Wednesday, 8 January 2025

(10.00 am)

LADY JUSTICE THIRLWALL: Ms Langdale.

MS LANGDALE: My Lady, may I call Dr Benneyworth, please.

LADY JUSTICE THIRLWALL: Dr Benneyworth, would you come forward, please.

DR ROSIE BENNEYWORTH (affirmed)

Questions by MS LANGDALE

LADY JUSTICE THIRLWALL: Do sit down.

A. Thank you.

MS LANGDALE: Dr Benneyworth, can you tell us a brief few facts about your career and your current employment now?

A. Yes, certainly. So I am the interim Chief Executive of the Health Services Safety Investigations Body, I started my career as a GP and was a GP for 17 years in Somerset. I have also been a clinical commissioner, I have been vice chair of NICE, I have led an academic health science network and prior to joining HSSIB and HSIB I was the Chief Inspector of Primary Medical Services and Integrated Care at the Care Quality Commission.

Throughout all of my career, quality and safety of care have been the kind of golden thread throughout that

I have been interested in improving.

Q. So you have a wide experience, it sounds like, of the NHS?

A. Yes, I have been working with the NHS for over 30 years.

Q. You helpfully provided two statements to the Inquiry, the first 5 February 2024 and the second 29 October 2024. If we could have the first one, please, on the screen, INQ0012335, page 1.

In this statement, Dr Benneyworth, you set out your role at the Health Services Safety Investigations Body when it was established and some facts about it.

Can you summarise for us what the body does when it was established and what you investigated?

A. Yes, certainly.

So if I start with HSIB, the Healthcare Safety Investigations Branch, which was established in 2017 the idea was to learn from other industries such as the aviation industry.

Q. You might have to go a bit slower, sorry.

A. Okay. In undertaking investigations that looked at the systemic reasons why things went wrong.

The aviation industry have been doing these type of investigations for over 100 years and have a huge amount of expertise and HSSIB was set up and initially sat

within NHS England to undertake the same function.

HSSIB had two functions. One was to look at national investigations covering all different areas and make recommendations into national bodies about things that needed to change. It also had a maternity programme within it as you can see from the statement and the changes that have happened recently. In October 2023 HSSIB was split up into two parts: the new Health Services Safety Investigations Body, which was established on 1 October 2023. That's a non-departmental body, a new arm's-length body of the government.

Q. Just pausing there, that is paragraph 16 of your statement, if we can put that on the screen.

A. And that undertakes investigations and I could tell you a little bit more about those in a moment. But just to say the maternity programme at that stage, the Maternity and Newborn Safety Investigations programme moved across to the CQC on 1 October 2023.

So --

Q. What's the rationale of moving that to the CQC? One might think, for example, patient safety investigations should be conducted in the same manner whatever they were. So what's the thinking behind them being separated off in that way?

A. The rationale for moving those at the time was related to the legislation we have at HSSIB regarding protected disclosure. The two programmes are very different. The maternity investigation programme looks at individual cases and makes reports to the Trusts and to the families for those investigations and those investigations are often subsequently used in legal proceedings.

HSIB investigations are investigating areas that occur in multiple providers. While we sometimes start with an individual case they are looking at the system-wide factors as to why things go wrong, they are looking at multiple cases across multiple parts of the country and we make recommendations into the national system and the national bodies.

The HSSIB investigations are protected, the material that comes in to the organisation as part of the course of those investigations are protected by law.

What that means is we don't disclose any of that information into any kind of legal proceeding, we don't talk about names of individual organisations, individual Trusts and we don't name individuals that have contributed to our investigations --

Q. Again, sorry, just to interject. For ease of those following, you set out that in a table at

pages 15, 16 and 17, what is not disclosed. Do continue, it is just so people can read that in conjunction, if they want to.

A. Yes, certainly. So we think that legislation is very important for the work we do because it means that people can speak freely during the course of the investigation and tell us what has happened without any fear of recrimination in any way and without fear of being blamed individually. So that was the rationale originally as to why the maternity programme split off into the Care Quality Commission when the new legislation for HSSIB came into force.

Q. Because they might look to need to blame or name or know what's happened in the context of maternity?

A. Yes, because those -- because they are very individual investigations and they do name, they work with Trusts and they, they make recommendations into the hospitals, and sometimes I believe those investigations go on as part of the clinical negligence proceedings and are used by Coroners and other parties going forward.

Q. Fact-finding organisations?

A. Yes.

Q. If we look at paragraph 58 you set that out in your statement:

"The purpose of HSSIB investigation does not include assessing or determining blame, civil or criminal liability, or whether action needs to be taken in respect of an individual by a regulatory body."

So it follows obviously you are not investigating where there are suspicions or concerns about deliberate harm being caused or anything of that nature?

A. No, that's right. We do have exceptions in the legislation though. So if -- if my team when they are out investigating areas have concerns about negligence, have concerns about any criminality or do have concerns that there is a very significant risk that the provider is not addressing then we will escalate those and we have the exceptions within our legislation to be able to do that.

Q. Do you have safeguarding training as a team in terms of when you are dealing with children or anything that relates to children?

A. Yes, all of our team are trained in safeguarding and we have members of the team that are trained to the highest level in safeguarding as well.

Q. We see at paragraph 23 going back in your statement that you don't have permanent office locations and staff are employed as remote workers.

It can be difficult, can't it, to engender a team

spirit in those circumstances. So how does that -- how do you manage that?

A. Well, we work -- we work very hard at that. We have -- as you can see we are a small organisation, we have 44 whole time equivalents and we are based across the country, so we didn't feel it was good use of taxpayers' money to have an empty office that -- that sat when we actually want people right across the country so that we are a national organisation.

We have regular team meetings online, we have regular away days face to face, the team meet up when they are out on investigations and we have put in a whole series of team-based development and growth that actually helps us deliver as a virtual team. It's not always easy and there are challenges being a truly virtual team but we think the benefits of having that spread across the geography and the benefits of actually using the money on the front line investigation rather than on empty offices far outweighs the downsides.

Q. Right. So in --

LADY JUSTICE THIRLWALL: Sorry, I'm sorry, Ms Langdale. How many of you are there on the team all together?

A. There is 44 of us so we are very small, a small team. We have a number of people who are

educators in that team as well, about nine of the team are educators and part-time. And they are -- they are based in some in Scotland as well as England and we have some back office functions in -- in the team, so it's, it's a very small team of investigators.

LADY JUSTICE THIRLWALL: How big is the -- sorry, about 44 investigators or.

A. No, 44 in the whole organisation.

LADY JUSTICE THIRLWALL: How many investigators are there?

A. So we have 12 investigators, 12 senior investigators and support teams and analysts that work with those investigators.

MS LANGDALE: A truly virtual team is cost-driven really; as you say, you would rather use your money for investigations?

A. Yes, yes. We, we absolutely want to, we have worked very hard to make sure the organisation is as lean as possible in terms of all its back office functions so as much as our resource goes right on the front line in terms of our investigation and education function.

Q. You set out, it begins at paragraph 45 of your first statement, the education function of HSSIB. Can you tell us a bit more about that and particularly

paragraphs 53 and 54 and who attends that online training?

A. Yes. This is a really important function, I think, that -- that we have. We want to professionalise investigation. So often we hear from patients and families involved in investigations that they are not involved well in investigations.

We often hear that staff are often made to feel blamed when local investigations happen and often that the local investigations don't lead to the changes and the improvements that are needed on the ground. So we think it's very important that we upskill investigators that are undertaking these very complex investigations locally and even -- even the most straightforward of issues can have quite complex reasons behind them.

We need to take a human factors approach. We really need to understand the system wide factors as to why things go wrong. Often it is not one individual -- one individual person or one individual problem that leads to things going wrong. Often it's a -- a multitude of different reasons why things -- there is errors and mistakes and incidents.

And our education function has been working across the NHS to look at how we support local investigators to develop the skills in this area.

We provide education free of charge to the NHS. We have had over 30,000 people enrol in our courses. We would love to be able to do more because we have -- predominantly that's been in the secondary care sector and we think there is an awful lot more to do out in the community and out in primary care and we have a whole range of courses ranging from kind of the basic understanding of human factors and safety science which underpins our investigations to supporting the roll-out of the patient safety incident report -- response framework that NHS England have put in place which we think is a very positive development.

We have -- we have modules about how to support patients and families and how to work with patients and families through an investigation. And I think that's --

Q. How to communicate with them?

A. To communicate with them, to work with them and also most importantly sometimes we hear and we have just done a huge piece of work in mental health and that area, particularly. Sometimes you hear that actually if an investigation is done poorly it just compounds the harm for patients and families and to an already distressed situation, you can make it worse. And so how to work how to engage with patients and families in

a way that doesn't compound that harm, how do you use the process of investigation to help, help support their, their kind of healing through this process as well and how to really make sure you are listening to their voices as you undertake an investigation.

Q. Just pausing there. You say most people who have taken it up from the NHS have been in secondary care. Have you had many or any groups within hospitals?

A. Yes, that would be hospitals. So a lot of our education courses are taken up by people working in Trusts, often people doing investigations by Trusts and often, often patient safety specialists as well within Trusts.

There is quite a lot of variability in the numbers we get from different Trusts. We have had some Trusts that have had hundreds, in the hundreds of people on our course, we have had some Trusts that have had very, very small numbers.

So it is something we want to dig into further in terms of that variation.

Q. Do you do courses for clinicians, nurses?

A. Anyone -- anyone working in the NHS can join our courses for free.

Q. And managers, have you had many senior managers attend?

A. Yes, we have had senior managers and we actually run a programme that is becoming increasingly popular, which is called a strategic decision managers -- makers programme and that's a two hour programme that we run with boards, with senior leadership teams face to face and it really gives, gives the kind of people in those boards and those senior leadership teams the understanding as to how to support people doing these investigations, understanding about how you take a systems-wide approach so how do you move away from looking at what an individual has done to what actually the environments, the processes the systems that are going to help your teams deliver better care.

Q. You say the courses are delivered online or in person, does that mean you go into a hospital when they are in person given you haven't got premises, how would it work?

A. Yes, so the biggest proportion of our courses are delivered online purely because -- and we have, we have tried to make them as easy as possible for people to access.

So our most popular course is a course that people can do over six months that is 15 hours of bite-sized chunks that people can-- can access at their own -- in their own time. But we do deliver face-to-face courses.

We go into Trusts and work with boards face to face.
We are an incredibly small team so our resources are limited but we -- we think a mixture of both is very important and we just are launching a new course cause which is called SEIPS in action, SEIPS is a mechanism for looking at investigation and understanding the environment and the processes around and the tools that people are using and we are doing a two-day intensive face-to-face course for that just to take people who are, who are already kind of skilled in investigation to the next level and to really kind of upskill them.
As I said at the beginning, investigation is one of those skills that is often undervalued. It's often -- it needs very specialist skills it doesn't need necessarily clinical skills, it needs the subject matter expertise, it needs specialist investigation skills and I think that's quite under-recognised really in the system in terms of the skills need.
Q. What are those skills?
A. Those skills are really to be able to -- well, firstly people need to understand the science behind investigation. They need to have that toolkit of investigation methodologies to be able to pull on and use. They need to have the skills to be able to interview people properly. We, we run a course about

interviewing that's actually run by a previous homicide detective, in terms of actually how to really develop those skills to interview people.
They need to be able to know how to engage with patients and use a trauma informed approach to engage with patients and families.
And then they need to be able to analyse that in a scientific way using specific methodologies, develop good recommendations and then there needs to be support from the local providers and local systems to actually make sure that the recommendations are then implemented.
Q. At paragraph 64 of your statement, you say:
"Any person that intentionally obstructs an investigator in the performance of their functions fails without reasonable excuse to comply with the notice to provide information or provides false or misleading materials to an HSSIB investigation may be liable on summary conviction to a fine."
To what extent have those powers been used or had to be used?
A. We haven't as yet had to draw on those powers. Those powers have been in place since we became an arm's-length body on 1 October.
We want to work with the system and want to kind of ensure that the system sees the benefits of engaging

with us as an investigatory body. We do remind people of those powers if, if we are coming across any obstruction but we haven't actually had to put in place any of those legal powers to date. But we are, we are very prepared to use those if needed.
Q. At paragraph 76, you set out at the fourth bullet point that under the Act you require to determine and publish the processes for ensuring that patients and their families are involved in investigations. What processes can be put in place for ensuring that they are involved in investigations?
A. So in the investigations we undertake at HSSIB we use a variety of mechanisms to ensure patients and families are involved in every step of the process. We are just piloting, for example, a piece of work to look at how we identify what areas we are going to investigate with one of the patient representative bodies. We make sure that during the course of the investigation we work with families and patients. And just to give you an example of this, I have just mentioned our recent work we have been doing in mental health and we have undertaken four significant investigations into mental health.
We have been working with MIND, the charity, who have been incredibly helpful at organising focus groups,

we have been liaising with MPs to hear from their constituents about experiences in mental health services. We have -- we work with individual families and individual patients where appropriate and we also -- anyone can contact HSSIB to raise a concern with us. We hear from patients and families on a fairly regular basis about concerns across the health service and, and we use that information to decide whether we are going to proceed with an investigation as well.
Q. So they can have an input, can they, into the determination of whether an investigation is going to take place?
A. Yes, absolutely.
Q. If we go to page 22 of your statement, there is a table. 22 and 23 and 24. Can you tell us what this table communicates?
A. Yes. This is the, this is the criteria we use to decide about an investigation and what we choose to investigate. This has changed slightly since my statement was written and we have now consulted with the Secretary of State and our criteria are on the website but essentially it's, it's broadly the same.
So what we want to make sure with our criteria firstly that it's a significant patient safety issue. In the past HSIB did receive some criticism that

sometimes the investigations they undertook were not always the most significant patient safety concerns that were impacting patients. So we have worked hard to think about how do we identify those significant patient safety concerns, how do we make sure that they are the most -- the ones that are impacting significantly right across the country?

We also want to make sure that we can add value with our investigations. Sometimes again in the past we have learnt that we have proceeded with a piece of work and then found out lots of other organisations are doing work in the area and we haven't been able to kind of add anything new. We want to make sure our resources are really adding value and adding a new lens into any particular area.

Equalities is a big issue for us as well --

Q. Page 23, if we can, Mrs Killingback. Thank you. Sorry, carry on?

A. So looking at actually how do we make sure that our investigations really understand the impact that we are having on in qualities and how we firstly make sure that we are not driving any negative impact through our work in equalities but most importantly how we are adding positively to improving and addressing inequalities.

The one thing that we have take own out is the feasibility aspect from the criteria with the new criteria --

Q. Page 24, if we can, for feasibility.

Sorry, carry on, Dr Benneyworth?

A. And that is because actually we don't want our investigations to be decided based on how easy or not they are to do and so we have removed that as a criteria. We want to be really tackling the most difficult things to look at and things that actually some people might not look at because they are not easy areas to investigate.

Q. In relation to neonatal care we see at page 30 of your statement, paragraph 107, you tell us you are able to investigate any patient safety incident that would meet the requirements of the Act.

Can you tell us what you say in paragraph 108 about what it would need to satisfy for you to be conducting an investigation?

A. Yes. So what we need to satisfy is we need to make sure that it is something that meets our criteria, that we have just talked about, and so that it's a kind of area of significant patient safety concern that's happening in multiple places across the country.

It needs to be something we can add value to and it

needs to be something that does address inequalities.

So we look at all of those areas in terms of how we prioritise and make sure -- there are so many incidents, as you know, across the country, thousands of incidents, and we have a small team and what we want to do is increase the capability of local teams to be able to manage most of those incidents.

But we know that quite a lot of things, you know, actually are without, without -- not within an organisation's control to manage and so some of those things that are happening in multiple organisations, that's where we would step in and look at taking on an investigation.

Q. Paragraph 130 of your statement, page 48, you tell us that:

"Investigations have shown [you] healthcare staff greatly value the opportunity to speak with an independent and professional investigation team. Speaking openly about what happened after a patient safety event is easier when staff know the purpose of the conversation is to identify the systemic risks that made delivering healthcare safely more difficult rather than to pinpoint individuals for blame."

That makes perfect sense the way you set that out.

Just looking at the reverse, if you can, and please

say if you can't. Conducting investigations where people are worried in those rare cases about deliberate harm and that someone may be to blame for something very serious, how difficult and what skills are required addressing that kind of scenario by contrast?

A. Yes. So we know that in the vast majority and I recognise that this is a different case here, but in the vast majority of incidents that occur, often it is related to individuals, their interaction with their environment and the systems and processes that they are working with.

And often we know that healthcare staff feel terrible when they when something has gone wrong. Sometimes it can be career-ending for them, sometimes they go off sick for a long time. Often these things -- and I know from a clinician, being a clinician myself when things don't go well actually it has a huge impact on the member of staff.

So often the process that we put in place is to support that staff in terms of understanding what's happened, that member of staff understanding what's happened and looking at how we can really kind of prevent things from happening again.

I think clearly in the unusual situation, my investigators I think would -- would understand if, if,

would pick up if there was a concern that was outside what we normally saw in terms of those usual patterns and they would flag those concerns at that stage as per our legislation when we had -- when we had those concerns. I have to say the vast majority of incidents that we see, it's because people are there trying to do a good job and trying to do their job well.

We know that the vast majority of people working in the NHS kind of go to work to deliver good care and it's -- people talk about the second victim in these incidents and often it's the healthcare professionals working in, you know, very challenging environments that end up feeling -- feeling, you know, very responsible for what's happened despite the fact sometimes there's a whole range of human factors and other factors that have led to the incident happening.

And it's vital that we support -- we encourage kind of senior managers and managers working in organisations to understand how they can support health and care professionals in these -- in these situations.

How people are supported after an incident is really important. If, if people are made to feel that they are individually at blame for something going wrong, then that also can lead to, you know, significant additional distress for the healthcare staff themselves.

So, so I think it's important that as well as people investigating locally, understand how to identify these factors as to why things have gone wrong that actually managers and staff around them have that understanding as well.

Q. When you say "support", it's an important issue, support, isn't it, and you have got formal support, you can have occupational health support. What other support can leaders offer, how would you articulate what support is for somebody who's facing a situation that's difficult or challenging?

A. Well, I think -- firstly I think it's important that all managers listen to what their staff are telling them. I think it's -- you know, we talk a lot about speaking up, I think it's vital that that is listened to people are listened to and actually there's a good flow of communication in terms of when things are, have been listened to people really understand what the outcome of that is.

Now, it may be that things don't change as a result of raising concerns or speaking up about something going wrong but actually it's vital that people understand that at least they have been listened to and even if no action is taken that there's a rationale for that and they understand the rationale.

I think it's vital so I think there needs to be support right from the senior level of any organisation. There needs to be that kind of no blame philosophy, a just culture where people feel encouraged to -- to talk about things in a very open way and don't feel that actually if they do that they are going to be bullied. We still see too many examples of people facing all sorts of poor behaviour when they are raising concerns and not being listened to.

Q. Why do you think that is because the concerns are difficult, equivocal or worse? What do you think?

A. I think it's a variety of factors. Certainly we know that sometimes these problems are very challenging to solve and I think that sometimes that, you know, there isn't an easy fix and so for a very busy person working in a challenging -- working in a challenging environment I suspect when someone raises concerns and they don't know how to fix it that can cause tensions.

We know from -- we have done some work recently looking at temporary staff and we know that hierarchical cultures can lead to problems in terms of people feeling comfortable raising concerns and actually what was worrying with the work we looked at with temporary staff was the inequalities in terms of ethnic minority staff

and they felt they -- they often had even more of a difficult time raising concerns than, than the non-ethnic minority counterparts.

So there can be -- there can be racism at play and sexism and other kind of discrimination that underpins people not being able to raise concerns in the way that they should be able to.

LADY JUSTICE THIRLWALL: Can I just ask a sort of supplementary. Going back to the example you originally gave, which is a really busy person working under enormous pressure and someone comes to them with a concern and I think I infer from what you say that there is almost a natural inclination to say "I haven't got time for this" and then that undermines any kind of effective response. Can you give an example of what you mean by that?

A. Well, I think for example, I am just trying to think of a good example. So there might be a whole range of issues, it might not just be, just be busyness but there might be, so for example there might be financial pressures on an organisation.

LADY JUSTICE THIRLWALL: Yes, indeed.

A. There might be operational delivery pressures on an organisation, there might be staff vacancies. So a person might come to a manager and say: actually, we

don't feel it's safe because there's not enough staff here. If, if there's, if there's a whole range of other factors ranging from kind of issues that the board of the organisation is having to deal with, then actually it's quite difficult I guess for a middle manager to sometimes be able to influence that and so ...

So I think it's -- I think this is where we are really keen as an organisation to make sure that safety is at the heart of all decision-making right from board level to every level in the system. Sometimes we see that operational delivery, financial performance, that drives the decision-making and sometimes safety is an afterthought. And we would like to see safety put right at the centre of all decision-making. Learning from other industries, other industries have very different mechanisms of dealing with patient safety, dealing with safety, safety is represented at board level and it's, there is clear accountability for safety. There's very much more kind of granular understanding of risk and how that drives the decision-making than we have in healthcare.

And we think there is a huge amount of learning from other industries in terms of how we should approach safety in healthcare that at the moment is not done in a consistent way and in a proactive way.

LADY JUSTICE THIRLWALL: So if I may, just to sort of finish the point, if you were a middle manager who feels they can't do anything about it, is what you are saying that that can, that is the thing that or one of the things it that may lead to the person blowing the whistle, if you like, or raising the concern feeling as a minimum undervalued and also probably bullied?

A. Yes. I think if you, if you constantly raise something but don't feel you are being listened to and you feel like you are having to kind of continually bang the drum and you get -- I think what we see sometimes is people get more and more frustrated because they don't feel people are being listened to, they see the harm that patients are continuing to suffer and sometimes that frustration can also lead to tensions within relationships and that can then escalate.

So you can see how some of these things which can start off by people raising quite genuine kind of concerns can escalate and become much bigger issues without, without them being resolved and actually also sometimes I guess it depends if that, if that middle manager then doesn't have a route of escalation and --

LADY JUSTICE THIRLWALL: That was my next question.

