhs-management-and-leadership>
- xxv NHS Data Dictionary [https://www.datadictionary.nhs.uk/nhs\\_business\\_definitions/nhs\\_trust.html#ariaid-title2](https://www.datadictionary.nhs.uk/nhs_business_definitions/nhs_trust.html#ariaid-title2)
- xxvi NHS England. (no date) Whistleblowing. <https://www.hee.nhs.uk/our-work/whistleblowing>

# Appendix 1: The Nuffield Trust team

This research was undertaken by a team from the Nuffield Trust which is an independent health think tank. The Trust aims to improve the quality of health care in the UK by providing evidence-based research and policy analysis and informing and generating debate.

The team was led by Dr Sarah Scobie, Acting Director of Research. Stephenie Kumpunen, Senior Fellow, lead the methodology for the project, and the research and analysis was undertaken by Stephenie Kumpunen, Rachel Hutchings, Fellow, Nadia Crellin, Fellow, and Sarah Scobie.

Additional advice was provided by Thea Stein, Chief Executive, and Mark Dayan, Policy Analyst and Head of Public Affairs.

The research team were supported with data entry by Warren Carl, Administrative Assistant, and Serena Lander, Research and Policy Team Assistant. Serena Lander also provided invaluable support for the final production of the report. The final report was also reviewed by the communications team.

Curriculum Vitae are provided below for the research team.

## Dr Sarah Scobie

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### Present appointment:

Acting Director of Research, The Nuffield Trust (May 2023 to present) and previously Deputy Director of Research (Jan 2018 – April 2023),

Director for the research programme of the Nuffield Trust, which aims to improve the quality of health care by providing evidence-based research and policy analysis and informing and generating debate.

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### Qualifications

MSc Health Economics and Health Policy, University of Birmingham, Sept 2014 – Jan 2017 (Distinction).

PhD, University of Manchester: The geography of psychiatric service use in Salford, involving the analysis of psychiatric case register, socio-demographic and service provision information over space and time. Jan 1987-November 1989.

MA, Human Sciences II, University of Oxford, Oct 1982-June 1985.

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### Previous appointments

Associate Director, Transformation Analytics and Health Economics, South, Central and West Commissioning Support Unit (SCWCSU), April 2013- Jan2019, and at predecessor organisation, Head of Analysis, Avon IM&T Consortium, August 2009 – March 2013

Leading teams working across the south of England, I was responsible specialist analytics services, including service evaluation and quality improvement.

Head of Analysis and Patient Safety Observatory, National Patient Safety Agency, Feb 2005 – July 2009

Analysis of patient safety incident data, and working with national stakeholders to maximise use of diverse information sources on patient safety, for example clinical negligence records, activity, complaints and surveys.

Assistant Director, Healthcare Commission, formerly Commission for Health Improvement, Oct 2000 – Feb 2005

Analysis support for clinical governance reviews and commissioning the national surveys and related studies, including establishing the first NHS staff survey in 2002.

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### Research experience and training

Extensive experience of leading, managing and conducting research, focusing on quality of care and organisation of health services. This includes developing research to use new data sources, measurement of quality of care, development and analysis of surveys in healthcare and synthesising information from a range of sources. I have extensive

experience working in the patient safety field and contributed to the development of the first clinical governance reviews.

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### **Selected publications**

Keeble E, Scobie S, Georghiou T and David M (2023) Deaths at home during the Covid-19 pandemic and implications for patients and service. Research report, Nuffield Trust.

Georghiou T, Spencer J, Scobie S and Raleigh V (2022) The elective care backlog and ethnicity. Research report, Nuffield Trust.

Scobie S. Covid-19: How has the pandemic differed across the four UK nations? *BMJ* 2022; 377 :o1482 doi:10.1136/bmj.o1482

Reed S, Oung C, Davies J, Dayan M and Scobie S (2021) Integrating health and social care: A comparison of policy and progress across the four countries of the UK Research report, Nuffield Trust.

Sherlaw-Johnson C, Crellin N, Hutchings R, Oung C, Rolewicz L, Kumpunen S and Scobie S (2021) 10 practical lessons for implementing digital innovations - learning from the Care City test bed. Research report, Nuffield Trust.

Scobie S, Castle-Clarke S. Implementing learning health systems in the UK NHS: Policy actions to improve collaboration and transparency and support innovation and better use of analytics. *Learn Health Sys.* 2020; 4:e10209. <https://doi.org/10.1002/lrh2.10209>

Pham JC, Colantuoni E, Dominici F, Shore A, Macrae C, Scobie S, Fletcher M, Cleary K, Goeschel CA, Pronovost PJ, The harm susceptibility model: a method to prioritise risks identified in patient safety reporting systems, *QualSaf Health Care* qshc.2009.035444, 2010 doi:10.1136/qshc.2009.035444

Raleigh V, Cooper J, Bremner S, Scobie S, Patient safety indicators for England from hospital administrative data: case-control analysis and comparison with US data, *BMJ* 2008; 337;a1702. <https://www.bmj.com/content/337/bmj.a1702>

Hogan H, Olsen S, Scobie S, Chapman E, Sachs R, McKee M, Vincent C, Thomson R, What can we learn about patient safety from information sources within an acute hospital- a step on the ladder of integrated risk management? *Quality and Safety in Health Care* 2008;17;209-215.

Scobie S, Thomson R, Building a memory: preventing harm, reducing risks and improving patient safety, The first report of the National Reporting and Learning System and the Patient Safety Observatory, National Patient Safety Agency, 2005.

## Stephanie Kumpunen

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### Present appointment

*Senior Fellow*, Nuffield Trust (December 2018-present) and previously Fellow (Nov 2014 – Dec 2018)

Leading and contributing methods expertise to qualitative and mixed-methods research projects and evaluations across a range of community and primary care policies and services in the UK.

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### Qualifications

PhD (in Applied Health Research), University College London, 2019-2025 (P/T)

MSc in Health Policy, Planning and Financing, London School of Hygiene and Tropical Medicine/London School of Economics, 2010-2011

MSc in Health Promotion, Western University (Canada), 2006-2008

Bachelor of Health Sciences, Western University (Canada), 2002-2006

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### Previous and other appointments

Nov 2013-Nov 2014 Department of Health, NHS Group, *Policy Advisor* (12-month secondment)

Jan 2011-Oct 2013 London School of Economics and Political Science, LSE Health/Personal Social Services Research Unit, *Research Officer*

Feb 2009-Jan 2011 University College London, Institute of Child Health and London South Bank University, Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH), *Research Assistant*

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### Research experience and training

Experience of designing, leading, managing and conducting qualitative research on the organisation of health and care services. This includes developing the research approach, sampling strategies, data collection tools, analytical framework, as well as leading on the execution of fieldwork (including analysis of documents, observations and interviews), varied analysis approaches, and production of outputs (for example, internal advisory notes, book chapters, etc. for varied audiences and purposes). Session lead/tutor on qualitative research methods course at University College London.

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### Relevant publications\*

*\*Studies below have examined large qualitative data sets across a range of research topics OR are publications providing methodological guidance.*

Kumpunen, S., Bridgwood, B., Irving, G., Matthews, J., Amuthalingam, T., and Pettigrew, L.M., 2023. Workplace-based knowledge exchange programmes between academics, policymakers and providers in the health and social care sector: a scoping review and mapping exercise. *Humanities and Social Science Communications*.