A. -- people listening to them then that also leads them to, you know, not, feeling helpless and

feeling powerless in terms of what they can do.

So I think that's why we really need to make sure the culture is set from, you know, the board level and that hierarchal cultures are cultures that don't encourage speaking up, cultures that don't listen when people do speak up and take appropriate action. Those are the cultures we need to address and change.

LADY JUSTICE THIRLWALL: Thank you, Ms Langdale.

MS LANGDALE: Do you think the pressure on senior management boards, senior leaders, are different pressures from the pressures clinicians face?

A. I think there is no doubt, I think there is challenges for both in different ways and I think there are different pressures that boards face and sometimes those pressures are external as well as from internal in the organisation.

They, they, boards are often kind of working with a whole range of external partners as well and there's no doubt that that sometimes can bring pressures as well as the pressures, you know, that they are having to manage in terms of looking at risk in the wider system. We know that individual organisations don't exist within -- on their own. They have to work with multiple organisations in their local systems to be able to deliver good care and that's quite variable as well

across the country.

I think also, sometimes I think the best organisations really kind of empower people on the frontline to be thinking about, to be taking ownership of the kind of challenges around operational delivery and financial planning and actually, you know, from our point of view as an organisation we feel that unless you get safety right and quality right, those other issues around finances and operational planning are not going to be solved.

The OECD talk about somewhere between 12 and 15% of an organisation's spend being on safety failure. So unless we can address that, we are not going to be able to ever kind of manage the pressures that a board is, is having to face within. So I think we need to kind of empower people at the front line to understand that bigger picture and to understand their role in that bigger picture and, you know, people, clinicians, their main focus will be how do I deliver the best quality care for this patient in front of me and, you know, often if we can enable them to do that then actually the waste that we will take out of the system by the rework, the ongoing costs of safety failure will be lessened.

Q. Your second statement, if we can, Dr Benneyworth, that's INQ0108372, page 1. You were

asked to chair a workstream by the Department of Health and Social Care. Can you tell us all about that?

A. Yes. Certainly.

The arm's-length body Chairs and Chief Executives meet on a regular basis and we were asked to consider how we work more closely together. I was asked to chair a workstream looking at safety in risk and initially we started with the arm's-length bodies and --

Q. Just tell us what arm's-length bodies are?

A. So they are the bodies that work with the Department of Health and Social Care, so NHS England, CQC ourselves, NHS Resolution and there's -- I think there's 13, I believe. I might not have got that right I think there are 13 arm's-length bodies that work with the Department of Health and Social Care. All have different functions across the system.

And when we brought the group together, we looked at a whole range of different areas that we felt that there could be effective collaboration. But at the time we were hearing a lot from provider organisations like hospitals that, you know, one Medical Director said to me I have got 390 recommendations sitting at my Trust board, you know, how do we manage that, how do we prioritise those, how do we keep track of them? And so we decided to look at this as an issue.

The, the group grew kind of exponentially actually over the last 18 months we have been working on this and we now have many of the other national organisations involved in this work such as --

Q. Shall we get on the screen the report itself actually, it will assist us to know which bodies you are talking about as well. INQ0108741. It's the report published on 16 September 2024 which you kindly drew to our attention, Dr Benneyworth, and we see at page 3. Well -- we can start at page 2 with the Executive summary, perhaps.

And that sets out:

"The sheer number being made of recommendations and the variance in their quality that they can be a burden to an already pressured healthcare system which is expected to digest, prioritise, pay for and implement actions in relation to them."

So that's, as you have told us, what you were looking at and the next page, 3, sets out and going on to page 4, the organisations and individuals who contributed, has that list expanded since then?

A. I -- not significantly I don't think. I -- I am just trying to think. I think that's, that's the most of the national organisations we have expanded the group to include certain parts of NHS England as

different parts of NHS England but apart from that, that's a comprehensive list.

Q. Then if we see page 4, if we perhaps go through them in turn, the findings of the group.

So the first bullet point, would you like to expand on each of these as we go through? So:

"Failure to implement actions following recommendations can impact public confidence in the healthcare system and compound harm to patients."

A. Yes. We have heard this a lot both through this work and also the work we have done with our investigations at HSSIB.

I think when something happens to a family or a patient what we very commonly hear from them is: we really don't want this to happen to someone else. We have been through so much pain and so much distress that actually what we want now is to make sure that things change so no one else has to go through this.

And what we see often is that recommendations at every level when they are not implemented, that can just add to the distress families feel so they know that there's actions that should be being taken, they know that there are things that could be done but those actions haven't done. And very sadly actually we have seen directly with our HSSIB investigations that some of

the recommendations, we have seen prevention of future death notices from recommendations we have made with HSIB in our previous organisation that if they had been implemented, those people wouldn't have died. So we have got direct examples of where people continue to die because recommendations have not been implemented.

So I think there's, there's the harm to individual patients and families and we outline in the report a very sad case of a family particularly we worked with in this work who lost their 22 month-old son and they talked about the distress they felt when actually they saw the response to recommendations from the organisations because they, they -- you know, we, the system is kind of churning out recommendations and then organisations respond to them but sometimes those responses are very much tick box, they are not thought through, and what we heard from this particular family is they saw the response and actually it was just, you know, further harm to them because they couldn't see any change that was going to happen as a result of -- this was, this was following an Inquest, that recommendation.

But it's -- it's something we have heard very regularly in our, we have just been doing a big piece of work from learning from deaths in mental health and that is something we regularly hear as well from families and

patients, so ...
Q. The second point, the finding was:
"The noise created by the significant volume of recommendations being made to the healthcare system means that providers struggle to prioritise and implement recommendations, concentrating on those which are addressed directly to the provider or where there are immediate patient safety risks?"
A. Yes. And often we have heard from providers they only have the ability to deal with kind of regulatory must-dos or from prevention of future deaths. So there's this huge amount of work going on nationally often to try and improve various areas, sometimes at regional level, sometimes at ICB level and -- and often the providers are left with a whole range of recommendations of variable quality, often they are not costed, often they don't -- it's not clear how they will kind of work in their local system.
And as a result of that, and it's not really very clear often when recommendations about which are the important ones, which are the most impactful ones, often they haven't been evaluated to look at their impact. And so providers are in this very difficult situation where they have a huge amount of things coming at them and no kind of support to understand how they prioritise

those.
Q. The third point:
"Some recommendations duplicate or contradict others. The development of a searchable repository which includes recommendations made across the healthcare system may help to reduce this."
What were you envisaging there or thinking there?
A. Yes. So we have been doing some work since this paper was published around what a repository could look like. I think it's really difficult when you get multiple recommendations that say virtually the same thing but slightly different, that all ask for different measurements, different way of collecting the data on them.
It is even worse when you get recommendations that contradict each other and there is no mechanism at the moment if recommendations do contradict each other, no mechanism to be able to resolve that, so it makes it easier for the system to be able to understand what they should be doing.
Q. Is that common in your experience, to get recommendations that actually contradict each other?
A. It is not an infrequent occurrence so I couldn't tell you how much but it's something we do hear. More often it is the duplication that is the

issue, but duplication in wording that's slightly different.
So they are similar themes but not quite the same.
Q. But in terms of clinical outcomes, it is not a clinical recommendation. I mean, NICE wouldn't send something one day that contradicted something they sent the other day, would it?
A. We have heard of examples where there is clinical contradictions as well.
Q. So that can happen?
A. Yes, so it's not -- it's not unheard of.
And then what the, what we find is that when recommendations are made, there's no way of -- actually if you are sat in a provider or even in a national body it takes a manual trawl to work out what recommendations have been made in a certain area. So for example if you are looking at urgent emergency care at the moment, there is a whole number of organisations that have made recommendations about how you should improve urgent emergency care services. But to do, to really kind of understand that you have to look through multiple different websites, multiple different trawls and there is no easy way of identifying what recommendations have been made.
And then there is no way of actually then seeing

have they been implemented with those recommendations.
The recommend -- this links to the proposal around guidance for recommendations because what I would like to see is that actually we have firstly organisations making really good quality recommendations based on guidance that really considers the evidence for them, considers how they are thinking about inequalities, considers costing if appropriate and, and considers how they are going to be measured and tracked.
Q. Do you think it's possible to cost recommendations at the time of making the recommendations, would that be better if there was a system for that?
A. I think some you can. I don't think you can for all of them. But I think some of them you certainly can. So if you are changing the number of people, I don't know, required in terms of staffing or if you are changing -- if you are changing certain drugs over another. I mean, what we see it's interesting, I used to work with NICE, NICE do this kind of economic evaluation all the time with new drugs going out into the system and yet when you look at recommendations, we don't do that type of cost-effectiveness evaluation.
And so often when recommendations are made, we don't know whether the -- you know, the very expensive

one is going to impact on a bigger number of people and -- and the kind of least expensive one so I think there does need to be consideration especially in the tight economic climate that we are working at the moment we need to be really sure that we are driving kind of cost-effective really impactful recommendations through the system.

Q. You say at bullet point 5:

"There is currently a lack of visibility of ongoing work across arm's-length bodies that would enable collaborative working on related workstreams."

Can you expand on that?

A. Yes. Certainly. And I think this probably is not just the across the arm's-length body, it is across the national -- all of the kind of national organisations working in healthcare more generally.

So healthcare, it is a complex area and there are lots of different streams of work and often we find that lots of organisations are quite rightly kind of identifying areas that they are concerned about that they are worried about and they are starting well-intentioned pieces of work. But often that kind of collaboration and the co-ordination between those different bodies isn't there.

So people are working on lots of different pieces

of work in isolation, they will kind of reach out to stakeholders very often but sometimes that is not comprehensive.

So that leads to, you know, the situation where you get two different reports coming out in the same week on the same area with slightly different recommendations because there hasn't been that collaboration.

There is a lot of informal collaboration, which is good, across the national system but I think that needs to be strengthened and there needs to be better mechanisms for co-ordination and the kind of mechanisms that enable us to use the resources across all of the different bodies in the most appropriate way.

Q. You refer to the arm's-length bodies. You also helpfully attached, if we can have on the screen, please, INQ0010447, page 1, an article that's no doubt out of date already from 2019 about the number of regulators within the NHS and mapping the regulatory landscape of healthcare.

When it comes up on the screen, can you tell us your thoughts about that?

A. Yes. And I think this underpins the, the -- you know, the work we have been doing around the recommendations in that I think this is a really important piece of work by this, this team and it shows

the complexity of the multiplicity of organisations that have an impact on if you are sat in an organisation I think they came up to 126 organisations that exert regulatory influence as well as the Clinical Commissioning Groups. Now things have moved on some of those organisations have changed, we don't have CCGs, we have Integrated Care Boards now instead.

But the message from this is absolutely clear in that we have a very complex expansive landscape for patient safety.

So I know that Penny Dash has been commissioned at the moment to undertake a review into the patient safety landscape with particular focus on six organisations which I think is a really great stepping stone to look at this.

I think -- I think how we make sure that it's easy for providers to be able to do their job and not add to the complexity I think we need much more national co-ordination and much more joint working and collaboration across the national system so that actually we -- we don't add to that noise that we described in the recommendations report and we really kind of streamline things. So it's much easier for people working in the system to be able to, I guess, see the wood for the trees really.

Q. And if we look at page 2 of this, and the need to map the regulatory landscape of the NHS.

"This short overview of regulation history in the UK demonstrates a stream of structural reforms over the last 25 years which have gradually increased the extent and complexity of the regulatory structures."

As you have just told us. What does that do in terms of the risk of wasting money and duplication of function?

A. I think every time there is a structural reform it requires resource, it requires time and energy and my personal view is that actually we need to be working together much better, we need to set up kind of the structures that are going to enable to pull those organisations together. Every time you change an organisation, it, it's almost a distraction from actually really concentrating on what we should be concentrating on, improving quality and safety for patients.

So my view is we need mechanisms that pull all the different parts, strands of the system together so that we can work collaboratively.

I don't think that requires structural reform and if you look at different industries again and learn from other industries, they have very elaborate systems that

enable that to happen pulling all of the different, different parts of the landscape together.

I think what we also can learn from other industries is about accountability. We need much more clarity about accountability and where that sits particularly with patient safety.

Q. If we go back to the findings of your report, INQ0108741, page 4, your observation or finding at point 7, it's unclear how some recommendations are intended to impact the patient which should be a key consideration in their development where possible. And if I can ask you at the same time two bullet points below:

"Some recommendations may be of limited relevance to certain providers and could promote inequalities by negatively impacting certain patient groups if implemented. However, providers can feel they are not empowered to reject recommendations especially those related to safety."

Do both those two points link in the sense that the recommendations being made in the first place may not have been adequately thought through --

A. Yes.

Q. When prescribed for providers where the situation has arisen as you set out?

A. Yes. It -- I think sometimes the

recommendations don't have the evidence base, they are not -- they are not really clear in terms of thinking about the next step in the pathway of implementation. Sometimes they are too prescriptive as well. Sometimes recommendations can solutionise when actually whether we need to do is make sure recommendations say what needs to happen but don't say exactly how it needs to happen and that needs to -- because when providers are trying to implement recommendations they will need to take into their local population needs, they will need to take into consideration their understanding of their, their demographic and how it's going to work in their local area.

So it's really important with recommendations that they are not, they are not solutionising but they are actually saying what improvements need to occur.

Q. Be achieved?

A. Mmm.

Q. When you say recommendations, are you speaking about Public Inquiries, reviews, investigations: what are you including when you speak of recommendations here?

A. So this, this work we have deliberately not defined a recommendation because -- and that's part of the work going forward and I think that will come in

when we start to decide what goes on to the repository and what doesn't go on to the repository if we are able to implement that.

But this work started with recommendations that the individual kind of national organisations made but I think it's very applicable to Inquiries and I think it's applicable to local investigations and the outputs of Inquests and other local work as well. So I think it's whilst, whilst we haven't specifically looked at Inquiries with this work, I think speaking to providers and speaking to other people in the system, I think it is also relevant.

Q. I think we have seen, you make reference to it, the Thirlwall legal inquiry table on the website with summaries of what has and has not been implemented from previous Inquiries.

Drawing together what you say here, part of that I suppose might be attributed to cost factors?

A. Well, I think it might be. But actually I -- I think it's about the visibility and the national visibility and accountability around recommendations.

So that's why I think there needs to be a system where people can see and systems can be held to account in terms of delivery of those recommendations. We need -- you know, my ideal and I think this, this would

be for that recommendations repository to be open for all to see, so it's very visible and transparent in terms of the progress that's being made in terms of the recommendations and how they are implemented.

I think we need to be really clear about how we are tracking progress and then how do we escalate when recommendations are not being made. There needs to be a mechanism -- and we have talked about a co-ordination board in the paper here, but there needs to be a mechanism that if recommendations have these barriers to implementation they need to be understood, they need to be unblocked and we also need to have a mechanism to decommission recommendations, for want of a better word because actually some recommendations by very nature go out of date and are superseded by other things that have come along, so we need to be able to say: actually, this recommendation is -- no longer.

Q. Relevant?

A. -- relevant, let's stand it down and everyone kind of understands that and understands the rationale.

I think it's about visibility, I think it's about being clear about how these are going to be tracked and monitored and it's about mechanisms for escalation when things aren't happening.

Q. You mentioned accountability, visibility and

accountability. Whose responsibility is it, where does responsibility lie where recommendations of Public Inquiries are not implemented, as far as you are concerned?

A. Well, I think that is what needs to be set out when recommendations are made and that very -- we need clear accountability at every level as to whose responsibility, whose responsibility it is for implementation and where that responsibility lies and we need to hold people and organisations to account.

In other industries, they have very clear lines of accountability and they have named people for who are accountable for delivery of safety.

Q. The last bullet point of findings on the screen in front of us:

"Few recommendation require a formal response from the recipient organisation and there is a lack of monitoring of the actions planned or taken to address recommendations. A monitoring system could help to track actions and identify opportunities for escalation where changes have not been made."

You have just referred to that and the need for escalation but what about the formal response: do you think there are should be a requirement for formal responses from those to whom recommendations are

directed?

A. Yes, I do, because actually they need to be -- well, I think going back a step. I think when recommendations are being developed, good practice we think is to work with organisations that are going to receive those recommendations so they don't come as a surprise and so that any kind of areas that, you know, may not be implementable or there is -- there's an understanding before recommendations are published about how they have been arrived at.

But then when a recommendation is made I think it's vital that there is a response and not a tick box response to that recommendation. I think it's vital in terms of the organisation taking responsibility for delivering on that recommendation but I also think it's vital that we give the public and patients and families confidence that that recommendation has been noted, has been addressed and there is action in place to address it.

Q. How do we overcome the difficulties that arise from the fact that recommendations from Inquiries are developed as a result of a response to a specific disaster or incident and might not necessarily be looking at the holistic issues involved?

A. I think that's where -- what I would like to

do is if with this repository we look at a system of coding recommendations that are available so that actually we can kind of work out where the recommendation should be going. We have heard two things throughout this work: one is that we have heard that some recommendations are too targeted. So, for example, I heard from mental health providers that when we looked at the maternity recommendations from Bill Kirkup's work in East Kent actually those recommendations, those findings, were very relevant to mental health as well as maternity and actually it would have been good to think about how they were translatable across the whole system. Whereas some recommendations we have heard are put out a blanket at all organisations when they should be more targeted.

And I think if there is a mechanism that we can make that easier for organisations to understand through a kind of system of coding recommendations as to who they are relevant for and who they should be targeted for, I think that would be helpful.

I think with, with many I think our learning with HSSIB is actually most issues are, are present in some way or another in most organisations and it's not usually unique to one organisation hence the reason for our body to be in existence.

Q. Do you think new recommendations should explicitly supersede previously related ones?

A. So I think there needs to be that conversation in a transparent manner which isn't happening I don't think at the moment, so I think if new recommendations, I think there needs to be formal process to look at whether recommendations can be stood down and whether the new recommendations should supersede them but at the moment there isn't that process to enable that to happen.

So I think it's -- I think it's about transparency of how these things are done and the mechanisms to do, to do this.

Q. Page 7 of your statement, please, the last paragraph, you refer to the recommendations registers there. Do you agree this initiative in the context of maternity and neonatal services could be replicated in other areas?

A. Yes. I think -- I think there is a lot of learning from the work that has happened in maternity and neonatal services and I think one of the things that we are doing as a group actually is -- is that team that have been working on that work are talking to us as a group around the work they have done.

But I think there is learning from learning -- from

that work, HQIP, as we have mentioned as well, have done a lot of good work in this area and so I think we are trying to look at best practice and think about how we develop something that is going to be as useful as possible for the system.

Q. Can we have a look at page 8, please. Development. And you say here the intended meaning of the recommendation could also be lost if the wording was unclear.

Do you have any comment about language and the language used generally in the NHS in documents?

A. Yes. So what we have heard across the system is that often recommendations use different language. So there's not a consistent language across many of the different -- across many of the organisations that are making recommendations as to how recommendations are made and this can lead to a different interpretation on the ground of those recommendations.

That is what we are trying to -- with the development of the guidance about how organisations should make recommendations we are hoping to drive some consistency within that, that's at a very early stage at the moment. But our ambition would be to drive more consistency in terms of that language across the system so that people can understand and I know some

organisations have, have very much looked at that, such as I believe the CQC looked at kind of "must" and "should" as certain words.

But we need to think about how do organisations across the system build that consistency.

Q. There does seem to be an enormous amount of acronyms in the NHS and they change, we have seen that from the research article, and what you are telling us, it is very difficult for people outside to keep up?

A. It is and actually even within the NHS, so I have worked on in a number of different bodies and each of those different bodies has a different set of acronyms as well, so it is not just within the NHS those pockets of acronyms.

So I think we do need to work really hard at looking at how do we make the language simpler and how do we have much more clarity about the words we use, so it's easier for everyone to engage and we can empower patients to work with us as organisations.

I think sometimes we hear from lay members working from us and patients that actually it's very confusing to actually try and, you know, if they are in a meeting to understand what -- what people are talking about because of the acronyms used.

Q. It is important it is accessible to everyone,

isn't it?

A. It is, it is.

Q. Users, patients, everybody?

A. Yes.

Q. "Next Steps", page 15.

You say:

"The current situation in relation to recommendations is untenable."

Would you like to expand upon that and what you say there or what it says there?

A. Yes. Well, for the reasons that we have outlined in that, firstly, there is so much work that's going on that's not leading to the impact for patients, it's not leading to, it's wasting resource by the work that's going on. It's leading to distress from patients and we have -- we have heard from a number of other Inquiries and patient groups, Inquest, for example, around the impact this is having not just in healthcare but more broadly.

I think with the current challenges the NHS is undoubtedly under huge pressure with -- from both the demand that it's facing and also from the financial position that it's facing.

So we need to make sure that recommendations -- we are really confident that recommendations that are being

made, there's a prioritisation system, so recommendations that are going out in the system are going to lead to the maximum impact for the costs that they take and that they are going to lead to the change that is required and that, you know, people in -- once a recommendation has been made we can be absolutely confident that progress will be made in implementation. There needs to be much more focus on implementation and, and measuring and monitoring that implementation than that we have at the moment.

Q. Professor Dixon-Woods gave expert evidence to the Inquiry at the beginning and she raised the issue you have about the duplication and number of bodies within the NHS or related to the NHS and suggested there might be a review to consider how do you reduce it where is the duplication how might you reduce it.

If there was such a review, who do you think is best to conduct that, she suggested the DHSC, I think, but what do you think about that?

A. Well, we know that there is a current review under way, being undertaken by Penny Dash which has been commissioned by DHSC so that is under way and will be publishing I believe some time in the near future.

Q. Do you have any idea when in the near future?

A. I don't know a date exactly but it's likely to

be in this quarter, I believe.
So the -- that is looking at some aspects of the landscape but I think looking, you know, referring back to that paper with the 126 organisations and thinking about the impact that collectively all organisations have on the local systems and how we kind of work together to empower those local systems to be able to deliver good care for their -- their population, I think is something we are going to need to do much more work on and I think how we work together, I think it might be kind of rationalisation of organisations.
But I said -- as I said before I think there's something we could do much quicker than that which is about how we collaborate, how we work together, how we coordinate things much more formally across the system.
Q. And perhaps remote working makes that a bit more feasible than it has been in the past in some ways for groups to get together and share what they are doing?
A. Absolutely, absolutely. There is no reason now with Teams and the technology that we use that we can't collaborate, we just need to prioritise it as a system across the -- across the system. We need to understand what skills and resources we have across the system and we need to make sure we are maximising those.

MS LANGDALE: Thank you. Those are my questions, Dr Benneyworth. I think Mr Baker may have some.

Questions by MR BAKER

MR BAKER: Dr Benneyworth, I ask questions on behalf of a number of the Family groups.
I wanted to ask you some questions about protected disclosure and candour --
A. Yes.
Q. -- in particular.
So your evidence before the Inquiry was that material that comes into the HSSIB as part of its investigations would be treated as protected?
A. That's correct.
Q. Might a synonym for that be "secret"?
A. No. I think -- so it is, it is protected by law. As -- it's a very different role we have to those individual investigations that are happening with individual families and patients across -- across local areas and as I said before very different than the kind of maternity type investigations that are undertaken by MNSI.
We work very, very closely with families and patients during the course of our investigations and actually we -- and with healthcare staff. As I said earlier, we do have exceptions so if we are ever worried

about the kind of --
Q. Well, perhaps I can go back to it. So if -- your investigation will relate to a particular case so you will be asked to investigate a particular event within an NHS Trust; that is correct, isn't it?
A. So we -- we start, it's -- we don't replace the local investigations that will occur --
Q. No, no. I --
A. -- in those particular events. So our investigations are often looking at multiple events that have happened across the same theme across multiple different Trusts.
So we -- in some of our investigations we will start with a reference event and then build out and we will then go to -- which is an investigating an individual case but we will then go to lots of different organisations to see if similar things have happened, we will look at then what's happening in different organisations --
Q. Yes --
A. -- to see if as an individual problem within that Trust or whether it is a wider problem.
Q. But there is a triggering event, there is an individual triggering event within a Trust --
A. Not always.

Q. -- that brings about --
A. Not always.
Q. Well, but in cases there has to be an event which forms part of the investigation?
A. So.
Q. That has to be right then, doesn't it, there has to be --
A. So in some of our investigations what we do is we -- so, for example, we heard a lot of concern from patients and families about the use of GP digital tools but we didn't have a reference event with that investigation but we felt we were hearing enough concerns from patients across the country and from stakeholders that some of the digital triage tools were causing difficulties in accessing general practice.
So we -- we undertook an investigation that didn't have a specific individual event but we went out to practices and looked and noticed that and the reason we think that is important is sometimes we want to investigate areas of emerging risk rather than just areas of risk that have happened.
Q. I understand that. But as part of those investigations, you will have to look at individual cases; correct?
A. Yes, yes.

Q. Yes. Now, within the course of that investigation, whilst looking at individual cases, if a disclosure is made to your organisation, that is treated as protected?

A. Yes.

Q. Yes. And it is treated as protected, and you set this out at paragraph 71 of your witness statement, to the extent that it would be a criminal offence --

A. Yes.

Q. -- by an employee of the HSSIB to disclose that information to an unauthorised person?

A. That's correct.

Q. An unauthorised person in this context could include or indeed would include the individual who was harmed or their family?

A. Yes, that's correct.

Q. Yes. So going back to my question. The disclosure that is made to you insofar as a family or individual patient is concerned, is secret?

A. So it's protected. I would not say it is secret. I think it's, it's -- we protect all of the interviews from patients and families as well as from staff and -- and just to say sometimes patients and families, it's as important this, this legislation for patients and families as it is for staff. Sometimes we

hear from patients how they are very worried that if they tell us what's happened they will be treated differently by -- with their ongoing care.

So this -- this legislation actually protects patients and families as much as it protects staff.

Q. What particular issue do you take with the word "secret" though?

A. Well, I think -- I don't want this to feel like it's a cover-up or we are hiding things. We very much put all of our findings that we find in our reports so our reports are transparent in terms of the findings, the learning, the recommendations that we make.

Q. Can you use critical language within your report?

A. We, we can use critical language, yes.

Q. There are no restrictions or guidance provided to investigators as to the type of words that they might use or not use within their reports?

A. No, we are -- we are very much -- we are an independent body, our independence is vital so that we can use language that we choose and language that we feel important and sometimes, you know, what we say is not always popular with what with some of the other bodies and some of the recommendations that we make but we feel it's very important that we -- you know, our

recommendations are there to and our investigations are there to raise those concerns, to talk about the things that have gone wrong and to be able to make sure that anything nationally needs to change, does change, so that these things don't happen again.

Q. But if it were disclosed to you over the course of your investigations, so for example in a maternity context, if a midwife said, "I simply didn't read the critical CTG trace and therefore didn't take any action in response to it", that would be treated as a protected disclosure, wouldn't it?

A. No. If, if we have any concerns and this is where the exemptions come in to play in our legislation, if we have any concerns about negligence, any concerns about criminal behaviour, any concerns that there are kind of areas that are of immediate risk to patients that are not being dealt with by the people we flag them, we always flag any issues both internally with the organisation. If we don't feel the organisation is -- is taking any action then we would raise it with regulators. We would clearly raise any criminality with the police if needed.

Q. Okay. So if we go to page 15 of your witness statement which is INQ0012335. So we have the exemptions to the general prohibition on disclosure set

out there. Begin at the bottom. So under paragraph 69, if we work through those to page 16, would you identify for me, please, the schedule and part which enables you to make a disclosure in the event that you identify negligence?

A. Yes, Schedule 14, Part 4.

Q. So that is on the following page, that is on page 17. So:

"In circumstances where the HSSIB believes that the disclosure of material is necessary to address a serious and continuing risk to the safety of any patient and the chief investigator reasonably believes that the person is in a position to address the risk. The disclosure is limited only to the extent necessary to enable the person to take steps to address that risk."

A. Yes.

Q. So if there were an identification of negligence, you would have to be confident that there was an ongoing competency issue --

A. Yes.

Q. -- in order to make a disclosure and then that disclosure would be limited presumably to an individual within the Trust employing that individual?

A. Not necessarily. If we felt that --

Q. Or the regulator?

A. If -- yes. If we felt that there was not the appropriate action or if we had significant concerns them we would refer to the regulator and we have had numerous discussions with the regulatory bodies as we came into being as an organisation about how that would work.

Q. But not to the affected family?

A. So we wouldn't -- so it would depend on, on the circumstances of, of this. So we wouldn't --

Q. Well, I think under Part 4 of Schedule 14, the disclosure is strictly limited?

A. Yes.

Q. To the person who is in a position to address the risk, so not to a family member?

A. So we -- we don't, our legislation doesn't replace the duty of candour an individual organisation would have to the family and --

Q. Well, in fact, it introduces a layer of secrecy, doesn't it?

A. It introduces, we -- the protection that we have with our legislation is, is vital because we need to get to the nub of why things have happened and why things have gone wrong and unless we really understand that we are not going to be able to kind of change this for future.

We hear so often, like I said, not just from staff members, sometimes it is from families as well, they don't feel confident talking about things, they don't feel able to speak up, they don't feel able to kind of disclose what happened. Unless we really understand that ideally we will have a culture in the future where our legislation is not required and, you know, people feel able to be able to have these conversations without it.

But the learning from -- from industries like the Air Accidents Investigation Branch who have been doing this for years and years and years that driving that just culture is really important and that this legislation enables that to develop.

Q. But if we look at the aviation industry and protected disclosure in that context, it usually relates to near miss incidents, doesn't it, not incidents where there are fatalities or casualties because air crews simply cannot make disclosures?

A. Well, there is a lot of investigations that they undertake that don't end up in fatalities.

Q. Indeed.

A. And they have this legislation, the AAIB have the same -- the same protected disclosure.

Q. But is there any evidence that in the

healthcare industry that people or any investigations or data or indeed any information at all to suggest that individuals who cause harm negligently to patients are more likely to disclose information if that information is then protected?

A. I haven't seen any evidence related to that. I don't think it's something that's been looked at.

Q. So this has been introduced without any data to suggest that it's likely to bring about greater disclosure in circumstances where it actually introduces a level of secrecy and removes candour from patients?

A. The learning, like I said, the learning from the other industries is that this does improve the ability to understand the facts as to why things have gone wrong. And we -- we know that we have a culture in the NHS where people are afraid to speak up at times. Sorry.

Q. But that's presumably a cultural issue. There is a difference in the culture between the aviation industry and the healthcare industry and the aviation industry are far more willing to report safety issues that they have identified because they know that they can be engineered out?

A. Yes.

Q. The healthcare -- the healthcare industry, the

NHS in particular has a poor reputation for transparency?

A. It -- it does and we have got to change that. Collectively we have got to change that.

And actually what we are trying to do is engineer out, this is exactly what we are trying to do as an organisation is engineer out, really think about human factors, safety science that engineers out those risks for errors and risks for things to go wrong.

Q. But on behalf of patients, the reputation for transparency, how is that enhanced by introducing protected disclosure?

A. So as I said before, what we hear from patients and families that we work for, work with, is that what they want is for things, what they -- they kind of want from us is to drive the changes that are going to make sure that families, further families, further patients, don't go through the same, same events and we think that the way we work it's very different.

This is not -- as I said before, this is not replacing a local investigation and part of our education work is really working to upskill investigators so they do engage families.

We do believe that transparency is very important, in those local investigations that happen transparency

is vital. It is vital that families are engaged right the way through an investigation.

Sorry, I have got a tickle.

But the work that we do is different in terms of we are looking at the national learning, we are looking at the reasons, the systemic reasons why things go wrong. It's not the same as a local investigation with an individual family and our recommendations go into national bodies.

So we are not saying that, you know, transparency is vital in every aspect of the work and local investigators should be working in a very open and transparent way. Providers should be very open with patients and families, there should be no attempt at any kind of cover-up, there should be no attempt to any hiding anything from families and patients in those situations.

The work we do looks at those national reasons as to why things, often are kind of happening in multiple different providers.

So we are not replacing in the work we do the local investigation and the local learning that needs to happen after incidents.

Q. But, but if -- and this is my final question -- you have a situation where an individual

member of staff is too scared to say what really happened because of a fear of repercussions, so scared that they need to have a level of protected disclosure that has criminal sanctions attached to it, how can you count on them to be open with the local investigation? How can you count upon the local Trust to be candid with the affected parties? You can't, can you?

A. Well, we, we -- I think we need to make sure that this is where we need properly professionalised skilled investigators that actually understand how they can really get to the bottom of these issues, how they interview people properly so that they can get that information without people feeling scared.

We need organisational boards to drive that culture of transparency and openness and support those investigators in their work and support the families and be really open about what's happening. So there is a huge amount to do.

I completely agree we have not got the culture right at the moment. We have got a huge amount to do in terms of culture and we hear on a daily basis as to where those patients and families are not getting that kind of support and that help through those investigations, we really want to address that.

Q. Would you agree you need cultural change so

that one doesn't need a situation where you have protected disclosure?

A. Absolutely. Absolutely. If we can, if we can do ourselves out of a job, we would be very pleased.

MR BAKER: Thank you. Thank you, my Lady.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Thank you, Mr Baker.

Dr Benneyworth, just picking up on a theme that you have developed throughout your evidence which is the role of your team in education.

A. Yes.

LADY JUSTICE THIRLWALL: And I think the way you put it was "upskilling" investigators. We know obviously there are all sorts of levels of investigation within hospitals, GP surgeries, et cetera. How many of you are there in the team involved in the education side?

A. So we have a very small faculty of -- we have a director, we have a faculty of 3.4 whole time equivalents and a support manager.

So it is an incredibly small team.

LADY JUSTICE THIRLWALL: Yes, and a huge task --

A. Yes.

LADY JUSTICE THIRLWALL: -- as you have described it. And some of the work, is it done face to face,

mostly it's done remotely for the reasons that you have explained.

But being realistic, with that size of team, how long is it going to take to upskill all those who need to have upskill, if that is the only way of doing it?

A. So it's going to take -- it's going to take quite a long time to get people to -- really to the skill we need, although we are doing some other work. Alongside that, our education team are developing competencies, a competency framework for investigators that we are hoping we will able to kind of use and roll out and -- and encourage the system to so that investigators often, they can be sometimes quite a junior member of staff and sometimes quite a senior clinician and anywhere in between and we think that we need to make sure all investigations are done by skilled people with the correct competencies.

And so we would love to have more resource to be able to kind of roll out our education programme. We have got waiting lists for quite of lot of our education programme and there's a huge demand and as I said I think we have only just scratched the surface in terms of not being able to at the moment roll out in primary care community care as much as we would like to.

LADY JUSTICE THIRLWALL: What difference would it

make -- I mean, I appreciate everything -- I really do appreciate that everything costs.

A. Yes.

LADY JUSTICE THIRLWALL: And you need to be able to demonstrate a benefit for the cost, preferably a benefit which is greater than the cost.

A. Yes.

LADY JUSTICE THIRLWALL: But what's the benefit of training people within organisations, at whatever level, and whether it's primary, secondary or tertiary care?

A. So firstly I think from a patient and family point of view the benefit is that they will, they will feel an investigation is done properly. You know, quite often we hear of patients and families who they have had an investigation and then feel that actually it hasn't really answered their questions, they haven't been listened to.

So actually making sure patients and families are right at the centre of the investigation is vital.

Secondly, it will really make sure that investigators understand how to kind of untangle the complexity of the system that people are working with, look at the system-wide factors as to why things have gone wrong and most importantly really look at how, how we can make the changes, what changes are going to lead

to the changes needed on the ground that will prevent these things from happening again.

Sometimes we -- you know, investigations don't always lead to recommendations that lead to change and we need to make sure that when investigations occur, they occur and they lead to the changes. So we don't see the continual harm.

We see all the time the impact of recommendations not being implemented and the harm continues and we hear again and again about the same harm continuing and we have to change this cycle and we have to get to a place where once we have identified something that's gone wrong, we know what to fix and how to fix it and those changes happen quickly.

LADY JUSTICE THIRLWALL: Thank you. You have mentioned repeated harm as a result of failure to follow or implement recommendations. I assume you are relying there on an evidence base, I am sure you are.

I don't want to take time with that now but would you be able to provide the Inquiry with what it is you are referring to in that regard?

A. Yes.

LADY JUSTICE THIRLWALL: So that we can then ask other people about it --

A. Yes, we certainly can.

LADY JUSTICE THIRLWALL: -- as well?

Thank you very much indeed. Does anybody want to ask anything arising out of those questions?

No, in which case, Dr Benneyworth, I am glad your tickle has been resolved. Thank you very much for coming to help us today. You are free to go.

A. Thank you.

LADY JUSTICE THIRLWALL: So we will take the break now and we will start again at 5 to 12.

MS LANGDALE: Thank you, my Lady.

(11.36 am)

(A short break)

(11.55 am)

LADY JUSTICE THIRLWALL: Mr De La Poer.

MR DE LA POER: My Lady, our second witness today is Ms Helen Herniman and I wonder if she might come forward, please.

LADY JUSTICE THIRLWALL: Come forward, please.

MS HELEN HERNIMAN (affirmed)

Questions by MR DE LA POER

LADY JUSTICE THIRLWALL: Do sit down.

MR DE LA POER: Please could you give us your full name.

A. Yes, my name is Helen Rachel Herniman.

Q. And Ms Herniman, is it correct that you have

provided to the Inquiry two witness statements, one dated 7 August of this year and one 7 November of this year (sic)?

A. Yes, that is correct.

Q. Is the content of those statements true to the best of your knowledge and belief?

A. Units.

Q. In addition you gave those statements in the context of Ms Andrea Sutcliffe having provided four witness statements to the Inquiry; is that correct?

A. Yes, that is correct.

Q. Have you had an opportunity to familiarise yourself with the content of her statements?

A. Yes, I have, thank you.

Q. Have you satisfied yourself that the content of those statements, save as you update them in your subsequent statements, is true to the best of your knowledge and belief?

A. Yes.

Q. Now, before we come to introduce you, I am just going to read from paragraphs 5 and 6 of your statement and then ask you a question about it. What you say at paragraph 5 of your first statement is this:

"My thoughts and condolences go out to the Families and loved ones of the babies who were killed and harmed

by Lucy Letby. We are deeply saddened by the unimaginable extent of the loss and harm caused to so many Families. We want to ensure that our role as the regulator of nurses, midwives and nursing associates fulfils our vision of a safe, effective and kind nursing and midwifery practice for everyone. I welcome the opportunity to provide this reflective statement and evidence to the Inquiry on behalf of the NMC setting out the reviews we have undertaken in response to Lucy Letby and Alison Kelly cases.

"What we have learned from our reviews, how we have implemented that learning to date and how we will continue to implement learning going forward to ensure public safety is maintained in the nursing and midwifery professions."

So my question is this: are those statements that you wish to be on the record as you begin your evidence?

A. Yes, they are, thank you. Since I am here in person today I wanted to reiterate our condolences both personally and on behalf of the NMC to the Families of those whose suffering is, is at the heart of this Inquiry today and also as the acting Chief Exec and also the interim who will be taking over later this month to reiterate our commitment to the Inquiry and to learning from the recommendations made by the Inquiry.

Thank you.

Q. Now, Ms Herniman, at the time of making your first statement, as I think you have just told us, you were the acting Chief Executive Officer of the NMC; is that correct?

A. Yes.

Q. Were you also at the time of that statement the acting Registrar?

A. Yes.

Q. Is that a position you still hold today?

A. It is until 20 January, yes.

Q. Did you take up both of those positions on 4 July of last year?

A. I did, yes.

Q. Are you an accountant by background?

A. I am. I am a Fellow member of the Institute of Chartered Accountants of England and Wales.

Q. And have you before joining the NMC acted as the Chief Finance Officer for the Law Society?

A. I was the Chief Finance Officer for the Law Society yes, I have over nine years' experience within the regulatory sector, over three and a half of those has been with the Nursing and Midwifery Council. Previously in an operational director level role -- excuse me -- with a previous regulator.

Q. So far as the NMC is concerned, did you join in 2021?

A. I did, yes.

Q. Was that as the interim Executive Director of Resources and Technology Services?

A. Yes, yes, it was.

Q. You have told us that your current roles are going to subsist for some short further period. Please could you tell us what the plan for the leadership of the NMC and for yourself is once we reach that changeover date?

A. Yes. So I am the acting Chief Exec currently -- sorry, Chief Executive currently. An interim Chief Executive and Registrar has been appointed. He will start on the 20th of the month and as I said Paul Rees is here as part of his readiness for taking on that role. I return to my substantive role that is the Executive Director of Resources and Technology Services later this year.

In this quarter, this calendar quarter, the organisation will look to appoint a permanent Chief Executive and Registrar for the organisation.

Q. So we are going to turn now to the topic of what the NMC is and what its role is. This is all laid out in substantial detail, you can agree in

Andrea Sutcliffe's statement which will in due course be published.

But is it right to summarise it in this way: this year a number of regulatory functions that the NMC has: firstly, education, training and standards; secondly, registration; thirdly, revalidation; and fourthly, fitness to practise?

A. Yes, that is an accurate summary of what we do as the regulator.

Q. We are going to focus your evidence today on the matters directly with which the Inquiry is concerned. But one of those four functions, fitness to practise, requires just a little further amplification at this stage and we will come back to revalidation at the end of my questions.

But in terms of the principles concerning fitness to practise, are there essentially two parts to fitness to practise, there is the interim orders side of things and then there is the fitness to practise proceeding side of things?

A. Yes, there are the two elements.

Q. Insofar as interim orders, so that we all understand this, is as it would suggest, an interim order, a measure which is placed before there is a full determination of any concerns which may be applied on

the basis of a statutory test?
A. Yes.
Q. I will just read that statutory test. The wording is important to my questions:
"An interim order can be imposed if it is necessary for the protection of members of the public or is otherwise in the public interest or is in the interests of the persons concerned for the registration of that person either to be suspended or to be made subject to conditions."
A. That's correct, yes.
Q. So that we all understand or we can readily understand suspension, but conditions. That is to say restrictions or limitations on the extent to which any particular nurse or midwife may practice while their case is being investigated?
A. Yes, that is correct.
Q. So typically that might mean something like working only under direct supervision or perhaps being excluded from a particular area of nursing or midwifery?
A. Yes.
Q. So far as the second part of the fitness to practise directorate is concerned, the fitness to practise proceedings, those are what people would ordinarily recognise as the substantive trial of any

particular allegation for a breach of the code?
A. Yes.
Q. That process can result in sanctions including suspension and the removal -- or the removal of the name from the register?
A. Yes.
Q. So that is very much a whistlestop tour of some of the functions of the NMC.
I would like to turn now to the Employer Link Service, again a very substantial amount of detail about this service is included.
But for context for my later questions, can we summarise it in this way: first, that it was set up in response to the Mid Staffordshire Inquiry?
A. Yes.
Q. That it was piloted in September of 2015 and that it started as a substantive service in April 2016?
A. Yes, that is correct.
Q. So when we come to the facts that the Inquiry is concerned with, it was, as a substantive service, very much in its infancy by June -- forgive me, by July of 2016?
A. Yes, it was, I think it had been operating for about three months at that time.
Q. Now, I can take you to the reference if you

need but what Andrea Sutcliffe says in her statement at paragraph 83 is that:
"The Employer Link Service aims to encourage robust local investigation where there is concern relating to nurses or midwives."
Is that your understanding of the function of that service?
A. It is, yes.
Q. So just the language that we focus upon in that sentence is that it is to encourage robust local investigation; in other words, that it gives help, support and guidance to people who contact it about how they can better understand what the problem that they think they have might be?
A. Yes, what concerns they have about an individual that is on our register with regard to their fitness to practise; yes.
Q. But it's not just an opportunity for a concern to be voiced but the function of the service is to say: this is what you might do about it?
A. That is correct.
Q. We note the word "robust"; in other words, that it isn't simply giving lightweight advice. It is saying: these are the steps we advise that you take?
A. Yes.