<https://doi.org/10.1057/s41599-023-01932-3>

Kumpunen, S., Webb, E., Permanand, G., Zheleznyakov, E., Edwards, N., van Ginneken, E. and Jakab, M., 2022. Transformations in the landscape of primary health care during COVID-19: Themes from the European region. *Health Policy*, 126(5), pp.391-397. <https://doi.org/10.1016/j.healthpol.2021.08.002>

Kumpunen, S. and Vindrola-Padros, C., 2022. Rapid Ethnographies in Organizations: Ensuring rich data and timely findings. *Organizational Ethnography: An Experiential and Practical Guide*. SAGE. <https://doi.org/10.4324/9781003021582-9>

Chisnall, G., Kumpunen, S., and Vindrola-Padros, C. 2022. Rapid qualitative research. *International Encyclopedia of Education 4th Edition*. Edited by Tierney, R., Rizvi, F., Ercikan, K. Blackwells. <https://doi.org/10.1016/B978-0-12-818630-5.11083-8>

Kumpunen, S., Trigg, L., Holder, J. 2019. Helping older people to use quality information to choose residential care. *Journal of Long-Term Care*. (2019), 87–98. <https://doi.org/10.31389/jltc.14>

Bryan, G., Bluebond-Langner, M., Kelly, D., Kumpunen, S., Oulton, K., Gibson, F. 2018. Studying Children's Experiences in Interactions With Clinicians: Identifying Methods Fit for Purpose. *Qualitative Health Research*. 29 (3), 393-403. <https://doi.org/10.1177/1049732318801358>

Gibson, F., Kumpunen, S., Bryan, G., Forbat, L. 2018. Insights from parents of a child with leukaemia and healthcare professionals about sharing illness and treatment information: A qualitative research study. *International Journal of Nursing Studies*. 83, 91-102. <https://doi.org/10.1016/j.ijnurstu.2018.04.008>

Kumpunen, S., Curry, N., Farnworth, M., Rosen, R. 2017 and 2015. Collaboration in general practice: Surveys of GP practice and clinical commissioning groups. Slide pack. Nuffield Trust, Royal College of General Practitioners. [Collaboration in general practice: Surveys of GP practice and clinical commissioning groups | Nuffield Trust](https://www.nuffieldtrust.org.uk/collaboration-in-general-practice-surveys-of-gp-practice-and-clinical-commissioning-groups)

Coast E, Jones E, Hukin E, Kumpunen S. (2013) Inventory report of a systematic mapping of interventions implemented to address cultural factors that affect women's use of skilled maternity care services. Prepared for the World Health Organization. Available upon request.

## Rachel Hutchings

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### Present appointment

Fellow, The Nuffield Trust (March 2022 to present) and previously Researcher (June 2018 – March 2022)

Researcher and policy analyst supporting Nuffield Trust research projects across a wide range of topics aiming to improve the quality of healthcare across the UK.

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### Qualifications

LLM Human Rights, Conflict and Justice, School of Oriental and African Studies, London, Sept 2014 – Sept 2015 (Distinction).

BA, Jurisprudence, University of Oxford, Oct 2010 - June 2013 (2.1).

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### Previous appointments

Policy Officer, Alzheimer's Society, Oct 2016 – May 2018.

Led policy and research for Society's work on mental capacity and mental health law, end of life care and human rights working closely with people affected by dementia.

Information and Legal Support Officer, Compassion in Dying, Dec 2014 - Oct 2016.

Managed public-facing helpline and produced information on complex medical issues for the public; conducted outreach work and policy analysis on ethical issues in health and care.

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### Research experience and training

Several years' experience managing and conducting qualitative research and policy projects. Confident working with methods including interviews, focus groups, surveys, literature reviews and case studies. Knowledge and expertise across a range of healthcare issues such as workforce, prison health and health inequalities.

Training in rapid qualitative research methods (December 2019)

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### Selected publications

Hutchings R (2023) Exploring the national data opt-out rate. Blog, Nuffield Trust

Davies M, Hutchings R and Keeble E (2023) Growing up inside: Understanding the key health care issues for young people in young offenders institutions and prisons. Research report, Nuffield Trust

Davies M, Hutchings R, Keeble E and Schlepper L (2023) Living (and dying) as an older person in prison. Research report, Nuffield Trust

Hutchings R (2023) What does it mean to be an older person in prison? Blog, Nuffield Trust

Hutchings R and Edwards N (2023) Virtual wards: the lessons so far and future priorities. Long read, Nuffield Trust

Hutchings R, Lobont C, Fisher E and Palmer B (2023) Future proof: The impact of parental and caring responsibilities on surgical careers. Research report, Nuffield Trust

Gainsbury S and Hutchings R (2022) Review of the Mayor of London's Health Inequalities Test. Research report, Nuffield Trust

Davies M, Hutchings R and Keeble E (2022) Inequality on the inside: Using hospital data to understand the key health care issues for women in prison. Research report, Nuffield Trust

Scobie S and Hutchings R (2022) End of life care explained: what is it, how is it provided, and what are the challenges? Explainer, Nuffield Trust

Keeble E, Scobie S and Hutchings R (2022) Support at the end of life: The role of hospice services across the UK. Research report, Nuffield Trust

Hutchings R, Scobie S and Edwards N (2021) Fit for the future: What can the NHS learn about digital health care from other European countries? Research report, Nuffield Trust

Davies M, Hutchings R and Keeble E (2021) Injustice? Towards a better understanding of health care access challenges for prisoners. Research report, Nuffield Trust.

Hutchings R and Mitchell P (2021) Questions of fairness: how should the NHS prioritise people waiting for care?

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## Nadia Crellin

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### Present appointment

Fellow, The Nuffield Trust (October 2019 to present)

Working on qualitative and mixed-methods research projects across a wide range of topics aiming to improve the quality of healthcare across the UK. Member of NIHR Rapid Service Evaluation Team (RSET), conducting mixed-methods evaluations of new health and care services and policies.

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### Qualifications

PhD, Division of Psychiatry, University College London. 2011-2015.

MSc Neuropsychology (Distinction), University of Bristol. 2008-2009.

BSc Psychology (First class), Lancaster University. 2005-2008.

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### Previous appointments

Programme manager and research fellow, Jan 2016 – Oct 2019.

Overseeing the running of the RADAR (Research into Antipsychotic Discontinuation and Reduction) programme, a 6-year National Institute for Health Research (NIHR) programme grant.

Trial Manager, Jan 2014 - Jan 2016.

Overseeing the running of the VALID (Valuing Active Life in Dementia) trial, conducted as part of a 5-year National Institute for Health Research (NIHR) programme grant.

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### Research experience and training

Experience leading and conducting research trials and mixed-methods research, and current co-applicant and member of the NIHR funded Rapid Service Evaluation Team (RSET). Experienced with both quantitative and qualitative research methods, including design, sampling, data collection methods (for example interviews, focus groups, surveys), methods of analysis and write-up of a range of outputs.

Training in rapid evaluation, rapid qualitative research and ethnographic methods (January 2021).

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### Selected publications

Fulop NJ, Walton H, Crellin N, Georghiou T, Herlitz L, Litchfield I, Massou E, Sherlaw-Johnson C, Sidhu M, Tomini SM, Vindrola-Padros C, Ellins J, Morris S, Ng PL. A rapid mixed-methods evaluation of remote home monitoring models during the COVID-19 pandemic in England. *Health Soc Care Deliv Res.* 2023 Jul;11(13):1-151. doi: 10.3310/FVQW4410.

Sidhu M, Walton H, Crellin N, Ellins J, Herlitz L, Litchfield I, Massou E, Tomini SM, Vindrola-Padros C, Fulop NJ. Staff experiences of training and delivery of remote home monitoring

services for patients diagnosed with COVID-19 in England: A mixed-methods study. *J Health Serv Res Policy*. 2023 Jul;28(3):171-180. doi: 10.1177/13558196231172586.

Walton H, Crellin NE, Sidhu MS, Sherlaw-Johnson C, Herlitz L, Litchfield I, Georghiou T, Tomini SM, Massou E, Ellins J, Sussex J, Fulop NJ. Undertaking rapid evaluations during the COVID-19 pandemic: Lessons from evaluating COVID-19 remote home monitoring services in England. *Front Sociol*. 2023 Feb 13;8:982946. doi: 10.3389/fsoc.2023.982946.

Walton H, Vindrola-Padros C, Crellin NE, Sidhu MS, Herlitz L, Litchfield I, Ellins J, Ng PL, Massou E, Tomini SM, Fulop NJ. Patients' experiences of, and engagement with, remote home monitoring services for COVID-19 patients: A rapid mixed-methods study. *Health Expectations*. 2022, 25:2386–2404. <https://doi.org/10.1111/hex.13548>.

NIHR RSET (2022) Patient-initiated follow-up: findings from phase 1 of a mixed-methods evaluation. Slide deck report.