Q. So before we come to our facts, I just want to touch briefly on the case of Beverley Allitt and in particular the Clothier Inquiry's recommendation about the need for the possibility that a person may be maliciously causing harm to be part of the NHS's corporate memory and as we know Beverley Allitt was a nurse and so the NMC which at the time of the report didn't exist but had a predecessor organisation would have, do you agree, a real interest in ensuring that corporate memory?
A. Yes.
Q. We know that there have been confirmations before Letby's crimes of the need for such vigilance such as nurses as Colin Norris and Victorino Chua. Are you aware at least in general terms of both of those cases?
A. I am afraid I am not, no.
Q. Well, you can take it from me they were cases which occurred shortly in the years before Letby began her crimes and in the case of Victorino Chua he was sentenced, he being a nurse, for murder shortly before Letby began the crimes that she has been convicted of.
So in relation to the preservation of the corporate memory that maliciously -- malicious harm may be caused, so far as you are aware, what has the NMC done to embed

that in all of its practices and thinking?
A. As the NMC, our starting point has to be that those that are referred to us, those that contact us are that we trust them themselves, we trust the process.
However, our overarching objective is to protect the public so any concerns that are raised with us, we need to take an approach whereby we ensure we are reducing any risk of any harm to the public and throughout all of our processes, whether it's from the Employer Link Service, the LS team or whether it's from the standards we set with our educational institutions, we make sure that they start by looking at the health and character of those that not only they take into the profession at that early stage but we apply that all the way through our processes whilst they are on our register.
Q. Now, your reference there to health in character was a separate recommendation made by the Clothier Inquiry. The recommendation that I was just inviting you to focus upon is ensuring that it was in the minds of people when they are presented with issues or problems that they allowed for the possibility that what was being described to them was the product of deliberate harm and so I will ask my question a slightly different way which is: do you know whether the NMC

provides training to its staff which includes reference to the need for them to have that possibility in mind when they are dealing with people who are making referrals to them?
A. I'm afraid I don't know specifically that that is included in the training. I am not close enough to the training.
Q. You feel in a position to agree that that if it isn't in the training, it ought to be.
A. I absolutely feel that it's appropriate for me to confirm that is the case and obviously the learnings from the Lucy Letby case need to be either directly or indirectly included in that training because of the significance of the events within this case.
Q. Of course mercifully these are rare events but history has demonstrated that they are not Never Events, they are events which do occur and when they occur they are catastrophic and so it's extremely important that they are identified and managed appropriately as soon as is possible; do you agree?
A. I do agree, yes.
Q. So we will turn now just to look at a review of the first part of the timeline before I ask you some more detailed questions. So we are here dealing with the timeline up to the point of referral by

Alison Kelly. So if I can invite you to bring up in front of you in your hard copy materials paragraph 33 of your first statement?
A. Thank you.
Q. As you will be aware, Ms Herniman, we have heard some of this from Mr Newman just before Christmas so some of these dates and events will be familiar. But we can see that the starting point, so far as the NMC was concerned, was on 6 July 2016 when Alison Kelly contacted the Employer Link Service.
We will come back to the email that identifies what was discussed in that meeting. But we can see that the next event isn't in your list here, it's in the subsequent paragraph, I think your list was drawn from Andrea Sutcliffe's statement?
A. Yes.
Q. And other events were identified, again we will come back to the circumstance of that but the next event chronologically is 23 August 2016, which is where the NMC contacted the Countess of Chester Hospital seeking an update arising from the 6 July; is that right?
A. Yes.
Q. We can see from the content of your paragraph 34 that there was a response to that some

eight days later on 31 August 2016, from Alison Kelly to the effect that there had been a thorough internal review and nothing of significance was identified and that Letby had been placed on non-clinical duties and that there was reference to Letby being understandably very distressed and there was then an acknowledgement the next day from your Employer Link Service about that contact?
A. Yes.
Q. Returning to your paragraph 33, the next event was in fact nothing to do with Letby's case; it was part of the roll-out of the Employer Link Service; is that right?
A. That is.
Q. 15 September and this was to confirm an introductory meeting that was to take place at the back end of the year, effectively with the Employer Link Service introducing themselves to personnel at the hospital; is that right?
A. Yes, that's correct.
Q. That presumably was driven in large part by the fact that it was a new service and it was about raising the visibility of that service and ensuring people knew about it?
A. Yes.

Q. Then just before that meeting, on 24 November, material relevant to that meeting was sent by the Nursing Midwifery Council; is that right?

A. Yes.

Q. The meeting took place on 29 November and participating in that were Alison Kelly and Sue Hodkinson?

A. As I understand it now, yes.

Q. Yes, you can take that from me, that is recorded in Ms Sutcliffe's statement.

A. Thank you.

Q. What we know from the record of that meeting is that there was some discussion of the referral and reference to the Royal College of Paediatrics and Child Health having conducted an investigation?

A. Yes.

Q. We then see your next event is 5 January when Alison Kelly contacted the Employer Link Service to confirm the publication date of the Royal College report?

A. (Nods)

Q. Then nothing until 18 May. This contact being driven by the Employer Link Service, seeking to understand from Alison Kelly more about the circumstances there having been a press release to do

with the police investigation?

A. Yes.

Q. So that chronology being the press release, the NMC becomes aware of it, and the NMC then contacts Alison Kelly to find out what's going on?

A. Yes.

Q. Again, advice given by or information given by Alison Kelly that Letby remained on restricted duties and that the investigation was at its early stage?

A. Yes.

Q. We then see that there was a meeting at the Countess of Chester on 15 June seeking further information and effectively there was not a great deal further reported to the NMC at that stage about the police investigation; it was just a month or so after it had begun.

9 October, were the NMC notified that the police had started interviewing employees? Then on 3 July 2018 bringing us to the end of this first part of the chronology, again, through the media, did the NMC learn that an individual had been arrested and that that resulted in contact with Alison Kelly which, in turn, prompted the referral that was made two days later?

A. Yes.

Q. Now, just speaking generally in terms of the

NMC's expectations. Is it the position that the NMC has any expectation that an individual organisation such as the Countess of Chester would be proactive in providing significant updates such as the commencement of a police investigation or the arrest of an individual or does the NMC operate simply on the basis that it will scan the local press and find out for itself?

A. No. It is the -- we do expect proactive notification to be given to us of matters of this kind. The scanning of the press is almost like an assurance measure just in case Trusts -- employers aren't proactively updating us, as was the case in this situation that we have just discussed.

Q. Is the NMC satisfied that it made it sufficiently clear to the Countess of Chester that that expectation existed?

A. My understanding of reading of the information that was available, I believed that we did make it clear to the Countess of Chester Hospital, to Alison Kelly, that we expected to be notified of any significant changes.

Having said that, there was also an onus on us to proactively chase up for updates, for information, if we had further questions in addition.

Q. But just in terms of those two key events,

whatever the regular process of ensuring that you were up to date was concerned, does it come to this, that the NMC would have expected to have been notified about both of those immediately?

A. We would have expected to have been notified immediately, yes.

Q. So pausing there in our chronology, we will just look at some of these events in greater detail and we will go back to 6 July which is the initial contact and I am going to ask for a document to come up on screen, please. INQ0002445. If we can crop into the email at the bottom of the page. This is one that the Inquiry has looked at several times previously and in particular with Mr Newman but I just want to look at the information that is available in this email before asking you some questions about it.

We can see that the bullet points are that:

"There was a rise in mortality of babies on the neonatal unit;

"That deaths had been subject to a clinical team case review;

"The reviews have produced no evidence as to a lack of competence by the individuals or team; further analysis has identified one registrant as being present nearly all these incidents;

"Some clinicians are concerned that the registrant may present a serious risk to public safety although no evidence is available at this time.

"The registrant concerned [Lucy Letby] has received occupational support following the deaths and is currently on leave;

"And the Executive Team are due to meet today [that is 6 July] to decide if the registrant will be reported to the police to investigate."

Now, you have said at your paragraph 37 that the advice provided by Mr Newman was appropriate advice; that's the current view of the NMC:

"Although these were potentially extremely serious concerns [you say in your statement] Mr Newman was informed that the Countess was investigating and had not reached any full-time decision about the next steps. We think it was reasonable for us to wait until the Countess of Chester had made a decision about a police referral before taking any further steps."

Now, that is the advice that you are talking about but the advice, do you agree, is entirely dependent upon the information that is provided to the person giving the advice?

A. That is absolutely correct, yes.

Q. And one of the acknowledgments that you have

made in an overarching way about the NMC's approach and which has led to further guidance, namely the culture of curiosity, is that, speaking generally, the NMC's position is that its employees should have been more curious?

A. Yes.

Q. Is this first call an occasion on which it's the NMC's view that more curiosity should have been shown?

A. Yes. That, that -- that I agree with that. I think we just have to remember at this time that the first call came through the Employer Link Service had only just been established with -- there were experienced people but it was an inexperienced function but even on reflection, and as you have mentioned my colleague Mr Newman, who appeared in the Inquiry before Christmas, the reflections from him and the reflections from the organisation is that in this situation there should have been a higher degree of curiosity that maybe would have helped elicit more information with regard to the circumstances that we are discussing here, yes.

Q. Of course, as you rightly say, Mr Newman has given his own evidence. What we are interested in today is what the NMC thinks which may be the same as Mr Newman, it may be different.

If we just have a look in practical terms what "curiosity" means because it is a phrase or a word that is used often.

But we can see, for example, at the third to last bullet point "some clinicians", which is the correction, it seems that Mr Newman originally formed the impression it was the Trust that had the concern, that is he wrote the email, then we have "some clinicians".

As an example of curiosity, knowing who those clinicians are is potentially highly relevant information?

A. Agreed, knowing who those clinicians are and what the specific concerns of those clinicians are would have been important.

Q. Yes, well, we will come to the concerns in a moment because had there been a concerted effort to identify exactly who it was who had concerns, we know that the answer, the truthful answer, will have been the head of the neonatal unit, the lead Consultant for children's services and all five Consultant colleagues, which adds quite a lot of colour, do you agree, and potential potency to simply "some clinicians"?

A. Agree, which is why it is the position of the NMC that we should have shown more curiosity at this time.

Q. And again -- and I acknowledge you have made that concession, but as you have said already, understanding what risk, as it's described there, the person may pose is extremely important because the risk that was perceived by the Consultants was that she was murdering babies, which may not necessarily be in the mind of a person when they are talking about the fact that an individual staff member poses a risk, as we know the mind often goes to competence and we can see earlier in the list that incompetence had apparently been ruled out by individuals.

So getting that absolutely expressed would be extremely important, do you agree?

A. I do agree because at the time that we received this information the -- what we were aware of the information that was provided to us was an increase in the mortality rate and whether it's because we -- well, we didn't follow up from a curiosity perspective, we were not aware of the risk that the individuals thought that somebody was murdering babies; correct?

Q. Again perhaps would you agree this underlines the importance of the Clothier recommendation that if your staff had in their mind that they should always consider the possibility of deliberate harm, that this is exactly the sort of conversation that might develop

into a: look, you just tell me exactly what is it that you are saying, has that been excluded, is that a worry that people have, and again that will inform how advice is given and how seriously it is taken?

A. I do agree with that. The NMC receives on average about 500 referrals per month and the referral or a situation like this is exceptional and extraordinary. However, having said that, the seriousness of an issue like this does mean that I can understand why it would be beneficial to always have that in -- at the forefront when we are receiving any information into us as the regulator.

Q. And so in terms of this very early stage, is it the NMC's position that the fact that there wasn't greater investigation in the conversation as to exactly what was going on may have impacted the overall management of Letby by the NMC?

A. The advice that was given back in 2016 was based on the information that was provided to us which was based on the curiosity, the questions that we asked.

Had we have asked further questions, shown more curiosity, as you have mentioned, we may have received information which would have potentially led us to give different advice regarding the referral.

Q. And might have that advice included: look,

I would really like to understand exactly what it is the Consultants are saying and why they are saying it?

A. That's -- asking those questions, yes, absolutely.

Q. Because we know that following advice given by a barrister in April of 2017, the Consultants in May 2017 produced a document which set out in some detail exactly why they were concerned and that we know that that document effectively formed the touchpaper for the police investigation. So it clearly is capable --

A. Yes.

Q. -- on the facts that we know of having an effect on the minds of investigators and do you agree that is exactly the sort of thing that might have been provoked had this conversation been conducted in greater depth?

A. Yes, I do agree.

Q. Similarly if that sort of conversation had been discussed and it had been articulated that what the Consultants were really saying is that they thought that she may be killing babies, would the service at that stage have been sufficiently robust to have been in a position to advise the Trust: well, look, I know you are thinking about calling the police, the NMC's position is really that is warranted if that's what that

body of people are saying?

A. Sorry, could you repeat that, sorry?

Q. Of course. I am trying to factor into my question, which is perhaps why it is overcomplicated the fact that the service was in its infancy at this stage.

A. Yes.

Q. But would have expected even at that stage that if your adviser was being told a group of senior Consultants are worried that she is murdering babies, your Executives I know are having a meeting to decide whether the police should be called, the NMC's position is that that should occur, given that level of concern?

A. If -- if that's, if those words had been used and the seriousness was more apparent or concerns about the seriousness was more apparent yes, I do agree.

Q. So in other words, even at that early stage there was an expectation from the NMC that your advisers would be clear thinking enough to say: this is a situation for the police what you are describing to me?

A. There would have been an expectation as a minimum for the advisers to discuss internally as we do with peer reviews to take different views within the organisation and also at the time the escalation process for -- for decision-making or for understanding across

the whole organisation, we could have used some sort of escalation to get to understand and therefore advise the regulatory adviser on how they should engage on receiving this information.

So yes, I think internally, it would have potentially put a different perspective on it which in turn would have directly impacted the advice that was given to the Countess of Chester Hospital.

Q. As it was -- the advice was effectively: you carry on as you were and we need to speak about this in due course.

A. Based on the information that was given to us, accepting the level of curiosity that was or wasn't shown at the time, based on that information, the -- the advice given was bearing in mind that we were informed that there was a decision imminently to be taken by the Executive Team as to whether or not to inform the police, which actually wasn't the next step, the decision that was taken, so it wasn't really: just carry on.

It was a little bit more specific than that. But in essence it wasn't relating to a seriousness if, if we were, had been aware that the clinicians had concerns that there was an individual on our register murdering babies.

Q. Now, we know that there was a follow-up by the NMC on 23 August. So again this is the new information in your statement which we looked at a moment ago which appears to be effectively a chase from the NMC saying: what's going on? Which prompted a result eight days later from Alison Kelly.

Now, what you appear to concede in your statement is that whilst it was reasonable for the NMC to await the outcome of the decision that was to be made that day, the NMC should have been more proactive in chasing that?

A. I would agree with that. Yes.

Q. So in other words, although in fairness to the NMC this was a proactive step by the NMC to find out what's going on, it was too late?

A. It took longer than it should have done, yes.

Q. And was there any good reason why bearing in mind the decision was slated to be taken that day that in the call on 6 July the adviser shouldn't have said: well, look, you are making this decision today, let's speak in 48 hours once you know where you are, and let's schedule a call now; is that something that should have been said, do you think?

A. Again on reflection, yes. I think the understanding of the individual from the NMC that took

the call, their interpretation of what was told to them was that there was a concern about the increase in mortality, in the mortality rate, that there were concerns by clinicians, there was information that one individual had been on duty for the majority of the -- of the deaths but that individual had a good track record from a clinical perspective.

That information that was known at the time probably didn't ensure that the individual readily said within 24 hours or followed up within 24 hours. Again in hindsight, the importance or the potential seriousness of the matter on that information let alone if we had been more curious and had obtained more information would have meant that we should have asked for a follow-up much more quickly.

Q. And of course whoever it was who was thinking this, whether it be the clinicians or someone else, somebody thought that this might be a matter for the police because -- and that information was communicated to your adviser because they are told the decision about whether the police would or wouldn't be contacted was going to be made that day, so plainly it was of that level of seriousness in at least somebody's mind?

A. Yes, that is correct. Yes, we were aware of that.

Q. Now, insofar as why Ms Sutcliffe didn't identify that contact on 23 August in her statement subsequently came to light and you provided it in yours, what you tell us is that that information has only recently come to light, you deal with it at your paragraph 52 and you go on to explain why and it would appear that there -- the system that you had for recording when something was simply being chased didn't allow for that chaser to be put in the single repository of knowledge, is that a fair way of describing it?

A. It is, because other time there wasn't a reason code which is not really a very satisfactory explanation, given where we are today. But as I understand it, that was the reason that it wasn't filed accordingly yes.

Q. Is the NMC satisfied that having recognised this deficiency in the system as it existed at that time, that all relevant information has now been provided to the Inquiry?

A. On that, absolutely, yes.

Q. So we then although there is some contact about the RCPCH report, there is the discussion at the 29 November meeting. The next substantive action that occurs is the NMC proactively contacting the hospital in the light of the press release in May of 2017 and again,

you made a general concession that the NMC should have been more proactive.

Does that apply to the period that is covered by what I have just described in other words from August through to May of 2017, that although there was sporadic contact, the NMC should have proactively been saying exactly what is going on, who is saying what, what's being done about it?

A. Yes, I would agree that we should have been more proactive.

Q. Now, at paragraph 39 of your witness statement, you provide some commentary upon the advice that as it's recorded on 18 May, and the note, I will just read it into the record, it is recorded in your paragraph 39, made by the adviser is:

"I advised that at this stage as she has been advised previously there is nothing which could amount to an identifiable or sustainable allegation of impaired fitness to practise. However, the outcome of the police investigation has the potential to be very significant and if this individual or any other registrant is identified as having been involved in the deliberate endangerment or murder of any infants in question then plainly a referral or referrals would be necessary. Accordingly we will need to be updated as matters

progress."

So that is the note and you have added a sentence after that, which I would just like you to remind yourself of and then assist us with, where you point to what you think may be an impression given by that advice which, if it accurately reflects the advice given, wouldn't be appropriate.

So however I have phrased it there, perhaps you just in your own words, what comment do you have as you recorded there about, about the advice, insofar as the NMC is concerned?

A. So, sorry, just to be clear, we are looking at paragraph 39 here?

Q. Yes.

A. Then it is the final -- excuse me, the final sentence that you are specifically asking me about; is that correct?

Q. Yes, exactly, yes?

A. Apologies sorry.

Q. Not at all, it is my question?

A. The -- my understanding is that the Alison Kelly or the Countess of Chester Hospital misunderstood what we meant or what the regulatory adviser meant with regard to the importance of the police investigation and as it says in the sentence

there, the RA, the regulatory adviser, was specifically responding to the issues that had been raised, although it seems that it was taken that they, they were suggesting that the bar that had to be met for referral to us was that there had to be involvement from the police.

Whereas my understanding is that the regulatory adviser wasn't -- that wasn't the point that they were making.

Q. So, I mean, on the face of the note what it seems to be saying is: if the police are interested in this, then make a referral, and -- and the NMC has conducted its own internal investigations, spoken to that individual, understood what that individual says that they meant by it. But just on the face of that note, that's what it says, I think the NMC's position is that that isn't an accurate way of approaching it?

A. That, that is correct, yes, that -- that doesn't define the bar for us to advise for a referral to be made to us.

Q. So for example it would have been and it should have been open to Alison Kelly, if she had wanted to, to pass on any information that she had to the NMC about what the Consultants were saying as at 18 May?

A. Yes. Absolutely. Again for her, the Countess

of Chester Hospital to be proactive in any other developments any other information that had come to light, yes.

Q. Now, it is a matter for the evidence whether Alison Kelly in fact had access to the Consultants document prepared for the police, so I am not going to go there, we are talking in the hypothetical here.

But in terms of the NMC's approach, is the NMC satisfied that it was sufficiently clear with Alison Kelly that she should be providing the most up-to-date information to them so that that could be considered by the NMC regardless of what the police were doing?

A. From what I have read with regard to what happened at this time, and the documentation that I have seen, I feel that we did remind Alison Kelly on more than one occasion to keep us updated. Given that her interpretation of this communication was slightly different, there is potential that we have been clearer in our expectations from her again given the potential seriousness of this matter.

Q. I mean, because the note in fact rather suggests the opposite?

A. Yes.

Q. So you would recognise on the NMC's behalf,

would you, that the adviser should have said in the clearest possible terms: we would like all the latest information you have about this whatever the police are doing, so that we can consider it?

A. I would agree with that, yes.

Q. Now, before we get to the point of referral, which occurs a year or so later, I just want to pause to ask you about working with partners as you term it in your witness statement. By partners, here I mean the General Medical Council and the Care Quality Commission in particular.

Firstly, there is an expectation, isn't there, that the NMC will communicate with such organisations when there are relevant matters of shared interest?

A. Yes.

Q. And so the NMC doesn't simply sit in a silo; if it's given information of potential magnitude it should be telling other organisations that it knows would want to know that?

A. Yes.

Q. And at this stage, we can go back to July, 6 July when we know a police investigation is in contemplation, we know that clinicians have serious concerns. Simply on the basis that was provided setting aside the curiosity point, was there sufficient

information there for the NMC to be prompted to contacting the CQC to say: do you know about this? This rise in mortality which is not specific to a nurse but is general, the fact that these individual reviews are being done, the fact that clinicians are worried about a particular individual, is that in itself sufficient information in the NMC's view to be saying: we really need to just check the CQC are sighted on this?

A. So, if -- if I could start by answering that by saying that if we had that situation today, we would expect and we would contact the CQC and the GMC given the involvement in others here. I don't believe we did that back in 2016. Now, we --

Q. Can I just pause you there. That last answer may be ambiguous. You mean you didn't have that process or as a matter of fact you didn't do that or both? So in other words --

A. To be honest, I can't be clear on that, I'm sorry I am not that -- that familiar with quite if that process was in place back in 2016.

My recollection was that we didn't contact the GMC to follow up with the clinicians. My recollection is I don't believe we did directly contact the CQC either. I do believe there were some other follow-on meetings that took place where they may be present but I am not

certain about that.

Q. Was it something that the NMC should have been actively discussing with the CQC and the GMC from July of 2016?

A. Given that if we were faced with that scenario today it's something we should do, something we would do. I would suggest I would agree that it is something that we should have done back in 2016.

Q. Again if we just try to understand in simple terms what -- the potential consequences of that. That would be capable, for example, of prompting the CQC to say: Right, we want to come in and inspect this department, we want to find out what's going on here, we need you operating under the duty of candour to tell us everything you know about this.

A. Yes.

Q. And, again, we can only consider this as one possibility, that might have led to the CQC taking a grip of this much, much earlier?

A. It may have led. I can't really say whether it would have led to them taking a better grip. But you -- I would have expected it to have provided more information that may have led to the CQC taking more of a grip of it, may have provided more information that would have changed the advice as we have said previously

that we would have given with regards to the referral to.

Q. And obviously we have simply focused on 6 July 2016 for the purpose of my questions. But obviously by the time we get to May of 2018, sorry, 2017 as we have just been looking at we have got an even greater impetus, haven't we, for the NMC to share what it knows; what it's seen in the press, namely, the arrest?

A. The -- yes. The actual information, again having reflected within the organisation on this, hadn't increased necessarily. But as, as we have said the involvement of the police that in itself does provide a different perspective on the seriousness.

So I suppose in its own right, yes, it is additional information.

Q. So I mean, the conversation is quite simple: Does the CQC know what's happening at the Countess of Chester about the increase in mortality? And: Did you know that one of our members has been arrested by the police for murder?"

And then the CQC can say, yes, either we do know that or we don't and there can then be a dialogue about who's going to do what next?

A. Yes.

Q. So we are now just going to briefly repeat the exercise that we did previously by running through the chronology from this point through and here we are post-arrest.

So we get to 5 July of 2018 and we know that Alison Kelly makes the referral and as at 5 July, the NMC now has a formal document from somebody outside the NMC saying: We need you to investigate this.

Is that the effect of the referral?

A. That -- yes it is. That gives us the power then, once the referral has been made about an individual on a register, the power to investigate that referral.

Q. So in some senses the power dynamic shifts. Before a referral the NMC's role is to give advice, which may include, "You need to make a referral", but it can include others such as a robust local investigation as we heard Ms Sutcliffe had indicated, but at this point now the NMC is seized of it, it has formal powers available to it and it can now start taking proactive steps if it wishes to?

A. Yes, that is correct.

Q. So again we will come back to some of the detail behind this. But we know, don't we, and you confirm in terms of the chronology and here I am looking

at 57 of your witness statement, which is on page 14, that on a number of dates after that referral -- we will just recite them out loud -- 30 May of 2019, 11-13 June of 2019, 18 July 2019, 11 November 2020 and 12 November 2020, which are all rehearsed in Ms Sutcliffe's statement, there was a consideration of the interim order position?

A. That's correct.

Q. And the practicalities of that consideration varied on different occasions, but on each occasion at least one person within the NMC was asking the question does Letby need to be referred to the Interim Orders Panel/Committee, so that there can be consideration about restriction on her registration?

A. Correct.

Q. So if we just consider the first of those occasions, which is 5 July, which comes in on the same day as the referral; the moment the NMC is empowered to start taking proactive steps in relation to Letby. And the conclusion was that the test was not met, is that right?

A. The decision was not to make an application, yes.

Q. Yes. That a referral to the Interim Orders Committee wasn't justified presumably because there was

an expectation that it would fail?

A. That is correct, yes.

Q. At your paragraph 56 on page 13, you list a number of factors. And we will remind ourselves this is post-arrest which had occurred on 3 July of 2018. Post-arrest.

You list the factors that are recorded as being in the decision-maker's mind about whether or not a referral would be made. And if we just look at (c), what is said here and this is the decision-maker's thinking:

"We decided that the fact of arrest alone in these circumstances did not provide the evidence needed to apply for an interim order. The police have informed us that the arrest was a step taken to gather evidence and interview under caution. The police did not provide any further detail explaining the information they had to form the grounds to arrest Letby."

Now, as a matter of fairly basic law the police can't arrest somebody unless they have reasonable grounds to suspect that they have committed an offence and presumably that is the sort of relatively basic level of legal knowledge you would expect those considering these questions to have?

A. Our interim order guidance that existed at the

time -- if you could just bear with me just to explain this if this is okay please -- it was a two-stage approach and the first stage that had to be applied in order for us to put forward an application for an interim order was that there was evidence, there was a prima facie case for evidence linked to an individual that there were concerns about their fitness to practise.

In the organisation at that time, the interpretation by colleagues, by the organisation -- and this was included in our guidance -- was that an arrest wasn't sufficient.

An individual -- and as I understand it this was based on case law -- the individual had to be charged. So the organisation was looking at it in that way despite the seriousness, despite the concerns, the seriousness of the concerns involved here, all the risk assessments kept referring back to that stage 1.

You couldn't, with that interim order guidance, move on to stage 2 unless stage 1 was complied with. And we have seen in the correspondence within the organisation that even some of the people involved in this consideration, their views changed.

They moved from: We haven't met the threshold for evidence to: Actually, now we know a little bit more,

now, different consideration being given, there could be a case here to make the application for the order. So the -- whatever the detail behind the arrest that was the position and the consideration at the time.

And, again, the NMC has reflected and has already changed the interim order guidance because it was felt on reflection of the Lucy Letby matter, as well as another case that the GMC were involved in, as well as comparing our guidance to that of other regulators, we felt that the way the guidance was written didn't give flexibility to, in extraordinary circumstances, see that you don't have to have an individual being charged in order to make the application.

The guidance that was in place at this time, we could have interpreted that guidance and still made the application, but, as I have just previously mentioned, the understanding of those in the NMC and the NMC that was involved in this, they interpreted we have to have evidence, we have to have prima facie evidence and that an arrest wasn't sufficient for that.

So I'm sorry I haven't directly answered the question, but I have tried to explain that that is how things -- the guidance was interpreted at the time.

This is an area that, having reflected on it, we should have applied, whether it was when Letby was

originally arrested or further down the process, certainly before she was charged, we should as an organisation have made that application for an interim order. But as I say that's the organisation's sort of guidance and interpretation that we give to our colleagues.

It doesn't mean to say that the order would have been granted. It doesn't mean to say that even if it was granted and it was appealed by the individual that the appeal wouldn't have been upheld.

But as I say I understand the question you are asking. I just wanted to explain why the decisions were made at the various points as to why we didn't apply for the order.

Q. Entirely accepting that the individuals concerned were seeking to look at this case by reference to the guidance that existed, but just looking at the factors that are being recorded as operating, at (g) there is repetition of a phrase that comes in many documents and from a number of witnesses: the gut feeling.

And I am just wondering whether, setting aside the guidance issue, that the decision-maker, bearing in mind that they must have known that the police considered there were reasonable grounds to suspect an offence had

been committed and bearing in mind that you wouldn't expect a gut feeling to be reasonable grounds to suspect that at this moment the NMC should have been saying to itself: we obviously don't have the full picture, we need to find out more?

A. Again agreed. And actually once the referral had been made, we did try to gain more information about the details of the arrest from the police at the time. And my understanding was that we didn't actually gain any more information and at that time, the consideration of the people looking as to whether or not we should apply for an order was that the threshold for the evidence was not met based on the guidance.

Q. Was there anything stopping the NMC contacting, perhaps with permission from the police, the hospital itself to say, "What material have you provided to the police that the police are happy for us to have so that we can carry out our statutory function, because there is clearly more to this given the arrest than we are aware of?"

A. Yes, actually there was something that stops us doing that is that normally the police will ask us to put our investigations on hold so that we don't prejudice their investigation and I believe that was the situation at this time.

Again where we are today, where we have matters, where we are dealing with referrals to us, fitness to practise concerns, and there is ongoing police investigation, we try and agree information sharing agreements so that we can have an amount of information that allows us to proceed with the regulatory process and we are also looking at a memorandum of understanding across all police forces to enable us to do that.

But at this time, as I understand it, we were not able to contact -- to get any more information to help our process.

Q. Just two short points and then, if my Lady wills it, we will have a break, but it's concerned directly with this, this topic and we can then start afresh one after lunch.

The first is this. At your paragraph 67, you suggest that:

"This difference of internal opinions was particularly impacted by our experience in the High Court in Northern Ireland regarding Muckamore Abbey Hospital and the fact that we were updating our guidance".

I just wanted to understand, very briefly, what that may be saying. Putting that a different way, is what you are saying by that that because the NMC had

just recently lost some high profile cases in the High Court, it was perhaps more risk averse as a result than it would otherwise have been?

A. Yes. In essence, it was an interim order that we -- that was awarded by our panel with regard to that matter, the registrants appealed it at the High Court and the High Court overturned our decision on the basis of the quality, the poor quality of the source of that information and the quality of that information and that resulted in us amending, as I understand it, our interim order guidance; not the recent amendments we made in 2024, this is previous to that, and, yes, I think it would have had an impact on one, making us slightly more risk-averse but ensuring that the evidence needed at this Stage 1 in the interim order guidance in order to proceed was higher, as I say, because of the result of that order being overturned.

Q. The final short point is this, that we have identified five occasions on which some sort of review was carried out. You describe two of them as being ad hoc reviews and what you say at paragraph 68 and 69 is that there was lacking a standardised escalation process; in other words that it appears that not all of them were as rigorous and robust and formal as each other and that that was a failing in the approach that

was taken in relation to some of these assessments, two in particular; is that fair?

A. Yes. If -- the organisation feels that if we had had a more robust and clearer escalation process, that would have taken the consideration and the decision -- sorry, the decision about applying for an order either to a higher level of seniority or requesting that we commission external advice on making that order, a different decision might have been made. So, yes.

MR DE LA POER: My Lady, would that be a convenient moment? I apologise for having overrun past 1 o'clock.

LADY JUSTICE THIRLWALL: Yes. How much longer do you have, Mr De La Poer?

MR DE LA POER: I anticipate that I have got about 25 minutes or so.

LADY JUSTICE THIRLWALL: Then I think we have got~...

MR DE LA POER: We have got Sir Gordon Messenger.

LADY JUSTICE THIRLWALL: I think there are questions from others.

MR DE LA POER: There are questions from Core Participants, I think it is indicated a maximum of 20 minutes between the two but both have told me that they are having that under review.

LADY JUSTICE THIRLWALL: All right, let's see where we get to. So we will rise now and we will start again at 2 o'clock.

(1.06 pm)

(The luncheon adjournment)

(2.00 pm)

LADY JUSTICE THIRLWALL: Yes, Mr De La Poer.

MR DE LA POER: Ms Herniman, moving forward in your witness statement to paragraph 73, where we are just going to touch on the relationship between the NMC and the police.

So once you have got that, I will ask you some questions.

So the starting point is that on 6 July, so of 2018, so the day after the referral, Alison Kelly informed the NMC that she understood from the police and NHS England that Letby's bail conditions prevented her from working in a healthcare environment; is that right?

A. Yes.

Q. Then from the police themselves, on 20 July 2018, the NMC was informed that Letby was not to work in any healthcare setting or have unsupervised contact with anyone under the age of 16 as part of her bail conditions; is that right?

A. Yes.

Q. Just help us with that communication, was that a formal communication, were the police with the NMC as it was understood at the time or was there some informality about it?

A. Could you just refer me to the paragraph of the communication from the police themselves?

Q. The last sentence of paragraph 73 where I ...

A. Okay, "police advised".

So it wasn't formal insofar as I understand it, it was the actual bail conditions.

Q. So it wasn't, for example, the bail sheet?

A. Correct, apologies, the bail sheet.

Q. Formally setting that out?

A. Yes.

Q. Following that informal notification by the police, is the NMC take steps by contacting the police to try and get hold of a formal copy of the bail conditions?

A. As I understand it we did request whether it was the actual bail sheet or formal confirmation of the bail conditions, we did follow up on that.

Q. But it wasn't until nearly a year later that the NMC was told that the actual bail condition was not gaining employment with babies or children, which was rather different?

A. That is correct.

Q. Because in theory under that bail condition as a Registered Nurse, she could go and work in a care home, for example, or she could apply for a nursing role outside child services, for example?

A. Yes, that is correct.

Q. Both of which I am sure the NMC would recognise would be of very considerable concern to you as a regulator in terms of protecting the public from risk of harm?

A. We do recognise that and we do now recognise the risk that did exist between the informal information regarding the bail conditions and then actually receiving the formal bail sheet itself.

Q. Now, the NMC has article 25 which is a legal power of compulsion, effectively in relation to the provision of information and that can be used to as a power to elicit information under compulsion from the police; is that right?

A. That is correct, yes.

Q. Now, it wasn't until June of 2019 which is when the true bail conditions became clear, that article 25 was invoked; is that correct?

A. Correct.

Q. Do you recognise on behalf of the NMC that far

too long a period passed before resort was made to article 25?

A. I do recognise that on behalf of the NMC, yes, that -- that's correct and we are actually -- I mentioned earlier an MOU, a memorandum of understanding, which is hopefully to be concluded in the imminent future with the police and as we roll out training across our organisation with regard to that MOU we are also looking to roll out additional training on the use and the purpose of article 25 and a follow-up to what we are discussing here.

Q. In fact, is this what should have happened: a request not under article 25 as was made initially should have been made for that information to be provided within a relatively short period of time, because it's not complex, something like 14 days, failing which the NMC should have immediately said: well, our role protecting the public requires us to be certain of this, so we are asking for this under or requiring it under article 25. So it would have been very shortly after the failure to reply to the first request that the NMC should have invoked article 25?

A. I agree that we should have on a much more timely basis taken steps to get the formal bail conditions and if they weren't forthcoming then yes, we

should have on a more timely basis invoked article 25, yes.

Q. Given how important it is to protect the public, is there any good reason why the first request could not have been made under article 25?

A. I don't think there is a good reason for it now whatsoever. I think given again where we are today and the relationships that we have with various other agencies, including with the police in certain case, we would hope to ensure that those relationships, the engagement we would get that information anyway and if not we would escalate it within our organisation to whether it goes up to the Chief Executive, the same with the other agency and to be honest the last step would be to then use article 25, but certainly for the scenario that we are looking at, we should have taken more definitive steps to have clarity and if that meant using article 25 earlier then we should have done that too, we should have had clarity on that information much sooner.

Q. And had the NMC done so, that would have brought forward the time at which the NMC would be able to recognise that the bail conditions themselves may not be adequate to protect the public?

A. That is correct, yes.

Q. Turning to a new topic which you deal with

from paragraph 79, whistleblowing, we can take this fairly shortly.

As part of the NMC's investigation into its management of Letby and of Alison Kelly's referral when that was made, was it identified that there appeared to be some confusion in relation to the status of whistleblowers?

A. Yes, that is correct.

Q. Has the NMC taken steps to receive expert advice about what the correct approach should be?

A. With regard to the whistleblowers in this circumstance, I am not aware that we have taken steps to take external advice on whistleblowers of this kind. The -- the reason I am -- let me just check that paragraph, apologies.

Yes, this is referring to the individuals who referred Alison Kelly to us and their request to be treated -- for that referral to be treated or them to be treated as whistleblowers.

So apologies if I have misunderstood. If you are asking has the NMC taken external advice in regard to this situation, I am not aware that we have with regard to these, the whistleblowers here.

Q. But has the training and guidance been improved?

A. I believe that is a work in progress.

Q. Next topic, clinical advice, which you deal with at paragraph 81 and following. Here again we are focused upon the Alison Kelly referral and does the NMC recognise that it would have been helpful for clinical input to have been obtained sooner as part of the decision-making process? I am here looking at your paragraph 83. I have largely read it straight to you.

A. We at the NMC recognise and respect the relevance of both clinical, legal and operational input into our processes and the cases we put through fitness to practise.

I think on reflection with regard to this case, we have to -- we did have involvement from a clinical perspective through the -- sorry, let me just reflect on that ...

Q. At 82, you identify that that advice --

A. Yes.

Q. -- was tendered only once the criminal trial had ended?

A. Yes.

Q. And what you are saying at 83 is that it should have been sought sooner than that?

A. And I think in light of our reflections on the curiosity, understanding the context in which the

allegations were being made, I would agree that it could have been beneficial for clinical advice to have been obtained earlier.

Q. Now, I said that I would come back to the topic of revalidation. We can just deal with this in fairly short form given the depth of information provided in the witness statements that are to be published.

But has your process of reflecting upon events concerned with the Countess of Chester led you to conclude that the revalidation process needed improvements?

A. Yes, it has. Revalidation isn't about a registrant's fitness to practise; it's about their development as a professional and the reflection from themselves and with others on their role.

The process, the information provided as part of that process including the requirement for a confirmer to somebody's revalidation process is we have identified, helped by this case, that there are areas there that we do need to reflect on to consider whether improvements need to be made and I am, if you don't mind me just explaining quite carefully what I am saying there because I know there are challenges about an individual, a registrant going through a fitness to

practise where a referral has been made and they have passed the fitness to practise process.

Taking into account the extraordinary circumstances of this case, looking at revalidation and referrals where we get, as I say, 6,000 a year, some of which are vexatious at one end of the scale, some are so horrific, as we are discussing here at the other end the scale, we have to ensure that we are as well as protecting the public, fair to those registrants.

So if somebody is subject to a fitness to practise process does that mean that they can't be a confirmer, does that mean through revalidation it has to be noted on record on the system somewhere that that is the case when actually there is an allegation but no -- no proof that the allegation will be upheld.

So in answer to your question, yes, there is thought that must be given to our revalidation process but there are many areas that need to be considered in order for improvements potentially to be made to that process.

Q. And just to bring the matter into sharp focus to state the problem rather than the solution. Part of the revalidation process requires a declaration of good character and it may be thought that a blanket unequivocal declaration of good character in

circumstances where it's known for example that someone's on restricted duties because they are -- there is concern about their practice, potentially their competence, potentially something else, that in those circumstances, considerable care needs to be given to how that declaration is framed and what information may be included as part of it as a caveat to ensure that we don't have a situation whereas in Letby's case that she was the subject of revalidation on 30 August 2017 despite the fact that she had been on restricted duties in part on some of the evidence due to concern about the risk that she might pose and in circumstances where the police had begun an investigation and she was the nominated suspect at the outset so far as the person making the referral to the police was concerned.

So all of that highly nuanced information needs to be taken into account so that we don't have, do you agree, a situation where someone is just of good character and the NMC is potentially blind to all of that potentially relevant information?

A. I agree that that's the scenario you just painted -- well, it's not a scenario, the actual position that you have painted there does need to be considered when we are looking at if amendment is to be made for revalidation.

Q. So we turn to my penultimate topic which is that of safeguarding.

And here we are concerned with the question of whether or not as part of the ELS process and/or at the referral stage, the NMC ought to have been advising and encouraging the Countess of Chester Hospital to think about its safeguarding responsibilities. So that is the issue.

In short, should that have been something that the NMC was prompting?

A. In short, as part of our questioning from a curiosity perspective, I would agree that it is something we should have at least ensured. We assumed that they were aware and adhering to their safeguarding responsibilities but I would agree that given the, the situation it was something we should have been absolutely certain that they were doing that and that goes back to talking, excuse me, to other parties, for example the CQC and ensuring that they were doing something similar with regard to the Trust itself. So yes.

Q. Just to float a potential practical way in which this might be applied. If your ELS adviser had, for example, a tick list that they could provide at the end of any call to say: what you have raised with me may

be a safeguarding issue, have you informed the hospital safeguarding department? Have you informed the LADO, if not you need to actively consider both of those things, that might be quite a helpful way of making sure that the organisation who is speaking to the NMC doesn't overlook doing those things?

A. It may be a very useful way of doing it and we would welcome a recommendation from the Inquiry to that effect.

Q. Now, you have dealt with what would be different today both in the course of your evidence and in the detail of your statement but I am just going to pause before I conclude to just draw together some of the themes that the NMC, would you agree, has been through a particularly turbulent time in the recent past; is that fair?

A. I would agree with that, yes.

Q. So far as this Inquiry is concerned, we know that Rise Associates have conducted an investigation into the NMC's culture and found areas of concern. King's Counsel was instructed to look at the handling of the Letby/Alison Kelly case. King's Counsel was advised to review on the management of an internal whistleblower and you have had a King's Counsel review on safeguarding, so far as we are aware.

So a lot of time, energy and effort has been spent looking back in order to get it right in the future; is that fair?

A. Absolutely, yes.

Q. Are you satisfied in the position that you hold right now as at today as the head of that organisation that the necessary changes either have been made or are imminently to be made?

A. I am -- as the acting Chief Executive, I am satisfied the organisation has held itself up to independent scrutiny and as you say it's been difficult but it's been very, very necessary and I am satisfied that the reviews that we have undertaken and the steps that I have either started or overseen initially in my role and that will continue under the leadership of the interim Chief Executive coming on board will make a difference, will make the changes that we need to the culture and the performance and the way in which we regulate.

The only element I would be more specific about is the definition of "imminent". There are some changes that we have already made in relation to the independent culture review from Rise and Nazir Afzal because they were that important that we needed to.

There are changes we have already implemented

following our internal and our external review of learning from how we handled the Letby case. Again we have brought some of those in but there are more that we will do.

So I think it's fair to say we have quite a journey ahead of us but the reflection, the recruitment, and changes as I say with the interim Chief Exec coming in and the fact that we have been so open to independent scrutiny a lot of it in the public domain will ensure that we are held accountable to making the changes.

If you don't mind, the final point I would say on this is that there are -- the majority of colleagues at the NMC are so committed to what they do, very experienced at what they do and are very much involved and driving ensuring that the role that we do to protect the public is as effective as it can be, as it needs to be.

So, yes, we have a journey to go.

In short response, my current role, the future as I see it, the plans we have in place I believe that we will make the change that is needed and we will make that sustainable change that is needed too.

MR DE LA POER: Ms Herniman, thank you very much, those are my questions.

My Lady there are two sets of permissions, each in

relation to the Family groups. Can I go to Mr Baker first who is shaking his head, thank you, Mr Baker.

Mr Sharghy for Family Group 1?

LADY JUSTICE THIRLWALL: Mr Sharghy.

Questions by MR SHARGHY

MR SHARGHY: Ms Herniman, good afternoon, I ask questions on behalf of one of the Family groups that are Core Participants in this Inquiry.