Reed S and Crellin N (2022) Patient-initiated follow-up: will it free up capacity in outpatient care? Briefing, NIHR RSET.

Wenborn J, O'Keeffe AG, Mountain G, Moniz-Cook E, King M, Omar RZ, Mundy J, Burgess J, Poland F, Morris S, Pizzo E, Vernooij-Dassen M, Challis D, Michie S, Russell I, Sackley C, Graff M, Swinson T, Crellin N, Hynes S, Stansfeld J, Orrell M. Community Occupational Therapy for people with dementia and family carers (COTiD-UK) versus treatment as usual (Valuing Active Life in Dementia [VALID]) study: A single-blind, randomised controlled trial. *PLoS Med*. 2021 Jan 4;18(1):e1003433. doi: 10.1371/journal.pmed.1003433

Thompson J, Stansfeld JL, Cooper RE, Morant N, Crellin NE, Moncrieff J. Experiences of taking neuroleptic medication and impacts on symptoms, sense of self and agency: a systematic review and thematic synthesis of qualitative data. *Soc Psychiatry Psychiatr Epidemiol*. 2020 Feb;55(2):151-164. doi: 10.1007/s00127-019-01819-2.

Melunsky N, Crellin N, Dudzinski E, Orrell M, Wenborn J, Poland F, Woods B, Charlesworth G. The experience of family carers attending a joint reminiscence group with people with dementia: A thematic analysis. *Dementia*. 2015 Nov;14(6):842-59. doi: 10.1177/1471301213516332.

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## Thea Stein

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**Present appointment:** CEO Nuffield Trust - September 2023 – present day

To lead the Nuffield Trust ensuring that the work we do helps to support best practice and excellence in health and social care across the UK.

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### Qualifications

1997 City University, London, MBA Health Service Management (P/T)

1989 University College, London, London University MSc Dip Clinical Psychology

1986 Oxford University, BA and MA Experimental Psychology

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### Previous and other appointments

*Chief Executive Leeds Community Health Care Trust* October, 2014 – September 2023

*Trustee, Nuffield Trust, 2019 - 2023*

*Board member: Leeds Academic Health Partnership and Leeds Personalised Medicine Boards, 2016 – 2023*

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### Relevant experience

Extensive experience at board level in the NHS and other organisations. Prior to being Chief Exec at Leeds Community Healthcare NHS Trust, Thea was Chief Executive of Carers Trust, Yorkshire Forward and North East Leeds Primary Care Trust. Thea has also held a number of non-executive roles in housing organisations and academia.

## Mark Dayan

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### **Policy Analyst and Head of Public Affairs, Nuffield Trust** February 2019-present

Manage our relations with Government, arms-length bodies and political parties, our planning for this and our response to General Elections

Oversee our responses to consultations, briefings for parliamentary debates and legislation, and advice to Ministers and civil servants

Manage and conduct research on politically relevant topics, especially Brexit, trade policy, and the NHS in Scotland and Northern Ireland

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### **Qualifications**

2012 London School of Economics, MSc Philosophy and Public Policy

2010 University of Oxford, BA Modern History

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### **Previous and other appointments (over last 5 years)**

September 2015-January 2019: Policy and Public Affairs Analyst, Nuffield Trust

Led research projects on the Scottish NHS and international comparisons of the UK health systems, conducted qualitative and quantitative research, carried out communications planning

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### **Research experience and training**

Managing cross-organisational reviews, briefings, and responses, and providing advice to external organisations on health policy.

Drawing up interview schedules, carrying out research interviews, demonstrating adherence to required ethical standards for collecting and storing data through interview, and managing others to deliver these tasks

Working in R and Excel to analyse data on medicines, healthcare workforce, and science funding, and to model the application of the English allocation formula to other countries of the UK

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### **Relevant publications**

Thorlby R, Smith J, Dayan M and Williams S (2014) The Francis Report: one year on. Research report. Nuffield Trust.

Dayan M and Edwards N (2017), Learning from Scotland's NHS. Research report. Nuffield Trust.

Nuffield Trust (2018) Doomed to repeat? Lessons from the history of NHS reform. Essay collection. Nuffield Trust.

Reed S, Oung C, Davies J, Dayan M and Scobie S (2021) Integrating health and social care: A comparison of policy and progress across the four countries of the UK Research report, Nuffield Trust.

Dayan, M., Hervey, T., Fahy, N. view all authors (2023). Parallel, divergent or drifting? Regulating healthcare products in a post-Brexit UK. *Journal of European Public Policy*, 30(11), pp. 2540-2572.

# Appendix 2: Letter of instruction

Nuffield Trust

By email only: [sarah.scobie@nuffieldtrust.org.uk](mailto:sarah.scobie@nuffieldtrust.org.uk)

15 January 2024

Dear Sarah,

## **Thirlwall Inquiry into events at the Countess of Chester Hospital and their Implications Letter of Instruction to Nuffield Trust**

### **Introduction**

I am writing on behalf of the Rt. Hon. Lady Justice Thirlwall, the Chair of the Inquiry, in my capacity as Solicitor to the Inquiry to confirm the instruction of Nuffield Trust to assist with the review and analysis of questionnaire responses received from neonatal units in England.

The Inquiry was established on 19 October 2023 following the convictions on 18 August 2023 of Lucy Letby ('Letby') for offences of murder and offences of attempted murder of babies in the neo-natal unit at the Countess of Chester Hospital between June 2015 and July 2016.

### **Terms of Reference**

As set out in the enclosed Terms of Reference, which can also be accessed here: [Thirlwall Inquiry: terms of reference - GOV.UK \(www.gov.uk\)](#), the Inquiry will investigate three broad areas:

- A. The experiences of the Countess of Chester Hospital and other relevant NHS services, of all the parents of the babies named in the indictment.
- B. The conduct of those working at the Countess of Chester Hospital, including the board, managers, doctors, nurses and midwives with regard to the actions of Lucy Letby while she was employed there as a neonatal nurse and subsequently, including:
  - i. whether suspicions should have been raised earlier, whether Lucy Letby should have been suspended earlier and whether the police and other external bodies should have been informed sooner of suspicions about her;
  - ii. the responses to concerns raised about Lucy Letby from those with management responsibilities within the Trust;
  - iii. whether the trust's culture, management and governance structures and processes contributed to the failure to protect babies from Lucy Letby.
- C. The effectiveness of NHS management and governance structures and processes, external scrutiny and professional regulation in keeping babies in hospital safe and well looked after, whether changes are necessary and, if so, what they should be, including how accountability of senior managers should be strengthened. This section will include a consideration of NHS culture.

## **The Inquiry's Approach**

This is a searching and active Inquiry. For that reason, we are inviting suggestions for recommendations from all participants. One suggestion, from parents, is in the public domain already (the installation of CCTV on neonatal units).

The Inquiry team are working on the basis that many people will be reflecting on the Letby murder convictions and will be reviewing practice in their own organisations already. Some will have ideas for change, some may even have implemented them. These can all be tested in the Inquiry so that recommendations under terms of reference C may be made by Lady Justice Thirlwall as soon as practicable by way of an interim report. Wherever possible the Inquiry seeks to identify and promulgate best practice.

## **Instructions**

In light of the terms of reference the Inquiry has sent a questionnaire to all neo-natal units in England (save for those units which are already engaged with an Inquiry process). The Inquiry is investigating a number of issues, including the nature of working relationships across and between professional groups working on neo-natal units in hospitals; the culture of units and the ability to raise concerns about colleagues; the level and manner of staffing on neo-natal units; safeguarding; what works well and doesn't work well to keep babies safe in hospital and whether there is a correlation between size and level of neo natal unit and any or all of the above. The questionnaires are directed to the Medical Director and a non clinical senior manager with responsibility for the Trust's neonatal services. They have been asked to complete the questionnaires separately.

We would like an expert researcher at Nuffield Trust to compile and present the responses to the questionnaires in a clear and accessible format, identifying and summarising key issues and themes to assist the Chair understand the matters arising from the responses. The lead researcher may be required to give oral evidence to the Chair during the Inquiry's hearings. To the extent that the expert researcher is assisted by other researchers or support staff, this will need to be agreed in advance by the Inquiry and details of those involved set out in the report that is produced.

You may use graphs, charts and other graphics if that will assist the reader. It is important that the report is not overly academic and does not use complex concepts or terminology. When addressing a theme or summarising a particular series of responses, you may quote from particular questionnaire responses or reference an answer provided by a particular Trust. If you consider that there is a particular answer from a particular Trust or a general issue that it may assist the Inquiry to obtain more information about, then you should inform the Inquiry as soon as possible. Please do not wait until you submit your report to identify any such responses.

Although the questionnaires have not been provided anonymously, when producing your report we suggest that you refer to each unit by an internally consistent number and not by name. Please do not use the names of the respondents to the questionnaire. It may assist in the preparation of your report if you refer to the two types of respondent as A and B-so that 1A denotes the Medical Director responding from Trust 1, and 1B denotes the non-clinical senior manager responding from that Trust and so on.

In your presentation and analysis of the data please highlight any significant differences between the responses of A and B, within a Trust, and nationally. Please explain if there is any consistency in the differences? Please also highlight any significant differences between hospitals in the responses (from both A and B) and if the differences between hospitals and between A and B correlate with the size and level of unit? Please note that by significant differences we mean differences of sufficient importance to inform findings in respect of the issues raised by the Terms of Reference.

As far as possible, please explain the likely reasons for the themes, correlations and differences that you identify and where there is a range of possibilities these should all be explained. You should not however make findings of fact based on this analysis, that is the role of the Chair but she will be assisted by your expert analysis and opinion on the issues raised by the responses to the questionnaire.

Your analysis of responses should seek to assist the Inquiry with the above issues and the questions set out below. The **Q.** numbers relate to the Questionnaire, appended.

1. **Q1&2** How similar are the Trust management and governance structures reported across the hospitals surveyed? Where are the differences? Are differences linked to the level of the unit (1-3) and/or any other factor/s?
2. **Q3** What are the structures in place within Trusts for reporting concerns about neo natal services? Are there significant differences in responses between hospitals? Are any concerns expressed about the structures in place?
3. **Q8** What are the different cultures described within Trusts generally and neo natal units specifically? How effective is the culture described likely to be in ensuring the quality of the care of babies?
4. **Q4** Who are Trust boards accountable to? Are there significant differences in responses and the level of external scrutiny?
5. **Q5&6** How effective are the working relationships between doctors and managers (clinical and non-clinical) reported to be? What is the range of responses between the respondents in A and B to this question, and what are the likely explanations for the differences?
6. **Q5&6** How effective are working relationships between nurses, midwives and managers said to be?, what is the range of responses between the respondents in A and B. and what are the likely explanations for the differences?
7. **Q5&6** How effective are working relationships said to be between medical professionals (doctors, nurses, midwives and neonatal practitioners) and managers, what is the range of responses between the respondents in A and B and what are the likely explanations for the differences?
8. **Q7** How many Trusts have been referred to or involved in external reviews in respect of culture at the Trust and what are the reasons given?
9. **Q9** What are the levels of parent/guardian involvement in neo natal care? Is there a significant variation in responses?
10. Please compile and present the responses to **Q10-19** regarding the raising of and actions in response to complaints, drawing attention to variations in responses, the reported adequacy of the processes and procedures described for raising concerns and how effective they are considered to be.
11. **Q20** What are the variations in response regarding numbers of Child Death Overview Panels, are there any given or apparent explanations for the variations (for example due to Trust size)?
12. **Q22** Please compile and present information provided about medical examiners. How effective are they described to be in assessing cause of death in neo-nates?
13. **Q23,24,25,26,27** Please present and analyse the data requested. How effective are the processes described in analysing and understanding unexplained, unexpected and /or reportable deaths and patient safety incidents?
14. **Q28&29** Please present and analyse evidence provided in respect of staffing ratios on neonatal units and the financial and practical consequences of using bank staff and locums, and/or being

understaffed where applicable. Where there are said to be staff shortages is there a correlation between staff shortages and the level of unit? ?

15. **Q30(a-e)** How similar are the policies provided across trusts within each of the categories identified at(a-e)? How do they differ across hospitals? For the avoidance of doubt, we do not require an exhaustive analysis of every policy but please highlight examples where the policies appear particularly clear in respect of what to do where a colleague is suspected of causing harm to babies. If there are no, or few, examples that is relevant and should be explained in your report.
16. **Q31** What is the range of incidents, concerns or complaints reported across Trusts and how often have the policies been used in the comparative 12-month period?
17. **Q32** What changes, if any, do Trusts report as a consequence of the Letby case? Are they reported to be in response to guidance of any kind? Are any improvements in the safety of babies described?
18. **Q34** Please compile and present the responses in respect of use of CCTV in neo-natal units.
19. **Q35 (a-d)** Please compile and present the responses relating to storage and administration of medication.
20. **Q36 a-d** Please describe the level of bereavement and counselling services provided across Trusts.? How adequate are services reported to be?
21. **Q37** Please compile and present responses on whether medical records are annotated in this way.
22. Please scrutinise the responses at **38(a-f)** in order to set out whether there is consistency in data collected across neonatal units and furthermore in respect of how it is distributed and evaluated. Are any benefits in the way the data is evaluated described?
23. **(Q39a-b)** Please summarise the factors that Trusts say inhibit, alternatively encourage, raising concerns about the care of babies.
24. **(Q39c)** How many Trusts report escalating concerns to the Trust Board since 2022?
25. **(Q39d)** How many Trusts have commissioned external reviews of neonatal services in the last 5 years?
26. **Q40** Please compile and present responses regarding managers acting upon concerns.
27. What suggestions are made to improve management and governance structures(**Q40**) and what views are provided in respect of the regulation of managers (**Q41**)?
28. Please draw together material offered in response to **Q43** and **44** and in particular identify any improvements to baby safety in hospital described.

In addition to the data collected from the questionnaires, please also provide us with research summaries (supported by links to the reports and associated research) from relevant questionnaires or research completed by the Nuffield on the topics addressed within the Inquiry's questionnaire. For example, the 2016 research conducted by Alison Powell and Huw Davies, entitled, "Managing doctors, doctors managing". It may be that authors of any related reports will be asked further questions about them by the Inquiry, but at this stage a summary of relevant research conducted by the Nuffield in the *last ten years*, to be presented alongside the data analysis and report of the survey would be helpful.

The researcher who compiles the report should be prepared to give oral evidence at a public hearing in Chester in September 2024. I have set out in the next section the duties of an expert that the researcher, and anyone who assists them, must ensure that they comply with,

### **Duties of an Expert**

Your overriding duty is to assist the Inquiry and provide your unbiased opinion as an independent witness in relation to those matters that are within your expertise. I have set out in an appendix to this letter a copy of the duties and responsibilities of an expert witness. If you have any queries about your role, and the limits of it, please raise those with me as soon as possible.

Your report will need to be completed in final form by early April 2024, at the latest. I understand from our discussions that you are content to work to this timetable. The lead and any other researchers who compile the report will need to provide a copy of their CV, which will be provided to Core Participants. Each CV must explain the professional experience of the researcher, any work they have done for or connected with the NHS and details of any relevant articles you have published.

In due course, I may invite you to undertake further work to assist the Chair. This may include preparing supplementary reports, asking you to give oral evidence at the Inquiry's hearings and carrying out other duties appropriate to the role of an expert witness as directed by the Chair through me. I will write to you to set out formally any further work that may be required. A copy of this letter of instruction and any other letters of instruction I provide to you will be disclosed to Core Participants.

Your report will be disclosed to Core Participants and will likely be published on the Inquiry's website in due course. The report should be written so that it can be understood by a wide audience. The report should identify sources, with hyperlinks where available. All material relied on or referred to should also be exhibited to your report. If you wish to include diagrams and graphs, please do so. I am available to discuss presentation of your written evidence with you as your work progresses.

As an expert you must only express your opinion on matters that are within your own expertise. If there is any question that you cannot answer, in whole or part, then you must make that clear. Where you are assisted in writing any part of the report or views are expressed that are not your own this must be made clear in the report. The role of an expert is to provide their expert view on the matters they are instructed to comment on, it is not to make findings of fact. Fact finding is matter only for the Chair. As an expert your duty is to assist the Inquiry. This means that you must give an honest and accurate answer to the matters you are asked to comment on.