I appreciate your interim role, as you have indicated to Mr De La Poer, so if there are any answers that you are not able to give but you are able to assist as to who may at the NMC be able to provide that, could you just clarify as we go along --

A. I will do.

Q. -- in terms of the questions.

I would like to start with the issue of revalidation which Mr De La Poer asked you not so long ago and your answer in terms of the improvements that need to be made was that it's still a work in progress.

It is slightly concerning, certainly for the Families that I represent, and no doubt the other Families, to hear that coming into the tenth year after these tragic events began the NMC is still not in a position to indicate what steps it is looking to take in order to ensure that a revalidation process is fit

for purpose.
Is there a reason behind why there is such a delay?
A. I think our starting point on that is whether or not the challenge as to whether or not the revalidation process is fit for purpose.
As I said, the revalidation process itself is not looking at a registrant's ability of the fitness to practise. We have a separate process. If anybody has a concern about any individual that's on our register that they are not fit to practise then they follow the referral process, referral of a fitness to practise allegation.
We feel that revalidation, the process as it stands at the moment, is fit for purpose for, if not all, the majority of cases.
However, the learning from the Letby case, the -- not just from that case but in other areas, other cases, the work that we have done, there are areas, for example, the confirmer not necessarily being the individual's line manager and as we have heard with regard to Letby, it wasn't her line manager, whether the confirmer knew that she was on restricted duties, they are areas that we need to reflect on and see if they need -- if we need to revise the revalidation process.
Apologies, I don't know if it has been revised for

other reasons over sort of the past few years. So I would challenge on fit for purpose.
But as I have said earlier it is an area that we do need to give consideration as to whether improvements are needed to eliminate any risk as I say of somebody who is on restricted clinical duties or any other elements to be reflected in there to maintain the protection or patient safety.
Q. One of the easiest issues you have just identified that the revalidation process could very quickly fix is a declaration by the registrant whether or not they are on restricted duties, whether or not they are subject to any internal or external investigations.
Why have those steps not been taken to simply improve the form?
A. So if it would be okay I would like to take that back to my colleagues that have already given consideration. I know there is a process that we have to go through regarding consultation on various changes that were made, I apologise that I haven't got the specific detail if that is what we need to do here but I am very happy, as I say, to take that back to the Executive Board and either answer and explain why or if it is something that we can do more rapidly.

Q. One of the other drawbacks I would like to just ask you questions about is in relation to the internal information sharing. So the Employers Liaison Service was aware of the concerns that had been raised and were aware of the fact that they were related or at least associated with Letby and it appears that information, that knowledge was perhaps not available to the revalidation team or indeed any curiosity or proactivity for there to be any kind of search made within the internal NMC system to see is this person subject to any potential restriction or any issues.
What work has been done in order to improve that element of the internal processes?
A. So at the moment I am not aware that any changes have been made. Bearing in mind that we have 6,000 referrals on the go at the moment, so quite a large number, I am not aware that changes have been made to our systems to flag the scenario that you have just described there. I do -- which would give potentially both teams or different teams access to the same information.
Yes, I'm sorry, I am not aware that we have made any progress on that.
Q. Final question on the revalidation point.
As we are present today because the changes have

not been made, is it possible that a registrant is still validated, even if there are concerns such as there were against Letby back then present and known to the NMC or others?
A. I would say it is still possible. But what I would also say is that where there are concerns, our ELS team is eight years on from where they were and the discussions internally, the assurance checks internally, as well as the engagement that we have now which is much more developed with external parties, would reduce the timeliness and increase the curiosity if there were any fitness to practise concerns.
Given that we haven't as I understand it made changes to the systems to make it that accessible, potentially, that situation could still exist today.
Q. It brings me neatly on to the second issue I would like to discuss with you and that is safeguarding processes and training changes that have been made.
You mentioned the ELS team. Can I please have a document loaded up so you can see this. It's INQ0108377. This is a statement that was prepared by the ELS team and has been disclosed to the Inquiry.
I'm not sure I should have asked whether you have actually had an opportunity of seeing this witness

statement prior to today?
A. I haven't got it popped up yet.
LADY JUSTICE THIRLWALL: No, it's still on its way.
A. Thank you.
MR SHARGHY: INQ0108377. It's being reloaded, my Lady. Can I ask you briefly to read the first four paragraphs of that and then I will pick up when you have had that opportunity.
(Pause)
A. Yes, I am familiar with this statement.
Q. You are familiar?
A. Sorry, yes.
Q. Therefore your answer a few moments ago that the expectation is that the ELS team will pick these matters up, those are not the views of the words or certainly the feelings of the ELS team.
A. So as I understand it, there is a follow-up statement which aligns after a short period of time which I can explain, more the views of the same colleagues, the ELS team, that does say that they are more in line with the evidence that -- that was provided.
I think just the context on this, if I recall, was during the oral opening statements that were made last year, which resulted in information going into the

public domain as it does, people were referring to it, and the names of individuals from the Nursing & Midwifery Council who weren't expecting -- they weren't named in our statements and weren't necessarily expecting for their names to be in the public domain.
And the anxiety, the concern at what they had heard or what they had seen, bearing in mind the undertakings they hadn't seen the statements that we had provided. They were concerned as we see here that some of the evidence that had been provided didn't reflect the true position and I think one of the key elements was the NMC if you were faced -- or ELS if you were faced with the same scenario today, would your position be different? And they interpreted, as I understand it, that the statement, our statement, the NMC statement, was saying yes, it would be different, and they didn't agree with that.
But actually, the detail behind our statements which with permission from the Inquiry we were able to share elements with them, we were able to clarify that our statements weren't saying that but what our statements were saying that from an ELS perspective, we on reflection would have expected to show more curiosity and to have dealt with things on a more timely basis, had we shown more curiosity we may have gained

information which may have changed the advice whatever that's given, so it was, we expanded on their understanding and, as I understand it, the follow-up statements when they had understood more the detail of the content of the statements from the NMC, they as I say felt more aligned that it wasn't that they didn't agree with what we had said, they had a much better understanding of what we said. Sorry, I hope that answers your question.
Q. Well, if there was a second statement we will no doubt see it on the Inquiry website. But can I ask the pages to go down to the final page which is page 6 and the penultimate paragraph and again if you could have a read of that.
A. Sorry, the penultimate?
Q. The penultimate paragraph on page 6 just above 5, "Next steps".
(Pause)
A. Yes.
Q. Again, that seems to be quite damning because it is an indication that the ELS's voice and views were not necessarily being listened to. How has that changed?
A. So that was also reflected whether it was ELS or different teams, whether from a functional

perspective or a skills perspective, within the NMC that came through in the independent culture review that Nazir Afzal and his colleagues carried out, that some people felt that they were not being listened to, some colleagues feel that there isn't psychological safety to speak out at the NMC.
So this specific example here is part of what we are trying to address within the organisation to improve the culture, to ensure that there is equal voice from all parties that we need to be an effective regulator whether you are operational, legal or clinical and to ensure that we create an environment where people do feel psychologically safe and they do feel listened to. We are, I think it's fair to say, at the very early stages of that cultural journey and as much as I presided over it for the last five months, one of the attributes of the new interim that is coming on board is his experience and leadership for culture change in organisations with similar challenges.
So again sorry if that was long-winded. Yes, we have a challenge with our culture, this is an example of that. We know we need to change that.
Q. Going back to the safeguarding issue. From paragraphs 87 of your first witness statement onwards, you very helpfully set out the changes that are being

made as part of this programme of improvement.
You mention safeguarding training which was introduced in 2019, strategic safety lead who was appointed in October 2022, a Safeguarding Board, and plan to establish a safeguarding hub. It is very clear what has been done.
What is less clear in the evidence is what are the practical implication of these changes if the same situation was to arise today?
A. So in addition to what is laid out in paragraph 88, I think it was, we have now created a safeguarding hub and we -- to support that safeguarding hub as well as to improve safeguarding, our approach to safeguarding across the organisation, we have recruited more specialists in this area. That hub is operational, it was from September last year.
That hub, the approach that we are taking is for all new referrals that come into us bearing in mind we have about 500 a month, for them to be looked at by that safeguarding hub. So we have much more of a safeguarding lens on referrals that are being made to us.
We have further to go to look at potential safeguarding issues within our existing case holding and that work is progressing and where we are now almost

having taken some immediate steps to improve safeguarding within the organisation, within the way we regulate, we are now doing a stocktake to understand the effectiveness, the practicality of that, that it's making a difference and to align that to our responsibility as a regulator for safeguarding and having clarity on that versus that of others.
We don't fall under the duties and we don't have the powers of the Care Act 2014. Again having said that, in any healthcare setting, we as the regulator have a general duty to protect the public and we must if we ever see any issues regarding patient safety, safeguarding, we need to ensure that we share those with other agencies, with the relevant parties.
So we have, we have made significant or taken action, as I say we are now moving into a phase of understanding have we done what we need to do to be more effective? So we still have a way to go but this is one of the areas that we did move on very quickly after the Nazir Afzal report.
Q. Can I move on to fitness to practise and the interim orders which again you were asked extensively by Mr De La Poer so I am not going to cover the same grounds but can I ask for another document to be brought up so you have got an opportunity of reviewing it. It's

INQ0017804 and it's internal page 4.
This is the interim order guidance which has been updated, the IMT2. And it's in particular the fourth bullet point down which is one of the considerations to be given as to whether a referral is made is:
"Whether there are existing restrictions in place imposed by the police (bail conditions), an employer or another regulator."
That can be read in one of two ways, in other words if there are those restrictions, then it may lessen the need for an interim order to be obtained or it could be the alternative which is it heightens the need for the order to be sought.
Which is it?
A. Sorry, just repeat that question, sorry?
Q. Yes. One way of reading this consideration is that if there is a bail condition or if the employer has taken steps or the regulator has put in some -- another regulator is putting some restrictions, then the NMC will not necessarily consider applying for an interim order.
The alternative interpretation is that if there are those steps that have been taken by others that heightens the need for the NMC to take steps to obtain an interim order. Which interpretation is meant by this

bullet point?
A. In response to your question, I'm not sure. However, what I will say is that if there are existing restrictions, the police are involved, there are bail conditions, at that stage, as we saw with Letby, then a referral would be made to us and we would take the referral through our process and we will go back to the guidance, the revised guidance which looks at the risk associated with that individual and evidence of concerns about their fitness to practise.
And even -- I can't be clear on this, so maybe that is something I do need to check. I -- if I speak -- even if there are bail conditions but there are concerns that for public protection or public interest we should ensure that there is an interim order, we would still proceed with that.
As I say, I know that is not necessarily directly answering your question and I apologise that I don't know if that would be the case even if there were strict bail conditions. So it may be that is something that the Inquiry would appreciate me coming back and clarifying.
Q. The short point is do you think that this guideline guidance may need to be reviewed to ensure that any ambiguity is removed?

A. I think that's, yes, there would be value in doing that, yes.

Q. And Mr De La Poer took you through the chronology in your witness statement and elsewhere that led to the decision to refer Letby for an interim order to be made on 20 November 2020 some time after her arrest, some time after other information was known to the NMC and insofar as the knowledge or the information that was available to the NMC, what changed between her arrest and the charge?

A. With regard to?

Q. Any additional information that the NMC received that suddenly heightened it other than the decision by the police to charge. Did anything actually change?

A. Let me just reflect. I don't think we were furnished with any additional information. As far as the interim order was concerned, as I mentioned earlier, the way in which the organisation interpreted our guidance at the time, this prima facie case, prima facie evidence meant that the arrest wasn't -- was interpreted as not being sufficient for an interim order.

When she was charged, our interpretation meant that that then was sufficient to apply for an interim order. But I would like to make the point again that we have

reflected on that and we should, could have at the time interpreted our guidance differently so that earlier on, before she was charged we could have applied for an interim order.

Q. Two final points, if I may. Concerns that the families still have, one of which is in relation to whether or not the NMC has considered or would consider carrying out some form of psychological screening as part of the process of either validation or ongoing development.

And this came and arose out of the evidence that Mother A gave to this Inquiry and my Lady for reference it is the transcript on 16 September 2024 pages 41-42 and her evidence was that if there is such an evaluation of registrants it may in fact pick up on issues that will prevent those who work with vulnerable patients, whether children or otherwise, would not necessarily be allowed to do so unsupervised.

Have you considered that, has that ever crossed the NMC's mind?

A. Could I just check, did you say psychological screening, sorry?

Q. Yes, a psychological screening process, some kind of declaration, some kind of assessment --

A. Yes.

Q. -- for those specifically working with vulnerable patients.

A. I think it's fair to say that specifically something of that level of detail hasn't yet been raised, been discussed been considered but what we have agreed to do, and it's in our statement, is to look at the health and character declarations that we -- we ask for -- that we ask to comply with let alone that are needed for revalidation and again very happy and we will do that, the health and character declarations are very much linked to our code to the standards of education, revalidation. They kind of weave throughout all of it. So we are later this year now in 2025 looking at how we scope changes to our code for revalidation, the timing of that as it is intertwined and very happy to take away that specific point for consideration.

Q. The final point. The NMC now have some guidance available regarding social media use of its members/registrants. I don't believe one existed at the time in 2015, 2017. One of the other tragedies that the Families discovered after the event in particular during the criminal trial were the private messages that were passing between healthcare professionals, in particular nurses, a nurse and a doctor in one case, referring to patients, referring to very private information about

patients.

Now, the NMC's current social media guidance doesn't cover things such as WhatsApp messages or Facebook Messenger.

Is that something that is worth looking into to ensure that patient information is actually kept private in all circumstances?

A. Again, we have a social media guidance as you said and if it's felt that registrants use that -- use social media misappropriately, then we would expect a referral to be made to us and it is our starting position but again the comment you have made I am very happy to take that away and ask colleagues to give further consideration. If more detail is needed in that guidance specifically looking at WhatsApp, whatever different types of social communication people use these days.

But yes, you know, whether it is WhatsApp or any other form of communication issues misappropriately then, as I say, a referral should be made to us from a conduct perspective and we can deal with that but we will be happy to take that away and see if any revisions are required.

MR SHARGHY: Thank you. Thank you, my Lady.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Thank you very much indeed, Mr Sharghy. So if I can just do a bit of a sweep-up of the things you are going to come back on.

A. Sure.

LADY JUSTICE THIRLWALL: So taking the last one first whilst it is fresh in our minds.

So you are going to review the guidance in relation to social media but in particular look at guidance, if any, in relation to the use of WhatsApp and any other messaging service or indeed texting, I suppose?

A. Yes.

LADY JUSTICE THIRLWALL: When being used to communicate private patient information at work or elsewhere. I mean, it seems to me there is probably quite a few complicated things to think about there as to when it's appropriate and when it's not appropriate but if we can leave that in your hands --

A. Yes, you can.

LADY JUSTICE THIRLWALL: -- to be clear about what you are being expected to do.

Then going back to the question of revalidation that Mr Sharghy raised with you. I think it will be particularly helpful to have a timetable for progress I'm not sure when you -- when this particular exercise started but I am most interested in when is it going to

finish, so what is the timetable and when will there be a product of that work, so would you be able to provide that perhaps in the next 14 days, the timetable?

A. I am happy to agree to that, yes, my Lady. Yes.

LADY JUSTICE THIRLWALL: Thank you.

Then you were asked some questions about communications from members of the ELS team and you thought they were, that they had been resolved and that there was a further statement.

I'm afraid the technology has failed on my laptop again today, so I can't help about that and I wanted to ask a question, Mr De La Poer, I hope you have got the answer to the question I was going to ask.

MR DE LA POER: I have got the answer to the reference to the document.

LADY JUSTICE THIRLWALL: That was the one I was going to ask you, yes.

MR DE LA POER: 0108376.

LADY JUSTICE THIRLWALL: Could we call that up, please. So that's an addendum. Is that the one you were thinking of?

A. Yes, it was, sorry yes.

LADY JUSTICE THIRLWALL: Thank you. When was that served? Can we just be clear that it was served, that

is the important thing.

Mr Sharghy, I don't think had seen it. No, no, I assumed you couldn't have done otherwise you wouldn't have asked the question and I thought I had but couldn't quite remember.

So it looks as though it's there and we can find out what's happened to it and why it hasn't got to various people in due course.

I'm not sure -- would you like to just read through it now in case there is anything you want to add to what you said earlier?

(Pause)

Or if you would rather you can take it away and add it to the additional statement you are going to send.

A. My Lady, if you wouldn't mind I would just like to refer to the third paragraph there which I think is important from the NMC's perspective.

LADY JUSTICE THIRLWALL: Yes.

A. That the excerpts and discussion that these colleagues, the ELS colleagues, had have provided some reassurance to the team that the information provided to the Inquiry has been corrected.

So, you know, I would not want the Inquiry to think that we weren't providing the right information or information that colleagues didn't agree with.

Let me just see if there's anything else.

(Pause)

I think there's a few more pages on that so I am happy to take it away if there's --

LADY JUSTICE THIRLWALL: If there is anything else please just include it with the update in a couple of weeks' time.

A. Yes, of course.

LADY JUSTICE THIRLWALL: I say a couple of weeks, if you want to write it earlier I obviously will be delighted to receive it earlier.

A. Of course, thank you.

LADY JUSTICE THIRLWALL: Does anyone else have any other questions?

Further questions by MR DE LA POER

MR DE LA POER: Very briefly, if I may.

LADY JUSTICE THIRLWALL: Yes.

MR DE LA POER: Just to help you with a document that you referred to earlier but didn't recall the name.

You mentioned as we were discussing the collaboration between regulators and the fact that the system has improved now, is that document called the Emerging Concerns Protocol?

A. Thank you, yes, it is the Emerging Concerns Protocol. I appreciate your help on that, which is

hosted by the CQC. I think that came in in 2021, we are a signatory to that and we have actually invoked the protocol recently as well so it is implemented and effective.

Q. My Lady, we have managed to conduct some preliminary investigations in relation to that document, I don't know whether you wish to receive what update I have just been given or whether we deal with it separately, in terms of the disclosure of that document?

LADY JUSTICE THIRLWALL: Do we know when it was disclosed?

MR DE LA POER: 19 November.

LADY JUSTICE THIRLWALL: Very good. No doubt if there is any follow-up on that it can be done at least we have a date to start with.

MR DE LA POER: Thank you.

LADY JUSTICE THIRLWALL: Thank you very much, Mr De La Poer. Thank you very much indeed, Ms Herniman, for your evidence and you are now free to go. Thank you.

A. Thank you.

LADY JUSTICE THIRLWALL: I think I see the next witness.

MS LANGDALE: My Lady, yes, may I call General Sir Gordon Messenger.

LADY JUSTICE THIRLWALL: Do come forward.

GENERAL SIR GORDON MESSENGER (sworn)

Questions by MS LANGDALE

LADY JUSTICE THIRLWALL: Thanks very much indeed, do sit down. Ms Langdale.

MS LANGDALE: Thank you. General Messenger, can you give us your background first of all briefly and tell us the review that you were asked to undertake?

A. Yes. So I served a 36-year career in the military. I became known to the Department of Health as a result of supporting them during the pandemic and as a result of that, I was asked by the previous Government to lead a review into leadership and culture in the healthcare and social care sectors.

Q. You have helpfully provided us with a statement dated 28 March 2024, the reference number is INQ0017276, page 1 and that can be on the screen as we move forwards.

LADY JUSTICE THIRLWALL: I just wonder, Ms Langdale, I know we are usually very economic with time but perhaps we ought to have the witness' name.

MS LANGDALE: Sorry, give us your full name, please?

A. Gordon Kenneth Messenger.

Q. Sir Gordon Messenger, thank you. And it is of

course the Messenger Review that you undertook that you have just explained at the request of the Department of Health and Social Care?

A. The original request came from Number 10 but I was reporting to the Secretary of State for Health throughout at the time who was Sajid Javid.

Q. Right. And what was your methodology for that task?

A. It was to create around me a team of experts from both healthcare and social care from the NHS at all levels and from social care and then to consult as widely as possible and as deeply as possible on the specific issues of leadership, workforce development, the building of teamwork, the establishment of appropriate and effective workforce cultures and my methodology was to be as supportive as possible to the workforce rather than to create orthogonal recommendations that would make their life more complicated or even more pressured.

And I found that whilst we did identify a lot of areas which needed improvement that the community that they were there to effect actually were very sort of supportive and recognised the need for them. So this idea of trying to have as little create as little perturbations as possible in the generation of the

recommendations actually was quite a smooth process because we were mostly going with the tide in terms of what the workforce at all levels felt needed to happen.

Q. And you had a coauthor?

A. I did. Dame Linda Pollard, who was the Chair of the Leeds Acute Trust Hospital.

Q. And how did you select who you spoke to and where you went in the eight months?

A. I mostly did that on sort of recommendations. I mean, there are the key players, I got good access to the top of the National Health Service and the senior leadership there. But we also created access to the workplace through the creation of shadow boards, through the visiting of hospitals and trying to communicate with as many layers and as many professional bodies as we could.

I have to say I don't think we did as well with primary care and social care as we were able to do with secondary care because it's an easier -- it is an easier community to access, primary care and secondary care is a rather more diffused and more difficult to get a sort of common view from which I think was a failing of the review and it is stated as much, but I think we got a good sense of the challenges, particularly in secondary care.

Q. And in secondary care, did you speak with people in collective groups, I mean collective across different disciplines within the hospital, across senior managers, clinicians and the like, or how did you do it?

A. Yes, we did.

I mean, the number of actual visits was limited because we were still in Covid restriction times and (a) the hospital staff were hugely busy and limited by those restrictions; and secondly of course travelling and the ergonomics of having those types of meetings. So ample of those things were conducted but done virtually but we also visited a number of hospitals and made a point of not just talking to the senior leadership but getting down to the -- to the front line and talking to -- to those there.

Q. You tell us at paragraph 2 of your statement that you concentrated almost exclusively on culture, leadership, management, personal development, behaviours and the importance of team building and you set out at paragraph 3 your key judgment and the central relevant judgment.

Can you expand and tell us what that was the central judgment and expand on it?