You have confirmed that you have no interests in or connection with the matters under investigation by the Inquiry or any of the individuals or organisations that are involved or may become involved. It is important that you notify me immediately should that change. You are instructed as an independent expert and if there is anything which a well-informed observer may consider impacts on any views you express, for example because you are employed by an organisation you are commenting on, then you must disclose that to the Inquiry.

Finally, although this should not impact on your work, please note that there are in place orders made by the Crown Court prohibiting the publication of the names of the babies on the indictment, their parents and some clinicians.

I would be grateful if you can please provide a draft copy of your report responding to these questions by no later than **Monday, 11<sup>th</sup> March 2024**. On receipt of the draft report, we will liaise with you about next steps so that the report is completed in final form by early April 2024, at the latest.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Tim Suter', with a long horizontal stroke extending to the right.

**Tim Suter**  
**Solicitor to the Thirlwall Inquiry**

## **Appendix A**

### **Duties of an Expert**

1. The duties and responsibilities of an expert witnesses are outlined in the Civil Procedure Rules Part 35 and the relevant Practice Direction, a copy of which I have enclosed with this letter. To assist, I have also set out below a summary of your duties in relation to your instructions and compilation of your report:
  - a. Your overriding duty is to help the inquiry on matters within your expertise.
  - b. You must provide opinions that are independent.
  - c. You should confine your opinions to matters which are material to the issues that you have been asked to consider and provide opinions only in relation to matters which lie within your expertise. You should indicate as soon as practicable where any questions or issue you have been asked to consider falls outside your expertise.
  - d. You should take into account all material facts before you. Your report should set out those facts and any literature or material on which you have relied in forming your opinions. You should indicate if an opinion is provisional, or qualified, or where you consider that further information is required or if, for any other reason, you are not satisfied that an opinion can be expressed finally and without qualification.
2. You should inform me without delay if:
  - a. These instructions are not acceptable because, for example, they require work that falls outside your expertise, impose unrealistic deadlines, or are insufficiently clear. If you find the instructions insufficiently clear you should request clarification;
  - b. You consider that instructions are insufficient to complete the work;
  - c. You become aware that you may not be able to fulfil any of the terms of appointment;
  - d. The instructions and/or work have, for any reason, placed you in conflict with your duties as an expert; or
  - e. You are not satisfied that you can comply with the agreement as to the timetable for the provision of your report.
  - f. You must neither express an opinion outside the scope of your field of expertise, nor accept any instructions to do so.
  - g. You may request directions and/or guidance from myself or the Chair to assist you in carrying out your functions, for example, if you consider that you have not been provided with information you require.
3. In preparing your report please make sure that:
  - a. It sets out details of your academic and professional qualifications. You should include the detail of particular training and/or experience that qualifies you to provide any specialised evidence.
  - b. It gives details of any literature or other material which you have each relied on. Separate guidance will be provided about formatting and referencing the Inquiry's evidence, as far as any material is supplied to you.

- c. It contains a statement setting out the substance of all facts and instructions which are material to the opinions expressed in the report or upon which those opinions are based.
- d. It makes clear which of the facts stated are within the knowledge of each expert (if applicable).
- e. Where there is a range of professional opinion on the matters dealt with in the report that it summarises the range of opinions and gives reasons for the opinion reached.
- f. It contains a summary of your conclusions, or joint conclusions if more than one expert is appointed.
- g. If more than one expert is appointed, it sets out any qualification to an opinion or conclusion provided where you do not agree with a view expressed.
- h. When addressing questions of fact and opinion, you should keep the two separate. You must state those facts (whether assumed or otherwise) upon which your opinions are based. You must distinguish clearly between those facts that you know to be true and those facts which you assume.
- i. You should not assume that the accounts given in witness statements and interviews are true or otherwise.
- j. Where there are material facts in dispute you should express separate opinions on each hypothesis put forward. You should not express a view in favour of one or other disputed version of the facts unless, as a result of particular expertise and experience, you consider one set of facts as being improbable or less probable, in which case you may express that view and should give reasons for holding it.
- k. Where there is a range of opinion on the matters dealt with in the report and the range of opinion is based on published sources, you should explain those sources and, where appropriate, state the qualifications of the originator(s) of the opinions from which you differ, particularly if such opinions represent a well-established school of thought. Where there is no available source for the range of opinion, you may need to express opinions on what you believe to be the range that other experts would arrive at if asked. In those circumstances, you should make it clear that the range that you summarise is based on your own judgment and explain the basis of that judgment.
- l. The final report must be verified by a statement of truth that says: ***"I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true."***

# Appendix 3: Questionnaire sent to NHS trusts with neonatal units

## Private & Confidential

By email only

1 November 2023

Dear Chief Executive

## Request for Initial Information from every NHS Trust (the “Trust”)

The **Thirlwall Inquiry** was established on 19<sup>th</sup> October 2023 following the convictions on 18 August 2023 of Lucy Letby for seven counts of murder and seven counts of attempted murder. The Inquiry’s **Terms of Reference** are enclosed.

I am writing on behalf of The Rt. Hon. Lady Justice Thirlwall DBE, Chair of the Inquiry, in my capacity as Solicitor to the Inquiry. This is a request made under Rule 9 of the Inquiry Rules 2006. It is a formal request for evidence and it is important that you do not ignore it.

## **How you can help the Inquiry - information gathering**

I have identified that your Trust provides neonatal services.

The Inquiry is sending a questionnaire to every Trust providing neonatal services in England in order to gain an understanding of the reality of how neonatal units work. In particular, we are looking to see what practices are effective and where there may be difficulties.

I set out at **Annex A**, a series of questions, the answers to which will assist the Inquiry in fulfilling its Terms of Reference. A template, into which you can add your responses, is provided at **Annex B**. Your responses should be signed and dated under the section “Statement of Truth”. This is a declaration that the responses to the questionnaire are true and accurate.

The Chair requests that a copy of this questionnaire is completed by **both** the Trust Medical Director and a Non-Clinical Director with responsibility for the Trust's neonatal services. Each should complete the questionnaire separately and with as much detail as possible. If the person completing the questionnaire is unable to answer any question, they should indicate that in their response and give a brief explanation.

In due course each response may be disclosed to the organisations and individuals involved in the Inquiry, known as Core Participants. Accordingly, please anonymise any examples in your answers so that they do not lead to the identification of any patients, staff or other individuals.

Please return your response to the questionnaire to me by email at the address [contact@thirlwallinquiry.co.uk](mailto:contact@thirlwallinquiry.co.uk). Please include the reference number from the heading of this letter in the email subject of any correspondence relating to this request.

The Chair intends to conduct the Inquiry as quickly and efficiently as possible and welcomes the assistance of all individuals and organisations with her task. Therefore, please ensure that your response to the questionnaire is returned to the Inquiry promptly and **by 4pm on Monday, 18th December 2023**. **If there is any difficulty with meeting this deadline please let me know no later than Monday, 27th**

**November 2023.**

**Please acknowledge receipt of this correspondence and confirm the best email address for contact going forward.**

If you have any questions concerning the above, please do not hesitate to contact me.

Yours sincerely

A handwritten signature in black ink, appearing to be 'TS', written in a cursive style.

Tim Suter  
Solicitor to the Inquiry

## Annex A

### Questionnaire issued pursuant to Rule 9 of the Inquiry Rules 2006

#### Thirlwall Inquiry: Request for information every NHS Trust (the “Trust”)

##### Overview

1. Please provide a short description of the neonatal services in the Trust including:
  - a. the level (i.e. Level 1-3) of the unit;
  - b. the numbers of cots;
  - c. how these cots are divided between intensive care/high dependency/special care/transitional care/normal;
  - d. the staffing structure for the unit; and
  - e. the current number of vacancies within the staffing structure.
  - f. the number of infants admitted in gestational age bands and the number of days of Level 1, Level 2 and Level 3 care provided since October 2022
2. Please describe, in general terms, the management and governance structures within the Trust, the role of the Trust Board, committees that report to the Trust Board and, where relevant, NHS Governors.
3. What are the arrangements for reporting concerns in the neonatal services to the Trust Board and to other Trust management and governance structures?
4. Please explain to whom the Trust Board is accountable?
5. Describe the working relationships in your neonatal service within each of the groups of professionals set out at (a), (b) and (c) below. Are these relationships in the neonatal service typical of the Trust generally?
  - a. doctors and managers (clinical and non-clinical);
  - b. nurses, midwives and managers (clinical and non-clinical) and
  - c. between medical professionals (doctors, nurses, midwives, and neonatal nurse practitioners)
6. In respect of each group set out at (a), (b) and (c):
  - a. How does the Trust seek to facilitate an effective working relationship within the groups of staff identified above?
  - b. When has the Trust received any staff feedback about the working relationships in the neonatal service?
  - c. What was the response rate to the NHS Staff survey in respect of the neonatal unit and did this provide any feedback in relation to culture & leadership within the unit?
7. Have there been any external reviews undertaken on culture at your Trust, including the neonatal unit?
8. How would you describe the culture of the Trust, generally and in particular of the neonatal unit? If you consider that the different professions have different cultures, please set that out briefly. Please note that we will issue a separate questionnaire on culture to be completed by staff within the neonatal service at the Trust.
9. What are policy and procedures in place in respect of parent/guardian involvement in neonatal care, in particular:

- a. Are parents/guardians included in ward rounds?
- b. Do they have access to a parent portal and/or medical records?
- c. Do they routinely receive copies of discharge summaries?
- d. What other involvement do parents / guardians have?

### **Internal & External Scrutiny**

10. What are the processes within the Trust for investigating concerns or complaints (whether raised by staff or parents/guardians) about neonatal care?
11. What Board level oversight is in place in respect of concerns or complaints that are received?
12. How many complaints, formal or otherwise, and concerns were raised between 19 October 2022 and 19 October 2023 by staff, parents or guardians? If records are not kept of any complaints made, please explain why.
13. How many investigations into complaints and concerns have taken place between 19 October 2022 and 19 October 2023?
14. How many complaints, formal or otherwise, have been upheld?
15. What action has been taken in respect of concerns?
16. What processes are in place for reporting incidents, concerns or complaints about neonatal services and/or staff members to external bodies?
17. How often have those processes been used between 19 October 2022 and 19 October 2023 and, if reports have been produced, to whom have these been made?
18. What are the policies of the Trust for reporting concerns or complaints to professional bodies such as the Nursing and Midwifery Council ("NMC"), the General Medical Council ("GMC"), the Health and Care Professions Council ("HCPC") or the General Pharmaceutical Council ("GPC")?
19. How often have matters relating to the neonatal unit and/or staff working within that unit been reported to any of the Regulators either regulator directly or through the Responsible Officer between 19 October 2022 and 19 October 2023?
20. How many Child Death Overview Panels has the Trust participated in relating to neonatal deaths at the Trust between 19 October 2022 and 19 October 2023?
21. Do you consider these Panels are an effective way to investigate a neonatal death? Please explain why you take that view?
22. Does your Trust have a Medical Examiner Office?
  - a. When was this established? Please provide a history of appointments.
  - b. Do Medical Examiners have in place processes to be able to identify themes or patterns such as clusters of cases displaying similar characteristics?
  - c. Have any neonatal deaths been reported to the Medical Examiner?
  - d. Have Medical Examiners ever escalated any concerns about care to, for example, local clinical governance teams?
  - e. Have Medical Examiners ever identified any themes or patterns?
  - f. What is the interaction between the Medical Examiners and coronial system and have Medical Examiners referred any cases to the coroner?
23. How many perinatal pathology requests has the Trust made since 19 October 2022?

- a. What time frame did the Trust receive results in respect of those requests?
  - b. How are requests processed and questions/challenges made?
  - c. Are there appropriate data sharing arrangements in respect of pathology requests?
24. How many unexplained deaths or unexpected patient safety incidents within neonatal services at your Trust have been reported between 19 October 2022 and 19 October 2023?
25. Please explain the Trust's process for reporting, reviewing and responding to unexplained, unexpected and/or reportable deaths and patient safety incidents? Please describe how parents are involved and able to participate in the process?
26. What do you consider is the purpose of these processes?
27. In your experience do these processes achieve that purpose/those purposes?

### **Policies**

28. Are the required staffing levels and ratios for the neonatal unit at the Trust in line with The British Association for Perinatal Medicine Framework for Practice Service Standards for Hospitals providing Neonatal Care (3rd Edition) 2010, the NICE Quality Standards, the DHSC Neonatal Toolkit and NHS England's Special Commissioning specifications for neonatal care?
29. If not, why not? If so, does that require the use of bank staff and locums? Does that have a financial consequence for the Trust?
30. Please provide copies of the Trust's current policies in relation to the following:
- a. Safeguarding policies for babies.
  - b. Investigating a neonatal death.
  - c. Freedom to Speak Up Guardians and/or any other policies relating to the escalation of concerns.
  - d. Whistleblowing.
  - e. Complaints.
31. In relation to the provision of incidents, concerns or complaints relating to the neonatal service how often have these policies been used between 19 October 2022 and 19 October 2023 and with what effect?
32. Have those policies been reviewed in light of the Lucy Letby case at any point and, if so, what changes, if any, have been recommended and or implemented?
33. Please provide examples of any changes to the policies at paragraph 30 that have been implemented since October 2018 which you consider are improvements. Please explain your view.

### **CCTV**

34. Is CCTV installed to monitor babies within the neonatal and/or maternity units within the Trust?
- a. If so: when was it installed and why?
  - b. What areas are covered (e.g., entrances/exits or wider)?
  - c. Does it cover the storage areas for controlled and non-controlled drugs, including insulin?
  - d. Does the Trust provide remote access for parents via webcam or video footage?
  - e. Alternatively, if CCTV is not installed, please explain why?

### **Storage and Administration of Medication**

35. Please explain the security arrangements and policies for the storage and administration of medication (controlled and non-controlled drugs) where babies are cared for within the neonatal and/or maternity units within the Trust, including in relation to insulin. In particular:
- a. Whether an electronic record is kept of who accesses drug storage cabinets, when and for what purpose?
  - b. Whether the electronic records are stored securely?
  - c. When records are destroyed?
  - d. Whether there is a process for regular auditing of such records.

### **Bereavement Counselling & Future pregnancies**

36. Please explain any policies and/or processes in place within the Trust which ensure any family suffering the death of a baby or a serious health outcome on a neonatal unit is offered access to:
- a. Patient Advice and Liaison Services.
  - b. Bereavement counselling.
  - c. Perinatal mental health services for future pregnancies.
  - d. Any other advice/support offering.

### **Medical Records**

37. Please explain any policies and/or processes in place within the Trust's neonatal services (or the wider network within which the Trust operates) whereby medical records, including those accessed in hospital and by GPs, are marked to show that:
- a. a mother has suffered a neonatal death and how that is relevant to her care and the care of any subsequent babies she has; and/or
  - b. parents have suffered a neonatal death, so they do not need to give their full patient history each time they access NHS services.

## **Data systems**

38. Please list and briefly summarise the health information requested below.
- a. The categories of data that are collected in relation to each baby and why.
  - b. Who, if anyone, has responsibility within the Trust for analysing that data and with what frequency?
  - c. What is the purpose of the analysis?
  - d. What arrangements, if any, are there to submit that data to external bodies (including benchmarking organisations)?
  - e. Is the data shared more widely than as described at (d)? If yes, please indicate how and with whom it is shared and for what purpose. I.
  - f. What local, regional, national and international reporting and data systems for perinatal and neonatal care has the Trust reported to since 19 October 2022?