A. Yes. The central judgment was that and as a result of the sort of eye-watering pressure that the

workforce has been under/is under is that what I would call commonplace bedrock workforce support tools had been disinvested and that the workforce were suffering as a result and here I am talking about personal development, I am talking about leadership development, I am talking about time to build teams, I am talking about the effective use of appraisals in order to identify talent and I am talking about the management of that talent to ensure that the right people were in the right roles.

None of those things were happening as well as they could or should, not through the fault of the individuals that were part of a system but because over time those what I believe are key workforce tools had been disinvested in and other things had been prioritised.

Q. What other things did you think had been prioritised?

A. I think the workforce pressure, so I think there is a lot of external pressures on the workforce not least the -- the day job of making sick people better and broken people fixed. But there is also additional external pressures. I think the regulatory framework is a pressure on the workforce, I think the targets that are imposed on the workforce add to

pressure, we heard earlier today about the sort of blizzard of recommendations that are being managed consistently and sometimes complicatedly.

All these create a great deal of, of pressure on the workforce and has forced the workforce to concentrate on those I would argue to the detriment of two really important parts of leadership and effective working: one is creating a team spirit, creating a collective endeavour, a natural instinct to deal with things collectively, that certainly has suffered. And I have forgotten where I was going with the second.

Q. We were talking about the pressures, you mentioned first of all regulatory framework. Why is that a pressure? Why do you say?

A. So what I am not making a judgment on is whether it's an appropriate pressure or not. But the -- the varying regulatory requirements that the workforce have to meet including the CQC and others is a constant that they, they feel that they have to manage and it takes up a great deal of focus and time for the workforce.

Q. Do you mean bureaucratic time, administrative time or?

A. I think to a degree, yes. But it's preparatory time for -- for what many -- and I certainly

wouldn't push back on this -- would conclude is unnecessary regulatory framework given the work that they do.

Q. Targets. You also mention targets as being a pressure. What targets and who are imposing the targets?

A. So there are a lot of targets as you know. Many of them are politically driven. Some are driven from NHSE.

There are those that feel that they are the stepping stone to better productivity, there are those that think that essentially that means that the system is gamed, that there are too many targets, then everything is important, then nothing is important and there are very conflicting views.

But I have heard the view that in fact this was given to me by someone, a prominent individual who said if you make one review recommendation, then end targets because that will lift the sort of the blanket from the workforce and they will be able to focus on other things.

Q. You say at paragraph 3 at the end if workers feel unsupported and alone either by colleagues or by the system more broadly they will make decisions accordingly. The results can be a widespread blame

culture which itself dissipates the likelihood of real wrongdoing being exposed or the avoidance of shouldering any collective responsibility, ie simply coming to work and doing no more than obligated.

Can I just ask you about the blame culture which you say here itself dissipates the likelihood of real wrongdoing being exposed. Why do you think that?

A. I think what we detected, observed and had referred to us on many occasions as we did our consultations was -- and I should caveat that by saying that of course there are huge numbers of examples of great teamwork and superb leadership throughout our healthcare sector and our social care sector but too often we heard examples where a lack of leadership at the front line led to a lack of collective instinct and team building at the front line and I am of the view that the first recourse to things going wrong or things happening that are unexpected are to rally around amongst the team that you work with in order to see what to fix it in state of transparency and short of shoulder to the wheel in order to get it done.

If that collective spirit doesn't exist, if the leadership that drives that teamwork doesn't exist then people don't feel valued, respected, able to voice their concerns within their immediate colleagues and what that

means is that they will either feel that their only recourse is to go outside the immediate team as a first, as a first act and of course that can be a -- that can be a symptom and whistleblowing is of course a very important aspect and every organisation needs to have it, but it can be a symptom of a failure of a collective instinct at the workplace if one feels that one's only recourse is to do that rather than to converse and work together with one's colleagues.

So I think that blame culture is people feeling alone, not wanting to be isolated, not wanting to be pulled out from the crowd and have the focus put upon them. I think the responsibility of avoidance which I think I said in my evidence was not limited to any particular grade or level of skill, I think this was something that we witnessed at all levels.

Q. Can I just ask you about that. Responsibility, accountability, in some cases blame. I mean, if it is a deliberate act of harm, rare as they are, and such as this Inquiry is examining, blame follows, doesn't it? I mean, you can't never be blamed or never be responsible, whatever the action.

Presumably you are not linking that in the sense that there can be a widespread blame culture and there should never be blame, sometimes there must be blame,

mustn't there?

A. So absolutely, but I think if you have a team that is effective, if you had -- for example I mean a lot of this of course are systems that are going wrong, the human factors, they are not the fault of an individual. But if you do have a bad apple within a team, then the best way of exposing that bad apple is to have an effective strong collective team instinct that can -- that can in its first instinct try and self-correct and self-police and the best local teams are those that can self-correct and self-police. You know, take someone to one side and say "I don't think you are doing that right" or, you know, "There are some people who don't feel you are doing that in an appropriate way".

Q. You think those direct conversations can and should happen in the NHS?

A. I think I -- obviously there is a severity of event that, that clearly drives a different type of approach and we may well -- certainly this Inquiry is very much in that vein but I am talking about the things that are going wrong on an everyday basis or unexpected things which are going wrong which are quite often systemic quite often sort of, you know, low level human based and I think having good leadership at all levels

and not just focusing on the very senior levels but focusing on leadership, you know, at the coalface I think is the best way to flush those out and essentially subdue them at the appropriate level.

Q. How do you encourage constructive criticism or performance management if you were looking at it in an appraisal context, but when you say picking things up and dealing with those or addressing those matters with colleagues, that can be very difficult and very uncomfortable territory in a number of organisations, can't it, without people feeling defensive and criticised and not interested to hear that?

A. It -- it can. And I -- I -- you know, I do think though that too often we saw that people were too -- felt too exposed being criticised. I have been I have been in teams where you can criticise, not everyone is perfect every day and if you do create the right sort of safe space, the right sort of -- where people feel valued, they know they are valued. It doesn't mean that they are doing a perfect job on every day. If you can build that maturity around your team, then actually you can have those conversations and -- and people don't feel that they are stuck out there and isolated and alone if -- if it comes their way.

Q. So maturity of reflection within a team and

across colleagues?

A. And it all boils down to the cultural approach to leadership whereby -- I like the phrase that everyone is a leader and everyone is a team player. It doesn't matter where you fit in the system, the person who leads the cleaning rota, the person who runs the porter shifts, the person who is the most eminent cardiovascular surgeon. These are all leaders but they are also team measures and if they feel that and they feel valued in that regard then you will get the workforce culture that you need.

Q. And you say that at paragraph 4, "Leadership":

"The most effective way to counter instinct is to create a team culture where people feel valued, invested in and collectively responsible for both the good and bad regardless of their role, status or skill level."

So people feeling valued, how can people do that in the NHS across the board?

A. I think by feeling that both their colleagues, their team, their line managers and the system as a whole, you know, has their back and they are not being done to, that they are very much a key part in the system, whatever it is that they -- that they do.

And I -- I feel that part of this disinvestment that I have described places too much reliance on the

individual to essentially self-value themselves, self-develop themselves, self-define themselves and their role and I believe there is benefit in a little bit more oversight from the system where, wherever that system should, should be delivered to give a person a sense that they have they are part of something bigger.

Q. Mm.

A. That they are, you know, a valued part of that larger system and that someone is actually looking after them and that goes for both welfare issues, but it also goes for career development issues and I think currently too often the onus is on the individual to define their own career development rather than it being seen as something that the system has a rightful interest in.

Q. And say in paragraph 4 as well:

"Investment in leadership in the NHS is patchy and overly focused on senior bands"?

A. Yes. So patchy in that it is largely -- the onus is on the individual as to whether or not they avail themselves of leadership development. So yes, one could point to the Leadership Academy and you could point to the courses that the Leadership Academy ran and runs with a reasonable attendance.

But what those courses don't do are tailored or

targeted at those that need them most. It is those individuals who are interested in leadership or who quite rightly feel that they need to be developed, who then go and avail themselves of those courses.

It can be related to how much budget there is to allow them to do it. It can certainly be related to how busy they are, whether their line manager supports the idea that they go and conduct those leadership courses.

To my mind, there should be a greater level of mandation for those that are going to be in certain positions that they conduct leadership training and that that leadership training is accredited and what that does is give the individual more confidence in their ability but it also gives the system more confidence in its people.

Q. Did you think the system was particularly transparent or not? You talk about line managers supporting et cetera, do you think it was open to all as it were or not?

A. I think that that's -- I mean, we start to stray into -- so I think there is scope for certain leadership facilities being available for all, and I mean all, I mean even some of the lowest skilled level bands because one of the challenges I think is there is very little migration between the lower skilled bands

and the medium skilled bands in the National Health Service. Great, because there is a lot of talent and potential in the lower skilled bands that simply can't get out.

So I think it would be wrong for any system to preclude access to leadership and career development at any level. But I think very quickly you get into the sort of productivity of this and you need to align your leadership training and development with your talent management and so with this comes a system of identifying who your people of potential are, where your future leaders are and skewing your leadership training offer to support them.

Q. Do you think the future leaders in the NHS need to have been successful wherever they are working and placed in the NHS in their own jobs first or is it a different pathway?

A. I think mostly of course they would be successful in their jobs. I think the route which people ascend up a career is not well structured or systemic and I think that means that too many people get to the top without having proven that they have the sort of credentials and the skills to -- to do it and certain people don't get to the top who had the skills to do it because opportunity or whatever did not come their way.

Q. Can I just ask you when you mention that, the skills, what are the skills and qualifications for someone at the top? So we are talking senior managers, Chief Executives, medical directors. What would be your bucket list for qualifications, firstly, and their level of understanding of medicine or what hospitals do and then attributes, skills?

A. So well, I mean I think that the key thing that a leader -- let's take a leader of a Trust a Chief Executive of a Trust. The first thing that individual needs to be is a strong, compelling leader and a builder of a team and the user of the expertise around that, that person.

They would have inevitably had to have had some resource management skills to get to -- to where they are but they should be accruing that whether they are going up a clinical route or a non-clinical route.

Q. Understanding how the money is spent -- understanding how the money is spent when you say resource management --

A. I mean, obviously you rely upon but, but understanding the -- the ways the resources are allocated, how one can get access to the resources would have to be.

I think a third criteria -- I am starting to run

out of essentials here because I think there are plenty of different types of people that can succeed, is a network and a knowledge of the system around them.

So the last thing you want from a CEO of an organisation, be it a Trust -- is for them to solely focus on their own organisation. They need to recognise that whatever role they perform, they are reliant upon other sectors, other Trusts, local government, and other partners in, you know, wherever it is that they work.

Q. So where they fit into the wider NHS?

A. Where they fit in and how -- how they can be net positive in that relationship because if you have someone who is simply interested in how their own organisation can function to the best of its ability that is almost certainly detrimental to the health of the community more broadly because otherwise you are ignoring primary care, social care, local government and all these other things that are such an important part of our social network.

Q. You comment at paragraph 5 "Collaboration" and the importance of collaboration. In circumstances let's take for example clinicians and senior managers where there is competing pressures or may be competing pressures between groups on a day by day or longer basis.

How can effective collaboration be encouraged, how do you achieve this?

A. Yes, I mean, I think you achieve it through human dynamics and a recognition that collaboration is almost always the best, the best route. How can you slightly drive those dynamics, I think that people -- firstly there needs to be a more effective appraisal system and that effective appraisal system of course needs to cover one's professional acumen in whatever profession you are, but it also needs to cover your ability as a leader, I would argue it needs to cover your potential as a leader. I think it needs to cover your interaction with others of all levels so your behaviour, if you like.

And I think it needs to cover your contribution to outputs and organisations beyond your own.

If you start to capture that and reward that, then I think that does have a -- an effect on driving, driving the right behaviours.

One of the -- one of the recommendations which has really struggled to pick up from the review is a mandated mid-career training intervention for not just health professionals but social care professionals, essentially the team at place, bringing them together in a learning environment to understand other people's

sectors also to understand how to collaborate across those sorts of boundaries.

One of the challenges has been of course that involves so many stakeholders, it's been really difficult to pull together a funding mechanism and a syllabus and I think that's a shame.

Q. You speak of appraisal. We heard some evidence yesterday from Mr Jarrold about appraisal who described I think competency, meaning the competency assessments, they are more self-assessments but a proper appraisal involving 360 degrees feedback from colleagues and so on.

Where do you sit on what "appraisal" means?

A. I think I personally think that 360 is -- I don't think one could do that for everyone I think one would need to have a level above which a 360 was mandatory. So I think it's a very good thing because I think that drives an assessment of behaviours that you don't always get from peers or, you know, let's call them well-managed line managers.

So I do think there is something, there is a qualitative aspect to appraisals which I think really needs to come to the fore and be rewarded and to be seen as important.

Q. You gave in your example of a senior leader,

so for example a Chief Executive and a chair of a board might have a very close working relationship, might they, and the appraisal could be different perhaps than if you have the 360 degrees --

A. Exactly.

Q. -- where someone is working in a different context?

A. Having a peer or one person judge it, I mean, there are systems that work like that but I think having recourse to regular if not frequent 360s I think is a really important part of any effective ... and the other piece about the appraisal is that of course it has to be of value to the individual who gets them in terms of pointers for, you know, what they are doing well, where they can improve and I think it also should be used as a value for the organisation as a whole.

So someone's potential is identified, someone's career aspirations are identified, and that means that they can be placed, you know, to the benefit of the system as a whole, whether that be on a regional basis or a national basis would obviously depend on the level we are at.

Q. At paragraph 6 you speak about board governance and you say you would argue that a tighter definition of a board's responsibilities and

accountability should be a central feature of the ongoing NHS work on its new operating model. And you also make a comment about the differentiated governance arrangements for Foundation Trusts. Can you tell us what you think about those?

A. Yes, I feel a bit of a show-off in saying this, of course this is -- but to me, to my understanding, the original rationale for them has long since dissipated and yet they are retained in the system and are governed differently and therefore the authorities that the NHSE has over them differs from those that haven't achieved Foundation Trust status.

That seems to me to be a rather confusing and obfuscating issue when it comes to accountability and directing activity. That was specifically on the Foundation Trusts.

I think I -- the other observation from the review was the, the impact on behaviours more broadly of what, what was essentially set up in 2012 was a competitive system whereby those organisations that were seen to be doing well were given more autonomy, were invested in, had more financial flexibility whilst those that weren't doing so well had the opposite effect and of course the purpose of that was to try and you know, "pour encourager les autres", that the reality was that in too

many cases it actually meant that the best were getting better and the worse were getting worse and regional iniquity and what have you has certainly been exacerbated by -- by that.

It also extended into a behavioural impact. One of the techniques we saw that didn't like was what we call talent hoarding. Well, if you have got in your Trust someone who was very good, almost certainly been there for quite a long time, you didn't want to let them go, so you just essentially hoard them knowing full well, that actually for the benefit of the system as the whole they would be better off, you know, sharing their skills in either more challenged parts of the systems or different types of Trusts so they could build experience which would better prepare them for senior leadership.

So some of that sort of slightly small-mindedness can arise from an overly competitive system and as I said, I think there is some hope that the ICSs and ICBs might help to break those down.

Q. The Messenger Review you tell us refers specifically to the selection procedure for Non-Executive Directors. What are your recommendations there?

A. That rather than essentially the Chair scouting around, I am being slightly pejorative,

scouting around the local area for either people he liked or knew and could encourage to become Non-Execs wasn't the right way to get a diverse capable functioning board and the recommendation was that at the regional level there should be held a pool, a talent pool of future Non-Execs who could be educated, warmed and induced into that role and it would be -- obviously the Chair could and should have a role, a role but not necessarily the singular defining role on who his or her Non-Execs should be but that it would be from that pool that those Non-Execs would come.

Q. With effectively some training or education in advance?

A. With pretraining, prewarming, preinduction but also the ability to pick from a more diverse group of -- of, people and therefore get a better representation around the table.

MS LANGDALE: I see the time, Sir Gordon. It is 3.30 so it might be a good time to stop for the afternoon break.

LADY JUSTICE THIRLWALL: So we will take a break now and we will start again at quarter to 4.

(3.30 pm)

(A short break)

(3.44 pm)

MS LANGDALE: You set out at paragraphs 7 and 8, Sir Gordon, some reviews on senior leadership and developing leadership talent and if we can go to paragraph 9 of your statement, page 4, you refer to the regulation of managers.

What's your view about how managers should be accountable, how do you strengthen accountability, should it be regulation or can it be done in different ways? We have had example of the Code, reference to the Code of Conduct for managers that was of course put together back in 2002 and moved on since then.

But what do you think about how accountability for managers can be strengthened, senior managers?

A. So I realise this has moved on since the review. But at the time and frankly still I -- I would suggest that if one gets the appropriate structures and accreditation with the right level of mandation into the training and the developing of managers that a formal regulatory system is unnecessary and that you get everything you need and that you have a known product that has gone through a known set of -- of training to deliver the skills and the leadership required at any level.

If we go down the route of regulation, my only comment would be that that would -- that regulation

would absolutely need to be accompanied by everything that I have just described: that development, that accredited upskilling which is at the heart of, of regulation rather than it being seen as just a sort of you don't make the cut and so therefore we are going to deal punitively with you.

Q. So get the right people in the first place?

A. So I think there's something about, well, so one of the -- the pieces of work that has come on some way since the review was published is that the definition of the competencies required of managers as they go through their career and it hasn't yet been published but it's very mature and is shortly to be so. And there they identify five waypoints in a manager's career with waypoint 1 being entry and waypoint 5 being preparation for the most senior of roles and lay out what training is required at those points in the career and ensuring that that training is accredited so that it is standardised and that the qualities and skills that one can expect of managers at certain points in their career are more of a known quantity than they are now.

Q. Can we have on the screen INQ0108673 which I think is November 2024, the NHS management and leadership programme and then we see -- cast your eye over that and then at page 2 -- you have seen this

before, have you, what's endeavoured that the programme could achieve --

A. I haven't seen this but I know -- I know of it.

Q. And we see there "Setting the right standards for our leaders and managers", workstream 2, "Developing our leadership and management", and then over the page, "Talent support and career development", reflecting your recommendations 5 and 7.

And have you seen the NHS Leadership Competency Framework for Board Members, have you seen that?

A. I -- I have seen that, yes.

Q. Yes, the Inquiry has seen that as well before so I don't need to take you to that.

So those developments obviously since your review.

We also gave you this morning, Sir Gordon, a reference to a document if we can have that on the screen, please, INQ0108364. I don't know how well it will appear on the screen, we will do our best. But while we are getting it up, this is an Inquiry legal document setting out recommendations made from various Inquiries and whether or not they have been implemented at the time of beginning this Inquiry.

If we go to page 2, we see next to your recommendations an update helpfully provided by DHSC and

NHS England. Have you had an opportunity today when you were waiting to give evidence to have a look --

A. I did.

Q. -- at all that is contained against page 2, 3 and 4. Had you seen that information and were you aware of that information before about what was being done?

A. Some, but not in this -- in this form, I haven't seen -- I mean, I am still engaged with those that are doing the work and I pick up things but I haven't seen it laid out in this way.

Q. I don't want you to go into any detail you don't wish to or aren't prepared to, but in terms of reading it, anything surprised you in that or any comments on any of that?

A. No. And as I say, I -- I continue to work with those including Amanda and Navina at the top of the NHS on taking this forward. It -- it I certainly wouldn't argue with any of the activities that are -- that are laid out there and I certainly wouldn't argue with the intent to improve which, which comes from the very top and is felt at every part of the organisation.

I still think there is a bit of an inertia before these -- this activity manifests itself in progress and delivery and whilst some things are very ready and could -- could be applied now I would, I would pick on

the induction process which is essentially a culture-setting package for all those who join the NHS, that is actually very mature and I would argue very good but it's -- it hasn't yet made it into the domain of the workforce because there are still Ts to be crossed and Is to be dotted.

Q. That is on page 2, the induction framework --

A. Yes.

Q. -- for all new staff. Does that reflect what your --

A. So the work that's been done absolutely reflects it is a sort of culture setting, these are the expectations of you, this is what you should expect of others, this is the -- you know, it explains the system in a way that if this didn't exist people join the NHS without really understanding the totality of the system that they are part of or where it all fits together. So it seeks to do that.

Q. The same document for everyone regardless of where they fit into the NHS?

A. Yes, it is for any new joiner at any stage into the -- into the NHS and it's an online package which I think is very good. But not yet -- but not yet out there. I mean I -- why, why do these things sometimes -- I mean, there are a lot of reasons some of

which I have got -- I have sympathy for. I mean, they are a very busy organisation and priorities keep -- keep coming up the pecking order which knocks other things down.

I -- I do think that there's sometimes a sort of culture in Trusts and organisations that the NHS are just pumping out direction and that is slightly swamping the organisations and because there is quite so much it is very difficult to know how to prioritise your implementation of it. So I think there's that sort of, you know, where do the authorities and the accountabilities sit for this?

I think there is in any hugely complex organisation, and this is a hugely complex organisation, there are always second and third order effects of what one does and therefore if -- if you, you know, are fearful of those then you sometimes don't act as quickly or as stridently as perhaps you should and in an organisation that has so many stakeholders and communities of interest all it takes is a couple to sort of not necessarily see it the same way and those can be blockers for the implementation of what -- what should be far-reaching change.

And the other observation I would have is that they are not by any means the only organisation that I have

seen that do this but they -- you spend 90% of the time on getting the product right and 10% of the time on instilling it in the organisation when the reality is that you should probably reverse those -- those two things and I think partially because of the -- the problems I have outlined at the beginning they are sometimes guilty of perfectly polishing a product only for it to land on an organisation that either isn't ready for it or doesn't buy into it and I think that needs to sort of be more joined up, I think, would be -- would be I hope a constructive observation.

Q. How would you characterise the complexities? You said it is a complex organisation, the NHS. In terms of effecting change, what makes it complex?

A. So I think its, its component parts, it is made up of however many different Trusts, it has a number of arm's-length bodies that we described earlier, it's got a number of regions. I sometimes have struggled to identify the operating model; in other words, who is responsible for -- for divining what and who is responsible for delivering what and where the accountabilities are, I'm not sure they are as clean in every regard as they could be and there is too many, there is too much variation around the system.