## **Effectiveness of NHS management and Governance Structures**

39. Look at your answers to the questions at 2 to 7 above. Are there features of the management structure, the governance structure, the culture at the Trust, which:
- a. You think may inhibit people from raising concerns about the care of babies?
  - b. You think encourages people to raise those concerns. Please briefly explain your answer.
  - c. Have any issues been escalated to the Trust Board since 19 October 2022 in respect of neonatal services?
  - d. Has the Trust commissioned any external reviews of neonatal services in the last 5 years?
40. Is there anything within those structures, the culture or the conditions in which the Trust operates which may inhibit managers (clinical or non-clinical) from acting upon concerns raised?
41. Do you have any suggestions about the way management and governance structures might be improved? This is not a request for a general review of structures, but rather of those structures that affect neonatal care.
42. Do you have any reflections on the issue of whether and how senior managers should be regulated?

## **Other**

43. Are there any other matters which you consider are relevant to the Terms of Reference, and which would be of assistance to the Inquiry. If so, please set these out in the section marked "further information"?

**Conclusion**

44. What lessons has the Trust learned, if any and/or what changes has the Trust put in place, and when, if any, in particular in relation to neonatal perinatal services, since 19 October 2022??

**Further information**

Please set out below any further information you think relevant to the Inquiry.

**Statement of Truth**

I believe that the facts stated in this response 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: \_\_\_\_\_ [Job Title]

Dated: \_\_\_\_\_

# Appendix 4: Summary of additional responses for trusts providing different levels of care

Responses to questions which could be quantified were analysed by the level of care provided by trusts where it was possible that there might be variation between trusts. Where all or almost all trusts gave a similar responses this analysis was not undertaken. Where differences were found, these are noted in the main body of the report. The tables here summarise additional questions which were analysed by type of care provided.

## Trust policies

Table A3.1: Did the trust review at least one policy?

	SCU	LNU	NICU	All trusts
Yes (including review ongoing)	9	30	22	61
No	10	26	19	55
Unclear		2	2	4
Total	19	58	43	120

Table A3.2: Was a policy changed?

	SCU	LNU	NICU	All trusts
Yes (including review ongoing)	6	17	10	33
No	3	9	7	19
Unclear		4	5	9
Total	9	30	22	61

## Reporting and managing concerns and complaints

Table A3.3: Has the trust investigated neonatal concerns or complaints?

	SCU	LNU	NICU	All trusts
Yes	13	46	38	97
No (including no investigations of neonatal concerns/complaints)	3	4	4	11
Unclear and no neonatal concerns/complaints received	3	8	1	12
Total	19	58	43	120

Table A 3.4: Was a concern or complaint upheld?

	SCU	LNU	NICU	All trusts
Yes	10	32	25	67
No	1	9	9	19
Unclear	2	5	4	11
Total	13	46	38	97

Table A 3.5: Was a concern or complaint escalated to the board?

	SCU	LNU	NICU	All trusts
Yes	8	27	15	50
No	8	28	21	57
Unclear	3	3	7	13
Total	19	58	43	120

## What safety nets exist

Table A3.6: Is CCTV used in the neonatal unit?

	SCU	LNU	NICU	All trusts
At entrances/exits	15	49	35	99
In communal areas	2	15	12	29

\* more than one option possible

Table A3.7: Is there an electronic record of controlled drug use?

	SCU	LNU	NICU	All trusts
Yes	6	8	5	19
No	13	50	38	101
Total	19	58	43	120

# Appendix 5: Summary of related Nuffield Trust research and analysis

This section provides research summaries (supported by links to the reports and associated research) from relevant questionnaires or research completed by the Nuffield on the topics addressed within the Inquiry's questionnaire.

**Table. Overview of relevant Nuffield Trust research, analysis and commentary**

Title	Year	Authors	Link	Summary
<b>Research reports</b>				
The Francis Report: one year on	2014	Mark Dayan, Prof Judith Smith, Sally Williams, Ruth Thorlby	<a href="https://www.nuffieldtrust.org.uk/research/the-francis-report-one-year-on">https://www.nuffieldtrust.org.uk/research/the-francis-report-one-year-on</a>	<p>This report explored how acute trusts responded to the Francis Inquiry and drew on a survey and interviews with NHS staff.</p> <p>The research found that several themes from the Francis Inquiry Report, including the importance of openness, adequate staffing levels and a patient-centred culture, resonated with hospital leaders.</p> <p>Four in five of the hospitals responding to the online survey conducted as part of the research said they were taking new action in response to the report, and an even greater proportion said they already had work underway on many of the relevant recommendations when the report was published.</p> <p>Senior NHS staff said that the 2013 Francis Report added impetus to their efforts to put quality of care as their top priority, despite the straitened financial conditions facing the NHS. But, hospital leaders described how both meeting financial goals and ensuring safe staffing levels in hospitals was very difficult and would only get harder in the future. Furthermore, cultural change is slow and the reality was that many of the people we interviewed still recognised that many staff would not perceive an open culture for raising concerns.</p>
Managing doctors, doctors managing	2016	Dr Alison Powell, Prof Huw Davies	<a href="https://www.nuffieldtrust.org.uk/research/managing-doctors">https://www.nuffieldtrust.org.uk/research/managing-doctors</a>	This report summarises findings from a survey of doctors and managers to understand their views on the doctor-manager relationship in the UK.

			<a href="#">doctors-doctors-managing</a>	<p>It found that managers and senior doctors in management see things differently with chief executives the most positive overall on a wide range of issues. Clinical directors, the NHS's frontline medical leaders, were least positive. There was "a lack of confidence on the part of managers and doctors in the leadership capabilities of the 'other' group, as well as poor communication between the two groups around decision-making and service development.</p> <p>Compared to a previous survey (undertaken in 2002), there had been some improvement in overall positive scores of local doctor–manager relationships but a growing proportion of respondents believed that these relationships were likely to deteriorate over the coming year.</p>
Strategic health authorities and regions: lessons from history	2020	Nigel Edwards, Helen Buckingham	<a href="https://www.nuffieldtrust.org.uk/research/strategic-health-authorities-and-regions-lessons-from-history">https://www.nuffieldtrust.org.uk/research/strategic-health-authorities-and-regions-lessons-from-history</a>	<p>Following the merger of NHS England and NHS Improvement in 2019, this research examined historical approaches to oversight of healthcare through regional health authorities. It drew on a literature review and interviews with people who had responsibility for running regional health authorities.</p> <p>The report identified that important prerequisites for successful regional management of this kind included clarity and consistency of purpose, understanding the local and historical context and a good social and cultural 'fit' between the leader and their area of influence.</p> <p>It noted that "although the regional 'tier' is important, getting it right is not easy and requires frequent adjustment in style and approach (but probably less frequent changes of structures and people)."</p>
Maternity services in smaller hospitals: a call to action	2020	Nigel Edwards, Louella Vaughan, Billy Palmer	<a href="https://www.nuffieldtrust.org.uk/research/maternity-services-in-smaller-hospitals-a-call-to-action">https://www.nuffieldtrust.org.uk/research/maternity-services-in-smaller-hospitals-a-call-to-action</a>	<p>This report was based on a workshop which explored the challenges facing smaller maternity services in rural areas. It identifies several recommendations to address these challenges.</p>
Review of North Central London's Start Well maternity and neonatal	2024	Sally Gainsbury, Camille Oung, Dr Elizabeth Fisher, Sophie Julian,	<a href="https://www.nuffieldtrust.org.uk/research/review-of-north-central-london-s-start-well-maternity-and-neonatal-care-reconfiguration-proposals-against">https://www.nuffieldtrust.org.uk/research/review-of-north-central-london-s-start-well-maternity-and-neonatal-care-reconfiguration-proposals-against</a>	<p>The Mayor of London has developed six tests to apply to major health care reconfiguration programmes in the capital, designed to ensure that major changes are in the best interests of all Londoners. The Nuffield Trust has been involved in supporting the development of these tests, and the Mayor commissioned the Nuffield Trust to undertake a review of proposals by North Central London Integrated Care Board to consolidate maternity and neonatal care services within its geographic area. This report sets out our assessment of those proposals against the first four of the Mayor's tests.</p>

care reconfiguration proposal against the Mayor's first four tests		Emma Dodsworth	<a href="#">the-mayor-s-first-four-tests</a>	
<b>Blogs and commentary</b>				
Fact or Fiction? The NHS has too many managers	2015	Mark Dayan, Nigel Edwards	<a href="https://www.nuffieldtrust.org.uk/news-item/fact-or-fiction-the-nhs-has-too-many-managers">https://www.nuffieldtrust.org.uk/news-item/fact-or-fiction-the-nhs-has-too-many-managers</a>	This blog was part of a pre-election series which examined data on the number of NHS managers, and their professional background, in response to the discourse around management and bureaucracy.
Who is accountable in the NHS?	2016	Mark Dayan	<a href="https://www.nuffieldtrust.org.uk/news-item/who-is-accountable-in-the-nhs">https://www.nuffieldtrust.org.uk/news-item/who-is-accountable-in-the-nhs</a>	<p>This blog discusses who is accountable for the NHS, whether politicians, clinical commissioning groups, regulators, NHS England, and that ultimately there is no clear answer. It draws on discussions which took place at a seminar hosted by the Nuffield Trust which explored the question of accountability in the NHS following structural reforms.</p> <p>It highlights that there is complexity at a high level because of the numbers of bodies present (with at times conflicting strategies), and argues that there must be some local accountability too.</p>
Are the government's targets for reducing stillbirths and neonatal deaths achievable?	2018	Jessica Morris, Dr Dougal Hargreaves	<a href="https://www.nuffieldtrust.org.uk/news-item/are-the-government-s-targets-for-reducing-stillbirths-and-neonatal-deaths-achievable">https://www.nuffieldtrust.org.uk/news-item/are-the-government-s-targets-for-reducing-stillbirths-and-neonatal-deaths-achievable</a>	This blog examines the data on stillbirths and neonatal and infant mortality and questions whether the government's targets to reduce these (by 20% in England by 2020) was achievable.

Specialised commissioning: lessons from history and looking to the future	2020	Nigel Edwards	<a href="https://www.nuffieldtrust.org.uk/news-item/specialised-commissioning-lessons-from-history-and-looking-to-the-future">https://www.nuffieldtrust.org.uk/news-item/specialised-commissioning-lessons-from-history-and-looking-to-the-future</a>	This long read looks at the historic problems associated with specialised commissioning, why finding solutions has been difficult and future actions.
Safety in maternity services: factors to consider	2020	Louella Vaughan	<a href="https://www.nuffieldtrust.org.uk/news-item/safety-in-maternity-services-factors-to-consider">https://www.nuffieldtrust.org.uk/news-item/safety-in-maternity-services-factors-to-consider</a>	This blog reports on a workshop hosted by the Nuffield Trust which explored factors relating to safety in maternity services. This was following an announcement by the chair of the Health and Social Care Committee of an inquiry into the subject in 2020. The blog notes that factors such as rurality, funding, skills and experience and workplace culture should all be considered as part of the investigation.
Stillbirths and other adverse outcomes for babies in Britain during the pandemic	2021	Dr Elizabeth Fisher	<a href="https://www.nuffieldtrust.org.uk/news-item/stillbirths-and-other-adverse-outcomes-for-babies-in-britain-during-the-pandemic">https://www.nuffieldtrust.org.uk/news-item/stillbirths-and-other-adverse-outcomes-for-babies-in-britain-during-the-pandemic</a>	This blog looks at the evidence around stillbirths and other adverse outcomes for babies in Britain during the Covid-19 pandemic. It also looks at how maternity services were impacted by the pandemic (such as the number of hospital admissions, and outpatient attendances).
10 years on: An interview with Sir Robert Francis	2023	Shaun Lintern	<a href="https://www.nuffieldtrust.org.uk/news-item/years10-years-on-an-interview-with-sir-robert-francis">https://www.nuffieldtrust.org.uk/news-item/years10-years-on-an-interview-with-sir-robert-francis</a>	<p>This is an interview with Sir Robert Francis conducted by Shaun Lintern ten years after the publication of the inquiry into Mid-Staffordshire NHS Foundation Trust. Francis highlights concern that the progress made on safety is being “derailed by the pandemic and huge pressures of demand on the NHS” which is “still too defensive and top-down.” He also reflects on the working conditions of staff in the context of ongoing industrial action.</p> <p>Other reforms he highlighted included listening and involving patients fully in investigating incidents, regulating managers in line with proposals made by Tom Kark KC in 2019, and making it a criminal offence to block whistleblowers raising concerns.</p>
What steps should we take to	2024	Professor Martin Marshall	<a href="https://www.nuffieldtrust.org.uk/news-item/what-steps-should-we-take-to">https://www.nuffieldtrust.org.uk/news-item/what-steps-should-we-take-to</a>	In advance of the Nuffield Trust annual summit, a blog from the Chair, Martin Marshall explores NHS staff and colleagues’ perceptions of organisational culture.

create a more conducive culture in health and care?			<a href="#">create-a-more-conducive-culture-in-health-and-care</a>	
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**Select Committee submissions**

<b>NHS leadership, performance and patient safety</b>	2024	Nuffield Trust submission to the Health Select Committee		<p>This is the Nuffield Trust’s submission to the Health Select Committee inquiry into NHS leadership, performance and patient safety. It responds to the question of how effectively leadership recommendations from previous reviews of patient safety crises have been implemented.</p> <p>As well as drawing on previous research, key points include:</p> <ul style="list-style-type: none"> <li>□ Several organisations and entities (not just NHS England) influence the culture in relationship to leadership and patient safety. This complexity makes it all the more important that all these bodies understand the totality of the reporting burden placed on local organisations, the part they can play in ensuring that burden is proportionate to the accountabilities placed on local leaders, and the way in which their interactions with organisations influence culture.</li> <li>□ There is a clear risk that while reducing the weight of external oversight and empowering ICSs to focus on their local communities feels more important than ever, the current state of NHS performance across the country makes it harder than ever before for politicians and the central officials closer to them to loosen their grip. The NHS’s tendency towards hierarchy, central interference and a defensive culture is deeply rooted in many institutions and changing it will mean different behaviour at every level.</li> <li>□ There has been little evidence of behaviour change. As well as performance, the current focus on productivity in the NHS has the potential to lead to similar dynamics. Whilst there is a common understanding that productivity is a legitimate subject on which to focus, in much the same way that there is a common understanding that patient safety is a high priority for the NHS, it appears to be difficult to frame discussions about productivity in a</li> </ul>
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				genuine spirit of curiosity and learning, rather than defensiveness and blame. We explore this theme further in a recent <a href="#">article</a> .
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<b>Data and analysis</b>				
Chart of the week: How serious is the fall in job satisfaction among midwives?	2022	Lucina Rolewicz	<a href="https://www.nuffieldtrust.org.uk/resource/chart-of-the-week-how-serious-is-the-fall-in-job-satisfaction-among-midwives">https://www.nuffieldtrust.org.uk/resource/chart-of-the-week-how-serious-is-the-fall-in-job-satisfaction-among-midwives</a>	This Chart of the Week compares responses from midwives to the NHS Staff Survey in 2017 and 2021 across four areas – raising concerns, working culture, providing safe care and health and wellbeing. It shows that in the 2022 NHS Staff Survey despite concerns across all staff groups, midwives reported the sharpest decline in how satisfied they are in work.
Safety culture in the NHS	2023	QualityWatch	<a href="https://www.nuffieldtrust.org.uk/resource/safety-culture">https://www.nuffieldtrust.org.uk/resource/safety-culture</a>	This indicator uses data from the NHS Staff Survey to look at safety culture in the NHS such as staff perceptions of resources, workload and burnout, and how secure they feel about raising concerns about unsafe clinical practice.
Maternity care	2023	QualityWatch	<a href="https://www.nuffieldtrust.org.uk/resource/maternity-care">https://www.nuffieldtrust.org.uk/resource/maternity-care</a>	This indicator explores how the quality of maternity care has changed over time, looking at hospital admissions of newborn babies, the experiences of midwives and continuity of antenatal care.
Stillbirths and neonatal and infant mortality	2023	QualityWatch	<a href="https://www.nuffieldtrust.org.uk/resource/infant-and-neonatal-mortality">https://www.nuffieldtrust.org.uk/resource/infant-and-neonatal-mortality</a>	This indicator explores how rates of infant mortality, neonatal mortality and stillbirth have changed in England from 1993 to the current period.

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