I think it is also an organisation that has frankly

too many sort of in-built sort of status and tribal instincts which can be counterproductive to, you know, true teamwork, you know, focus on patient care and productivity as the utmost priorities and I think sometimes they can get in the way of the right amount of collaboration. So it's a hugely complex piece and it must be very hard for those at the very top to -- to want to make something happen and to make it happen.

Q. Can you give us an example of those kinds of instincts that get in the way?

A. In terms of the status and the ...

Q. Yes.

A. I mean --

LADY JUSTICE THIRLWALL: Status and tribal.

A. The tribal things, I mean -- well every, every specialisation of -- every surgical specialisation has its own little tribe. Every Trust has its own team. Every associated medical professional has their own skillset. All these come with bodies that represent them, that often regulate them, that support them and they are not always pulling in the same direction and that can mean that when you are trying to do real cross-cutting change, for example in investing in and prioritising your workforce and how you look after them and value them, that can be really hard to make that

sort of difference when you are faced with that -- that that sort of melting pot of other agendas.

MS LANGDALE: Were you looking at pay scales when you conducted your review, so what people were being paid?

A. No.

Q. How they were paid was not part of that?

A. No.

Q. It is not the only part of how people are valued but it is not an insignificant part of it, is it?

A. It's not, no and it's -- it is one of the challenges when one is trying to get senior clinicians to take on senior management roles, is -- is the pay difference between the non-clinical and the clinical, and some of the clinical staff.

Q. Can we look at page 3 of the document on screen. The Leadership Competency Framework for Board Members in February 2024, we see that was published and designed with six competency domains. Have you seen that?

A. That's the thing I was talking about earlier. I don't think that has been yet, does it say there it has been published?

Q. Yes, I think it has.

A. So the competency that is for board members,

yes, I have seen that. I was thinking about the managerial cohort, the board members.

I have seen it but I am not well versed in it.

Q. Mmm mm.

In terms of progress since you conducted your review if you look at page 4, we see at point 5:

"In line with the NHS England operating framework regional talent and career hubs are being re-established. These will ensure there is a structured approach in place to identify leadership talent and support."

Have you seen anything behind that or looked at that?

A. I have and I am currently engaged in a bit of work by request of the current Secretary of State to, to look at this and to see whether a bit more impetus can be put behind it. So this is very much work in progress because I don't have to report to him until the end of February.

But I would say there's an awful lot of work still to be done to identify a talent management system that is systemic, that, that reaches down into middle management, that identifies and supports people of talent, nurtures that talent, develops it so that it creates a feeder mechanism for senior leadership.

I don't think such a thing exists anywhere to any degree how it needs to be and so, therefore, the sort of selection of those at the very top is not informed by a through career process and mechanism that best prepares people for those positions.

Q. If we look at page 5:

"Work continues to develop the new very senior manager pay framework and this will replace existing guidance for pay for very senior managers and it is in advanced stage of development."

Are you sighted on that at all, Sir Gordon?

A. No.

Q. And also:

"The framework aims to improve consistency and transparency of pay settling processes and will be made publicly available."

That has been an issue, hasn't it, about the visibility or transparency of people moving on and having pay settlements in the NHS?

A. Sorry, just --

Q. You see there at page 5, it's highlighted on the screen.

A. Yes. I -- I wasn't deeply involved in pay and can't comment, I'm afraid.

Q. That can come down then and if we could have

your report on the screen, INQ0002377, page 1. If you can go to page 3 and the fourth paragraph of your foreword, and you say:

"The NHS is itself far from a homogenous, unified organisation but rather a federated ecosystem where complex tribal and status dynamics continue to exist."

A federated ecosystem. Can you just tell us what you mean by that?

A. It was a while ago since I wrote that. I mean, I -- it is -- well, it is essentially governed in a federated manner and the responsibilities and accountabilities of those that run its component parts, ie its Trusts is, is considerable and there is occasionally debate as to the degree to which the central headquarters has the ability to direct activity or process change.

So I think it touches on that point I made earlier about the sort of complexity of the system and the multitude of stakeholders, most of which have a sort of vote as to how fulsomely they, they adopt the processes or how they adapt them to their own organisation and I think that's, you know, it's a -- it's a perennial conundrum with large, complex organisations, is this issue about to what degree do you centralise and to what degree do you decentralise and there are certain

functions that it makes total sense to -- to have the principal point of sort of decision-making and collaboration forward and in place so that the people who are closest to the problem can make the most appropriate decisions.

I suppose my point coming back to the workforce management and the culture setting is that I am of the view that they need to have more organisational, pan-organisational oversight and, and framing than, than they currently do. So I am talking there about the workforce not just seen as being owned by each individual Trust but being seen as, you know, potentially of utility to the system as a whole.

I -- I do think that, that the culture yes, of course individual organisations can have microcosms of their culture, but what we want is a culture where a healthcare worker has the same sort of sets of values, the same understanding of what's expected of have them behaviourally, how they should be treated in the workplace. All those things should be set in stone across the organisation and that requires that cultural set to come from the very top.

Q. From the centre?

A. The centre. The centre, yes. Now, you can -- you can have oversight of that or delivery of that

delegated to the region or whatever. But I think that sort of, you know, setting a culture is an organisational responsibility and, and both looking after your workforce but also ensuring you are getting the most for your workforce for the organisation as a whole is something that I think is a pan-organisational responsibility.

Q. Page 6, please. You say:

"There are many examples of world-class leadership in the NHS. We would observe it often exists through the endeavours of on individual rather than as a consequence of proper talent management."

World-class leadership. Which pockets or where did you see that or what would you highlight there?

A. I mean, I -- I saw -- and here I was talking about middle, middle level leadership but also senior leadership in Trusts doing the most complex of tasks in the most challenging circumstances under huge pressure and doing so consummately.

You know, I have been under a lot of pressure in leadership situations in my career. I would absolutely equate this as as complex as difficult or more than what I have ever had to face in my career and yet I saw people doing it whilst bringing people with them, whilst inspiring others, whilst calming the organisation that

would otherwise be a sort of slightly sort of febrile, febrile mess.

So I have witnessed that both in the guts of these organisations and also at the top.

Q. Page 14.

LADY JUSTICE THIRLWALL: Sorry, just before we move from there, do you mind if I just ask a supplementary on that. So you have obviously got a very clear memory of those experiences. I think you said at the beginning middle management, but I just want to be clear in my own mind, what sort of hospitals are we talking about?

A. We are talking about an acute Trust.

LADY JUSTICE THIRLWALL: Acute Trust. Yes, and in what part of the country?

A. The North.

LADY JUSTICE THIRLWALL: The North; north of here or -- it's just that "the North" differs depending on where you are from.

A. I would say east of here.

LADY JUSTICE THIRLWALL: Right, okay.

Presumably the hospitals that you are talking about, these are known about to NHS England? You will have discussed --

A. Yes.

LADY JUSTICE THIRLWALL: -- and identified them?

A. Yes.

LADY JUSTICE THIRLWALL: I understand your reticence about identifying them here, but we can see whether we need to do that or not.

A. Yes. I think --

LADY JUSTICE THIRLWALL: It is something that I am very interested in.

A. Forgive me, my Lady. The -- the leadership of the NHS have a good idea of who their very, very good --

LADY JUSTICE THIRLWALL: Who their best people are?

A. -- senior, senior leaders are.

LADY JUSTICE THIRLWALL: Yes.

A. I don't think that they have the sight of the feeder system that's going to provide the next, the next generation.

LADY JUSTICE THIRLWALL: Thank you, and how many places were you able to visit where you felt that was the quality of the leadership? I appreciate this was Covid so you might not have --

A. Yes. I would say two or three.

LADY JUSTICE THIRLWALL: Yes, thank you. And we have asked NHS England to identify some, so it's interesting to hear it from your perspective as well. Thank you.

Sorry, Ms Langdale.

MS LANGDALE: Page 14, third paragraph:

"We found that management tends not to be perceived, formally or informally, as a professional activity. Management lacks the status enjoyed by the established professions in health and social care."

Can you expand on that for us, please?

A. Yes.

Q. And was that patchy or consistent?

A. No, I thought this was a really consistent feedback from the sort of non-clinical leaders, the managerial cohort who all, without fail, had leadership responsibilities too and it stems from this idea that they don't have that structure to their competencies and their, their upskilling. And that has an effect on -- it means sometimes that some below par individuals can find themselves in places because there is no way to mitigate that really and that can have an effect on the sort of status or reputation of managers more broadly.

Q. Why is there no way to mitigate that? Why do you say there was no way to mitigate that? Because of employment law or --

A. Well, because -- because you don't have that central sort of oversight. Sometimes individuals are moved either because there's a line manager who's worked with them before or because they don't particularly like

the environment they are in at the moment and so they refuse to go and all those things are valid reasons to move people around, but it's not done in a systemic way.

I think the reason why the sort of the status issue is that, you know, they work everyday with clinical professions who have obviously very strong professional qualifications, have revalidation criteria and are sort of, you know, regulated and, and therefore they have those sort of the standards inbuilt into their profession in the way that wasn't the case for managers.

I hope that this, the new work that we have discussed previously, will, will bring them that structure and that sort of mandated competencies at various levels in their career and that that will have a commensurate effect on how they feel about their profession because, as I hope I have made clear elsewhere, it's an absolutely necessary profession and there are many fine people delivering it.

Q. You say at the end of that paragraph:

"Management can therefore appear as an undervalued career rather than one at the very heart of great care."

Do you think it's under-respected as well as undervalued?

A. Yes, I think it can be, and I think it's, it's partially because it has sometimes a reputation of just

being a sort of, you know, a -- a, you know, delivering process when actually, you know, every manager has to lead people, has to manage processes and systems, has to manage resources. It's a, you know -- every complex system requires managers to run it.

Q. Do you think there should be a clear and robust mechanism for removal of individuals who fail to demonstrate the required skills and ability to fulfil the role into which they have been recruited?

A. Yes. But at the moment, because there is no structure to ensure that individuals have the right skills and experience, it's a bit unfair if they get sort of removed without having them by mandating these competencies. Then what you're doing is creating a standard and if someone doesn't meet that standard then it's right that they should be, be moved. But at the moment, without those standards being fixed enough, it can be quite an unfair conversation.

Q. Wider observations, page 16. Regulation and oversight. At the bottom, you say:

"The role of the professional regulators (GMC, Nursing and Midwifery Council and others) relates primarily to individuals but is increasingly important in assuring organisational quality. To ensure better read-across to professional standards we would promote

collaboration across all regulators in developing the management standards and the training materials for managers."

Did you have any consultation with the regulators about this or was this talking to clinicians and nurses, et cetera, that led you to this?

A. Both. Both. So we did and actually in fairness to both the GMC and NMC received very little pushback from, from this. One of the key conversations we had with them was: How does one include more leadership development in a standard clinical career including at graduate entry? How, you know, a junior doctor, a newly-qualified nurse needs to display leadership qualities from Day 1.

There is, and certainly was at the time, an inadequate component of, of both leadership in initial training and an inadequate component of I would describe as organisational awareness. So that too often people were leaving medical training or nursing training or graduate managerial entry training, which is the only sort of standardised managerial entry scheme, being put into the workplace without really a sense of the context in which they were working and without any real exposure to the leadership demands upon them. So that was it.

The other thing from a clinical perspective was we

expect our clinicians to go to jobs like clinical directors and medical directors and others which are very strong leadership roles. We would like to see more clinicians of all sorts act as CEOs of Trusts, but again there is no -- unless an individual is specifically interested in this, and many are and can go hunting for opportunities and for training, there isn't anything that is sort of standardised or expected of a clinician. Most of their sort of professional stepping stones are professional rather than broader leadership and managerial skills.

Q. Page 17, third paragraph under the heading "Clinical leadership", you say:

"Senior nurses talked about going to the dark side as a comment often made when they moved into senior management roles, although nurse post-graduate training does provide elements of management learning. Again the approach was felt to be ad hoc and inconsistent."

Going to the dark side. What do you -- did you make of that or --

A. That's the same point as the sort of the status if you like of managers. Managers being seen as, you know, slightly sort of bureaucratic, brakes on the system rather than, you know, essential facilitators of it. So I think that that point is really about the

perception of managers, which I -- I don't believe is fair or accurate in the main.

Q. In the main. So what's the reality of management?

A. So I think the reality of management is that they are an essential part of the system because -- and the more complex a system, the more they are required to be part of it; that they are not universally given the tools that they need to deliver the roles that they are expected to perform.

Now, some are extremely well monitored, extremely well trained by the Trusts that they join and -- but that is not, that is not consistent across the board and because it's not consistent across the board some of them feel sort of slightly undervalued by the system, and that becomes slightly self, self-fulfilling I think.

Q. Just so we understand, Sir Gordon. In terms of your recommendations, what involvement do you have on an ongoing basis, if any, in terms of those recommendations?

A. Informal only in that I made a number of sort of friendships by doing it and I, you know, lock-in with individuals that continue to do it and obviously ask about how it's going. So it's not, it's not a formal relationship.

Q. No. But obviously you have spent the time doing it and you are interested presumably to know what happens with them?

A. Yes and, and, you know, but because I -- I feel it's important. I mean, I -- I would've hated to have produced a review that was seen as sort of super critical of individuals or the workforce. I would like to think that we produced a review that was positive and supportive and played with many of the themes that people on the frontline talk about every day.

Q. In terms of the pace of the implementation, have you got any comment about that, you have read the table and you have -- what do you think about that?

A. I -- I go back to that comment about sort of the reasons I gave for, you know, what could be seen as inertia some of which are valid, some of which are perhaps a little bit sort of cultural and I have seen the same in I -- have seen the same in defence, another big, complex organisation. It's really hard to make sort of sweeping changes.

But what, what I think the review was trying to get over and what I'm trying to get over is that, that of course patient care is the key priority and that consistently chasing after the best patient care is of course something that we have to do. But currently, we

seem to be throwing more and more footballs on to the pitch for the workforce to chase after, which I'm not sure is having the desired effect on the workforce -- on the patient safety.

And in many ways you could turn that around and say that the best route to patient safety is a well led, well motivated, valued, collaborative resilient workforce and if you had that, then a lot of, a lot of those footballs that you feel the need to throw onto the pitch to chase would be self-erased by the fact that you have the right workforce cultures and the right collaborative instincts where they are needed.

And that, that's quite a bold shout because that's quite a, that's quite a big cultural shift and it might mean taking some risk in certain areas.

But to my mind if, if -- if we don't take that risk then the risks to patient safety inexorably increase because of the number of footballs that are on the pitch that need to be, that need to be chased after if that isn't mixing too many metaphors.

MS LANGDALE: Thank you. Those are my questions, Sir Gordon. I am going to scan the room to see if there are any others and I don't think there are.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Can I just follow up on

the last point, if I may, the idea of turning things around and instead of assuming that first of all you look at patient care and then you look at all the things that support it to look at team building, et cetera, all the things that you just outlined.

And I just wondered you have told us that there is in development, ready to go, a new induction process which, as I understand it, will incorporate all of these very important aspects of the way people will conduct themselves, the culture of the organisation, the understanding of the organisation, the importance of each person, team building; all the things that no one could possibly disagree with all of which are a good idea.

So there are two things: firstly, when are we going to get it and that is something we can ask others. I mean you have indicated how close to ready it is.

But the thing I was wondering was why would you not introduce that to everyone who's already there, so it's not just an induction thing but: Look, everybody, this is what we are saying to the new starters, this is how it should be.

I know it's probably not rocket science but what about that as a possibility?

A. That's exactly what I said when I saw it.

This isn't just about, you know, using that opportunity when everyone joins because the one thing that everyone in the NHS has in common is that they all joint it, so why don't we make the most -- so it's making the most of that moment.

But you are absolutely right. When you look at it, this is -- it's, it's trying to set a cultural blueprint for the organisation as a whole, whether you have been in it for decades or whether you have just joined, and I think that's exactly how it should and will go.

LADY JUSTICE THIRLWALL: Just thinking about the workforce to use that description at the moment.

What one hears -- I don't mean necessarily in the Inquiry because we have not been looking at the post-pandemic phase other than in a very limited way -- but these are people who have worked extraordinarily hard under huge pressure over a number of years and have come out of the pandemic, insofar as they have come out of it, and one reads about exhaustion, being demoralised and all of those things.

Do you have any thoughts about how the current leadership of the NHS, as you would wish to define it, you know, what is it that can be done to make people feel better in order that when they are asked to well, let's look at this induction, they say: Actually,

that's a really good idea?

A. Yes, I think it -- it's really hard and I have huge respect and, you know, admiration and a degree of sympathy for those who, who are in those, in those positions.

But I do think that -- I mean, there's a very well-known leadership model which says that a leader needs to divide his or her time between the task in hand, building the team that delivers that task and looking after the individuals within that team and there are three concentric circles and of course you can veer towards one at a time of crisis, but if you spend too long focusing unduly on one and to your point, my Lady, the NHS has been task-focused and has been driven towards a task for many, many years now to the detriment of the team and to the, and to the individuals within it then the bit of that suffers the most ultimately is the task.

And it goes back to that point about unless we sort of step back and start thinking about that sort of collective instinct, that team, that -- collaborative instincts and start looking after and valuing our people more, then the task will suffer.

And I think how to do that whilst one has the targets one has, when it has the, the reality in the

hospitals on a day-to-day basis is a really, really hard, hard thing to do and may or may not need the foot taken off the gas on the task. But from a longer-term perspective, when one sees the inexorable sort of reduction in quality that I think everyone would accept is happening because of the pressure, then I think my, my proposal would be that the only way to reverse that is to take that step back and focus on the people that are going to deliver it for you in the longer term.

LADY JUSTICE THIRLWALL: Thank you. You were asked some questions by Ms Langdale about how managers are regarded and you dealt with the example of below par people being in situ and how difficult that could be and you talked about status and you identified that, for example, the doctors and nurses, you know, they have a clinical qualification and they then can revalidate and they have training as well in relation to their medical area of expertise and that's not the same insofar as managers are concerned.

But at the same time I think I read, well, I know I read in your report that there is a graduate scheme for recruiting managers and I wondered; the description you gave didn't really address the level at which people come in as managers and what their background is, what their qualifications are and the reference to the

graduate training scheme seemed to be that that's something that works well and the reason I think it was mentioned was to say, well, it's sort of treated as an elite and that's not really fair on anybody else.

But leaving aside the fairness point, in terms of what the organisation wants, presumably it does want people who can come in on that elite scheme and it may be -- I mean, is what's necessary to ensure that those who come in via another route, and there will always be other routes, and people who, for whatever reason, are shining later than others did, you want to get those as well. But you don't get that, do you, by just saying, "We don't want to be unfair." You have got to develop them, haven't you, bring them in?

A. And I think that's, that's a very live debate.

So there is the conversation about whether or not to enlarge the graduate management training scheme. I think as you say, my Lady, it's absolutely accepted that not everyone is going to come through that route. There are plenty of other routes.

I think -- and I think that it's a really difficult thing to get, to get right. To me, the key is that when you join, however you join, if you feel that the sort of, you know, there is a organisational arm around your shoulder --

LADY JUSTICE THIRLWALL: Yes.

A. -- and that you're embarking on a profession that matters a great deal to the organisation and to the, and to the outputs of the organisation you join and to patient safety and to the health of the nation and you are able to feel that and you have that sense of purpose -- and that would have to be delegated down to the organisations that they join, but that's not by any means impossible -- then I think you will get a much greater sort of output and sense of value from, from that community. And I think the question of whether the -- I think that that's a live debate as to how --

LADY JUSTICE THIRLWALL: Sure.

A. -- how large the intake should be for a graduate management scheme.

LADY JUSTICE THIRLWALL: Thank you. One of the other points you made rather vividly was the idea that people within the NHS are the recipients from a pipeline which just pumps out stuff, directives.

I think I am probably entitled to infer from that that it wouldn't be a bad thing if the number of things reduced that people were having to dealing with.

While you consider whether I am reasonable in making that inference, we had some very compelling evidence from Professor Dixon-Woods, I don't know if you

have had a chance to look at that or would be interested in it, but she talked about a "priority thicket" that people in the NHS are having to deal with. There are so many priorities, where do you start? So much stuff coming at you, how do you decide what to do?

I mean, is there something to be said for culling the amount of stuff that comes to the people who are trying to get on with the job?

A. As someone who doesn't receive it, it would be hard for me to reply to that authoritatively other than to say that there is a lot I heard from a lot of people that they felt that priority thicket and of course if everything matters then, then nothing matters.

LADY JUSTICE THIRLWALL: Yes.

A. My -- I'm -- you will have to believe me, I am not one of these sort of ex-generals who thinks that all you have to do is apply a military solution to it, but there is, there is a phrase we use in the military called "mission command" and how one gets one's sort of intent and direction down through the system and it's all about -- the orders that are passed are all about what it is that we want to achieve, what is the outcome that we want rather than: I want you to do this, this, this, this and this in a ...

And actually for many of the sort of day-to-day

operational and financial issues that I know place and Trusts deal with on a -- it's, I can see that being -- I'm conscious that I could be being critical of an organisation and a process that I don't live and breathe on a daily basis, but my instincts are that being a little bit more selective and to utilise the sort of concept, if not the language, of mission command would be welcome on the sort of frontline.

LADY JUSTICE THIRLWALL: Thank you.

Thank you. You have dealt with all the points that I wanted to raise with you, thank you.

Would anybody else like to ask any questions the time notwithstanding?

MS LANGDALE: No. My Lady.

LADY JUSTICE THIRLWALL: Thank you very much indeed, Sir Gordon, for giving your evidence and you are now free to go. Thank you.

I think we have an early start tomorrow, have we?

MS LANGDALE: 9.30.

LADY JUSTICE THIRLWALL: Yes, thank you. Just keeping you on your toes, Ms Langdale.

Thank you all very much. We will see you all tomorrow at 9.30.

(4.33 pm)

(The Inquiry adjourned until 9.30 am,

on Thursday, 9 January 2025)

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